In the weeks following enactment of the historic "Patient Protection and Affordable Care Act" ("PPACA" or the "Act") on March 23, 2010, insurers, plans, plan sponsors and administrators have faced the daunting task of digesting the Act's complex provisions, rules and effective dates. Put simply, PPACA is the most sweeping healthcare reform law in U.S. history, and it requires insurers, plan sponsors and administrators to make significant policy and plan changes in a very short time period.

Attached is a revised chart that summarizes key provisions of PPACA, as amended by the Health Care and Education Reconciliation Act of 2010 ("Reconciliation Bill") that was subsequently enacted on March 30, 2010. The chart summarizes PPACA's provisions with respect to the following areas:

- **Insurance Market Reforms;**
- **Employer Responsibility;**
- **Exchange;**
- **Individual Responsibility; and**
- **Revenue Raisers**

If you have any questions, feel free to contact Jon Breyfogle, Thomas Fitzgerald, Cheryl Risley Hughes, Christine Keller, Tammy Killion, Mark Nielsen, Bill Sweetnam, Christy Tinnes, or Brigen Winters at (202) 857-0620.

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A. ADMINISTRATION / ENFORCEMENT		
a. Enforcement of Benefit Plan Standards	2014	States are generally responsible for the enforcement of standards relating to Exchanges. [PPACA §§ 1311; 1321]
b. Annual Premium Review	Date of enactment.	HHS, with the states, shall annually review (beginning in 2010) unreasonable increases in health insurance coverage premiums. Health insurance issuers must justify to HHS and the relevant state any unreasonable premium increase prior to implementation. State insurance commissioners shall provide HHS with information regarding premium trends and make recommendations about excluding providers from the Exchange for premium increases. Beginning in 2014, HHS and the states shall monitor premium increases in and out of the Exchange. (New PHSA § 2794) [PPACA § 1003] See also Medical Loss Ratio Rebates and Cost Accounting.
c. Health Insurance Ombudsman	Date of enactment.	HHS shall award grants to states to establish or expand offices of health insurance consumer assistance or a health insurance ombudsman program. Effective date of enactment. (New PHSA § 2793) [PPACA § 1002] A state office of health insurance consumer assistance or health insurance ombudsman shall: • assist with the filing of complaints and appeals; • collect, track, and quantify problems encountered by consumers; • educate consumers on their rights and responsibilities regarding health care coverage; • assist consumers with enrollment; and • resolve problems with premium tax credits. (New PHSA § 2793) [PPACA § 1002]
d. Administrative Simplification	Varies.	Accelerates HHS adoption of 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 (HIPAA) (such as benefit eligibility verification, prior authorization and electronic funds transfer (EFT) payments). Requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. Adopts unique plan identifier and transaction standards for EFT. [PPACA § 1104]

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e. Information Regarding Coverage Options / Internet Portal	Date of enactment.	HHS, in consultation with the states, will establish a mechanism, including an Internet website, through which an individual may identify affordable health insurance coverage options. Information shall be in a standard format, including information required under new PHSA § 2718, eligibility, availability, premium rates and cost sharing, consistent with PHSA § 2715. [PPACA § 1103]
B. GENERAL REFORM		
i. Market Reforms		
a. Offering Individual Policies	Date of enactment.	Health insurers may continue to offer coverage outside of the Exchange. [PPACA § 1312(d)]
b. Risk Pooling	2014	Rating: States required to apply rating rules to the individual and small group market. Also applies to large group markets that offer coverage through the Exchange (where states permit such coverage). (New PHSA § 2701) [PPACA § 1201] Risk Adjustment: Each state shall assess a charge on plans in the individual and small group market (grandfathered plans excluded) if the actuarial risk of the enrollees is less than the average actuarial risk of enrollees in all plans in the state for that year (except self-insured plans). HHS, in consultation with the states, will establish criteria to carry out the risk adjustment. [PPACA § 1343] Reinsurance: By 2014, each state shall establish a reinsurance program. HHS, in consultation with NAIC, shall set standards. Health insurance issuers and self-funded plans are required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity. [PPACA §§ 1341; 10104] Risk Corridors: HHS shall establish a program of risk corridors in the individual and small group market in 2013, 2014, and 2015, modeled after the program for regional participating provider organizations in Medicare Part D. [PPACA § 1342]
c. Medical Loss Ratio Rebates and Cost Accounting	Reporting: plan years beginning on or after the date of enactment. Rebates: not later January 1, 2011	A health insurance issuer offering group or individual health insurance coverage shall publicly report (in a manner to be established by the Secretary through regulation) the percentage of total premium revenue that such coverage expends: • on reimbursement for clinical services provided to enrollees under such plan or coverage; • for activities that improve health care quality; and • on all other non-claims costs, including costs associated with compliance with the PPACA, with an explanation of the nature of such costs. (New PHSA § 2718(c)) [PPACA § 1001]

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		A health insurance issuer offering large group coverage shall provide an annual rebate to each enrollee if more than 15% of premium revenue is expended on non-claims costs (excluding taxes) or 20% (or lower by state regulation) for insurers offering coverage in the small group and individual market. States may adopt a higher percentage. Insurance issuers shall report to HHS the ratio of incurred claims to earned premiums. (New PHSA § 2718(b)) [PPACA §§ 1001, 10101(f)] Each hospital shall make public a list of the hospital's standard charges. (New PHSA § 2718(c)) [PPACA § 1001] See also Insurance Market Reforms, Annual Premium Review.
d. Premium Rating Rules	2014	Premium rates in the individual or small group health market may vary only by: • family structure; • community rating area; • actuarial value of the benefit; • age (except it may not vary by more than 3 to 1); and • tobacco use (except it may not vary by more than 1.5 to 1). (New PHSA § 2701) If a state allows large groups to participate in the Exchange, these rules shall apply. [PPACA § 1201]
e. CO-OPs	Date of enactment, but states are not required to certify qualified health plans before 2014.	HHS shall establish the Consumer Operated and Oriented Plan (CO-OP) program to create non-profit, member-run health insurance companies that operate in the individual and small group markets. In order to receive federal funds (loans granted and administered by HHS) to create a CO-OP, an organization must: • be organized as a non-profit, member corporation under State law; • limit substantially all its activities to the issuance of qualified health plans in the individual and small group market; • not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization; • not be sponsored by a State, county, or local government, or any government instrumentality; • incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference in its governing documents; • be subject to a majority vote of its members (i.e., beneficiaries), • be required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members (under regulations from HHS); and • use any profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members.

