MEDICAL MUTUAL®

Focus on Healthcare Reform

AFFORDABLE CARE ACT MANDATES SUMMARY

Updated November 1, 2015

This document contains a high-level summary of the Affordable Care Act (ACA) mandates going into effect over the next several years.

The table of contents on the next page includes a link to each topic and is followed by market segment charts showing which mandates apply to each market segment. The charts also include links to each applicable mandate:

- Individuals
- Small Group (1-50 full-time equivalent employees for plans sold on the exchange; 1-50 eligible employees for plans sold off the exchange)
- Large Group

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

* Plan = Provision applies to plans at their first plan year o or after the date noted. Calendar = Provision applies to plans on the calendar date noted.

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ACA Provisions for Small Group Plans

Definition of Small Group Plans
Sold on the exchange: 1 –50 full-time equivalent employees
Sold off the exchange: 1 – 50 eligible 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	■	■	■	■
Employers Provide Notice of Coverage Options	TBD	Calendar	■	■	■	■
Essential Health Benefits	1/1/14	Plan		■		■
Exchanges (American Health Benefit Exchanges)	1/1/14	Calendar		■		■
Excise Tax on High-Cost Employer-Sponsored Coverage	1/1/18	Plan	■	■	■	■
Guaranteed Availability	1/1/14	Plan	■	■		
Guaranteed Renewability	1/1/97	Plan	■	■		
Lifetime Dollar Limits Eliminated	9/1/10	Plan	■	■	■	
Market Share Fee	1/1/14	Calendar	■	■		■
Maximum Out of Pocket	1/1/14	Plan		■		■
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		■		■
Open and Special Enrollment Periods	10/1/13	Calendar		■		■
Patient-Centered Outcomes Research Institute (PCORI) Fee	9/30/12	Plan	■	■	■	■
Preexisting Health Conditions Coverage	1/1/14	Plan	■	■	■	■
Premium Stabilization Programs	1/1/14	Calendar		■		■
Preventive Care Services With No Cost Sharing	9/23/10	Plan		■		■
Provider Nondiscrimination	1/1/14	Calendar		■		■
Qualified Health Plans	1/1/14	Plan		■		■
Rate Review	1/1/12	Calendar		■		■
Reporting the Cost of Group Health Coverage on W-2 Forms	1/31/13	Calendar	■	■	■	■
Small Business Tax Credits Expanded	1/1/14	Calendar		■		■
Summary of Benefits and Coverage and Notices of Material Modification	9/23/12	Plan	■	■	■	■
Waiting Period Limitation (90-Day)	1/1/14	Plan	■	■	■	■
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GF = Grandfathered Plans **NGF = Non-Grandfathered Plans**

* Plan = Provision applies to plans at their first plan year o or after the date noted. Calendar = Provision applies to plans on the calendar date noted.

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ACA Provisions for Large Group Plans

	Effective		Fully Insured		Self-Insured	
	Date	Term[1]	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[2]	Plan	■	■	■	■
Employers Provide Notice of Coverage Options	TBD	Plan	■	■	■	■
Excise Tax on High-Cost Employer-Sponsored Coverage	1/1/18	Plan	■	■	■	■
Guaranteed Availability	1/1/14	Plan		■		
Guaranteed Renewability	1/1/97	Plan	■	■		
Lifetime Dollar Limits Eliminated	9/1/10	Plan	■	■	■	■
Market Share Fee	1/1/14	Plan	■	■		
Maximum Out of Pocket	1/1/14	Plan		■		■
Medical Loss Ratio	1/1/11	Plan	■	■		
Medicare Tax Withholding	1/1/13	Plan	■	■	■	■
Nondiscrimination Based on Health Status	1/1/14	Plan	■	■		
Open and Special Enrollment Periods	10/1/13	Plan		■		
Patient-Centered Outcomes Research Institute (PCORI) Fee	9/30/12	Plan	■	■		
Preexisting Health Conditions Coverage	1/1/14	Plan	■	■	■	■
Premium Stabilization Programs	1/1/14	Plan		■		■
Preventive Care Services With No Cost Sharing	9/23/10	Plan		■		■
Provider Nondiscrimination	1/1/14	Plan		■		■
Reporting Requirements for Large Employers and Self-Insured Plans	1/1/14[2]		■	■	■	■
Reporting the Cost of Group Health Coverage on W-2 Forms	1/31/13		■	■	■	■
Summary of Benefits and Coverage and Notices of Material Modification	9/23/12	Plan	■	■	■	■
Waiting Period Limitation (90-Day)	1/1/14		■	■	■	■
Wellness Program Rewards/Punishments	1/1/14	Plan	■	■	■	■
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Rate Review						
Small Business Tax Credits Expanded						

GF = Grandfathered Plans NGF = Non-Grandfathered Plans

1. Plan = Provision applies to plans at their first plan year o or after the date noted. Calendar = Provision applies to plans on the calendar date noted.
2. Reporting requirements and penalties postponed until 2015.

Actuarial Value (defined)

Actuarial Value, as defined under the Affordable Care Act (ACA), is the percentage of total spending on Essential Health Benefits (EHBs) that is paid by the health plan.

Actuarial Value provides a means for differentiating plan offerings by determining a cost/value ratio between what the plan covers and the share of its costs borne by the employer. Actuarial Value is the critical factor in determining the "metal level" (bronze, silver, gold, platinum) of Qualified Health Plans (QHPs) sold on the exchanges. (Bronze plans must offer 60 percent Actuarial Value, the lowest coverage level permitted for QHPs available on the exchanges.) Actuarial Value also applies to non-grandfathered plans sold in the individual and small group markets off the exchanges.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

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

Additional information:
Actuarial Value is calculated as follows: Divide the total expected payments by the plan for EHBs (based on the plan's cost-sharing requirements), for a standard population at standard pricing, by the total costs for those EHBs a standard population is expected to incur at standard pricing. The difference between total cost and plan contributions, as a percentage of the total cost, determines the Actuarial Value of a particular plan offering.

- New plans will be labeled as bronze, silver, gold and platinum, demonstrating the Actuarial Values:
  - Bronze: 60 percent of Actuarial Value
  - Silver: 70 percent of Actuarial Value
  - Gold: 80 percent of Actuarial Value
  - Platinum: 90 percent of Actuarial Value
- The Department of Health and Human Services (HHS) has provided an Actuarial Value (AV) Calculator to help issuers determine if health plans for individuals or small groups meet the required Actuarial Values for the "metal plans"

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)
2014 AV Calculator: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/av-calculator-final.xlsm
2015 AV Calculator: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsm
2015 AV Calculator Methodology: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-methodology.pdf

Affordability (defined)

"Affordability" of healthcare coverage for individuals and families is defined in the provisions of the Affordable Care Act (ACA) listed below. The definition of affordability varies by provision, as noted below.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

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

Additional information:

- **Individual Responsibility Penalties** [Internal Revenue Code (IRC) §5000A, effective January 1, 2014]
  - Individual coverage: For an individual, coverage is considered "affordable" if the cost of the individual's coverage does not exceed 8 percent* of the individual's household income. Individuals are exempt from the individual penalty if coverage is unaffordable.
    a) For an individual who is eligible to purchase coverage under an eligible employer-sponsored plan, the determination of affordability is based on the employee's share of the annual premium for self-only coverage.
    b) For individuals who do not have access to an eligible employer-sponsored plan, the determination of affordability is based on the self-only premium for the lowest cost bronze level coverage available in the individual market on a public exchange (i.e., Health Insurance Marketplace) serving the rating area in which the individual lives, reduced by the credit allowable under IRC §36B for the taxable year.
    c) Through IRS Rev. Proc. 2014-62, released November 21, 2014, the Internal Revenue Service (IRS) established an Applicable Percentage Table to index certain provisions of Code sections 36B and 5000A for tax years beginning in 2016. This table identifies parameters for determining if an individual may be exempt from the shared responsibility penalty because of the lack of affordable coverage.
  - Family coverage: Family coverage is considered "affordable" if the cost of the family coverage does not exceed 8 percent* of a family member's household income.
    a) For a family eligible to purchase coverage under an eligible employer-sponsored plan, the determination of affordability is based on the employee's share of the annual premium for family coverage.
       i. If employee-only coverage is affordable, but family coverage is not, the employee is not exempt from the individual penalty, but the eligible dependents would be exempt.
    b) For families that do not have access to an eligible employer-sponsored plan, the determination of affordability is based on the family premium for the lowest cost bronze level coverage available in the individual market on a public exchange (i.e., Health Insurance Marketplace) serving the rating area in which the family lives, reduced by the credit allowable under IRC §36B for the taxable year.

  *The "8 percent of household income" figure is subject to change each year to reflect the rate of premium growth over the rate of income growth.

  Note: There are other individuals who are exempt from the Individual Responsibility Penalties. Additional guidance is provided in IRS Notice 2014-76, released November 21, 2014.

- **Premium Subsidies** (tax credits and cost-sharing reductions) (IRC §36B)
  - Tax credits will be available to eligible individuals to purchase coverage on the new Health Insurance Marketplaces. An individual is eligible for credits if his or her income is between 100 percent and 400 percent of the federal poverty level based on household size (unless he or she qualifies for Medicaid).
  - If employed and if he or she has access to employer-based coverage, an individual will have to demonstrate that the coverage is unaffordable by showing the premiums exceed 9.5 percent of household income (9.56 percent for 2015), or the plan does not meet Minimum Value requirements.
  - Cost-sharing reductions will be available for families with incomes at or below 250 percent of the federal poverty level.

- **Employer Shared Responsibility Penalties** (IRC §4980H)
  - Individual coverage: Coverage for an employee under an eligible employer-sponsored plan is deemed "affordable" if the employee's share of the premium for self-only coverage does not exceed 9.5 percent of the employee's household income. There are three safe harbors employers can use to determine affordability if household income cannot be determined by the employer: the employee's W-2 wages, rate-of-pay equivalent income or the federal poverty level (FPL) for a single individual ($11,670 in 2014) (see http://aspe.hhs.gov/poverty/figures-fed-reg.cfm). If multiple healthcare coverage options are offered to the employee, the affordability test will be applied to the lowest-cost option available.
  - Family Coverage: Coverage for an employee and his or her eligible dependents under an eligible employer-sponsored plan is "affordable" based on the same determination as that used for individual coverage (see above).

IRS Notice 2014-76: http://www.irs.gov/pub/irs-drop/n-14-76.pdf
IRS Final Rule (Applicable Percentage Table): http://www.irs.gov/pub/irs-drop/rp-14-62.pdf

Annual Dollar Limits Eliminated

No plan may impose an annual dollar limit on Essential Health Benefits (EHBs) for any member for plan years beginning on or after January 1, 2014. The only exceptions involve "restricted" annual dollar limits for EHBs for plan years beginning before January 1, 2014. Nothing restricts the use of annual dollar limits for covered benefits that are not EHBs.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Annual limits eliminated for EHBs 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
☒ SG; ☒ 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)

Beginning January 1, 2015, the maximum amount an employee can contribute to a health FSA on a pre-tax basis cannot exceed $2,550 per taxable year. This amount is indexed for cost of living adjustments for plan years beginning after December 31, 2013, and is a slight increase from the previous $2,500 limit.

