



The Patient Protection and Affordable Care Act

*An In-Depth Analysis of Provisions Directly or Indirectly
Affecting Group Health Plans*

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Section 1 - Insurance Plan Provisions

Prohibition on Maintaining Lifetime Limits

All self-insured health plans (and all other group health plans) are prohibited from establishing lifetime limits on the dollar value of benefits for any participant or beneficiary.

Exclusion – Self-insured health plans (and all other group health plans) and health insurance providers are not restricted from placing lifetime per-beneficiary limits on non-essential health benefits¹ to the extent that such limits are otherwise permitted under Federal or State law.

Effective date – Plan years beginning after 9/23/10

Restrictions on Maintaining Annual Limits

Prior to 2014, all self-insured health plans (and all other group health plans) may only establish a restricted annual limit on the dollar value of the benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits¹. Starting in 2014, plans are prohibited from establishing any limits on the dollar value of benefits.

Exclusion – All self-insured health plans (and all other group health plans) and health insurance providers are not restricted from placing annual per-beneficiary limits on non-essential health benefits to the extent that such limits are otherwise permitted under Federal or State law.

Effective date – Plan years beginning after 9/23/10

Prohibition on Rescissions

All self-insured health plans (and all other group health plans) are prohibited from rescinding coverage from any beneficiary unless that beneficiary has committed an act of fraud against the plan or a misrepresentation of material fact.

Effective date – Plan years beginning after 9/23/10

Coverage of Preventative Health Services

All Non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) must provide first-dollar coverage for the following preventative services:

- Items or services with a rating of A or B in the current recommendations of the U.S. Preventative Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants and children
- Preventative care and screenings for women as provided for by the Health Resources and Services Administration

Plans may cover additional services and/or deny coverage for services not required to be covered.

A minimum time interval of at least one year will be established for plans to begin covering any newly mandated preventative services.

Effective date – Plans years beginning after 9/23/10

Extension of Dependent Coverage

All self-insured health plans (and all other group health plans) that cover dependent children, will have to extend that coverage to dependents up to their 26th birthday. Prior to 2014, grandfathered² self-insured plans (and all other grandfathered² group health plans) are only required to offer coverage to dependent children without access to a plan through their own employer.

Marriage or student status is not a factor in dependent eligibility.

A dependent's coverage is not taxable as income.

Plans are not required to cover a child of a child dependent.

Effective date – Plan years beginning after 9/23/10

Prohibition of Discrimination Based on Salary

All non-grandfathered² group health plans (excluding self-insured health plans) are prohibited from establishing rules regarding coverage eligibility (including continued eligibility) that are based on hours worked or annual salaries.

Plans allowed to cost-share at higher amounts for low-income beneficiaries.

Effective date – Plan years beginning after 9/23/10 for non- grandfathered² plans

Medical Loss Ratio

All group health plans (excluding self-insured health plans) are required to submit a report presenting the percentage of collected premiums that provided coverage spends on:

- Reimbursement for clinical services
- Activities that improve healthcare quality
- An explanation of all non-claims costs (excluding State taxes and regulatory fees)

All reports will be made available to the public.

Plans are prohibited from spending less than 85% of collected premiums on medical services listed above for large group coverage. Through 2013, plans are required to rebate their beneficiaries on a pro-rata basis amounts under the required percentage.

Plans are prohibited from spending less than 80% of collected premiums on medical services listed above for small group and individual coverage. Through 2013, plans are required to rebate their beneficiaries on a pro-rata basis amounts under the required percentage.

Effective date – Plan years beginning after 9/23/10

Prohibition of Preexisting Conditions Exclusions

All self-insured health plans (and all other group health plans) are prohibited from imposing any preexisting condition exclusions on enrollees under the age of 19. For plan years beginning after 1/1/14, all group health plans (including self-insured) are prohibited from imposing any preexisting condition exclusions on any enrollee.

Effective date – Plan years beginning after 9/23/10 from excluding children, plan years beginning after 1/1/14 for all enrollees

Rating Restrictions

All group health plans in the large group market (excluding self-insured health plans) will now be restricted in their levels of premium variance. Plans may only rate based on:

- Whether the coverage is for an individual or family
- Rating area³
- Age (but no more than 3:1)
- Tobacco use (but no more than 1.5:1)

Effective date – Plan years beginning after 1/1/14

Guaranteed Availability of Commercial Coverage

All health plans (excluding self-insured plans) are required to accept every employer and individual in the State they are certified in that applies for coverage. Plans are allowed to maintain set enrollment periods as well as enrollment periods for qualifying events⁴.

Effective date – Plan years beginning after 1/1/14

Guaranteed Renewability of Commercial Coverage

All health plans (excluding self-insured plans) that offer coverage in the individual or group market, must provide the opportunity for the individual or plan-sponsor to renew.

Effective date – Plan years beginning after 1/1/14

Prohibition of Discrimination Against Beneficiaries Based on Health Status

All self-insured health plans (and all other health plans) are prohibited from establishing rules for eligibility (including continued eligibility) based on the following health status-related factors:

- Health status
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability
- Disability

Effective date – Plan years beginning after 1/1/14

Prevention and Wellness Program Rules and Restrictions

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) must comply with provisions relating to prevention and wellness programs.

Plans may offer wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a premium discount, rebate or other reward, if it does so to all similarly situated beneficiaries. Such programs include:

- A partial or full subsidy for membership in a fitness center

- A diagnostic testing program
- Programs that encourage preventive care through the waiving of a copayment or deductible
- Smoking cessation programs
- Health education seminars

Plans may offer discounts, rebates or rewards for participants of a wellness program based on achieving a change in health status, but only under certain conditions:

- If the premium discount is less than 30%
- The program is has a reasonable chance of improving the health of, or preventing disease in, participating individuals
- The program is offered at least once a year

Effective date – Plan years beginning after 1/1/14 for non-grandfathered² plans

Waiting Periods Restrictions

All self-insured health plans (and all other health plans) are prohibited from maintaining waiting periods⁵ longer than 90 days.