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		[PPACA §§ 1322; 10104]
f. Quality of Care Payment Structure	Regulations required within 24 months after date of enactment.	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall report on plan benefits and structures that provide incentives for: • the implementation of case management, care coordination, chronic disease management, and medication and care compliance activities for treatment or services under the plan or coverage; • the implementation of activities to prevent hospital readmissions; • improving patient safety and reducing medical errors through best clinical practices, evidence based medicine, and health information technology; and • the implementation of wellness and health promotion activities. Plans shall report to the Secretary annually. Reports shall be made available to enrollees at open enrollment. HHS may define exceptions to the above requirements for insurers that substantially meet the goals provided. (New PHSA § 2717) [PPACA § 1001]
g. Discrimination in Health Care and Related Services	2014	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan against any health care provider. See also PPACA § 1558 (prohibition against retaliation). (New PHSA § 2706) [PPACA § 1201] Individuals are protected against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination in Employment Act, and the Rehabilitation Act from exclusion or participation in, or denial of benefits under, any health program or activity. [PPACA § 1557]

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ii. Plan Standards		
a. Grandfathered Coverage	Date of enactment.	Group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the Act is grandfathered indefinitely. Provisions for the enrollment of family members and new employees in grandfathered health plans are included. The Act does not expressly require that terms or benefits of a grandfathered health plan are required to remain the same. [PPACA §§ 1251(d); 1401] For health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of this title, the Act shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. [PPACA § 1251(d)] Grandfather rules generally do not apply to employer mandates, tax provisions, or the following insurance market reforms: PHSA §§ 2708 (excessive waiting periods), 2711 (lifetime limits), 2711 (annual limits - group only), 2712 (rescission), 2715 (uniform plan summaries), 2718 (medical loss ratio reporting and rebating), 2704 (prohibition on pre-existing condition exclusions – group only), and 2714 (extension of dependant coverage to age 26). [PPACA §§ 1251; 10103(d); HCEARA § 2301]
b. Qualified Benefit Plans	2014	Group health plans and health insurance issuers offering group and individual health coverage must meet certain criteria. Qualified health plans are certified through an Exchange, provide essential health benefits, are offered by licensed issuers that offers at least one silver and one gold plan in each Exchange in which it participates, charge the same premium rate for the same plan whether offered in or out of the Exchange, and comply with applicable Exchange regulations. [PPACA § 1301(a)] Self-insured plans and MEWAs are generally not included in the term "health plan." [PPACA § 1301(b)] Health insurers may continue to offer coverage outside of the Exchange. [PPACA § 1312(d)] Grandfathered plans excused from complying with some of these standards. See Insurance Market Reforms, Grandfathered Coverage.
c. Annual and Lifetime Limits	Plan years 6 months after date of enactment.	A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish lifetime or annual limits on the dollar value of essential benefits for any participant or beneficiary. Until plan years beginning on or after January 1, 2014, restricted annual limits on essential benefits, as determined by HHS, are permitted. (New PHSA § 2711) [PPACA § 1001, 10101]
d. Preexisting	2014 (except for children	A group health plan and a health insurance issuer offering group or individual health insurance may not impose any

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Conditions	under 19, effective for plan years 6 months after effective date of the Act).	preexisting condition exclusion. (New PHSA § 2704) [PPACA §§ 120] A temporary high-risk health insurance pool shall be established to provide coverage for eligible individuals who had been denied health care coverage on the basis of a preexisting condition. The pool will exist until 2014 (when Exchanges are operational). Health insurance coverage in the pool shall cover not less than 65 percent of the total allowed costs of benefits. Out of pocket limits shall be not greater than the limit in IRC § 223(c)(2), but may be modified. Individuals who are currently covered must be uninsured or not have creditable coverage for six months before joining the high-risk pool. If Secretary finds insurer or employer plan has encouraged individual to disenroll in that plan prior to enrolling in high risk pool, issuer or plan must reimburse high risk pool for medical expenses incurred by individual. Example would be offering financial incentive to disenroll. [PPACA § 1101]
e. Guaranteed Issue/ Renewal/Rescissions	Guaranteed Issue: 2014 Renewal: 2014 Rescissions: Plan years 6 months after date of enactment.	Health insurance issuers in the individual and group health insurance market in a state must accept and renew coverage for every employer and individual who applies in the state. The issuer is not required to accept applicants outside of open or special enrollment periods. A health insurance issuer shall establish special enrollment periods for qualifying events in accordance with ERISA § 603. (New PHSA § 2702) [PPACA § 1201] Group health plans and health insurance issuers offering group or individual coverage may not rescind coverage except in the case of fraud or intentional misrepresentation of material fact. (New PHSA § 2712) [PPACA § 1001]
f. Preventive Care	Plan years 6 months after date of enactment.	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for preventive coverage (as defined in the Act). HHS may develop guidelines for value-based insurance. (New PHSA § 2713) [PPACA § 1001]
g. Dependent Coverage	Plan years 6 months after date of enactment.	A group health plan or health insurance issuer offering group or individual health insurance coverage of group or individual insurance that provides dependent coverage must allow an adult dependent to continue coverage until the child turns 26, regardless of student or marital status. (New PHSA § 2714) [PPACA § 1001] For plan years beginning before January 1, 2014, group health plans are not required to extend adult dependent coverage if the child is eligible to enroll in another eligible employer-sponsored health plan. [HCEARA § 2301(a)] The Act also allows HHS to issue regulations regarding the scope of dependents that will fall under the age 26 requirement. This provision does not require a health plan or insurer to cover children of children receiving dependent coverage. (New PHSA § 2714) [PPACA § 1001]. Coverage for adult children is nontaxable until the end of the year in which the adult child turns age 26. [HCEARA § 1004(d)]
h. Essential Benefits	2014	Health insurance offered in the individual or small group market must offer the essential benefits package (which includes coverage for the essential health benefits, limits cost-sharing, and provides bronze, silver, gold or platinum level of

