Summary of the Impact of Health Care Reform on Employers

How to Use this Summary

This summary identifies the main provisions of the Patient Protection and Affordable Care Act (Act), as amended by the Health Care and Education Affordability Reconciliation Act, that directly affect employers. The "Ice Miller Comments" column provides Ice Miller's analysis of specific provisions, which is intended to help employers understand and plan for changes required or desired as a result of the Act. Several terms in the summary are capitalized and link directly to the term's definition on the first reference for each topic. The link references the glossary at the end of the summary. The brief introduction explains how employer sponsored coverage is affected by the Act's requirement on individuals to have health coverage, the creation of health insurance exchanges, and the concept of "grandfathered" health plans.

This is a first look at a work in progress. While the Act is over 2,000 pages long, it still provides only a framework. Much more detail, in the form of regulations and guidance from various government agencies, will be needed in the weeks, months and years to come. Nevertheless, employers must start planning for new responsibilities and opportunities almost immediately. This summary is intended to provide general information only. Employers need to analyze their own unique situations and should consult their Ice Miller employee benefits attorney for specific questions related to their obligations under the Act.

The Employer's Continued Role in Coverage After Health Care Reform

The Act builds upon the existing role that many employers already play in providing health coverage to employees. The Act does not affirmatively require employers to offer coverage, but it does change some of the rules regarding the coverage offered and an employer's responsibilities if the employer chooses not to offer Minimum Essential Coverage. In the short term, any employer that sponsors a Group Health Plan will be required to make certain changes, such as extending dependent coverage, eliminating annual and lifetime limits, and ending pre-existing condition exclusions for children. Beginning generally in 2014, additional changes, such as ending all pre-existing condition exclusions, limiting waiting periods to 90 days or less, and cost-sharing limits, will be required of any employer sponsoring a Group Health Plan. Large employers will additionally be required to pay certain penalties, depending on

whether Minimum Essential Coverage is offered or not offered, when their employees obtain government-subsidized health insurance through an Exchange.

Status of Grandfathered Plans

The Act contains a number of health coverage reforms that require fully and self insured Group Health Plans to meet certain coverage and reporting requirements as early as January 1, 2011. However, the Act "grandfathers" Group Health Plans that were in existence on March 23, 2010, with respect to some of these requirements. A Grandfathered Plan's grandfathered status will continue even if the plan permits employees on the plan to add family members and permits new employees (and their families) to join the plan. Grandfathered Plans are exempt from many, but not all, health coverage reforms under the Act, as indicated in this summary.

Individual Mandate

One of the Act's most sweeping changes is to require most individuals to obtain Minimum Essential Coverage for themselves and their dependents beginning in 2014. Individuals can obtain coverage through their employer (if available), through an Exchange (discussed below), or through government programs such as Medicare or Medicaid (if eligible). Individuals who do not obtain health plan coverage will generally be required to pay a penalty.

To assist individuals for whom the cost of obtaining health coverage is too high, the Act provides subsidies in the form of tax credits and reduced costs for coverage. Large Employer penalties are triggered when an employer's employee qualifies for these subsidies. Generally, individuals are eligible for the subsidies if their household income is between 133 percent and 400 percent of the federal poverty line and they are not eligible for Minimum Essential Coverage other than through the individual market (individuals with a household income of less than 133 percent are eligible for Minimum Essential Coverage under the significantly expanded Medicaid program). However, individuals who are offered health coverage that is Minimum Essential Coverage through their employer may also be eligible for subsidies if the cost of their employer's coverage either exceeds 9.5 percent of their household income or their employer does not pay for at least 60 percent of the actuarial value of the benefits provided under the plan.

The Exchange

The Act requires each state to establish private insurance marketplaces, called Exchanges, by 2014 under which individuals and Small Employers can purchase health insurance at varying cost levels. The primary purpose of the Exchange is to provide individuals who cannot obtain health coverage through an employer (or who cannot afford health coverage offered by their employer) health insurance coverage options that meet uniform minimum standards in order to meet their individual coverage responsibilities. A

Health Insurance Issuer seeking to offer coverage through an Exchange must meet certain criteria and provide a plan that covers Essential Health Benefits and meets specified cost-sharing requirements.

Defined terms have been capitalized in this summary. The definitions of these terms are in the "Glossary of Terms" at the end of this summary.

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EXPANSION OF COVERAGE REQUIREMENTS		
No Lifetime or Annual Coverage Limits *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) may not establish any lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary. ➢ Group Health Plans may still place annual or lifetime limits on specific covered benefits that are ***not*** Essential Health Benefits. ➢ For plan years beginning prior to 2014, Group Health Plans may place reasonable restrictions on annual limits (but not lifetime limits) that apply to Essential Health Benefits. • **This requirement applies to Grandfathered Plans.**	While annual and lifetime benefits can still be placed on specified covered benefits, the extent of an employer's ability to do so will depend on how the Secretary of Health and Human Services defines Essential Health Benefits. It appears, however, that employers can still place other limitations on benefits, such as limits on days of treatment, number of visits, etc.
Extension of Dependent Coverage *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) that provide dependent coverage of children must continue to make such coverage available for an adult child until the child turns age 26. • Coverage provided to adult children who as of the end of the tax year have not turned age 27 will not result in imputed income to the employee. • **This requirement applies to Grandfathered Plans.** However, for plan years beginning before January 1, 2014, this rule applies to Grandfathered Plans that are Group Health Plans only if the adult child is not eligible to enroll in any other Eligible Employer Sponsored Health Plan.	• Note that a Group Health Plan is not required to cover dependents. The Secretary of Health and Human Services is required to issue regulations to define "dependents" for purposes of this requirement. • This requirement will eliminate many imputed income concerns, which often arise due to state insurance mandates that require coverage of children for longer than they can be treated as dependents for purposes of exemptions under the Internal Revenue Code. • There are many questions relating to this requirement that will need to be answered

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		by regulations, such as whether adult children can be charged higher premiums and whether the Secretary (by regulation) will limit this coverage to dependents who are not eligible for coverage elsewhere.
Rescission of Coverage Prohibited *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) are prohibited from rescinding coverage with respect to a participant once covered, except in the event of fraud or intentional misrepresentation. • **This requirement applies to Grandfathered Plans.**	Group Health Plans are already prohibited from rescinding coverage based on an individual's health status.
Mandated Coverage for Preventive Health Services *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) must provide first dollar coverage, without any cost sharing requirements (*e.g.* deductibles, co-pays, co-insurance), for: ➢ Preventive care services recommended by the U.S. Preventive Services Task Force. ➢ Immunizations recommended by the Centers for Disease Control and Prevention. ➢ Preventive care and screenings for infants, children, adolescents and women provided for in guidelines supported by the Health Resources and Services Administration. • There will be at least a one year period between the time a recommendation/guideline is made and the plan year with respect to which the service must be covered by the Group Health Plan without cost sharing requirements. • **Grandfathered Plans are exempt from this requirement.**	• Current recommendations by U.S. Preventive Services Task Force relating to breast cancer screening, mammography and prevention do not include those issued in November 2009, which were the subject of some controversy. • It is uncertain how these requirements will coordinate with the requirements relating to preventive care that currently apply to high deductible health plans and health savings accounts.

