The Patient Protection and Affordable Health Care Act of 2010

The Patient Protection and Affordable Health Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Health Reform Bill" or "Bill") was recently signed into law by President Obama. The Health Reform Bill has been referred to as "the most significant health care expansion in more than four decades" and is expected to provide public or private health insurance coverage for more than 30 million uninsured Americans. The provisions of the Health Reform Bill will be phased in between now and 2019, with several provisions taking effect in 2010. Below please find a brief summary (compared to the 2,700 pages of legislation) of what we believe to be the most important provisions of the Health Reform Bill with the greatest impact to our clients, including employers, providers, group health plans, insurers, and taxpayers.

Impact on Employers[1]

- Automatic Enrollment (effective date not clear, but appears to be effective following issuance of applicable regulations). Employers with 200 or more full-time employees and that offer at least one health benefit option must automatically enroll new employees in one of the benefit options and continue the enrollment of current employees in a benefit option. Adequate notice must be provided to an individual to opt-out of any coverage in which he or she was automatically enrolled.
- Notice to Employees (effective for plan years beginning on or after January 1, 2014). In accordance with regulations to be promulgated by the Department of Health and Human Services ("HHS"), at the time of hiring, each employee must be notified of certain information concerning the American Health Benefit Exchanges ("Insurance Exchange") required by the Health Reform Bill for each state (with an initial notice required by March 1, 2013) to facilitate the purchase of qualified health plans.
- Retiree Health Subsidy. For plans that satisfy various application and submission rules, the federal government will reimburse participating employers 80% of an early retiree's (age 55 and over but not eligible for Medicare) health claims between $15,000 and $90,000. This program is to be effective as of June 23, 2010, and will cease upon the earlier of exhaustion of its $5 billion in funding or January 1, 2014.
- Changes to Black Lung Benefits. Instead of workers having to prove they were 100% disabled and suffering from black lung disease in order to get financial and medical support, companies that want to challenge a miner who has worked for at least 15 years and is totally disabled from lung disease must now prove that the miner does not have black lung

[1] For additional provisions affecting employers, please see the Impact on Taxpayers section entitled "Tax Provisions Affecting Employers."

disease or did not become disabled as a result of his job. Also, surviving spouses of coal miners (who were totally disabled by black lung and were collecting benefits) can continue to receive those benefits without having to reapply. The changes apply to claims filed after January 1, 2005 that are pending on or after March 23, 2010.

Impact on Providers[2]

Waste, Fraud, and Abuse Provisions

- Increased Resources. The Health Reform Bill allocates an additional $300 million to fight health care fraud and abuse over the next 10 years.
- Overpayments. Amounts owed to Medicare or other government programs (e.g., overpayments) must be reported and returned within 60 days of identifying the overpayment. Any overpayment retained after 60 days is considered a violation of the federal False Claims Act.
- Stark Law Self-Disclosure Protocols. Within 6 months of enactment of the Bill, HHS will implement a protocol to allow providers to voluntarily disclose to the government violations of the Stark Law. Under the protocol, HHS will have the authority to reduce the Stark Law penalties depending on the timeliness of the providers' disclosure and their cooperation.
- Transparency. Effective immediately, physician practices who provide their patients MRI, CT, and PET imaging services are required to inform those patients in writing of other suppliers in the community who can provide those services. The Health Reform Bill also requires disclosure of financial relationships between physicians, hospitals, pharmacists and other providers and manufacturers and distributors of certain drugs, devices, biologicals, and medical supplies.
- Anti-kickback Statute. A violation of the Anti-kickback Statute can occur without the government showing that a provider knew of the statute's prohibitions and intended to violate the statute. Also, a claim submitted to the government as a result of an arrangement in violation of the Anti-kickback Statute constitutes a false claim under the federal False Claims Act.
- RAC Program. The Health Reform Bill mandates the expansion of the RAC programs into Medicaid, Medicare Part D prescription drug plans, and Medicare Advantage Plans. CMS is required to submit an annual report to Congress regarding the effectiveness of the RAC programs.
- Medicaid Termination, Exclusion, and Suspension. The Health Reform Bill establishes mandatory Medicaid termination if a provider is terminated by Medicare or if a provider has unpaid overpayments determined to be delinquent. It also expands civil penalties for the ordering or prescribing of medical items or services by a person excluded from participation in the Medicare program. A potentially devastating new provision allows Medicare and Medicaid payments to be suspended during an investigation of fraud.