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and Cost-Sharing		coverage). (New PHSA § 2707(a)) [PPACA § 1001]. See Exchange, Essential Health Benefits for specific benefit mandates. Group health plans must ensure that any annual cost-sharing imposed does not exceed the limits for qualified health plans offered through the Exchange (PPACA § 1302(c)). (New PHSA § 2707(b)). See Exchange, Essential Health Benefits for limits. Plans may not apply deductibles to benefits under new PHSA § 2713 (preventive care). [PPACA § 1302(c)]
i. Nondiscrimination in Benefits (including Mental Health Parity & Wellness Programs)	Salary nondiscrimination: Plan years 6 months after date of enactment. Mental health parity: date of enactment. Nondiscrimination based on health status: 2014 Wellness provisions: 2014	Insured group health plans are prohibited from discriminating in favor of highly compensated individuals. (New PHSA § 2716) [PPACA § 1001] PHSA § 2726 (Parity in mental health and substance use disorder benefits) applies to qualified health benefit plans. [PPACA § 1311(j)] A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual: • health status; • medical condition (including both physical and mental illnesses); • claims experience; • receipt of health care; • medical history; • genetic information; • evidence of insurability (including conditions arising out of acts of domestic violence); • disability; or • any other health status-related factor determined appropriate by the Secretary. Wellness programs may condition a premium discount or rebate on an individual satisfying a standard that is related to a health status factor if the plan meets certain requirements. Codifies current HIPAA wellness rules, but increases the wellness incentive limit from 20% to 30%. Labor, HHS and Treasury may promulgate regulations to effectuate this section and have discretion to increase limit to 50%. (New PHSA § 2705) [PPACA § 1201] (New PHSA § 2706) [PPACA § 1201]

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j. Choice of Providers	Plan years 6 months after date of enactment.	A group health plan and a health insurance issuer offering group or individual health insurance coverage may not require a referral or preauthorization for and must provide the same level of cost-sharing out-of-network as is normally provided for emergency care in-network in a hospital where the plan offers coverage for some services. (New PHSA § 2719A) A group health plan and a health insurance issuer offering group or individual health insurance coverage may not require a referral or preauthorization for female participants who seek coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in such care. (New PHSA § 2719A(d)) Children may have pediatricians as primary care providers. (New PHSA § 2719(c)) [PPACA § 10101]
k. Clinical Trial Participation	2014	An group health plan and a health insurance issuer offering group or individual health insurance coverage may not discriminate against an individual for participating in a clinical trial. If plan covers qualified individual, it may not deny or impose additional conditions for participation in clinical trial. (New PHSA § 2709) [PPCAC §10103]
C. CONSUMER PROTECTIONS		
i. Appeal and Grievance Procedures		
a. Appeal and Grievance Procedures	Plan years 6 months after date of enactment.	A group health plan and a health insurance issuer offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations and claims. Participants must have the ability to receive continued coverage during the review process. (New PHSA § 2719) [PPACA §§ 1001, 10101]
b. Internal Claims and Appeals	Plan years 6 months after date of enactment.	A group health plan and a health insurance issuer offer group or individual health insurance coverage must have an effective internal appeals process, including notice to enrollees of available appeals processes, along with an opportunity to review their file and present evidence. (New PHSA § 2719) [PPACA §§ 1001, 10101]
c. External Review	Plan years 6 months after date of enactment.	Must establish external appeals process that meets the NAIC Uniform Review Model Act or the standards established by HHS. (New PHSA § 2719) [PPACA §§ 1001, 10101]

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ii. Plan Disclosures		
a. Uniform Summary of Benefits	2013	Within 24 months of enactment, group health plans (including self-insured health plans) and health insurance issuers offering group or individual health insurance coverage shall use HHS standards for the provision of summary of benefits and coverage explanations. HHS will consult with NAIC to develop standards. Standards shall ensure that outline of coverage: • is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font; • is presented in a manner determined to be understandable by the average health plan enrollee; • includes uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for benefits as identified by HHS; • includes the exceptions, reductions and limitations on coverage; • includes the cost-sharing provisions; • includes the renewability and continuation of coverage provisions; • includes examples of common benefit scenarios; • includes a statement as to whether the plan provides minimum essential benefits; • includes a statement as to whether the plan meets 60% of actuarial value; • includes a statement that the outline is a summary; and • includes a contact number for the consumer and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. Requirements apply to grandfathered plans as well. Electronic delivery is acceptable. 60 day advance notice of modification in a plan is required. These standards preempt any related state standards that require an outline of coverage. An entity that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense. (New PHSA § 2715) [PPACA § 1001]
b. Pharmacy Benefit Managers Transparency	HHS will specify.	New disclosure requirements apply to Medicare Advantage plans, qualified health benefits plans offered through an Exchange and PDP sponsors. (New SSA § 1150A) [PPACA § 6005]

