Health Reform Primer

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The Affordable Care Act of 2010 (the ACA) substantially changed the way health care services are covered and paid for by insurers and self-insured group health plans, purchased or designed by employers, and purchased by individuals. Some of the ACA’s requirements have already been implemented, while others will be phased in during the next 6 years. This Health Reform Primer summarizes many of the ACA’s key requirements for employers and insurers, including the new rules about individual eligibility for health coverage; the benefits provided or covered by a health plan or insurance policy; taxes, penalties and fees that apply or are passed through to insurers and self-insured plans; and the affordability subsidies for individuals with qualifying income levels who purchase health coverage through an exchange.

This primer is only a summary of some of the ACA’s requirements, and is not a comprehensive explanation. It is also subject to change as additional guidance is issued or the law changes. It is not intended as legal, tax or financial advice and should not be relied upon as such. We encourage you to contact your tax or legal advisor for professional advice that is specific to your organization and its business needs.

Reform Timeline - Phased-in over 9 years

Phase I Reforms
- Tax Credits for Small Employers in 2010+
- and Individuals in 2014+
- Taxes/Penalties/Fees in 2011+
- Individual Mandate and Subsidies in 2014
- Employer “Shared” Responsibility in 2014
- Exchanges for Individuals in 2014
- SHOP Exchange in 2014

Phase II Reforms
- Final Phase Reforms

2010 2012 2014 2017 2018

Delayed to 2015
## Phase I Reforms Start in 2010 - 2011

### Coverage

**No Lifetime or Annual Dollar Limits on “Essential Health Benefits.”** Restricted annual limits are allowed but only until 2014. Essential health benefits fall into 10 broad categories.

**No Pre-existing Condition Exclusions for Enrollees Under 19**

**No Retroactive Rescission of Coverage,** except for participant fraud, intentional misrepresentation of a material fact and nonpayment of premium

**No Reimbursement of Unprescribed Over the Counter Drugs** (other than insulin) by HSAs, HRAs, FSAs, and group health plans effective January 1, 2011

### Eligibility

**Extends Dependent Eligibility to Age 26**

### Taxes/Penalties/Fees & Credits

**Tax Credits for Qualifying Small Employers** with 25 or fewer full-time equivalent employees

**Increases Penalty to 20% on HSA Non-Medical Distributions** starting in 2011

### Other Reforms

**HHS Internet Portal**

**Temporary Early-Retiree Reinsurance Pool (ERRP)**

**Temporary High Risk Pool**

### Additional Reforms that Apply to Non-Grandfathered Plans and Policies

- 100% coverage of in-network preventive care with no cost sharing
- No prior authorization of emergency services and must treat as in-network
- No discriminatory eligibility/benefits in favor of highly compensated employees/owners under insured plans (enforcement delayed until IRS guidance is issued)
- New consumer appeals procedures and external review for medical judgment issues
- Plans and policies that require enrollees to designate primary provider must allow enrollees to designate any available in-network primary care provider including pediatricians for child-enrollees. Female enrollees must be allowed direct access to participating OB-GYNs, without referral or prior authorization.

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1These rules apply to grandfathered and non-grandfathered insured and self-insured group health plans.
Phase II Reforms Start in 2012 - 2013

Coverage

Preventive Benefits for Women’s Contraceptive Methods and Counseling (WCMC)
- Requires 100% coverage of in-network WCMC for policies and plan years that begin or renew on and after August 1, 2012
- Does not apply to grandfathered plans
- Exemption applies if plan is sponsored by qualifying religious employer (churches, their integrated auxiliaries, conventions or associations of churches, and the religious activities of religious orders)
- Non-enforcement applies for one year if plan is sponsored by a non-profit organization that consistently has not, at any point on and after February 10, 2012, covered all or the same subset of the contraceptive coverage that’s otherwise required by the ACA, consistent with any applicable state law, because of the organization’s religious beliefs
  - Organization must also meet federal certification and participant notice requirements. Insurer must still provide contraceptive coverage, however, with no charge to insured organizations and no cost-sharing to member.

Each state to select “essential health benefits” benchmark by the December 2012 extended federal deadline or default to largest small group plan in the state with highest enrollment. Individual and small group insurance products offered inside and outside Exchange must cover essential health benefits as set forth in the benchmark, starting in 2014, but large group insured and all self-insured plans, including ERISA plans, are not required to do so. More information about the EHB set is available at www.cciio.cms.gov. Final EHB rules were published on February 25, 2013.

