

HEALTH CARE REFORM

2012 AND BEYOND

A guide to the major provisions of health care reform legislation affecting employers in 2012 and 2013 and a timeline of the reforms to be introduced through 2018.

Employers who successfully navigated the first round of health care reform changes, many of which took effect on January 1, 2011, may be tempted to turn their attention away from health care reform and focus on other priorities for the remainder of the year. However, given the number of requirements that are looming on the horizon, employers would be well advised to stay the course, and take steps now to prepare for 2012 and beyond. This article examines the key health care requirements that employers should be mindful of in 2012 and 2013 and sets out a timeline of the reforms through 2018.

>> Health care reform is changing rapidly, with new guidance being issued frequently. This article represents the position as of September 1, 2011. To keep up to date with all the latest developments, subscribe to our weekly e-mail updates by visiting the Updates section on the Employee Benefits & Executive Compensation Practice Center page on practicallaw.com.

POLITICAL CONTEXT

Health care reform became a reality when the Patient Protection and Affordable Care Act (Act) was signed into law on March 23, 2010. Significant amendments to the Act were

made just one week later, on March 30, 2010, as part of the Health Care and Education Reconciliation Act of 2010.

During the campaign leading up to the 2010 elections, congressional Republican leaders stated that they planned to repeal health care reform if they regained the congressional majority. However, given the Democratic control of the Senate, that effort has not been successful. In addition, there have been a number of challenges to the Act, yielding various conclusions regarding its constitutionality. It is likely that the question of whether the Act is constitutional will ultimately be resolved by the US Supreme Court sometime within the next two years.

Meanwhile, the Act continues to be the law of the land, and employers must continue to administer their plans to comply with existing and new requirements.

The key provisions requiring attention in 2012 relate to:

- Benefit summaries.
- Comparative effectiveness fees.
- Quality of care reporting.
- W-2 reporting.

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The key provisions requiring attention in 2013 relate to:

- Administrative simplification.
- Health flexible spending account (FSA) limits.
- Loss of the Medicare Part D subsidy deduction.
- Increase of the Federal Insurance Contributions Act (FICA) Medicare tax rate.
- Notice of state insurance exchanges.
- Automatic enrollment.

PROVISIONS REQUIRING ATTENTION IN 2012

BENEFIT SUMMARIES

The Act requires health plans to issue a summary of benefits to applicants and enrollees that describes the plans' coverage in a uniform manner. The Act required HHS to develop standards within 12 months of enactment (by March 23, 2011). The statute then sets the distribution date for plans and insurers for 24 months after enactment — or March 23, 2012. As required under the Act, the Secretary of the US Department of Health and Human Services (HHS) consulted with the National Association of Insurance Commissioners (NAIC) on the content to be included in the summary. However, HHS, the US Department of Labor (DOL) and the US Department of the Treasury (together, the Departments) have sought comments on the timing of implementation.

On August 22, 2011, months after the statutory deadline, the Departments published a proposed rule requiring group health plans and health insurance issuers providing group or individual coverage to provide applicants and enrollees with a uniform Summary of Benefits and Coverage (SBC). The new SBC requirement applies to:

- Insured and self-insured group health plans under the Employee Retirement Income Security Act of 1974 (ERISA), including grandfathered plans (generally, plans that existed on March 23, 2010).
- Non-ERISA group health plans.
- Individual health insurance coverage.

The Departments request comments as to whether the requirement should apply to expatriate health insurance coverage. Comments are due by October 21, 2011.