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D. RELATION TO CURRENT LAWS		
a. Collective Bargaining	Varies.	For health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of the Act's enactment, the requirements of Subtitles A and C of Title I of the Act shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. [PPACA § 1251(d)]
b. Hawaii Prepaid Health Care Act	Not applicable.	Nothing in the Act modifies or limits the current ERISA exemption for Hawaii's Prepaid Health Care Act. [PPACA § 1560(b)]
c. ERISA Preemption	Not applicable.	No provision explicitly saves or eliminates ERISA preemption for plans outside of an Exchange.
d. Cafeteria Plans	2011	Exempts employers who make contributions for employees under a simple cafeteria plan from nondiscrimination requirements applicable to highly compensated and key employees. (New IRC § 125(j)) [PPACA § 9022] Allows Exchange-eligible employers (but not other employers) to offer employees the opportunity to enroll in Exchange coverage through a cafeteria plan offered by the employer. (IRC § 125(f)(3)) [PPACA § 1515]
e. State and Federal Laws Regarding Abortion and Title VII of the Civil Rights Act	Date of enactment, but Exchanges are not required to be available before 2014.	State laws regarding the prohibition or requirement of coverage, funding or procedural requirements for abortions are not preempted. Federal conscience protections and abortion-related antidiscrimination laws are not affected. Title VII of the Civil Rights Act of 1964 would also not be affected by the Act. [PPACA § 1303(b)] A state may opt to prohibit abortion coverage from being offered through exchanges within that state. [PPACA §§ 1303, 10103]
f. Emergency Medical Treatment and Active Labor Act	Not applicable.	Section 1867 of the Social Security Act (EMTALA), which requires health care providers to provide emergency services, is unaffected by the Act. [PPACA § 1303(c)]

II. EMPLOYER RESPONSIBILITY		
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A. EMPLOYER MANDATE		
a. Shared Responsibility Requirements	2014	<u>No Coverage</u> Employers (with an average of at least 50 full-time employees) that do not offer minimum essential coverage to full-time employees (i.e., average of 30 or more hours per week) and have at least one employee receiving federal premium assistance credits for coverage through an Exchange are subject to up to a $2,000 annual fee for each full-time employee employed (calculated on a monthly basis). The penalty is calculated based on number of full-time employees after subtracting the first 30. <u>Insufficient Coverage</u> Generally, employees who are eligible for employer-sponsored coverage are not eligible for federal premium assistance credits for coverage through an Exchange. However, employees whose income is within 100-400% of the FPL who are offered coverage by an employer where the plan's share of the costs of benefits provided is less than 60 percent (the coverage does not provide "minimum value") or the premium exceeds 9.5 percent of the employee's household income (the coverage is "unaffordable") are not considered to have minimum essential coverage and are eligible for premium assistance for coverage through an Exchange. (New IRC § 36B) [PPACA § 1401]. As a result, employers with at least 50 full-time employees who offer coverage to full-time employees (and dependents) and have at least one full-time employee obtain premium assistance (because the employer coverage does not provide minimum value or is unaffordable) will pay the lesser of $3,000 for each full-time employee receiving assistance or $2,000 per employee for each full-time employee employed, after subtracting the first 30 (calculated on a monthly basis). <u>Calculation Rules</u> In calculating the number of full-time employees for purposes of the 50-full-time employee cut-off for applicability, an employer includes full-time equivalents. Full-time equivalents are based on the number of hours all part-time workers work over the course of a month divided by 120. The resulting number is added to the number of full-time employees to determine whether the employer is subject to the requirement. Employer aggregation rules from IRC § 414 apply. When calculating the penalty owed, employers may subtract the first 30 full-time employees for the no coverage penalty or the $2,000 per full-time employee portion of the insufficient coverage penalty. (New IRC § 4980H) [PPACA § 1513, § 10106(e); HCEARA § 1003]

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b. Small Business Exemption from Penalties	2014	For purposes of the shared responsibility section, the term "employer" means an employer that employs an average of at least 50 full-time employees for the prior year (for more than 120 days, if employer hires "seasonal" workers). Employers with fewer than 50 employees are not required to pay a fee for each employee who receives premium assistance for coverage through an Exchange. [PPACA § 1513]
c. Free Choice Vouchers		Employers that offer minimum essential coverage through an employer-sponsored plan and pay any portion of such coverage must provide free choice vouchers to qualified employees to purchase qualified health plan coverage through an Exchange. A qualified employee eligible for free choice vouchers is one whose required contribution for minimum essential coverage through the employer's plan exceeds 8% but is less than 9.8% of the employee's household income for the year, whose household income does not exceed 400% of the FPL, and who does not participate in a health plan offered by the employer. The income thresholds are indexed. The amount of the voucher is the most generous amount the employer would have contributed for self-only (or family, if applicable) coverage under the employer's plan. Employers pay this amount to the Exchange; the Exchange will credit the amount to the monthly premium of the Exchange plan elected by the employee. If the voucher amount exceeds the Exchange plan premium, the difference is paid to (and is taxable to) the employee. Employers may deduct the amount paid in vouchers as an amount paid for personal services. Employers that provide free choice vouchers will not be assessed a shared responsibility penalty under Code § 4980H with respect to those employees that receive vouchers. (New IRC § 139D) [PPACA § 10108]
d. Auto-Enrollment for Large Employers	Date of enactment, but in accordance with DOL regulations	In accordance with DOL regulations, employers with more than 200 full-time employees that offer coverage must automatically enroll new and current full-time employees in one of the plans offered (subject to any waiting period authorized by law) with the opportunity to opt-out. This provision appears to have an immediate effective date, but as a practical matter will not apply until DOL regulations are issued. (New FLSA § 18A) [PPACA § 1511]
e. Prohibition Against Retaliation	2014	Prohibits employers from discriminating against employees who receive premium tax credits. (New FLSA § 18C) [PPACA § 1558]