Effective date – Plan years beginning after 1/1/14

Development and Availability of Plan Explanations

All self-insured health plans (and all other health plans) will be required to provide to their enrollees and applicants a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the plan.

The Secretary is required to develop standards for plans to follow in complying with requirement. The Secretary will consult the NAIC, a group of representatives of health-related consumer advocacy groups, health insurance issuers, health care professionals and patient advocates.

The standards to be developed will include:

- A summary of benefits and coverage presented in uniform format that does not exceed 4 pages and has a font of at least 12 point
- A summary written in a culturally and linguistically appropriate manner using terminology understandable by the average plan enrollee
- The summary of benefits will be required to include:

- Uniform definitions of insurance terms
- A description of the coverage including cost-sharing for; each of the categories of the essential health benefits¹
- Other benefits
- The exceptions reductions and limitations on coverage
- Cost-sharing provisions, including deductible, coinsurance and co-payment obligations
- The renewability and continuation of coverage provisions
- Examples of common benefits scenarios including; pregnancy and chronic medical conditions and cost-sharing scenarios for each
- Whether the plan provides minimum essential coverage⁶ and provides a cost-share of at least 60%
- A statement that the summary should be consulted to determine the governing contractual provisions
- Contact information for the beneficiary to contact with questions and an Internet address for the beneficiary where a certificate of insurance can be reviewed

The summary will be presented to the enrollee at the time of their application for the plan and prior to their reenrollment. The summary is to be in paper or electronic form.

A health insurance issuer or the administrator of a self-insured plan is responsible for development of the summary.

If the plan makes any material modification⁷ not reflected in the most recent summary, it will provide notice to enrollees no later than 60 days prior to the effective date of such modification.

Effective date - Plan years beginning after 9/23/12

Reporting Requirements

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) are required to report to HHS and plan enrollees, information on initiatives and programs that improve health outcomes. Information required to be submitted will be decided on by the Secretary no later that 9/23/12.

The general information to be reported will be as follows:

- Programs that improve health outcomes through the implementation of quality reporting, effective case management, care coordination, chronic disease management and medication
- Activities implemented to prevent hospital readmissions

- Activities implemented to improve patient safety and reduce medical errors through the use of clinical practices, evidence based medicine and HIT
- Wellness and prevention programs

A report is to be issued annually and is to outline how the benefits under the plan satisfy the required goals. The report is to be made available to enrollees and prospective enrollees during each open enrollment period.

Effective date – non-grandfathered² plans will be required to begin issuing reports for plan years that begin after the Secretary formally releases the reporting requirements

Appeals Process

All non-grandfathered² self-insured plans (and all other non-grandfathered² group plans) are required to implement a process for the appeal of coverage determinations and claims. The process at a minimum should:

- Have an internal claims appeal process (already current law for employer-sponsored plans)
- Provide notice (culturally and linguistically appropriate) of the availability of an internal and external appeals process and the availability of the Office of Consumer Assistance
- Allow employees to review their files, present evidence and testimony as part of the appeals process and continue to be covered until the appeal is closed
- Have an external appeals (fully-insured – follow NAIC consumer protection standards; self-insured follow TBD DOL guidelines)

Plans must provide notice of their process as well as availability of ombudsman's office.

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Choice of Primary Care Provider

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) who require beneficiaries to designate a primary care physician, must permit each beneficiary to designate any available provider.

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Coverage of Emergency Services

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) covering emergency department services, must cover emergency services⁸:

- Without the need for any prior-authorization determination
- Whether the provider is a participating provider
- If emergency services⁸ are provided:
 - Services will be provided without imposing any requirement for prior authorization of services or limitation on coverage where the provider does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements of limitations that apply to providers who do have a contractual relationship with the plan; and
 - If services are provided out-of-network, the cost-sharing requirement is the same requirement that would apply if such services were provided in-network
- Without regard to any other term or condition of coverage

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Access to Pediatric Care

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) that require the designation of a participating primary care provider for a child, now must allow beneficiaries to designate a participating physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider.

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Access to Obstetrical and Gynecological Care

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) providing coverage for obstetric or gynecologic care and require the designation by a beneficiary of a participating primary care provider, may not require authorization or referral from a beneficiary for obstetrical or gynecological care by participating providers.

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Access to Clinical Trials

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) that provide coverage to an individual eligible to participate in a clinical trial dealing with the treatment of a life-threatening disease, may not:

- Deny the participation in the clinical trial

- Deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial
- Discriminate against the individual on the basis of the individual's participation in a clinical trial

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Transparency of Coverage

All non-grandfathered² self-insured health plans (and all other non-grandfathered² group health plans) are required to make details of their plan available. Plans are required to submit the following information to HHS, the applicable State insurance department and the general public:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to any out-of-network coverage
- Information on enrollee and participant rights

The information is required to be presented in plain language⁹.

Plans must make available to individuals the amount of cost-sharing (including deductibles, copayments, and coinsurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider.

Effective date - Plan years beginning after 9/23/10 for non-grandfathered² plans only

Health Information Technology Standards

All self-insured health plans (and all other health plans) will have to adopt new HIT procedures based on Federally set standards. The procedures will be a set of uniform standards and operating rules for the electronic transactions that occur between providers and plans.

The Federally adopted standards and operating rules will:

- Enable determination of an individual's eligibility and financial responsibility for specific services prior to or at point of care
- Require no or minimal augmentation by paper
- Provide for timely acknowledgment, response and status reporting supporting a transparent claims and denial process
- Describe all data elements

No later than 12/31/15, plans must file a statement certifying that their data and information system are in compliance with the adopted standards and rules.

Plans will be required to comply immediately with any revised standards and/or rules.

Plans may be audited as to whether they are in compliance. Starting no later than 4/1/14, plans will be assessed a \$1 per-life/per-day penalty if they are in non-compliance of any of the standards and/or rules.

Effective date – Plans required to comply once standards and rules are adopted by HHS

Cost-Sharing Limitations

All self-insured health plans (and all other health plans) will be limited on the amount of cost-sharing they can require from their beneficiaries.