The SBC must include the following:

- Uniform definitions.
- A description of coverage.
- A description of the plan's exceptions, reductions and limitations.
- The plan's cost-sharing provisions, including:
 - deductibles;
 - coinsurance; and
 - copayments.
- Renewability and continuation of coverage provisions.
- For coverage beginning on or after January 1, 2014, a statement on whether the:
 - plan provides minimum essential coverage (generally, coverage that meets the individual responsibility requirement under the Act); and
 - plan's share of total allowed costs of benefits meets applicable requirements.
- A statement that the SBC is a summary only and that the plan document or policy should be consulted to determine governing provisions.
- Contact information for questions or to obtain a copy of the plan or policy (such as a phone number for customer service and web address for obtaining a copy of documents).
- If the plan maintains more than one network, the internet address or similar contact information for obtaining a list of network providers.
- If the plan uses a prescription drug formulary, the internet address or similar contact information for obtaining information on prescription drug coverage.
- The internet address for obtaining the uniform glossary.
- Information on premiums for insured coverage or the cost of coverage for self-funded coverage.

In addition, the SBC must include coverage examples for common benefits scenarios adopted by HHS. The coverage examples would be based on criteria provided by HHS that all plans must include (such as type of treatment and dates of service). The plan then must calculate and report:

- Whether the service would be covered.
- What level of cost-sharing would apply.

Initially, HHS has adopted coverage examples for three common benefits scenarios:

- Pregnancy.
- Breast cancer treatment (except for individual policies).
- Diabetes.

The proposed rule states that HHS may adopt up to six coverage examples.

If a plan or insurer makes a mid-year material modification to coverage that would affect the content of the SBC, the plan or insurer must provide notice of the modification to enrollees no later than 60 days before the date the modification becomes effective. The notice requirement does not apply to modifications made in connection with a renewal of coverage. This new 60-day requirement does not mean that all plan amendments require advance notice (only those plan amendments that would cause a corresponding change to the SBC).

An insurer or health plan that willfully fails to provide an SBC will be subject to a fine of up to \$1,000 for each failure. The proposed rule provides that a failure with respect to each participant and beneficiary constitutes a separate offense. The Preamble to the proposed rule notes that failures are also subject to the excise tax reporting requirements for group health plans (other than governmental group health plans) under Internal Revenue Code (IRC) Section 4980D. The DOL has enforcement authority over ERISA plans and has indicated it will issue separate penalty regulations. HHS has enforcement authority over insurers and non-federal governmental plans.

>> For more information on the SBC requirement, search [Summaries of Benefits and Coverage under Health Care Reform](#) on our website.

COMPARATIVE EFFECTIVENESS FEE

For policy and plan years ending after September 30, 2012, and before October 1, 2013, health insurers and self-insured health plans will have to pay an annual fee equivalent to \$1 (\$2 after September 30, 2013, and indexed thereafter for inflation) multiplied by the average number of covered lives (including active and retired employees and their spouses and other dependents) under the plan. The revenue from this fee will go towards research to determine the effectiveness of various forms of medical treatment. The fee is scheduled to end for plan years ending after September 30, 2019.

The Internal Revenue Service (IRS) issued guidance and requested comments concerning the mechanics of making this payment and determining the average number of covered lives. In Notice 2011-35, the IRS acknowledged that the fee requirements will impose administrative and financial burdens on insurers and plan sponsors. Consequently, it appears that the IRS may be receptive to:

- Reducing administrative burdens and allowing issuers and plan sponsors to use existing data and safe harbors to determine the average number of covered lives.
- Creating exceptions for certain types of arrangements like FSAs and health reimbursement accounts.

QUALITY OF CARE REPORTING

Not later than March 23, 2012, HHS is required to develop reporting requirements for all non-grandfathered health plans and healthcare provider reimbursement structures that affect the quality of care. Plans that are subject to these requirements will have to report on efforts to:

- Improve health outcomes through implementation of activities including: quality reporting; effective case management; chronic disease management; and medication and care compliance initiatives.
- Prevent hospital readmissions.
- Improve patient safety and reduce medical errors.
- Implement wellness programs and health promotion activities.

The report will be submitted annually to HHS (and posted on a website) and provided to participants at the time of each open enrollment period. Not later than September 23, 2012, a federal study will be conducted regarding the impact of this reporting.