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Mandated Patient Protections *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) must contain certain patient protections: ➢ Participants and beneficiaries may designate a participating primary care provider of choice for themselves, and a participating primary care provider who specializes in pediatrics of choice for their child's primary care provider. ➢ If a Group Health Plan covers hospital emergency department services, it must do so without requiring prior authorization, regardless of whether the service provider is a participating provider, without imposing requirements or costs different than those imposed on in-network participating providers, and generally without regard to any other term or condition of coverage. ➢ If a Group Health Plan covers obstetrical and gynecological care, women participants are required to have direct access to such care without referral or authorization. • **Grandfathered Plans are exempt from this requirement.**	
Extension of Nondiscrimination Rules *Effective for plan years beginning on or after September 23, 2010.*	• Nondiscrimination rules under Internal Revenue Code Section 105(h)(2) that currently apply to self-insured Group Health Plans are extended to ***fully-insured*** Group Health Plans. • **Grandfathered Plans are exempt from this requirement.**	• The nondiscrimination rules under Internal Revenue Code Section 105(h)(2) prevent Group Health Plans from discriminating in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under a plan. Prior to this change, these nondiscrimination rules only applied to ***self-insured*** Group

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		Health Plans. • This extension of the nondiscrimination rules to fully-insured plans could impact employers who provide health care coverage to executives only through fully-insured plans to avoid the nondiscrimination test.
Mandated Claims Appeals Processes *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) are required to have an ***internal appeals process*** for appeals of coverage determinations and claims in accordance with the existing ERISA claims regulations, as amended, plus: ➢ Provide notice to participants of the internal and external appeals process in a culturally and linguistically appropriate manner. ➢ Allow participants to review their file, present evidence and testimony, and receive continued coverage pending outcome of appeal. • Group Health Plans (self and fully insured) are required to have an ***external review process***: ➢ Fully-insured Group Health Plans must meet State external review standards that satisfy National Association of Insurance Commissioners Uniform External Review Model Act. ➢ Self-insured Group Health Plans and fully-insured Group Health Plans in states that do not have compliant external review process must meet similar minimum standards established by Secretary of Health and Human Services.	• The claims and appeals processes in this section of the law codify the claims and appeals procedures that already exist for ERISA plans under Section 503 of ERISA. • However, this provision goes further and establishes a new *external* claims procedure that Group Health Plans must implement. • The National Association of Insurance Commissioners Uniform External Review Model Act establishes standardized protocols for external review to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination regarding benefits for specific procedures or services.

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	• **Grandfathered Plans are exempt from this requirement.**	
Cost Ratio Requirements *Effective for plan years beginning on or after September 23, 2010.*	• Beginning no later than January 1, 2011, a Health Insurance Issuer offering Group Health Plans, including Grandfathered Plans, must provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on (i) reimbursement for clinical services provided to enrollees and (ii) for activities that improve healthcare quality, to the total amount of premium revenue is less than 85 percent in the large group market, or 80 percent in the small group market. • A Health Insurance Issuer must also provide an annual report to the Secretary of Health and Human Services concerning its medical loss ratio. • The National Association of Insurance Commissioners, subject to certification by the Secretary of the Health and Human Services, is required to establish a uniform definition of the phrase "activities that improve health care quality" no later than December 31, 2010. • **This requirement applies to Grandfathered Plans.**	• This requirement should have no effect on self-funded Group Health Plans. However, employers that provide fully insured Group Health Plans could be affected if the insurer's medical loss ratio does not comply with these standards. In other words (and in very general terms), if the insurer spends less than 85 cents of every premium dollar on reimbursement for clinical services and healthcare quality improvements, then enrollees in the plan must receive rebates. • It is not yet clear how these rebates will be calculated or distributed. For example, if an employer pays a part of the premium and the employee pays a part of the premium, it is not clear whether the employer will receive any part of the rebate, whether the rebate will be distributed on a pro-rata basis between the employer and the employee, or whether it will be distributed in some other manner. It is also not clear what "activities that improve healthcare quality" include, and whether this requirement will limit an insurer's ability to provide wellness programs. Regulations will hopefully clarify these issues.

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Guaranteed Availability and Renewability of Coverage *Effective for plan years beginning on or after January 1, 2014.*	• If a Health Insurance Issuer offers coverage in a state, the issuer must accept every employer and individual in that state that applies for coverage. • If a Health Insurance Issuer offers health insurance coverage for a Group Health Plan, the issuer must renew or continue in force such coverage at the option of the Group Health Plan sponsor. • **Grandfathered Plans are exempt from this requirement.**	• The guarantee issue provision should ensure that coverage is ***available*** for employers to purchase for their employees; however, the absence of direct premium controls in the Act makes it questionable whether the coverage will necessarily be affordable. • This provision will prevent Health Insurance Issuers from cancelling an employer's Group Health Plan coverage in the event that the employer's Group Health Plan suffers poor claims experience.
Prohibition on Pre-Existing Condition Exclusions *Effective for plan years beginning on or after January 1, 2014; however, for enrollees under age 19, effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) may not impose any pre-existing condition exclusions. • **This requirement applies to Grandfathered Plans.**	• While many Group Health Plans have already eliminated pre-existing condition exclusions altogether, those that have not will have to do so by 2014. In the meantime, calendar year plans will have to eliminate these exclusions for children under 19 before 2011. Note, however, that some insurers are already taking the position that this requirement only requires them to eliminate a pre-existing condition exclusion ***if*** they issue a policy to a child under age 19. Insurers are contending that they are not ***required*** to ***issue*** policies under the guaranteed availability sections of the Act until 2014. • With the elimination of pre-existing condition exclusions by 2014, Congress could repeal the creditable coverage and