If a plan is amended to allow participants to carry over up to $500 in unused funds to be used to pay for qualified medical expenses incurred during the following plan year (pursuant to IRS Notice 2013-71), any amounts carried over would not count toward the $2,550 maximum annual contribution.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF*
☒ FI; ☒ SI
*Applies to health FSAs when offered under a cafeteria plan.

Effective date: Plan years on or after January 1, 2015

Additional information:
IRS bulletins:
http://www.irs.gov/pub/irs-drop/rp-14-61.pdf (2015 tax year inflation adjusted items)
http://www.irs.gov/pub/irs-drop/n-10-59.pdf (expenses incurred for medications can only be reimbursed by a health FSA if the medication is a prescribed drug or prescribed over-the-counter drug, or insulin)
http://www.irs.gov/pub/irs-drop/n-13-54.pdf (application of provisions to HRAs, health FSAs and certain other employer healthcare arrangements)
http://www.irs.gov/pub/irs-drop/n-13-71.pdf (modification of "use-or-lose" rule for health FSAs and non-calendar year salary reduction elections)

Cost-Sharing Subsidies

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

Applies to: ☒ I*: ☒ GF; ☒ NGF
☐ SG; ☐ LG*: ☐ GF; ☐ NGF
☒ FI; ☐ SI
***United States citizens and legal residents in families whose household incomes are between 100 percent and 400 percent of the federal poverty level (FPL) are eligible for the subsidies (see http://aspe.hhs.gov/poverty/figures-fed-reg.cfm for the FPL).

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.
d) Low-income individuals purchasing health coverage on the exchanges may receive an advance payment of the tax credit (APTC) which is then reconciled against the actual amount due the taxpayer. For taxable years beginning 2015, Code Section 36B(f)(2)B) has updated the overall limit on the excess APTC that may be owed. Limits are specified for individuals whose household incomes are between 200 percent and 400 percent of the FPL.
e) On April 22, 2015, the Centers for Medicare & Medicaid Services (CMS) released guidance on marketplace eligibility redeterminations and renewals for the 2016 benefit year. The guidance clarifies the process that will be used by the federally facilitated marketplace (FFM) to redetermine subsidy eligibility and re-enroll consumers. The 2016 process builds on procedures used in 2014, but notes a change for subsidy determination for enrollees who do not take action during open

enrollment. The FFM will re-calculate their APTC and Cost Sharing Reduction subsidies. (The previous process maintained the APTC for most enrollees.)

IRS bulletin: http://www.irs.gov/pub/irs-drop/rp-14-61.pdf (2015 tax year inflation adjusted items)
IRS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02136.pdf
Medical Mutual Tax Subsidy Estimator: On http://www.medmutual.com, Click Try it out under Tax Subsidy Estimator. (*Note:* The results shown are only an estimate. Only the federal health insurance marketplace can tell you for sure whether or not you will receive a tax subsidy and what the amount of the subsidy would be.)
Final Rule for detailing the procedures employed by state and federal exchanges to verify eligibility for advance payments of the premium tax credit and cost-sharing reductions under the Affordable Care Act (ACA): https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs-essential-health-benefits-in-alternative-benefit
Summary of Administrative Simplification: Certification of Compliance for Health Plans Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31318.pdf
AHIP Summary: Summary of Administrative Simplification: Certification of Compliance for Health Plans Proposed Rule
CMS Guidance on Annual Eligibility Redeterminations and Re-enrollments for Marketplace Coverage for 2016: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/annual-redeterminations-for-coverage-42215.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

If a group health plan is subject to the Employer Shared Responsibility ("Pay or Play") mandate, it must provide coverage to the dependent through the end of the month in which the dependent turns 26.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ 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). Beginning with plan years on or after January 1, 2014, young adults can choose to stay on their parent's health plan (both grandfathered and non-grandfathered) until age 26, even if they are eligible for their own employer-sponsored insurance plan.

Ohio law aligned its dependent child coverage with federal law in December 2014. Ohio House Bill 201 (HB.201) lowers the dependent eligibility maximum to age 26 from age 28. There are many qualifiers in the Ohio law that are now preempted by the federal law.

Ohio HB.201: http://archives.legislature.state.oh.us/bills.cfm?ID=130_HB_201
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 (Reporting Requirements and Penalties Postponed Until 2015 for Employers with 100 or More Employees; Full Delay Until 2016 for Employers with 50 – 99 Employees)

Beginning January 1, 2015,* applicable large employers (i.e., those that employ, on average, 100 or more full-time employees, including full-time equivalent employees) must pay an assessment if either:

1. The employer fails to provide minimum essential (healthcare) coverage to at least 70 percent of full-time employees, **and** any full-time employee receives premium assistance through an exchange

   PENALTY: If these two events occur, the employer must pay $2,000 multiplied by the total number of full-time employees minus 30 (the first 30 employees are exempt). 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)

or

2. The employer offers minimum essential coverage, but the coverage does not meet minimum value or is not affordable

   PENALTY: If this event occurs, the employer must pay the lesser of: $3,000 for each full-time employee who receives premium assistance through an exchange or $2,000 per full-time employee (minus 30).

Through IRS Rev. Proc. 2014-62, released November 21, 2014, the Internal Revenue Service (IRS) established an Applicable Percentage Table regarding affordability to index certain provisions of Code sections 36B and 5000A for tax years beginning in 2016.

*The enforcement of the "Pay or Play" penalties for employers with 100 or more employees is postponed until 2015. In addition, the Employer Shared Responsibility mandate will NOT apply to employers with 50 – 99 full-time employees, including full-time equivalent employees, until January 1, 2016, if the employer provides required certification.

Note: Employer health plans are not required to offer coverage to employees' spouses. However, 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. The penalty for non-compliance is delayed until 2016. However, if a group is audited, the government may require proof that the group attempted to comply in 2015. In summary, the penalty will not apply in 2015 to employers that are taking steps to provide coverage for dependents to begin in 2016.

In Frequently Asked Questions issued on March 14, 2014, the Centers for Medicare & Medicaid Services (CMS) announced that if any group asks to cover same-sex spouses (groups are not required to do this), the insurer *must* offer that coverage to the requesting group.

Applies to: ☐ I: ☐ GF; ☐ NGF
☐ SG; ☒ 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, 2015, for employers with 100 or more full-time employees; January 1, 2016, for employers with 50 – 99 full-time employees

Additional information:
As defined by the statute, employees are full time if they average at least 30 hours of service per week. Ohio House Bill 201, passed in December 2014, redefines a full-time employee to align with federal standards. Beginning January 1, 2016, an Ohio full-time employee is one who works 30 hours or more per week. A volunteer firefighter is not an employee for the purpose of Pay or Play rules. Also excluded are temporary or substitute employees, and seasonal employees who work only part of the year.

A total of 120 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. (Note: The Final Rule indicates that to avoid a penalty, applicable employers with 100 or more full-time or full-time equivalent employees must offer coverage to at least 70 percent of employees in 2015 and 95 percent of employees in 2016 and beyond, helping employers that may not yet offer coverage to employees who work 30 – 34 hours per week.)

If an applicable large 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 premium tax credits, and may also be able to access cost-sharing subsidies, to apply toward coverage purchased on an exchange. Individuals are eligible for credits if their income is between 100 percent and 400 percent of the federal poverty level based on household size (see http://aspe.hhs.gov/poverty/figures-fed-reg.cfm). Individuals

eligible for Medicaid are not eligible for premium tax credits or cost-sharing subsidies. If a state does not expand Medicaid, those individuals with household income between 100 and 133 percent of the federal poverty level and do not qualify for Medicaid (such as young men) will be able to get subsidies and could trigger penalties for employers with very low paid workers. Individuals are eligible for cost-sharing subsidies if their household income is between 100 percent (for states that do not expand Medicaid) percent or 138 percent (for states that expand Medicaid) and 250 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.

IRS Notice 2013-41, issued on June 26, 2013, provides guidance on when individuals may claim a premium tax credit based on their eligibility for minimum essential coverage where:

a) It may take a period of time to determine eligibility for coverage (e.g., Medicaid eligibility based on a finding of disability);
b) Eligibility is based on certain factors (e.g., eligibility for student health coverage based on enrollment at a college or university); or
c) There is a waiting period for coverage to start (e.g., pre-enrollment CHIP waiting period).

This Notice provides guidance regarding eligibility for the premium tax credit for individuals enrolling in Medicaid or Medicare Part A (i.e., disability/blindness eligibility), Children's Health Insurance Programs, state high risk pools, student health plans and TRICARE.

IRS Notice 2013-42, also issued on June 26, 2013, provides transition relief for individuals employed by any size employer with a non-calendar year plan when the plan year begins in 2013 and ends in 2014. Typically, employees and covered family members may only enroll during the plan's annual open enrollment period. As a result, some employees and related individuals with non-calendar year plan options may not have access to employer-sponsored coverage until the next open enrollment period after January 2014. This Notice indicates these employees and eligible family members will not be liable for the penalty under the Individual Mandate for failing to maintain minimum essential coverage until the next open enrollment period beginning in 2014.

IRS Notice 2013-45, issued on July 9, 2013, provides transition relief for applicable large employers from the reporting requirements and penalties associated with the Employer Shared Responsibility provision. Employers, insurers and other reporting entities are encouraged to voluntarily comply with the information reporting provisions for 2014 (once the information reporting rules have been issued) in preparation for the full application of the provisions for 2015. However, information reporting (§6055 and §6056) will be optional for 2014 and no penalties will be applied for failing to comply with these provisions in 2014. The transition relief is expected to make it impractical to determine which employers owe shared responsibility payments for 2014. Therefore, no employer shared responsibility payments will be assessed for 2014.

On November 14, 2013, President Obama announced insurance carriers could renew existing health plans in the individual and small group markets that were in effect on October 1, 2013, but that do not meet ACA requirements for minimum essential coverage and the law's market reforms. State departments of insurance could decide if carriers in their states would be allowed to renew non-compliant plans.

- The Ohio Department of Insurance indicated it would work with carriers to reissue non-ACA compliant plans if they choose.
- CMS then provided notices health insurance carriers must use to notify individuals and small businesses whose coverage would have been canceled before the President's announcement. The notices include instructions for keeping a non-compliant plan, as well as information about market reforms the non-compliant plan excludes.
- CMS also provided a short Q&A to help carriers understand how and when to use the notices.

Insurers that choose to renew plans that do not comply with ACA requirements will be required to notify enrollees about any ACA requirements that are not met by the coverage they are renewing, and about the availability of alternative coverage options and tax credits on the exchanges.

CMS announced on March 5, 2014, that individuals and small groups enrolled in non-grandfathered transitional plans will be able to renew their plans through policy years beginning on or before October 1, 2016. (Transitional plans are not fully compliant with the ACA.) This option would only be available if also allowed by the state and health insurance issuer. The Ohio Department of Insurance announced on April 22, 2014, that insurers in Ohio may offer their insureds the ability to renew their current coverage for policy years beginning on or before October 1, 2016.

