Issue brief

Federal Healthcare Reform: Summary of Provisions and Its Impact on Employers

On March 21, 2010 the U.S. House of Representatives approved H.R. 3590 creating the Patient Protection and Affordable Care Act. President Obama signed the legislation into law on March 23, 2010 effectively implementing sweeping changes to the nation's healthcare system that will be rolled out over the next eight years. Congress then approved a series of changes to the Act included in H.R. 4827—the Reconciliation Bill—that made some alterations to the final reform bill based on compromises made between the House, the Senate, and the White House.

The Congressional Budget Office (CBO) estimates that the total cost of the final healthcare reform package over 10 years to be approximately $940 billion, financed through a combination of savings from Medicare and Medicaid, and the imposition of new taxes and fees (including the excise tax on high cost insurance plans—cadillac plans).

The overall effect of the new reform law, according to an analysis provided by the CBO and the Joint Committee on Taxation (JCT), will be to extend coverage to an additional 32 million individuals who are currently uninsured by 2019. The CBO and JCT further estimate that approximately 24 million individuals would purchase their own coverage through the new state-administered insurance exchanges (which will be operational by 2014) and approximately 16 million more individuals will be enrolled in Medicaid and the Children's Health Insurance Program as a result of the programs expansions that take place under this reform law.

While it is nearly impossible to determine the complete effect this new reform law will have on the marketplace and all of its players, there are undoubtedly significant changes that will take place as early as this year, with many of the largest and most direct changes to employers taking effect in 2014. This analysis is intended to make employers aware of the changes that will occur over the next 8-10 years that have the most direct impact on the employer community, keeping in mind that many of the changes included in the new reform law will be shaped by forthcoming federal regulations and implementation decisions made at the state level (not to mention potential federal legislation in the future, as well as possible court decisions regarding state challenges to the constitutionality of the reform law).

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CONSIDERATIONS FOR EMPLOYERS

Impact on Coverage Costs:

Overall, employers should not anticipate lower costs as a result of this reform law, and while cost increases could slow in the years to come, the CBO estimated in a November 2009 analysis that the average premium per person is expected to increase 10-13% under the reform provisions. While there will undoubtedly be winners and losers under reform, certain cost pressures beyond new taxes and fees have been created under this new law that should be noted, including alterations to the insurance market that could translate into higher costs for private payers as insurers are required to assume more risk through the elimination of lifetime limits, annual limits, and pre-existing condition exclusions, among other changes. While premium rate increases will be subject to the approval by the Director of Insurance based on guidelines developed by the Department of Health and Human Services, those guidelines have not yet been released.

Furthermore, it should be noted that the small business tax credits to assist in the purchase of healthcare coverage for employees that becomes available this year are very limited in their applicability. Not only will those credits only be available to the very smallest of employers, those employers will have to meet

certain coverage conditions for their employees in order to qualify for the assistance, and the credits are only available through 2013. Beginning in 2014, the credit is restricted to those small employers purchasing coverage in the state Exchange and is further limited to just two years.

Hidden Taxes:

The expansions to Medicaid and the cuts to Medicare rates, while not an immediate and obvious cost pressure for employers, have ramifications as far as exacerbating the cost-shift to private payers that already represent approximately $90 billion a year. In Pennsylvania, outstanding Medicaid liabilities have already reached historic proportions, and while the federal legislation increases federal cost-sharing of the impending expansion, there are growing concerns that increased demands on the state's Medicaid program will result in higher costs to private payers as providers look to recoup their losses caused by traditionally lower reimbursement rates under the public programs and lengthy delays in payments; a problem that is all too familiar to Pennsylvania providers. Furthermore, it should be noted that the taxes imposed on insurers, the pharmaceutical industry, and medical device manufacturers will most likely be passed along to consumers and employers, according to the CBO.

The Employer Mandate and Consumer Purchasing Decisions:

The changes instituted under the reform law will also alter consumer purchasing behaviors in a way that will impact employers and their own coverage purchasing decisions that will likely result in reduced flexibility. The CBO estimates, for instance, the number of individuals obtaining coverage through their employer will be about 3 million lower in 2019 as a result of the reform changes. While the imposition of the individual mandate in 2014 may encourage more individuals to take coverage through their employer's plan, according to the CBO, this number will be counterbalanced against the fact that some employers, particularly small employers with a large number of lower-wage workers, will likely opt not to offer coverage and instead allow those employees to obtain coverage in the state Exchange. Other employers will also likely see employees leave their coverage plan in favor of purchasing coverage in the Exchange; a decision that will impose certain penalties on the employer.

