MEDICAL MUTUAL®

CAROLINA CARE PLAN | CONSUMERS LIFE

Focus on Healthcare Reform

AFFORDABLE CARE ACT MANDATES SUMMARY

Updated April 29, 2013

This document contains a high-level summary of the Affordable Care Act (ACA) mandates going into effect in 2013 and 2014.

The table of contents on the next page includes a link to each topic and is followed by market segment charts (for Individuals, Small Group – 2-50, Small Group – 51-99, Large Group – 100+) showing which mandates apply to each market segment. The charts also include links to each applicable mandate summary.

Please use this document as a reference tool as you work with your customers.

Note: This document will be updated as regulations are finalized and additional information is provided by the federal government. Please refer to the revision date on the cover to ensure you have the most up-to-date version.

Links to the AHIP website require a username and password on ahip.org.

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GF = Grandfathered Plans **NGF = Non-Grandfathered Plans**

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ACA Provisions for Small Group Plans (2–50 Employees)

	Effective		Fully Insured		Self-Insured	
	Date	Term	GF	NGF	GF	NGF
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Employers Provide Notice of Coverage Options	TBD	Calendar	■	■	■	■
Essential Health Benefits	1/1/14	Plan		■		■
Exchanges (American Health Benefit Exchanges)	1/1/14	Calendar		■		■
Guaranteed Issue and Guaranteed Renewability	1/1/14	Plan	■	■	■	■
Lifetime Dollar Limits Eliminated	9/1/10	Plan	■	■	■	■
Market Share Fee	1/1/14	Calendar	■	■		■
Medical Loss Ratio	1/1/11	Calendar	■	■		■
Medicare Tax Withholding	1/1/13	Calendar	■	■	■	■
Modified Community Rating or Adjusted Community Rating (ACR)	1/1/14	Calendar		■		■
Nondiscrimination Based on Health Status	1/1/14	Plan		■		■
Patient-Centered Outcomes Research Institute (PCORI) Fee	9/30/12	Plan	■	■	■	■
Preexisting Health Conditions Coverage	1/1/14	Plan	■	■	■	■
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Summary of Benefits and Coverage and Notices of Material Modification	9/23/12	Plan	■	■	■	■
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GF = Grandfathered Plans **NGF = Non-Grandfathered Plans**

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ACA Provisions for Small Group Plans (51–99 Employees)

	Effective		Fully Insured		Self-Insured	
	Date	Term	GF	NGF	GF	NGF
Applicable Provisions						
Annual Dollar Limits Eliminated	1/1/14	Plan	■	■	■	■
Clinical Trials Coverage	1/1/14	Plan		■		■
Contribution Amounts for Health Flexible Spending Accounts (FSAs)	1/1/13	Plan	■	■	■	■
Dependent Age Limit Increased to Age 26	9/23/10	Plan	■	■	■	■
Employer Shared Responsibility ("Pay or Play" Mandate)	1/1/14	Calendar	■	■	■	■
Employers Provide Notice of Coverage Options	TBD	Calendar	■	■	■	■
Guaranteed Issue and Guaranteed Renewability	1/1/14	Plan	■	■		
Lifetime Dollar Limits Eliminated	9/1/10	Plan	■	■	■	■
Market Share Fee	1/1/14	Calendar	■	■		
Medical Loss Ratio	1/1/11	Calendar	■	■		
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GF = Grandfathered Plans **NGF = Non-Grandfathered Plans**

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ACA Provisions for Large Group Plans (100+ Employees)

	Effective		Fully Insured		Self-Insured	
	Date	Term	GF	NGF	GF	NGF
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Guaranteed Issue and Guaranteed Renewability	1/1/14	Plan	■	■		
Lifetime Dollar Limits Eliminated	9/1/10	Plan	■	■	■	■
Market Share Fee	1/1/14	Calendar	■	■		
Medical Loss Ratio	1/1/11	Calendar	■	■		
Medicare Tax Withholding	1/1/13	Calendar	■	■	■	■
Minimum Value	1/1/14	Calendar	■	■		
Nondiscrimination Based on Health Status	1/1/14	Plan		■		■
Patient-Centered Outcomes Research Institute (PCORI) Fee	9/30/12	Plan	■	■	■	■
Preexisting Health Conditions Coverage	1/1/14	Plan	■	■	■	■
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GF = Grandfathered Plans **NGF = Non-Grandfathered Plans**

Annual Dollar Limits Eliminated

No plan may impose an annual dollar limit on Essential Health Benefits (EHB) for any member for plan years beginning on or after January 1, 2014. The only exceptions involve "restricted" annual dollar limits for EHB for plan years beginning before January 1, 2014. The regulations allowed gradually increasing annual limits ($750,000 for plan year 2011, $1.25 million for plan year 2012, $2 million for plan year 2013) until the limits are eliminated completely in 2014. Nothing restricts the use of annual dollar limits for covered benefits that are not EHB.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Gradually increasing annual limits for plan years 2011-2013; annual limits eliminated for EHB beginning with plan years on or after January 1, 2014.

Additional information:
Excludes: Grandfathered individual policies, health FSAs, health reimbursement arrangements/accounts (HRAs) and medical savings accounts (MSAs)

Affordable Care Act: Section 2711 of H.R. 3590 (the Patient Protection and Affordable Care Act, or PPACA) and Section 2301 of H.R. 4872 (the Health Care Education and Reconciliation Act, or HCERA)
Interim Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf
CCIIO: http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html
Federal Register: https://www.federalregister.gov/articles/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual#h-11

Clinical Trials Coverage

The Affordable Care Act (ACA) prohibits health plans from:

- Prohibiting "qualified individuals" from participating in an approved clinical trial
- Denying, limiting or placing conditions on the coverage of routine patient costs associated with participating in an approved clinical trial
- Discriminating against "qualified individuals" on the basis of their participation in approved clinical trials

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan years beginning on or after January 1, 2014

Additional information:
For purposes of this provision, the ACA defines a "qualified individual" as an individual who is eligible to participate in an approved clinical trial for treatment of cancer or other life-threatening disease or condition, and who either has a referring healthcare provider who has concluded the individual's

participation is appropriate, or who provides medical and scientific information establishing that participation in a clinical trial would be appropriate.

Public Health Services Act Section 2709:
http://www.naic.org/documents/index_health_reform_general_ppaca_ins_provs.pdf
http://www.accc-cancer.org/advocacy/pdf/PPACA-Coverage-for-Approved-Clinical-Trials.pdf

Contribution Amounts for Health Flexible Spending Accounts (FSAs)

The maximum amount an employee can contribute to a health FSA on a pre-tax basis cannot exceed $2,500 per taxable year (this amount is indexed for cost of living adjustments for plan years beginning after December 31, 2013). While the reduced limit is effective January 1, 2013 (or the first day of the plan year beginning on or after January 1, 2013, for plans with non-calendar years), employers have until December 31, 2014, to adopt amendments to reflect this reduced limit.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF*
☒ FI; ☒ SI
*Applies to health FSAs when offered under a cafeteria plan.

Effective date: Plan years on or after January 1, 2013

Additional information:
IRS bulletins:
http://www.irs.gov/irb/2012-26_IRB/ar09.html ($2,500 limit)
http://www.irs.gov/pub/irs-drop/n-12-40.pdf ($2,500 limit)
http://www.irs.gov/pub/irs-drop/n-10-59.pdf (over-the-counter drugs)

Cost-Sharing Subsidies

Low- and moderate-income families that don't have access to affordable employer-sponsored insurance will qualify for sliding-scale tax credits to help them purchase Qualified Health Plans (QHPs). These tax credits, available starting in 2014, will lower the cost of premiums and cost sharing for coverage individuals and families purchase through an Exchange.

Applies to: ☒ I*: ☒ GF; ☒ NGF
☐ 2-50; ☐ 51-99; ☐ LG*: ☐ GF; ☐ NGF
☒ FI; ☐ SI
***United States citizens and legal residents in families whose household incomes are between 138 percent and 400 percent of the federal poverty level (FPL) are eligible for the subsidies.