The reporting requirements will cause an additional administrative burden for non-grandfathered plans. Employers should be aware that since reports will be publicly available online, participants may compare and contrast their plans with other employers' plans. Employers may wish to prepare for this requirement before guidance is issued by:

- Gathering information that must be included in the reports.
- Establishing a process for providing the reports to participants and the government.

W-2 REPORTING

Beginning with the Form W-2s provided to employees in January 2013 (for 2012), group health plans, regardless of grandfathered status, must report the value of employer-provided health coverage. Health coverage generally includes coverage provided under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under IRC Section 106, which generally excludes employer-provided health coverage from income.

The amount reported includes both the portion of coverage paid by the employer and by the employee, regardless of whether the portion is paid on a pre-tax basis through salary reductions under the employer's cafeteria plan or on an after-tax basis.

Employers should work with their health care and payroll providers to understand:

- The scope of this requirement.
- The system changes and processes needed to be able to accurately capture required data beginning in 2012.

>> For more information, search [W-2 Reporting for Employer-sponsored Coverage](#) on our website.

PROVISIONS REQUIRING ATTENTION IN 2013

ADMINISTRATIVE SIMPLIFICATION

The Act updates existing rules that apply to certain electronic “standard transactions” that exchange health information, including transactions between physicians and health plans. These rules apply to all group health plans regardless of grandfathered status. However, the actual requirements will likely be carried out by insurers and third-party administrators hired by a self-insured health plan. Specific deadlines include the following:

- Systems must be effective starting January 1, 2013.
- Employers must certify compliance by:
 - December 31, 2013, for electronic funds transfer, eligibility, health claim status and payment and remittance advice; and
 - December 31, 2015, for claims and encounter information, enrollment and disenrollment, premium payments, health claims attachments and referral certifications and authorizations.

Plans that do not comply with these requirements will be assessed a penalty of \$1 per covered life per day, up to a maximum of \$20 per covered life per day. This penalty is doubled if the plan knowingly provides false information.

Employers should begin to:

- Check with their administrators to confirm that the guidance will be followed since the penalties apply to health plans directly.
- Confirm whether plan administrators engage in any of these types of transactions other than through a third-party administrator.

HEALTH FLEXIBLE SPENDING ACCOUNT LIMIT

The Act imposes a \$2,500 annual limit on health FSA deferrals for 2013. There is currently no annual limit on FSA deferrals, although employers typically impose one. The \$2,500 annual limit will apply regardless of grandfathered status.

Since participants may be used to making health FSA deferrals in excess of \$2,500, this rule may pose administrative and communication challenges. Communications as well as plan documents (including cafeteria plans) will need to be updated accordingly. Human resource departments should also be trained and prepared to answer questions.

LOSS OF MEDICARE PART D SUBSIDY DEDUCTION

The Medicare Modernization Act of 2003 created both the Medicare Part D prescription drug benefit and a related 28% federal subsidy for employers that provide retiree coverage to eligible retirees. Before the Act, the subsidy was excludable from the employer sponsor’s taxable income, and the

employer did not have to reduce its deduction for retiree drug expenses as a result of receiving the subsidy.

Effective January 1, 2013, the deduction for the portion of health care expenses that are reimbursed to the employer through the Medicare Part D subsidy program will no longer be available. This applies to insured and self-insured health plans regardless of their grandfathered status.

In addition to increasing employer costs for providing retiree prescription drug coverage, this change caused a number of companies to incur large expense charges in their income statements for the quarter that included the enactment date of the Act.

Employers may wish to:

- Determine whether other methods of providing retiree health benefits may be possible.
- Change communications, including plan documents and summary plan descriptions (SPDs) if a decision is made to modify or terminate retiree health benefits.

>> For more information on changes to Medicare Part D under health care reform, search [Changes Affecting Retiree Medical Plans under Health Care Reform](#) on our website.

