Health Care Reform Summary

The Patient Protection and Affordable Care Act (now referred to as the "ACA" by federal regulators ("ACA")), as amended, contains significant new requirements for employers and their health plans. This summary describes the main provisions of the ACA but not every provision.

This summary is divided into five sections:

1. *Plan Changes* – Describes what health benefits a plan must cover (e.g., preventive care without cost-sharing) and restrictions a plan must eliminate (e.g., lifetime limits). Also includes new enrollment rules (e.g., covering older children).

2. *Employer and Insurer Administrative Requirements* – Describes the administrative actions employers must take (e.g., reporting the value of health plan coverage on Form W-2).

3. *Tax Incentives / Penalties for Employers, TPAs and Insurers* – An overview of tax benefits offered by the ACA (such as the early retiree reinsurance program), tax increases (e.g., additional FICA tax of 0.9%) and tax penalties that can apply (e.g., the $2,000 and $3,000 penalties that can apply under the "pay or play" rules) to employers, third party administrators ("TPAs") and insurers.

4. *Exchanges and Co-Ops* – The new rules for health plan "exchanges" are described.

5. *Requirements, Taxes and Benefits for Individuals* – An overview of the requirements individuals must follow (such as obtaining "minimum essential coverage" as of 2014), along with related tax credits and penalties.

Grandfathered Plan Exceptions. Some ACA changes do not apply to a "grandfathered" health plan (a "GF" plan). Where applicable, this is noted in the "Comments" section.

Notices and Plan Amendments: We state in the "Comments" section whether the ACA requires a specific notice relating to the change. In addition, many plan changes will require an amendment and a related summary of material modifications ("SMM").

Which Plans are Affected? The ACA's changes generally apply to "group health plans." However, the ACA does not apply to every group health plan. In general, the ACA applies to:

Major Medical Plans	**"Mini Med" Plans** – But, see the Comments section below for how a waiver was available for the "no annual limit" rule
Many Employee Assistance Plans ("EAPs") – EAPs are covered by the ACA to the extent they provide "significant benefits in the nature of medical care or treatment". Through at least 2014, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits. For example, an EAP offering	**Health Reimbursement Arrangements ("HRAs")** – But, see the Comments section below for how HRAs are affected by the "no annual limit" rule

3-5 visits with a trained counselor might not be subject to the ACA because such benefits arguably are not "significant benefits."	
Government Medical Plans	**Executive Medical Expense Reimbursement Plans**
Some Dental and Vision Plans – Most stand-alone dental or vision plans will be an "excepted benefit" under HIPAA and will therefore avoid the ACA's requirements. However, a minority of stand-alone dental or vision plans will not be an "excepted benefit" under HIPAA and will be subject to the ACA's requirements	**Some Health Flexible Spending Arrangements (a "Health FSA")** – Most Health FSAs will be an "excepted benefit" under HIPAA and therefore avoid most of the ACA's requirements. A minority of Health FSAs will not be an "excepted benefit" under HIPAA and will be subject to the ACA's requirements. All Health FSAs (whether or not they are an excepted benefit) are affected by the ACA's requirement that employee elective deferrals be limited to $2,500

Which Plans are Not Affected?

Most Fixed Indemnity Policies	**Most Dental Plans**
Most Health FSAs	**Medigap Policies**
Most Specified Disease Policies	**Most Vision Plans**
Most Retiree-Only Plans	

1. Plan Changes

2010

	Summary of Change	Effective Date	Comments
a. Coverage of Older Children	If plan covers dependents, adult child must be allowed coverage until age 26 (i.e., through age 25). No requirement to cover child of such a dependent child (i.e., the grandchild). Coverage of adult child generally is not taxable until year in which child will attain age 27	Plan years beginning on or after September 23, 2010 (tax change effective March 30, 2010)	Limited exemption for GF plans. GF plans can, prior to 2014, refuse to provide coverage to older child if child is eligible to enroll in an "eligible employer-sponsored health plan"