Starting in 2014, required cost-sharing will be limited to the maximum non-premium out-of-pocket expenses allowable for High-Deductible Health Plans.

In plan years beginning in 2015 and beyond, cost-sharing will be limited to twice the product of the maximum non-premium out-of-pocket expenses allowable under High Deductible Health Plans and the yearly Premium Adjustment Percentage¹⁰.

For plans offered in the small group commercial market, the deductible under the plan may not exceed \$2,000 for individual coverage and \$4,000 for family coverage.

Effective date – Plan years beginning after 1/1/14 for non-grandfathered² plans

Premium Review Process

Starting with the 2010 plan year, plans (excluding self-insured) will have their premium increases reviewed to determine if the increases are unreasonable. Plans will be required to submit to HHS and to the State in which they are domiciled a justification for an unreasonable premium increase. The submission is required prior to the implementation of the increase. Plans are required to post this information on their website.

Effective date – 2010 plan year

Section 2 – Temporary Coverage Expansion Programs

Temporary High-Risk Pool

No later than 6/23/10, a temporary high-risk pool program will be implemented to provide coverage for individuals with preexisting conditions. The program will be run by a State or non-profit private entity. The pool will terminate on 1/1/14.

Issued coverage will have a cost-share by the plan of at least 65% and have a maximum out-of-pocket limit of the applicable yearly HSA limit. The plan must comply with the newly instituted rating rules.

Individuals are eligible if they have not had credible coverage¹¹ for at least 6 months prior to their application to the pool and have a preexisting condition.

Criteria will be developed to determine whether insurers or employer-sponsored plans (including self-insured) have discouraged individuals from remaining in their plan.

Effective date – No later than 6/23/10

Reinsurance for Early Retirees

No later than 6/23/10, a reinsurance program will be implemented to provide reimbursement to participating employer-sponsored plans (including self-insured) for a portion of the cost of providing coverage to early retirees (and their dependents). The program will terminate 1/1/14 (the date of implementation of the exchanges).

An early retiree must be age 55 and older, not eligible for coverage under the Social Security Act and not an active employee.

In order to participate, plans must submit an application to HHS, maintain programs to lower costs for high-cost conditions and provide the actual cost of medical care involved to be certified by HHS.

In order to receive payments, plans must:

- Submit claims for reimbursement that document actual costs of the items and services that the plan is seeking reimbursement for eligible reimbursable treatments and services.

Plans will receive an 80% reimbursement for claims that exceed \$15,000, but are less than \$90,000. Any payment is required to lower costs of the plan. Payments are prohibited from being used simply as revenue.

Effective date – No later than 6/23/10

Section 3 - Health Insurance Exchanges

American Health Benefit Exchanges

Each State is required to establish its own health insurance exchange by 1/1/14. The exchanges will be used to help individuals and employers purchase qualified health plans¹². States have the option of having separate exchanges for individual coverage and employer-sponsored group coverage.

Plans offered in an exchange will receive ratings from HHS based on quality and price. Beneficiary satisfaction survey results for each plan will also be made available. All such information will be available online.

Exchange will receive Federal start-up funds, but are required to be self-sufficient no later than January 1, 2015.

Functions of an Exchange

The responsibilities of each State-based exchange are as follows:

- Certify all participating plans as Qualified Health Plans¹²
- Operate a telephone assistance hotline
- Operate a website contain comparative information on all participating plans
- Rate each participating plan
- Present health benefit plan options using the HHS standardized reporting requirements
- Inform resident of eligibility requirements for Medicaid and CHIP and enroll any eligible residents
- Certify eligible individuals as exempt from the individual coverage mandate
- Provides to each employer the names of each of their employees exempt from the individual coverage requirement

Enrollment Periods

Exchanges are required to have the following enrollment periods:

- An initial open enrollment period – prior to the exchange’s implementation
- Annual open enrollment periods
- Special enrollment periods¹³

Additional Benefits

States may require plans in their exchange(s) to cover additional benefits that are not defined essential health benefits¹⁴. For any resident receiving a credit, the State must pay any increased costs directly to their plan due to additional mandated benefits.

Levels of Coverage

The following are the coverage tiers that plans will be offered in:

- A plan in the Bronze Level shall provide coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided
- A plan in the Silver Level shall provide coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided
- A plan in the Gold Level shall provide coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided
- A plan in the Platinum Level shall provide coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided

The level of coverage of a plan shall be determined on the basis that the essential health benefits shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

Catastrophic Plans

Carriers may offer a catastrophic-only plan through an insurance exchange. Coverage purchased by eligible individuals will satisfy the individual coverage mandate. To be eligible to purchase coverage through a catastrophic plan, an individual must:

- Be under the age of 30 at the start of the plan year; or
- If other coverage is deemed unaffordable due to:
 - An individual's contribution exceeds 8% of income (net income + coverage amount)
 - Is deemed by HHS to have suffered a hardship¹⁵

Effective date – 1/1/14

Free Choice Vouchers

Plan sponsors of employer-based plans (including self-insured) are required to offer vouchers to employees who meet un-affordability requirements for use to purchase coverage through an insurance exchange.

Employees eligible for a voucher are ones:

- Whose contribution for coverage is between 8% and 9.8% of their household income for the taxable year which ends with or within the plan year; and
- Whose household income is less than 400% of FPL; and
- Does not participate in any health plan offered by the employer

The amount of any free choice voucher provided shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan.

An Exchange shall credit the amount of any voucher to the monthly premium of any qualified health plan¹² in the Exchange in which the qualified employee is enrolled and the offering employer shall pay any amounts so credited to the Exchange.

If the amount of the voucher exceeds the amount of the premium of the qualified health plan¹² in which the qualified employee is enrolled for such month, such excess shall be paid to the employee.

The cost of the voucher will not count as taxable income for any recipient.

The cost of any vouchers to an employer is deductible for such employer.