The IRS issued two notices on September 18, 2014, proposing to change the rules for:

- When a taxpayer can revoke healthcare coverage in a cafeteria plan and enroll in a plan on the Health Insurance Marketplace exchanges (see IRS Notice 2014-55): This rule change would allow employees to revoke their election of employer-sponsored coverage under a cafeteria plan and purchase a qualified health plan through an exchange in two situations:
  1. If the employee's hours of service are reduced below 30 hours and he or she is no longer considered a full-time employee but the employer's plan will still cover the employee.
  2. If an employee enrolled in an employer's group health plan would like to cancel coverage under that health plan and purchase coverage through an exchange without a period of duplicate coverage or no coverage.
- Measuring the look-back period for determining who is a full-time employee when an employee moves positions within the same employer group (see IRS Notice 2014-49): This rule change proposes an approach for applying the look-back measurement period used to determine if an employee is a full-time employee for purposes of the shared-responsibility penalty when the measurement period for a particular employee changes. This might occur when an employee transfers positions within the same applicable large employer or within the same applicable large employer member to which different measurement periods apply. It may also occur if the applicable large employer member modifies the measurement period it applies to a position.

IRS Final Rule (Applicable Percentage Table): http://www.irs.gov/pub/irs-drop/rp-14-62.pdf
Medical Mutual flier: ACA Shared Large Employer Responsibility and Related Provisions

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
Treasury Department announcement of postponement: http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx
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
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf
U.S. Treasury Department Fact Sheet explaining delay for employers with 50 – 99 full-time employees: http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf
Final Rule (Information Reporting of Minimum Essential Coverage): http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf
CMS Frequently Asked Questions about coverage for same-sex spouses: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf
AHIP Summary: Summary of the Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage (January 4, 2013)
AHIP Summary: Summary of IRS Proposed Rules – Information Reporting of Minimum Essential Coverage; Information Reporting of Applicable Large Employers (October 16, 2013)
For additional AHIP guidance, visit http://www.ahip.org/Employer-Coverage/ (AHIP username and password required)

Employers Provide Notice of Coverage Options

The Department of Labor published Technical Release 2013-02, Guidance on the Notice to Employees of Coverage Options Under Fair Labor Standards Act, on May 8, 2013. This document provides temporary guidance about the Affordable Care Act's requirement that employers notify employees of their coverage options, particularly coverage options available through the exchanges. The guidance provided in the Technical Release should be followed until the department issues other regulations or final guidance. Any future guidance will allow adequate time to comply with additional or different requirements.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF*
☒ FI; ☒ SI
*All group health plans subject to the Fair Labor Standards Act (FLSA). The Department of Labor's Wage and Hour Division provides guidance relating to the applicability of the FLSA in general, including an internet compliance assistance tool to determine its applicability, at http://www.dol.gov/elaws/esa/flsa/scope/screen24.asp.

Effective date: October 1, 2013

Additional information:
According to Technical Release2013-02, applicable employers (i.e., those subject to the FLSA) must give employees at the time of hire a written notice to:

- Inform the employee of the existence of the Health Insurance Marketplaces, including contact information and a description of services provided by the Marketplaces

- Tell the employee that he or she may be eligible for a premium tax credit if: (1) the employer's plan does not cover at least 60 percent of the total allowed cost of benefits provided by the plan, and (2) the employee purchases a Qualified Health Plan (QHP) through the Marketplace
- Remind the employee that he or she may lose the employer contribution (if any) to the employer's health benefit plan if the employee purchases a QHP through the Marketplace and all or some portion of such contribution may be excludable from income for federal income tax purposes

The Technical Release announces the availability of two model notices:

- For employers offering health benefit plans
- For employers not offering health benefit plans

In May 2014, the Department of Labor updated the model COBRA Continuation Coverage General Notice (http://www.dol.gov/ebsa/modelgeneralnotice.doc) and model COBRA Continuation Coverage Election Notice (http://www.dol.gov/ebsa/modelelectionnotice.doc) for group health plans when they offer continuation coverage under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Employers must provide the applicable notice of coverage options to all employees, both full-time and part-time, regardless of whether the employees are enrolled in any available employer-sponsored plan. However, employers are *not required* to provide a separate notice to employees' dependents. In a Frequently Asked Questions (http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html) posted on September 11, 2013, the Department of Labor and Employee Benefits Security Administration announced companies would not be fined or penalized for failing to provide the notice.

Note: Even though the reporting requirements for large employers have been postponed (see Employer Shared Responsibility or "Pay or Play" Mandate), no change was made to the Notice of Coverage Options that employers must distribute. The Notice of Coverage Options must still include a certification telling the employee whether or not the employer's coverage is affordable and meets minimum value. Because of this provision, employers will still have to perform the calculations to determine if their plan meets affordability and minimum value requirements.

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

Essential Health Benefits

The Affordable Care Act (ACA) defined 10 broad categories of Essential Health Benefits (EHBs) that insurers must include when developing Qualified Health Plans (QHPs) for sale to Individual and Small Group 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 EHBs may not discriminate based on an individual's age, expected length of life, present or predicted disability, quality of life or other health conditions.

Please refer to the Additional Information below for details about cost-sharing requirements when groups cover EHBs.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☐ LG: ☐ GF; ☒ NGF*
☒ FI; ☐ SI
*Self-insured plans and large group plans—unless they enter the exchanges in 2017—are exempt from the requirement to cover all EHBs.

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

Additional information:

a) Benchmark plans:
- Each state chose 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
- Following are links to what Ohio has determined are EHBs. (Note: These plans are not necessarily what can be bought on the exchanges, but merely a list of what is an EHB.)
  - Ohio's EHB Benchmark plan: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ohio-ehb-benchmark-plan.pdf
  - State EHB Requirements: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/oh-state-required-benefits.pdf
  - Federal Dental and Vision plans that supplement Ohio's EHB Benchmark: http://www.opm.gov/healthcare-insurance/dental-vision/plan-information/

  - Guide to EHBs: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ehb-benchmark-review-guide.pdf
- The Final Notice of Benefit and Payment Parameters for 2015 extends the existing benchmark selection process for the 2016 benefit year. It also allows states to select new state benchmarks for 2017 based on 2014 benchmark plans.
- 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 didn'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 EHBs 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:
- In 2014, the out-of-pocket limits on cost sharing are $6,350 Single / $12,700 Family and **apply to all EHBs offered by a group**. If a large group offers some or all EHBs, the EHBs it covers are subject to the out-of-pocket maximum.
- 2015 out-of-pocket limits on cost sharing will be $6,600 Single / $13,200 Family for individuals who do not have a high-deductible health plan (HDHP)/Health Savings Account (HSA); or $6,450 Single / $12,900 Family for those who do have a HDHP/HSA.
- 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.

When EHBs are covered by a plan, the cost-sharing requirements apply to:

☒ I: ☐ GF; ☒ NGF
☒ SG; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

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 EHBs 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 EHBs, 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 EHBs 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.

g) Health Savings Accounts (HSAs):
Through IRS Notice 2013-57, the Internal Revenue Service clarifies that a health plan will not fail to qualify as a high-deductible health plan that is compatible with an HSA simply because it covers the preventive health services required under the ACA without requiring cost sharing (i.e., a deductible). The notice also confirms that services considered preventive for high-deductible health plan/HSA purposes under prior guidance continue to be treated as preventive.

h) Health Reimbursement Accounts (HRAs), Health Flexible Spending Accounts (FSAs) and Employee Assistance Programs (EAPs):
IRS Notice 2013-54 provides guidance on how the ACA applies to HRAs (including those integrated with group health plans), health FSAs, EAPs and other group health plan arrangements where an employer reimburses employees for some or all of their premiums for an individual policy.

On October 1, 2014, the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") released Final Rules implementing requirements for certain types of "excepted benefits" offered by sponsors of group health plans. The rules apply to plan years beginning on or after January 1, 2015, and provide additional guidance on the following:

- Employers that self-fund health benefits may offer stand-alone vision and dental coverage without requiring employees to pay for the coverage. (Previously, the excepted benefits rules only permitted such coverage if plan participants funded a portion of the cost.) Employers can automatically enroll employees in such coverage but must offer the opportunity to opt-out.
- Employee Assistance Programs (EAP) will be considered excepted benefits if: (a) the program does not provide significant benefits in the nature of medical care and (b) the EAP benefits are not coordinated with other group health plan benefits (for example, employees are not required to first exhaust EAP benefits before accessing coverage under the group health plan).

On March 18, 2015, the Departments also issued Final Rules establishing a new category of HIPAA-excepted benefits. These "wraparound" insured or self-funded benefits are intended to be offered by employers to certain employees and family members to supplement coverage purchased on or through the individual public exchanges (i.e., federally facilitated or state-run marketplaces). The final rule is effective as of May 17, 2015, and includes certain restrictions:

- These benefits may only be offered to part-time employees or retirees and dependents.
- Employers offering the wraparound coverage must also offer:

- Affordable coverage meeting minimum essential coverage criteria to their full-time employees.
- Other group health coverage that is not limited to excepted benefits for their part-time employees or retirees and dependents.

Amendments to Excepted Benefits Final Rules: http://www.gpo.gov/fdsys/pkg/FR-2015-03-18/pdf/2015-06066.pdf
2015 Benefit and Payment Parameters Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf
Essential Health Benefits 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)
Proposed Rules for Amending HIPAA-Excepted Benefits: http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-30553.pdf
FAQs (Part XVIII): http://www.dol.gov/ebsa/faqs/faq-aca18.html
AHIP Summary: AHIP Summary of FAQs Addressing ACA Implementation Issues (January 9, 2014)

Exchanges (Health Insurance Marketplaces and Small Business Health Options Program)
Effective in 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. Exchanges selling coverage to qualified individuals are referred to as Health Insurance Marketplaces; exchanges selling coverage to small groups are referred to as Small Business Health Options Programs, or SHOPs.

Applies to: ☒ I: ☐ GF; ☒ NGF*
☒ SG; ☐ 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 were established as of January 1, 2014, for the Individual and Small Group 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) for 2015 plans will be November 15, 2014, through February 15, 2015.

All states must define "small group" as fewer than 100 employees and large group as 100 or more employees in 2016.

States may allow large employers (100 or more eligible employees) to purchase coverage through a Health Insurance Exchange in 2017.

On January 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released a document indicating carriers issuing exchange coverage could begin making certain changes to enrollment data, including adding a dependent and correcting data that does not affect eligibility (e.g., name spelling; email, phone or address changes within the same county or ZIP code; contact preferences). See https://www.regtap.info/uploads/library/Changes_Authorized_for_Issuers_v4_5CR_010714.pdf for additional information.

On February 6, 2014, CMS issued a bulletin that allows carriers to continue to make changes that do not affect eligibility but now requires members to make changes such as adding a dependent to be done on the exchange (https://www.regtap.info/uploads/library/Guidance_for_Issuers_5CR_020714.pdf).