1. Plan Changes (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
b. New Appeals Process / External Review	A new health plan appeals process must be followed. The new appeals process must permit participants to present evidence and testimony, receive continuing coverage and receive certain new appeal rights. An external review process must be implemented	Plan years beginning on or after September 23, 2010	Does not apply to GF plans. Some portions of rule delayed and became effective in 2011 or 2012
c. Any Available Primary Care Provider / Pediatrician	If plan requires or allows designation of participating primary care provider, plan must allow any who are available. Similar rules for pediatric care	Plan years beginning on or after September 23, 2010	Does not apply to GF plans. If applicable, a notice is required to be distributed in summary plan description ("SPD") or other, similar description of benefits. Sample language available here: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc
d. Coverage of Emergency Services	Emergency services must be covered without prior authorization and as though services were in-network	Plan years beginning on or after September 23, 2010	Does not apply to GF plans
e. Access to Ob/Gyn Care	For female enrollees, cannot require authorization or referral for Ob/Gyn care from Ob/Gyn specialist	Plan years beginning on or after September 23, 2010	Does not apply to GF plans. If applicable, a notice is required to be distributed in SPD or other, similar description of benefits. Sample language available here: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc
f. Limits on Preexisting Condition Exclusions (Under Age 19)	Plan cannot impose any preexisting condition exclusion with respect to plan coverage for enrollee under age 19	Plan years beginning on or after September 23, 2010	
g. No Lifetime Limits on Essential Health Benefits	Lifetime limits for “essential health benefits” are eliminated. Benefits that are not "essential" may have lifetime limit	Plan years beginning on or after September 23, 2010	Notice had to be provided to individuals who reached a lifetime limit and are otherwise still eligible for benefits or coverage under the plan. Internal Revenue Service

1. Plan Changes (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
			("IRS"), Department of Labor ("DOL") and Department of Health and Human Services ("HHS") have indicated that stand-alone, active-employee HRAs do not comply with the annual limit prohibition if they are not "integrated" with an employer's group health plan. Some guidance released on definition of "essential health benefits" but effect on self-funded plans and multistate insured plans remains somewhat unclear.
h. Restricted Annual Limits on Essential Health Benefits	Annual limits on "essential health benefits" prior to January 1, 2014 are subject to a "restricted annual limit." Limit starts at $750,000 in 2010-2011 and increases to $2,000,000 in 2012-2013. Benefits that are not "essential" may have annual limits.	Plan years beginning on or after September 23, 2010	Waiver previously available but application cut-off date of September 22, 2011. IRS, DOL and HHS are seeking comments on how this rule applies to a stand-alone, active-employee HRA. Some guidance released on definition of "essential health benefits" but effect on self-funded plans and multistate insured plans remains somewhat unclear
i. No Rescission	Plan cannot rescind coverage once individual is enrolled unless fraud or intentional misrepresentation of material fact and plan's term prohibit such fraud / misrepresentation	Plan years beginning on or after September 23, 2010	Sponsor must provide 30 days advance notice of rescission (no government model language)
j. Preventive Health Coverage	Plan must cover, generally without cost-sharing, certain preventive services (e.g., immunizations and infant screenings)	Plan years beginning on or after September 23, 2010. Coverage generally required for additional services released in August 2011 by first plan year beginning on or after August 1, 2012. Temporary enforcement safe harbor available for some religious employers for plan	Does not apply to GF plans. List of additional covered services issued August 2011 (e.g., certain contraceptives). Exemption from contraceptive coverage rule available for some religious employers; "accommodation" available for some non-exempt religious organizations.