>> For information on the Early Retiree Reinsurance Program under health care reform, which provides reimbursement to plans for certain health benefits costs for early retirees, search [Early Retiree Reinsurance Program under Health Care Reform](#) on our website.

FICA MEDICARE TAX RATE INCREASE

For tax years beginning after December 31, 2012, the Act increases the FICA Medicare tax rate by 0.9% for wages over \$200,000 (\$250,000 for married couples filing jointly). While FICA taxes are made up of Social Security and Medicare taxes, this change increases the employee’s portion of FICA Medicare taxes from 1.45% to 2.35% for wages over this threshold. An employer is required to collect the employee’s portion of FICA Medicare tax. Employers will need to ensure that their payroll providers or systems comply with this requirement.

NOTICE OF STATE INSURANCE EXCHANGES

By March 1, 2013, plans must provide notice to employees and new hires of the upcoming existence of state insurance exchanges, which are to be established by all states in 2014. This notice requirement was added under health care reform as an amendment to the Fair Labor Standards Act (FLSA). Insurance exchanges are insurance marketplaces where individuals and small businesses can buy affordable health plans that meet certain benefit and cost standards.

Notices must be in the form specified in upcoming guidance from the DOL, which enforces the FLSA. This requirement applies to insured and self-insured health plans regardless of their grandfathered status.

Notices must include a description informing employees of:

- The existence of the exchanges.
- The services provided by the exchanges.
- How to contact the exchanges to request assistance.
- The availability of premium assistance if the employer plan's share of the cost of benefits is less than 60%.
- The circumstances under which the employee loses employer contributions to the health plan and explaining that tax-free employer contributions may be lost when an employee enrolls in an exchange.

Employers may wish to determine now if their share of the cost of benefits is less than 60%. Employers may also begin developing the notice and a process for distributing the notice.

AUTOMATIC ENROLLMENT

Employers with more than 200 full-time employees must automatically enroll new full-time employees in one of the health plans offered, with notice of the opportunity to "opt out" of coverage. This requirement applies to insured and self-insured health plans regardless of grandfathering.

Employers are not required to comply with this provision until further guidance is issued, which is expected to be by 2014. At that time employers should:

- Examine administrative systems and procedures and prepare to make changes as necessary.
- Review new hire materials and revise as necessary to provide an opportunity to opt out of coverage.
- Revise plan materials, including plan documents and SPDs.

KEY PROVISIONS UNDER HEALTH CARE REFORM: 2010-2018

This chart sets out the key provisions under health care reform from 2010 onwards, together with a timeline of their introduction.

2010

Rate Review

The US Department of Health and Human Services (HHS), in connection with the states, must now annually review "unreasonable" increases in health insurance coverage premiums.

Consumer Information

HHS introduced a program awarding grants for states to establish offices of health insurance consumer assistance or health insurance ombudsman programs. Programs will assist with: filing complaints and appeals; collecting, tracking and quantifying problems encountered by customers; educating consumers on their rights and responsibilities regarding health care coverage; assisting consumers with enrollment; and resolving problems with premium tax credits.

Temporary High Risk Pool

- This pool was established to provide coverage for eligible individuals with pre-existing conditions who have no health care coverage.
- The pool will exist until 2014, when health insurance exchanges are operational.
- Insurers or employers may not encourage an individual to disenroll or enroll in the high risk pool.

Internet Portal

HHS developed an internet consumer tool, available at *healthcare.gov*, to help individuals and small employers shop for affordable coverage.

Temporary Reinsurance for Early Retirees (until 2014 or \$5 billion spent)

- This temporary program was created to reimburse eligible employers that sponsor retiree coverage for 80% of claims between \$15,000 and \$90,000.

- Only claims for individuals of ages 55 to 64 who are not active workers or dependents of an active worker and not eligible for Medicare may be reimbursed.
- The reimbursement must be used to reduce costs, premiums or cost-sharing of plan participants.
- The program was closed to new applicants on May 6, 2011.