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 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 has 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.

d) Subsidies:

- Under regulations released in July, all the exchanges or marketplaces must first check the income level that an individual reports on his or her subsidy application against a federal database that contains information on the applicant's federal income tax returns as well as Social Security and current wage data. If an individual projects their income up to 10 percent higher than shown in the data, such as a prior tax return, there will be no questions asked. However, if there is more than a 10 percent discrepancy, individuals may be asked to provide more information, such as a pay stub. If an applicant is unable to provide proof, exchanges can rely on the individual's "self-attestation" in 2014 to determine the subsidy. This "self-attestation" process only applies when someone overestimates his or her income.
- 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 100 or 138 percent and 250 percent of the Federal Poverty Level (FPL), depending on Medicaid expansion. (Refer to http://aspe.hhs.gov/poverty/figures-fed-reg.cfm 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.
- Medical Mutual's Tax Subsidy Estimator is available at http://www.medmutual.com. Click Try it out under Tax Subsidy Estimator. (*Note:* The results shown are only an estimate. Only the federal health insurance marketplace can tell for sure whether or not an individual will receive a tax subsidy and what the amount of the subsidy would be.)
- Individuals who enrolled in a plan through the exchanges for 2014 are responsible for re-enrolling and updating their income information for 2015 plans. This will help ensure the appropriate subsidy (if applicable) will apply in 2015.

e) Pricing and fees:
In 2014 and 2015, HHS requires 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")

On December 19, 2013, CMS announced guidance that would allow individuals who believed the plan options available in their marketplaces to be more expensive than their canceled health insurance policies to purchase catastrophic coverage. The guidance also reminds individuals of the other options available to them for picking a policy, including insurers' individual policies both on and off the exchanges.

h) Small Business Health Options Program (SHOP):
In December 2013, HHS and CMS provided links to the federally facilitated SHOP (FF-SHOP) employer application (used for making eligibility determinations) and the content for two letters CMS plans to use for notifying employers about SHOP eligibility (eligible letter and ineligible letter). CMS expects to notify employers by email or mail and then follow up with a phone call. Therefore, health plans participating in the FF-SHOP should begin hearing from small employers or their agents who are interested in purchasing coverage.

The revised and streamlined employer application includes in a roster chart to list all employees who will get an offer of coverage even if they may not enroll, and must include all full-time employees (30+ hours).

CMS will launch SHOP Early Access on HealthCare.gov prior to November 15 in the following states with FF-SHOPs: Delaware, Illinois, Missouri, New Jersey and Ohio. Early Access will make key portions of FF-SHOP functionality accessible to small employers, agents and brokers. Early Access allows for incremental release of Marketplace functionality and consumer testing of the FF-SHOP online environment prior to go-live in all states.

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
Final Rule Program Integrity: Exchange, SHOP and Eligibility Appeals: http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf
AHIP Summary: Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Eligibility Appeals

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://www.federalregister.gov/articles/2013/03/11/2013-04952/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans
FAQs for Federally Facilitated SHOP Issuers:
https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
CMS FAQs on New Enrollment Process for the Federally Facilitated SHOP:
http://marketplace.cms.gov/getofficialresources/publications-and-articles/faqs-on-shop-enrollment.pdf
SHOP Full-time Equivalent Employee (FTE) Calculator: https://www.healthcare.gov/fte-calculator/
SHOP Tax Credit Estimator: https://www.healthcare.gov/small-business-tax-credit-calculator/

Final Rule (Navigators and non-Navigator assistance personnel):
http://www.ofr.gov/OFRUpload/OFRData/2013-17125_PI.pdf
AHIP Summary: Summary of Final Rule on Standards for Navigators and for Non-Navigator Assistance Personnel, Consumer Assistance Tools, and Certified Application Counselors (July 15, 2013)
Certified Application Counselor Program: CMS Guidance on Certified Application Counselor Program for the Federally-Facilitated Marketplace including State Partnership Marketplaces
CMS Fact Sheet: Types of Consumer Assistance Available through the Exchanges
CMS Guidance on APTC and CSR Information for Renewal and Discontinuation Notices:
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-on-Distribution-of-Information-Regarding-APTC-and-CSR-061215.pdf

Proposed Rule (Exchange and Insurance Market Standards for 2015 and Beyond):
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf
AHIP Summary: AHIP Summary of the HHS Proposed Rule on Exchange and Insurance Market Standards for 2015 and Beyond (March 18, 2014)
Final Rule (Exchange and Insurance Market Standards for 2015 and Beyond):
http://www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf
CMS FAQs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf

Final Rule (Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges): http://www.gpo.gov/fdsys/pkg/FR-2014-09-05/pdf/2014-21178.pdf
AHIP Summary: Final Rule on Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs
CMS Fact Sheet: CMS Finalizes Auto-Enrollment Process for Current Marketplace Consumers

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

Excise Tax on High-Cost Employer-Sponsored Coverage

In 2018, the federal government will institute the "Cadillac" tax, a 40 percent tax on employer-sponsored health coverage that exceeds certain thresholds based on single and family coverage.

The 2018 thresholds are tentatively set at $10,200 for individuals and $27,500 for families. Thresholds for 2019 and later will increase based on inflation. Benefits counted toward the threshold are proposed to include:

- Premiums for medical and prescription drug coverage
- Certain types of vision and dental benefits
- Certain contributions to health savings accounts (HSAs), flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs), regardless of whether contributions are made by the employer or employee
- The value of wellness programs

There are higher thresholds for retired individuals age 55 and older and for plans that cover employees engaged in high-risk professions.

As of current printing of this document, organizations are responsible for calculating the tax. Insurance carriers will collect the tax from their customers and pay it on their behalf. Self-funded groups will be responsible for calculating the tax and submitting payment.

Additional details are expected in additional guidance from the federal government prior to 2018 implementation.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

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

Federally Mandated Fees

Outlined below are federally mandated fees affecting a variety of market segments (note: some fees are subject to change in subsequent years):

	Individual	Small Group (1-50) Fully Insured	Large Group (51+) Fully Insured	Large Group Self Insured
Patient-Centered Outcomes Research Institute (PCORI) Comparative Effectiveness	2015: $2.18 Per Member Per Year (PMPY)	2015: $2.18 PMPY	2015: $2.18 PMPY	Subject to group's calculation method[1]
	2016: $2.28 PMPY	2016: $2.28 PMPY	2016: $2.28 PMPY	
	2017: $2.40 PMPY	2017: $2.40 PMPY	2017: $2.40 PMPY	
Reinsurance	2015: $44 PMPY	2015: $44 PMPY	2015: $44 PMPY	2015: $44 PMPY

	2016: $27 PMPY 2017: N/A	2016: $27 PMPY 2017: N/A	2016: $27 PMPY 2017: N/A	2016: $27 PMPY 2017: N/A
Market Share	2015: 2.4% of Premium	2015: 2.4% of Premium	2015: 2.4% of Premium	N/A
	2016: 2.4% of Premium	2016: 2.4% of Premium	2016: 2.4% of Premium	
	2017: 3.0% of Premium	2017: 3.0% of Premium	2017: 3.0% of Premium	
Risk Adjustment[2]	2015: $0.96[4] PMPY	2015: $0.96[4] PMPY	N/A	N/A
	2016+: $1.75 PMPY	2016+: $1.75 PMPY		
Public Exchange[3]	2015: 3.5% of Premium	2015: 3.5% of Premium	N/A	N/A
	2016: 3.5% of Premium	2016: 3.5% of Premium		

1. PCORI is applicable to self-insured clients; they must pay the excise tax directly to the government via IRS Form 720.
2. Risk Adjustment fees are charged to all ACA-compliant metal plans for Individual and Small Groups sold on or off the public exchange.
3. The Public Exchange fee applies only to Individual and Small Group plans sold on the public exchange.
4. The Risk Adjustment fee for 2015 is $0.96 per the Final Notice of Benefit and Payment Parameters for 2015, effective March 11, 2014, and $1.75 per the Final Notice of Benefit and Payment Parameters for 2016, effective February 27, 2015.

For more information, refer to: Market Share Fee, Patient-Centered Outcomes Research Comparative Effectiveness (PCORI) Fee and Premium Stabilization Programs.

Guaranteed Availability (Guaranteed Issue)

Coverage must be offered on a "guaranteed availability" basis to all non-grandfathered fully insured group health plans, as well as to grandfathered plans in the Small Group market[†]. "Guaranteed availability" requires issuers to offer all products approved for sale in a particular market segment to fully insured small or large groups within that market segment. Issuers must also accept any individual applying for any individual products, as long as the applicant agrees to the terms and conditions of the offer (such as the premium).

[†]The Health Insurance Portability and Accountability Act (HIPAA) required small group health plans to have guaranteed availability beginning in 1997.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☐ SI

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

Additional information:
A health insurance issuer is required to allow employers in the large group market to purchase health insurance coverage upon request, regardless of the time of year and regardless of the employer failing to meet contribution or minimum participation requirements. For small groups that fail to meet participation and contribution requirements, issuers can limit the availability of coverage to an annual enrollment period beginning November 15 and ending December 15 each year beginning in 2014 for 2015 effective dates and later.

There are a small number of exceptions to this mandate:

1. Insurers offering network plans may deny offers of coverage to employers whose eligible individuals live, work or reside outside the network plan's service area.
2. Issuers can deny coverage if an insurer can show it will not have the capacity to deliver services adequately to additional groups or individuals due to obligations to existing customers (group or individual).
3. Subject to certain conditions and future limitations, an issuer can decline to offer coverage if the insurer can demonstrate it is not financially able to underwrite the additional coverage being requested.

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)
CMS Uniform Modifications and Plan/Product Withdrawal FAQ: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/uniform-mod-and-plan-wd-FAQ-06-15-2015.pdf

Guaranteed Renewability

Coverage must be offered on a "guaranteed renewal" basis to all fully insured plans, both grandfathered and non-grandfathered[†]. "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. There are a small number of exceptions to this mandate, such as when a group is not renewed due to fraud or misrepresentation, fails to pay premiums or fails to meet minimum participation or contribution requirements.

Due to changes in the definitions of renewing and discontinuing plans, individuals and group health plan sponsors must receive either a renewal notice or a discontinuation notice. Renewal notices must be sent 60 days in advance and discontinuation notices must be sent 90 days in advance to certain individual and group health plans.

[†]The Health Insurance Portability and Accountability Act (HIPAA) required all fully insured plans to be guaranteed renewable beginning in 1997.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☐ SI

Effective date: Plan or policy years beginning on after January 1, 1997 (HIPAA). Healthcare reform provisions are effective on the first day of the first plan year on or after January 1, 2014.

Additional information:
CMS has been conducting outreach to individuals enrolled in coverage through the federally facilitated marketplace (FFM) who have an application inconsistency due to income or citizenship/immigration status. Impacted enrollees have been asked to provide the necessary documentation to ensure coverage can continue. (Sample Annual Income Notice for Issuers updated.pdf) The agency will accept updated documentation from enrollees to resolve an inconsistency until mid-August 2014 before taking any action.

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 requirement 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. MEC, as defined in IRS Code §5000A(f)(1) includes:

- Government-sponsored programs, including but not limited to, Medicare Part A, Medicaid, CHIP and TRICARE
- Eligible employer-sponsored plans
- Health plans in the individual market
- Grandfathered health plans
- Transitional policies (i.e., non-metal tier plans that were effective before October 1, 2013, and will expire on the first plan year on or after September 30, 2016)
- Other health benefits recognized by the Department of Health and Human Services (HHS), such as the State health benefits risk pool

Proposed regulations have suggested that additional healthcare coverage options may be added to this list, including Medicare Advantage plans and self-funded student health insurance plans.