1. Plan Changes (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
		years beginning before January 1, 2014. Accommodation for some religious organizations available for plan years beginning on or after January 1, 2014.	
k. Native American Plans are Payer of Last Resort	Certain Native American health programs are the payer of last resort, notwithstanding other laws	Apparently March 2010	
2011			
	Summary of Change	**Effective Date**	**Comments**
l. Simple Cafeteria Plans	A small employer (average 100 or fewer employees) can adopt a new type of cafeteria plan. If adopted, plan has a safe harbor from nondiscrimination rules if minimum employer contributions are made	January 1, 2011	
m. Over-the-Counter Medicines	Cost of over-the-counter medicine (other than doctor-prescribed and insulin) may not be reimbursed through health FSA, HRA, HSA or Archer MSA	Tax years beginning January 1, 2011	
2012			
	Summary of Changes	**Effective Date**	**Comments**
n. No Questions on Firearms	Certain wellness plans cannot require disclosure of lawful firearm or ammunition ownership, storage, or use	Originally, standards were required to be developed within 24 months after enactment. However, no guidance has yet been issued and thus it is unclear when plans must comply	
o. Automatic Health Plan Enrollment	Employers with 200 or more employees must automatically enroll employees into health insurance plan offered by employer. Employees may opt out of coverage	Unclear. Seems to be March 23, 2010 but guidance indicates it will be delayed, likely until 2015 or later	Opt out notice must be provided. No model notice available. Likely wait for additional guidance

1. Plan Changes (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
p. Additional Preventive Services	See description in Section 1.j	Plan years beginning on or after August 1, 2012 (religious employers may receive accommodation or complete exemption)	
2013			
	Summary of Changes	**Effective Date**	**Comments**
q. Cap on Health FSA Salary Reductions Contributions	Health FSA salary reduction contributions limited to $2,500	Plan years beginning January 1, 2013	
r. Medicare Part D Subsidy Deductions	Deduction for Medicare Part D subsidy eliminated	Tax years beginning January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
s. Coverage for Clinical Trials; No Discrimination	Plan cannot deny participation in approved clinical trial, deny routine costs of same or otherwise discriminate based on participating in clinical trial for treatment of certain cancers or other life-threatening conditions	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
t. Limits on Waiting Periods	Plan cannot impose any waiting period that exceeds 90 days	Plan years beginning on or after January 1, 2014	
u. Pre-Tax Payments for Exchange Individuals	Cafeteria plan can allow pre-tax premium payments for exchange-eligible individuals only if employer is a “qualified employer"	January 1, 2014	A "qualified employer" is a small employer that elects to make its employees eligible for health coverage in the small group market through an Exchange. Beginning in 2017, a large employer may also be a "qualified employer" if it elects to make its employees eligible for health coverage in a large group market through an Exchange.

1. Plan Changes (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
v. Codification of Wellness HIPAA Regulations	Codifies many existing HIPAA nondiscrimination regulations	Plan years beginning on or after January 1, 2014	Appears GF plans need not comply; however, similar HIPAA regulations likely would apply. Updated HIPAA regulations will require many employers to restructure existing wellness programs.
w. Wellness "Carrot / Stick" Limits Raised	Raises current 20% cap on wellness discount / surcharge to 30% of coverage cost. Allows HHS, IRS and DOL to increase amount to 50% if increase due to tobacco use prevention/reduction program	Plan years beginning on or after January 1, 2014	
x. Limits on Preexisting Condition Exclusions (for Enrollee of Any Age)	Plan cannot impose preexisting condition exclusion with respect to plan coverage	Plan years beginning on or after January 1, 2014	
y. No Discrimination Against Health Care Providers	Plan and insurer may not discriminate against any health care provider acting within the scope of that provider's license or certification. Does not require plans to contract with any willing provider or to refrain from establishing varying reimbursement rates based on quality or performance measures	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
z. No Annual Limit on Essential Health Benefits	Plan cannot impose annual limit on essential health benefits	Plan years beginning on or after January 1, 2014	
aa. Out-Of-Pocket and Cost-Sharing Limitations	Out-of-pocket costs for in-network, essential health benefits are limited to those applicable to high deductible health plans (i.e., HSA–related plans). Insured plans in the individual and small group markets generally cannot impose deductibles that are higher than $2,000 for single coverage and $4,000 for any other coverage (increased by amount of employer contributions to health FSA)	Plan years beginning on or after January 1, 2014	Does not apply to GF plans. For 2014, a special rule generally allows some prescription drug plans to have a separate out-of-pocket limit on essential health benefits