>> For more information, search [Early Retiree Reinsurance Program \(ERRP\)](#) on our website.

Grandfathering Provisions

Group health plans or health insurance coverage in which an individual was enrolled March 23, 2010, are now grandfathered indefinitely. Plans and coverage may make certain changes without losing their grandfathered status. Nevertheless, they are still subject to some of the insurance reforms.

Small Business Tax Credit (35%)

This provision provides tax credits for small employers of small businesses of up to 35% of employer costs for employees' health insurance.

>> For more information, search [Small Business Health Care Tax Credit under Health Care Reform](#) on our website.

Tax Credit for Adoption Expenses

The federal tax credit for adoption expenses increased from \$10,000 to \$13,170.

Reforms for Grandfathered and Non-grandfathered Plans (effective for plan years beginning on or after September 23, 2010)

Grandfathered and non-grandfathered plans must:

- Not impose exclusions for preexisting conditions for enrollees under age 19.
- Extend coverage for adult children to age 26. This requirement is not applicable if the child is eligible for employer coverage before January 1, 2014 (grandfathered plans only).

>> For more information, search [Coverage for Adult Children to Age 26 under Health Care Reform](#) on our website.

- Not rescind coverage unless there is fraud or misrepresentation by the enrollee (failure to pay a premium is not a rescission).
- Comply with restrictions on annual or lifetime limits on essential health benefits. Before 2014, a plan may establish an annual limit of at least:
 - \$750,000 for the 2011 plan year;
 - \$1.25 million for the 2012 plan year; and
 - \$2 million for the 2013 plan year.

>> For more information, search [Lifetime and Annual Limits under Health Care Reform](#) on our website.

>> For a standard notice of a waiver from the annual limit requirement, search [Notice of Waiver from Annual Limit Requirement](#) on our website.

Reforms for Non-grandfathered Plans (effective for plan years beginning on or after September 23, 2010)

Non-grandfathered plans must:

- Comply with additional standards for internal claims and appeals and external review.

>> For information on the internal claims and appeals rules, search [Internal Claims and Appeals under Health Care Reform](#) on our website.

>> For information on external reviews, search [External Review under Health Care Reform](#) on our website.

- Not discriminate in favor of highly compensated individuals for insured health plans (effective date and related sanctions are delayed, pending additional guidance).
- Cover emergency services without pre-authorization and treat them as in-network.
- Allow designation of gynecologist, obstetrician or pediatrician as primary care provider.
- Cover immunizations and preventive care without cost-sharing.

>> For more information, search [Coverage of Preventive Health Services under Health Care Reform](#) on our website.

Medical Loss Ratio (Insured Plans Only)

A rebate must now be provided to enrollees if more than 15% of premium revenue is extended on non-claim costs (for large groups) or 20% (for small groups and individual markets). States may adopt a higher percentage.

Health Savings Account, Flexible Spending Account and Health Reimbursement Arrangement Changes

- The definition of qualified medical expense for Health Savings Accounts (HSAs), FSAs and Health Reimbursement Arrangements was amended to exclude over-the-counter medicine except for insulin, unless obtained with a prescription.

>> For more information, search [Reimbursement of Over-the-Counter Medicines and Drugs under Health Care Reform](#) on our website.

- An increase in additional tax to 20% will now be charged on distributions from HSAs that are not used for qualified medical expenses.

Phasing Out of the Medicare Part D Coverage Gap

A \$250 rebate will be provided for all Medicare Part D enrollees who enter the lapse in coverage that occurs once an individual reaches the coverage limit under Medicare Part D Prescription Drug Coverage (known as the "donut hole"). The donut hole will be completely closed by 2020.

>> For more information, search [Changes Affecting Retiree Medical Plans under Health Care Reform](#) on our website.

Summary of Benefits and Coverage

Insurers and plan sponsors of self-insured health plans will have to provide to all participants and applicants a Summary of Benefits and Coverage (SBC), which is based on a format set by HHS, using uniform definitions.