Restricted Annual Dollar Limit on “essential health benefits” increases to $2,000,000 for policy and plan years that begin on and after September 23, 2012 and before 2014, and is not allowed thereafter; applies to grandfathered and non-grandfathered insured and self-insured group health plans.

Summary of Benefits and Coverage (SBC)
- New disclosure document consisting of template SBC with coverage examples (4 double-sided pages) and glossary of terms
- Applies to: Insured individual policies and insured and self-insured group health plans including grandfathered plans and HRAs
- Does not apply to: dental, vision, flex, short-term disability, stand alone retiree-only plans, and other HIPAA excepted benefits such as short-term medical and accident-only medical

SBC should not be used to administer benefits or the employer’s plan

Timing: Must provide SBCs for enrollment periods that begin on and after September 23, 2012 and plan/policy years that begin or renew on and after September 23, 2012. Also must provide SBCs at other intervals and upon request.

Update: In 2014 the SBC must specifically state that the plan or policy:
  - provides (or doesn’t) “minimum essential coverage” (MEC), and
  - provides (or doesn’t) “minimum value,” which means that the plan or policy pays at least 60% of the cost of benefits, based on an array of medical and drug service categories

Planning Note: Employers should select and finalize plan designs earlier to avoid last-minute changes to SBC content and meet statutory deadlines. Mid-year changes may require new SBC.

Taxes/Penalties/Fees & Credits

Form W-2 Reporting by employer of total health care costs paid by employer and employee, starting with 2012 Form W-2 issued January 2013 (employers filing under 250 W-2s for 2011 are exempt)

Starting in 2013, Medicare Hospital Insurance (HI) Payroll Tax Increases by .9% on wages/income from self employment over certain thresholds - - see page 7

Patient-Centered Outcomes Research Institute (PCORI) temporary fee paid by insurers and by self-insured sponsors - - see pages 6 and 7

Other Reforms

Employers must provide written notice about Exchanges to current employees, originally by March 1, 2013; however, the U.S. DOL postponed the notice deadline to late summer/fall 2013, and is considering issuing a model notice or allowing employers to include the information in the “employer coverage template” that will be used during the Exchange enrollment process

Medical Loss Ratio (MLR) for Insurers starting in 2011. Insurers in individual and small group markets must spend at least 80% of premiums on health care and quality (85% for large group market). If an insurer falls below required MLR for a year, it must rebate the difference to individuals or employers by the next August 1.

Health FSA Contributions limited to $2,500 for flex plan years that begin or renew on and after January 1, 2013 (dollar limit is indexed thereafter)
Phase II Reforms Start in 2014

Coverage

Prohibits pre-existing condition exclusion for all enrollees

Increases HIPAA group wellness reward limit from 20% to 30% of cost of coverage (HHS may increase to 50%)

- For “health standard based” or “health-contingent” wellness plans, a reasonable alternative must be offered to all participants even if the individual doesn’t have a health condition that prevents him/her from meeting the standard

- Rewards for health contingent programs cannot exceed 30% of the cost of single coverage, but limit increases to up to 50% for tobacco cessation programs (if HHS approves)

- Small group issuers can rate for tobacco use (1.5:1) only if the employer offers a wellness program designed to prevent/reduce tobacco use

Requires coverage of routine patient costs associated with approved clinical trials for qualified individuals, which include Phase I-IV clinical trials approved or funded by one of seven organizations or agencies; and routine patient costs associated with certain investigational drug clinical trials and studies

Limits member cost sharing:

- For non-grandfathered insured and self insured group plans, the maximum out of pocket will match the limit that applies to HSA-qualified high deductible plans in 2014 and will be adjusted annually thereafter (for 2013, the adjusted out of pocket limit for HSA-qualified high deductible plans is $6,250 single/$12,500 family), and the maximum deductible for non-grandfathered insured small group products will be limited to $2,000 single/$4,000 family

- For non-grandfathered insured individual products, the maximum out of pocket will match the limit that applies to HSA-qualified high deductible plans in 2014 and will be adjusted annually thereafter

Eligibility

Rating factors for insured individual and small group products are limited to four factors: family size, age (by 3:1), geographic rating area defined by the state, and tobacco use (by 1.5:1)

Requires guaranteed issuance and renewability for insured products

Limits eligibility waiting period to 90 days or less

Following release of guidance, a larger employer with more than 200 full-time employees will be required to automatically enroll new full time employees in the employer’s group health plan, subject to plan’s waiting period, if any, of 90 days or less. Employees must be provided opportunity to opt out.