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		portability provisions of HIPAA and/or the Departments of Treasury, Labor and Health and Human Services could suspend the need to provide creditable coverage notices when a participant loses coverage under an employer health plan. • The Secretary of the Health and Human Services is required to establish a temporary high risk insurance pool by June 22, 2010, through the end of 2013 to cover persons who cannot get coverage due to preexisting conditions and who have been uninsured for at least six months.
Waiting Period Restrictions *Effective for plan years beginning on or after January 1, 2014.*	• Group Health Plans (self and fully insured) may not impose any waiting period in excess of 90 days. • **This requirement applies to Grandfathered Plans.**	This provision will have the biggest impact on employers with more transient employee populations such as the retail and food service industries.
No Discrimination Based on Health Status *Effective for plan years beginning on or after January 1, 2014.*	• Group Health Plans (self and fully insured) may not establish rules for eligibility (including continued eligibility) to enroll based on Health Status Related Factors. • **Grandfathered Plans are exempt from this requirement.**	This requirement is not new for, and already applies to, Group Health Plans. ERISA, the Internal Revenue Code, and the Public Health Service Act have all prevented discrimination in eligibility on the basis of health status since 1996 upon the passage of HIPAA.
Mandated Cost-Sharing Limits *Effective for plan years beginning on or after January*	• Group Health Plans (self and fully insured) must limit cost-sharing amounts (out-of-pocket expenses) (*e.g.*, deductibles, co-insurance, co-pays) incurred by participants to the limits applicable to high deductible health plans under	• Out-of-pocket maximums will be limited to the out-of-pocket maximums that are allowed under a high deductible health plan under Internal Revenue Code Section 223. To put this into context, the

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1, 2014.	Internal Revenue Code Section 223. • When this provision goes into effect in 2014, the 2014 high deductible health plan limits will apply. For years after 2014, the law provides adjustment factors to increase the limits in out years. • Group Health Plans (self and fully insured) cannot have deductibles that exceed $2,000 for single coverage and $4,000 for any other coverage, subject to adjustments for cost-of-living after 2014. Deductibles may be increased by the amount of reimbursement available to participants under flexible spending accounts (regardless of whether employee or employer contributions). • **Grandfathered Plans are exempt from this requirement.**	out-of-pocket maximum limitations for high deductible health plans in 2010 are $5,950 for single coverage and $11,900 for family coverage. • The requirement that Group Health Plans cannot have deductibles that exceed $2,000 for single coverage and $4,000 for family coverage could theoretically collide with the ***minimum*** deductible requirements for high deductible health plans under Internal Revenue Code Section 223. In 2010, a high deductible health plan must have a deductible of ***at least*** $1,200 for single coverage and $2,400 for family coverage. These amounts generally increase every year.
Mandated Coverage for Clinical Trials *Effective for plan years beginning on or after January 1, 2014.*	• Group Health Plans (self and fully insured) cannot deny the participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with the clinical trial, or discriminate on the basis of participation in a clinical trial. • A qualified individual is a participant or beneficiary in the Group Health Plan who is: ➢ Eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. ➢ Referred by a participating health care provider who has concluded that the individual's participation in the trial is appropriate, or who provides information	

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	establishing that his participation would be appropriate. • **Grandfathered Plans are exempt from this requirement.**	
EMPLOYER COVERAGE RESPONSIBILITIES		
Penalties for Employers Not Offering Coverage *Effective January 1, 2014.*	• This penalty applies to Large Employers that employed an average of at least 50 FTEs in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (*i.e.*, whether the employer employed an average of at least 50 full-time employees on business days during the preceding calendar year), but they are ***not*** counted to determine the amount of the penalty. • If a Large Employer with at least 50 FTEs (including FTE equivalents): ➢ ***Does not provide*** health coverage to its FTEs in any month; ***and*** ➢ At least one FTE of the employer enrolls in an Exchange and qualifies for a Premium Tax Credit or Cost Sharing Reduction for that month, The employer must pay a penalty for that ***month*** equal to: **total number of FTEs x $166.67** or for that ***year*** equal to: **total number of FTEs x $2,000**	• This penalty is imposed on a monthly basis and the penalty must be paid for ***every*** FTE employed by the employer in that month – even if only ***one*** FTE enrolls in an Exchange and qualifies for a Premium Tax Credit or Cost Sharing Reduction for that month. • The Secretary shall certify to an employer whether the penalty is due and the time for payment. This process will be more fully described in upcoming regulations, but the Secretary has the discretion to require payment on an annual, monthly or other periodic basis. • In determining whether an employer employs 50 FTEs, an employer must apply the "controlled group" and "affiliated service group" rules under the Internal Revenue Code. ***In very general terms***, this means that subsidiaries and affiliated companies may have to be combined and considered to be a ***single*** employer for purposes of counting FTEs and paying the penalty. • It is not yet clear how to calculate whether an employee is employed on

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	• In calculating this penalty, the first 30 FTEs do not count. • After 2014, the penalty amounts are subject to an inflation adjustment formula in the Act. • When no employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400 percent of the federal poverty line).	average at least 30 hours of service per week, particularly with regard to employees who are not employed on an hourly basis. The Act gives the Secretary of the Health and Human Services discretion to promulgate regulations to perform this calculation. • Anticipating that some employers might reduce employees' wages to offset penalty amounts owed by employers, the Act requires the Secretary of Labor to conduct a study to determine whether this occurs and to present the report to the Committee on Ways and Means of the House of Representatives and the Committee of Finance of the Senate. This offset is not currently prohibited by the Act, but abuses could lead to further legislation.
Penalties for Employers Offering Coverage *Effective January 1, 2014.*	• This penalty applies to Large Employers that employed an average of at least 50 FTEs in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (*i.e.*, whether the employer employed an average of at least 50 FTEs on business days during the preceding calendar year), but they are ***not*** counted to determine the amount of the penalty. • If an employer with at least 50 FTEs (including	• This penalty is imposed on a monthly basis and the penalty must be paid ***only*** for FTEs who enroll in an Exchange and qualify for a Premium Tax Credit or Cost Sharing Reduction for that month. • The Secretary shall certify to an employer whether the penalty is due and the time for payment. This process will be more fully described in upcoming regulations, but the Secretary has the discretion to require payment on an annual, monthly or other periodic basis.

