

A photograph of a stethoscope resting on an American flag. The flag's stars and stripes are visible, with the stethoscope's chest piece and tubing in focus.

# Health Insurance Reforms That Will Impact Private Health Insurance

## Plan-Related Health Insurance Reform Provisions

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# Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<b>INSURER RELATED PROVISIONS</b>		
<p><b>Minimum Loss Ratios</b></p>	<p>Minimum loss ratio requirements will be established for insurers in all markets (self-insured plans are exempt).</p> <p>The Minimum Loss Ratio is:</p> <ul style="list-style-type: none"> <li>o 85% for large group plans (101 employees or more)</li> <li>o 80% for small group plans (100 and below)</li> <li>o 80% for individual plans</li> </ul> <p>The calculation is independent of:</p> <ul style="list-style-type: none"> <li>o Federal taxes</li> <li>o State taxes</li> <li>o Any payments as a result of the risk adjustment provisions</li> <li>o Any payments as a result of the reinsurance provisions</li> </ul> <p>Carriers will have to issue a <b>premium rebate to individuals</b> for plans that fail to meet the Minimum Loss Ratio requirements.</p> <p>Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets.</p> <p>The National Association of Insurance Commissioners (NAIC) is required to establish uniform definitions regarding the Minimum Loss Ratio and how the rebate is calculated by December 31, 2010.</p>	<p>Regulatory process with DHHS and NAIC begins in 2010.</p> <p>The standards and any potential rebates to policy-holders being applied to the 2011 plan year.</p>
<p><b>Quality Information Reporting by Group Health Plans</b></p>	<p>Requires the Secretary of DHHS to develop quality reporting requirements for use by group health plans and group and individual health plans about their coverage benefits and health care provider reimbursement structures that:</p> <ul style="list-style-type: none"> <li>o Improve health outcomes</li> <li>o Prevent hospital readmissions</li> <li>o Improve patient safety</li> <li>o Reduce medical errors</li> <li>o Implement wellness and health promotion activities</li> </ul> <p>All group health plans (including <b>self-insured</b> plans) and group and individual health insurance carriers must annually submit to:</p> <ul style="list-style-type: none"> <li>o the Secretary of DHHS</li> <li>o to plan enrollees during the annual open enrollment period a report on whether the benefits under the plan or coverage include the specified components.</li> </ul>	<p>Within two years of enactment (March 2012).</p>

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	The Secretary of DHHS will make the reports available to the public through an Internet website and can develop and impose appropriate penalties on employer groups and health plans for non-compliance.	
<b>Modified Community Rating Requirements</b>	<p>Strict modified community rating standards must be adhered to by:</p> <ul style="list-style-type: none"> <li>o All individual health insurance policies</li> <li>o All fully insured group policies of 100 lives and under</li> <li>o Larger groups purchasing coverage through the exchanges</li> </ul> <p>Premium variations would only be allowed for:</p> <ul style="list-style-type: none"> <li>o Age (3:1)</li> <li>o Tobacco use (1.5:1)</li> <li>o Family composition</li> <li>o Geographic regions to be defined by the states</li> </ul> <p>Experience rating would be prohibited.</p> <p>Wellness discounts are allowed for group plans under specific circumstances.</p>	Plan years beginning on or after January 1, 2014.
	<b>Grandfathering</b>	
<b>Grandfathering</b>	<p>The HHS released a list of employer actions which would cause a plan to lose grandfathering status. Most significantly, an employer cannot:</p> <ul style="list-style-type: none"> <li>o Raise coinsurance charges;</li> <li>o Raise copayment charges more than \$5 or a percentage equal to medical inflation plus 15 percentage points;</li> <li>o Raise deductibles more than a percentage equal to medical inflation plus 15 percentage points;</li> <li>o Lower employer contributions by more than 5 percentage points;</li> <li>o Change insurance companies;</li> <li>o Add a new annual dollar limit unless replacing a lifetime limit of same or a lesser amount; and</li> <li>o Significantly cut or reduce benefits</li> </ul> <p>A plan or insurer must also include a statement to participants that the plan believes they are grandfathered and must maintain records documenting the status of being grandfathered.</p>	Interim update as of June 14, 2010

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<b>PLAN COVERAGE RELATED PROVISIONS</b>		
<b>Coverage of Preventive Care</b>	<p>Mandates coverage of specific preventive services with <b>no</b> cost-sharing for:</p> <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul> <p>The services that must be covered at minimum include:</p> <ul style="list-style-type: none"> <li>o Evidence-based items or services with a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force</li> <li>o Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved</li> <li>o For infants, children, and adolescents: evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</li> <li>o For women, additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.</li> <li>o For women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.</li> </ul>	<p>Plan years beginning on or after October, 2010</p> <p>(Grandfather rules apply for group health plans.)</p>

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<b>Varying Health Plan Rules Based on Salary</b>	Requires group health plans (other than a self-insured plan) to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals (which currently apply to self-insured plans).	Plan years beginning on or after October, 2010 (Grandfather rules apply)
<b>Policy Rescissions</b>	Prohibits rescissions of health plan coverage in all insurance markets and <b>self-insured</b> group health plans, except for: <ul style="list-style-type: none"> <li>o Cases of fraud</li> <li>o Enrollees making an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.</li> </ul> <p>Coverage may not be cancelled without prior notice to the enrollee.</p>	Plan years beginning on or after October, 2010
<b>Lifetime Benefit Limits</b>	Prohibits lifetime limits on the dollar value of benefits for any participant or beneficiary of: <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul>	Plan years beginning on or after October, 2010
<b>Annual Benefit Limits</b>	Annual benefit limits on coverage would be limited to DHHS-defined "non-essential" benefits for plan years beginning prior to January 1, 2014 for: <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul> <p>Annual limits would be prohibited entirely for plan years beginning on or after January 1, 2014.</p>	Plan years beginning on or after October, 2010
<b>Coverage of Emergency Services</b>	Mandates coverage of emergency services at in-network level regardless of provider for: <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul>	Plan years beginning on or after October, 2010  (Grandfather rules apply)
<b>Designating a Primary Care Physician</b>	Allows enrollees to designate any in-network allopathic or osteopathic doctor as their primary care physician (including OB/GYN and pediatrician) for: <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul>	Plan years beginning on or after October, 2010  (Grandfather rules apply)