Furthermore, employers should take note that the new law not only requires coverage for employers with more than 50 full-time employees, it also requires that coverage to meet certain "adequacy" requirements. Employers with 50 full-time employees or less are exempt, but employers will want to pay close attention to how the new law defines "full-time" employees.

Employers, therefore, will need to be extremely diligent in their analysis of coverage purchasing decisions because under the employer penalties set to take effect in 2014, employee coverage decisions will have just as much, if not more, impact on employer coverage decisions in terms of weighing the costs of providing coverage versus the costs of not providing coverage.

Administrative Requirements:

Finally, this bill imposes a number of new administrative requirements on employers that, like the cost-shift associated with changes to Medicaid and Medicare, may not be immediately apparent to employers. For instance, employers will be required to report the value of their health benefits on their W2s beginning in 2011. Similarly, employers will also be required to institute automatic employee payroll deductions for the purchase of long-term care insurance ***unless*** the employee chooses to opt out of this coverage; a requirement that many employees may not realize they face. Furthermore, these administrative changes are in addition to the administrative burdens that will arise from new employer coverage penalties set to begin in 2014 and other tax code changes.

The following provides a breakdown of the major provisions pertinent to the employer community and the anticipated timeline for implementation (and assumes changes made under the Reconciliation Bill). Changes related to Medicaid, Medicare, and other changes directed at the provider and healthcare community that do not have a direct impact on employers have not been included in this analysis.

2010

Insurance/ Coverage Reforms

- **Lifetime Limits, Annual Limits, Pre-Existing Condition Exclusions, and Recissions:** All new individual and group health plans are prohibited from placing lifetime limits on the dollar value of coverage, rescinding coverage except in cases of fraud, or excluding children (under the age of 19) with pre-existing conditions from receiving coverage. Furthermore, both new and existing plans are only allowed to place annual limits on coverage, as determined by the Secretary of Health and Human Services. Existing individual and group health plans (those in place at the time this law takes effect—March 23) are also prohibited from rescinding coverage and must eliminate pre-existing conditions for children.

- **Dependent Coverage:** All individual and group policies (including those in existence prior to the effective date) are required to extend coverage to employee's dependents up to age 26 that lack access to other employer-sponsored coverage. Pennsylvania already allows for the option of group plans to offer coverage for dependents up to age 29 with certain conditions.

- **Medical Loss Ratio Reporting:** Health plans are required to report the proportion of premium dollars spent on clinical services, quality and other costs. Health plans are required to keep administrative costs to 15% or less (in other words, at least 85% of premiums must go towards providing direct medical care) in the large group market (more than 100 employees) and 20% or less (leaving 80% of premiums to be used towards providing direct medical care) in the individual and small group markets. "Administrative costs" are not well-defined in terms of their applicability (for instance, they could apply to the administration of certain wellness programs or the administrative costs associated with the implementation of Electronic Health Records and other Heath Information Technology initiatives).

- **Premium Increase/Rate Review:** The Department of Health and Human Services is responsible for establishing a process for reviewing increases in health plan premiums and requiring plans to justify those increases. States are required to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange (which is set to go into effect in 2014) based on unjustified premium increases.

  All premium rate increases will be subject to the approval of the Pennsylvania Insurance Commissioner, based on standards set by the Secretary of HHS. (HHS will also provide grants to states to support efforts to review and approve premium increases.)

- **Preventive Services:** Health plans are required to remove all cost-sharing obligations for preventive services (those determined as qualified services by the U.S. Preventive Services Task Force), including recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.

- **Appeals Process:** Requires health plans to offer a mandatory internal and external claims appeal process.

- **Other Changes/Plan Requirements:** For new plans, eliminates preauthorization requirement for emergency services and OB-GYN services and referrals; provides enrollee choice of primary care physician or pediatrician; imposes annual cost-sharing limits for non-preventive services under all plans to high-deductible plan limits; and prohibits discrimination based on salary.