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	FTE equivalents): ➢ ***Provides*** qualifying health coverage to its FTEs in any month; ***and*** ➢ At least one FTE of the employer enrolls in an Exchange and qualifies for a Premium Tax Credit or Cost Sharing Reduction for that month, the employer must pay a penalty for that ***month*** equal to the lesser of: **total number of FTEs receiving a Premium Tax Credit and/or Cost Sharing Reduction x $250** **or** **total number of FTEs x $166.67** or for that ***year*** equal to the lesser of: **total number of FTEs receiving a Premium Tax Credit and/or Cost Sharing Reduction x $3,000** **or** **total number of FTEs x $2,000** • In calculating the maximum penalty, the first 30 FTEs do not count. • After 2014, the penalty amounts are subject to an inflation adjustment formula in the Act. • An employer is not assessed a penalty with respect to any employee receiving a free choice voucher (see below).	• In determining whether an employer employs 50 FTEs, an employer must apply the "controlled group" and "affiliated service group" rules under the Internal Revenue Code. ***In very general terms***, this means that subsidiaries and affiliated companies may have to be combined and considered to be a ***single*** employer for purposes of counting FTEs. • It is not yet clear how to calculate whether an employee is employed on average at least 30 hours of service per week, particularly with regard to employees who are not employed on an hourly basis. The Act gives the Secretary discretion to promulgate regulations to perform this calculation. • Anticipating that some employers might reduce employees' wages to offset penalty amounts owed by employers, the Act requires the Secretary of Labor to conduct a study to determine whether this occurs and to present the report to the Committee on Ways and Means of the House of Representatives and the Committee of Finance of the Senate. This offset is not currently prohibited by the Act, but abuses could lead to further legislation.

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	• When employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400 percent of the federal poverty line); ***and*** either: ➢ The employee's contribution under the employer plan exceeds 9.5 percent of household income (indexed after 2014); ***or*** ➢ The employer plan pays less than 60 percent of the total cost of benefits provided under the plan.	
Employers Offering Coverage: Free Choice Vouchers for Certain Low-Income Employees *Effective January 1, 2014*	• Employers that offer Minimum Essential Coverage to employees and pay a portion of the premiums of that coverage are required to provide vouchers to eligible employees for purchase of coverage in an Exchange. • An employee is eligible if the employee's required premium contribution under the employer's health plan is between eight percent and 9.8 percent of the employee's household income for the year, the employee's household income does not exceed 400 percent of the federal poverty line, ***and*** the employee does not participate in the employer's plan. The percentages are indexed after 2014. • The voucher equals the amount the employer would have paid to provide single coverage for the employee under the plan (or family coverage if elected by the employee) with respect to which the employer pays the largest portion of the cost of the	• The free choice voucher is designed to assist individuals for whom employer coverage is a large percentage of their household income, but who have too much income to qualify for Premium Tax Credits or Cost Sharing Reductions on the Exchanges. • There appears to be a legislative disconnect between the eligibility for free choice vouchers and the eligibility for the Premium Tax Credit and the Cost Sharing Reduction on the Exchanges. Individuals for whom employer coverage costs up to 9.8 percent of their household income may be eligible for a free choice voucher; however, Premium Tax Credits and Cost Sharing Reductions may be available to individuals whose share of employer

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	plan. • The employer is required to pay the voucher amounts to the Exchange, and the Exchange is required to credit the amount of any voucher to the monthly premium of any Qualified Health Plan in the Exchange in which the qualified employee is enrolled. • The voucher amount is not taxable to the employee to the extent used to pay for coverage on the Exchange. • Any amount of the voucher in excess of the cost of coverage on the Exchange is paid to the employee, but is taxable. • Employers may deduct the amount of a free choice voucher as an amount for compensation for personal services actually rendered. • Employers are not required to pay any penalties with regard to employees to whom they provide free choice vouchers.	provided coverage is as low as 9.5 percent. This disconnect may be corrected in future legislation.
Automatic Enrollment for Employers Offering Coverage *Effective by regulation.*	• Employers with more than 200 FTEs that offer health coverage are required to automatically enroll new full time employees, subject to any waiting period of 90 or less days. • Automatic enrollment must include adequate notice and opportunity for an employee to opt out of coverage.	• This requirement will impose the greatest burden on employers with transient workforces. • In the absence of regulatory guidance, it appears that an employer that offers multiple health plan options may choose the default option into which employees will be automatically enrolled.
EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES		
Uniform Notice of Coverage Requirements	• By March 23, 2012, plan administrators, sponsors and insurers must provide a summary of benefits and coverage explanation that accurately	• This new requirement is essentially a summary of a summary plan description. While church and governmental plans

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Effective for plan years beginning on or after September 23, 2010.	describes benefits and coverage under the Group Health Plan to participants prior to enrollment. The summary must be presented in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee. • The content and format is prescribed by statute and standards developed by the Secretary of Health and Human Services. The summary must state whether the Group Health Plan: ➢ Provides Minimum Essential Coverage: and ➢ Pays less than 60 percent of the total cost of benefits provided under the plan. • In addition, the summary must provide information such as: a description of coverage and cost-sharing under the plan; exceptions, reductions and limitations on coverage; renewability and continuation of coverage provisions; a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions; and contact numbers and web addresses where the actual group certificate or policy may be obtained. • Plan administrators/sponsors and insurers of group health plans must provide notice to participants of any material modification to the Group Health Plan terms or coverage no later than 60 days prior to the effective date of the change. • Penalty for willful noncompliance is $1,000 per failure.	have not been required to provide a summary plan description under ERISA (because of their ERISA exemption), they will now have to provide this new notice. • ERISA plans will apparently still have to provide the summary plan description required by ERISA, as well as this new notice. However, the Department of Labor is required to update its regulations concerning the accurate and timely disclosure of plan terms and conditions to harmonize with the Act. • States may adopt more stringent standards for the summary. • The Secretary is required to provide standards for developing this summary by March 23, 2011, and plans will be required to distribute the new summary by March 23, 2013.

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	• **This requirement applies to Grandfathered Plans.**	
Employer Annual Reporting Requirements regarding Quality of Care *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans must provide an annual report to participants at open enrollment and to the Secretary of Health and Human Services regarding Group Health Plan and health care provider reimbursement structures that improve the quality of care, including wellness and health promotion activities. • The Secretary of Health and Human Services is required to develop reporting requirements and issue regulations by March 23, 2012. • The Secretary of Health and Human Services is required to make these reports public on the Internet. • **Grandfathered Plans are exempt from this requirement.**	
Information to Secretary of Health and Human Services *Effective for plan years beginning on or after September 23, 2010.*	• Group Health Plans (self and fully insured) must provide information regarding the following to the Secretary of Health and Human Services and make such information publicly available: ➢ Claims payment policies and practices. ➢ Periodic financial disclosures. ➢ Data on enrollment. ➢ Data on disenrollment. ➢ Data on the number of claims that are denied. ➢ Data on rating practices. ➢ Information on cost-sharing and payments with respect to any out of network coverage. ➢ Information on enrollee and participant rights.	The Department of Labor is required to update its regulations concerning the accurate and timely disclosure of plan terms and conditions to harmonize with the Act.