Effective date – 1/1/14

Reviews of Proposed Premium Increases

Exchanges may require participating plans to submit a justification for any premium increase prior its implementation. Plans would then be required to post that information online. The State would then make a determination as to whether the plan would still be allowed to be offered through its exchange.

Multi-State Exchanges

Exchanges may operate in more than one State if each State that it would operate in approves and if it is approved by HHS.

Ability for States to Establish Multiple Exchanges

States may choose to establish one or more subsidiary exchange if such an exchange serves a geographically distinct area that is as large as a rating area³ within the State.

Ability of Exchanges to Contract with Service Providers

A State may contract with private entities to carry out functions of the exchange. To be eligible, the entity must be incorporated by at least one State, have demonstrated experience in the individual and small group markets as well as in benefits and coverage and is not a health insurance issuer.

Quality Incentives

States may choose to provide incentives to plans, including increased reimbursements for areas that improve quality such as, improving health outcomes, prevention of hospital readmissions, improvements in patient safety and the implementation of prevention and wellness programs.

Mental Health Parity

All exchange plans will have to comply with current mental health parity standards as applied to health plans and health insurers.

Employer Coverage Through an Exchange

Employers may purchase coverage for their employees through an exchange. The employer may choose the level of plan they will cover. Employees would then choose a plan within that level.

Large Employer Eligibility

Starting in 2017, States may open their exchanges up to large employers.

Stand Alone Dental Plans

Exchanges may allow stand alone dental benefit plans to be offered through their exchange. Plans at a minimum must offer pediatric dental benefits.

CO-OPs

Non-profit, member-run insurance issuers known as, Consumer Operated and Oriented Plans (CO-OPs) will be allowed to offer coverage through the State insurance exchanges.

Federal loans will be provided for start-up costs. Grants will be awarded to help plans meet solvency requirements. Loans and grants will be awarded no later than 7/1/13. Loans are required to be paid back in 5 years; grants are required to be paid back in 15.

The following are the guidelines CO-OPs must follow:

- All profits made by the plan must be used to lower premiums, improve benefits or for programs intended to improve the quality of healthcare of its members
- In order for an issuer to offer a CO-OP, it must be organized under State law as a non-profit, member organization
- Issuers may not be sponsored by a State or local government
- Plans must meet all insurance laws of the State in which they operate

Governance standards of CO-OPs include:

- That the governance of the organization be subject to a majority vote of its members
- That its governance documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference
- That the organization operates with a strong consumer focus, including timeliness, responsiveness and accountability to members

Plans that are in non-compliance will be assessed a penalty off 110% of any loans and grants amount that the plan was awarded.

If no health insurance issuer applies to be a qualified non-profit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified non-profit health insurance issuer within the State or the expansion of a qualified non-profit health insurance issuer from another State to the State.

Section 4 – Multi-State Plans

Health Care Choice Compacts

Plans will be allowed to be offered in two or more States starting 1/1/16. States may enter into an agreement under which:

- One or more Qualified Health Plans¹² could be offered in the individual markets of each State entering into the compact. A plan would abide by the regulations of the State in which it was domiciled
- The issuer of a plan would:
 - Continue to be subject to market conduct, unfair trade practices, network adequacy and consumer protection standards;
 - Be required to be licensed in each State in which it offers the plan under the compact; and
 - Clearly notify consumers that the plan may not be subject to the laws and regulations in which they reside

Multi-State Plans Overseen by OPM

The Office of Personnel Management (OPM) is required to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through exchanges in each State.

OPM is required to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits Program (FEHBP).

Multi-state plans are required to cover essential health benefits¹ and meet all of the requirements of a qualified health plan¹². States may require multi-State plans to offer additional benefits, but must pay for the additional cost.

Section 5 – Reinsurance and Risk Adjustment

Temporary Individual and Small Group Market Reinsurance Program

For the years 2014, 2015 and 2016, States will be required to establish a temporary reinsurance program. The intent of the program is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of the exchanges.

Health insurance issuers and third party administrators of self-insured health plans will be required to make payments to the program for each of its years in operation. Contribution amounts will be based on the percentage of revenue for an insurer or the total costs of providing benefits to enrollees in self-insured health plans.

The reinsurance program will make payments to issuers that cover high-risk beneficiaries in the individual market (excluding grandfathered² plans).

Risk Corridors

A temporary risk-adjustment program will be established for the first three years of implementation of the exchanges (2014-2016). Qualified Health Plans¹² offered in the individual and small group markets will participate in a payment adjustment system based on a ratio of allowable costs¹⁶ to collected premiums.

Plans will receive payments from the program if;

- Their allowable costs¹⁶ for a plan year are between 103% - 108% of their collected premiums. They will receive payments of 50% of costs that exceed 103%
- Their allowable costs¹⁶ for a plan year exceed 108% of their collected premiums. They will receive payments of 2.5% of their allowable costs¹⁶ plus 80% of those costs that exceed 108%

Plans will make payments into the program if:

- Their allowable costs for a plan year are less than 97% of allowable costs¹⁶, but not less than 92% of that amount, the plan will make a payment equal to 50% of collected premium that exceed 97% of those costs
- Their allowable costs are less than 92% of their allowable costs¹⁶, the plan will make a payment equal 2.5% of allowable costs¹⁵ plus 80% of those costs that exceed 92%.

Risk Adjustment

Plans (excluding self-insured) with lower than average risk will be required to make payments that will be distributed to those plans (excluding self-insured) that have a higher than average risk of their enrollees.

Such plans will be those non-grandfathered² plans that offer coverage in the individual and small group market.

Section 6 – Assistance for Low-Income Workers

Premium Assistance Tax Credits

Individuals and families with incomes between 100% - 400% of the Federal Poverty Level and who are covered by an exchange plan are eligible for advanceable, refundable tax credits, paid to the issuer, against the cost of their healthcare coverage. The payment of credits will begin in 2014.