Applies to: ☒ I: ☒ GF; ☒ NGF
☐ SG; ☐ 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 HHS 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. Additional guidance is provided in IRS Notice 2014-76, released November 21, 2014.

   Exemptions:
   On March 20, 2015, the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIO) issued guidance further clarifying four categories of Affordable Care Act individual shared responsibility hardship exemptions.

   On October 28, 2013, the Centers for Medicare and Medicaid Services issued guidance indicating individuals who purchase a Qualified Health Plan at the end of the initial open enrollment period (March 31, 2014) will not have to pay a penalty for the months prior to the plan's effective date when filing their federal tax returns in 2015.

IRS Notice 2013-41, issued on June 26, 2013, provides guidance on when individuals may claim a premium tax credit based on their eligibility for minimum essential coverage where:

a) It may take a period of time to determine eligibility for coverage (e.g., Medicaid eligibility based on a finding of disability); or
b) Eligibility is based on certain factors (e.g., eligibility for student health coverage based on enrollment at a college or university); or
c) There is a waiting period for coverage to start (e.g., pre-enrollment CHIP waiting period).

This Notice provides guidance regarding eligibility for the premium tax credit for individuals enrolling in Medicaid or Medicare Part A (i.e., disability/blindness eligibility), Children's Health Insurance Programs, state high risk pools, student health plans and TRICARE.

IRS Notice 2013-42, also issued on June 26, 2013, provides transition relief for individuals employed by any size employer with a non-calendar year plan when the plan year begins in 2013 and ends in 2014. Typically, employees and covered family members may only enroll during the plan's annual open enrollment period. As a result, some employees and related individuals with non-calendar year plan options may not have access to employer-sponsored coverage until the next open enrollment period after January 2014. This Notice indicates these employees and eligible family members will not be liable

for the penalty under the Individual Mandate for failing to maintain minimum essential coverage until the next open enrollment period beginning in 2014.

IRS Notice 2013-45, issued on July 9, 2013, provides transition relief for applicable large employers from the reporting requirements and penalties associated with the Employer Shared Responsibility provision. Although the employer penalty is delayed until 2015, individuals will continue to be eligible for a premium tax credit if they enroll in a Qualified Health Plan through the exchanges. Individuals may be eligible for a premium tax credit if their household income is within a specified range and they are not eligible for other MEC, including an eligible employer-sponsored plan that is affordable and provides minimum value.

IRS Notice 2014-10, issued on January 23, 2014, provides relief from the individual shared responsibility payment required under § 5000A of the Internal Revenue Code for months in 2014 in which individuals have limited-benefit health coverage that is not minimum essential coverage. Limited-benefit health coverage under this Notice includes:

- Medicaid coverage for the medically needy (i.e., individuals who are not eligible for Medicaid except for a spend-down of income for incurred medical expenses)
- Certain Medicaid demonstration projects for expansion populations
- TRICARE coverage for individuals who access a facility of the uniformed services on a space available basis
- TRICARE coverage for certain individuals not on active duty who are entitled to care based on an injury, illness or disease incurred or aggravated in the line-of-duty

The Notice also clarifies that any coverage that consists solely of excepted benefits, whether fully insured or self-funded, does not constitute MEC.

On November 14, 2013, President Obama announced insurance carriers could renew existing health plans in the individual and small group markets that were in effect on October 1, 2013, but that do not meet ACA requirements for minimum essential coverage and the law's market reforms. State departments of insurance could decide if carriers in their states would be allowed to renew non-compliant plans.

- The Ohio Department of Insurance indicated it would work with carriers to reissue non-ACA compliant plans if they choose.
- The Centers for Medicare and Medicaid Services (CMS) then provided notices health insurance carriers must use to notify individuals and small businesses whose coverage would have been canceled before the President's announcement. The notices include instructions for keeping a non-compliant plan, as well as information about market reforms the non-compliant plan excludes.
- CMS also provided a short Q&A to help carriers understand how and when to use the notices.

On December 19, 2013, CMS announced guidance that would allow individuals who believed the plan options available in their marketplaces to be more expensive than their canceled health insurance policies to purchase catastrophic coverage. The guidance also reminds individuals of the other options available to them for picking a policy, including insurers' individual policies both on and off the exchanges.

CMS announced on March 5, 2014, that individuals and small groups enrolled in non-grandfathered transitional plans will be able to renew their plans through policy years beginning on or before October 1, 2016. (Transitional plans are not fully compliant with the ACA.) This option would only be available if also allowed by the state and health insurance issuer. The Ohio Department of Insurance announced on April 22, 2014, that insurers in Ohio may offer their insureds the ability to renew their current coverage for policy years beginning on or before October 1, 2016.

CMS announced on March 26, 2014, that individuals who were "in line" to purchase coverage through a federally facilitated marketplace on March 31, 2014, would have until April 7, 2014, to submit a paper application. These individuals would then have until April 30, 2014, to pick a plan. Individuals "in line" to purchase coverage on Healthcare.gov on March 31, 2014, would have until April 15, 2014, to complete their online enrollment, including selecting a plan. Coverage for individuals applying by paper or online in April would be effective May 1, 2014, as long as the individual paid his or her initial premium by the deadline set by the insurer of the chosen plan. These individuals will be treated as having enrolled during a "special enrollment period" and will therefore not be subject to penalties for the months before their coverage became effective.

CCIO Guidance (individual shared responsibility hardship exceptions): https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Hardship-Exemption-Guidance-3-20-15-FINAL.pdf
IRS Notice 2014-76 (Individual Shared Responsibility hardship exemptions): http://www.irs.gov/pub/irs-drop/n-14-76.pdf
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf
IRS Q&A: Questions and Answers on the Individual Shared Responsibility Provision (January 30, 2013)
Final Rule (Information Reporting of Minimum Essential Coverage): http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf
AHIP Summary: Summary of IRS Proposed Rules – Information Reporting of Minimum Essential Coverage; Information Reporting of Applicable Large Employers (October 16, 2013)
AHIP Summary: Summary of CCIIO Q & A about hardship exemption for individuals who have received cancellation notices
IRS Proposed Rules implementing requirements in the ACA for individuals to either maintain MEC or pay a shared responsibility payment penalty starting in 2014: http://www.gpo.gov/fdsys/pkg/FR-2014-01-27/pdf/2014-01439.pdf

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 (EHBs) for any participant or beneficiary. Plans will be able to put lifetime limits on specific covered benefits that are not EHBs, as long as the limits are otherwise permitted by federal and state law.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ 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 charge, 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: 2.4 percent of premium in 2014; 2.7 percent of premium in 2015
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:
On August 12, 2014, the Internal Revenue Service (IRS) published Notice 2014-47 to clarify the scope of the term "covered entity" (entities that must pay the "health insurance providers fee"). The Notice clarified the term by outlining that this fee is not required in 2014 for the members of a controlled group that did not write premiums for the 2014 fee year but only wrote premiums for individuals at the end of the day on December 31 of the 2013 data year. A controlled group is any entity that provides health insurance for a United States citizen or resident during the fee year.

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)
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28412.pdf

Maximum Out of Pocket

For plan years beginning on or after January 1, 2014, all non-grandfathered individual policies and group health plans, both fully insured and self-insured, must comply with the following maximum out-of-

pocket (MOOP) limitations. These amounts are subject to change annually by the Department of Health and Human Services (HHS). For 2015, the MOOP is $6,600 for single coverage and $13,200 for family coverage for individuals who do not have a high-deductible health plan (HDHP)/Health Savings Account (HSA); or $6,450 Single / $12,900 Family for those who do have a HDHP/HSA. For 2016, limits are $6,850 Single / $13,700 Family. For plan years beginning on or after January 1, 2016, there is an additional requirement for family plans to embed MOOP limits for each family member not to exceed the individual MOOP limits.

In guidance released May 26, 2015, the Centers for Medicare & Medicaid Services clarified that the MOOP limitations apply to all non-grandfathered policies and plans beginning January 1, 2016, including self-funded and large employer group health plans.

MOOP is the most money a member of a health plan can spend out of his or her own pocket to pay for covered services related to Essential Health Benefits (EHBs) received from an in-network provider.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

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

Additional information:
MOOP includes copays, deductibles and coinsurance amounts for in-network medical and prescription drug services that are considered EHBs. A plan may (but is not required to) count cost sharing for non-EHBs toward the MOOP. Out-of-pocket costs for services received from non-network providers are excluded from MOOP, as are premium dollars.

Note: The government provided a one-year safe harbor (expiring 2015) for plans that use separate administrators for medical and prescription drug coverage.

FAQs (Part XVIII) – January 9, 2014: http://www.dol.gov/ebsa/faqs/faq-aca18.html
AHIP Summary: AHIP Summary of FAQs Addressing ACA Implementation Issues (January 9, 2014)
FAQs (Part XXVII) – May 26, 2015: http://www.dol.gov/ebsa/pdf/faq-aca27.pdf

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
☒ SG; ☒ 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)

The Final Notice of Benefit and Payment Parameters for 2016 includes new provisions that no longer permit the deductibility of federal and state employment taxes from premiums in MLR calculations. These changes are effective January 1, 2016 for the 2016 MLR reporting year.

Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

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.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ 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 (defined)

"Minimum Value" (MV) applies to any healthcare plan that covers at least 60 percent of the total allowed cost of benefits provided under the plan. If the coverage offered by an employer fails to provide Minimum Value, an employee may be eligible to receive a premium tax credit. In most cases, the Affordable Care Act (ACA) requires an applicable large employer (i.e., one who employed, on average, more than 50 full-time employees on business days during the *preceding* calendar year) to pay a penalty

when at least one of that employer's full-time employees receives a premium tax credit for healthcare coverage.

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. The MV Calculator differs from the Actuarial Value (AV) Calculator, also provided by HHS, which will be used by health insurance issuers to ensure plans meet the "metal level" requirements established by the ACA. The MV Calculator is based on the continuance tables reflecting claims data of typical self-insured employer plans. But because neither self-insured nor large group plans are required to comply with the Essential Health Benefits (EHBs) provision of the ACA, whether or not these employers are in fact providing Minimum Value coverage in compliance with ACA standards requires a different means of attributing value to the benefits offered under a plan.

Note: The out-of-pocket limits on cost sharing are $6,350 Single / $12,700 Family in 2014. In 2015, the out-of-pocket limits on cost sharing will be $6,600 Single / $13,200 Family for individuals who do not have a high-deductible health plan (HDHP)/Health Savings Account (HSA); or $6,450 Single / $12,900 Family for those who do have a HDHP/HSA. These limits apply to all EHBs offered by a group. If a large group plan offers some or all EHBs, the EHBs it covers are subject to these out-of-pocket maximums.

Applies to: ☐ I: ☐ GF; ☐ NGF
☐ SG; ☒ 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 large employers and their employees. An employee may not claim the premium tax credit for the purchase of healthcare coverage through a state exchange if that employee (or any family member) is eligible to enroll in an employer-sponsored health plan that meets the Minimum Value standard. The only exception occurs when the premium for that coverage does not pass the "affordability" test (based on the employee's household income). Premium tax credits are also not available 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 healthcare 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. If the healthcare plan offers EHBs not otherwise included in the MV Calculator, an actuary can determine the value of those benefits and add it to the result from the MV Calculator in accordance with generally accepted actuarial principles and methodologies.