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	➢ Other information determined appropriate by the Secretary of Health and Human Services. • The information must be provided in "plain language" that the intended audience can readily understand. • The Group Health Plan must also provide a participant information regarding the amount of cost-sharing that the participant would be responsible for paying with respect to a specific service in a timely manner at the request of the participant. • **Grandfathered Plans are exempt from this requirement.**	
Reporting to Internal Revenue Service of Health Insurance Coverage *Effective January 1, 2014.*	• Employers that provide Minimum Essential Coverage are required to file a report with the Internal Revenue Service by January 31 of the following year that provides information about the employees who are covered by the Minimum Essential Coverage, the portion of the premium (if any) required to be paid by the employer, and such additional information as may be required if the Minimum Essential Coverage is offered through an Exchange. • The employer must provide to each employee included in the report a statement showing the information reported with respect to that employee.	The purpose of this reporting requirement is to assist the Internal Revenue Service in its determination of whether individuals are meeting their obligations to have coverage and to determine whether such individuals are eligible for a Premium Tax Credit or Cost Sharing Reduction.
Large Employer Reporting to Internal Revenue Service Regarding Coverage Offered	• Large Employers (for purposes of applying the employer penalties) are required to file a report with the Internal Revenue Service by January 31 of the following year that provides certification	• The purpose of this reporting requirement is to provide the Internal Revenue Service with the information necessary to determine whether the

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Effective January 1, 2014.	as to whether the employer offers FTEs the opportunity to enroll in Minimum Essential Coverage through an Eligible Employer Sponsored Health Plan, and if so, information on the length of waiting periods imposed, costs of premiums, total cost paid by the employer, number of FTEs, and information on each FTE and the months covered under the plan. • The information required to be reported must also be provided in a statement to each FTE.	employer may be subject to a penalty. • To the extent possible, the Secretary of the treasury may permit that a return required to be provided by Large Employers under this provision be included as part of the return required to be provided by employers offering Minimum Essential Coverage generally (see above). • Employers may contract with their insurer to report this information.
Employee Notices Regarding Exchange *Effective March 1, 2013.*	• Employers must provide written notices to employees regarding the Exchange at the time of hire for new employees and for all other employees by March 1, 2013. • The notice must inform the employee of: the existence of an Exchange, its services, and how to contact the exchange; that if the employer plan's share of the total allowed costs of benefits under the plan is less than 60 percent of such costs, that the employee may be eligible for a Premium Tax Credit or a Cost Sharing Reduction through the Exchange; and that if the employee purchases a plan through the Exchange, the employee will lose the employer contribution (if any) to any health plan offered by the employer and that all or a portion of such contribution may be excludable from federal income taxes.	• This notice is intended to provide information to employees about the existence of the Exchange, as well as provide information so that the employee can evaluate whether he or she is eligible for Premium Tax Credits or Cost Sharing Reductions under the Exchange. • Further specifics regarding this notice will be provided by regulation.
Cost of Employer-Sponsored Health Coverage Included on	Employers must report the cost of employer-provided coverage (employee plus employer portion)	

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W-2 *Effective January 1, 2011.*	on their employees' Form W-2.	
PROVISIONS APPLICABLE TO SMALL EMPLOYERS ONLY		
Coverage through an Exchange *Effective January 1, 2014.*	• A Small Employer can offer Qualified Health Plan coverage to its full time employees through an Exchange. An employer in the small group market generally must have between one and 100 employees during the preceding year, applying the controlled group rules. However, for plan years beginning before January 1, 2016, a state can elect to limit the small group market to employers with no more than 50 employees. • An employer providing coverage through an Exchange that outgrows the parameters for the small group market is permitted to continue to offer coverage through the Exchange until such time as the employer discontinues coverage. • Beginning in 2017, states may elect to permit employers in the large group market to offer insurance through an Exchange.	• In determining the number of FTEs employed by an employer, an employer must apply the "controlled group" and "affiliated service group" rules under the Internal Revenue Code. ***In very general terms***, this means that subsidiaries and affiliated companies may have to be combined and considered to be a ***single*** employer for purposes of determining whether an employer may purchase coverage through an Exchange. • There has been much discussion regarding the provision of coverage for abortions and how no Federal funds may be used to pay for such coverage. There has been less discussion of how these rules apply with respect to Small Employers who offer coverage through an Exchange. If an employee seeking such coverage qualifies for a Premium Tax Credit or Cost Sharing Reduction, and that employee pays his or her portion of the premiums through employee payroll deposit, separate payroll deposits must be made to segregate out the portion of the premium equal to the actuarial value of coverage

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		for abortion services. • Employers offering coverage through an Exchange must allow ***all*** full time employees to be eligible. • Coverage through an Exchange is limited to lawful residents of the United States.
Transitional Small Employer Tax Credit *Effective January 1, 2010.*	• An employer with no more than 25 FTEs and average wages of less than $50,000 that purchases health insurance for its employees ***and*** covers at least 50 percent of total premium cost is eligible for a tax credit: ➢ For 2010-2013, the tax credit equals up to 35 percent of the employer's premium cost based on the average premium contribution in the small group market (up to 25 percent credit in the case of tax-exempt employers). ➢ For 2014 forward, the tax credit equals up to 50 percent of the lesser of the employer's premium contribution toward insurance that is purchased through an Exchange, or the average premium contribution in the small group market (up to 35 percent in the case of tax-exempt employers). • The amount of the credit is phased-out based on the small employer's number of employees and average wages. • Beginning in 2014, the credit is only available for two years.	• When determining "full-time equivalents" for purposes of this credit, an employer calculates the total number of hours of service for which wages were paid by the employer during the taxable year and divides that number by 2,080; however, no more than 2,080 hours may be counted for any individual employee. The Secretary may issue regulations to clarify how to count hours for this purpose. • In addition, an employer must apply the "controlled group" and "affiliated service group" rules under the Internal Revenue Code. ***In very general terms***, this means that subsidiaries and affiliated companies may have to be combined and considered to be a ***single*** employer for purposes of counting full-time equivalent employees. • Special rules may apply to tax-exempt employers that are beyond the scope of this summary.
Insurance Access and Premium Rating	• Premium rates charged by Health Insurance Issuers for health insurance coverage offered in	