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<b>Increased Dependent Coverage</b>	<p>Increases the age of a dependent (including married and/or non-student dependents) for health plan coverage to age 26 for:</p> <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul> <p>For grandfathered group plans until 2014, the coverage to age 26 provisions would only apply to those dependents that do not have another source of employer-sponsored health insurance.</p>	Plan years beginning on or after October, 2010
<b>Coverage Appeals Process</b>	<p>Requires plans to have an internal and external coverage appeals process for:</p> <ul style="list-style-type: none"> <li>o Fully-insured individual health plans</li> <li>o Fully-insured group plans</li> <li>o <b>Self-insured</b> group health plans</li> </ul> <p>At a minimum, plans and issuers must:</p> <ul style="list-style-type: none"> <li>o have an internal claims process in effect, which process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001</li> <li>o provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes</li> <li>o allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process</li> <li>o implement an external review process that meets applicable state requirements and guidance that is to be issued by HHS</li> </ul>	<p>Plan years beginning on or after October, 2010</p> <p>(Grandfather rules apply)</p>
<b>OB/GYN Non-Referral Provision</b>	<p>Where the plan provides obstetrical and gynecological coverage, and requires designation of a primary care physician, the plan must allow covered females to obtain obstetrical or gynecological care from an in-network provider without authorization or referral from the primary care physician.</p>	<p>Plan years beginning on or after October, 2010</p> <p>(Grandfather rules apply)</p>
<b>Penalties for Non compliance with Benefit Mandates</b>	<p>Penalties for non-compliance with any mandated benefit provision is \$100 per violation per employee.</p>	Plan years beginning on or after October, 2010
<b>Non-retaliation Provisions</b>	<p>An employer may not discriminate or retaliate against an individual on account of the fact the individual:</p> <ul style="list-style-type: none"> <li>o qualifies for federal insurance subsidies or tax credits</li> <li>o notifies the government of the employer's violation of the health reform laws</li> <li>o etc.</li> </ul>	January 1, 2011

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<b>Cafeteria Plan Safe Harbor for Small Employers</b>	<p>Small employers (generally those with an average of 100 or fewer employees over the prior two year period) will be allowed to adopt new "simple" cafeteria plans.</p> <p>In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the non-discrimination requirements that would otherwise apply to the cafeteria plan.</p> <p>Minimum contribution requirements:</p> <ul style="list-style-type: none"> <li>o At least 2% of pay <b>or</b></li> <li>o Lesser of:               <ul style="list-style-type: none"> <li>o 6% of pay</li> <li>o 200% of employee contributions</li> </ul> </li> </ul>	January 1, 2011.
<b>Pre-existing Conditions</b>	<p>Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable.</p> <p>Exclusions based on pre-existing conditions would be prohibited in all markets.</p> <p><b>For enrollees under age 19, pre-existing conditions are prohibited beginning in plan years beginning October, 2010.</b></p>	Plan years beginning on or after January 1, 2014.
<b>Employee Waiting Period for Coverage</b>	<p>An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care may not impose a waiting period in excess of 90 days.</p>	Effective plan years beginning on or after January 1, 2014.
<b>Employer Wellness Plans</b>	<p>Codifies and improves upon the HIPAA bona fide wellness program rules:</p> <ul style="list-style-type: none"> <li>o Increases the value of workplace wellness incentives to 30% of single premiums</li> <li>o With agency discretion to increase the cap on incentives to 50%.</li> </ul>	Plan years beginning on or after January 1, 2014.
<b>Coverage of Clinical Trials</b>	<p>Group plans must provide coverage for participation in clinical trials for the treatment of cancer or other life-threatening diseases.</p> <ul style="list-style-type: none"> <li>o Plans cannot carve out different coverage levels for routine patient costs due to participation in the trial</li> <li>o Plan cannot deny coverage on out-of-network grounds, if the trial is conducted out-of-state, but it appears that routine patient costs can be paid at OON levels</li> </ul> <p>Rule kicks in if:</p> <ul style="list-style-type: none"> <li>o the individual is eligible to participate in the trial per the trial's protocol <b>and</b></li> <li>o a participating provider says the individual is an appropriate candidate, or</li> <li>o insured provides evidence proving his participation is appropriate</li> </ul>	Plan years beginning on or after January 1, 2014.  (Grandfather rules apply)

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<b>EMPLOYER NOTICE AND REPORTING REQUIREMENTS</b>		
<b>Reporting on W-2s</b>	<p>Requires all employers to include on W-2s the aggregate cost (COBRA -2%) of employer-sponsored health benefits.</p> <p>If employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude:</p> <ul style="list-style-type: none"> <li>o All contributions to HSAs</li> <li>o All contributions to Archer MSAs</li> <li>o Salary reduction contributions to FSAs</li> </ul>	Benefits payable during taxable years beginning after December 31, 2010.
<b>Summary of Benefits</b>	<p>Requires that all:</p> <ul style="list-style-type: none"> <li>o group health plans (including <b>self-insured</b> plans)</li> <li>o group health insurers</li> <li>o individual health insurers</li> </ul> <p>provide a summary of benefits and a coverage explanation to:</p> <ul style="list-style-type: none"> <li>o All applicants at the time of application</li> <li>o To all enrollees prior to the time of enrollment or re-enrollment</li> <li>o All policyholders or certificate holder at the time of issuance of the policy or delivery of the certificate.</li> </ul> <p>The summary must include specific information to be determined by the Secretary of DHHS in consultation with the National Association of Insurance Commissioners.</p> <p>It may not exceed four pages (DHHS will provide a template) and must be linguistically appropriate.</p> <p>The summary can be provided in paper or electronic form.</p> <p>Employers and health plans that willfully fail to provide the information required can be fined up to \$1,000 for each such failure.</p> <p>Each failure to provide information to an enrollee constitutes a separate offense.</p>	<p>DHHS and NAIC must develop the summary of benefits standards within one year of enactment (March 2011).</p> <p>Health Plans and employer groups must begin notifying enrollees within two years of enactment (March 2012).</p>
<b>Material Modification of Plan Provision</b>	<p>If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.</p>	<p>Health Plans and employer groups must begin notifying enrollees within two years of enactment (March 2012).</p>