2. Employer and Insurer Administrative Requirements

2010

	Summary of Change	Effective Date	Comments
a. No Retaliation	Employer cannot discharge or discriminate against an employee for objecting to, or refusing to participate in, a violation of certain provisions of the health care reform law	March 23, 2010	
b. Health Program or Activity May Not Discriminate	A "health program or activity" receiving federal financial assistance cannot discriminate in violation of certain federal laws. Term "health program or activity" not yet defined	March 23, 2010	Unclear if provisions will significantly impact employers and their health plans
c. Notice of Grandfathered Plan Status	Sponsor must provide notice that plan is grandfathered in order to maintain GF status	Apparently June 14, 2010	Sample language available here: http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc

2011

	Summary of Change	Effective Date	Comments
d. Insurer Report on Costs	Insurer must report various costs to federal government	January 1, 2011	
e. Report Plan Cost on W-2	Aggregate cost of employer-sponsored health plan coverage must be reported on employee's W-2. Some health plans excluded (e.g., stand-alone, fully insured dental and vision plans)	Originally effective for 2011 Form W-2 (i.e., W-2 distributed in January 2012). Delayed until 2012 (i.e., W-2 distributed in January 2013)	

2. Employer and Insurer Administrative Requirements (Cont'd.)			
2012			
	Summary of Change	**Effective Date**	**Comments**
f. Summary of Benefits and Coverage ("SBC")	Applicants and enrollees receive SBC and glossary of standard terms. Various content and format requirements (e.g., description of cost-sharing and coverage; 12-point font). Sixty (60) days advance notice of plan changes if change affects contents of summary, unless change is in connection with open enrollment	**Open Enrollment**. For individuals enrolling through open enrollment, provide by first open enrollment period beginning on or after September 23, 2012. For many calendar year plans this would be November 2012. **Not Open Enrollment**. For individuals who begin participating at times other than open enrollment (e.g., special enrollees or newly hired employees), provide SBC starting with first day of first plan year that begins on or after September 23, 2012 (e.g., January 1, 2013 for a calendar year plan)	Sample SBC template available at www.dol.gov/ebsa/
g. Quality of Care Reporting	Secretary to develop reporting requirements related to various quality of care items (e.g., effective case management, preventing hospital readmissions). Plan must then annually submit to Secretary and enrollees a report on these elements	Originally, standards were required to be developed within 24 months after enactment. However, no guidance has yet been issued and thus it is unclear when plans must report	Does not apply to GF plans
h. Fully Insured Plans Subject to Nondiscrimination Rules	Fully insured group health plans must satisfy nondiscrimination rules of Code Section 105(h)(2) (eligibility to participate and eligibility for benefits)	Originally, plan years beginning on or after September 23, 2010. IRS guidance from December 2010 delayed effective date until at least 2012, and to date there still has been no guidance applying the nondiscrimination rules to fully insured plans	Does not apply to GF plans

2. Employer and Insurer Administrative Requirements (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
i. Medical Loss Ratio ("MLR")	An insurer usually must provide a rebate to policyholders if not enough premium revenue is used for claims, to improve health care quality or for certain other expenses	Rebates, if applicable, began in 2012	Employers may want to amend plan documents to clarify how rebates are classified (e.g., whether they are ERISA plan assets) and how they can be used, in accordance with Department of Labor Technical Release 2011-04
2013			
	Summary of Change	**Effective Date**	**Comments**
j. Certify Compliance with Certain HIPAA Transactions	By December 31, 2013, health plans must certify to HHS that their data and information systems comply with, and have tested, current standards and operating rules for certain Standard Transactions	Upon enactment (2013)	
k. Provide Notice of Exchange	Employers must provide to employees notice of exchange and related items (such as tax credits or cost-sharing reductions)	Originally, March 1, 2013, but DOL delayed deadline for providing notice until October 1, 2013	Sample Notices available at http://www.dol.gov/ebsa/healthreform/
l. New HIPAA Transactions	New Standard Transactions include health claim status (by 1/1/2013), electronic funds transfer (by 1/1/2014) and health claims attachments (by 1/1/2016)	Upon enactment (2013, 2014, 2016)	
2014			
	Summary of Change	**Effective Date**	**Comments**
m. Fair Health Insurance Premiums	An insurer offering coverage in the individual or small group market may vary premium rates only according to certain criteria, including (i) individual or family coverage, (ii) rating area and (iii) age	Plan years beginning on or after January 1, 2014	Does not apply to GF plans