Existing plans, otherwise referred to as grandfathered plans (plans in place prior to the imposition of new benefit standards) may lose status upon renewal (regulations are not clear as to when grandfather status is no longer granted). For coverage under a Collective Bargaining Agreement, all new coverage and cost-sharing rules will apply upon termination of the agreement as it relates to coverage, as long as the agreement was ratified prior to March 23 (the day the law took effect). Any coverage amendments to comply with the new rules are not viewed as terminating the agreement.

New Taxes, Credits and Fees

- **Small Business Tax Credit—Phase I:** Small employers with no more than 25 employees and average annual wages of less than $50,000 qualify for a tax credit to assist in the purchase of health insurance for employees. Phase I applies to tax years 2010 through 2013, providing a credit of up to 35% of the employer's contribution toward the employee's health insurance premium *if* the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.

  The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.

- **Indoor Tanning Services Tax:** Establishes a new tax of 10% on the amount paid for indoor tanning services.

- **Black Liquor Biofuel Credit Repeal:** Unprocessed fuels, including "black liquor" byproduct of paper processing, will not qualify for the $1.01 per gallon cellulosic biofuels credit.

Other Changes

- **Temporary High-Risk Pool:** Establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions (U.S. Citizens and legal immigrants) who have been uninsured for at least 6 months. Individuals eligible for the high-risk pool with receive subsidized premiums established for a standard population (the subsidies may vary by no more than 4 to 1 due to age and the maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family). The high-risk pool will only be in effect until January 1, 2014. (Approximately $5 billion has been appropriated to support the program.)

- **Temporary Reinsurance Program for Employers:** This reinsurance program is intended to provide health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. This program only runs through Jan. 1, 2014.

- **Follow-On Biologics:** Grants biologic drug manufacturers 12 years of exclusive use before generics can be developed.

- **Medicare Donut Hole:** Eliminates the Medicare Part D "donut hole," beginning with a $250 rebate for those individuals falling in the coverage gap.

- **Internet Portal for Consumers:** Requires the Department of Health and Human Services to establish a new Internet website to help individuals/consumers identify health coverage options.

2011

Insurance/ Coverage Reforms

- **Medical Loss Ratio Refunds:** Health plans are required to provide refunds to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for the large group market and less than 80% in the individual and small group market.

- **Voluntary Long Term Insurance:** Establishes a national, voluntary insurance program for the purchase of community living services and supports (otherwise known as the CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence.

  The program is financed through voluntary payroll deductions; ***however, all working adults are responsible for opting out, as they will be automatically enrolled in the program. Employers will therefore need to institute automatic payroll deductions for their employees for CLASS coverage.***

New Taxes, Credits and Fees

- **Tax Changes to HRAs, FSAs, and HSAs:** Excludes the costs for over-the counter drugs not prescribed by a doctor from being reimbursed through an HRA or FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. The changes also increase the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and 15% for Archer MSAs) of the disbursed amount.

		• **Pharmaceutical Manufacturing Fees:** First annual fee takes effect in the amount of $2.5 billion and increases to $3 billion in 2012 through 2016.
	Other Changes	• **Small Employer Wellness Grants:** Grant funding (up to 5 years) will be available for small employers that establish wellness programs. • **Employer W-2 Reporting:** Employers are required to begin reporting value of their health benefits on W-2s. • **Medicare Drug Rebates:** Requires pharmacy companies to provide a 50% discount on prescriptions filled in the Part D coverage gap. • **Medicare Advantage:** Freezes current plan payments and restructures payments to plans by phasing-in benchmark payments of current average fee-for-service costs in a particular area. • **Voluntary Coverage for Community Living Assistance & Supports:** Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program provides individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. ***The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt out.*** • **Standards for Coverage Information:** The Department of Health and Human Services, in consultation with the National Association of Insurance Commissions, is responsible for developing standards for insurers to use in providing information on benefits and coverage (insurers must comply with these standards by 2012). • **Nutritional Information Disclosure:** Chain restaurants (those with 20 or more locations) and food sold from vending machines are required to disclose the nutritional content of each item (federal regulations will be issued in 2011 for compliance moving forward).
2013	**Insurance/ Coverage Reforms**	• **Consumer Operated and Oriented Plan (CO-OP) Program:** The reform law appropriates $6 billion to finance the program and award loans and grants to establish new co-ops by July 1. The intent of the program is to foster the creation of a non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits or improve the quality of healthcare delivered to its members.
	New Taxes, Credits and Fees	• **Tax Changes to FSAs:** Limits the amount of contributions to flexible spending accounts for medical expenses to $2,500 per year increased annually by the cost of living adjustment. • **Itemized Deduction for Unreimbursed Medical Expenses:** Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income for regular tax purposes and waives the increase for individuals age 65 and older for tax years 2013 through 2016. • **Medicare Payroll Tax:** Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly.