[2] For additional provisions affecting providers, please see the Impact on Taxpayers Section entitled "Miscellaneous Tax Provisions."

- Qui Tam Suit. Beginning immediately for suits filed after the date of enactment, the Health Reform Bill makes it easier to file a qui tam or whistleblower lawsuit by eliminating the public disclosure element which required dismissal of the lawsuit if the allegations had been previously disclosed in a criminal, civil or administrative proceeding, government hearing or investigation, or the news media.
- Integrated Data Repository. CMS will establish The Integrated Data Repository to collect claims and payment data from Medicare, Medicaid, Veterans Affairs and other government programs in order to compare data for the purpose of identifying potential waste, fraud, and abuse.
- Physician-Owned Hospitals. After December 31, 2010, new physician-owned hospitals are prohibited and existing physician-owned hospitals are prevented from increasing the percentage of physician ownership in the facility.
- DME Providers. Beginning in 2011, the Health Reform Bill imposes a 90-day period of enhanced oversight for initial claims filed by DME providers.

Tax-Exempt Hospitals

- Community Health Assessment. A tax-exempt hospital must conduct a community health needs assessment every 3 years, and adopt a plan to meet the needs identified by the assessment. The assessment must be based on input from community representatives. Failure to conduct the assessment will subject the hospital to an excise tax of $50,000.
- Financial Assistance. A tax-exempt hospital must have written policies to address financial assistance and emergency medical care. The policies must address eligibility criteria for financial assistance, the basis for calculating patient charges, the application process, and the means of publicizing the policies. A separate billing and collections policy is also required. Individuals who are eligible for financial assistance under a hospital's policy cannot be charged more than the lowest amount charged to insured individuals. Further, a tax-exempt hospital must use "reasonable efforts" to determine if a patient is eligible for assistance under its financial assistance policies before filing a lawsuit, imposing liens or making other similar collection efforts. The Treasury Department is required to issue regulations to define reasonable efforts, which are expected to include notifying the patient of the policy, determining eligibility, and communicating with the patient before collection efforts.
- Filings. A tax-exempt hospital must file a copy of its audited financial statements with Form 990 filings.

Reimbursement

- In General. The overall intent of the Health Reform Bill is to transition Medicare from a fee-for-service program to a quality-based reimbursement system, to increase payment to primary care providers, and to address geographic disparities in payment. Regulations will be implemented between 2013 and 2016 to standardize and streamline the Medicare claim processing requirements.

- Medicaid. In 2014, Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the Federal Poverty Level, which will result in millions of new Medicaid enrollees.
- Primary Care Physicians. Primary care physicians (e.g., family medicine, internal medicine, geriatrics, and pediatricians) will be eligible for a 10% bonus payment for 5 years beginning in 2011 if their Medicare charges for office, nursing facility and home visits comprise at least 60% of their total Medicare charges. For 2013 and 2014, Medicaid payment rates to primary care physicians cannot be lower than Medicare Part B payment rates.
- Surgeons. General surgeons who perform major procedures in a health professional shortage area will be eligible for a 10% bonus Medicare payment for 5 years beginning in 2011.
- Evaluation and Management Codes. Medicare reimbursement for select evaluation and management codes furnished by physicians and other primary care providers will be increased by 5% (10% for providers in health professional shortage areas). The increase begins January 1, 2011 and lasts for 5 years.
- Diagnostic Imaging. The utilization rate (the amount of time in use during office hours) for diagnostic imaging services costing more than $1 million (i.e., CT, MRI and PET) has been increased from 50% to 75%. The larger the gap between the actual usage and 75% is expected to result in cuts in reimbursement. The national utilization rate is 54%.
- Hospitals. Beginning in October, 2012, the Health Reform Bill reduces Medicare payments to hospitals for certain preventable hospital readmissions. Beginning in 2015, Medicare payments to hospitals for hospital-acquired conditions will be reduced.
- Quality Reporting. Medicare quality reporting incentives (the Medicare Physician Quality Reporting Initiatives ("PQRI")) will continue at the incentive rate of 1% in 2011 and 0.5% from 2012 to 2014. Beginning in 2015, physician payments will be reduced by 1.5% for failure to participate in the PQRI, to be increased to 2% thereafter.
- Medicare Advantage Plans. Payments by the federal government to Medicare Advantage ("MA") Plans will be cut by $132 billion over a 10 year period by increasing payments in areas with low Medicare fee-for-service, but reducing payments in areas with high fee-for-service rates. Beginning in 2012, bonus payments will be made to MA Plans that achieve certain quality standards.
- State Grants. Beginning in 2011, states will receive grants to develop, implement and evaluate medical malpractice tort reform.
- Payment Advisory Board. An Independent Payment Advisory Board ("IPAB") will be appointed to submit proposals to MedPAC, Congress and the President to reduce per-capita Medicare spending which exceeds the Consumer Price Index measures for a 5 year period. The IPAB will first propose cuts in spending in 2014 for implementation in 2015.