Effective date: January 1, 2014

Additional information:
a) Individuals eligible for public coverage (i.e., Medicaid, Medicare, state Children's Health Insurance Program) are not eligible for premium assistance in the Exchanges.

b) In states without expanded Medicaid coverage, individuals with incomes less than 100 percent of FPL will not be eligible for Exchange subsidies, while those with incomes between 100 percent and 400 percent of FPL will be eligible.
c) Under the Final Rule, insurers are required to provide the cost-sharing reductions at the point-of-service. This means that an individual who is eligible for cost-sharing reductions will only be required to pay the lower amounts under the applicable Silver plan. Insurers will be reimbursed directly by the Department of Health and Human Services for cost-sharing reductions.

IRS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02136.pdf

Dependent Age Limit Increased to Age 26

The Affordable Care Act (ACA) allows children to remain on their parent's health plan up to age 26, regardless of whether they are:

- Living with their parent(s)
- A dependent on a parent's tax return
- A student or employed
- Married

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan or policy years beginning on or after September 23, 2010

Additional information:

The requirement to extend coverage to dependents up to age 26 provides transitional relief for adult children who were denied or lost coverage prior to age 26. Dependents enrolling in a parent's plan cannot be required to pay more than "similarly situated individuals."

- Eligible adult children wishing to take advantage of the new coverage will be included in the parent's family policy.
- Children who are eligible but have COBRA continuation coverage must be allowed to attain coverage as a dependent of an active employee.
- If the parent's plan has more than one benefit option, the dependent must be able to choose from the various options.

This requirement applies to all plans in the individual market and to group plans created after March 23, 2010 (the date the ACA was enacted). For employer plans that were in existence prior to March 23, 2010 (i.e., grandfathered plans), young adults can qualify for dependent coverage only if they are not eligible for their own employment-based health insurance plan until 2014.

- Beginning with plan years on or after January 1, 2014, young adults can choose to stay on their parent's health plan until age 26, even if they are eligible for their own employer-sponsored insurance plan.
- Prior to January 1, 2014, the ACA does not require a plan or issuer to offer dependent coverage; however, if coverage is offered, it must be extended to young adults up to age 26. On or after January 1, 2014, groups with 50 or more full-time equivalent employees must offer coverage to

dependents up to age 26 or the employer will pay a "shared employer responsibility penalty" for not offering the coverage.

Ohio law allows an unmarried, dependent child who is an Ohio resident or a full-time student to remain on a parent's plan up to age 28, or regardless of age if the adult child is incapable of being employed due to disability. For a child to qualify as a dependent in Ohio, the child must be related to the parent (for example, children, stepchildren and descendants, such as grandchildren). The dependent child must also live with the policyholder for six or more months each year and be under the age of 19. If the child is enrolled in school full-time, he or she can qualify for coverage as a dependent until age 28.

- As part of the state of Ohio budget that was passed in July 2009 and became effective in October 2009, insurers, Multiple Employer Welfare Arrangements (MEWAs) and public employee benefit plans had to offer parents the opportunity to purchase coverage for their children up to age 28. This mandate was effective for plan years beginning on or after July 1, 2010, but does not apply to self-insured employer plans.

AHIP Summary: Highlights of Key Provisions of the Interim Final Rule on the PPACA Extension of Dependent Coverage (up to age 26) (June 15, 2010)
State law vs. federal law chart:
http://insurance.ohio.gov/Consumer/Documents/Dependent%20Age%20Coverage%20Expansion%20state%20vs%20federal%20chart.pdf

Employer Shared Responsibility, or "Pay or Play" Mandate

Beginning January 1, 2014*, applicable large employers (i.e., those that employ, on average, at least 50 or more full-time employees, including full-time equivalent employees) must pay an assessment if either:

- The employer (1) fails to offer at least 95 percent of its full-time employees (and their dependents if dependent coverage is offered by the employer) coverage that is affordable and meets Minimum Value requirement under an employer-sponsored health plan and (2) any full-time employee receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange, or
- The employer does offer healthcare coverage to full-time employees and dependents under an employer-sponsored plan but one or more full-time employees purchases coverage through an Exchange and receives a premium tax credit or cost-sharing reduction because the employer's coverage is either unaffordable or fails to provide minimum value.

*Note: The proposed regulations provide transition relief for applicable large employers with fiscal year plans. The relief allows non-calendar year plans to avoid penalties for months prior to the first day of their 2014 plan year, but only if coverage that is both affordable and provides minimum value is offered to full-time employees starting no later than the first day of the 2014 plan year. To be eligible for transition relief, an employer must have used the non-calendar fiscal plan year on or before December 27, 2012.

Applies to: ☐ I: ☐ GF; ☐ NGF
☐ 2-50; ☒ 51-99; ☒ LG*: ☒ GF; ☒ NGF
☒ FI; ☒ SI

*****Employers must evaluate their responsibility under this mandate each year to determine if they will be considered an applicable large employer for the next year based on their current number of employees.

Effective date: January 1, 2014

Additional information:
As defined by the statute, employees are full time if they average at least 30 hours of service per week. A total of 130 hours of service in a calendar month is treated as the equivalent of at least 30 hours of service per week as long as an employer applies this standard to its employees on a reasonable and consistent basis.

Beginning in 2014, an applicable large employer is subject the following penalties:

- The "**Pay or Play" Penalty** (also referred to as the Sledgehammer Penalty)**:** An employer who has more than 50 full-time (or full-time equivalent) employees and does not offer healthcare benefits will be assessed a penalty if just one employee obtains a subsidy and coverage on an Exchange. The penalty is **$2,000 annually** per full-time employee (excluding the first 30 employees).
  - For example, an employer with 75 full-time employees could pay a penalty of $90,000 (75 employees – the first 30 employees = 45 employees x $2,000 each)

- The "**Pay and Play" Penalty** (also referred to as the Tack-Hammer Penalty): Even if an employer offers healthcare benefits, a penalty may be assessed if those benefits are not "affordable" and do not meet the Minimum Value requirement. This penalty will be assessed when just one employee obtains a subsidy and coverage on an Exchange. The penalty is **$3,000 annually** per full-time employee who receives a subsidy, but is capped at the amount the employer would be penalized if it did not offer coverage at all.

If an employer does not offer coverage or offers Single coverage that is not affordable or does not meet Minimum Value, an employee will be able to access cost-sharing subsidies and premium tax credits to apply towards coverage purchased on an Exchange if his or her household income is between 100 and 400 percent of the federal poverty level.

An employer can determine the affordability threshold based on self-only (Single) coverage. Employers have available three safe harbors (Rate of Pay, Federal Poverty Line, Form W-2) to use to determine affordability based on an individual employee's income. Coverage is deemed "unaffordable" when the employee's share of the premium exceeds 9.5 percent of the employee's household income.

It is possible that Family coverage will not be affordable for an employee under this rule; however, the employee will *not* be eligible for Exchange premium tax credits or cost-sharing subsidies if Single coverage is affordable under the rules.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
IRS Proposed Regulation: http://www.irs.gov/pub/newsroom/reg-138006-12.pdf
IRS Q&A: Employer Shared Responsibility Provisions Under the Affordable Care Act
AHIP Summary: Summary of the Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage (January 4, 2013)

For additional AHIP guidance, visit http://www.ahip.org/Employer-Coverage/ (AHIP username and password required)

Employers Provide Notice of Coverage Options (Delayed)

On January 24, 2013, the Department of Labor (DOL) issued an update of Frequently Asked Questions stating the March 1, 2013, deadline for employers to provide notice of the Exchanges will be delayed. The DOL expects the new deadline will likely be in late summer or fall 2013 to coordinate with the open enrollment period for the Exchanges. The DOL is expected to continue issuing guidance about the notice requirement and to provide adequate time for employers to comply.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF*
☒ FI; ☒ SI
*All group health plans subject to the Fair Labor Standards Act (FLSA)

Effective date: To be determined

Additional information:
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf
Correction: http://www.gpo.gov/fdsys/pkg/FR-2012-05-29/pdf/2012-12914.pdf
Employers can find more information about the delay at www.dol.gov/ebsa/faqs/faq-aca11.html
For additional AHIP guidance, visit http://www.ahip.org/Exchanges/ (AHIP username and password required)

Enrollment Rules

See: Open and Special Enrollment Periods in the Individual Market

Essential Health Benefits

The Affordable Care Act (ACA) defined 10 broad categories of Essential Health Benefits (EHB) that insurers must include when developing Qualified Health Plans (QHPs) for sale to Individual and Small Group (2-50) fully insured plans on and off the Exchanges. Each state must decide how the following categories will be defined into specific benefit packages:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric services, including oral and vision care (to age 19)

The implementation of EHB may not discriminate based on an individual's age, expected length of life, present or predicted disability, quality of life or other health conditions.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☒ NGF*
☒ FI; ☐ SI
*Self-insured plans and large group plans—unless they enter the Exchanges in 2017—are exempt from this requirement.