		• **Medicare Tax on Unearned Income:** Imposes a 3.8% tax on unearned income (capital gains, interest, dividends , and other net income, including some profits from investments and in partnerships and S-Corporations) for higher-income taxpayers (over $200,000 for individual taxpayers and $250,000 for married couple filing jointly). The thresholds are not indexed. • **Medicare Part B:** Eliminates the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. • **Tax on Medical Devices:** Imposes an excise tax of 2.9% on the sale of any taxable medical device after December 31, 2012.
	Other Changes	• **State Compacts and National Plans:** Regulations that will allow states to form healthcare choice compacts and allow insurers to sell policies in any state participating in the compact must be developed; however, these compacts are not allowed to take effect before January 1, 2016. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. These compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. • **Employer-Based Wellness Survey:** Requires a national worksite health policies and programs survey to assess employer-based health policies and programs to be completed within 2-years of enactment (anticipated disclosure of survey results in 2013). • **Health Insurance Administrative Simplification:** Health plans must adhere to a single set of operating rules governing eligibility verification and claims status (based on federal rules adopted by July 1, 2011).
2014	**Insurance/ Coverage Reforms**	• **New Employer Coverage Requirements:** Employers with more than 50 full-time employees must offer full-time employees coverage that pays at least 60% of benefits covered by the plan, and for which an employee's contribution is less than 9.8% of household income. *(See New Taxes, Credits, and Fees for details of penalty.)* **For purposes of calculating the fees, the law defines a full-time employee as having worked an average of 30 hours or more for at least one week in a month.** Employers with more than 50 employees that ***do not*** offer adequate coverage ***and*** have at least one full-time employee who receives federal premium assistance must pay a penalty (the bill allows exclusion of the first 30 employees for assessment calculation purposes). Employers with more than 50 employees that ***do*** offer adequate coverage ***and*** have at least one full-time employee who receives federal premium assistance must pay a penalty (there is no exclusion of the first 30 employees applied for assessment calculation purposes). Employers with fewer than 50 employees are exempted from the coverage penalties.
		• **Employer Free Choice Vouchers:** Employers that offer coverage must provide "free choice vouchers" to employees with incomes less than 400% of the federal poverty level if their contribution for employer-sponsored coverage exceeds 8% but is less than 9.8% of their household income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. ***Employees are allowed to keep excess voucher amounts if the voucher exceeds to the cost of plan under the Exchange. Employers providing free choice vouchers are not subject to penalties for employees the receive premium credits in the Exchange.***

- **Automatic Enrollment in Coverage:** Employers with more than 200 employees are required to ***automatically*** enroll employees in health insurance plans offered by the employer; however, employees may opt out of coverage.

- **Individual Mandate:** All U.S. Citizens and legal residents are required to obtain qualifying coverage. Those without coverage will be subjected to a new penalty based on the lesser of the national average premium for the year or the greater of a flat fee and a certain percentage of income *(see new taxes, credits, and fees for details of that penalty)*.

  Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than 3 months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

- **New State Health Insurance Exchange:** Each state is required to establish a health insurance exchange to be administered by a governmental agency or non-profit organization through which individuals and employers with up to 100 employees can purchase qualified coverage

  States may form regional Exchanges or allow more than one Exchange to operate in the state as long as each Exchange serves a distinct geographic area.

  State Exchanges are required to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. State are also required to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail, or by phone (Exchanges are allowed to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges). These Exchanges are also required to submit financial reports to the Secretary of HHS and comply with oversight investigations including a GAO study on the operation and administration of these entities.

  Funding for these state Exchanges become available in 2011 through January 1, 2015, but Exchanges will not go into effect until 2014.

- **Multi-State Plans in the Exchange:** The Office of Personal Management is required to contract with insurers to offer at least 2 multi-state plans in each Exchange. At least one plan must be offered by a non-profit and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan.