Impact on Group Health Plans

(applies to self-insured and fully-insured group health plans, unless otherwise specified)

Except as otherwise specified below, the following reforms are effective for plan years beginning 6 months after the date of enactment (January 1, 2011 for calendar year plans). For many of the reforms, there is a delayed effective date for collective bargained plans (generally, the date on which the last of the related collective bargaining agreements expires). Some of the reforms do not apply to grandfathered plans (group health plans in effect on the date of enactment).

All group health plans (regardless of grandfathered status):

- No Lifetime Limits. Plans may not establish lifetime dollar limits. As otherwise permitted under federal or state law, plans can place lifetime per beneficiary limits on specific covered benefits that are not essential health benefits (as defined in the Health Reform Bill and by the Secretary of HHS).
- Restricted Annual Limits. The Secretary of HHS will establish a cap on annual limits for essential health benefits (as defined by the Health Reform Bill and by the Secretary of HHS). For plan years beginning on or after January 1, 2014, plans may not impose an annual limit, except (as otherwise permitted under federal or state law) plans can place annual per beneficiary limits on specific covered benefits that are not essential health benefits (as defined in the Health Reform Bill and by the Secretary of HHS).
- Prohibition on Rescissions. Plans may not rescind coverage, except in cases of fraud or intentional misrepresentation.
- Extension of Dependent Coverage. Plans that provide coverage for dependent children must provide coverage for them until age 26, regardless of whether or not the child is married, if the child is not eligible to enroll in an employer-sponsored plan. For plan years beginning on or after January 1, 2014, such coverage is required regardless of whether or not the child is eligible to enroll in an employer-sponsored plan.
- Uniform Explanation of Coverage Documents. In addition to the summary plan description required by ERISA, the plan administrator of a self-insured plan or the insurer of a fully-insured plan must prepare and distribute a summary of coverage to all applicants and enrollees at initial enrollment and at annual enrollment. The summary must be distributed by March 23, 2012 and must satisfy uniform standards to be established by the Secretary of HHS by March 23, 2012. Enrollees must be notified of material changes to the summary at least 60 days in advance of the effective date of the changes.
- Reimbursing the High Risk Pool. A group health plan must reimburse the high risk pool established under the Health Reform Bill for pool medical expenses incurred for individuals found to have been offered financial incentives not to enroll in the group health plan.
- HIPAA Administrative Simplification. Plans must implement certain electronic transaction standards and must certify compliance to HHS. The timing of the certification varies according to the type of transaction, with deadlines ranging from December 31, 2013 to December 31, 2015.

- Preexisting Condition Exclusions. Plans may not impose a preexisting condition exclusion on a child under the age of 19. Effective for plan years beginning on or after January 1, 2014, plans may not impose any preexisting condition exclusions.
- Prohibition on Excessive Waiting Periods. Effective for plan years beginning on or after January 1, 2014, waiting periods in excess of 90 days are prohibited.