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B. REPORTING / DISCLOSURE REQUIREMENTS		
a. IRS Reporting Requirements	2014	Employers subject to the shared responsibility requirement and those required to offer free choice vouchers must file a return regarding health insurance coverage, including the number of months during which coverage was offered. Those employers must also provide this information in a statement provided to covered individuals. (New IRC § 6056) [PPACA § 1514]
b. W-2 Reporting Requirements	2011	Employers must include the aggregate cost of employer-sponsored coverage on an employee's W-2. (New IRC § 4980I) [PPACA § 9002]
c. Exchange Notification	By March 1, 2013 for current employees or at the time of hiring for employees hired after 3/1/2013.	Employers must notify employees (i) about the Exchange, (ii) that employees may be eligible for premium assistance and cost-sharing reduction if the plan's share of the cost of benefits is less than 60% of the costs, and (iii) that if the employee chooses coverage through the Exchange, the employee will lose the employer's contribution to coverage, all or part of which may be excludable from taxable income. (New FLSA § 18B) [PPACA § 1512]
C. SUBSIDIES / CREDITS		
a. Small Business Credit	2010	A sliding scale tax credit is available for small employers with fewer than 25 full-time equivalent employees and average annual wages of less than $50,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than $25,000. To be eligible for a tax credit, the employer must contribute a uniform percentage of at least 50 percent of the total premium cost. Beginning in 2014, the credit is available only for qualified health plan coverage through an Exchange. (New IRC § 45R) [PPACA §§ 1421; 10105]
b. Retiree Coverage Reimbursement	Program established not later than 90 days after enactment.	Temporary program would reimburse eligible employers that sponsor retiree coverage for 80 percent of claims between $15,000 and $90,000. It would reinsure only the claims for individuals ages 55 to 64 who are not active workers or dependents of active workers and who are not Medicare-eligible. Reimbursement must be used to reduce premium costs of the entity sponsoring the plan or to reduce premium costs or cost-sharing of plan participants. [PPACA § 1102]

III. EXCHANGE		
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A. ADMINISTRATION / STRUCTURE		
a. Establishment	2014	By January 1, 2014, states must establish an American Health Benefit Exchange ("Exchange") to facilitate the purchase of qualified health plans by individuals and will receive a grant from the federal government to do so. If a state does not implement the necessary requirements, HHS shall establish and operate the Exchange. Each Exchange must: • be a governmental or non-profit entity; • offer only qualified benefit plans; • allow limited scope dental benefits to be sold through the Exchange; • implement procedures for the certification of health plans; • provide a telephone hotline and Internet website; • use a standardized format for the presentation of health benefit plan options; • make a calculator available to calculate costs, including after a premium tax credit; • certify individuals are exempt from the individual responsibility requirement; • provide required information to Treasury and employers; and • establish a Navigator program. Regional, Interstate or Subsidiary Exchanges may be established. The Act also provides for the establishment of a Small Business Health Options Program (SHOP) Exchange for small businesses to purchase coverage. States may merge an Exchange and a SHOP Exchange. [PPACA § 1311] Territories may also establish exchanges. If a territory does not establish an Exchange, Medicaid caps are raised. HHS does not establish Exchanges in territories. [HCEARA § 1204; PPACA § 1323]
b. Federal / State Duties	Varies.	HHS shall: • establish regulations regarding plan certification; • develop a rating system for qualified health plans offered through an Exchange; • continue to operate and update the Internet portal required by PPACA § 1103(a) and provide a template to interested states; • establish enrollment periods; • establish market-based incentive guidelines; and

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		• establish Navigator standards. [PPACA § 1311] States may elect to have in effect federal standards for the operation of Exchanges or state laws or regulations that HHS determines are acceptable. If a state does not implement the necessary requirements, HHS shall establish and operate the Exchange. [PPACA § 1321(c)]
c. Navigators	2014	Exchanges will award grants to entities (*e.g.*, trade associations, licensed insurance agents and brokers) to conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance and referrals to consumer assistance office ombudsmen. HHS shall establish standards for Navigators. Under such standards, health insurers are ineligible to serve as Navigators, and a Navigator may not receive any consideration from an insurer in connection with participation or enrollment of employees of qualified employers or individuals. [PPACA § 1311(i)]
d. Role of Brokers	2014	Agents and brokers are permitted to serve as Navigators and may continue to enroll individuals in qualified health plans offered in an Exchange and assist in applying for premium tax credits and cost-sharing credits. [PPACA §§ 1311(i), 1312 (e)]
e. Risk Pools	2014	A health insurance issuer shall consider all enrollees in all health plans (except grandfathered plans) offered by the issuer in the individual market, including those who do not enroll through an Exchange, to be members of a single risk pool. A health insurance issuer shall consider all enrollees in all health plans (except grandfathered plans) offered by the issuer in the small group market, including those who do not enroll through an Exchange, to be members of a single risk pool. States may require the individual and small group markets to merge. [PPACA § 1312(c)]
f. Multi-State Plans	2014	Office of Personnel Management ("OPM") shall contract with health insurance issuers to offer at least 2 multi-state qualified health plans through the Exchange in each state to provide individual and small group coverage. At least one contract shall be with a non-profit entity. Medical loss ratios, profit margins, premiums and other terms and conditions shall be implemented in a manner similar to the Federal Employee Health Benefit Program. Plans offered must be uniform in each state, offer essential benefits, meet the requirements of a qualified health plan,