- 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 the process of determining Minimum Value compliance by using the MV Calculator and then having a certified actuary make the valuation adjustments needed to reflect the impact of the non-standard features on the benefit/cost valuation. This option is available only when one of the other two methodologies is not applicable to the employer-sponsored plan.

b) Shared Responsibility Penalties
Beginning January 1, 2015, employers with more than 100 full-time employees (including full-time equivalent employees) may have to pay "shared responsibility penalties" 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 or the Affordability requirements. Therefore, large employers or self-insured employers will need to accurately determine the value of the coverage provided through their plans. Shared responsibility penalties will apply to groups with 51-99 full-time employees beginning January 1, 2016.

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

c) Coverage of inpatient hospitalization
The IRS issued a notice on November 5, 2014, along with the Department of Labor (DOL), the Department of Health and Human Services (HHS) and the Department of the Treasury. This notice clarified that in order to satisfy the minimum value requirement, group health plans must provide substantial coverage for inpatient hospitalization services, regardless of any minimum value calculator.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf
IRS Proposed Regulation (December 2012): http://www.irs.gov/pub/newsroom/reg-138006-12.pdf
IRS Q&A: Employer Shared Responsibility Provisions Under the Affordable Care Act
IRS Proposed Regulation (November 2014): http://www.irs.gov/pub/irs-drop/n-14-69.pdf
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
☒ SG; ☐ 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

CCIIO Sub-Regulator Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (for self-funded student health plans beginning after December 31, 2014):
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf
Final Rule Designating Self-Funded Student Health Coverage as Minimum Essential Coverage on a Temporary Basis [CMS-9958-F]: http://www.gpo.gov/fdsys/pkg/FR-2013-07-01/pdf/2013-15530.pdf
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
☒ SG; ☒ LG: ☐ GF; ☒ NGF

☒ FI; ☒ SI

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

Additional information:
On November 14, 2013, President Obama announced insurance carriers could renew existing health plans in the individual and small group markets that were in effect on October 1, 2013, but that do not meet ACA requirements for minimum essential coverage and the law's market reforms. These "transitional" plans are still subject to medical underwriting (i.e., they do not have to follow Community Rating rules).

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

The open enrollment period for Individual plans in 2015 will be November 15, 2014, through February 15, 2015, according to the Notice of Benefit and Payment Parameters for 2015. The Notice of Benefit and Payment Parameters for 2016 notes the open enrollment period for individual plans for 2016 will be November 1, 2015, through January 31, 2016.

For the Small Group market, the 2015 final rules establish continuous open enrollment, except for small groups 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.

Ohio House Bill 201, passed in December 2014, redefines a full-time employee to align with federal standards. Beginning January 1, 2016, an Ohio full-time employee is one who works 30 hours or more per week.

2016 Small Group Plans	**On-Exchange: (SHOP)**	**Off-Exchange**
Special Open Enrollment	**1-50** (no participation requirement) (November 15-December 15, 2015)	**1-50** (no participation requirement) (November 15-December 15, 2015)
Continuous Open Enrollment	**1-50** (70% participation requirement)	**1-50** (90% participation requirement)
Counting Methodology	Full-Time Equivalent	Eligible (30 hours or more per week)

2015 Small Group Plans	**On-Exchange: (SHOP)**	**Off-Exchange**
Special Open Enrollment	**1-50** (no participation requirement) (November 15-December 15, 2014)	**1-50** (no participation requirement) (November 15-December 15, 2014)
Continuous Open Enrollment	**1-50** (70% participation requirement)	**1-50** (90% participation requirement)
Counting Methodology	Full-Time Equivalent	Eligible (25 hours or more per week)

2014 Small Group Plans	**On-Exchange: (SHOP)**	**Off-Exchange**
Special Open Enrollment	**1-50** (no participation requirement)	**1-50** (no participation requirement)

	(November 15-December 24, 2013)	(November 15-December 15, 2013)
Continuous Open Enrollment	**1-50** (70% participation requirement)	**1-50** (90% participation requirement)
Counting Methodology	Full-Time Equivalent	Eligible (25 hours or more per week)*

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☐ SI

Effective dates:
November 15, 2014, for 2015 plans
January 1, 2016, for 2016 plans

Additional information:

a) The Affordable Care Act also provides for special enrollment periods after a qualifying event, which are limited to 30 days for small group plans and 60 days for individual policies. Qualifying events will be the same for individuals as those established under ERISA for group health plans and include loss of coverage due to divorce or death of the primary member.
b) Special enrollment periods. The exchange must allow qualified individuals and enrollees to enroll in or change from one Qualified Health Plan (QHP) to another as a result of any the following events:
   - A qualified individual or dependent loses minimum essential coverage (e.g., through loss of employment, reduction in hours, death of a spouse, divorce, reaching limiting age)
   - A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption
   - An individual who was not previously a citizen, national or lawfully present gains such status
   - A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent or erroneous and is the result of the error, misrepresentation or inaction of an officer, employee or agent of the exchange or the Department of Health and Human Services (HHS) or its agencies as evaluated and determined by the exchange. In such cases, the exchange may do what is necessary to correct or eliminate the effects of the error, misrepresentation or inaction
   - An enrollee adequately demonstrates to the exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee
   - An individual is determined newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether he or she is already enrolled in a QHP. The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period before the end of his or her coverage through such eligible employer-sponsored plan
   - A qualified individual or enrollee gains access to new QHPs as a result of a permanent move
   - An Indian, as defined by Section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month
   - A qualified individual or enrollee demonstrates to the exchange, in accordance with guidelines issued by HHS, that he or she meets other exceptional circumstances as the exchange may provide
c) During open enrollment, an individual can voluntarily drop his or her COBRA coverage and enroll in an exchange plan instead, even if his or her COBRA coverage has not expired. The individual may

also be determined to be eligible for an advance premium tax credit (APTC). If an individual's COBRA coverage expires outside of the annual open enrollment period, he or she would qualify for a special enrollment period and may be eligible for APTC. However, if an individual voluntarily drops his or her COBRA coverage outside of open enrollment (i.e., his or her COBRA coverage has not yet expired), the individual would not qualify for a special enrollment period. During the next open enrollment period or when the COBRA coverage expires, he or she could enroll in a QHP and may be eligible for APTC.

CMS announced on March 26, 2014, that individuals who were "in line" to purchase coverage through a federally facilitated marketplace on March 31, 2014, would have until April 7, 2014, to submit a paper application. These individuals would then have until April 30, 2014, to pick a plan. Individuals "in line" to purchase coverage on Healthcare.gov on March 31, 2014, would have until April 15, 2014, to complete their online enrollment, including selecting a plan. Coverage for individuals applying by paper or online in April would be effective May 1, 2014, as long as the individual paid his or her initial premium by the deadline set by the insurer of the chosen plan. These individuals will be treated as having enrolled during a "special enrollment period" and will therefore not be subject to penalties for the months before their coverage became effective.

Also on March 26, 2014, CMS provided guidance for issuers on special enrollment periods for complex cases in the federally facilitated marketplace after the initial open enrollment period (which ended March 31, 2014). The guidance indicates categories of individuals that CMS determined could be eligible for a special enrollment period under 45 CFR 155.420, paragraphs (d)(4), (d)(9) and (d)(10). Categories currently include individuals who:

- Experience a natural disaster or medical emergency that prevents the individual from enrolling
- Were given misinformation by individuals or entities providing formal enrollment assistance (e.g., navigators)
- Can't complete their application due to technical difficulties
- Experience other complications

CMS may add categories that warrant special enrollment periods in the future if other appropriate circumstances, as determined by CMS, become known.

Ohio HB.201: http://archives.legislature.state.oh.us/bills.cfm?ID=130_HB_201
2016 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf
2015 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf
2014 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 September 30, 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 year, first plan year ending after September 30, 2012; $2 per member per year next plan year; increases for inflation

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ 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 by 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 maintained by the same plan sponsor, 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 by an employer to any participant's general purpose health FSA for a year cannot exceed an amount equal to the participant's salary reduction amount under the FSA for the plan year (or, if the employee's salary reduction is less than $500 for the plan year, the employer can contribute up to $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)
IRS Notice 2014-56: http://www.irs.gov/pub/irs-drop/n-14-56.pdf (Updates the fee amount for plan and policy years ending on or after October 1, 2014, and before October 1, 2015, to $2.08 per covered life.)

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
☒ SG; ☒ 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 by offsetting the expenses of high-cost individuals. 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. Contributing entities (carriers for fully insured groups and plan sponsors for self-insured groups) must report their number of enrollees by November 15 of each benefit year; the Department of Health and Human Services (HHS) will notify these contributing entities of their required reinsurance payment by December 15. 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 Individual Qualified Health Plans (QHPs) to offset the cost of covering high-cost individuals.

Fee:	$5.25 per member per month (2014); $3.66 per member per month (2015); contributions are anticipated to be approximately $2 per member per month in 2016
Applies to:	Fees are charged to plans in all market segments
Excludes:	The Transitional Reinsurance Program 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. Self-insured, self-administered plans that do not use a TPA in connection with core administrative functions like claims processing, adjudication or plan enrollment are exempt from the fee for 2015 and 2016 only.
Effective date:	Calendar years 2014, 2015, 2016
Payout:	Calendar years 2014 and 2015: Reinsurance distributions to insurers in 2014 are set at a 100 percent coinsurance rate for total incurred claims that fall between $45,000 and $250,000 for the calendar year for a member with an Individual QHP. (Note: The Final Notice of Benefit and Payment Parameters for 2015 changed the limits to claims that fall between $45,000 and $250,000 for 2014, not between $60,000 and $250,000 as originally set. On June 17, 2015, CMS released a memo announcing an increase in the 2014 coinsurance rate from 80 percent to 100 percent.) The reinsurance distributions in 2015 are set at a 50 percent coinsurance rate for total incurred claims that fall between $70,000 and $250,000. Calendar year 2016: The Final Notice of Benefit and Payment Parameters for 2016 establishes a uniform reinsurance contribution rate of $27 annually per enrollee. It

also includes proposed updates to reinsurance parameters, including a $90,000 attachment point, a $250,000 reinsurance cap and a 50 percent coinsurance rate.

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 goal of the program is to be budget neutral for each state and market segment by transferring funds from carriers with lower-risk members (i.e., low claims experience) to plans with higher-risk members (i.e., high claims or high-cost claims 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 $0.96 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: $0.96 per member per year
Applies to: Fees are charged to all QHPs for Individual and Small Groups sold on or off the public exchange
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. The Department of Health and Human Services (HHS) calculates the Risk Corridor based on a target return equal to premium earned minus allowable administrative costs. This target is calculated annually after reinsurance and risk adjustment fees (above), but before Medical Loss Ratio (MLR). If the actual allowable costs are less than 97 percent of the health plan's target amount, a percentage of these savings will be paid to HHS (limiting gain). Similarly, if the actual allowable cost is more than 103 percent of the health plan's target amount, a percentage of the difference will be paid by HHS to the health plan (limiting loss). Carriers falling in the acceptable target range will not be charged an amount or be entitled to receive an amount.