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<b>Business Tax Reporting (1099 Forms)</b>	<p>Expands obligation of persons engaged in a trade or business to report on payments of other fixed and determinable income or compensation.</p> <p>Extends reporting to include payments made to corporations other than corporations exempt from income tax under section 501(a).</p> <p>Also expands the kinds of payments subject to reporting to include reporting of the amount of gross proceeds paid in consideration for property or services. Generally, businesses that pay any amount greater than \$600 during the year to corporate and non-corporate providers of property and services will be required to file an information report with each provider and with the IRS.</p>	January 1, 2012.
<b>New Employer Disclosure Obligation re: Exchanges</b>	<p>Employers subject to the FLSA (\$500,000+ in sales or engaged in interstate commerce) must supply employees with written notice regarding:</p> <ul style="list-style-type: none"> <li>o the existence of the insurance Exchange(s)</li> <li>o the services supplied by the Exchange</li> <li>o how the employee may contact the Exchange</li> <li>o if the employer is not supplying qualifying coverage, that the employee might qualify for subsidies in the Exchange for the purchase of insurance</li> </ul>	March 1, 2013.
<b>New Employer Reporting Obligation re: "Minimum Essential Coverage"</b>	<p>Health plans, including <b>self-insured</b> employer plans and public programs, must provide an annual statement (Form 1099-HC) reflecting the months during the calendar year for which the individual had "minimum essential coverage" (to avoid the individual mandate penalty for those months) to both:</p> <ul style="list-style-type: none"> <li>o Covered individuals</li> <li>o The IRS</li> </ul> <p>Penalty for noncompliance: \$50 for each missed statement to an employee, to max. of \$100,000.</p>	January 1, 2014.
<b>New Employer Reporting Obligation re: Furnishing of Qualifying and Affordable Coverage</b>	<p>To allow the IRS to determine if surcharges apply, employers potentially subject to the "free rider surcharge" must annually, by January 31, report the details of:</p> <ul style="list-style-type: none"> <li>o the employer's coverage</li> <li>o eligibility</li> <li>o premium requirements</li> <li>o employer contributions</li> <li>o health plan enrollees</li> </ul> <p>The report must be delivered to both:</p> <ul style="list-style-type: none"> <li>o Covered individuals</li> <li>o The IRS</li> </ul> <p>Penalty for noncompliance: \$50 for each missed statement to an employee, to max. of \$100,000.</p>	January 1, 2014.

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	<b>EMPLOYER COVERAGE REQUIREMENTS</b>	
<b>Employer Mandate</b>	<p>An employer does NOT have to offer coverage.</p> <p><b>If they do not offer "qualified" and "affordable" coverage and both:</b></p> <ul style="list-style-type: none"> <li>o Employ more than 50 "full-time equivalent" employees during the preceding year (with no exception for temporary seasonal workers, including retail workers employed exclusively during holidays) AND</li> <li>o One or more employees receives a premium assistance tax credit to buy coverage through an Exchange</li> </ul> <p>the employer must pay a fine:</p> <ul style="list-style-type: none"> <li>o If no coverage is offered, \$2,000 per year (calculated monthly) times the number of full-time employees; however: <ul style="list-style-type: none"> <li>o the first 30 employees are exempted from the calculation</li> <li>o full-time employees in the waiting period (90 days or less) are not counted</li> <li>o the surcharge does not apply to employees who get vouchers</li> </ul> </li> <li>o If you offer coverage but it is not "qualified" AND "affordable", \$3,000 for each of those employees receiving a premium assistance tax credit (penalty capped at \$2,000 times the number of FTEs; the first 30 employees are again disregarded in this calculation.)</li> </ul> <p>"Full-time equivalent employees" - total part-time hours for the month divided by 120 (plus number of "normal" FTEs - 30 hours per week or more)</p> <p>"Qualified" coverage - Plan design is expected to pay at least 60% of allowed charges and meet minimum benefit standards.</p> <p>"Affordable" coverage - Employee contributions to the plan must not exceed 9.5% of employee's household income.</p> <p>An employer is not subject to the fine if:</p> <ul style="list-style-type: none"> <li>o The employer exceeded 50 full-time equivalent employees for fewer than 120 days in the preceding year and</li> <li>o The employees in excess of 50 full-time equivalent employees were seasonal workers.</li> </ul> <p>For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers with:</p> <ul style="list-style-type: none"> <li>o More than 5 employees</li> <li>o Annual payrolls of more than \$250,000</li> </ul>	January 1, 2014.

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<b>Employee Free Choice Requirements</b>	<p>An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute between 8.0% and 9.8% of the employee's household income toward the cost of coverage, if:</p> <ul style="list-style-type: none"> <li>o Such employee's household income is less than 400% of FPL and</li> <li>o The employee does not enroll in a health plan sponsored by the employer.</li> </ul> <p>The 8.0% and 9.8% factors are to be indexed to the rate of premium growth.</p> <p>The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost.</p> <p>The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized.</p> <p>The employee can keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount</p>	January 1, 2014.
<b>Auto-Enrollment by Employers</b>	<p>Requires employers of 200 or more employees to auto-enroll all new employees (and re-enroll existing employees) into any available employer-sponsored health insurance plan.</p> <p>Waiting periods in existing law can apply.</p> <p>Employees may opt out if they have another source of coverage.</p>	January 1, 2014.  (After issuance of regulations.)
<b>STATE GOVERNMENT RELATED PROVISIONS</b>		
<b>Group Size</b>	<p>Redefines small group coverage as 1-100 employees.</p> <p>States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.</p>	January 1, 2014.
<b>Premium Assistance for Employer-Sponsored Coverage</b>	<p>Requires <b>states</b> to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage, if cost-effective to do so, under terms outlined already in current law.</p>	January 1, 2014.