  If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

- **Qualifications of Participating Health Plans in Exchange:** Qualified health plans participating in the Exchange are required to meet certain marketing requirements, have adequate provider networks, contract with essential community providers and navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use uniform enrollment forms and a standard format to present plan information.

  Qualified health plans are also required to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

  All participating health plans in the Exchange are required to comply with the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market.

In regards to the controversial coverage of abortions, states can prohibit plans participating in the Exchange from providing coverage for abortions. If states do not explicitly prohibit plans from providing this type of coverage, plans that choose to offer coverage beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) must create allocation accounts for segregating premium payments for abortion coverage from premium payments for coverage of all other services to ensure that no federal subsidized premiums are used for the coverage of such procedures. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit and cannot take into account any savings that might be reaped as a result of the abortions. Plans participating in the Exchange are also prohibited from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

- **Benefit Tiers/Standards:** Under the Exchange, there must be four benefit categories offered, plus a separate catastrophic plan available to those up to age 30 or those who are exempt from the mandate to purchase coverage (catastrophic plan is only available in the individual market). Each benefit category provides for a certain percentage of coverage of the benefit costs of the plan, from the lowest of 60% up to 90% of benefit costs. The benefit tiers also provide for reduced out-of-pocket limits for those with incomes between 100% and 400% FPL.

  All new policies (except stand-alone dental, vision, and long-term care insurance plans) offered outside of the Exchange are also required to comply with one of 4 benefit categories.

- **Basic Health Plans:** States are given the option of creating a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the highest tiered benefit plan (the Platinum Plan) for enrollees with income less than 150% FPL or the next highest tiered benefit plan (the Gold Plan) for all other enrollees.

  States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating these plans will not be eligible for subsidies in the Exchanges.

- **Essential Benefits Package:** All qualified health benefits plans, including those offered through the Exchanges and those offered outside of the Exchanges to offer at least the essential health benefits package, which must cover at least 60% of the actuarial value of the covered benefits, limit annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family), and is not more extensive than the typical employer plan. Coverage for abortions is not required to be a part of the essential health benefits package. The Secretary of HHS is required to define and annually update the benefit package through a transparent and public process. *Grandfathered plans- both individual and employer-sponsored plans (those in place prior to January 1, 2014) are not required to comply with these essential benefits package requirements.*

- **Market Merge Option:** States are given the option of merging the individual and small group markets.

- **Wellness Incentives:** Allows employers to offer employee rewards- in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided- of up to 30% of the cost of coverage for participating in a wellness program (that meets certain health-related standards).

  Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.

- **Guarantee Issue and Rating Restrictions:** Health plans in the individual and small markets, as well as those plans within the Exchange are required to guarantee issue and renewability and allow rating variation based only on age (limited to 3:1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5:1 ratio). Risk adjustment is also required for these health plans- both inside and outside of the Exchange.

- **Pre-Existing Condition Exclusions:** All plans (new and existing) are prohibited from imposing pre-existing condition exclusions on adults.

- **Deductible Limits:** Deductibles for health plans in the small group market are limited to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.

- **Waiting Periods:** Any waiting periods for coverage may not exceed 90 days (this also applies to existing or "grandfathered" plans.

- **Lifetime and Annual Limits:** Prohibits all plans (new and existing) from imposing lifetime limits and any annual dollar limits for essential benefits.

- **Clinical Trials:** Requires coverage for approved clinical trials.

New Taxes, Credits and Fees

- **Individual Mandate Penalty:** Penalty for lack of coverage is the greater of $95 per year or 1% of taxable income.

- **Employer Coverage Penalty:** Employers (with more than 50 employees) that do not offer coverage and have at least one full-time employee taking advantage of federal premium assistance must pay a fee of $2,000 per full-time or full-time equivalent employee (first 30 employees are exempt).

  For example, an employer with 51 employees would pay a total annual penalty of 51-30($2,000) or $42,000 a year.

  Employers (with more than 50 employees) that do offer coverage, but have at least one full-time employee taking advantage of federal premium assistance must pay the lesser of $3,000 per employee receiving a premium credit or $750 for each full-time employee.