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Effective for plan years beginning on or after January 1, 2014.	the small group market (and large group market if offered through an Exchange) cannot vary except with respect to certain factors: ➢ Individual vs. family coverage; ➢ Rating area; ➢ Age (limit of 3 to 1); and ➢ Tobacco use (limit of 1.5 to 1).	
Simple Cafeteria Plans *Effective January 1, 2011.*	• An employer that employed on average 100 or fewer employees in the preceding two years is permitted to establish a "Simple Cafeteria Plan" by complying with the contribution, eligibility, and participation requirements established for "Simple Cafeteria Plans." • Employers that establish a Simple Cafeteria Plan, but later grow beyond 100 employees may continue to offer the Simple Cafeteria Plan until they reach 200 employees. • The contribution requirements require an employer to make ***employer*** contributions to qualified benefits under a cafeteria plan (regardless of whether an employee makes salary reduction contributions) in an amount equal to: (i) a uniform percentage (of at least two percent) of an employee's compensation for a plan year; or (ii) the lesser of six percent of an employee's plan year compensation or twice the amount of the salary reduction amounts of the employee. • The eligibility requirements require that all employees who had at least 1,000 hours of service in the preceding plan year be eligible to participate and be able to elect any benefit	The Simple Cafeteria Plan essentially creates a safe harbor from the rules under Internal Revenue Code Section 125 that prevent discrimination with respect to eligibility and benefits in favor of highly compensated employees in a cafeteria plan. By making minimum required contributions to benefits under a cafeteria plan and providing broad eligibility for the plan, the employer's cafeteria plan will be deemed to pass the Internal Revenue Code Section 125 nondiscrimination rules. In concept, this is similar to safe harbor 401(k) and 403(b) plans.

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	offered through the cafeteria plan. Certain employees are excludable such as those under age 21, those with less than one year of service, those who are collectively bargained, and those who are nonresident aliens. • If the Simple Cafeteria Plan requirements are met by an eligible employer, the plan is treated as meeting any applicable non-discrimination requirements under Internal Revenue Code Section 125.	
WELLNESS PROGRAM INCENTIVES		
Requirements for Wellness Programs Offered by an Employer *Effective for plan years beginning on or after January 1, 2014.*	• Employers can establish wellness programs that provide a premium discount or rebate or other reward for participation without violating the nondiscrimination rules that prevent discrimination in Group Health Plans based on Health Status-Related Factors. These wellness programs are permissible under the following circumstances: ➢ If the reward ***is not*** based on the participant satisfying a health standard, the program is permitted if the reward is made available to all similarly situated individuals. ➢ If the reward is based on the participant satisfying a health standard, the program is permitted if: (i) The reward is not greater than 30 percent of the cost of the health plan's coverage	• These provisions essentially codify the wellness regulations that were issued by the Secretaries of Labor, Treasury, and Health and Human Services under the portability provisions of HIPAA that already applied to Group Health Plans, and broaden them to include Health Insurance Issuers. • These provisions (and other wellness provisions included in the Act) demonstrate the federal government's promotion of wellness programs. Note that the wellness incentive limit has been raised from 20 percent (as provided in the regulations under HIPAA) to 30 percent, and this provision gives the Secretaries discretion to raise it to 50 percent if

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	(taking into account both employer ***and*** employee contributions to the coverage); (ii) The program is reasonably designed to promote health or prevent disease; (iii) Individuals eligible for the program have an opportunity to qualify for the reward at least once per year; (iv) The full reward is available to all similarly situated individuals (including provision of reasonable alternatives for those unable to satisfy the health standard due to a medical condition); and (v) The availability of reasonable alternatives is disclosed in plan materials describing the terms of the program. • The Act permits the Secretaries of Labor, Health and Human Services and the Treasury to increase by regulation the reward available to up to 50 percent of the cost of coverage. • The Act also creates a wellness program demonstration projects for ten states under which the participating states will apply the wellness program rules to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in each state.	deemed appropriate. • These provisions do not, however, address other issues about which employers offering wellness programs need to be aware such as ensuring that wellness programs comply with the Genetic Information Nondiscrimination Act (*e.g.*, ensuring that family history or other genetic information questions are not asked before enrollment, or that health risk assessments that are tied to a reward do not contain questions about genetic information, including family history). Another concern about which employers should be aware is increasing informal guidance from the Equal Employment Opportunity Commission that requiring employees to participate in medical exams or to answer disability related questions as a condition of participating in a health plan could violate the Americans With Disabilities Act.
Grants to Small Employers to Establish Wellness Programs *Effective January 1, 2011.*	• The Secretary of Health and Human Services is authorized to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs. • An employer is eligible if it employs less than	

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	100 employees who work 25 hours or greater per week and did not provide a wellness program prior to March 23, 2010. • $200 million has been appropriated for these grants for fiscal years 2011 through 2015.	
CHANGES FOR RETIREE HEALTH INSURANCE		
Temporary Reinsurance Program for Early Retirees *Effective no later than June 22, 2010.*	• Employment-based plans (self or fully insured) providing health benefits, including prescription drugs, to early retirees (retirees age 55 through 64) and their dependents can apply to receive reimbursement for a portion of the cost of coverage. ➢ An employment-based plan is a plan maintained by a current or former employer (including a state or local government), employee organization, VEBA, or multiemployer plan. ➢ An employment-based plan that participates in the reinsurance program must implement programs and procedures to generate cost savings with respect to participants with chronic or high cost conditions. • Reimbursement is 80 percent of a valid retiree claim between $15,000 and $90,000 (as adjusted each year based on the Medicare percentage increases). • Reimbursements must be used to lower costs for the plan. • Reimbursement are not included in the employer's gross income. • The reinsurance program ends on January 1,	• The reinsurance program for early retirees is an incentive for employers to continue offering retiree coverage at least through the inception of the Exchange in 2014 (when the reinsurance program ends). It can be an important funding opportunity to entities providing retiree health coverage. • Reimbursements must be used to lower retiree health costs and may not simply be deposited into an employer's general assets. The payments may be used to reduce premium costs, premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. The Secretary is required to develop a mechanism to monitor the appropriate use of such payments.

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	2014; however, only $5 billion has been allocated to this program and the Secretary has authority to stop taking applications for the program based on the availability of funding.	
Elimination of Deduction for Retiree Prescription Drug Subsidy *Effective for tax years after December 31, 2012.*	Employers who receive a federal subsidy for maintaining retiree prescription drug coverage can no longer deduct the amount of the subsidy.	• This change could have an immediate impact on the accounting statements of employers that receive this subsidy because the value of the subsidy will be reduced, and thus the actual cost to an employer to provide retiree prescription drug coverage will increase. This increase will need to be recognized this year as an increased future liability for accounting purposes. • The loss of this deduction, in combination with the elimination of the Medicare Part D "doughnut hole" (see below), could lead employers to reevaluate whether they want to continue to provide retiree prescription drug coverage at all.
Elimination of Medicare Doughnut Hole *Effective beginning in 2011 with the complete elimination of the doughnut hole effective by 2020.*	• Part D Medicare beneficiaries who hit the doughnut hole in 2010 will receive a $250 rebate. • In 2011, Part D Medicare beneficiaries who hit the doughnut hole are eligible for a 50 percent discount in brand name drugs. • Beginning in 2010, preventive care is free of co-payments and deductibles. • The doughnut hole will be eliminated by 2020.	• Part D Medicare enrollees are responsible for 25 percent of their drug costs until they incur $2,700 in costs, then they are responsible for 100 percent of their drug costs until they incur $4,350 in costs, at which time they are responsible for only five percent of their drug costs. This gap between $2,700 and $4,350 is referred to as the "doughnut hole." • The elimination of the doughnut hole, in