Applies to: Applies only to Individual and Small Group QHPs
Effective date: Calendar years 2014, 2015, 2016

Final Rule: Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment; Correction: 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: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans;

Small Business Health Options Program; Proposed 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)

Final Rule: Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014: http://www.gpo.gov/fdys/pkg/FR-2013-10-30/pdf/2013-25326.pdf

Final Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015: http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf
AHIP Issue Brief: Affordable Care Act Premium Stabilization Programs: How Reinsurance, Risk Corridors, and Risk Adjustment Protect Consumers
AHIP Summary: Summary of HHS Notice of Benefit and Payment Parameters for 2015 (November 26, 2013)

For additional AHIP guidance, visit http://www.ahip.org/3Rs/ (AHIP username and password required)
FAQs: Distributed Data Collection for Reinsurance and Risk Adjustment: https://www.regtap.info/uploads/library/DDC_FAQ5_092313_5CR_092413.pdf
HHS-Operated Data Collection Policy FAQs: Supplemental Diagnosis Code Sources for HHS-operated Risk Adjustment Data Submission

2016 Final Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

Preventive Care Services with No Cost Sharing

All non-grandfathered group health plans, both fully insured and self-insured, and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive care services without any cost-sharing requirements (copays, coinsurance or deductible) when the services are rendered by providers who participate in the plan's network.

Applies to: ☒ I: ☐ GF; ☒ NGF
☒ SG; ☒ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

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

Additional information:
The Department of Health and Human Services defined the preventive services to be covered with no cost sharing as those services described by a variety of organizations:

- U.S. Preventive Services Task Force A and B recommendations
- Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA) Guidelines, including the American Academy of Pediatrics Bright Futures (certain guidelines for infants, children, adolescents and women)

The following list of preventive services is not all-inclusive and is subject to change:

a) All members
   All standard immunizations recommended by the American Committee on Immunization Practices
b) All members at an appropriate age or risk status
   - Certain sexually transmitted diseases screening, including HIV
   - Cholesterol and lipid disorders
   - Colorectal cancer screening (including fecal occult blood testing, screening sigmoidoscopy and screening colonoscopy)
   - High blood pressure, diabetes and depression screening
   - Screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, diet and nutrition
c) Men's health
   - Abdominal aortic aneurysm: one-time screening for men of specified ages who have ever smoked
   - Alcohol misuse screening and counseling
   - Aspirin use to prevent cardiovascular disease for men and women of certain ages
   - Blood pressure screening for all adults
   - Cholesterol screening for adults of certain ages or at higher risk
   - Colorectal cancer screening for adults over 50
   - Depression screening for adults
   - Diabetes (type 2) screening for adults with high blood pressure
   - Diet counseling for adults at higher risk for chronic disease
   - HIV screening for everyone ages 15 to 65, and other ages at increased risk
   - Obesity screening and counseling for all adults
   - Sexually transmitted infection (STI) prevention counseling for adults at higher risk
   - Syphilis screening for all adults at higher risk
   - Tobacco use screening for all adults and cessation interventions for tobacco users
d) Children's health
   - Newborn screening for hearing, thyroid disease, phenylketonuria and sickle cell anemia; standard metabolic screening panel for inherited enzyme deficiency diseases
   - Counseling for fluoride use
   - Developmental/autism screening
   - Lead and tuberculosis screening
   - Major depressive disorders screening
   - Obesity counseling
   - Vision screening
e) Women's health (see Women's Preventive Health Services)

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
☒ SG; ☒ 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
☒ SG; ☐ LG*: ☐ GF; ☒ NGF
☒ FI; ☐ SI
*Groups of 1-100 will be classified as Small Groups beginning January 1, 2016, and will be able to join exchanges at that time. Large Groups with 101 or more full-time employees may join 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 $6,350 Single / $12,700 Family in 2014 and are tied to health savings account limits.
- 2015 out-of-pocket limits on cost sharing will be $6,600 Single / $13,200 Family for individuals who do not have a high-deductible health plan (HDHP)/Health Savings Account (HSA); or $6,450 Single / $12,900 Family for those who do have a HDHP/HSA.
- On March 31, 2014, President Obama signed the Protect Access to Medicare Act of 2014, which repealed certain paragraphs of the Affordable Care Act, including those that limit deductibles in the Small Group market. The language that was removed required small groups to cap

deductibles at $2,000 Single / $4,000 Family in 2014 for Small Group market. The law did not modify any other provision related to cost sharing.

- **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 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.

d) Transparency:
On August 11, 2015, the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") released joint guidance regarding transparency in reporting and cost-sharing disclosures. Certain information will be reported on the Exchange, such as cost-sharing and out-of-network liability, balance billing, claims submission and rating practices. Individuals will be able to review this information while shopping for coverage.

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)
QHP Applications: 2014 Proposed Changes to QHP Application Templates.pdf
Production Enrollment and Payment Data Template: Exchange Product Payment DataTemplate.xls
(Note: This Production Enrollment and Payment Data Template is for reference only. This version of the template should not be used for submission. Use the password-protected version received directly from CMS.)

Centers for Medicare and Medicaid Services (CMS) FAQ about third-party payments of premiums for QHPs: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf
Clarification of CMS' FAQ: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf

Centers for Medicare & Medicaid Services (CMS) Information Collection for Transparency in Coverage Reporting by Qualified Health Plan Issuers: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10572.html

Rate Review

All rate increases for small group and individual health plans must follow a standardized filing process. The final rule makes several changes in U.S. Department of Health and Human Services (HHS) oversight of state rate review processes. In addition, the Ohio Department of Insurance (ODI) requires that large group (51+) rates or rating formulas be filed.

Applies to: ☒ I: ☒ GF; ☒ NGF
☒ SG; ☒ 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, most states, including Ohio, have met federal standards for effective rate review programs in the Individual and Small Group markets, including a requirement that all proposed rate increases be reviewed to determine if they are reasonable. Some state regulators, including ODI, are authorized under their state's law to deny unreasonable rate increases. HHS does not have that same authority under federal law, but publishes 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 (Reporting Requirements and Penalties Postponed Until 2015)

(Additional guidance forthcoming.)
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
☐ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Coverage provided on or after:

- January 1, 2015 (for employers with 100 or more full-time employees, including full-time equivalent employees); the first information returns must be filed with the IRS in 2016
- January 1, 2016 (for employers with 50 – 99 full-time employees, including full-time equivalent employees); the first information returns must be filed with the IRS in 2017

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 on average more than 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.

IRS Notice 2013-45, issued on July 9, 2013, provides transition relief for applicable large employers from the reporting requirements and penalties associated with the Employer Shared Responsibility provision. Employers, insurers and other reporting entities are encouraged to voluntarily comply with the information reporting provisions for 2014 (once the information reporting rules have been issued) in preparation for the full application of the provisions for 2015. However, information reporting (§6055 and §6056) will be optional for 2014 and no penalties will be applied for failing to comply with these provisions in 2014. The transition relief is expected to make it impractical to determine which employers owe shared responsibility payments for 2014. Therefore, no employer shared responsibility payments will be assessed for 2014.

On March 5, 2014, the IRS issued final regulations concerning Information Reporting by Applicable Large Employers. The final regulations require large employers with 50 or more full-time employees (including full-time equivalent employees) to file an annual report on healthcare coverage offered to full-time employees and their family members. The final rules generally adopt the reporting requirements in the proposed rules the IRS issued in 2013, but with a few changes to simplify the reporting process for the applicable large employers.

IRS Reporting Forms
In late 2014 and early 2015, the IRS issued reporting forms for:

- Health insurers, employers and other entities to report health coverage information to the IRS under Code sections 6055 and 6056
- Premium tax credit claims
- Small employer health insurance tax credit claims
- Claims for a health coverage exemption

The forms released by the IRS are as follows:

- 1094-B – Transmittal of Health Coverage Information Returns: form and instructions

- 1094-C – Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns: form and instructions
- 1095-B – Health Coverage: form and instructions
- 1095-C – Employer-Provided Health Insurance Offer and Coverage: form and instructions
- 8941 – Credit for Small Employer Health Insurance Premiums: form and instructions
- 8962 – Premium Tax Credit: form and instructions
- 8965 – Health Coverage Exemptions: form and instructions

The IRS also released a Fact Sheet outlining the provisions of the Final Rules.

IRS Questions and Answers about Reporting Offers of Health Insurance Coverage by Employers (Section 6056): http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056
IRS Questions and Answers about Employer Information Reporting on Form 1094-C and Form 1095-C: http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Information-Reporting-by-Employers-on-Form-1094-C-and-Form-1095-C
Final Rule (Information Reporting by Applicable Large Employers): http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf
Final Rule (Information Reporting of Minimum Essential Coverage): http://www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf
AHIP Summary: Information Reporting of Minimum Essential Coverage Under Code Section 6055 (May 7, 2014)
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
IRS Notice 2013-45: www.irs.gov/pub/irs-drop/n-13-45.pdf
Treasury Department announcement of postponement:
http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx
AHIP Summary: Summary of IRS Proposed Rules – Information Reporting of Minimum Essential Coverage; Information Reporting of Applicable Large Employers (October 16, 2013)

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
☒ SG; ☒ 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 small 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 a Qualified Health Plan (QHP) 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 (FTEs)
- Pay average annual wages less than $51,600 per employee (subject to cost of living adjustment for tax years beginning with 2015)
- 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 and is phased out for small employers with more than 10 FTEs and average annual wages in excess of $25,800 (subject to inflation adjustment).

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ SG; ☐ LG: ☐ GF; ☒ NGF
☒ FI; ☒ SI

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, 2015, is available to employers with 10 or fewer employees and paying annual average wages of $25,800 or less per year.
c) The tax credit only reimburses expenses for health insurance plans of non-family member employees.
d) 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.

IRS bulletin: http://www.irs.gov/pub/irs-drop/rp-14-61.pdf (2015 tax year inflation adjusted items)

Proposed rule: http://www.gpo.gov/fdsys/pkg/FR-2013-08-26/pdf/2013-20769.pdf
The Proposed Rules address a number of issues including defining when an employer is an eligible small employer, determining full-time equivalency counts for employees and calculating the amount of the premium paid by the employer and the available tax credit (and any phase-out of the credit amount). In addition, the Proposed Rules set forth the process for applying for the tax credit.
AHIP Summary: Summary of the IRS Proposed Rules on the Tax Credit for Employee Health Insurance Expenses of Small Employers (October 9, 2013)

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
☒ SG; ☒ 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

Note: Even though the reporting requirements for large employers have been postponed (see Employer Shared Responsibility or "Pay or Play" Mandate), no change was made to the SBC that plans must distribute. SBCs must still include a statement indicating whether or not the plan is affordable and meets minimum value. Because of this provision, employers will still have to perform the calculations to determine if their plan meets affordability and minimum value requirements.

On June 12, 2015, the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") released the Final Rules on the SBC and Uniform Glossary. The Final Rule finalizes prior guidance released through multiple Department of Labor FAQs. It also includes additional requirements for providing online access to individual coverage policy or group certificate of coverage documents to those shopping for coverage. For the group market, this requirement can be satisfied with a sample group certificate of coverage for each applicable product.