Effective date: First day of the first plan year on or after January 1, 2014

Additional information:

a) Benchmark plans:
- Each state must choose a benchmark plan from:
  - The plan with the largest enrollment for any of the three largest products in the state's Small Group market
  - One of the state's three largest state employee plans
  - One of the three largest Federal Employee Health Benefit Plan (FEHBP) options
  - The state's largest non-Medicaid HMO
- A state's benchmark plan must be supplemented if it lacks services in any of the 10 EHB categories that are not otherwise covered by the plan. It should be noted that habilitative services are not typically covered by these small group plans and will be added at the state level. An example of a habilitative service is coverage for autism services.
- If a state doesn't select a benchmark, the automatic default plan is the plan with the largest enrollment for any of the three largest small group insurance products in the state's Small Group market.
- The vast majority of state EHB benchmark plans (46 states, including Washington, DC) are based on one of the three largest small group plans in the particular state. This regulatory approach and benchmark selection will apply for at least the 2014 and 2015 benefit years.

b) Index rate:
- Once each plan year (Group market) or policy year (Individual market), issuers must establish an index rate for each state risk pool based on the total combined claims costs for providing EHB in the pool.
- The index rate will be adjusted on a market-wide basis. Adjustments will also be made due to the risk adjustment and reinsurance programs.

c) Cost sharing:
- The out-of-pocket limits on cost sharing are $6,400 Single / $12,800 Family and apply to all EHB offered by a group. If a large group offers some or all EHB, the EHB it covers are subject to the out-of-pocket maximum.
- Only cost sharing for in-network services will count toward the out-of-pocket limits and annual deductible limits; cost sharing for services provided outside of a plan's provider network will not count toward the out-of-pocket limit.

d) Actuarial value:
- New plans will be labeled as bronze, silver, gold and platinum, demonstrating the actuarial value of the plan (the percentage of costs covered by the plan rather than the enrollee for a typical population):
  - Bronze: 60 percent of actuarial value

  - Silver: 70 percent of actuarial value
  - Gold: 80 percent of actuarial value
  - Platinum: 90 percent of actuarial value
- EHB actuarial value will be calculated based on an AV calculator developed and made available by the Department of Health and Human Services.

e) Stand-alone dental plans:
- Stand-alone dental plans sold on an Exchange must demonstrate they offer the pediatric dental EHB at either
  - A low-level of coverage with an actuarial value of 70 percent, or
  - A high-level of coverage with an actuarial value of 85 percent
- If an individual purchases certified stand-alone dental coverage off the Exchange, he or she is already covered by the same pediatric dental benefit that is part of EHB, and the issuer will not need to include the benefit in its QHP.

f) Exempt plans:
- Exempt plans (i.e., grandfathered plans, large group plans) that include any EHB must remove the annual dollar and lifetime dollar limits for those services.
- Individual grandfathered plans must remove lifetime dollar limits but not annual dollar limits.
- On or after January 1, 2017, if a large group joins the state Exchanges and purchases a QHP, the group must follow all QHP rules, including cost-sharing limits.

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf
AHIP Summary: Summary of HHS Final Rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation under the Affordable Care Act (ACA) (February 20, 2013)
For additional AHIP guidance, visit http://www.ahip.org/Essential-Benefits/ (AHIP username and password required)

Exchanges (Health Insurance Marketplaces and Small Business Health Options Program)
Beginning January 1, 2014, individuals who don't have healthcare coverage, employees not offered healthcare coverage by their employer, or U.S. citizens who don't have healthcare coverage that meets the affordability and Minimum Value requirements of the Affordable Care Act (ACA), will be able to purchase healthcare coverage on their state's Exchange. Exchanges will be tightly regulated online healthcare marketplaces created for the sale of coverage to qualified individuals (Health Insurance Marketplaces) and small groups (Small Business Health Options Programs, or SHOP), as defined by the respective state.

Minimum Value means that the plan's share of total allowed costs of benefits provided under the plan is no less than 60 percent (sometimes referred to as actuarial value). Coverage is deemed "affordable" if an employee's contribution for coverage does not exceed 9.5 percent of household income.

Applies to: ☒ I: ☐ GF; ☒ NGF*
☒ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☒ NGF*
☒ FI; ☐ SI
*All individuals and members of groups who don't have or are not offered healthcare coverage, or who don't have healthcare coverage that meets the ACA affordability and Minimum Value requirements.

Effective date: January 1, 2014

Additional information:
The Exchanges are established as of January 1, 2014, for the Individual and Small Group (2-50) markets. The Individual market Exchange is referred to as the Health Insurance Marketplace, and the Small Group market Exchange is referred to as the Small Business Health Options Program (SHOP). Open enrollment to purchase a Qualified Health Plan (QHP) begins as early as October 1, 2013.

Groups of 51-100 will be classified as Small Groups beginning January 1, 2016; Large Groups (101+) may be eligible to enter Exchanges as of January 1, 2017.

a) Plan types:
Plans offered on the Exchanges must meet one of four actuarial value targets based on the plan's tier. Actuarial value is the percentage of healthcare costs covered by the plan rather than the enrollee:
- Bronze: 60 percent of actuarial value
- Silver: 70 percent of actuarial value
- Gold: 80 percent of actuarial value
- Platinum: 90 percent of actuarial value

b) State Exchanges
States can each establish their own Exchange ("state exchange"), a state-federal partnership Exchange or, if a state elects not to establish an Exchange, the responsibility defaults to the Department of Health and Human Services (HHS) for a Federally Facilitated Exchange (FFE). In a state-federal partnership Exchange, the state must oversee management of QHPs, consumer oversight programs or both.

Ohio will have a State Partnership Exchange where the state provides some Exchange services in partnership with HHS. In Ohio, the state will supervise health plans on the Exchange and consumer guidance provided by Navigators, brokers and any other individual qualified by the state to assist in the sale of QHPs.

Other state Exchange requirements include:
- Covering the entire state with one or more Exchanges.
- Exchanges must be run by a governmental agency or a non-profit entity with demonstrated experience in the Individual and Small Group markets and in benefits coverage.
- State notification to HHS if they will run the reinsurance program or defer to HHS.
- Deciding if the state will run eligibility certifications on the Exchange or defer to HHS.

c) Group sizes:
- Effective January 1, 2016, the definition of "Small Group" will be standardized to 100 or fewer full-time employees; on or after January 1, 2017, each Exchange will decide if Large Groups (i.e., those with more than 100 full-time employees) can enter the Exchange.
- In Georgia, Indiana, Ohio and South Carolina, "Small Group" is currently defined as a group of 50 or fewer full-time employees; this definition will change on January 1, 2016.

d) Subsidies:
- Exchanges must comply with IRS requirements related to advance payments of the premium tax credit.
- An individual who qualifies for a premium credit and is enrolled in a Silver plan through an Exchange will also be eligible for a cost-sharing subsidy. Cost-sharing subsidies are for those individuals whose income is between 138 percent and 250 percent of the Federal Poverty Level (FPL). (Refer to Families USA for current FPL guidelines.)
- In states that expand Medicaid, premium tax credits will be available for qualified individuals with income levels between 138 percent and 400 percent of FPL.
- In states that don't expand Medicaid, subsidies will be available for qualified individuals whose income is between 100 percent and 400 percent of FPL.
- Subsidies are only available for plans offered on the public Exchanges. However, it is important to note that Exchange-certified brokers can sell these plans on their websites, if the required criteria are satisfied and the respective state Exchange allows.

e) Pricing and fees:
For 2014, HHS will require a monthly user fee equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan.