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		combination with the elimination of the tax deduction for the retiree drug subsidy (see above), may cause many employers to rethink whether they wish to continue providing retiree prescription drug benefits. If the doughnut hole goes away, the actuarial value of the Part D benefit will increase. Employers who receive the retiree drug subsidy will have to increase their retiree prescription drug benefits to keep up with the richer Part D benefit in order to continue receiving the subsidy. As the Part D benefit becomes richer and the Exchanges are effective in 2014, many employers may simply decide to drop retiree coverage altogether.
CLASS ACT		
Voluntary Employer Participation in CLASS Program Premium Collection *Effective January 1, 2011.*	• The Community Living Assistance Services and Supports Act (CLASS Act) is a national voluntary insurance program for purchasing community living assistance services and supports. • The Secretary is authorized to create a system under which employers will automatically enroll employees in the CLASS program in the same manner as an employer may elect to automatically enroll employees in a 401(k), 403(b), or 457(b) plan. Employees may elect to opt-out of the program. • Employers that enroll employees in the CLASS program are responsible for making the monthly payroll deduction for the premium applicable to	Due to the delay in payments under the CLASS Act (i.e., five year vesting before benefits can start), this provision is expected to be a significant revenue raiser in the early years of the Act.

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	each employee enrolled in the CLASS program. • An employer only has to make deductions and withhold premiums for individuals enrolled in the CLASS program if the employer so elects. • Benefits will be no less than an average of $50 per day for qualifying individuals; however, there is a five year vesting period which means that an individual must pay premiums for five years before any benefits can be paid.	
ADOPTION ASSISTANCE		
Adoption Assistance *Effective January 1, 2010.*	• The dollar limitation for the credit for qualified adoption expenses and for the tax exclusion from gross income for such expenses paid under an employer's adoption assistance program increases from $10,000 to $13,170, adjusted for inflation after 2010. • The tax exclusion from gross income for expenses paid under an employer's adoption assistance program is currently set to decrease to $5,000 after December 31, 2010. This sunset date is changed to December 31, 2011. • The adoption credit is changed to a refundable tax credit.	
TAX PROVISIONS AFFECTING EMPLOYER-BASED HEALTH CARE		
Excise Tax on High Cost Employer-Sponsored Health Coverage *Effective January 1, 2018.*	• A tax is imposed on the coverage provider of high-cost health plans which is equal to 40 percent of the "excess benefit." For insured plans, the coverage provider will be the issuer and for self-insured plans the coverage provider will generally be the plan administrator. • The "excess benefit" is the amount of annual	• In earlier versions of health care reform bills, this tax was set to begin much sooner. Compromises pushed the effective date back to 2018 and excluded a number of kinds of plans from inclusion in the plan value calculation. • Although they agreed to the tax's higher

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	coverage that costs ***more than*** $10,200 for single coverage and ***more than*** $27,500 for family coverage. These limits are for 2018, but may be adjusted before that time under a formula set forth in the Act. • Any coverage provided under a group health plan that is excludable from an employee's gross income under Internal Revenue Code Section 106 is included in the cost calculation, including employer and employee pre-tax contributions to flexible spending accounts, health reimbursement accounts, and employer contributions to health savings accounts. The following are ***not*** included in the cost calculation: ➢ Coverage for long-term care; ➢ Dental and vision coverage offered under separate policies or certificates; and ➢ Specific disease or hospital indemnity policies if the payment for the coverage is not excludable from any employee's income. • There is a higher dollar threshold for qualified retirees and high risk professions, and adjustments are made for age and gender. • The employer is responsible for calculating the tax and notifying providers and the Secretary of Health and Human Services. • This tax does not go into effect until 2018.	thresholds and delayed effective date, labor unions in particular continue to be concerned about the tax's impact on coverage provided to collectively-bargained employees.
Revenue Provisions Affecting HSAs, FSAs and HRAs	• Over the counter (OTC) drugs are no longer qualified for purposes of distributions/reimbursements under HSAs, Archer	• When reimbursement for OTC drugs became available a few years ago, many flexible spending account plans were

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Effective January 1, 2011; however, the dollar limits on contributions to a health FSA is effective January 1, 2013.	MSAs, health FSAs and HRAs, ***except for*** prescription medicines and insulin. This provision is effective January 1, 2011. • The tax on distributions from HSAs for nonqualified medical expenses is increased from 10 percent to 20 percent. This provision is effective January 1, 2011. • The tax on distributions from Archer MSAs for nonqualified medical expenses is increased from 15 percent to 20 percent. This provision is effective January 1, 2011. • Contributions to a health FSA under a cafeteria plan is limited to $2,500 per year, indexed for inflation after 2013. This provision is effective January 1, 2013.	amended to allow for these reimbursements. Those amendments will now need to be reversed. • Traditionally, medical flexible spending accounts have only been subject to limits imposed by the employer in designing the plan. Many employers allowed elections of up to $5,000 or even more. This new limit of $2,500 will dramatically lower limits in many plans. This new limit is intended as a revenue raiser for the federal government because it will limit the amount of wages an employee may exclude from income and will also raise additional payroll taxes.
Increase in FICA Taxes on Earned Income *Effective for compensation received after December 31, 2012.*	• There will be an increase of 0.9 percent in the FICA tax paid on wages during a taxable year above $200,000 ($250,000 for joint returns). • The increase applies only to the employee-paid FICA taxes.	Although this tax does not apply to the employer-paid FICA taxes, employers will still be responsible for the withholding and reporting obligations with respect to this increase in employee-paid FICA taxes.
Increase in FICA Taxes on Unearned Income *Effective for taxable years beginning after December 31, 2012.*	• There will be a new tax imposed that is equal to 3.8 percent of the lesser of: the net investment income for a taxpayer's taxable year, or the modified adjusted gross income for such taxable year over $250,000 for joint filers (or $150,000 for married individuals filing as single, or $200,000 for single filers). • Net investment income includes gross income from interest, dividends, annuities royalties, rents other gross income derived from passive activities	This new tax does ***not*** affect employers and their withholding and reporting obligations. Affected taxpayers will report any applicable income on their personal tax returns. This tax replaces the so-called "millionaires' tax" that appeared in earlier versions of health care reform bills.