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		including the requirements related to bronze, silver, gold and catastrophic levels of coverage. Individuals enrolled in a multistate plan are eligible for credits and subsidies in the same manner as individuals enrolled in a qualified health plan. States may offer additional benefits, but such benefits may not result in additional federal cost. The rating requirements of the amended PHSA apply, except that states that have age rating requirements more restrictive than 3:1 may require the multi-state plan to abide by the more restrictive rating. The requirement to offer contracts in all states is phased in: • in the first year, the issuer offers such plan in 60% of states, • in the second year, the issuer offers such plan in 70% of states, • in the third year, the issuer offers such plan in 85% of states, • in the fourth year, the issuer offers such plan in all states. [PPACA §§ 1334; 10104]
g. State Basic Health Plan	2014	HHS will establish a basic health program under which states would be able to contract to offer plans for people with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL). Eligible individuals and families would have access to coverage options through the Basic Health Plans rather than through an Exchange. States may enroll the following income-eligible persons who: • are under age of 65; • do not have access to affordable employer sponsored coverage that meets minimum creditable coverage standards; • are residents of an area served by the plan; • have gross family income above 133 percent and below 200 percent of FPL. [PPACA §§ 1331; 10104]
h. State Opt-Out	2017	A state may apply to HHS and Treasury for a waiver of any of the following: • the establishment of qualified health plans; (§§ 1301-1304) • health benefit exchanges; (§§ 1311-1312) • reduced cost-sharing for individuals; (§ 1402)

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		• refundable credit for coverage (new IRC § 36B); employer responsibility requirements (new IRC § 4980H), individual responsibility requirement (new IRC § 5000A) [PPACA § 1332]
i. Exchanges in Operation Before January 1, 2010	Not applicable.	A state operating a State-based Exchange prior to January 1, 2010 that has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Act, that seeks to operate a State-based Exchange under the Act shall be presumed by HHS to meet the requirements of the Act unless the HHS determines that it does not comply with the requirements. [PPACA § 1321(e)]
B. AVAILABLE PLANS		
a. Plans Offered	2014	Only qualified health plans may be offered through the Exchange. Limited scope dental benefits are permitted, if the plan also provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J). [PPACA § 1311(d)(2)(B)] An Exchange shall make available qualified health plans. States may require additional benefits, but must assume the cost. To offer a qualified health plan through the Exchange, a provider must agree to offer at least one silver level and one gold level plan in the Exchange and must agree to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered inside or outside of the Exchange. [PPACA §§ 1301(a)(1); 1311(d)(2), (3)]
b. Essential Health Benefits	2014	The essential health benefits package provides coverage for the essential health benefits, limits cost-sharing, and provides bronze, silver, gold or platinum level of coverage. [PPACA § 1302] A plan may offer benefits in excess of the essential benefits. [PPACA § 1302(b)(5)] Coverage of abortion services is voluntary; no public funding (including premium credits) may be used for abortion for which federal funding is currently prohibited. [PPACA § 1303] Beginning in 2014, health plans (health insurance coverage and group health plans) shall not impose cost-sharing amounts greater than the dollar amounts in effect under IRC § 223(c)(2)(A)(ii) (high deductible health plans, currently $5,950 for an individual/$11,900 for a family). After 2014, cost-sharing amounts are limited to the 2014 limit, plus an amount calculated under the Act. Employer-sponsored plans in the small group market may not impose deductibles over $2,000/individual and $4,000/other, increased by the maximum reimbursement amount available under an FSA and increased annually by an amount calculated under the Act.

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c. Required Benefits	2014	Essential benefits consist of at least the following: • ambulatory patient services; • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance abuse services; • prescription drugs; • rehabilitative and habilitative services and devices; • laboratory services; • preventive and wellness services; and • pediatric services, including oral and vision care. HHS is required to establish the complete list of essential benefits. [PPACA § 1302(b)] Qualified health plans offered in the Exchange shall also offer the same plan as a child-only plan. [PPACA § 1302(f)]
d. Plan Levels	2014	• Bronze level coverage would be equal to the actuarial value of 60 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(A)] • Silver level coverage would have an actuarial value of 70 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(B)] • Gold level coverage would have an actuarial value of 80 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(C)] • Platinum benefit coverage would have an actuarial value of 90 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(D)] Young invincible policy, limited to those 30 years or younger or an individual that has a certification that he/she is exempt from the individual responsibility requirement (IRC § 5000A) because coverage is unaffordable or presents a financial hardship, which provides essential benefits but imposes cost-sharing in an amount equal to § 223(c)(2)(A)(ii), except that 3 primary care visits are covered. [PPACA § 1302(e)]

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C. ELIGIBILITY		
a. Individual Eligibility	2014	HHS will establish procedures for determining eligibility for Exchange participation and the receipt of premium tax credits or reduced cost-sharing. [PPACA § 1411] An individual that is a legal U.S. resident, resides in a state with an Exchange, and seeks to enroll in a qualified health plan in the individual market through the Exchange is a qualified individual. A qualified individual may enroll in any qualified health plan available and for which the individual is eligible. [PPACA § 1312(a), (f)]
b. Employer Eligibility	2014	Qualified Employers may elect to make all full-time employees eligible for plans through the Exchange. Qualified Employers are limited to small employers (generally 100 employees or less) until 2017, when states may allow large employers to participate in the Exchange. States may treat employers with no more than 50 employees as small for plan years beginning before 2016. Once eligible, an employer remains eligible regardless of the number of employees employed. [PPACA §§ 1304(b), 1311, 1312(f)]