Not applicable to grandfathered group health plans:

- Coverage of Preventive Health Services. Plans must provide first dollar coverage for certain evidence-based preventive care and certain immunizations.
- New Reporting Requirements. Group health plan and health insurance issuers are subject to the same reporting requirements applicable to plans offered in the state Insurance Exchange. Certain plan information will be required to be reported to the Secretary of HHS, the applicable state insurance commissioner, and the public.
- Nondiscrimination Rules. The nondiscrimination rules of Code Section 105(h), which have only been applicable to self-insured health plans, are now also applicable to fully-insured health plans.
- Ensuring the Quality of Care. In accordance with standards to be developed by the Secretary of HHS by March 23, 2012, plans must annually report to enrollees and HHS regarding plan benefits that improve health, such as wellness programs and case management.
- Appeals Process. Plans must establish an internal claims appeals process and an external review process that satisfies requirements set forth in the Health Reform Bill and that go beyond the existing ERISA claims procedures.
- Patient Protections. Plans providing for designations of primary care providers must allow participants to designate any participating primary care provider that will accept them. Plans are also required to comply with requirements concerning access to emergency services and obstetrical and gynecological care. Pediatricians must be allowed as designated primary care providers for children.
- Nondiscrimination Against Providers. Effective for plan years beginning on or after January 1, 2014, no discrimination is permitted against a provider acting within the scope of his or her license, but this does not mean that a health plan must contract with any willing provider.
- Requirements Relating to Cost-sharing. Effective for plan years beginning on or after January 1, 2014, certain cost-sharing requirements must be satisfied in regard to limits on out-of-pocket expenses and deductibles.
- Participation in Clinical Trials. Effective for plan years beginning on or after January 1, 2014, plans may not deny qualified individuals from participating in certain clinical trials or deny coverage of routine costs for items and services furnished in connection with the clinical trial.
- Prohibiting Discrimination Based on Health Status. Effective for plan years beginning on or after January 1, 2014, the Health Reform Bill generally includes the same prohibitions that currently exist under HIPAA. The maximum allowable incentive for wellness programs is

raised from 20% to 30% of the cost of coverage, and the regulatory authorities can increase the allowable percentage to 50%. Wellness programs may not require participants to provide information concerning lawful firearm or ammunition ownership, use, or storage.

Impact on the Insurance Industry

As a result of the passage of the Health Reform Bill, the insurance industry faces significant new regulations and restrictions. Although a majority of the changes will not take place until 2014, many of the changes will take place immediately, and the regulatory framework and rules for the health insurance industry will change drastically.

- Pre-existing Conditions Coverage and National High-Risk Insurance Pool. The Health Reform Bill basically guarantees that those with pre-existing conditions will have the ability to purchase insurance coverage. Within 90 days of enactment, each state will be required to set up a high risk insurance pool from which Americans who have pre-existing conditions and have not been covered by insurance for at least 6 months may sign up. These high-risk pools will continue until 2014, at which time all insurance carriers will be prohibited from excluding individuals based on pre-existing conditions. The coverages offered by the high-risk pools must have an actuarial value of at least 65% of the total allowed costs, an out-of-pocket limit no greater than $5,950 for an individual and $11,900 for a family, and no pre-existing condition exclusions. Further, premiums in the high-risk pools may not exceed 100% of the standard non-group rate, and they may not have an age rating greater than 4 to 1. There are several different ways that states may participate in these high-risk pools. Specifically, states may:

  - Operate a new high-risk pool alongside a current state high-risk pool;
  - Establish a new high-risk pool (for states that do not currently have a high-risk pool);
  - Build upon other existing coverage programs designed to cover high-risk individuals;
  - Contract with a current HIPAA carrier of last resort or other carrier to provide subsidized coverage for the eligible population; or
  - Do nothing, in which case HHS would carry out a coverage program in the state.

  The Health Reform Bill provides for sanctions against insurers who are found to have discouraged individuals from remaining enrolled in their health coverage prior to enrolling in the high-risk pool. In the event that insurers unload or "dump" enrollees they will be required to reimburse the high-risk pool for the medical costs of such individuals. An insurer will be deemed to have "dumped" an enrollee if it provides financial incentive to disenroll from the policy, or in certain cases where the enrollee pays premiums higher than the premiums for the high-risk pool. The Health Reform Bill provides for a total of $5 billion to be dedicated to the high-risk pools in order to jump start them until they become self-sufficient in 2014.