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	related to a trade or business, and net gain attributable to the disposition of property other than property held in a trade or business (subject to exceptions). • This tax does not apply to distributions under retirement plans under Internal Revenue Code Sections 401(a), 403(a), 403(b), 408, 408A or 457(b).	
New Federal Premium Tax *Effective for plans/policies ending after September 30, 2012.*	• Group Health Plans (self and fully insured) will be assessed a tax of $2 ($1 in the case of plan years during fiscal year 2013) per average number of insured lives to finance a comparative effectiveness research program. • This tax will be paid by the plan sponsor, which is the employer in the case of a single employer plan, an employee organization in the case of a plan established by such an organization, or associations, committees, or trustees in the case of a VEBA, MEWA or other multiple employer plan. • This tax will be indexed annually, and sunset for plan years ending after September 30, 2019.	• Excepted Benefits are not subject to this tax. • Comparative effectiveness research provides information on the relative strengths and weaknesses of various medical interventions. Its goal is to provide clinicians and patients with objective information to evaluate the effectiveness of particular treatment procedures to improve the health care system and provide better and more efficient care. This tax will be used to fund this research.

Glossary of Terms

(1) **Cost Sharing Reduction –** A reduction in the cost-sharing amounts required of certain low-income taxpayers (generally, taxpayers whose household income does not exceed 400 percent of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Cost Sharing Reduction is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Plan equals or exceeds 9.5 percent of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Plan is less than 60 percent.

(2) **Eligible Employer Sponsored Health Plan –** A Group Health Plan (self or fully insured) offered by an employer to an employee which is a governmental plan or any other plan or coverage offered in the small or large group market within a state, including a Grandfathered Plan offered in a group market.

(3) **Essential Health Benefits –** Benefits that are required to be included as part of any Qualified Health Plan that is made available through an Exchange. The scope of Essential Health Benefits is intended to be equal to the scope of benefits provided under a typical employer plan, as defined by the Secretary of the Health and Human Services. Essential Health Benefits include items and services covered within the following general categories:

a. Ambulatory patient services;
b. Emergency services;
c. Hospitalization;
d. Maternity and newborn care;
e. Mental health and substance use disorder services, including behavioral health treatment;
f. Prescription drugs;
g. Rehabilitative and habilitative services and devices;
h. Laboratory services;
i. Preventative and wellness services and chronic disease management; and
j. Pediatric services, including oral and vision care.

(4) **Essential Health Benefits Package –** Group Health Plan coverage that:

a. Provides for Essential Health Benefits;
b. Limits cost-sharing amounts (*e.g.* deductibles, co-insurance, co-pays) incurred by participants to the limits on health savings accounts (currently $5,950 for single coverage and $11,900 for family coverage), indexed after 2014;

c. Limits the deductible to $2,000 for single coverage and $4,000 for family coverage, increased by employee and employer contributions to a flexible spending account, indexed after 2014; and
d. At minimum, excepting only catastrophic plans for certain young individuals, provides benefits that are actuarially equivalent to 60 percent of the full actuarial value of the essential health benefits provided under the plan, taking into account employer contributions to a health savings account.

(5) **Excepted Benefits –** Benefits under one of the following**:**
a. Coverage only for accident or disability income insurance;
b. Coverage issued as a supplement to liability insurance;
c. Liability insurance, including general liability insurance and automobile liability insurance;
d. Worker's compensation or similar insurance;
e. Automobile medical payment insurance;
f. Credit-only insurance;
g. Coverage for on-site medical clinics; and
h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Excepted Benefits also include, if provided under a separate policy, certificate or contract of insurance:
a. Limited scope dental or vision benefits;
b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;
c. Coverage only for a specified disease or illness; and
d. Hospital indemnity or other fixed indemnity insurance.

(6) **Exchange –** A governmental agency or nonprofit entity that is established by the state for the purpose of making Qualified Health Plans available to qualified individuals and qualified employers.

(7) **Grandfathered Plan –** A Group Health Plan (self or fully insured) in effect on March 23, 2010. A Grandfathered Plan retains grandfathered status even if (i) family members of a participant who was enrolled in the Grandfathered Plan on March 23, 2010, are permitted to enroll in the Plan after March 23, 2010; and (ii) new employees and their families are permitted to enroll in the plan after March 23, 2010. A Grandfathered Plan also includes any health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010.

(8) **Group Health Plan –** Any plan, fund or program established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the plan) directly or through insurance, reimbursement or otherwise.

(9) **Health Insurance Issuer –** An insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance, and does not include a Group Health Plan.

(10) **Health Status-Related Factor** – Any of the following factors in relation to an individual or a dependent of the individual:

a. Health status;
b. Medical condition (physical and mental);
c. Claims experience;
d. Receipt of health care;
e. Medical history;
f. Genetic information;
g. Evidence of insurability;
h. Disability; and
i. Any other health status-related factor determined appropriate by the Secretary.

(11) **Large Employer -**

a. For purposes of applying the employer penalties, an employer who employed an average of at least 50 FTEs on business days during the preceding calendar year, applying the controlled group rules. A FTE means an employee who is employed on average at least 30 hours of service per week.
b. For purposes of eligibility to participate in the Exchange, an employer who employed an average of at least 101 employees on business days during the preceding calendar year, applying the controlled group rules, and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Large Employer as an employer who employed an average of at least 51 employees.

(12) **Minimum Essential Coverage –** Coverage under Medicare, Medicaid, CHIP, TRICARE for Life, the Veteran's health care program, the Peace Corps volunteer program, an Eligible Employer Sponsored Plan, a health plan offered in the individual

market, a Grandfathered Plan or a state health benefits risk pool. Excepted Benefits are ***not*** treated as Minimum Essential Coverage.

(13) **Qualified Health Plan –** A fully-insured Group Health Plan that (i) has been certified that it meets the criteria for certification in an Exchange; (ii) provides an Essential Health Benefits Package; and (iii) is offered by a Health Insurance Issuer that is licensed to offer health insurance coverage in that state and meets certain other requirements.

(14) **Premium Tax Credit –** A tax credit available to certain low-income taxpayers (generally, taxpayers whose household income does not exceed 400 percent of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Premium Tax Credit is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Plan equals or exceeds 9.5 percent of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Plan is less than 60 percent.

(15) **Small Employer –**

a. For purposes of applying the employer penalties, an employer that is not a Large Employer.
b. For purposes of eligibility to participate in an Exchange, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Small Employer as an employer who employed an average of at least one but not more than 50 employees.