The SBC and Uniform Glossary requirements are applicable to the individual marketplace for coverage issued for plan years beginning 2016. For group plans/insurers, the requirements are applicable for coverage beginning on or after September 1, 2015. The Departments plan on finalizing the SBC template and associated documents no later than January 1, 2016, effective for plan years beginning 2017.

Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30243.pdf
Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-02-14/pdf/2012-3228.pdf 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
Department of Health and Human Services Fact Sheet (released June 12, 2015):
https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Fact-Sheet_SBCFinalRule-6-11-15-MM-508.pdf

Tax Credits

See: Small Business Tax Credits Expanded

Waiting Period Limitation, 90-Day

Plans may not impose a waiting period for an eligible employee that is longer than 90 calendar days. However, employers may first impose bona fide employment-based conditions for the employee to be eligible for healthcare coverage. The employment-based conditions may be based on other factors such as achieving a license, being in an eligible job classification, etc. Once the employee becomes eligible, any waiting period that applies must not be longer than 90 calendar days.

- Group health plans that offer coverage must make coverage available to an eligible individual no later than 90 days after he or she first becomes eligible to enroll.
- An individual is first eligible to enroll if he or she has met the eligibility conditions of the group health plan.

If it cannot be determined when an employee is hired whether he or she can reasonably be expected to work for a specified number of hours to be eligible for coverage, the plan may use a reasonable period of up to 12 months to determine if the individual is a full-time employee. Coverage must be effective no later than 13 months from the individual's start date.

Applies to: ☐ I: ☐ GF; ☐ NGF
☒ SG; ☒ LG: ☒ GF; ☒ NGF
☒ FI; ☒ SI

Effective date: Plan years beginning on or after January 1, 2014. All plans subject to the 90-day rules must comply with the **proposed** rules (including the requirement that a waiting period may not extend beyond 90 days) for plan years beginning on or after January 1, 2014. However, plans may voluntarily comply with the **final** rules, which are not effective until January 1, 2015.

Additional information:
Final Rule (applies to plan years on or after January 1, 2015): http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf
Proposed Rule clarifying the maximum allowed length of any reasonable and bona fide employment-based orientation period: http://www.ofr.gov/OFRUpload/OFRData/2014-03811_PI.pdf
Proposed Rule: http://www.gpo.gov/fdsys/pkg/FR-2013-03-15/pdf/2013-05954.pdf (applies to plan years beginning on or after January 1, 2014)
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
Implementation FAQ: http://www.dol.gov/ebsa/pdf/faq-aca16.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*
☒ SG; ☒ 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
  6) A health-contingent wellness program must offer either a waiver or a reasonable alternative standard. For example, if the program provided a premium reduction for members meeting a certain Body Mass Index (BMI), the program must allow members to either meet a reasonable alternative to that BMI requirement or simply waive the requirement and provide the premium reduction.
  7) A program must give eligible individuals an opportunity to qualify for a reward at least once per year. The reward must be available to all similarly situated individuals and a reasonable alternative standard or waiver must be available to anyone for whom it is unreasonably difficult to satisfy the standard due to a medical condition. The plan must disclose qualifications for the reward, alternative standard and/or waiver.
  8) The issuers have flexibility to determine whether to provide the same alternative to an entire class of individuals or provide individual alternatives.
  9) A plan may seek physician verification of a member's inability to participate in an activity-only wellness plan, though it is neither required nor prohibited. An outcome-based plan MAY NOT seek verification from an individual's personal physician; however, if an individual does seek a doctor's recommendation, the plan MUST provide a reasonable alternative standard that complies with the individual's personal doctor.

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)
FAQs (Part XVIII): http://www.dol.gov/ebsa/faqs/faq-aca18.html
AHIP Summary: AHIP Summary of FAQs Addressing ACA Implementation Issues (January 9, 2014)

Women's Preventive Health Services

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
☒ SG; ☒ 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:
The following guidelines for women's preventive health services were effective for plan years beginning on or after September 23, 2010 (this list is not all-inclusive):

- Breast-feeding counseling and promotion
- Cervical cancer screening including Pap smears
- Counseling women at high risk of breast cancer
- Genetic screening and evaluation for the BRCA breast cancer gene
- Iron-deficiency anemia, bacteriuria, hepatitis B virus and Rh incompatibility screening in pregnant women
- Mammography screening (film and digital) for certain adult women
- Sexually transmitted diseases screening including gonorrhea, chlamydia, syphilis and HIV

New coverage guidelines under the Affordable Care Act (ACA) required health plans to cover an expanded list of women's preventive care services with no cost-share requirement (copay, coinsurance or deductible) as long as the services are received from a provider in the health plan's network (if applicable). Coverage for the following expanded women's preventive care services became effective on the first plan year beginning on or after August 1, 2012:

- Breast-feeding support, supplies and counseling, including costs for obtaining specified breast-feeding equipment
- Domestic violence screening and counseling
- FDA-approved contraception methods, sterilization procedures and contraceptive counseling
- HIV counseling and screening for all sexually active women
- Human papillomavirus DNA testing for all women 30 years and older
- Sexually transmitted infection counseling for all sexually active women annually
- Well-woman visits including preconception counseling and routine, low-risk prenatal care
- Follow-up and maintenance visits for contraceptive care

As of plan years on or after September 24, 2014, certain medications to prevent primary breast cancer (meaning the woman has not been diagnosed with it previously) must be available for no cost share to women deemed at high risk for developing the condition.

On June 28, 2013, the Department of Health and Human Services (HHS) released final rules for religious organizations' and eligible organizations' exemption from providing women's contraceptives. The regulations apply to group health plans and health insurers for plan years beginning on or after January 1, 2014. However, the amendments to the religious employer exemption apply for plan years beginning on or after August 1, 2013.

- A religious employer is any nonprofit entity that is described under the existing tax code definition that applies to group health plan houses of worship. As a result, a house of worship that operates a soup kitchen or parochial school is entitled to exemption.

- Eligible organizations are nonprofit organizations that hold themselves out as religious organizations and oppose providing coverage for some or all contraceptive services because of religious objections. The definition of eligible organizations that can be exempt from providing some or all women's contraceptive services to covered members was expanded in August 2014 to include closely held, for-profit corporations that object to providing coverage for contraceptives due to the religious beliefs of the corporations' owners.
- Eligible organizations must self-certify to HHS, their health plan issuer or third-party administrator (TPA) as to their status as exempt from providing contraceptive coverage for women. The health plan issuer or TPA must then enroll women who are members of the health plans sponsored by these organizations into contraceptive coverage, separate from the group health plan, at no cost. Eligible organizations may designate the specific contraceptives they do not want to fund. However, issuers may choose to only offer standard exclusions.
- Issuers of fully insured plans must expressly exclude contraceptive coverage from group coverage of the eligible organization and provide separate payment for any covered contraceptives. The issuer must also segregate premium revenue collected from the eligible organizations from the monies used to provide payments for contraceptives (guidance on applicability to Medical Loss Ratio is forthcoming). Issuers may not impose cost-sharing requirements on the members.
- Self-insured plans that are eligible organizations must deliver their self-certification to the TPA. The Department of Labor states it has the authority to require TPAs to become an ERISA 3(16) plan administrator for contraceptive payments; however, TPAs are not obligated to enter into such a contract with an eligible organization if they object. If the TPA agrees to the contractual relationship, the TPA will be considered an ERISA 3(16) plan administrator for contraceptive services.
- TPAs administering claims may be reimbursed for those claims payments if claims are paid by an issuer participating on a Federally Facilitated Exchange, based on a number of criteria.
- An issuer or TPA must provide written notice of availability of separate payments for contraceptive services.
- There is an exemption on an employer-by-employer basis when several affiliated employers offer coverage through a single group plan. If an eligible institution of higher learning self-certifies as an eligible organization, an issuer offering student health coverage must make payments for contraceptives without cost sharing.

On June 30, 2014, in the United States Supreme Court case *Burwell vs. Hobby Lobby Stores, Inc.*, the Supreme Court held that if providing women's contraceptive coverage would violate a sincerely held religious belief of a closely held company, that company cannot be required by law to provide it.

On July 17, 2014, the Departments of Labor, HHS and the Treasury released issued Frequently Asked Questions Part XX to help people understand the law and benefit from it. The FAQ states ERISA plans must notify its covered employees if it will no longer cover women's contraceptives.

On August 25, 2014, the Department of Health and Human Services (HHS) released new proposed and interim final rules regarding women's contraceptive services. The proposed rule expands the definition of "eligible organizations" that can be exempt from providing some or all women's contraceptive services to covered members to include closely held, for-profit corporations that object to providing coverage for contraceptives due to the religious beliefs of the corporations' owners. A corporation seeking this accommodation may have to provide evidence that providing contraceptive coverage would violate its religious beliefs. The government may require these corporations to demonstrate that this

religious objection has been incorporated into its company structure, bylaws and/or history of not covering contraceptives. Two possible definitions of a closely held corporation are outlined in the proposed rule, but neither has been officially adopted

The interim final rule provides a new way for these eligible organizations to indicate that providing contraceptive coverage for women would violate sincerely held religious beliefs. Instead of being required to submit a self-certification form (Form 700), an eligible organization may now notify HHS with an informal letter or a new model notice. Generally, the letter or notice must be sent to a specific HHS address and include the following information:

- Name of the organization
- Basis on which it qualifies for an accommodation
- Its objection based on a sincerely held religious belief
- The plan name and type (e.g., student health plan, church plan)
- The name and contact information for the plan's insurance carrier or third-party administrator (TPA)

HHS will then notify the group's carrier or TPA of its obligation to provide the women's contraceptive coverage to covered members of the eligible organization.

On May 11, 2015, the Departments of Labor, Health and Human Services, and Treasury ("the Departments") issued FAQs on the coverage of preventive services. To meet ACA requirements, plans must cover one contraceptive in all 18 contraceptive service methods listed in the Food and Drug Administration's Birth Control Guide. The FAQ guidance clarifies how plans can meet the no-cost-sharing requirements while allowing for continuing reasonable medical management techniques. Included in the guidance is clarification on these issues:

- Plans must cover BRCA ratings related to breast cancer screening if medically appropriate.
- Plans cannot deny coverage for preventive services based on gender or gender identity if medically appropriate.
- Plans must cover well-woman care for dependents, including preventive services related to pregnancy.
- Plans must cover anesthesia services performed in connection with preventive colonoscopy.

Health Resources and Services Administration (HRSA) guidelines:
http://www.hrsa.gov/womensguidelines
Final Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-07-02/pdf/2013-15866.pdf
AHIP Summary: Final Rule Addressing Coverage of Contraceptive Services Under the ACA (June 28, 2013)
FAQs (Part XVIII) – January 9, 2014: http://www.dol.gov/ebsa/faqs/faq-aca18.html
AHIP Summary: AHIP Summary of FAQs Addressing ACA Implementation Issues (January 9, 2014)
FAQs (Part XX) – July 17, 2014: http://www.dol.gov/ebsa/pdf/faq-aca20.pdf
FAQs (Part XXVI) – May 11, 2015: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf
Form CMS-10459 (for employers) – Coverage of Certain Preventive Services Under the Affordable Care Act: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10459.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending