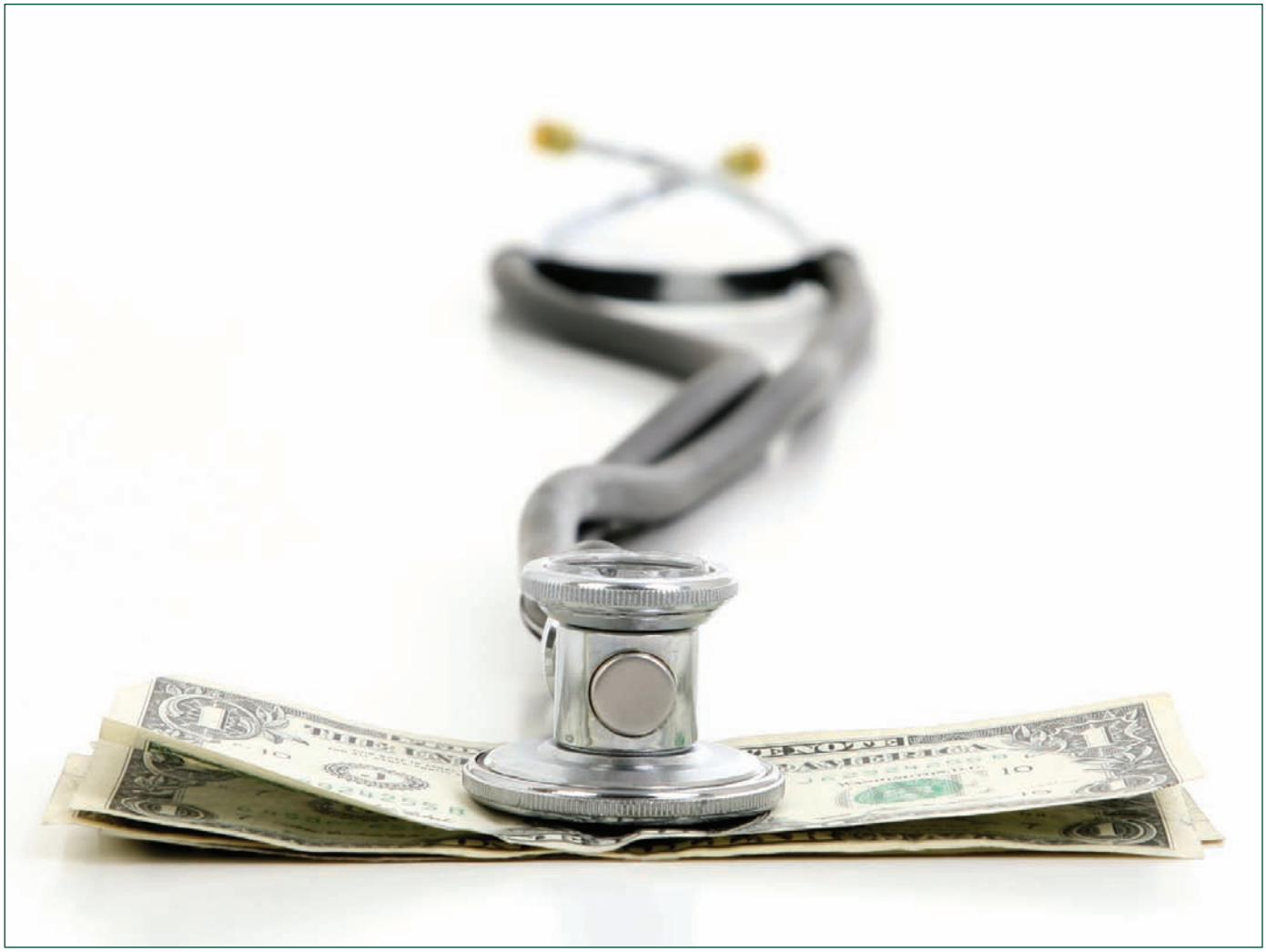
CBIZ HEALTH REFORM MATRIX:

A Tool for Understanding the Impact of Health Care Reform

Patient Protection and Affordable Care Act (Public Law 111-148, enacted March 23, 2010) and the Health Care and Education Reconciliation Act (Public Law 111-152, enacted March 30, 2010)



The following matrix of health reform provisions is divided into six categories:

EMPLOYER/PLAN SPONSOR ISSUES

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Employer/Plan Sponsor Issues

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2010**
Temporary Early Retiree Reinsurance Program. HHS will establish a temporary reinsurance program to provide reimbursement of certain expenses to plan sponsors of group health plans that provide retiree coverage to early retirees (age 55+ through 64), and their eligible spouses and dependents. To receive reinsurance, the plan must be certified in accordance with HHS criteria. Once certified, the program reimburses up to 80% of the cost of benefits in excess of $15,000 and below $90,000. The reimbursement must be used to lower plan costs or to reduce participant premiums, copayments, deductibles, coinsurance, or other out-of-pocket expenses. The program expires 1/1/14. ***(HHS Fact Sheet)***	All-sized employers	Program to be established by 6/23/10
Extension of Dependent Coverage. ■ Group health plans that provide dependent coverage must continue to make such coverage available to an adult child up to age 26. For grandfathered plans (those in existence on 3/23/10), dependent coverage need not be offered if the dependent is eligible for other employer-sponsored coverage until 2014. Nothing in the law requires the employee to contribute toward the cost of this dependent coverage. ■ The law also amends the tax code to provide that the cost of dependent coverage is not imputed into the employee's income.	All-sized employers	Plan years beginning on or after 9/23/10
Ban on Preexisting Condition Exclusions for Children. Group health plans, including grandfathered plans, are prohibited from imposing preexisting condition exclusions on enrollees under 19. (Beginning 1/1/14, preexisting condition exclusions cannot be imposed on anyone)	All-sized employers	Plan years beginning on or after 9/23/10
Ban on Rescissions. Group health plans, including grandfathered plans, cannot rescind such plan or coverage once an enrollee is covered under the plan, except in the event of fraud or intentional misrepresentation of material fact.	All-sized employers	Plan years beginning on or after 9/23/10
Ban on Annual and Lifetime Limits. Group health plans, including grandfathered plans, are prohibited from establishing lifetime limits and unreasonable annual limits on the dollar value of "minimum essential benefits" (to be defined by regulations) for a participant or beneficiary.	All-sized employers	Plan years beginning on or after 9/23/10
Coverage for Preventive Health Services. Group health plans must provide coverage for certain maternal and preventive health services, as well as evidence-based items or services recommended by the U.S. Preventive Services Task Force, without imposing any cost sharing requirements. (N/A to grandfathered plans)	All-sized employers	Plan years beginning on or after 9/23/10

Employer/Plan Sponsor Issues (continued)

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2010 (continued)**
Independent Appeals Process. Group health plans must implement an internal and external appeals process for coverage determinations and claims. (N/A to grandfathered plans)	All-sized employers	Plan years beginning on or after 9/23/10
Ban on Discrimination Based on Salary. Insured group health plans must comply with the nondiscrimination requirements for self-funded plans (IRC §105(h)), including rules that the plan does not discriminate in favor of highly compensated individuals as to eligibility and benefits. (N/A to grandfathered plans)	All-sized employers	Plan years beginning on or after 9/23/10
Choice of Primary Care Provider. Individual and group health plans that permit participants to designate their primary care providers must allow them to choose any primary care provider available to accept them. Insurers must also allow in-network physicians (allopathic or osteopathic) who specialize in pediatrics to be designated as primary care providers for children, as well as allow women to designate a participating OB/GYN as her primary care provider. (N/A to grandfathered plans)	All-sized employers	Plan years beginning on or after 9/23/10
Advanced Notice of Material Modification of Benefits. A notice of any material modification of benefits must be provided to plan participants no later than 60 days prior to the effective date of the change. *[Note: In addition to this requirement, plans subject to ERISA, presumably, will have to continue complying with all existing ERISA disclosure requirements; this may be clarified in future regulations. Plans exempt from ERISA will be subject to this new requirement.]*	All-sized employers	Effective date to be clarified
Automatic Enrollment in Health Plan. Employers who offer their employees enrollment in one or more health benefit plans, are required to automatically enroll new full-time employees in one of the plans offered, subject to any waiting period.	Employers with 200+ full-time employees	Notice due 3/1/13 Requirement for automatically enrolling is to be clarified.
		Effective Date 2011
OTC Medications Are Not Qualified Expenses. FSAs, HRAs, Archer MSAs, and HSAs can no longer reimburse the cost of over-the-counter (OTC) medications, except for insulin or prescribed OTC drugs.	Individuals	1/1/11

Employer/Plan Sponsor Issues (continued)

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2011 (continued)**
Medical Loss Ratio. Insurers in the individual and group markets, including grandfathered plans, are required to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended on costs related to reimbursement for clinical services and activities that improve health care quality versus the total amount of premium revenue is less than: ■ 85% for insurers in the large group market ■ 80% for insurers in the small group or individual markets Beginning January 1, 2014 the rebate amount will be based on averages for each of the previous 3 years for the plan.	Plans in the large group, small group and individual markets, including grandfathered plans. These restrictions do not appear to apply to self-insured plans.	1/1/11
Simple Cafeteria Plans. An eligible small employer can establish a simple cafeteria plan that includes a safe harbor from the nondiscrimination requirements applicable to cafeteria plans and certain qualified benefits. These Simple plans must meet certain minimum eligibility and participation requirements. The employer must make a contribution to provide qualified benefits under the plan on behalf of each qualified employee, without regard to whether a qualified employee makes any salary reduction contribution.	Employers with 100 or fewer employees	1/1/11
		Effective Date 2012
CLASS Act: Voluntary, Self-Funded Long-Term Insurance Program. HHS will establish a voluntary long term care insurance program for purchasing community living assistance services and supports (CLASS program). An individual would be required to contribute to the program for 5 years (vesting period) before benefits (up to $50/day cash benefit) are available. The payments can be used to purchase non-medical services and support necessary to maintain community residence, including, home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. The program is financed entirely through voluntary payroll deductions. All working adults will be automatically enrolled in the program, unless they choose to opt-out. Employers can voluntarily choose to provide enrollment tools and process the premiums for the program.	All-sized employers	1/1/12
Uniform Summary of Plan Benefits and Coverage. Plans must provide applicants and enrollees an additional disclosure document, explaining certain aspects of the health benefit coverage. The document must meet uniform standards, such as format, appearance, language, and content. *[Note: In addition to this requirement, plans subject to ERISA, presumably, will have to continue complying with all existing ERISA disclosure requirements; this may be clarified in future regulations. Plans exempt from ERISA will be subject to this new requirement.]*	All-sized employers	3/23/12 (or, 12 months after model forms issued)

Employer/Plan Sponsor Issues (continued)

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2012 (continued)**
Patient-Centered Outcomes Research Fee. Group health plans must pay a fee of $2 ($1 for policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy. The fee must be paid by insurers of fully-insured plans, and employers of self-funded plans. The fees will be used to measure patient-centered outcomes.	Insurers of fully-insured plans and All-sized employers of self-funded plans	Plan years beginning 9/30/12
		Effective Date 2013
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500.	All-sized employers with FSA plan	1/1/13
Retiree Prescription Drug Coverage. An employer's deduction for retiree prescription drug expenses is reduced by the amount of the Medicare Part D tax-free subsidy.	All-sized employer sponsored health plans claiming Medicare Part D retiree drug subsidy	1/1/13
		Effective Date 2014
Shared Responsibility for Employers regarding Health Coverage. A (tax) penalty could be imposed against employers who: ■ Fail to Offer Coverage to full-time employees; or ■ Offer coverage to employees qualified for premium tax credits or cost-sharing reductions. *Reporting Requirement.* Employers subject to the penalty for noncompliance are required to file an IRS return and furnish information statements to employees. The return and information statement must include: **1.** Identifying information for the employer and covered employees; **2.** Certification as to whether the employer offers minimum essential coverage; **3.** Length of any waiting period; **4.** The months during the calendar year for which coverage was available; **5.** The monthly premium for the lowest cost option in each enrollment category; **6.** The employer's share of the total costs of benefits, and **7.** The number of full-time employees.	Employers with 50+ full-time equivalent employees (FTEE). A FTEE is determined by dividing the aggregate number of hours worked by part-time employees in a month by 120. The number of FTEEs is reduced to 30 and part-time employees are not counted for penalty assessment purposes.	1/1/14

Employer/Plan Sponsor Issues (continued)

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2014 (continued)**
Free Choice Vouchers. Employers who offer minimum essential coverage to employees and pay any portion of the cost must provide free choice vouchers to certain qualifying employees (those exempt from the individual mandate, but do not qualify for premium subsidies). Qualified employees include any employee: **1.** Whose required contribution for minimum essential coverage is between 8 and 9.8% of household income; **2.** Whose household income does not exceed 400% of the FPL; and **3.** Who does not participate in the employer's health plan. The amount of the voucher includes what the employer would have paid to cover the employee in its plan. The employer pays these amounts to the Exchange plan in which the employee is enrolled. The entire cost of the voucher is deductible by the employer. Any excess over the cost of the premium for coverage through the Exchange is paid to the employee as taxable compensation.	All-sized employers	1/1/14
Ban on Discriminatory Premium Rates. Group health plans may only vary premium rates based upon: ■ Individual or family coverage; ■ The rating area; ■ Age (rates can't vary by more than 3 to 1); and ■ Tobacco use (rates can't vary by more than 1.5 to 1).	Employers with 100 or fewer employees. May be applicable to large employer plans (100+ employees) offered through Exchange.	1/1/14
Ban on Preexisting Condition Exclusions. No preexisting condition exclusions may be imposed on anyone.	All-sized employers	1/1/14
Ban on Excessive Waiting Periods. Group health plans cannot require enrollment waiting periods in excess 90 days.	All-sized employers	1/1/14

Employer/Plan Sponsor Issues (continued)

(also see Reporting and Disclosure, Tax Issues & Insurance Issues)

Provision* **Unless otherwise noted, these provisions apply to both insured and self-funded plans*	**Impact** *Note: The IRC control group rules apply for determining employer size*	**Effective Date 2014 (continued)**
Ban on Discrimination Based on Health Status. Group health plans and insurers are prohibited from establishing new or existing eligibility rules based on any of the following health status-related factors, relating to the covered individual or his/her dependent: ■ Health status; ■ Medical condition (including both physical and mental illnesses); ■ Claims experience; ■ Receipt of health care; ■ Medical history; ■ Genetic information; ■ Evidence of insurability (including conditions arising out of acts of domestic violence). ■ Disability; ■ Any other health status-related factor determined appropriate by HHS.	All-sized employers	1/1/14
Reward for Participation in Wellness Program. The reward under a standard-based wellness program can be up to 30% (currently 20%) of the cost of coverage (amount could increase up to 50%, if deemed appropriate by the Agencies).	All-sized employers	1/1/14
Coverage for Individuals Participating in Approved Clinical Trials. Individual and group health plans cannot deny individual participation in approved clinical trials and must cover routine costs in approved clinical trials. Insurers are not required to cover the following: ■ The investigational item, device or service; ■ Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or ■ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	All-sized employers	1/1/14
		Effective Date 2018
Excise Tax on High Cost Employer-Sponsored Health Coverage. A 40% excise tax will be imposed on the value of high cost employer sponsored health coverage ("Cadillac" health plans) exceeding certain threshold limits ($10,200/individual; $27,500/family). The employer calculates the excise tax and provides to the insurer or third party administrator, who then pays the tax.	All-sized employers	1/1/18

REPORTING AND DISCLOSURE ISSUES

(also see Employer/Plan Sponsor Issues, Tax Issues & Insurance Issues)

Reporting and Disclosure Obligations
(also see Employer/Plan Sponsor Issues, Tax Issues & Insurance Issues)

Provision	Impact *Note: The IRC control group rules apply for determining employer size*	Effective Date 2010
Advanced Notice of Material Modification to Benefits. A notice of any material modification of benefits must be provided to plan participants no later than 60 days prior to the effective date of the change. *[Note: In addition to this requirement, plans subject to ERISA, presumably, will have to continue complying with all existing ERISA disclosure requirements; this may be clarified in future regulations. Plans exempt from ERISA will be subject to this new requirement.]*	All-sized employers	Effective date to be clarified
		Effective Date 2011
New Form W-2 Reporting Rules. Employers are required to disclose the aggregate cost of any employer-sponsored health insurance coverage on the Form W-2, including both the employer's and employee's share. The calculation method will be clarified in future guidance.	All-sized employers	1/1/11
		Effective Date 2012
Uniform Summary of Plan Benefits and Coverage. Plans must provide applicants and enrollees an additional disclosure document, explaining certain aspects of the health benefit coverage. The document must meet uniform standards, such as format, appearance, language, and content. *[Note: In addition to this requirement, plans subject to ERISA, presumably, will have to continue complying with all existing ERISA disclosure requirements; this may be clarified in future regulations. Plans exempt from ERISA will be subject to this new requirement.]*	All-sized employers	3/23/12 (or, 12 months after model forms issued)
Quality of Care Reporting Requirement. Plans and insurers are required to submit a quality of care report to HHS. The type of information included in the report are details about coverage benefits, health care provider reimbursement structures, any improvement of health outcomes, and implementation of any wellness or prevention activities.	All-sized employers	3/23/12

Reporting and Disclosure Obligations (continued)
(also see Employer/Plan Sponsor Issues, Tax Issues & Insurance Issues)

Provision	Impact *Note: The IRC control group rules apply for determining employer size*	Effective Date 2013
Notice of Exchange Coverage. Employers are required to provide each employee at the time of hiring, as well as current employees, a written notice informing the employee of the existence of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance.	All-sized employers	3/1/13
		Effective Date 2014
Employer Health Insurance Reporting Requirement ■ Reports to IRS. Employers must satisfy an IRS reporting requirement relating to its health insurance coverage as to access, eligibility, waiting periods, costs, number of employees, and other coverage details. *Reporting Requirement.* Employers subject to the penalty for noncompliance are required to file an IRS return and furnish information statements to employees. The return and information statement must include: **1.** Identifying information for the employer and covered employees; **2.** Certification as to whether the employer offers minimum essential coverage; **3.** Length of any waiting period; **4.** The months during the calendar year for which coverage was available; **5.** The monthly premium for the lowest cost option in each enrollment category; **6.** The employer's share of the total costs of benefits, and **7.** The number of full-time employees. ■ Benefit Statements to Employees. The employees listed in the IRS report, above, must be furnished a written statement relating to information contained in the employer's report, applicable to the employee.	Employers with 50+ full-time employees	1/1/14

TAX ISSUES

(also see Employer/Plan Sponsor Issues, Insurance Issues & Medicare Issues)

Tax Issues

(also see Employer/Plan Sponsor Issues, Insurance Issues & Medicare Issues)

Provision	Impact	Effective Date 2010
Small Business Tax Credit. Small businesses (employers with no more than 25 employees and average annual wages of less than $50,000) will receive a tax credit of up to 35% of premiums, as long as they pay at least half the cost of health insurance for covered employees. Combined with the deduction for the premiums paid, this means Treasury pays approximately 2/3 of the cost. Eligible tax exempt employers receive a credit of 25%. After 2013, the credit increases to 50% for employers (35% for tax exempt) purchasing coverage through an insurance exchange, subject to a 2 consecutive-year limit. The entire amount of premiums can be claimed as a credit by employers with 10 or fewer employees whose annual wages are $25,000 or less.	Employers with up to 25 full-time employees with average annual wages between a maximum of $25,000 (10 or fewer employees) and $50,000 (25 or fewer employees)	1/1/10 Special credit carry back rules apply 1/1/11
Increase of Adoption Credit. Increase of the maximum amount of qualified adoption expenses eligible for tax credit from $12,170 (the 2010 indexed amount) to $13,170 (indexed for inflation). The credit is fully refundable in year claimed.	Individuals	1/1/10 *Sunset Date: 12/31/11*
Adult Dependent Children Coverage. The cost of employer-provided health coverage of dependent children under the age of 27 as of the end of the tax year is excluded from gross income. Self-employed individuals may deduct premiums paid on dependent coverage.	All-sized employers	Potential income issues could exist for first 3 months of 2010.
Excise Tax on Indoor Tanning Services. A 10% tax is imposed on the cost of indoor tanning services.	Individuals	7/1/10
Economic Substance Doctrine. The economic substance judicial doctrine has been codified. Transactions will be treated as having economic substance, and therefore, respected for tax purposes, only if the transaction results in a meaningful change to a taxpayer's economic position, and the taxpayer has a substantial purpose for entering into the transaction (apart from Federal income tax effects). Significant penalties apply to transactions that fail these requirements.	All-sized employers	Transactions entered into after 3/30/10
		Effective Date 2011
Increased Penalty for Nonqualified HSA or Archer MSA Distributions. Penalties on nonqualified HSA distributions will increase from 10% to 20%. The penalty for nonqualified distributions from Archer MSAs will increase from 15% to 20%.	Individuals	1/1/11
New Form W-2 Reporting Rules. Employers are required to disclose aggregate cost of any employer-sponsored health insurance coverage on Form W-2.	All-sized employers	1/1/11

Tax Issues (continued)
(also see Employer/Plan Sponsor Issues, Insurance Issues & Medicare Issues)

Provision	Impact	Effective Date 2012
Additional Reporting Requirements. Businesses that pay $600 or more to a single payee, whether a corporation or otherwise, will have to file an information return reporting the payment.	All-sized employers	1/1/12
		Effective Date 2013
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500.	All-sized employer sponsored FSA plans	1/1/13
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased by 0.9%, from 1.45% to 2.35%, to the extent his wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ Employer must withhold on all wages over $200,000 ■ Employee liable regardless of employer withholding ■ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals equal to 3.8% of the lesser of an individual's (1) "net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities) or (2) modified adjusted gross income in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ No employer withholding requirement ■ Counted for estimated tax payments ■ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13
Retiree Prescription Drug Coverage. An employer's deduction for retiree prescription drug expenses is reduced by the amount of the Medicare Part D tax-free subsidy.	All-sized employer sponsored health plans claiming Medicare Part D retiree drug subsidy	1/1/13
Modification of Itemized Deduction for Medical Expenses. The threshold for deductibility of unreimbursed medical expenses is increased from 7.5% to 10% of adjusted gross income. The 7.5% threshold is retained through 2016 for individuals who are at least 65 years old by year end.	Individuals	1/1/13

Tax Issues (continued)

(also see Employer/Plan Sponsor Issues, Insurance Issues & Medicare Issues)

Provision	Impact	Effective Date 2014
Shared Responsibility for Employers for Health Coverage. Covered employers may be subject to monthly nondeductible penalties: ■ For failure to offer minimum essential coverage (including, in an employer-sponsored plan, employer payment of at least 60% of the benefit costs) at an affordable rate (employee's contribution, including salary reduction amounts, cannot exceed 9.5% of household income): Monthly Penalty in 2014: (Number of full-time employees – 30) x 166.67. After 2014 the amount of the penalty is indexed for inflation. ■ Offering essential minimum coverage at an affordable rate, but at least one full time employee is eligible for or receives a premium tax credit or cost sharing assistance for buying insurance from a State exchange plan: Monthly Penalty in 2014: Number of credit employees x $250 (subject to cap in the amount described in the first penalty, above). After 2014, the amount of the penalty is indexed for inflation.		1/1/14
Free Choice Vouchers. Employers who offer minimum essential coverage to employees and pay any portion of the cost must provide free choice vouchers to certain qualifying employees (those exempt from the individual mandate, but do not qualify for premium subsidies). Qualified employees include any employee: **1.** Whose required contribution for minimum essential coverage is between 8 and 9.8% of household income; **2.** Whose household income does not exceed 400% of the FPL; and **3.** Who does not participate in the employer's health plan. The amount of the voucher includes what the employer would have paid to cover the employee in its plan. The employer pays these amounts to the Exchange plan in which the employee is enrolled. The entire cost of the voucher is deductible by the employer. Any excess over the cost of the premium for coverage through the Exchange is paid to the employee as taxable compensation.	All "qualifying employers"	1/1/14
Premium Assistance Tax Credit. Taxpayers with family income of 400% of the federal poverty level (FPL) or less, and whose employers fail to offer minimum essential coverage at an affordable rate (see above), are entitled to a tax credit for coverage purchased through a State exchange. The amount of the credit is based upon premium cost and family income, but starts at the amount by which premiums exceed 2% of family income if the income is at or below 100% of FPL. At 400% of FPL the credit is the amount by which premiums exceed 9.5% of income. The credit is refundable, payable in advance, and remitted directly to the insurer.	Individuals with family income at or below 400% of the Federal Poverty Level	1/1/14

Tax Issues (continued)

(also see Employer/Plan Sponsor Issues, Insurance Issues & Medicare Issues)

Provision	Impact	Effective Date 2018
Excise Tax on High Cost Employer-Sponsored Health Coverage. A 40% excise tax will be imposed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200/individuals; $27,500/family). The tax is imposed on health insurance issuers, plan administrators (for self-insured plans), or employers making contributions (HSAs and MSAs). The tax is calculated using overall cost of insurance, including premium costs and employer/employee contributions, but excludes stand-alone dental and vision plan coverage.	All-sized employers	1/1/18

INSURANCE ISSUES

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Insurance Issues

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2010
Extension of Dependent Coverage. ■ Individual and group health plans that provide dependent coverage must continue to make such coverage available to an adult child up to age 26. For grandfathered plans (those in existence on 3/23/10), dependent coverage need not be offered if the dependent is eligible for other employer-sponsored coverage until 2014. Nothing in the law requires the employee to contribute toward the cost of this dependent coverage. ■ The law also amends the tax code to provide that the cost of dependent coverage is not imputed into the employee's income.	Individual and Group Plans	Plan years beginning on or after 9/23/10
Coverage for Preventive Health Services. Individual and group health plans must provide coverage for certain maternal and preventive health services, as well as evidence-based items or services recommended by the U.S. Preventive Services Task Force, without imposing any cost sharing requirements.	Individual and Group Plans (N/A to grandfathered group health plans)	Plan years beginning on or after 9/23/10
Choice of Primary Care Provider. Individual and group health plans that permit participants to designate their primary care providers must allow them to choose any primary care provider available to accept them. Insurers must also allow in-network physicians (allopathic or osteopathic) who specialize in pediatrics to be designated as primary care providers for children, as well as allow women to designate a participating OB/GYN as her primary care provider.	Individual and Group Plans (N/A to grandfathered group health plans)	Plan years beginning on or after 9/23/10
Ban on Annual and Lifetime Limits. Health plans, including grandfathered plans, are prohibited from establishing lifetime limits and unreasonable annual limits on the dollar value of "minimum essential benefits" (to be defined by regulations) for a participant or beneficiary.	Individual and Group Plans	Plan years beginning on or after 9/23/10
Ban on Rescissions. Health plans, including grandfathered plans, cannot rescind such plan or coverage once an enrollee is covered under the plan, except in the event of fraud or intentional misrepresentation of material fact.	Individual and Group Plans	Plan years beginning on or after 9/23/10
Ban on Preexisting Condition Exclusions. Health plans, including grandfathered plans, are prohibited from imposing preexisting condition exclusions on enrollees under 19. (Beginning 1/1/14, preexisting condition exclusions cannot be imposed on anyone).	Individual and Group Plans	Plan years beginning on or after 9/23/10

Insurance Issues (continued)

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2011
Medical Loss Ratio. Insurers in the individual and group markets, including grandfathered plans, are required to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended on costs related to reimbursement for clinical services and activities that improve health care quality versus the total amount of premium revenue is less than: ■ 85% for insurers in the large group market ■ 80% for insurers in the small group or individual markets Beginning January 1, 2014 the rebate amount will be based on averages for each of the previous 3 years for the plan.	Plans in the large group, small group and individual markets, including grandfathered plans. These restrictions do not appear to apply to self-insured plans.	1/1/11
		Effective Date 2012
CLASS Act: Voluntary, Self-Funded Long-Term Insurance Program. HHS will establish a voluntary long term care insurance program for purchasing community living assistance services and supports (CLASS program). An individual would be required to contribute to the program for 5 years (vesting period) before benefits (up to $50/day cash benefit) are available. The payments can be used to purchase non-medical services and support necessary to maintain community residence, including, home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. The program is financed entirely through voluntary payroll deductions. All working adults will be automatically enrolled in the program, unless they choose to opt-out. Employers can voluntarily choose to provide enrollment tools and process the premiums for the program.	Individuals	1/1/12
Patient-Centered Outcomes Research Fee. Insurers must pay a fee of $2 ($1 for policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy. The fee must be paid by insurers of fully-insured plans and employers of self-funded plans. The fees will be used to measure patient-centered outcomes.	Insurers of fully-insured plans and Employers of self-funded plans.	Plan years ending after 9/30/12