f) Exchange functions:
- Carry out required functions outlined in the ACA, including enrollment, premium payments, Navigator programs, consumer tools, a SHOP, and plan certification and contracting.
- Make grants to public or private entities to serve as Navigators.
- Issuers are required to establish risk pools in each state where they offer coverage for their non-grandfathered Individual market (one pool) and non-grandfathered Small Group market (separate pool).
- Similar plans sold on and off the Exchanges must be priced in a similar manner. To avoid adverse selection, an issuer will be expected to not offer better pricing off the Exchange.
- On April 1, 2013, HHS released a proposed technical summary that would delay the date on which a state SHOP must offer all QHPs at a single "metal tier" level until plan years beginning on or after January 1, 2015. This means a SHOP will be available in 2014 for small employers but the plan choice will be at the *employer* level and not the *employee* level.

g) Catastrophic health plans:
In addition to QHPs, issuers may offer catastrophic health plans on the Exchanges, which will have actuarial values less than what is required to meet any of the levels for QHPs (described above). These plans:
- Are expected to have lower premiums because they will have less generous coverage and higher cost sharing
- Must be available through the Individual market and only to individuals under age 30, or individuals exempt from the individual mandate because they do not have access to affordable coverage or have experienced a hardship
- Will provide coverage for Essential Health Benefits, including coverage for at least three primary care visits

- Will have a deductible equal to existing cost-sharing limits specified in the tax code related to certain high-deductible health plans (the deductible will not apply to "preventive health services")

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf
Correction: http://www.gpo.gov/fdsys/pkg/FR-2012-05-29/pdf/2012-12914.pdf
Proposed Rule for Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02139.pdf
Small Business Health Options Program: http://cciio.cms.gov/resources/files/Files2/15_shop.pdf.pdf
SHOP: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10439.html (Zip file)
SHOP Proposed Rule: https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-04952.pdf (to be published 3/11/13)
For additional AHIP guidance, visit http://www.ahip.org/Exchanges/ (AHIP username and password required)

Guaranteed Issue and Guaranteed Renewability

Coverage must be offered on a "guaranteed issue" basis, as well as on a "guaranteed renewal" basis. "Guaranteed issue" requires issuers to offer all products approved for sale in a particular market segment to any individual or fully insured small or large group within that market segment. Issuers must also accept any individual or group applying for any of those healthcare coverage products, as long as the applicant agrees to the terms and conditions of the offer (such as the premium). There are a small number of exceptions to this mandate, such as a group that will not meet the participation requirement. "Guaranteed renewability" is the requirement for a plan to renew individual coverage at the option of the policyholder, or renew group coverage at the option of the plan sponsor/employer.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☐ SI

Effective date: Plan or policy years beginning on after January 1, 2014

Additional information:
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf
AHIP Summary: Highlights of Key Provisions of the Final Regulations on the Insurance Market Reforms under the Affordable Care Act (February 22, 2013)

Individual Mandate ("Individual Shared Responsibility")

Beginning in 2014, the Affordable Care Act includes a mandate for most individuals to have healthcare coverage or pay a penalty for noncompliance. Individuals will be required to maintain Minimum Essential Coverage (MEC) for themselves and their dependents. The individual mandate is now referred to in the latest regulations as "individual shared responsibility."

I=Individual; 2-50=Small Group 2-50; 51-99=Small Group 51-99; LG=100+
GF=Grandfathered; NGF=Non-grandfathered
FI=Fully Insured; SI=Self-Insured

Applies to: ☒ I: ☒ GF; ☒ NGF
☐ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☐ NGF
☒ FI; ☐ SI

Effective date: January 1, 2014

Additional information:

a) Excludes individuals who:
- Have a religious exemption
- Are not lawfully present in the United States
- Are incarcerated
- Cannot afford coverage based on formulas contained in the law
- Have income below the federal income tax filing threshold
- Are members of Indian tribes
- Were uninsured for short coverage gaps of less than three months
- Have received a hardship waiver from the Secretary of the Department of Health and Human Services (HHS), or are residing outside of the United States, or are residents of any possession of the United States.

b) The penalty for not complying with individual shared responsibility is:
- 2014: $95 per adult in the family plus $47.50 per child, up to a maximum of $285 or 1 percent of household income, whichever is higher
- 2015: $325 per uninsured person or 2 percent of household income
- 2016 and after: $695 per uninsured person or 2.5 percent of household income

The statute gives the Department of Health and Human Services the authority to exempt individuals determined to "have suffered a hardship with respect to the capability to obtain coverage." The exemptions and other pertinent information can be found in the Centers for Medicare and Medicaid Services Fact Sheet.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02141.pdf
IRS Q&A: Questions and Answers on the Individual Shared Responsibility Provision (January 30, 2013)

IRS Reporting Requirements

See: Reporting Requirements for Large Employers and Self-Insured Plans
Reporting the Cost of Group Healthcare Coverage on W-2 Forms

Lifetime Dollar Limits Eliminated

Plans are prohibited from establishing lifetime limits on the dollar value of Essential Health Benefits (EHB) for any participant or beneficiary. Plans will be able to put lifetime limits on specific covered benefits that are not EHB, as long as the limits are otherwise permitted by federal and state law.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI
Effective date: Plan years on or after September 1, 2010

Additional information:
Interim Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf
AHIP Summary: AHIP Preliminary Summary of Interim Final Rule Issued on June 22, 2010
Model Language Notice: http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc

Market Share Fee

A new fee will be assessed on healthcare coverage issuers beginning in 2014. The fee is a percentage assessed on the net premium collected by the insurer. The fee is due no later than September 30 of the fee year.

The fee is an aggregate tax, is not income tax deductible and will amount to the following national totals:

- 2014: $8.0 billion
- 2015: $11.3 billion
- 2016: $11.3 billion
- 2017: $13.9 billion
- 2018: $14.3 billion
- 2019 and beyond: Annual amount increases for inflation

Fee: 2-3 percent of premium in 2014
Applies to: Applies to all healthcare coverage issuers with more than $25 million in net premium collected annually.
Effective date: 2014 and going forward indefinitely

Additional information:
IRS Proposed Rule: http://www.irs.gov/PUP/newsroom/REG-118315-12.pdf
AHIP Summary: Summary of the Proposed Rules on the Health Insurance Provider Fee (March 1, 2013)

Medical Loss Ratio

As part of the Affordable Care Act (ACA), a new medical loss ratio (MLR) provision was implemented January 1, 2011, requiring every health insurer to spend a certain percentage of the premium it collects on qualifying medical expenses:

- 85 percent for fully insured large employers
- 80 percent for fully insured small employers and individual products

The remaining 15 percent or 20 percent in premiums can be used for administrative costs such as salaries, marketing, commissions and facility expenses.

Health insurers not meeting the medical loss ratio for a fiscal year must pay rebates to affected policyholders, both current and cancelled.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☐ SI
Effective date: January 1, 2011

Additional information:
Qualifying medical expenses include treatments, hospital admissions, doctor visits and programs aimed at improving members' quality of care.

Final rule: http://www.gpo.gov/fdsys/pkg/FR-2010-12-01/pdf/2010-29596.pdf
AHIP Summary: Highlights of Key Provisions of the Final Rule for the Medical Loss Ratio Provisions of the ACA (December 2, 2011)

Medicare Tax Withholding

Employers are required to withhold an additional 0.9-percent Medicare tax (hospital insurance) on an employee's compensation in excess of $200,000. This increases the rate from 1.45 percent to 2.35 percent. The additional tax does not have an employer matching requirement. For married couples filing jointly, the threshold is $250,000.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI
Effective date: January 1, 2013

Additional information:
IRS Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29237.pdf
Q&A: http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax
IRS Topic: http://www.irs.gov/taxtopics/tc751.html
Page 2 of IRS Publication 15 (2013): http://www.irs.gov/pub/irs-pdf/p15.pdf

Minimum Value

Minimum Value (MV) is the percentage of the total cost of benefits in an employer-sponsored plan that meets or exceeds the 60-percent threshold (i.e., the plan covers at least 60 percent of the cost of healthcare services covered by the plan). When individual or small group plans comply with the Affordable Care Act (ACA) by offering Qualified Health Plans (QHPs), they may, at a minimum, offer a bronze plan that covers 60 percent of the cost of Essential Health Benefits (EHB), with the covered individual paying 40 percent of the cost of coverage out of his or her own pocket.