- Pre-Existing Conditions Coverage for Children. Within 6 months of enactment, insurers will be prohibited from denying coverage to children under 19 years of age based on pre-existing conditions.

- Ban on Rescissions, Restrictions on Lifetime and Annual Limits. Within 6 months of enactment, insurers will no longer be permitted to rescind existing policies, except in cases of fraud or intentional misrepresentation of a material fact. Any such cancellation also will be permitted only with prior written notice. Moreover, insurers will no longer be permitted to set lifetime caps on benefits, and they will be restricted in setting annual limits for coverage until 2014, at which point annual limits also will be eliminated. Until 2014, annual limits may be imposed only on "essential benefits," as determined by HHS. At a minimum, the Health Reform Bill defines these "essential benefits" to include the following:

    - Ambulatory patient services;
    - Emergency services;
    - Hospitalization;
    - Maternity and newborn care;
    - Mental health and substance-use disorder services, including behavioral health treatment;
    - Prescription drugs;
    - Rehabilitative and rehabilitative services and devices;
    - Laboratory services;
    - Preventive and wellness services and chronic disease management; and
    - Pediatric services, including oral and vision care.

- Medical Loss Ratio Mandate. Starting no later than January 1, 2011, health insurers in the large group market (more than 100 employees) must have a medical loss ratio of at least 85%, while those insurers in the small group (fewer than 100 employees) or individual market must have a ratio of 80%. Insurers that do not meet the required ratio must rebate the extra revenue, on a pro rata basis, to their enrollees. Although rebates begin in 2011, the medical loss ratio will be determined based on data collected for the 2010 plan year. Because the ratios will be calculated based on data during the current plan year, health insurance issuers will want to begin carefully monitoring their required medical loss ratios immediately. According to a recent Senate Commerce Committee analysis, the current average for-profit medical loss ratio was 84% in policies offered to large employers, 80% in policies offered to small businesses, and 74% offered to individuals. Specifically, the Health Reform Bill requires group and individual insurers to submit a report to the Secretary of HHS providing information relating to the ratio of the incurred losses or claims and loss adjustment expenses to earned premiums. For purposes of the Health Reform Bill, the medical loss ratio is calculated as the amount spent on reimbursement for clinical services and activities that improve health care quality to the total amount of net premium revenue (after accounting for payments or receipts related to the Bill's reinsurance and risk adjustment programs). Finally, beginning in 2014, the medical loss ratio for that plan year will be calculated based on the average of the ratio for the previous 3 years. Obviously, this framework likely will foster significant debate regarding whether particular expenses constitute an "activity that improves health care quality" or whether they are merely an administrative cost.

- Health Insurance Exchanges and CO-OPS. Each state is required to establish (by January 1, 2014) an American Health Benefit Exchange (an "Insurance Exchange") to facilitate the

purchase of qualified health plans by individuals and small employers (companies with 100 or fewer employees). Prior to 2016, states may limit small employers to those with 50 or fewer employees. Beginning in 2017, states can make the Insurance Exchange available to all employers, regardless of size. Plans available through the Insurance Exchange must be certified as providing "essential health benefits." States can also form compacts for the purchase of individual insurance across state lines. CO-OPS (with the assistance of federal funding, available beginning in 2013) can be organized under state law as non-profit, member-run corporations to offer qualified health plans in the individual and small group markets in each state. The qualified health plans offered by CO-OPS can be included as an option through an Insurance Exchange, beginning in 2014.

Impact on Taxpayers

Tax Provisions Affecting Individuals

- Penalties on Uninsured Individuals. Individuals not otherwise eligible for Medicaid or Medicare or other government sponsored coverage will be required to maintain minimum essential coverage beginning in January, 2014. Individuals who fail to maintain minimum essential coverage would be liable for a penalty. The penalty is the greater of a flat dollar amount or a certain percentage of the taxpayer's income.
    - The flat dollar amount penalty begins at $95 per adult without minimum essential coverage in 2014. The nondeductible penalty rises to $325 per adult in 2015, to $695 per adult in 2016 and is indexed for inflation thereafter.
    - The percentage of income that is the alternative to the flat dollar annual penalty is 1.0% in 2014, 2.0% in 2015, and 2.5% for 2016 and subsequent years.
    - The flat dollar amount penalties are halved for individuals under the age of 18 or in college.
    - The total household penalty cannot exceed an amount equal to 300% of the per adult penalty for the year.
    - The following individuals are exempt: (1) Individuals who cannot afford coverage because their required contribution for employer sponsored coverage or the lowest cost "bronze plan" in the local Insurance Exchange exceeds 8% of household income; (2) Those who are exempted for religious reasons; (3) Those residing outside of the U.S.
- Refundable Premium Assistance Tax Credits for Low Income Individuals. Beginning in 2014, refundable tax credits will be available for individuals and families with incomes from 100% up to 400% of the federal poverty level who obtain health care coverage in newly established Insurance Exchanges. A cost sharing subsidy is also provided to reduce out of pocket costs for these individuals.
- Adoption Credits and Assistance. Beginning in 2010, the adoption tax credit will be increased by $1,000, and made refundable. The adoption assistance exclusion also will be increased by $1,000. Both credit and exclusion are extended through 2011.

- Additional Hospital Insurance Tax (HI) for high wage workers. Beginning in 2013, the HI tax rate imposed on individual taxpayers is increased by 0.9 percentage points on wages in excess of $250,000 for married couples filing jointly ($125,000 for married taxpayers filing a separate return) and $200,000 for other taxpayers.
- Unearned Income Medicare Contribution Tax. Beginning in 2013, a 3.8% Unearned Income Medicare Contribution Tax will apply to "unearned income" of higher income taxpayers. This tax is 3.8% of the lesser of: (1) net investment income or (2) the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for a joint return or surviving spouse, $125,000 for a married individual filing a separate return, and $200,000 in any other case. Net investment income includes interest, dividends, royalties, rents, gain from disposing of property (other than property held in a trade or business to which the tax does not apply), and income earned from a trade or business that is a passive activity. Self-employed individuals, as well as estates and trusts, would also be liable for the additional tax.
- Expanded Exclusion or Deduction for Dependent Coverage. Effective March 30, 2010 (the enactment date of the Health Care and Education Reconciliation Act), the exclusion from gross income for reimbursements for medical care expenses under an employer-provided accident or health plan is extended to any child of an employee who has not attained age 27 as of the end of the tax year. The change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. Also, self-employed individuals may take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the tax year.
- Medical Deductions. Beginning in 2013, the adjusted gross income ("AGI") threshold for claiming the itemized deduction for medical expenses will be increased from 7.5% to 10%. However, the 7.5%-of-AGI threshold will continue to apply through 2016 to individuals age 65 and older (and their spouses).

Tax Provisions Affecting Employers

- Health Coverage Excise Tax on Large Employers Not Offering Minimum Coverage. Starting in 2014, an "applicable large employer" (one that employed an average of at least 50 full-time employees during the preceding calendar year) not offering coverage for all its full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, will have to pay an excise tax if any full-time employee is certified to the employer as having purchased health insurance through an Insurance Exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee. The excise tax on employers not offering coverage for any month will be equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of $2,000 (adjusted for inflation after 2014). If an employer offers employees minimum essential coverage and any full-time employee is certified to the employer as having purchased health insurance through an Insurance Exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee, the excise tax is equal to the number of the

employer's full-time employees for any month who receive premium tax credits or cost-sharing assistance multiplied by one-twelfth of $3,000 (adjusted for inflation after 2014). The excise tax is capped at the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of $2,000 (adjusted for inflation after 2014).

- Small Employer Tax Credits. In tax years beginning in 2010 through 2013, eligible small employers may qualify for a tax credit for up to 35% of their contribution toward the employee's health insurance premium. In tax years beginning in 2014 and beyond, eligible small employers who purchase coverage through an Insurance Exchange may qualify for a credit for two years of up to 50% of their contribution. An eligible small employer generally is an employer with no more than 25 full-time equivalent employees ("FTEs") employed during the employer's tax year, and whose employees have annual full-time equivalent wages that average no more than $50,000. Qualified tax-exempt employers would be eligible for a reduced credit. The full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $25,000. These wage limits will be indexed to the Consumer Price Index for Urban Consumers ("CPI-U") for years beginning in 2014.
- Free Choice Vouchers. Beginning in 2014, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide qualified employees with a voucher whose value can be applied to purchase of a health plan through the Insurance Exchange. Qualified employees are employees: (1) who do not participate in the employer's health plan; (2) whose required contribution for employer sponsored minimum essential coverage (if they did participate in the plan) exceeds 8%, but does not exceed 9.8% of household income; and (3) whose total household income does not exceed 400% of the poverty line for the family. After 2014, the 8% and 9.8% will be indexed for premium growth. The value of the voucher is equal to the dollar value of the employer contribution to the employer offered health plan and is not includable in income to the extent it is used for the purchase of health plan coverage. If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid the excess value of the voucher. The excess amount received by the employee is includible in gross income. If an individual receives a voucher, he is disqualified from receiving any tax credit or cost sharing credit for the purchase of a plan in the Insurance Exchange. Similarly, if any employee receives a free choice voucher, the employer is not assessed the excise tax for that employee.
- Simple Cafeteria Plans. For years beginning after 2010, a new employee benefit cafeteria plan known as a Simple Cafeteria Plan will be available to eligible small businesses (those employing an average of 100 or fewer employees during either of the 2 preceding years, until such employer employs an average of 200 employees during any year preceding any such subsequent year). This plan will require minimum contributions for nonhighly compensated employees and will be subject to eased participation.

- New Employer Reporting Responsibilities.
    - Beginning in 2011, employers must disclose the value of the benefit provided by them for each employee's health insurance coverage on the employee's annual Form W-2.
    - Beginning in 2014, applicable large employers (including employers who self-insure) that are required to provide minimum essential coverage to any individual during a calendar year and each offering employer must report the following to both the covered individual and to the IRS: (1) name, address, and taxpayer identification number (TIN) of the primary insured, and name and TIN of each other individual obtaining coverage under the policy; (2) the dates during which the individual was covered under the policy during the calendar year; (3) whether the coverage is a qualified health plan offered through an Insurance Exchange; (4) the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage; and (5) such other information as the IRS may require. Penalties would be imposed for failure to file an information return.

- Deduction for Subsidized Retiree Drug Coverage. For tax years beginning after 2012, the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees will be eliminated.

Miscellaneous Tax Provisions

- Changes to Health Care Accounts
    - For purposes of employer provided health coverage (including health reimbursement accounts ("HRAs") and health flexible savings accounts ("FSAs"), health savings accounts ("HSAs"), and Archer medical savings accounts ("MSAs")), the definition of medicine expenses deductible as a medical expense is generally conformed to the definition for purposes of the itemized deduction for medical expenses. Thus, the cost of over-the-counter medicine (other than insulin or doctor prescribed medicine) cannot be reimbursed through a health FSA or HRA. In addition, the cost of over-the-counter medicines (other than insulin or doctor prescribed medicine) cannot be reimbursed on a tax-free basis through an HSA or Archer MSA. These changes for HSAs and Archer MSAs apply for amounts paid out with respect to tax years beginning after Dec. 31, 2010. The changes for health FSAs and HRAs apply for reimbursement of expenses incurred with respect to tax years beginning after Dec. 31, 2010.
    - Health FSA contributions will be capped at $2,500 per year after 2012, which is indexed annually for inflation after 2013.
    - For tax years beginning after 2010, the additional tax on nonqualified distributions from HSAs from 10% to 20% and from Archer MSAs from 15-20%.

- Credit for Qualifying Therapeutic Discovery Projects. A new 50% tax credit (or grants in lieu of credit) is provided to encourage investments in new health care therapies for qualified expenses in tax years beginning in 2009 and 2010. Each credit must be certified by the

Department of Treasury and the aggregate credits allowable under the program will be limited to $1 billion.