Insurance Issues (continued)

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2014
Rating Restrictions. Insurers in the individual and small group markets are only allowed to consider the following when determining premium rates: **1.** Whether coverage is for an individual or family **2.** The rating area as determined by each State **3.** Age, except that the rate cannot vary by more than 3 to 1 for adults **4.** Tobacco use, except that the rate cannot vary by more than 1.5 to one Regulations regarding permissible age bands will be issued. If a State offers large group coverage through the Exchange, insurers in the large group market are also required to comply with the rating restrictions.	■ Insurers in the Individual and Small Group (<100 lives) Markets ■ Insurers in the Large Group Market(100+ lives), if the State allows Large Group coverage through the Exchange. ■ These restrictions N/A to self-insured plans.	1/1/14
Coverage for Individuals Participating in Approved Clinical Trials. Individual and group health plans cannot deny individual participation in approved clinical trials and must cover routine costs in approved clinical trials. Insurers are not required to cover the following: ■ The investigational item, device or service; ■ Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or ■ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	Individual and Group Plans	1/1/14
Ban on Excessive Waiting Periods. An individual's waiting period to be able to enroll in a group health plan may not exceed 90 days.	Group plans	1/1/14

Insurance Issues (continued)

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2014 (continued)
Health Insurance Reporting Requirement. Insurers providing minimum essential coverage are required to provide returns in a format that will be determined. The return must include: **1.** Identifying information for the primary insured and others receiving coverage under the policy; **2.** The dates covered under minimum essential coverage during the calendar year; **3.** Whether the coverage is offered through an Exchange; and **4.** The amount of any advance payment of any cost-sharing reduction or any premium tax credit. Employer-provided coverage return and information statement must include: **1.** Identifying information for the employer and covered employees; **2.** Certification as to whether the employer offers minimum essential coverage; **3.** Length of any waiting period; **4.** The months during the calendar year for which coverage was available; **5.** The monthly premium for the lowest cost option in each enrollment category; **6.** The employer's share of the total costs of benefits, and **7.** The number of full-time employees.	Insurers providing Minimum Essential Coverage	1/1/14
Health Insurance Exchange. Health Insurance Exchanges will be established by the individual states to facilitate the purchase of qualified health plans by individuals and assist small employers in facilitating the enrollment of their employees (SHOP Exchange). A State may choose to combine the Individual and SHOP Exchanges if the Exchange has adequate resources. Limited scope dental benefits plan may be offered through the Exchange if the plan provides pediatric dental benefits. **Participating Insurer Requirements** Plans seeking to participate in the Exchange are required to submit justification for any premium increases to the Exchange prior to implementing the change and prominently post the information on their websites.	Insurers in the Individual and Small Group Markets Dental-only plans offering pediatric dental benefits Beginning in 2017, Large Groups may be allowed to participate in the Exchange.	1/1/14 for Individual and Small Group Plans 2017 for Large Group Plans

Insurance Issues (continued)

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2014 (continued)
Health Insurance Exchange (continued) Plans are required to provide information in a timely manner to individuals regarding the amount of cost-sharing under the plan or coverage the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. Plans are required to make this information available on their websites. Plans are also required to disclose the following information in plain language: **1.** Claims payment policies and practices; **2.** Periodic financial disclosures; **3.** Data on enrollment; **4.** Data on disenrollment; **5.** Data on the number of claims that are denied; **6.** Data on rating practices; **7.** Information on cost-sharing and payments with respect to any out-of network coverage; and **8.** Information on enrollee and participant rights **Rating Requirements** ■ Individual Market: Insurers are required to consider all enrollees in all health plans (other than grandfathered health plans) offered in the individual market, including those who do not enroll in individual plans through the Exchange to be members of a single risk pool. ■ Small Group Market: Insurers are required to consider all enrollees in all health plans (other than grandfathered health plans) offered in the small group market, including those who do not enroll in small group plans through the Exchange to be members of a single risk pool. Beginning in 2017, individual States may allow large groups to participate in the Exchange. Insurers are not required to offer large group plans through the Exchange. **Employer Size Defined** ■ Small Employers - those with at least 1 but not more than 100 employees. ■ Large Employers are those with at least 101 employees. ■ For plan years starting before 1/1/16, States may elect to define Small Employers as those with at least 1 but not more than 50 employees and Large Employers as those with at least 51 employees. Insurers are allowed to offer plans to qualified individuals and qualified employers outside of the Exchange.		