Low-income workers with access to minimum essential coverage⁶ through their (or their dependent's) employer, are only eligible for a Premium Assistance Credit (for use in purchasing an exchange plan only) if:

- They have incomes between 100% - 400% of FPL; and
- Their contribution for coverage exceeds 9.5% of their income; and
- Their (or their dependent's) employer's cost-sharing contribution is less than 60%

Premium Assistance Credit amounts will be the lesser of:

- The monthly cost of coverage of the taxpayer and any dependents; or
- The excess of:
 - The monthly premium amount of second lowest cost Silver Plan available in the individuals rating area³; over
 - 1/12 of the product of:
 - The taxpayer's household income; and
 - The applicable percentage for their income tier on a sliding scale basis between premium percentages as displayed in the following table:

Income Tiers	Initial Premium Percentage	Final Premium Percentage
133% up to 150%	2.0%	2.0%
150% up to 200%	3.0%	4.0
200% up to 250%	4.0%	6.3%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

Beginning in years after 2014, the initial and final applicable percentages shall be adjusted to reflect the excess of the rate of premium growth for the preceding year over the rate of income growth for the preceding year.

Out-of-pocket maximums for 2014 will be calculated as such:

Federal Poverty Level	Maximum Premium as % of Income	Maximum Annual Premium by Family Size			
		1	2	3	4
100%	2.0%	\$217	\$291	\$366	\$441
133%	2.0%	\$288	\$388	\$487	\$587
133.01%.	4.0%	\$570	\$766	\$963	\$1,160
150%	4.6%	\$739	\$994	\$1,250	\$1,505
200%	6.3%	\$1,365	\$1,836	\$2,307	\$2,778
250%	8.1%	\$2,180	\$2,932	\$3,685	\$4,438
300%	9.8%	\$3,184	\$4,284	\$5,583	\$6,483
350%	9.8%	\$4,245	\$5,711	\$7,178	\$7,563
400%	9.8%	\$4,245	\$5,711	\$7,178	\$8,644

For years after 2014, the percentages would be adjusted to reflect any percentage by which premium growth exceeded income growth.

Maximum Cost-Sharing

Individuals and families with incomes between 100% - 400% of the Federal Poverty Level will have reduced out-of-pocket maximums; with plans receiving Federal subsidies amounting to the difference between the standard maximum level and the allowable reduced maximums of their beneficiaries.

The applicable out-of-pocket maximums¹⁷ are reduced by the following amounts:

- 100% - 200% of FPL – maximums are reduced by 2/3
- 200.01% - 300% of FPL – maximums are reduced by 1/2
- 300.01% - 400% of FPL – maximums are reduced by 1/3

Section 7 – Small Business Tax Credits

Small Business Tax Credits

Small businesses are eligible for tax credits against the cost of their contributions to their employees' healthcare coverage. To be eligible, businesses must have less than 25 employees and less than \$50,000 in average full-time equivalent¹⁸ employee wages¹⁹.

Until 2014:

- Businesses will receive a credit amount of 35% of the lesser of:
 - Contributions made on behalf of their employees' coverage in a Qualified Health Plan¹²;
or
 - The contribution the employer would have made if each of their employees had enrolled in a Qualified Health Plan¹² with a premium equal to the average for the small group market in their rating area³

- The credit amount that the employer is eligible for will be reduced by the sum of:
 - The number of full-time employees minus 10 then divided by 15 then multiplied by the credit amount; and
 - The amount of average per-full-time employee wages minus \$20,000 then divided by \$20,000

In 2014 and beyond:

- Businesses will receive a credit amount of 50% of the lesser of:
 - Contributions made on behalf of their employees' coverage in a Qualified Health Plan¹²;
or
 - The contribution the employer would have made if each of their employees had enrolled in a Qualified Health Plan¹² with a premium equal to the average for the small group market in their rating area³

- The credit amount that the employer is eligible for will be reduced by the sum of:
 - The number of full-time employees minus 10 then divided by 15 then multiplied by the credit amount; and

- The amount of average per-full-time employee wages minus the previous year's wage threshold increased by the cost-of-living adjustment then divided by previous year's wage threshold increased by the cost-of-living adjustment

Section 8 – Individual Responsibility

Individual Coverage Mandate

All U.S. citizens and legal residents will now be required to maintain Minimum Essential Coverage⁶. For any month they (or their dependents) are uncovered, they will be assessed a penalty.

For each month an individual (or their dependents) went without coverage, they will be assessed 1/12th of the applicable penalty. Penalties will be included in the individual's following year tax return. Penalties amounts will be as follows:

- In 2014: The higher of \$95 or 1% of income - but no higher than the national average for Bronze Level Qualified Health Plans)
- In 2015: The higher of \$325 or 2% of income (but no higher than the national average for Bronze Level Qualified Health Plans)
- In 2016: The higher of \$695 or 2.5% of income (but no higher than the national average for Bronze Level Qualified Health Plans)
- For subsequent years: The product of the previous year's penalty and the annual cost-of-living adjustment (but no higher than the national average for Bronze Level Qualified Health Plans)

The penalty for any individual under the age of 18 who is in non-compliance of the coverage mandate will be one-half of the applicable amount.

Penalties will be capped at three times the penalty amount regardless of family size.

Exemptions based on affordability will be granted if one's required contribution²⁰ exceeds 8% of their gross income.

Section 9 - Employer Responsibility

Automatic Enrollment

Employers with over 200 full-time employees that offer at least one health benefits plan are required to automatically enroll new full-time employees and re-enroll current employees. Employers can wait up to 90 days to enroll employees.

Employers must provide adequate notice to their employees of their enrollment.

Employers must allow their employees the opportunity to opt-out of any coverage they were automatically enrolled in.