Self-insured and large group plans do not need to comply with the EHB provision, so the calculation of whether or not these employer plans are providing Minimum Value requires a different means of identifying the value of the benefits offered in the plan.

Note: The out-of-pocket limits on cost sharing are $6,400 Single / $12,800 Family and apply to all EHB offered by a group. If a large group offers some or all EHB, the EHB it covers are subject to the out-of-pocket maximum.

Applies to: ☐ I: ☐ GF; ☐ NGF
☐ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☐ SI

Effective date: January 1, 2014

Additional information:

a) Minimum Value determination
The determination of Minimum Value is important to both employees and large employers. An employee may not claim the premium tax credit for the purchase of healthcare coverage through a state Exchange if the employee (or a family member) is eligible to enroll in an employer-sponsored health plan that meets the Minimum Value standard, unless the premium for that coverage is not "affordable" (based on the employee's household income). Premium tax credits are also unavailable to any employee who is actually enrolled in an employer plan, even if that plan fails to provide Minimum Value or is not considered affordable.

There are three ways to determine a plan's Minimum Value:

- MV Calculator: The Department of Health and Human Services (HHS) provided a MV calculator that will allow an employer-sponsored plan to enter information about the plan's benefits, coverage of services and cost-sharing design to see if the plan meets the required 60-percent valuation threshold.
- Safe Harbor Check Lists: An employer-sponsored plan will be treated as providing Minimum Value if its cost-sharing attributes are at least as generous as those shown in any of the Safe Harbor check lists.
- Certified Actuary Review: Plans with "non-standard" features, such as limits on any of the core benefits (for example, a limit on the number of physician visits or covered hospital days), can start by using the MV calculator and then have a certified actuary make the valuation adjustments needed to reflect the non-standard features. An employer can also engage a certified actuary to make the entire calculation.

b) Shared Responsibility Payments
Beginning January 1, 2014, employers with more than 50 full-time equivalent employees may have to pay "shared responsibility payments" if any full-time employee uses a tax credit or a "cost-sharing reduction" to purchase healthcare coverage on a state Exchange. The formula used to calculate the amount of the shared responsibility payment will depend on whether the employer's plan has met the Minimum Value standard. Therefore, large employers or self-insured employers will need to accurately determine the value of the coverage provided through their plans.

Employers can manage or avoid the shared responsibility payments by offering all full-time employees the opportunity to enroll in healthcare coverage that is both affordable and provides Minimum Value—employees who have access to such coverage are not eligible for the premium tax credit, which would trigger an employer penalty.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
IRS Proposed Regulation: http://www.irs.gov/pub/newsroom/reg-138006-12.pdf
IRS Q&A: Employer Shared Responsibility Provisions Under the Affordable Care Act
AHIP Summary: Summary of the Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage (January 4, 2013)
For additional AHIP guidance, visit http://www.ahip.org/Employer-Coverage/ (AHIP username and password required)

Modified Community Rating or Adjusted Community Rating (ACR)

The Affordable Care Act requires a standardization of rating for certain market segments in 2014. Plans' ratings will vary based only on the following:

a) Family size
b) Location/geography of the policyholder's home (individual plans) or employer's place of business
c) Tobacco use (up to a 50-percent surcharge)
d) Age (the final rule allows maximum ratio of 3 to 1, highest to lowest rates, based on age bands):
   - Ages 0-20 in the same age band
   - Ages 21-63 each has a separate band rating
   - Ages 64 and above in the same age band
e) Benefit design

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☐ SI

Effective date: January 1, 2014 (the same limits will apply in 2017 to non-grandfathered large groups that enter an Exchange to buy coverage)

Additional information:

Final rules for student health insurance allow issuers to maintain a separate risk pool for student health insurance coverage rather than including them in the individual market risk pool

- While the coverage is considered "individual coverage" and is subject to the individual market Medical Loss Ratio requirements, it can be rated based on a group rating methodology
- The coverage will have to fit into one of the metal tiers of Qualified Health Plans and will have to eliminate all annual maximums

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf
AHIP Summary: Highlights of Key Provisions of the Final Regulations on the Insurance Market Reforms under the Affordable Care Act (February 22, 2013)
For additional AHIP guidance, visit http://www.ahip.org/Rate-Review/ (AHIP username and password required)

Nondiscrimination Based on Health Status

Health plans are prohibited from basing eligibility or coverage on health status-related factors. Such factors include medical condition (both physical and mental illness), claims experience, previous receipt of healthcare, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability and any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services. However, the Affordable Care Act does allow plans to offer premium discounts or rewards based on enrollees' participation in wellness programs, in keeping with prior federal law.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan or policy years sold on or after January 1, 2014

Additional information:

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf
AHIP Summary: Summary of HHS Final Rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation under the Affordable Care Act (ACA) (February 20, 2013)

Open and Special Enrollment Periods in the Individual Market

The first open enrollment period for the Exchanges will be October 1, 2013, through March 31, 2014. (Subsequent open enrollment periods for exchanges will be October 15 through December 7 of each year, a timeframe that coincides with the enrollment period for Medicare Parts C and D.)

Applies to: ☒ I: ☐ GF; ☒ NGF
☐ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☐ NGF
☒ FI; ☐ SI

Effective date: October 1, 2013, for the first coverage year on the Exchanges (January 1, 2014)

Additional information:

a) The Affordable Care Act also provides for special enrollment periods, which are limited to 30 days after a qualifying event. Qualifying events will be the same as those established under ERISA for group health plans and include loss of coverage due to divorce or death of the primary member.
b) For the Group market, the final rules establish continuous open enrollment, except for small groups (2-50) that do not meet participation and contribution requirements. For employers that do not meet these requirements, issuers may limit enrollment to a specific open enrollment period from November 15 to December 15 every year.

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf
AHIP Summary: Highlights of Key Provisions of the Final Regulations on the Insurance Market Reforms under the Affordable Care Act (February 22, 2013)

Patient-Centered Outcomes Research Institute (PCORI) Fee

Issuers and plan sponsors must pay an annual "PCORI Fee" to the IRS based on the average number of covered lives in the plan each plan year ($1 per member for the first plan year ending after September 30, 2012, $2 per member for the second plan year ending after October 2013, increased for inflation in future years). The fee will be used to fund the Patient-Centered Outcomes Research Institute, which supports clinical effectiveness research. Issuers and plan sponsors are responsible for paying the fee, which is treated like an excise tax by the IRS. IRS Form 720 should be used to report liability for the fee and must be filed annually by July 31 of the calendar year immediately following the last day of the plan year.

Fees: $1 per member per month, first plan year ending after September 30, 2012; $2 per member per month next plan year; increases for inflation

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: First plan year ending after September 30, 2012, effective through September 30, 2019. Plan years ending October through December 2012 must pay by July 31, 2013. Plan years ending January through September 2013 must pay July 31, 2014.

Additional information:

Excludes: The PCORI fee *does not apply* to lives covered by exempt governmental programs, including Medicare parts A, B, C and D and Medicare Supplemental; Medicaid and state Children's Health Insurance Programs; and federal programs covering members of the Armed Forces and members of Indian Tribes. The fee also *does not apply* to lives covered by HIPAA-excepted benefits.

For purposes of the calculation, "covered lives" includes all participants and beneficiaries (i.e., members) that are residents of the United States and its possessions (i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, Northern Marianas Islands).

a) The amount of the fee is $1 times the average number of covered lives under the plan for policy or plan years ending on or after October 1, 2012. The assessment is $2 times the average number of covered lives for plans ending after September 30, 2013, and then is subject to adjustment for projected increases in National Health Expenditures.
b) Medical Mutual will separately disclose the PCORI fee, along with other mandated taxes and fees, on invoices so policyholders can better understand reform costs.
c) Health plan issuers are responsible for paying the fee for their fully insured members. Self-insured plans are responsible for paying the fee to the government on their own, independent of their third-party administrator.
d) Health reimbursement accounts (HRAs) are considered self-funded products and, as such, the following rules apply:
    - For stand-alone HRAs (i.e., not paired with another plan), the plan sponsor pays the fee.
    - For HRAs paired with self-insured health plans, the government considers the pair to be one self-insured plan and levies the PCORI fee once on each member and each dependent.
    - For HRAs paired with fully insured health plans, the plans are treated separately and the PCORI fee applies to both – the HRA plan sponsor files and pays the fee on the HRA; the fully insured plan carrier collects and pays the fee on the health plan.

e) Health FSAs must satisfy two conditions to be exempt from the PCORI fee:
   - The maximum benefit payable to any participant for a year cannot exceed two times the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction election for the year, plus $500)
   - Some other non-excepted group health plan coverage must be made available by the group to the FSA participants

   For example, some health FSAs include employee salary reduction contributions matched with employer funds. If the employer matching contribution does not exceed the greater of the participant's salary election, or $500, it will generally satisfy the maximum benefit condition. A design that offers direct employer FSA contributions in excess of this level would cause the FSA to be subject to the PCORI fee.

IRS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf
AHIP Summary: Summary of the Final Rule on the Patient-Centered Outcomes Research Institute (PCORI) Fee (December 5, 2012)

Pay or Play, or "Employer Shared Responsibility"

See: Employer Shared Responsibility, or "Pay or Play"

Preexisting Health Condition Coverage

Plans cannot exclude coverage for preexisting health conditions, regardless of the age of the covered individual. A "preexisting health condition" is a medical condition that was present before the date of enrollment for healthcare coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Excluding coverage for preexisting conditions refers to the circumstance in which an applicant for coverage is offered health insurance but that coverage does not provide benefits for treating the applicant's current medical condition(s).

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan or policy years beginning on or after January 1, 2014 (this mandate was effective for plan years beginning on or after September 23, 2010, for children under age 19)

Additional information:
Interim Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf
AHIP Summary: AHIP Preliminary Summary of Interim Final Rule Issued on June 22, 2010

Premium Stabilization Programs (also known as the "3 Rs")

Under the Affordable Care Act (ACA), much of the expanded coverage will be provided through health insurers offering products on the new American Health Benefit Exchanges (Exchanges). Provisions related to reinsurance, risk adjustment and risk corridors—collectively known as the Premium Stabilization Programs, or the "3 Rs"—are designed to lessen the financial risk issuers and Exchanges will

face when enrolling additional individuals and small groups. The 3 Rs will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than by attracting the healthiest, lowest-cost enrollees.

Applies to: Market segment varies by program (see "Additional information" below)
Effective date: January 1, 2014

Additional information:

a) Transitional Reinsurance Program

The Transitional Reinsurance Program is designed to help stabilize premiums for coverage in the Individual health insurance market. On an annual basis, insurers and third-party administrators will be required to pay a fee to support the transitional reinsurance program for 2014, 2015 and 2016. Self-insured plans can elect to have their third-party administrators (TPAs) calculate and pay this fee on their behalf.

The fees will be distributed to insurers selling coverage on the Exchanges to offset the cost of covering high-cost individuals.

Fee: $5.25 per member per month
Applies to: Fees are charged to plans in all market segments
Excludes: The Transitional Reinsurance Program does not apply to lives covered by exempt governmental programs, including Medicare parts A, B, C and D and Medicare Supplemental; Medicaid and state Children's Health Insurance Programs; and federal programs covering members of the Armed Forces and members of Indian Tribes. The fee also does not apply to lives covered by HIPAA-excepted benefits.
Effective date: Calendar years 2014, 2015, 2016
Payout: Reinsurance distributions to insurers in 2014 are set at 80 percent of the total incurred claims that fall between $60,000 and $250,000 for the calendar year for a member with an Individual policy.

b) Risk Adjustment Program

The Risk Adjustment Program is being put in place to help smooth out or balance the adverse selection some carriers will experience. The Department of Health and Human Services (HHS) will administer the collection of money from certain carriers and disbursement of money back out to other carriers who have attracted a higher amount of risk. A "user fee" of $1 per member per year will be assessed on insurers each year beginning in 2014 and will be collected in June of the following year. It is intended to support HHS' cost of administering the program.

Fee: $1 per member per year
Applies to: Fees are charged to all non-grandfathered Individual and Small Group plans
Effective date: January 1, 2014 (permanent)

c) Temporary Risk Corridors Program

This program is designed to minimize the risk to health plan issuers insuring high-cost populations between 2014 and 2016. Health plans with unusually high claims and administrative costs will receive payments from this program, while health plans with unusually low claims and

administrative costs will make payments into this program. Carriers falling in the acceptable range of Medical Loss Ratio (MLR) and administrative costs will not be charged an amount or be entitled to receive an amount, as determined by the Department of Health and Human Services (HHS).

Applies to: Applies only to Individual and Small Group (2-50) QHPs sold only on the Exchanges
Effective date: Calendar years 2014, 2015, 2016

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-05-17/pdf/2012-11994.pdf
AHIP Summary: Summary of Final Rules on Standards Related to Reinsurance, Risk Corridors and Risk-Adjustment (March 16, 2012)

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
AHIP Summary: Summary of HHS Final Notice of Benefit and Payment Parameters for 2014 (March 1, 2013)
For additional AHIP guidance, visit http://www.ahip.org/3Rs/ (AHIP username and password required)

Preventive Care Services with No Cost-sharing

Coming Soon.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI
Effective date: Plan or policy years beginning on or after September 23, 2010

Additional information:

Final Rule: https://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=25828

Provider Nondiscrimination

The Affordable Care Act imposes nondiscrimination requirements with respect to healthcare providers. With respect to participation under the plan, plans cannot discriminate against any healthcare provider who is acting within the scope of his or her license or certification under applicable state law.

Note: This provision does not require a plan to contract with any or all healthcare provider(s) willing to abide by the plan's terms and conditions, and the provision cannot be construed as preventing a plan or the Secretary the Department of Health and Human Services from establishing varying reimbursement rates for providers based on quality or performance measures.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI
Effective date: January 1, 2014

Additional information:
Public Health Services Act Section 2706:
http://www.naic.org/documents/index_health_reform_general_ppaca_ins_provs.pdf

Qualified Health Plans

Under the Affordable Care Act, starting in 2014, an insurance plan that provides Essential Health Benefits, follows established limits on actuarial value and cost-sharing (e.g., deductibles, copays, out-of-pocket limits) and meets other requirements can be certified as a Qualified Health Plan (QHP) by each Exchange on which it is sold. QHPs will be available for sale on the Exchanges and may also be offered off the Exchanges by brokers in well-defined circumstances. There are well defined rules for QHP certification.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☐ 51-99*; ☐ LG**: ☐ GF; ☒ NGF
☒ FI; ☐ SI
*Groups of 51-100 will be classified as Small Groups beginning January 1, 2016, and will be able to join state Exchanges at that time
**Large Groups (i.e., those with more than 100 full-time employees) may join state Exchanges on or after January 1, 2017

Effective date: Plan or policy years sold on or after January 1, 2014

Additional information:

a) Cost-sharing limits:
Cost sharing is any expense paid by or on behalf of an enrollee for Essential Health Benefits as they are tied to QHPs:
- Includes deductibles, coinsurance, copayments or similar charges, but excludes premiums, balance billing amounts, cost-sharing for out-of-network providers and non-covered services
- Maximum out-of-pocket amounts cannot exceed $6,400 Single / $12,800 Family in 2014 and is tied to health savings account limits.
- Deductibles cannot exceed $2,000 Single / $4,000 Family in 2014 for Small Group (2-50) market.
- Insurers can exceed annual deductible limits for the Small Group market if their plans cannot "reasonably reach" the actuarial value the law sets for a given level of coverage
- **Apply to:** all market segments except grandfathered plans.

b) Actuarial Value/Minimum Value:
- The Department of Health and Human Services (HHS) has provided an Actuarial Value (AV) calculator to help issuers determine if their QHPs for individuals and small groups (2-50) meet the required actuarial values for the "metal plans" (actuarial value is the percentage of costs covered by the plan rather than the enrollee for a typical population):
  - Bronze: 60 percent of actuarial value
  - Silver: 70 percent of actuarial value
  - Gold: 80 percent of actuarial value
  - Platinum: 90 percent of actuarial value
- If an employer does not offer coverage or offers Single coverage that is not affordable or does not meet Minimum Value, an individual will be able to access Exchange cost-sharing subsidies

and premium tax credits to apply towards coverage purchased on the Exchange if his or her household income is between 100 and 400 percent of the federal poverty level.

- An employer can determine the affordability threshold based on self-only (Single) coverage. There are three safe harbors (Rate of Pay, Federal Poverty Line, Form W-2) available to employers to use to determine affordability based on an individual's income. Coverage is considered "unaffordable" when the employee's share of the premium exceeds 9.5 percent of the employee's household income.
- It is possible that Family coverage will not be affordable for an employee under this rule; however, the employee will *not* be eligible for Exchange premium tax credits or cost-sharing subsidies if Single coverage is deemed affordable under the rules.

c) Large groups:
If a large group joins a state Exchange for plan years on or after January 1, 2017, and purchases a QHP, the group must follow all QHP rules, including cost-sharing limits.

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf
AHIP Summary: Summary of Final Rule on Establishment of Exchanges and Standards for Qualified Health Plans (March 12, 2012)
AHIP Summary: Summary of HHS Final Rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation under the Affordable Care Act (ACA) (February 20, 2013)

Rate Review

All rate increases that exceed 0 percent for small group and individual health plans must follow a standardized filing process. The proposed rule makes several changes in U.S. Department of Health and Human Services (HHS) oversight of state rate review processes.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☐ SI

Effective date: 2012

Additional information:
The Affordable Care Act (ACA) requires states to meet federal standards for rate review. If a state does not meet the federal standards, HHS will review those states' rate increases. To date, 44 states—including Georgia, Indiana, Ohio and South Carolina—have met federal standards for effective rate review programs in the Individual and Small Group markets, including a requirement that all proposed rate increases of 10 percent or more be reviewed to determine if they are actuarially reasonable. Some state regulators are authorized under their state's law to deny unreasonable rate increases; HHS does not have that same authority under federal law, but does publish its rationale when it finds a rate increase unreasonable.

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf
AHIP Summary: Highlights of Key Provisions of the Final Regulations on the Insurance Market Reforms under the Affordable Care Act (February 22, 2013)
For additional AHIP guidance, visit http://www.ahip.org/Rate-Review/ (AHIP username and password required)

Reporting Requirements for Large Employers and Self-Insured Plans

According to the Affordable Care Act, both insurers and employers that self-insure must report certain health insurance coverage information to the Internal Revenue Service (IRS), and provide a written statement to covered individuals. In the case of fully insured plans, the regulations would make the insurer responsible for the reporting.

Applies to: ☐ I: ☐ GF; ☐ NGF
☐ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Coverage provided on or after January 1, 2014; the first information returns must be filed with the IRS in 2015

Additional information:

a) Insurers and Employers that Self-insure
The information report to the IRS must contain the following information:
- The name, address and taxpayer identification number (TIN) of the primary insured, and the name and TIN of every other individual obtaining coverage under the policy
- The dates during which the individual was covered during the year
- Whether the coverage is a Qualified Health Plan offered through a Health Benefit Exchange (and the amount of any advance cost-sharing reduction payment or any premium tax credit)
- The name, address and employer identification number (EIN) of the employer maintaining the plan
- The portion of the premium (if any) required to by paid by the employer
- Any other information required by the IRS

In addition to the report submitted to the IRS, the insurer or employer must provide a written statement to each covered individual whose name must be included in the IRS report. This statement must include the name, address and contact information of the reporting person or entity, and the information required to be shown on the return with respect to that individual.

b) Large Employers
Large employers (i.e., those that employed an average of at least 50 full-time equivalents on business days during the preceding calendar year) must also report to the IRS whether they offer 95 percent of their full-time employees and their employees' eligible dependents the opportunity to enroll in affordable coverage that meets Minimum Value under an eligible employer-sponsored plan, as well as certain other information. In addition, large employers must provide written statements of the report to full-time employees. The report is meant to determine whether the employer is complying with the employer mandate and to provide full-time employees with a written statement of their coverage.

The employer's report must include:
- The employer's name, date and EIN

- A certification of whether the employer offers its full-time employees and their eligible dependents the opportunity to enroll in affordable, Minimum Value coverage under an eligible employer-sponsored plan
- The number of full-time employees the employer has for each month during the calendar year
- The name, address and TIN of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan
- The months during the year for which affordable, Minimum Value coverage under the plan was made available
- The monthly premium for the lowest cost option in each of the enrollment categories
- The employer's share of the total allowed costs of benefits provided under the affordable, Minimum Value coverage
- Any waiting period with respect to the affordable, Minimum Value coverage
- Any other information required by the IRS

In addition, the insurer or employer must provide a written statement to each covered individual whose name is included in the IRS report. This statement must include the name, address and contact information of the reporting person or entity, and the information required to be shown on the return with respect to that individual. The written statement must be given to full-time employees on or before January 31 of the year following the calendar year for which the information was required to be reported to the IRS.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
IRS Notice 2012-32: www.irs.gov/pub/irs-drop/n-12-32.pdf
IRS Notice 2012-33: www.irs.gov/pub/irs-drop/n-12-33.pdf

Reporting the Cost of Group Healthcare Coverage on W-2 Forms

Form W-2s issued by employers in early 2013 must report the aggregate value of any healthcare coverage provided to each employee in 2012, regardless of who paid the premium for that coverage. Employers should have taken steps to ensure their payroll departments or payroll providers were prepared for the new reporting requirement.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ 2-50; ☒ 51-99; ☒ LG*: ☒ GF; ☒ NGF
☒ FI; ☒ SI
*Employers issuing at least 250 Forms W-2 for 2012 (transition relief applies to employers that issued fewer than 250 Forms W-2 for 2012, and certain types of plans – see “Additional information” below)

Effective date: Beginning with 2012 Form W-2s issued by January 31, 2013, and each year after

Additional information:
Employer-sponsored coverage does not include:
a) Stand-alone dental or vision coverage (if it qualifies as a "HIPAA-excepted" benefit)

b) Contributions to Archer medical savings accounts (MSAs), health savings accounts (HSAs) and salary reductions into a medical flexible spending account (FSA) (Note: employer flex credits to a medical FSA are reportable)
c) Health reimbursement arrangements (HRAs)
d) Coverage under an employee assistance program (EAP), wellness program or on-site medical clinic, as long as the employer does not charge a premium for that type of coverage provided under COBRA
e) Coverage only for a specified disease (if it qualifies as a "HIPAA-excepted" benefit and is paid for on an after-tax basis by the employee)
f) Coverage for long-term care
g) Coverage only for accident insurance
h) Hospital indemnity or other fixed indemnity insurance (if it qualifies as a "HIPAA-excepted" benefit, if the employer makes no contribution to the cost of coverage that is excludable from an employee's gross income, and if the premium is paid on an after-tax basis by the employee)
i) Contributions made on behalf of an employee to a multi-employer plan

IRS bulletins:
http://www.irs.gov/uac/Form-W-2-Reporting-of-Employer-Sponsored-Health-Coverage
http://www.irs.gov/pub/irs-drop/n-12-09.pdf

Small Business Tax Credits Expanded

While the Affordable Care Act does not require businesses to provide healthcare coverage to their employees, it does offer tax credits to encourage small businesses to provide it. From 2014 – 2016, small businesses that purchase coverage through the Small Business Health Options Program (SHOP) Exchanges will be eligible for a credit of up to 50 percent of premiums paid if they:

- Have fewer than 25 full-time equivalent employees
- Pay average annual wages less than $50,000 per employee (subject to cost of living adjustment for tax years beginning with 2014)
- Contribute 50 percent or more toward the employees' healthcare coverage premiums

The maximum credit for a tax-exempt organization is 35 percent of premiums paid.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ 2-50; ☐ 51-99; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: January 1, 2014 – December 31, 2016

Additional information:

a) Effective for 2010, many small businesses and not-for-profit organizations providing healthcare coverage to their employees qualified for a special tax credit of up to 35 percent of premiums paid (25 percent for tax-exempt organizations).
b) The new maximum credit (up to 50 percent of premiums paid), effective January 1, 2014, is available to employers with 10 or fewer employees and paying annual average wages of $25,000 or less per year.

c) Other eligibility criteria must be met to get the maximum 50-percent credit; that information is available at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers.