Taxes/Penalties/Fees & Credits

New taxes, penalties and fees - - see pages 6-7
New tax credits/subsidies - - see page 8

Exchanges for Individuals Start in 2014

Web-based marketplace for consumers to compare and enroll in insured qualified health plans (QHPs) offered by qualified carriers at differing actuarial value levels (AV) of essential health benefit coverage (aka “metallic levels”): bronze (60% AV), silver (70% AV), gold (80% AV), platinum (90% AV). Each silver QHP will have 3 variations (with AVs of 73%, 87% and 94%) for use in obtaining cost sharing reductions by individuals who are below 250% of FPL. Also includes “catastrophic” coverage option for individuals under 30 or with financial hardship. QHPs will be available for single and family coverage levels.

Initial open enrollment for individuals begins October 1, 2013 and ends March 31, 2014. QHP coverage effective on or after January 1, 2014.

Goal is to facilitate access to affordable, quality health coverage and reduce number of uninsured individuals
If state fails to submit “blueprint” application for state-based Exchange by mid-December, or submits application but doesn’t receive HHS’ conditional approval by January 1, 2013, and final approval thereafter, then:

- State’s Exchange reverts to federally-facilitated Exchange (FFE)
- Approximately 30 or fewer states may revert to FFE or a partnership Exchange (between federal and state governments)
- HHS conditionally approved Minnesota’s “blueprint” in December 2012
- Minnesota’s Exchange law was enacted on March 20, 2013. The Exchange is named MNsure.
- Minnesota has received $110 million in federal grants to establish an Exchange

Planning Note: Potential issues may exist for employers that have employees in more than one state i.e., eligible for another state’s Exchange

Minnesota Exchange Advisory Task Force created via Governor Executive Order in fall 2011. Minnesota Department of Commerce held primary leadership role that was transferred to Minnesota Management & Budget in late September 2012.

- Develop recommendations for Exchange’s operating rules and identify areas for future consideration
- Contemplates “robust” state-based exchange (SBE)
- 10 Workgroups provide input on variety of issues including adverse selection, QHP certification, roles of navigators/brokers, governance and financing
- IT Infrastructure - the State awarded the IT general contract to Maximus, with subcontracts going to various vendors for software, enrollment, customer call centers, billing, etc.

Required Functions of Exchange

- Determine individual eligibility for state programs: Medical Assistance, CHIP and the Basic Health Plan (if adopted by a state after federal guidance is released)
- Assess individual eligibility for “affordability assistance,” including premium tax credits (aka subsidies) and cost-sharing reductions
  - Based on sliding scale of household income for applicant/enrollee
  - Premium tax credits and cost-sharing reductions available for enrollees with household income between 133%* and 400% of Federal Poverty Level (FPL) (or 200% and 400% of FPL if state adopts Basic Health Plan)
  - Eligibility determinations made by Exchange using “single, streamlined consumer application”
  - Exchange to electronically verify household income with U.S. Treasury (IRS) or HHS
  - Employers and Exchange to share data about employees and employers’ group health plans to assist Exchange in determining affordability assistance and to report penalty

Optional Federally Funded Basic Health Plan (BHP) for Individuals between 133%*-200% FPL

- Offered outside the Exchange
- Exchange subsidies do not apply
- Includes state mandates (i.e. transportation, personal care attendants)
- Federal guidance is expected later in 2013

*Note: State may increase 133% threshold by another 5 percentage points to 138% FPL. Minnesota expanded Medicaid to 138% of FPL, effective January 1, 2014.

SHOP Exchange Starts in 2014 (Small Business Health Options Program)

- Group insured products for small employers as defined by state law (1-50 lives, and will include 51-100 lives by 2016)
- Voluntary market place for small employers
- Employer can limit QHP offerings or allow employees choice of selecting from all QHP offerings in MNsure’s SHOP (but delayed to 2015 for FFEs)
- SHOP aggregates premiums for employers and employees (but delayed to 2015 for FFEs)
- Minimum participation measured among all QHPs selected by that group’s enrollees
- Smaller employers in SHOP Exchange may be eligible for small employer tax credits - see page 8
- Enrollees in SHOP Exchange are not eligible for premium tax credits (subsidies) and cost sharing reductions. The premium tax credits (subsidies) and cost sharing reductions are only available to individuals in the individual Exchange (unless and until the individual and small group markets/risk pools are merged).
Shared responsibility “pay or play” penalties are payable by “applicable large employers,” starting in 2014, if at least one full time employee (FTE) buys coverage in a state’s Exchange and receives a federal subsidy.