>> For more information on the SBC requirements, search [Summaries of Benefits and Coverage](#) on our website

Advance Notice of Mid-year Changes (Notice of Material Modifications)

Plans will be required to provide 60-days advance notice of changes that will affect the content of the SBC.

>> For more information on the Notice of Modifications, search [Summaries of Benefits and Coverage](#) on our website.

Quality of Care Reporting

Plans and insurers will have to submit annual reports to HHS, which are designed to measure the quality of care. Regulations are required by March 23, 2012.

Comparative Effectiveness Research Fees

- Insurers will contribute \$1 multiplied by the number of lives covered under each health insurance policy (including self-insured health plans) for plan years or policy years ending after September 30, 2012.
- This amount increases to \$2 per participant in 2013, and is indexed thereafter.
- The fee will be phased out by 2019.

2013

Administrative Simplification

Beginning in 2012 and extending through 2016:

- HHS will adopt uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act of 1996.
- Plans will have to certify compliance or face financial penalties.

W-2 Reporting

Employers will be required to include the aggregate cost of employer-sponsored health coverage, beginning with the 2012 Form W-2 (issued to employees in January 2013).

>> For more information, search [W-2 Reporting for Employer-sponsored Coverage](#) on our website.

Employer Notice Requirements

Employers will be required to provide written notice informing employees about the health insurance exchanges and employees' potential eligibility for premium credits, if the employer's share of costs is less than 60% of the allowed total cost of benefits.

Flexible Spending Account Changes

FSA contributions will be limited to \$2,500, indexed in future years.

Retiree Drug Subsidy Deduction

Deductions will be disallowed to the extent that employers who provide prescription drug coverage to their Medicare Part D eligible retirees receive federal retiree drug subsidies.

>> For more information, search [Changes Affecting Retiree Medical Plans under Health Care Reform](#) on our website.

Deduction for Unreimbursed Medical Expenses

The threshold for the itemized deduction for unreimbursed medical expenses will be increased from 7.5% of adjusted gross income

(AGI) to 10% of AGI. Individuals of ages 65 and older are exempt from this threshold and continue to be eligible to deduct expenses that exceed 7.5% of AGI through 2016.

Executive Compensation

A deduction limit of \$500,000 will be applied for current and deferred compensation paid to officers, directors, employees and service providers of health insurers for taxable years beginning after 2012 with respect to services performed after 2009.

>> For more information, search [Section 162\(m\): Limit on Compensation](#) on our website.

Medicare Tax

Individuals earning more than \$200,000 (\$250,000 for married couples filing jointly) will pay an additional 0.9% of Medicare tax on wages and self-employment income.

2014

Summary of Benefits and Coverage

SBCs will be required to state whether the plan provides minimum essential coverage and whether the plan's share of costs is at least 60% of actuarial value.

>> For more information, search [Summaries of Benefits and Coverage](#) on our website.

Automatic Enrollment

Employers with more than 200 employees that offer health insurance coverage will be required to automatically enroll new full-time employees in coverage, with the opportunity to opt out. Although no effective date is given, the enrollment rules will likely apply when regulations are issued, which is expected to be by 2014.

Plan Design Changes and Benefit Mandates

- Coverage of essential benefits for insured individuals and small group plans will be required.
- Cost-sharing limits for group health plans will be required.
- Issuers in the individual and group market in a state will have to accept and renew coverage for every employer and individual who applies in the state.
- No preexisting condition exclusions will be allowed (for enrollees under 19 years old, this provision is effective for plan years on or after September 23, 2010).
- Plans and insurers will not be able to discriminate against any individual with respect to eligibility to enroll based on certain health status-related factors.

- Eligibility waiting periods of more than 90 days will not be allowed for group coverage (includes grandfathered plans).
- Coverage of routine costs for clinical trial participants will have to be provided.