Insurance Issues (continued)

(also see Employer/Plan Sponsor Issues, Tax Issues and Individual Responsibility)

Provision	Impact	Effective Date 2016
Health Care Choice Compacts. Insurers are permitted to sell insurance in states participating in health care choice compacts, provided the insurer is licensed in each state in which it offers the plan under the compact.	Individual plans	1/1/16
		Effective Date 2018
Excise Tax on High Cost Employer-Sponsored Health Coverage. A 40% excise tax will be imposed on the value of high cost employer sponsored health coverage ("Cadillac" health plans) exceeding certain threshold limits ($10,200/individual; $27,500/family). The employer calculates the excise tax and provides to the insurer or third party administrator, who then pays the tax.	All-sized employers	1/1/18

INDIVIDUAL RESPONSIBILITY ISSUES

(also see Tax Issues, Insurance Issues and Medicare Issues)

Individual Responsibility
(also see Tax Issues, Insurance Issues and Medicare Issues)

Provision	Impact	Effective Date 2010
Temporary High Risk Pool. This is to be established by the Secretary of Health and Human Services (HHS). Generally, to be eligible for the pool, the individual must have been without creditable coverage (as defined by HIPAA) for at least 6 months, and have a preexisting condition, to be defined by the Secretary.	Individuals	6/21/10
		Effective Date 2011
OTC Medications Are Not Qualified Expenses. FSAs, HRAs, Archer MSAs, and HSAs can no longer reimburse the cost of over-the-counter (OTC) medications, except for insulin or prescribed OTC drugs.	Individuals	1/1/11
		Effective Date 2013
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500.	Individuals participating in an employer-sponsored FSA plan	1/1/13
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased by 0.9%, from 1.45% to 2.35%, to the extent his wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ Employer must withhold on all wages over $200,000 ■ Employee liable regardless of employer withholding ■ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals equal to 3.8% of the lesser of an individual's (1) "net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities) or (2) modified adjusted gross income in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ No employer withholding requirement ■ Counted for estimated tax payments ■ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13

Individual Responsibility (continued)
(also see Tax Issues, Insurance Issues and Medicare Issues)

Provision	Impact	Effective Date 2014
Individual Mandate. Individuals are required to maintain minimum essential health coverage for themselves and their dependents. *Options for Coverage:* ■ Individuals with household income <133% of FPL may be eligible for minimum essential coverage through Medicaid. ■ Individuals who are between 134%-400% of FPL may be eligible for premium assistance or cost sharing possibilities. ■ Individuals with household income <400% of FPL would be entitled to a Free Choice Voucher, if their employer offers coverage with a cost of between 8% to 9.5% of the individual's household income and the individual does not participate in the employer's plan. See *Employer/Plan Sponsor chart* for details about the Free Choice Voucher.	All U.S. citizens, nationals and lawfully present aliens, except individuals meeting certain religious or immigration exemptions, and incarcerated individuals. Exceptions: ■ Members of Indian Tribes; ■ Individuals with short coverage gaps; ■ Individuals suffering a hardship; ■ Individuals with household modified AGI below the filing threshold.	1/1/14
Exchange Subsidy. Qualified taxpayers who get health insurance coverage by enrolling in a qualified health plan are eligible for a refundable tax credit.	Taxpayers whose income equals or exceeds 100% but does not exceed 400% of the FPL for the size of family involved.	1/1/14

MEDICARE ISSUES

Medicare Issues

Provision	Impact	Effective Date 2010
Medicare Coverage Gap Discount Program – Coverage Gap Rebate for 2010. Retirees who enter the coverage gap or "donut hole" will receive a one-time $250 rebate from the Medicare Prescription Drug Account no later than the 15th day of the third month following the end of the quarter when they enter the "donut" hole.	Medicare Part D Enrollees	3/23/10
		Effective Date 2011
Medicare Coverage Gap Discount Program. In order to have their drugs covered by Medicare Part D, pharmaceutical manufacturers must provide a 50% discount off the negotiated price for brand name drugs under plan formularies for beneficiaries who enter the coverage gap. Beneficiaries would be eligible for the discount if they don't qualify for low-income subsidies, do not have employer-sponsored coverage, or do not pay higher, income-related Medicare premiums under Parts B or D.	Medicare Part D Enrollees	1/1/11
		Effective Date 2013
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased by 0.9%, from 1.45% to 2.35%, to the extent his wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ Employer must withhold on all wages over $200,000 ■ Employee liable regardless of employer withholding ■ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals equal to 3.8% of the lesser of an individual's (1) "net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities) or (2) modified adjusted gross income in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ■ No employer withholding requirement ■ Counted for estimated tax payments ■ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13

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