**Definitions:**
- An applicable large employer is one that employed an average of at least 50 FTEs (including full time equivalent employees (FTEEs)) on business days during the preceding calendar year (2013 for purposes of the analysis for 2014). Employees of all entities that are members of the same controlled group (under Internal Revenue Code section 414(b), (c), (m) or (o)) must be counted. All employees in a controlled group are included in determining the controlled group’s status as an applicable large employer (less the first 30 FTEs), but each separate employer in the controlled group is liable only for the $2,000 penalty attributable to it (after pro rata reduction for its share of the first 30 FTEs).
- Safe harbor guidance issued in August 2012 (IRS Notice 2012-58) allows an applicable large employer to select a “look back period” (or “measurement period”) other than the preceding calendar year and use it to determine which employees are FTEs during a “stability period.”
  - The look back period may vary for “ongoing employees,” newly hired variable hour employees, seasonal employees and employees who are in transition.
  - For stability periods that begin in 2014, an employer can use an optional transition look back/measurement period of 6 to 12 months, but the transition period must begin by July 1, 2013 and end by the 90th day before the 2014 plan year begins.
- FTEs are employees who are employed on average at least 30 hours per week
- FTEEs are employed on average less than 30 hours per week, and, for a given month, are determined by dividing the aggregate number of hours of service performed by all non-FTEs by 120 hours. For example, if 12 employees who are not FTEs each work 25 hours/week and 100 hours/month, for an aggregate total of 1200 hours in a month for the group, the employer has 10 FTEEs (1200 hours/120 hours = 10 FTEEs) who “count” in determining whether the employer is an applicable large employer.

**Annual $2,000 penalty per FTE** applies if:
- Employer does not provide minimum essential coverage (MEC) to “substantially all” FTEs working 30 hours or more per week (at least 95%) and their nonspouse dependents; and
- One or more FTEs purchase coverage inside the Exchange and receive subsidy

Penalty is $2,000 per year for every FTE (minus the first 30 FTEs), but is prorated and does not apply for months in which no FTEs receive subsidies.

**Annual $3,000 penalty per FTE who actually receives subsidy** applies if:
- Employer offers MEC that is either unaffordable for the FTE or the plan does not provide minimum value; and
- The FTE purchases coverage inside the Exchange and receives subsidy

Penalty is the lesser of:
- $3,000 per year for each FTE who purchases coverage inside the Exchange and receives a subsidy, but is prorated and does not apply for months in which the FTE does not receive a subsidy, or
- The $2,000 penalty per FTE described above (again, minus first 30 FTEs)

Coverage is unaffordable for an FTE if the employee’s share of the premium for self-only coverage exceeds 9.5% of that employee’s household income (safe harbor allows employer to use employee’s W-2 Box 1 pay).

**Transitional Relief**
- Transition relief is available:
  - For employers with fiscal year plans that were in effect on December 27, 2012 and with respect to those employees who would be eligible for coverage as of the first day of the 2014 plan year (applying the plan’s eligibility rules as in effect on December 27, 2012), provided that the employer offers affordable, minimum value coverage to the employees on or before the first day of the 2014 plan year
  - For employers, a significant percentage of whose employees were eligible (at least 33.3%) for or covered (at least 25%) under the employer’s fiscal year plan as of December 27, 2012.

1Federal guidance issued in August 2012 provides that if an employer imposes a waiting period that meets the ACA’s requirements (i.e., does not exceed 90 days), the applicable large employer is not subject to a pay or play penalty for FTEs subject to the waiting period who purchase coverage through an Exchange and receive a subsidy during the waiting period.
HHS or the IRS will notify employers when an employee receives premium tax credits or cost-sharing reductions, and employers may respond before the IRS issues a notice and demand for payment of the penalty.

Planning Note: Large employers (with 50 or more FTEs) may want to review workforce demographics and plan designs and consider whether to (a) set self-only premiums at or below 9.5% of lowest FTE’s pay level; (b) adjust actuarial value to meet the minimum value requirement; and/or (c) lower eligibility threshold to 30 hours/week and offer coverage to nonspouse dependants - keeping in mind the impact of any changes on overall plan costs.