Effective date – TBD by agency guidance

Disclosure of Coverage Options

Employers are required to disclose the following to each employee at the time of their hire:

- Informing the employee of the existence of their State’s insurance 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
- If the employer’s share of the total allowed costs of benefits provided is less than 60% of such costs, that the employee may be eligible for a premium tax credit and a cost-sharing reduction if the employee purchases a Qualified Health Plan¹² through the exchange
- If the employee purchases a Qualified Health Plan¹² through the exchange, the employee will lose the employer contribution (if any) for its health plan and that all or a portion of such contribution may be excludable from Federal income tax

Effective date – 3/1/13

Employers Not Offering Coverage

Employers with over 50 employees will be penalized if:

- They do not offer minimum essential coverage⁶; and
- In any month have at least one employee receiving and using a premium assistance tax credit to purchase coverage through an exchange

Penalties equal:

- 2014 - A monthly fee of (1/12th of \$2,000) per full-time employee employed in such month - Employers may disregard first 30 employees from penalty calculations
- Subsequent years – the monthly fee will be 1/12th of (the previous year’s annual penalty amount plus the increase in the premium adjustment percentage¹⁰)

All employers required to pay the penalty are also required to report the following information to HHS as well as a personalized copy to each employee:

- The employer’s name and employer identification number
- A certification of whether the employer offer’s minimum essential coverage⁶
- If the employer certifies that it did offer minimum essential coverage⁶, it must:
 - The length of any enrollment waiting period
 - All of the months coverage was available
 - The monthly premium of the lowest cost option in each enrollment category (if applicable)
 - The employer’s share of total allowed costs of benefits
- The number of full-time employees for each month during the calendar year
- The name, address and TIN of each full-time employee during the calendar year and the months during which such employee (and any dependents) were covered

Effective date – 1/1/14

Employers Offering Coverage

Employers with over 50 employees will be penalized if:

- They do offer minimum essential coverage⁶; and
- In any month have at least one employee receiving and using a premium assistance tax credit to purchase coverage through an exchange

Penalties equal:

- 2014 - A monthly fee of (1/12th of \$3,000) per full-time employee receiving the premium assistance credit - Employers may disregard first 30 such employees from penalty calculations
- Subsequent years – the monthly fee will be 1/12th of (the previous year’s annual penalty amount plus the increase in the premium adjustment percentage¹⁰)

Penalties are capped at \$2,000 (in years after 2014, the previous year's amount plus the increase in the premium adjustment percentage¹⁰) times the number of full-time equivalent employees.

All employers required to pay the penalty are also required to report the following information to HHS as well as a personalized copy to each employee:

- The employer's name and employer identification number
- A certification of whether the employer offer's minimum essential coverage⁶
- If the employer certifies that it did offer minimum essential coverage⁶, it must:
 - The length of any enrollment waiting period
 - All of the months coverage was available
 - The monthly premium of the lowest cost option in each enrollment category (if applicable)
 - The employer's share of total allowed costs of benefits
- The number of full-time employees for each month during the calendar year
- The name, address and TIN of each full-time employee during the calendar year and the months during which such employee (and any dependents) were covered

Effective date – 1/1/14

Reporting of Employees' Coverage Status

All employers who provide minimum essential coverage are required to report the following information on each covered life:

- Name & Address
- TIN
- Dates of coverage
- Whether the coverage is through a Qualified Health Plan¹² offered through an insurance exchange – if so:
 - Advance payment of any cost-sharing reduction
 - Any premium tax credit

Effective date – 1/1/14

Reporting of the Cost of Coverage

Employers who offer minimum essential coverage⁶ are required to include the aggregate value of coverage for each employee (and any dependents) on the employees W-2 form.

Effective date - 2011

Section 10 – Changes to Consumer Driven Health Plans

Increased Penalties for Unqualified HSA & MSA Distributions

The tax penalty on those under the age of 65 for HSA & MSA withdrawals to purchase non-qualified medical²⁴ expenses is increased to 20%.

Unless prescribed by a provider, over-the-counter medications are no longer qualifying medical expenses.

Effective date - 2011

Limitation of FSAs

Contributions to Flexible Spending Accounts under cafeteria plans²⁵ are limited to \$2,500 per-year. Allowable amounts will be indexed by CPI-U each year.

The cap does not apply to an FSA that is not part of a salary reduction arrangement under a cafeteria plan.

Unless prescribed by a provider, over-the-counter medications are no longer qualifying medical expenses.

Effective date - 2013

Section 11 – Revenue Issues

Excise Tax on High-Cost Plans

A tax will be placed on the cost of any employer-sponsored coverage above the yearly allowable threshold. The cost of coverage is the sum of the employer's and employee's share.

An excise tax of 40% will be assessed on a monthly basis for any excess benefits valued above 1/12th of the yearly allowable threshold.

The monthly tax penalty is calculated as such:

$$\frac{(1/12^{\text{th}} \text{ the aggregate cost of coverage})}{(1/12^{\text{th}} \text{ the applicable allowable threshold})} \times .4 = \text{Monthly Penalty Amount}$$

Starting in 2018, threshold amounts are as following:

- \$10,200 for single coverage (\$11,850 for retirees and employees in high risk professions²¹)
- \$27,500 for family coverage (\$30,950 for retirees and employees in high risk professions²¹)

In years subsequent to 2018, threshold amounts will be:

- The previous year's allowable threshold; multiplied by
- The cost-of-living adjustment²² + 1%

Coverage providers²³ are responsible for payment of the tax penalty.

Coverage taken into account includes all employer-sponsored health coverage, including employee after tax premiums, reimbursements from Health FSA or an HRA, contributions to an HSA or Archer MSA, and, other supplementary health coverage.

Coverage taken into account does not include:

- Employer coverage for long term care
- Non-health benefits
- Separately-provided dental or vision coverage

This tax does not apply to long-term care coverage or any coverage not excludable from gross income and for which a deduction is not allowable.

Fees on Self-Insured and Fully-Insured Plans

Large group health plans (including self-insured) will be assessed a fee to contribute to the Patient-Centered Research Outcomes Trust Fund that will be responsible for comparative effectiveness research.

Fees on self-insured and fully-insured accident and/or health insurers providing coverage in the large group market are:

- The plan year ending in FY2013 - \$1 per covered life
- The plan year ending in FY2014 - \$2 per covered life
- In subsequent years – the amount of the previous Fiscal Year’s fee plus the percentage increase in the projected per-capita amount of National Health Expenditures

Plans that provide benefits exempted by HIPAA are not required to pay the fee.