IV. INDIVIDUAL RESPONSIBILITY		
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A. INDIVIDUAL MANDATE		
a. Tax for Failure to Obtain Minimum Essential Coverage	2014	Individuals are required to maintain minimum essential coverage for each month beginning in 2014. Failure to maintain coverage will result in a penalty, calculated on a monthly basis. The monthly penalty is 1/12th of the greater of: • For 2014, $95 per uninsured person or 1% of household income over the filing threshold, • For 2015, $325 per uninsured person or 2% of household income over the filing threshold, and • For 2016 and beyond, $695 per uninsured person or 2.5% of household income over the filing threshold. There is a cap on the flat dollar amount (but not the percentage of income test) of 300% of the per person amount, and the overall penalty is capped at the national average premium of a bronze level plan purchased through an Exchange. The applicable per person penalty is one-half of the amounts listed above for individuals under 18. [PPACA §§ 1501, 10106; HCEARA § 1002]
b. Minimum Essential Coverage Defined	2014	Minimum essential coverage includes Medicare Part A, Medicaid, CHIP, TRICARE, VA, eligible employer-sponsored coverage, individual health plans, grandfathered health plans, and such other coverage as designated by HHS. [PPACA § 1501; New IRC § 5000A]
c. Exceptions	2014	Exceptions to the individual responsibility requirement include: those with religious exemptions, individuals not lawfully present in the United States; incarcerated individuals; those who cannot afford coverage (required contributions toward coverage exceed 8% of household income); taxpayers with income under the tax filing threshold; those who have received a hardship waiver; and those who were not covered for a period of less than three months during the year. (New IRC § 5000A) [PPACA §§ 1501; 10106]
B. SUBSIDIES / CREDITS		
a. Premium Credits and Cost-Sharing Subsidies	2014	Provides a refundable tax credit to an eligible individual covered by a qualified health plan through an exchange. Cost-sharing subsidies are available to reduce out-of-pocket costs of eligible individuals in "silver" plan coverage through an exchange.
b. Premium Credit and Cost-Sharing Subsidy	2014	A premium assistance credit is available to individuals with household incomes between 100% and 400% of the FPL who are not eligible for minimal essential coverage. The amount of the credit is the lesser of: (1) the total monthly premium for the

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Eligibility		qualified health plan covering the taxpayer, spouse, and dependants, and (2) the product of the adjusted premium cost for the rating area of the second lowest cost silver plan multiplied by a percentage that is determined based on the taxpayer's household income and FPL for the year. Employees offered coverage by an employer where the plan's share of the costs of benefits provided is less than 60 percent or the premium exceeds 9.5 percent of the employee's income are not considered to have minimum essential coverage and are eligible for the premium assistance credit (if household income is within 100-400% of the FPL). Individuals must be a U.S. citizen or national or an alien lawfully present in the US to be eligible for the credit. [New IRC § 36B) [PPACA §§ 1401, 10105, HCEARA § 1001(a)] Eligible individuals with household incomes between 100% and 400% of the FPL enrolled in a "silver plan" through an Exchange are eligible for a cost-sharing subsidy. The cost-sharing maximum limits ($5,950/individuals and $11,900/families for 2010) for individuals in qualified health plans would be reduced by 2/3 for those between 100-200% FPL, by 1/2 for those between 200-300% FPL, and by 1/3 for those between 300-400% FPL. HHS will generally adjust the plan's share of total allowed costs of benefits to result in 94% actuarial value (AV) for those between 100-150 % FPL, 87% AV for those between 150-200% FPL, 73% AV for those between 200-250% FPL, and 70% for those between 250-400% FPL. An individual must be a U.S. citizen or national or an alien lawfully present in the US to be eligible. [PPACA § 1402]
c. Administration of Credits	2014	HHS will establish a program for determining eligibility for Exchange participation, premium tax credits, reduced cost-sharing and individual responsibility exemptions. Individual applicants are required to submit certain information, which is then submitted to various Cabinet departments and the SSA for verification. Appeals procedures will be provided; separate appeals of employer liability will also be provided. [PPACA § 1411] HHS, in consultation with Treasury, will establish a program to determine and pay premium tax credits and cost-sharing reductions in advance. [PPACA § 1412(a)]
d. Free Choice Vouchers	2014	Qualified employees are eligible to receive free choice vouchers to purchase qualified health plan coverage through the Exchange. Qualified employees are those whose required contribution for minimum essential coverage through the employer's plan exceeds 8% but is less than 9.8% of the employee's household income for the year, whose household income is less than 400% of the FPL and who does not participate in a health plan offered by the employer. The income thresholds are indexed. The amount of the voucher is the most generous amount the employer would have contributed for self-only (or family, if applicable) coverage under the employer's plan. Employers pay this amount to the Exchange; the Exchange will credit the amount to the monthly premium of the Exchange plan elected by the employee. If the voucher amount exceeds the Exchange

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		plan premium, the difference is paid to the employee. Amount of the voucher that exceeds the Exchange plan premium is considered gross income to the employee. (New IRC § 139D) [PPACA § 10107]