- Elimination of Black Liquor Tax Credit. A $1.01 per gallon tax credit applies for the production of biofuel from cellulosic feedstocks in order to encourage the development of new production capacity for biofuels that are not derived from food source materials. Congress is aware that some taxpayers are seeking to claim the cellulosic biofuel tax credit for unprocessed fuels, such as "black liquor." For fuel sold or used after Dec. 31, 2009, eligibility for the tax credit under the Health Reform Bill will be limited to processed fuels (i.e., fuels that could be used in a car engine or in a home heating application).
- Patient-Centered Outcomes Research Institute Fee. In order to fund a new Patient-Centered Research Institute, for fiscal year 2013, a $1 fee per covered person will be collected from issuers of insured plans and sponsors of uninsured plans. For each of fiscal years 2014 through 2019, the fee will be $2 per covered person.
- Excise Tax on High-Cost Employer Sponsored Health Coverage. Beginning in 2018, a 40% excise tax will be imposed on the aggregate value of Employer Sponsored Health Coverage that exceeds a threshold amount. For 2018, the threshold amount will be an inflation adjusted $10,200 for individual coverage and $27,500 for family coverage. An additional threshold amount of $1650 for single coverage and $3450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The excise tax will be levied at the insurer level. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.
- Executive Compensation Deduction Limit for Health Insurance Providers. A new deduction limit on executive compensation applies to insurance providers. If at least 25% of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the new Health Reform Bill ("covered health insurance provider"), an annual $500,000 per tax year compensation deduction limit will apply for all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider. The limit applies to remuneration paid in tax years beginning after 2012 for services performed after 2009.
- Pharmaceutical Manufacturing Fee. Pharmaceutical manufacturers and importers will have to pay an annual flat fee beginning in 2011 allocated across the industry according to market share. The schedule for the flat fee is: 2011, $2.5 billion; 2012 to 2013, $2.8 billion; 2014 to 2016, $3 billion; 2017, $4 billion; 2018, $4.1 billion; 2019 and later, $2.8 billion. The fee will not apply to companies with sales of branded pharmaceuticals of $5 million or less.
- Medical Device Manufacturing Fee. Beginning in 2013, manufacturers or importers of medical devices will have to pay a 2.3% excise tax based on the sale price of any taxable medical devices by the manufacturer, producer, or importer of the device. The excise tax will not apply to eyeglasses, contact lenses, hearing aids, and any other medical devices determined by IRS to be of a type that is generally purchased by the general public at retail for individual use.

- Health Insurance Provider Annual Fee. Health insurance providers will face an annual flat fee beginning in 2014. The fee will be allocated based on market share of net premiums written for a U.S. health risk for calendar years beginning after Dec. 31, 2012. The aggregate annual flat fee for the industry will be: $8 billion for 2014; $11.3 billion for 2015 and 2016; $13.9 billion for 2017; and $14.3 billion for 2018. The fee will not apply to companies whose net premiums written are $25 million or less.
- Tanning Tax. On or after July 1, 2010, indoor tanning services will be subject to a 10% excise tax.
- Blue Cross Blue Shield Loss Ratio Requirement. Beginning in 2010, nonprofit Blue Cross Blue Shield organizations must maintain a medical loss ratio of 85% or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves.
- Codification of the Economic Substance Doctrine. The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance. For transactions entered into after March 30, 2010, and to underpayments, understatements, and refunds and credits attributable to transactions entered into after March 30, 2010, this doctrine is codified, the manner in which the economic substance doctrine should be applied by the courts is clarified, and a 20% strict liability penalty (increased to 40% if not adequately disclosed on the taxpayer's return) is imposed on understatements attributable to a transaction lacking economic substance.
- Form 1099 Reporting to Corporations. For payments made after Dec. 31, 2011, businesses that pay any amount greater than $600 during the year to corporate providers of property and services will have to file an information report with each provider and with the IRS.
- Increased Estimated Tax Payment Requirements for Large Corporations. The required corporate estimated tax payments factor for corporations with assets of at least $1 billion will be increased by 15.75 percentage points for payments due in July, August, and September of 2014.

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