Individual Mandates

Individuals will be required to obtain minimum essential coverage, with the penalty for noncompliance being the greater of \$95 per individual or 1% of household income over the filing threshold (will rise to \$695 or 2.5% in 2016).

Individual Subsidies

Financial subsidies will be made available to individuals through:

- Premium assistance tax credits for individuals with income between 100% and 400% of the federal poverty level.
- Cost-sharing subsidies for individuals with income up to 250% of the federal poverty level to reduce out-of-pocket costs of eligible individuals in certain plan coverage obtained through an exchange.

Employer Provisions

Employers will have to report on whether minimum essential coverage was offered to employees. Employers will be penalized if they have:

- More than 50 employees and do not provide affordable insurance to full-time employees.
- Any full-time employees who receive premium assistance from the federal government.

Health Insurance Exchanges

- Each state will establish one or more health benefit exchanges through which individuals and small employers can purchase health insurance through the state in which they live.
- An exchange will make qualified health plans (QHPs) available. To offer a QHP through an exchange, a provider must agree to:
 - offer certain types of health coverage; and
 - charge the same premium for each QHP of the provider without regard to whether the plan is offered inside or outside the exchange.
- Other coverage requirements inside the exchange will include:
 - offering coverage equal in scope to “typical” employer-sponsored plans;
 - imposing cost-sharing limits; and
 - requirements for different benefit levels and actuarial values.

Offering of Qualified Health Benefit Plans through Cafeteria Plans

Exchange-eligible employers will be allowed to offer employees the opportunity to enroll in exchange coverage through a cafeteria plan offered by the employer.

State Basic Health Plan Option

- HHS will establish a basic health program, which states will be able to contract, to offer plans for people with income above Medicaid eligibility but below 200% of the federal poverty level.
- Eligible individuals and families will have access to coverage options through these plans rather than through an exchange.

Small Business Tax Credit (50%)

The small business tax credit will increase to up to 50% of employer costs.

>> For more information, search [Small Business Health Care Tax Credit under Health Care Reform](#) on our website.

Premium Variation for Participation in Employer-sponsored Wellness Programs

Employers will be able to vary premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs.

Insurance Market Reforms

- Uniform application premium rating rules will apply. Premiums will only be able to be based on: self or family enrollment; geographic rating area; age; and tobacco use.
- Health insurance issuers and self-funded plans will be required to contribute to a reinsurance program for individual policies.
- Risk corridors for individual and small group markets will be established. Plans whose costs are lower than anticipated make payments into a fund that reimburses other plans whose costs are higher than expected (known as “risk corridors”). This is a mechanism which adjusts payments to plans according to a formula based on each plan’s actual, allowed expenses.

Insurer Fee

An annual fee will be applied to any entity engaged in the business of providing health insurance.

Mental Health and Substance Abuse Benefits Parity

QHPs will be required to provide mental health and substance abuse benefits that are at parity with other medical and surgical benefits.

2015

Employer Reporting of Health Insurance Coverage

Every person who provides minimum essential coverage to an individual during a calendar year will have to file a special return.

Health Insurance Exchanges Must be Self-sustaining

States must ensure that their health insurance exchange has sufficient funding to support its ongoing operations.

Individual Mandate Penalty Increased

The penalty for noncompliance with respect to providing minimum essential coverage will increase by \$325 or 2% of household income over the filing threshold.

2016

Individual Mandate Penalty Increased

The penalty for noncompliance with the minimum essential coverage requirements will increase to \$695 or 2.5% of household income over the filing threshold.

2017

Large Employers in Health Insurance Exchanges

States will be able to permit large employers to purchase coverage through health insurance exchanges.

2018

Tax on High-cost Plans (“Cadillac” Tax)

An excise tax of 40% will be imposed on employer-sponsored health benefits above the aggregate value of employer-sponsored health plan coverage in excess of \$10,200 for self coverage and \$27,500 for family coverage.