V. REVENUE RAISERS		
Provision	**Effective Date**	
a. Additional Taxes on High Income Individuals	Taxable years beginning after December 31, 2012.	Additional employee payroll tax (hospital insurance tax) of 0.9% for wages over $200,000 for single returns and $250,000 for joint returns. Additionally, a 3.8% unearned income Medicare contribution tax is imposed on individuals, estates, and trusts on the lesser of: (i) the net investment income for the taxable year, or (ii) the excess of the modified AGI for the taxable year above the threshold (same dollar amounts as above). (New IRC §§ 3101(b)), 1411 [PPACA §§ 9015, 10906; HCEARA § 1402]
b. Tax Treatment of Reimbursement for Prescription Drugs and Insulin/Qualified Medical Expenses	Distributions paid for taxable years beginning after December 31, 2010 or expenses incurred in taxable years beginning after December 31, 2010.	The definition of qualified medical expense for HSAs, FSAs, HRAs, and other employer-provided health coverage is amended to exclude over-the-counter drugs unless the drug is a prescribed drug or is insulin. Applies to distributions made from HSAs or MSAs in taxable years beginning after December 31, 2010 or expenses incurred under a health FSA or HRA in taxable years beginning after December 31, 2010. (New IRC §§ 223(d)(2)(A); 220(d)(2)(A); 106(f)) [PPACA § 9003]
c. Excise Tax on High Cost Insurance	Taxable years beginning after December 31, 2017.	An excise tax of 40 percent applies to the aggregate value of employer-sponsored health plan coverage in excess of $10,200 for self-only and $27,500 for family coverage (indexed annually), but the thresholds could be increased in 2018 (when the provision takes effect) if actual growth in U.S. health care costs exceeds expected growth. Any coverage provided under a multiemployer plan is treated as family coverage. This tax is imposed on insurance companies, employers and/or plan administrators. The tax applies to fully-insured and self-insured plans. The thresholds may be increased to reflect the age and gender of the population covered. The thresholds are also increased for retired, non-Medicare eligible individuals ages 55-64 and for individuals in a plan of an employer the majority of whose employees in the plan are engaged in high risk professions. (New IRC § 4980I) [PPACA § 9001; HCEARA § 1401]
d. Additional Tax on HSA Distributions Not Used for Medical Purposes	Disbursements made for tax years after December 31, 2010.	The additional tax on distributions from an HSA or Archer MSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount. (New IRC §§ 223(f)(4)(A); 220(f)(4)(A)) [PPACA § 9004]
e. Limiting Health FSA Contributions	Taxable years beginning after December 31, 2012.	Employee salary reduction contributions under a cafeteria plan to a Health FSA are limited to $2,500 per year. This limitation is indexed for cost of living increases. (New IRC § 125(i)) [PPACA §§ 9005, 10902; HCEARA § 1403]

V. REVENUE RAISERS		
Provision	**Effective Date**	
f. Additional Requirements for 501(c)(3) Hospitals	Generally, taxable years beginning after date of enactment.	Section 501(c)(3) charitable hospital organizations would be required to conduct a community health needs assessment at least once every three years and adopt a strategy to meet these needs; each hospital would be required to adopt, implement and publicize a written financial assistance policy; each hospital would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients; the hospital would have to develop a policy limiting charges on certain procedures and the hospital would be required to take reasonable steps before extraordinary efforts regarding collections of debts. In addition, IRS would be required to review hospital's community benefit activities. (New IRC § 501(r)) [PPACA §§ 9007, 10903] The penalty for failure to meet these standards for any taxable year will be $50,000, effective after the date of enactment. (New IRC § 4959) [PPACA § 9007]
g. Annual Fee on Manufacturers and Importers of Branded Drugs	Calendar years beginning after December 31, 2010.	A fee will be imposed on any entity that manufactures or imports branded prescription drugs. The Secretary of the Treasury will establish individual assessments by determining the relative market share for each covered entity in the preceding calendar year. [PPACA § 9008; HCEARA § 1404]
h. Tax on Sale of Medical Devices	Effective for sales after December 31, 2012.	An excise tax of 2.3% will be imposed on the sale price of medical devices. Glasses, contacts, hearing aids, and any other medical device determined by HHS to be of a type which is generally purchased by the general public at retail for individual use are excluded. (New IRC § 4191) [HCEARA § 1405]
i. Annual Fee on Health Insurance Providers	Calendar years beginning after December 31, 2013.	An annual fee will apply to any entity engaged in the business of providing health insurance with respect to U.S. health risks. A company or organization that underwrites policies for government-funded insurance is also treated as a U.S. health insurance provider. Governmental entities and self-insured employers are not subject to the fee nor are insurers with less than $25 million dollars in net premiums written during the previous calendar year. For tax-exempt insurance providers, only 50% of net premiums are considered when calculating the fee. Certain union-established VEBAs and not-for-profit providers who receive 80% of their revenue from government programs targeting low-income, elderly or disabled populations are exempt. [PPACA § 9010, 10905; HCEARA § 1406]
j. Disallows Deduction for Certain Retiree Prescription Drug Plans	Taxable years beginning after December 31, 2012.	Disallows deduction to the extent employers who provide prescription drug coverage to their Medicare Part D eligible retirees receive federal retiree drug subsidies. (New IRC § 139A) [PPACA § 9012; HCEARA § 1407]

V. REVENUE RAISERS		
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k. Amend Itemized Deduction for Medical Expenses	Taxable years beginning after December 31, 2012.	The threshold for the itemized deduction for medical expenses is increased from the current 7.5% of AGI to 10% of AGI for taxable years beginning after December 31, 2012. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to deduct expenses that exceed 7.5% AGI through 2016. (New IRC § 213) [PPACA § 9013]
l. Health Insurance Executive Compensation Limits	Taxable years beginning after December 31, 2009 with respect to services preformed after such date.	In the case of a covered health insurance provider, the tax deduction of compensation is limited to $500,000 for remuneration which is attributable to services performed by an officer, employee, director, or other service provider performing services for or on behalf of a covered health insurance provider. This applies to health insurance issuers for taxable years beginning after December 31, 2009 and before January 1, 2013, and thereafter to a health insurance issuer with respect to which at least 25% of gross premiums received are for providing minimum essential coverage. (New IRC § 162(m)(6)) [PPACA § 9014]
m. Modification of § 833 Treatment	Taxable years beginning after December 31, 2009.	Organizations must have a medical loss ratio of 85% or higher to maintain status under Code § 833. (New IRC § 833) [PPACA § 9016]
n. Tax on Indoor Tanning	Services performed on or after July 1, 2010.	Imposes a ten percent tax on the amount paid for indoor tanning services. The individual performing the procedure will collect the tax. (New IRC § 5000B) [PPACA § 10907]
o. Corporate Information Reporting	Payments made after December 31, 2011.	Informational returns (*e.g.*, 1099s) will be required for payments over $600 made to corporations. (New IRC § 6041(h)) [PPACA § 9006]