  For example, an employer with 51 full-time employees, only 2 of which are taking advantage of the federal premium assistance program, would pay an annual fee of $6,000 (because the penalty per premium assistance employee is lower than the penalty assessed per full-time employee), but an employer with 51 full-time employees, 25 of which are taking advantage of the federal premium assistance program would pay an annual fee of $19,500 (because the penalty per full-time employee is lower than the penalty assessed per premium assistance employee).

  The fee on employers is not tax deductible. *(The CBO estimates the cost of this penalty to be nearly $30 billion through 2019.)*

- **Small Business Tax Credit- Phase II:** For tax years 2014 and later, a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium is available for eligible small businesses that purchase coverage through the state Exchange only. Eligible employers must contribute ate least 50% of the total premium cost and the credit will be available for 2 years.

  The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000, with the credit phasing out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

		• **Premium Credits:** Provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits are set on a sliding scale and tied to a percentage of income per specified income levels. • **Cost-Sharing Subsidies:** Cost-sharing credits are available to eligible individuals and families between 100%-400% FPL and are used to reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the certain percentages of the full value of the plan (based on the specified income level). • **Health Insurance Provider Fees:** Imposes a new annual fee schedule, starting with an $8 billion fee in 2014. For non-profit insurers, only 50% of new premiums are taken into account in calculating the fee. Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary association (VEBAs) not established by an employer. This fee will be used to fund comparative effectiveness (research comparing clinical effectiveness of medical treatments).
	Other Changes	• **Medicaid Expansion:** States are required to cover all individuals under the age of 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits. States will receive 100% federal funding for expansion of coverage through 2016 (eventually stepping down to 90% in 2020 and beyond). States that already have expanded eligibility to adults with income up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage for non-pregnant childless adults so by 2020 they receive the same federal financing (90%) as other states. • **Temporary Reinsurance Program:** Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. (Financing for the reinsurance program is achieved through mandatory contributions by health insurers totaling $25 billion over 3 years. The reinsurance program sunsets on December 31, 2016). • **State Wellness Pilot Programs for Individual Market:** Establishes a 10-year state pilot program to permit participating states to apply similar wellness participation rewards (as those granted to the private market) for those participating in wellness programs in the individual market (demonstrations may be expanded in 2017, if deemed effective). • **Wellness Program Effectiveness Report:** A full report on the effectiveness and impact of wellness programs is due three years following enactment. • **Health Insurance Administrative Simplification:** Health plans must adhere to a single set of operating rules governing electronic funds transfers and healthcare payment and remittance (based on federal rules issued by July 1, 2012). Rules will also be issued by July 1, 2014 governing standards for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization for health plan compliance by January 1, 2016. Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life, effective April 1.
2015	**New Taxes, Credits and Fees**	• **Individual Mandate Penalty Increase:** Penalty for lack of coverage increases to the greater of $325 or 2% of taxable income. • **Health Insurance Provider Fee Increase:** Annual fee increases to $11.3 billion though 2016.

Year	Category	Changes
2016	**New Taxes, Credits and Fees**	• **Individual Mandate Penalty Increase:** Penalty for lack of coverage increases to the greater of $695 or 2.5% of taxable income.
	Other Changes	• **State Compacts:** Any states that have joined a compact that meets regulations issued in 2013 may begin operation of that compact (in other words, insurers who wish to sell to states within that compact may start to do so).
2017	**Insurance/ Coverage Reforms**	• **State-Based Health Insurance Exchange Expansion:** States are allowed to open up the Exchange to employers with more than 100 employees to purchase coverage.
	Other Changes	• **State Waivers for New Health Insurance Requirements:** Beginning in 2017, states may obtain a 5-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit.
2018	**New Taxes, Credits and Fees**	• **Excise Tax on High Cost Insurance Plans:** New excise tax applied to insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these thresholds will be indexed to the CPI-U for years beginning in 2020). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if healthcare costs rise more than expected prior to implementation of the excise tax and the amounts will be increased for firms that may have higher healthcare costs because of the age or gender of their workers. The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under an FSA or HRA, employer contributions to an HSA, and coverage for supplementary health insurance coverage, excluding dental and vision coverage. • **Pharmaceutical Manufacturing Fee Increase:** Annual fee increases to $4.2 billion before dropping down to $2.8 billion in 2019 and beyond. • **Health Insurance Provider Fee Increase:** Annual fee increases to $14.3 billion. For subsequent years, the fee is increased over the previous year by the rate of premium growth.