Temporary Patient Centered Outcomes Research Institute (PCORI) fee payable by sponsors of self-insured group health plans (and insurers of insured plans) for plan years ending after September 30, 2012 and before October 1, 2019:
- For calendar year plans, applies for seven calendar years: 2012 through 2018
- $1 per covered member in first year, and $2 thereafter
- Reported and paid with IRS Form 720; first Form 720 due by July 31, 2013

Temporary reinsurance fee payable by sponsors of self-insured group health plans (and insurers of insured plans) for 2014 through 2016:
- Intended to reduce adverse selection and stabilize the individual market as Exchanges start
- Provides funding to insurers in the individual market that cover the less healthy population
- The reinsurance fee is initially set at $5.25 pmpm or $63 per member per year for 2014, and will be revised each November 1
- Self-insured employers are responsible for remitting the fees to the federal government, but may ask their TPA to perform the remittance function, for which service the TPA may charge a fee

High value plan tax (“cadillac plan” tax)
- Applies to self-insured plan sponsors (and insurers of group coverage) starting in 2018
- Tax is 40% of the amount by which the total value/premium for group coverage (including FSA, HRA and HSA contributions) exceeds $10,200/self-only and $27,500/family coverage
- Thresholds are higher for specified individuals
- All thresholds indexed annually for general, non-medical inflation

Individuals – 2 New Taxes

1. Additional Medicare Hospital Insurance (HI) tax of .9% on wages/self employment income that exceed certain thresholds that vary with filing status
- Applies on and after January 1, 2013
- Employer must withhold/remit tax for employees with wages over $200,000
- Does not apply to employer’s portion of HI

2. Penalty payable by individuals who fail to maintain minimum essential coverage (MEC) starting in 2014. Also called the “individual mandate” penalty/tax.
- Penalty is generally the greater of 1% of adjusted household income or $95/individual in 2014, $325 in 2015, and $695 in 2016
- Penalty is prorated for part-year failures to maintain MEC
- Flat dollar penalty component is halved for dependents age 18 and under
- Exemptions may apply

Insurers – 4 New Taxes

1. Temporary Patient Centered Outcomes Research Institute (PCORI) fee payable by insurers of group and individual policies (and self-insured plan sponsors) for plan years ending after September 30, 2012 and before October 1, 2019:
- For calendar year plans, it includes seven calendar years 2012 through 2018
- $1 per covered member in first year, and $2 thereafter
- Reported and paid with IRS Form 720; first Form 720 due by July 31, 2013

2. Temporary reinsurance fee payable by insurers (and sponsors of self-insured medical plans) for 2014 through 2016
- Intended to reduce adverse selection and stabilize the individual market as the Exchanges start
- Provides funding to insurers in the individual market that cover the less healthy population
- The reinsurance fee is initially set at $5.25 pmpm or $63 per member per year for 2014, and will be revised each November 1
- Self-insured employers are responsible for remitting the fees to the federal government, but may ask their TPA to perform the remittance function, for which service the TPA may charge a fee

3. High value plan tax (“cadillac plan” tax)
- Applies to self-insured plan sponsors (and insurers of group coverage) starting in 2018
- Tax is 40% of the amount by which the total value/premium for group coverage (including FSA, HRA and HSA contributions) exceeds $10,200/self-only and $27,500/family coverage
- Thresholds are higher for specified individuals
- All thresholds indexed annually for general, non-medical inflation

4. Health insurance industry tax (HIT) payable by insurers starting in 2014:
- Industry tax is $8 billion in 2014; $11.3 billion in 2015 and 2016; $13.9 billion for 2017; and $14.3 billion for 2018 (and indexed thereafter)
- Tax is applied pro rata to insurers based on net premiums
Medical Manufacturers – 2 New Taxes

1. Excise tax on manufacturers and importers of branded prescription drug is:
   - Effective for 2011 and later years
   - Applied to each entity based on its pro rata share of branded prescription drug sales in the preceding year
   - Expected to be passed through to purchasers
   - $2.5 billion to $4.1 billion depending on year

2. Excise tax on sales of taxable medical devices by manufacturers, producers and importers is:
   - Effective for sales made on and after January 1, 2013
   - 2.3% of the sale price
   - Expected to be passed through to purchasers

Tax Credits for Small Employers Start in 2010 and for Individuals in 2014

Small Employer Tax Credit

Applies to small employers that have:
- 25 or fewer full-time equivalent employees (FTEEs);
- Pay average wages of $50,000 or less to FTEEs; and
- Pay at least 50% of premium for single coverage offered to employees

Credit is up to 35% of small employer's (25% if tax-exempt) share of premium for 2010 through 2013; up to 50% (35% if tax exempt) for 2014 and later years

Full credit is available only to very small employers with 10 or fewer FTEEs and that pay average wages of $25,000 or less to them

Individual Premium Tax Credits (Subsidies) and Cost Sharing Reductions (also called “affordability assistance”)

Subsidies and cost sharing reductions available, starting in 2014, to eligible individuals with household income between 133%* and 400% of FPL who apply for insurance coverage inside the Exchange

- Individual must meet all of the following eligibility criteria:
  - Establish that his/her employer (if any) either provided no coverage or no minimum essential coverage, or if minimum essential coverage was offered, it’s unaffordable or the plan doesn’t provide minimum value

Provide income information to Exchange and have household income between 133%* and 400% of FPL for the individual’s family size

The subsidy is generally the lesser of (a) an amount determined by subtracting an “applicable percentage” of the individual’s household income from the self-only premium for second lowest cost “silver” plan in the rating area where the individual lives, and (b) the actual premium for the insured QHP plan selected by the individual inside the Exchange

- The “applicable percentage” varies from 2% (at 100% to 133% of FPL) to 9.5% (at 300% to 400% of FPL)

- The amount of subsidies and cost sharing reductions are reduced as income increases within FPL guidelines

- Subsidies can either be paid through the Exchange in the form of advance payments of tax credits or applied for and refunded with individual’s Form 1040

Individuals who receive subsidies must report to the Exchange any changes in family size or household income, and must reconcile on Form 1040 return the difference between any subsidies received and the amount allowed. Must repay, or can obtain additional credit for, the difference.

*Note: States may increase 133% threshold by another 5 percentage points to 138% FPL. The 133% threshold is reduced, but not below 100%, for individuals in states that lack Medicaid/CHIP programs at these FPL levels, i.e., did not expand Medicaid

High value plan tax (“cadillac plan” tax)

- Applies to insurers of group coverage (and to self-insured group plan sponsors) starting in 2018
- Tax is 40% of the amount by which the total value/premium for group coverage (including health FSA, HRA and HSA contributions) exceeds $10,200/self-only and $27,500/family coverage
- Thresholds are higher for specified individuals
- All thresholds are indexed annually for general, non-medical information

Excise tax on manufacturers and importers of branded prescription drug

- Effective for 2011 and later years
- Applied to each entity based on its pro rata share of branded prescription drug sales in the preceding year
- Expected to be passed through to purchasers
- $2.5 billion to $4.1 billion depending on year

Excise tax on sales of taxable medical devices by manufacturers, producers and importers

- Effective for sales made on and after January 1, 2013
- 2.3% of the sale price
- Expected to be passed through to purchasers

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New Employer and/or Issuer Reporting Obligations

Two reporting obligations apply to employers and/or issuers starting in 2015:

- Providers of MEC (employers and issuers) must report to IRS information about the employees to whom they provided MEC in the preceding tax year; and must notify each employee.

- Applicable large employers must report to IRS whether they did/did not provide MEC to substantially all of their FTEs and their nonspouse dependents, as well as the coverage months and contact information for each such employee; and must notify each employee.

Final Phase Reforms Start in 2017-2018

- Non-deductible excise tax on high-value plans ("cadillac plan" tax) - - see page 7
- States may permit insured large group products (101 or more lives) to be offered inside the Exchange
- PCORI fees are scheduled to expire

Delayed to 2016

Resources

The websites listed below contain useful information about the ACA. You may want to access them for more information about various ACA provisions. The websites are updated frequently so you may want to check them from time to time for new guidance and insight.

U.S. Department of Labor
http://www.dol.gov/ebsa/healthreform/
The DOL’s home page for technical information about the ACA

U.S. Department of Health and Human Services
http://cciio.cms.gov/
HHS’ home page for technical information about the ACA
http://cciio.cms.gov/resources/regulations/index.html
HHS’ web page for regulations and other forms of guidance that the Department has issued on many ACA requirements
HHS’ web page for 10 sets of “FAQ’s” about the ACA, and other topics
http://www.healthcare.gov/
HHS’ consumer friendly home page about the ACA

Internal Revenue Service
IRS’ home page with technical information about the ACA’s tax provisions, with links to specific revenue rulings, notices, proposed regulations, and other guidance
Another IRS home page with links in reverse chronological order to all IRS rulings and guidance on the ACA tax provisions
IRS’ home page with technical information about the tax credit for small employers

Minnesota Department of Commerce
http://mn.gov/commerce/insurance/topics/medical/exchange/
Information from the Minnesota Department of Commerce about Exchanges