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<b>State-Based Exchanges</b>	<p>Requires each state to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including:</p> <ul style="list-style-type: none"> <li>o The federally-administered multi-state plans</li> <li>o Non-profit co-operative plans.</li> </ul> <p>Levels of coverage to be offered through the Exchange:</p> <ul style="list-style-type: none"> <li>o Bronze Plan - provides 60% of actuarial value of minimum qualifying coverage</li> <li>o Silver Plan - provides 70% of actuarial value of minimum qualifying coverage</li> <li>o Gold Plan - provides 80% of actuarial value of minimum qualifying coverage</li> <li>o Platinum Plan - provides 90% of actuarial value of minimum qualifying coverage</li> <li>o A catastrophic-only policy would be available for those 30 and younger.</li> </ul> <p>"Actuarial value" - the anticipated amount of all eligible expenses (including deductibles, co-pays, etc.) that will be paid by the plan.</p> <p>Deductible limits of \$2,000 individual and \$4,000 family, unless contributions are offered that offset excess deductibles.</p> <p>Out-of-Pocket limits for all Exchange plans must be no more than OOP limits for HSA-compatible HDHPs (\$5,950 single; \$11,900 family)</p> <p>The states must create "SHOP Exchanges" to help small employers purchase such coverage.</p> <p>The states can establish regional Exchanges.</p> <p>The state can either:</p> <ul style="list-style-type: none"> <li>o Create one exchange to serve both the individual and group market</li> <li>o Create a separate individual market exchange and group SHOP exchange.</li> </ul> <p>States can also apply for a modification waiver from DHHS.</p> <p>U. S. territories would:</p> <ul style="list-style-type: none"> <li>o Be allowed to create Exchanges</li> <li>o Be treated like a state for funding purposes, if they establish an Exchange</li> </ul> <p>Exchanges must:</p> <ul style="list-style-type: none"> <li>o Maintain a call center</li> <li>o Provide consumer information (including open enrollment)</li> <li>o Maintain a website</li> <li>o Submit financial reports</li> <li>o Comply with oversight investigations</li> </ul>	January 1, 2014

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	<p>Health plans are required to submit a justification for any premium increase in advance.</p> <p>Exchanges may reject bids by insurance companies with "excessive" (undefined) premium increases.</p>	
<p><b>Minimum Essential Benefits for Exchange Plans</b></p>	<p>Establishes standards for qualified coverage, including:</p> <ul style="list-style-type: none"> <li>o Mandated benefits</li> <li>o Cost-sharing requirements</li> <li>o Out-of-pocket limits (tied to HSA limits)</li> <li>o A minimum actuarial value of 60%.</li> </ul> <p>"Essential benefits" - All the major categories of a comprehensive medical coverage, and the items and services included within those broad categories:</p> <ul style="list-style-type: none"> <li>o Ambulatory patient services</li> <li>o Emergency services</li> <li>o Hospitalization</li> <li>o Maternity and newborn care</li> <li>o Mental health and substance abuse</li> <li>o Prescription drugs</li> <li>o Rehabilitative services, habilitative services, and devices</li> <li>o Laboratory services</li> <li>o Preventive and wellness services</li> <li>o Pediatric services, including oral and vision care</li> </ul> <p>It is unclear whether or not employer-sponsored plans offered outside of the exchange have to provide essential benefits coverage.</p>	<p>Plan years beginning on or after January 1, 2014.</p>
<p><b>Health Care Choice Compacts</b></p>	<p>Permits states to form health care choice compacts and allows insurers to sell policies to individuals in any state participating in the compact.</p> <p>Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued (with exceptions.)</p> <p>Regulations will be issued by July 1, 2013.</p>	<p>January 1, 2016</p>
<p><b>Large Groups in Exchanges</b></p>	<p>States may choose to allow large groups (over 100) to purchase coverage through the exchanges.</p>	<p>January 1, 2017.</p>

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<b>State Opt-Out Provisions</b>	<p>Provided that they create their own programs meeting specified standards, states are allowed to apply for a waiver (for up to 5 years) of requirements relating to:</p> <ul style="list-style-type: none"> <li>o qualified health plans</li> <li>o Exchanges</li> <li>o cost-sharing reductions</li> <li>o tax credits</li> <li>o the individual responsibility requirement</li> <li>o shared responsibility for employers</li> </ul> <p>This provision does not apply to waivers of ERISA.</p>	Plan years beginning on or after January 1, 2017.
<b>FEDERAL GOVERNMENT RELATED PROVISIONS</b>		
<b>Health Insurance Premium Rate Review</b>	<p>Establishes <b>federal</b> review of health insurance premium rates.</p> <p>The Secretary of DHHS, in conjunction with the states, will have new authority to monitor health insurance carrier premium increases beginning in 2010 to:</p> <ul style="list-style-type: none"> <li>o prevent unreasonable increases</li> <li>o publicly disclose such information.</li> </ul> <p>Carriers that have a pattern of unreasonable increases may be barred from participating in the Exchange.</p>	<b>Immediately.</b>  (2010 Plan Year)
<b>"Fannie Med" Co-Operatives</b>	<p>Establishes a Consumer Operated and Oriented Plan (CO-OP) program to provide grants or loans for the establishment of non-profit insurance cooperatives to be offered through the Exchange.</p> <p>Authorizes \$6 billion in appropriations for start-up loans or grants to help meet state solvency requirements.</p> <p>Does not require states to establish such cooperatives.</p>	<b>Immediately.</b>
<b>Pre-existing Condition Coverage for Individual Market via High Risk Pool</b>	<p>Creates high-risk pool coverage for people who cannot obtain current individual coverage due to pre-existing conditions. It will be financed by a \$5 billion appropriation.</p> <p>This national program can work with existing state high-risk pools and will end on January 1, 2014, once the Exchanges become operational and the other pre-existing condition and guarantee issue provisions take effect.</p>	Within 90 days of enactment.

## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<b>Early Retiree Reinsurance Program</b>	<p>Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.</p> <p>This program would reimburse employers retrospectively 80% of claims between \$15,000 - \$90,000, which will be indexed for inflation.</p> <p>The employer is required to use any reimbursement to lower the cost to plan enrollees.</p> <p>It will be financed by a \$5 billion appropriation.</p> <p>The program will end either when the appropriation has been exhausted or on January 1, 2014.</p>	<p>Within 90 days of enactment.</p>
<b>Definition of Qualified Medical Expenses</b>	<p>Changes the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the itemized deduction.</p> <p>An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.</p>	<p>January 1, 2011.</p>
<b>CLASS Act</b>	<p>Creates a new voluntary public long-term care program, Community Living Assisted Services and Support (CLASS) for adults who become functionally disabled.</p> <p>Requires all employers to enroll employees, unless the employee elects to opt out.</p> <p>Requires employers to collect premiums through payroll deduction (employers without a payroll deduction program are NOT required to establish one).</p>	<p>January 1, 2011.</p>
<b>Federal Study on Large-Group Plans</b>	<p>Mandates a federal study on the impact the market reforms in the bill will have on the large group market, particularly on whether or not they have encouraged groups to self-fund.</p>	<p>Within a year of enactment (March 2011)</p>
<b>Federal Study on Self-insured Plans</b>	<p>Mandates annual studies by the federal Department of Labor on self-insured plans using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500) begin.</p> <p>The studies will include general information on self-insured group health plans, including:</p> <ul style="list-style-type: none"> <li>o Plan type</li> <li>o Number of participants</li> <li>o Benefits offered</li> <li>o Funding arrangements</li> <li>o Benefit arrangements</li> </ul>	<p>Within a year of enactment (March 2011).</p>

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	<p>The studies will also use data from the financial filings of self-insured employers, including information on:</p> <ul style="list-style-type: none"> <li>o Assets</li> <li>o Liabilities</li> <li>o Contributions</li> <li>o Investments</li> <li>o Expenses</li> </ul>	
<p><b>Medicare Reimbursements to Providers</b></p>	<p>Reduce annual market basket updates for inpatient hospital, home health, skilled nursing and hospice.</p> <p>Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess hospital admissions.</p> <p>Effective fiscal year 2014, reduces Medicare Disproportionate Share Hospital payments initially by 75%, and subsequently increase payments based on amount of uncompensated care.</p>	<p>Effective fiscal year 2014.</p>
	<p><b>TAX-RELATED PROVISIONS</b></p>	
<p><b>BCBS Plans</b></p>	<p>Limits the special deduction for Blue Cross Blue Shield organizations of 25% of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations' adjusted surplus.</p> <p>The special deduction will be available only to those otherwise qualifying BCBSA plans that expend at least 85% of their total premium on reimbursement for clinical services provided to enrollees.</p>	<p><b>Immediately.</b></p> <p>(Taxable years beginning after December 31, 2009).</p>
<p><b>OTC Drug Exclusion from Account-Based Plans</b></p>	<p>Changes the definition of medical expense for purposes of employer-provided health coverage (including reimbursements under employer-sponsored health plans, HRAs, and Health FSAs, HSAs, and MSAs) to the definition for purposes of the itemized deduction for medical expenses.</p> <p>Account-based plans cannot provide non-taxable reimbursements of over-the-counter medications unless the over-the-counter medications are prescribed by a doctor.</p> <p>Prescribed medicines, drugs, and insulin still qualify for non-taxable reimbursements from those accounts.</p>	<p>Taxable years beginning after December 31, 2010.</p>

## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<b>Tax on Brand-Name Prescription Drug Manufacturers</b>	<p>Imposes a new annual non-deductible fee on pharmaceutical manufacturers and importers of branded prescription drugs (including certain biological products).</p> <p>The aggregate annual fees, based on market share, to be imposed on covered entities will be:</p> <ul style="list-style-type: none"> <li>o \$2.5 billion in 2011</li> <li>o \$2.8 billion in 2012-2013</li> <li>o \$3.0 billion in 2014-2016</li> <li>o \$4.0 billion in 2017</li> <li>o \$4.1 billion in 2018</li> <li>o \$2.8 billion annually thereafter</li> </ul>	Payable in 2011 with respect to sales in 2010.
<b>HSA and Archer MSA Distribution Tax Increases</b>	Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20%.	Distributions made after December 31, 2010.
<b>Medicare Premium Changes</b>	<p>Freezes the threshold for income-related Part B premiums for 2011 through 2019.</p> <p>Reduces Medicare Part D premium subsidy for those with incomes above \$85,000 per individual and \$170,000 per family.</p>	January 1, 2011.
<b>Tax on Group Health Plans to Fund Comparative Effectiveness Research</b>	<p>New federal premium tax on fully-insured and <b>self-insured</b> group health plans to fund comparative effectiveness research program begins.</p> <p>As financing mechanism to fund Patient Centered Outcome Research, imposes a fee on private insurance plans equal to \$2 for each individual covered under a specified individual or group health insurance policy.</p>	<p>First plan year ending after September 30, 2012</p> <p>No longer applies to policy years ending after September 30, 2019.</p>
<b>Employer Subsidies of Medicare Part D Premiums</b>	<p>Elimination of employer deductible 28% subsidy under Medicare Part D. The employer deduction for prescription drug claims will be reduced by the retiree drug subsidy (RDS) amount payable to the employer.</p> <p>FAS 109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability. Under ASC 740, the expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income from continuing operations for the period that includes the enactment date.</p> <p>Therefore, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law may not be effective until later years.</p>	Applies to taxable years beginning after December 31, 2012.

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<b>FSA Limit</b>	Limits FSA contributions for medical expenses to \$2,500 per year. Indexes the cap for inflation. Prescriptions qualify for reimbursement only if physician-prescribed or if insulin.	Applies to taxable years beginning after December 31, 2012.
<b>Tax on Medical Devices</b>	New (non-deductible) annual excise taxes imposed on medical device manufacturers and importers, according to market share, in the amount of 2.3% of the price for which the medical device is sold.  The tax would not apply to: <ul style="list-style-type: none"> <li>o Eyeglasses</li> <li>o Contact lenses</li> <li>o Hearing aids</li> <li>o Any other device deemed by the Secretary to be of the type generally purchased by the public at retail for individual use.</li> </ul>	January 1, 2013.
<b>Medical Expense Tax Deduction Limitation</b>	The threshold for the itemized deduction for unreimbursed medical expenses would be increased to 10% of AGI for regular tax purposes.  The increase would be waived for individuals age 65 and older for tax years 2013 through 2016.	January 1, 2013.
<b>Medicare Payroll Tax Increase</b>	Beginning in 2013, an additional 0.9% Medicare Hospital Insurance (HI) tax is imposed on: <ul style="list-style-type: none"> <li>o self-employed individuals</li> <li>o employees</li> </ul> with respect to earnings and wages received during the year: <ul style="list-style-type: none"> <li>o Above \$200,000 for individuals</li> <li>o Above \$250,000 for joint filers (not indexed)</li> </ul> These earnings and wages thresholds are not indexed for inflation. The new taxes do not change employer HI tax obligations. Also levies a new 3.8% Medicare contribution on the lesser of: <ul style="list-style-type: none"> <li>o Net investment income (income from interest, dividends, annuities, royalties, rents, dispositions of properties, and similar passive activities) or</li> <li>o The excess of the taxpayer's modified AGI over the thresholds described above.</li> </ul> The tax does not apply to distributions from qualified retirement plans, including IRAs, 410(a) money purchase plans, 403(b) plans, and 457(b) plans.  Self-employed individuals are not permitted to deduct any portion of the additional tax.	January 1, 2013.

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<p><b>Tax on Private Health Insurance Premiums</b></p>	<p>Imposes annual taxes on private health insurers whose annual net premiums written exceed \$25 million, based on:</p> <ul style="list-style-type: none"> <li>o Net premiums written after December 31, 2011</li> <li>o Third-party agreement fees received after December 31, 2011.</li> </ul> <p>The tax is phased in at:</p> <ul style="list-style-type: none"> <li>o \$8.0 billion in 2014</li> <li>o \$11.3 billion in 2015 and 2016</li> <li>o \$13.9 billion in 2017</li> <li>o \$14.3 billion in 2018</li> <li>o After 2018, fee is indexed to the annual amount of premium growth in subsequent years.</li> </ul> <p>Reduces the tax for certain tax-exempt health plans by allowing them to calculate the fee based on only 50% of their premiums.</p> <p>The tax does NOT apply to:</p> <ul style="list-style-type: none"> <li>o <b>Self-insured plans</b></li> <li>o Governmental entities (other than those providing insurance through the Act's community health insurance option)</li> <li>o Certain non-profit insurers of last resort</li> <li>o Certain non-profit insurers with a medical loss ratio of 90 percent or more</li> <li>o Non-profit insurers that receive over 80% of their gross revenues from government programs like Medicare, Medicaid, and CHIP</li> <li>o Voluntary employee benefit associations that are established by non-employers</li> </ul>	<p>January 1, 2014, based on net premiums written after December 31, 2011 and third-party agreement fees received after December 31, 2011.</p>
<p><b>Tax on "Cadillac" Plans</b></p>	<p>The 40% excise tax on insurers of employer-sponsored health plans for active and/or retirees (both fully-insured and self-insured) with aggregate values that exceed:</p> <ul style="list-style-type: none"> <li>o \$10,200 for individual coverage</li> <li>o \$27,500 for family coverage</li> </ul> <p>Higher thresholds for retirees over age 55 and for employees in certain high-risk professions:</p> <ul style="list-style-type: none"> <li>o \$11,850 for individual coverage</li> <li>o \$30,950 for family coverage</li> </ul> <p>The tax would be indexed for inflation by:</p> <ul style="list-style-type: none"> <li>o CPI-U plus 1% beginning in 2018 and 2019</li> <li>o CPI-U beginning in 2020</li> </ul> <p>Aggregate values of health plans include:</p> <ul style="list-style-type: none"> <li>o Reimbursements from FSAs and HRAs</li> <li>o Employer contributions to HSAs</li> <li>o Coverage for dental, vision, and other supplementary health insurance coverage</li> </ul>	<p>Taxable years beginning after December 31, 2017.</p>

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	<p>Plans would be allowed to increase thresholds for plan costs higher than national pool, based on:</p> <ul style="list-style-type: none"> <li>o age</li> <li>o gender</li> <li>o certain other factors that impact premium costs (high risk populations, early retirees, etc.)</li> </ul> <p>Excise tax does not apply to:</p> <ul style="list-style-type: none"> <li>o Stand-alone dental plans</li> <li>o Stand-alone vision plans</li> <li>o Accident</li> <li>o Disability</li> <li>o Long-term care</li> <li>o After-tax indemnity coverage</li> <li>o After-tax specified disease coverage</li> </ul>	
	<p><b>GRANTS OR TAX CREDIT PROGRAMS</b></p>	
<p><b>Rebates for Medicare Part D "Donut Hole"</b></p>	<p>There is a gap in Medicare prescription drug coverage (Medicare Part D) between \$2,830 and \$6,440 in total drug spending. The health care reform bill provides a \$250 rebate check for all Medicare Part D enrollees who enter this "donut hole."</p> <p>Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted <b>and</b> generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.</p> <p>Beginning in 2011, the beneficiary co-insurance rate in the Medicare Part D coverage gap will gradually reduce from the current 100% to 25% in 2020 with 75% discounts on brand and generic drugs.</p>	<p>January 1, 2010 for rebate.</p> <p>Other measures noted begin January 1, 2011.</p>
<p><b>Therapeutic Discovery Tax Credit</b></p>	<p>Creates a federal tax credit for businesses with 250 or fewer employees that make a "qualified investment" in acute and chronic disease research during 2009 or 2010.</p>	<p><b>Immediately.</b></p> <p>Based on investments paid in taxable years beginning in 2009 or 2010.</p>
<p><b>Indian Health Benefits</b></p>	<p>Native Americans may exclude from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from and Indian tribe or tribal organization.</p>	<p><b>Immediately.</b></p> <p>For health benefits and coverage provided after the date of enactment.</p>

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<p><b>Small Employer Tax Credits</b></p>	<p>Makes available tax credits for qualified small employer contributions to purchase coverage for employees.</p> <p>In order to qualify, the business must ;</p> <ul style="list-style-type: none"> <li>o have no more than 25 full-time equivalent employees</li> <li>o pay average annual wages of less than \$50,000</li> <li>o provide qualifying coverage.</li> </ul> <p>In 2011-2013, the full amount of the credit (35%) will be available to employers with</p> <ul style="list-style-type: none"> <li>o 10 or fewer employees</li> <li>o average annual wages of less than \$25,000</li> <li>o will phase out when those thresholds are exceeded.</li> </ul> <p>The average wage threshold for determining the phase-out of credits will be adjusted for inflation after 2013.</p> <p>Beginning in 2014, small employers who purchase coverage through an Exchange will receive a maximum credit of up to 50% of premiums for up to 2 years <b>if</b> the employer contributes at least 50% of the total premium cost.</p> <p>Employers will not be eligible to use the credit for certain employees, including:</p> <ul style="list-style-type: none"> <li>o defined seasonal workers</li> <li>o self-employed individuals</li> <li>o 2% shareholders of an S corporation (as defined by section 1372(b))</li> <li>o 5% owners of a small business (as defined by section 416(i)(1)(B)(i))</li> <li>o dependents or other household members.</li> </ul> <p>However, leased employees <b>are</b> eligible employees for the credit.</p> <p>Employers receiving credits are denied any deduction for health insurance costs equal to the credit.</p>	<p><b>Immediately.</b></p> <p>Retroactive for premiums paid in taxable years beginning after December 31, 2009.</p>
<p><b>Small Group Wellness Program Grants</b></p>	<p>Small employers that develop wellness programs would be eligible for grants for up to 5 years.</p> <p>Appropriates \$200 million in funding from fiscal years 2011-2015.</p>	<p>October 1, 2010</p>

# Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date										
<p><b>Plan Design Cost-Sharing Subsidies in the Exchanges</b></p>	<p>Individuals with household incomes between 100% and 400% of the Federal Poverty Level (FPL) may purchase subsidized coverage in the health insurance Exchanges IF:</p> <ul style="list-style-type: none"> <li>o they are not enrolled in employer (or certain other coverage) coverage AND</li> <li>o do not have access to employer-based coverage that                             <ul style="list-style-type: none"> <li>o pays at least 60% of covered medical costs AND</li> <li>o is priced to the individual at 9.5% or less of the individual's household income.</li> </ul> </li> </ul> <p>100% - 400% of Federal Poverty Level for FY 2009-10:</p> <ul style="list-style-type: none"> <li>o \$10,830 - \$43,320 (individual)</li> <li>o \$22,050 - \$88,200 (family of four)</li> </ul> <p>"Household income" - gross income of the employee plus gross income of other family members on whom the employee takes the tax exemption, and who were required to file a tax return for the year.</p> <p>Cost-sharing subsidies apply as follows:</p> <table border="1" data-bbox="569 760 1461 971"> <thead> <tr> <th>Household income as a percent of FPL</th> <th>Plan cost-sharing subsidy results in coverage of % of plan's benefits</th> </tr> </thead> <tbody> <tr> <td>100% - 150%</td> <td>94%</td> </tr> <tr> <td>150% - 200%</td> <td>87%</td> </tr> <tr> <td>200% - 250%</td> <td>73%</td> </tr> <tr> <td>250% - 400%</td> <td>70%</td> </tr> </tbody> </table>	Household income as a percent of FPL	Plan cost-sharing subsidy results in coverage of % of plan's benefits	100% - 150%	94%	150% - 200%	87%	200% - 250%	73%	250% - 400%	70%	<p>January 1, 2014</p>
Household income as a percent of FPL	Plan cost-sharing subsidy results in coverage of % of plan's benefits											
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200% - 250%	73%											
250% - 400%	70%											
<p><b>Premium Tax Credits for Lower Income Individuals Purchasing Coverage via an Exchange</b></p>	<p>Individuals with household modified adjusted gross incomes (AGI) between 100% and 400% of the Federal Poverty Level (FPL) may purchase subsidized coverage in the health insurance Exchanges IF:</p> <ul style="list-style-type: none"> <li>o they are not enrolled in employer (or certain other coverage) coverage AND</li> <li>o do not have access to employer-based coverage that                             <ul style="list-style-type: none"> <li>o pays at least 60% of covered medical costs AND</li> <li>o is priced to the individual at 9.5% or less of the individual's household income.</li> </ul> </li> </ul> <p>100% - 400% of Federal Poverty Level for FY 2009-10:</p> <ul style="list-style-type: none"> <li>o \$10,830 - \$43,320 (individual)</li> <li>o \$22,050 - \$88,200 (family of four)</li> </ul> <p><b>Premium purchase tax credit:</b></p> <p>"Annual credit" is the sum of "monthly credits", for each month a credit-eligible individual begins the month enrolled in qualifying Exchange-based coverage.</p>	<p>January 1, 2014</p>										

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## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date																					
	<p>"Monthly credit" is lesser of:</p> <ul style="list-style-type: none"> <li>o monthly premium for an Exchange-based plan covering the employee, spouse or dependent.</li> <li>o The amount by which the "Adjusted Monthly Premium" for the month for the Silver Plan available to the employee through the Exchange EXCEEDS 1/12th of the employee's Household Income for the year multiplied by his "Applicable Percentage"</li> </ul> <p>"Adjusted Monthly Premium" is the age-adjusted premium the employee would pay for the Silver Plan for himself / family, less the premium cost for benefits judged non-essential benefits.</p> <p>"Applicable Percentage" is based on the following table (a sliding scale applies between the minimum and maximum %):</p> <table border="1" data-bbox="474 667 1398 946"> <thead> <tr> <th>Household income as a percent of FPL</th> <th>Minimum %</th> <th>Maximum %</th> </tr> </thead> <tbody> <tr> <td>Up to 133%</td> <td>2.0%</td> <td>2.0%</td> </tr> <tr> <td>133% - 150%</td> <td>3.0%</td> <td>4.0%</td> </tr> <tr> <td>150% - 200%</td> <td>4.0%</td> <td>6.3%</td> </tr> <tr> <td>200% - 250%</td> <td>6.3%</td> <td>8.05%</td> </tr> <tr> <td>250% - 300%</td> <td>8.05%</td> <td>9.5%</td> </tr> <tr> <td>300% - 400%</td> <td>9.5%</td> <td>9.5%</td> </tr> </tbody> </table> <p>Beginning in 2019, a fail-safe mechanism would be applied that reduces overall premium subsidies if the aggregate amount exceeds 0.504% of GDP.</p> <p>The IRS would be responsible for determining eligibility for the tax credit.</p>	Household income as a percent of FPL	Minimum %	Maximum %	Up to 133%	2.0%	2.0%	133% - 150%	3.0%	4.0%	150% - 200%	4.0%	6.3%	200% - 250%	6.3%	8.05%	250% - 300%	8.05%	9.5%	300% - 400%	9.5%	9.5%	
Household income as a percent of FPL	Minimum %	Maximum %																					
Up to 133%	2.0%	2.0%																					
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	<b>MISCELLANEOUS PROVISIONS</b>																						
<b>Economic Substance Doctrine</b>	<p>A transaction would have economic substance only if:</p> <ul style="list-style-type: none"> <li>o the taxpayer's economic position (other than its federal tax position) changed in a meaningful way AND</li> <li>o the taxpayer had a substantial purpose (other than a federal tax purpose) for engaging in the transaction.</li> </ul>	<p><b>Immediately.</b> Applies to transactions entered into after date of enactment.</p>																					

## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
<b>Grandfathered Health Plans</b>	<p>Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the plan limits change to those specified by the HHS guidelines.</p> <p>In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.</p>	<p><b>Immediately.</b> Grandfathered status is available for certain plan provisions in effect on date of enactment.</p>
<b>Individual Mandate</b>	<p>Requires all American citizens and legal residents to purchase qualified health insurance.</p> <p>Coverage considered qualifying for this purpose includes:</p> <ul style="list-style-type: none"> <li>o Qualified Exchange plans</li> <li>o Grandfathered individual and group health plans</li> <li>o Medicare and Medicaid plans</li> <li>o Military and veterans' benefits</li> <li>o Any employer-sponsored plan</li> </ul> <p>Existing policies could remain in effect - but only so long as an individual does not:</p> <ul style="list-style-type: none"> <li>o Move</li> <li>o Change jobs</li> <li>o Experience any other material change in life status</li> </ul> <p>Violators are subject to an excise tax penalty. The penalty structure would be the higher of:</p> <ul style="list-style-type: none"> <li>o A flat dollar amount per person or</li> <li>o A percentage of the individual's income</li> </ul> <p>The fixed dollar amount phases in beginning with:</p> <ul style="list-style-type: none"> <li>o \$95 per person in 2014</li> <li>o \$325 per person in 2015</li> <li>o \$695 per person in 2016</li> </ul> <p>The percentage of taxable gross household income used in determining the fine amount would be:</p> <ul style="list-style-type: none"> <li>o 1.0% in 2014</li> <li>o 2.0% in 2015</li> <li>o 2.5% in 2016, capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family</li> </ul> <p>Families will pay half the amount for children, with a cap of \$2,250 for the entire family.</p> <p>After 2016, dollar amounts will be increased by the cost-of-living adjustment.</p>	<p>January 1, 2014.</p>

## Plan-Related Health Insurance Reform Provisions

Topic	Provisions	Effective Date
	<p>No penalty is assessed if:</p> <ul style="list-style-type: none"> <li>o Coverage lapse is for 3 months or less</li> <li>o The lowest cost plan available to the individual exceeds 8.0% of AGI</li> <li>o The individual has income below 100% of FPL</li> </ul> <p>Exceptions are provided for:</p> <ul style="list-style-type: none"> <li>o Religious objectors</li> <li>o Individuals not lawfully present</li> <li>o Individuals who are incarcerated</li> <li>o Members of Native American tribes</li> <li>o Those who cannot afford coverage (cost is more than 8% of modified gross income)</li> <li>o Those with incomes below the federal tax filing threshold (\$9,350 individual; \$18,700 joint)</li> <li>o Those who have received a hardship waiver</li> <li>o Those who were not covered for a period of less than three months during the year.</li> </ul>	
	<p>This information is not intended, and should not be considered exhaustive, nor should it be considered legal advice. Please contact legal counsel for any required legal advice.</p>	

Questions??