Fees will cease to be collected after 2019.

Effective date – plan years that begin after 9/30/2012

Fees on Prescription Drug Manufacturers

Manufacturers and importers of branded prescription drugs are required to pay an annual fee. The fee will be based on a ratio of their yearly sales and the total yearly sales.

Effective date – 2011

Fees on Medical Device Manufacturers

Manufacturers and importers of medical devices are required to pay an annual fee. The fee will be an excise tax on the first sale for use of devices at a rate of 2.9 percent.

Effective date – 2013

Fees on Health Insurance Providers

Each issuer of health insurance (excluding self-insured plans and their administrators) will be assessed a yearly non-deductible fee.

Fees on insurers based on a ratio of market share will be calculated by:

- An insurer's net premiums; bearing to
- The aggregate net premiums of all health insurers

An insurer's fee will be the ratio of their market share as a percentage of each year's applicable amount. Yearly applicable amounts are as follows:

- 2014 - \$8 billion
- 2015 - \$11.3 billion
- 2016 - \$11.3 billion
- 2017 - \$13.9 billion
- 2018 – 14.3 billion
- Subsequent years – The previous year's applicable amount increased by the preceding year's rate of premium growth

Insurers with less than \$50 million in net premiums will be assessed a reduced fee:

- Insurers with less than \$25 million in net premiums will not be assessed a fee
- Insurers with more than \$25 million in net premiums, but less than \$50 million in net premiums, will only have 50% of their premiums taken into account

Effective date – 2014

Elimination of Deduction for Part D Subsidies

Plans who maintain prescription drug plans for their Medicare Part D eligible employees will no longer be allowed to deduct Federal subsidies for doing so.

Effective date - 2013

Modification of Itemized Deductions for Medical Expenses

The adjusted gross income threshold for claiming the itemized deduction for medical expenses is increased from 7.5% to 15%. Individuals age 65 and older would be able to claim the itemized deduction for medical expenses at 7.5% of adjusted gross income through 2016.

Effective Date - 2013

Increase of Hospital Insurance Tax

An employee's share of the FICA and SECA taxes are increased by .9% for all wages over:

- \$200,000 for individuals
- \$250,000 for families

Effective date – 2013

Unearned Income Medicare Tax

The Medicare portion of the FICA tax will be increased for high-income workers up to 3.8% (with the worker paying the all of increased .9%). The Medicare tax of 3.8% will now also be applied on net investment income. Those subjected to the tax increases are:

- Individuals with adjusted incomes over \$200,000
- Households with adjusted incomes over\$250,000

Taxable net investment income is income made on any of the following:

- Interest
- Dividends
- Royalties
- Rents
- Gross income from a trade or business involving passive activities
- A net gain from disposition of property (other than property held in a trade or business)

Effective date – 2013

Section 11 – Reports and Studies

Report on Self-Insured Health Plans

Prior to 3/23/11, the U.S. Department of Labor is required to issue a report on self-insured health plans. The Department will use information submitted on the Annual Return/Report of Employee Benefit Plan - Form 5500.

The Report will include:

- Plan type
- Number of participants
- Benefits offered
- Funding arrangements
- Benefit arrangements
- Data from the financial filings including:
 - Information on assets
 - Liabilities
 - Contributions
 - Investments
 - Expenses

Study of Large Group Market

The U.S. Department of Health and Human Services will conduct a study of the fully-insured and self-insured group health plan markets to:

- Compare:
 - The characteristics of employers (including industry, size and others)
 - Health plan benefits
 - Financial solvency
 - Capital reserve levels
 - The risks of becoming insolvent
- Determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employer to self-insure

Appendix A: Implementation Timeline

2010 plan year:

Small business tax subsidies available
Premium review process begins

By 6/23/10:

Early Retiree Reinsurance program to start

Plan years beginning after 9/23/10:

Prohibition of lifetime limits
Only restricted annual limits allowed
Prohibition on rescissions
Prohibition on preexisting exclusion conditions for dependents under age 19
Plans are required to offer first dollar coverage of preventative health services
Plans to cover dependents up to age 26 without access to own employer-sponsored plan
Prohibition of discrimination based on salary
Medical Loss Ratio limitations
Plans to implement claims and appeals procedures
Plans to start coverage of emergency services
Plans to allow choice of primary care provider
Plans to provide obstetrical and gynecological care
Plans to allow primary pediatric care provider designation
Plans to begin making plan details transparent

1/1/11:

Plans to begin reporting of cost of coverage on W-2 forms
Increase to the excise tax on unqualified use of HSAs and MSAs

3/23/11:

Deadline for HHS to provide uniform explanation of coverage standards

1/1/12:

Plans to begin reporting on quality and health outcomes

3/23/12:

Deadline for plans to begin to provide uniform explanations of coverage
Plans assessed \$1 per-life fee

9/23/12:

Plans to begin release of plan summaries

1/1/13:

Increase in Medicare taxes for high-income workers
Elimination of Medicare Part D subsidy deduction
Modification of itemized deductions for medical expenses
Per-life fee begins yearly increase
FSA contributions limited to \$2,500

3/1/13:

Plans to begin disclosing information on exchanges and available subsidies

1/1/14:

Large employers must begin automatic enrollment
Implementation of the insurance exchanges
Individual mandate penalties begin
Employer mandate penalties begin
Employer reporting of minimum essential coverage of their employees
Employers to offer free choice vouchers to eligible employees
Plans to begin reporting coverage information to employees and IRS

Plan years beginning after 1/1/14:

Prohibition on exclusions based on preexisting conditions for all enrollees
Rating
Guaranteed availability
Renewability
Prohibition on discrimination based on health status
Prevention and wellness restrictions
Waiting periods
Plans must offer coverage to dependents up to age 26 regardless of their coverage options
Plans must begin coverage clinical trials for life-threatening issues for eligible employees
Plans must comply with out-of-pocket maximums
Plans must comply with deductible maximums
Plans allowed to discount based on wellness incentives

1/1/17:

Exchanges may be open to large groups

1/1/18:

Excise tax on high-cost plans begins

1/1/19:

Large group plans no longer assessed per-life fees

Appendix B: Footnotes

1 - Essential Health Benefits:

Specific benefits to be defined by HHS, but will include the following general categories:

- 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

2 - Grandfathered Plan:

Plans that were in existence on 3/23/10 are considered “grandfathered” plans. Eligible dependents and new employees may continue to join plan. Grandfathered plans are exempted from certain provisions of the law.