Final regulation: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02136.pdf
IRS guidance: http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers

Summary of Benefits and Coverage and Notices of Material Modification

Group health plans and healthcare coverage issuers must provide a Summary of Benefits and Coverage (SBC) to all plan participants, as well as to all employees who are eligible to participate. If the employer makes a mid-year change in the plan provisions that would change the terms of the SBC, the plan also must provide a Notice of Material Modification at least 60 days before the change takes effect.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Open enrollment periods beginning on or after September 23, 2012; plan years beginning after September 23, 2012

Additional information:

a) SBCs must be provided:
To group officials:
- Upon application
- By the first day of coverage (if there are changes)
- Upon renewal
- When requested
- For any material modification (during the plan year, as defined under ERISA)

To members of groups:
- Upon initial enrollment
- At open enrollment
- By the first day of coverage (if there are changes)
- During special enrollment periods
- When requested
- For any material modification (during the plan year, as defined under ERISA)

To individual policyholders:
- Upon application
- By the first day of coverage (if there are changes from time of application)
- Upon renewal
- During special enrollment periods
- When requested
- For any material modification

b) SBCs must follow certain standards for appearance, language, form and content:
- Appearance – SBCs must be presented in a "uniform format."
- Language – SBCs must be presented in a culturally and linguistically appropriate manner and must use terminology understandable by the average plan enrollee. The final rule follows the same standards for language assistance that were adopted in the internal claims and appeals regulation. Under this standard, plans and issuers must disclose the availability of language assistance in non-English languages, and support any language assistance requests in such languages, based on county-level census data.
- Form – SBCs can always be provided in paper form, and can also be provided in electronic form if additional requirements are met. The final rule varies the requirements for electronic delivery depending on the market segment involved, and in the group market depending on whether or not a participant is currently enrolled in coverage.
- Content – at a minimum, SBCs must include:
  - Uniform definitions of standard insurance and medical terms
  - A description of the coverage, including cost sharing and its provisions
  - Exceptions, reductions and limitations on coverage
  - Renewability and continuation of coverage provisions
  - Coverage examples
  - A statement of whether the plan or coverage provides affordable coverage and a Minimum Value statement (for coverage beginning on or after January 1, 2014)
  - A statement that the SBC is a summary and that the coverage document itself should be consulted to determine the controlling contractual provisions
  - A contact number for questions and requesting a copy of the plan document or policy
  - The final rule also requires, as applicable, contact information for getting a list of network providers and information on prescription drug coverage, an Internet address and contact number for requesting the Uniform Glossary, and a disclosure that paper copies are available

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf#page=2
AHIP guidance: New Guidance Materials on Summary of Benefits and Coverage (May 11, 2012)
Implementation FAQs (released April 23, 2013):
http://www.cciio.cms.gov/resources/factsheets/aca_implementation_faqs14.html
Sample completed SBC (for the second year of applicability):
http://www.dol.gov/ebsa/pdf/CorrectedSampleCompletedSBC2.pdf

Tax Credits

See: Small Business Tax Credits Expanded

Taxes and Fees

See: Market Share Fee
Patient-Centered Outcomes Research Comparative Effectiveness (PCORI) Fee

Waiting Period Limitation, 90-Day

Plans will no longer be allowed to impose waiting periods for eligibility longer than 90 days. An employee must be allowed to enter the plan by the 91st day after satisfying that eligibility requirement.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan years beginning on or after January 1, 2014

Additional information:
Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
AHIP Summary: Summary of the Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage (January 4, 2013)
IRS Guidance: http://www.irs.gov/pub/irs-drop/n-12-59.pdf
DOL Technical Release: http://www.dol.gov/ebsa/pdf/tr12-02.pdf

Wellness Program Rewards/Punishments

Allowable rewards and punishments for participating (or not) in an employer-sponsored wellness program are increased to 30 percent of the cost of coverage (from 20 percent), and up to 50 percent for tobacco cessation programs, effective for plan years on or after January 1, 2014.

Applies to: ☐ I: ☐ GF; ☐ NGF*
☒ 2-50; ☒ 51-99; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI
*Per the Affordable Care Act (ACA), 10 states will participate in a wellness program trial for the Individual market in 2015.

Effective date: Plan years on or after January 1, 2014

Additional information:
a) There are two categories of wellness programs:
- Participatory wellness: Participants don't need to meet a health factor standard to earn a reward. Instead, rewards can be given for fitness center membership or completing a health assessment.
- Health-contingent wellness: Participants are required to meet a standard related to a health factor to earn a reward, such as not smoking, meeting a target body mass index (BMI) or exercise frequency.
  - In 2006, rules for health-contingent wellness programs included:
    1) The total rewards were less than or equal to 20 percent of the participant's cost of coverage
    2) Programs were designed to promote health or prevent disease and not as a way to discriminate based on a participant's health
    3) Participants could qualify for a reward at least once per year
    4) Awards were available to all similarly situated individuals with a reasonable alternative standard available to those for whom it was unreasonably difficult to meet the original standard due to a medical condition

- Amendments made to health-contingent wellness program rules in the Affordable Care Act (effective 2014) include:
  1) They apply to grandfathered and non-grandfathered plans (but not Individual policies)
  2) Nondiscrimination is extended to individual plans
  3) Any premium variation for tobacco use must be applied to the premium attributable to each family member on a family policy participating in the program
  4) The maximum reward for meeting a health target (e.g., BMI, blood pressure calculation) is increased to 30 percent of the cost of coverage (from 20 percent)
  5) The maximum reward is increased to 50 percent of the cost of coverage if the program is related to the prevention or reduction of tobacco use

b) In the Small Group market, healthcare coverage issuers can only use the 50-percent tobacco use rating surcharge if they also offer a wellness program with a tobacco use prevention/reduction discount of 50 percent.

EBSA Proposed Rule: http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=26492
AHIP Webinar presentation: Update on Wellness: New Proposed Regulations (December 10, 2012)

Women's Preventive Health Services (Final regulations not yet released)

Plans are required to provide in-network coverage with no cost sharing for preventive care such as contraceptive coverage and counseling; breastfeeding support, supplies and counseling; screening for human papillomavirus, gestational diabetes, human immunodeficiency virus and sexually transmitted diseases; and screening for domestic violence.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ 2-50; ☒ 51-99; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan years beginning on or after August 1, 2012 (January 1, 2013, for calendar year plans)

Additional information:

In February 2013, the Department of Health and Human Services (HHS) released a Notice of Proposed Rulemaking on Women's Preventive Services Coverage and Religious Organizations. The rule's objective is to ensure women have coverage for recommended preventive care, including contraceptive services, without cost sharing, while also ensuring that non-profit organizations with religious objections won't have to contract, arrange or pay for insurance coverage for these services to their employees or students.

a) The rule has broadened the definition of "religious employer," which for purposes of the exemption, would now follow a section of the Internal Revenue Code and primarily include churches, other houses of worship and their affiliated organizations, as defined by Section 6033(a)(3)(A)(i) or (iii).
b) Under the proposed accommodations, plan participants receive contraceptive coverage through separate Individual health policies, without cost sharing or additional premiums.
c) Different procedural steps are included in the proposed rules for issuers and third-party administrators (TPAs) to meet the needs of plan participants of non-profit organizations with religious objections.

d) Eligible organizations with fully insured group health plans will provide self-certification of their exemption eligibility to the health insurance issuer, which must then automatically provide separate, Individual policies for contraceptive coverage at no cost to the plan participants. The issuer would be financially responsible for the contraceptive coverage.
e) Eligible organizations with self-funded group health plans will notify the TPA of their exemptions, and the TPA must then automatically work with a healthcare coverage issuer to provide separate, individual policies for contraceptive coverage at no cost to the plan participants. The costs to both the issuer and the TPA will be offset by adjustments made to the total of the Exchange user fee (3.5 percent) insurers must pay.

Health Resources and Services Administration (HRSA) guidelines:
http://www.hrsa.gov/womensguidelines
Proposed Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-06/pdf/2013-02420.pdf
AHIP Summary: Summary of Proposed Rule Addressing Coverage of Contraceptive Services under the Affordable Care Act (February 1, 2013)