3 - Rating Area:

Each State is required to establish 1 or more rating area within the State.

4 - Enrollment Period Qualifying Events:

Qualifying event means, with respect to any covered employee, any of the following events which, but for the continuation coverage required under this part, would result in the loss of coverage of a qualified beneficiary:

- The death of the covered employee
- The termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment
- The divorce or legal separation of the covered employee from the employee’s spouse
- The covered employee becomes entitled to benefits under the Social Security Act
- A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

5 - Waiting Periods:

Waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

6 - Minimum Essential Coverage:

Minimal essential coverage, which satisfies the individual mandate, is coverage through any of the following plans:

- A governmental plan
- An employer-sponsored plan (a group health plan or a group health insurance plan)
- Plans in the individual market
- A grandfathered plan

7 - Plan Modifications:

Plan modifications as described in Section 102(a) of ERISA - A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished.

8 - Emergency Services:

The term emergency services means, with respect to an emergency medical condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
- Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required

9 - Plain Language:

The term plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing.

10 - Premium Adjustment Percentage:

The premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for 2013

11 - Credible Coverage:

Creditable coverage generally includes period of coverage under an individual or group health plan not followed by a break in coverage of 63 days. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits.

12 - Qualified Health Plan:

Qualified health plans are health plans that:

- Have in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered; and
- Provides the essential health benefits package; and
- Is offered by a health insurance issuer that:
 - Is licensed and in good standing to offer health insurance coverage in each State in which it is available
 - Agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange; and
 - Agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and
 - Complies with the regulations and such other requirements as an applicable Exchange may establish

13 - Special Enrollment Periods:

A special enrollment period is any of the following:

- Individuals losing other coverage - A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

- The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual; and
- The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time; and
- The employee's or dependent's coverage:
 - Was under a COBRA continuation provision and the coverage under such provision was exhausted; or
 - Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated
- For dependent beneficiaries:
 - A group health plan makes coverage available with respect to a dependent of an individual
 - The individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period)
 - A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption

14 - Essential Health Benefits Package:

An essential health benefits package is, any health plan, coverage that:

- Provides for the essential health benefits defined by
- The Secretary under subsection (b);
- Limits cost-sharing for such coverage
- Subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage

15 - Hardship:

An individual is exempted from the individual mandate due to hardship based on:

- There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or
- The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty

16 - Allowable Costs:

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

17 - Applicable Out-Of-Pocket Maximums:

Maximums are equal to the yearly allowable HSA contribution as defined under Section 223 of the IRS Code.

18 - Full Time Equivalent Employee:

The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing (rounded to the next lowest whole number if not otherwise a whole number):

- The total number of hours of service for which wages were paid by the employer to employees during the taxable year, by
- 2,080

19 - Average Annual Wages:

The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing (rounded to the next lowest multiple of \$1,000 if not otherwise such a multiple):

- The aggregate amount of wages which were paid by the employer to employees during the taxable year; by
- The number of full-time equivalent employees of the employees for the taxable year

20 - Required Contribution:

The term required contribution means:

- In the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage; or
- In the case of an individual eligible only to purchase minimum essential coverage, the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the exchange), reduced by the amount of the credit allowable for the taxable year (determined as if the individual was covered by a qualified health plan offered through the exchange for the entire taxable year).

21 - High Risk Professions:

The term employees engaged in a high-risk profession means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

22 – Cost-Of-Living Adjustment:

The cost-of-living adjustment for any calendar year is the percentage (if any) by which:

- The CPI for the preceding calendar year, exceeds
- The CPI for the calendar year 1992

23 – Coverage Provider:

The term coverage provider means each of the following:

- Health insurance coverage - If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer
- HSA and MSA contributions - If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions the employer

- Other coverage - In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits

24 – Qualified Medical Expense:

The term qualified medical expense means amounts paid:

- For the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body
- For transportation primarily for and essential to medical care
- For qualified long-term care services
- For insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care or for any qualified long-term care insurance contract

25 - Cafeteria Plans:

The term cafeteria plan means a written plan under which:

- All participants are employees, and
- The participants may choose among 2 or more benefits consisting of cash and qualified benefits

Appendix C: Definitions of Commonly Used Terms:

Group Health Plan:

The term group health plan means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health Insurance Issuer:

The term health insurance issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

Group Market:

The term “group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and dependents) through a group health plan maintained by an employer.

Individual Market:

The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

Large and Small Group Markets:

The terms “large group market” and “small group market” mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer or by a small employer, respectively.

Large Employer:

The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

Small Employer:

The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

Appendix D: Issues Awaiting Agency Guidance:

- ❖ The definition of “essential health benefits”
- ❖ The definition of minimal essential benefits”
- ❖ Allowable “restricted” annual limits
- ❖ Allowable “specific” benefits plans may have annual limits on
- ❖ Standards for uniform explanations
- ❖ Standards for summaries of benefits
- ❖ The definition of “unreasonable” premium increases for the premium increase review process
- ❖ Mandated prevention services plans will be required to provide first-dollar coverage for
- ❖ External appeals process standards for self-insured plans
- ❖ Date employers are required to auto-enroll employees into their health plans
- ❖ HIT standards and guidance
- ❖ Allowable age bands (for rating) – in consultation with NAIC
- ❖ The definition of high-risk individuals, payment amounts and payment calculations for the temporary reinsurance program
- ❖ Criteria for risk adjustment programs
- ❖ Percentages of employer contributions levels deemed unaffordable for after 2014
- ❖ Definition of claims for purposes of reimbursements in the temporary early retiree pool