2. Employer and Insurer Administrative Requirements (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
n. Guaranteed Availability and Guaranteed Renewability of Coverage	Insurers in the individual or group markets generally must accept every employer and individual in the state that applies for coverage, and generally must renew or continue in force such coverage at the option of the plan sponsor or the individual	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
o. Comprehensive Health Insurance Coverage	A health insurance issuer offering coverage in the individual or small group market must offer those essential health benefits that are required to be offered on the state exchanges	Plan years beginning on or after January 1, 2014	Does not apply to GF plans
2015			
	Summary of Change	**Effective Date**	**Comments**
p. Certify Compliance with Certain HIPAA Transactions	By December 31, 2015, health plans must certify to HHS that they comply with certain Standard Transactions	Upon enactment (2015)	
q. Report to Government on Plan Coverage (known as "Code § 6055 Reporting")	Insurers, employers sponsoring self-insured plans, and other entities offering minimum essential coverage must report to IRS about health coverage (including the name of each employee and dependent covered by plan, portion of premium paid by employer, and other items)	Delayed to January 1, 2015 (first reports will be filed in 2016) (originally effective January 1, 2014)	
r. Summary Report to Employees	Summary of information provided to federal government, above, in 2.q, must be provided to each covered individual	Delayed to January 1, 2015 (first summaries will be provided in 2016) (originally effective January 1, 2014)	

2. Employer and Insurer Administrative Requirements (Cont'd.)			
	Summary of Change	**Effective Date**	**Comments**
s. Reporting of Employer-Sponsored Coverage for Applicable Large Employers (known as "Code § 6056 Reporting")	Employers with at least 50 full-time and full-time equivalent employees must report to IRS whether they offer full-time employees and dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (along with other information regarding the coverage)	Delayed to January 1, 2015 (first summaries will be provided in 2016) (originally effective January 1, 2014)	
t. Summary Report to Employees	Summary of information provided to federal government, above, in 2.s, must be provided to each covered individual	Delayed to January 1, 2015 (first summaries will be provided in 2016) (originally effective January 1, 2014)	
u. Transparency in Coverage Reporting	Health plans must disclose certain plan-related information (e.g., claims payment policies, enrollment data) to federal and state governments	Apparently 2015	Rule is tied to exchange coverage, and will apply to group health plans outside the exchanges no sooner than this rule applies to exchange plans (i.e., after an exchange plan has been certified for one benefit year). Impact on employers uncertain.

3. Tax Incentives / Penalties for Employers, TPAs and Insurers			
2010			
	Summary of Change	**Effective Date**	**Comments**
a. Credits to Small Employers	Limited tax credit to small employers to provide health insurance	Tax years beginning after 2009	
b. Early Retiree Reinsurance Program	Federal government to reimburse eligible plans (including multiemployer plans or VEBAs) 80% of "early retiree" (age 55+ but not eligible for Medicare) health claims between $15,000 - $90,000. Program expires January 1, 2014	June 2010	New, first-time applications no longer being accepted. As of April 2013 funds exhausted

3. Tax Incentives / Penalties for Employers, TPAs and Insurers (Cont'd)			
2011			
	Summary of Change	**Effective Date**	**Comments**
c. Wellness Grants	Small business (generally, with less than 100 employees who work 25 hours or more per week) that did not have a wellness program as of March 23, 2010 can apply for a federal grant to establish a comprehensive workplace wellness program	Apparently October 1, 2011, but not yet implemented	
d. Comparative Effectiveness Research Fees	Plan sponsors must pay annual fees of $1 or $2 per plan participant (amount varies based on year). Fees used to fund comparative effectiveness research	Plan years ending after October 1, 2012	
2013			
	Summary of Change	**Effective Date**	**Comments**
e. Additional Payroll Taxes	Additional FICA and SECA payroll tax of 0.9% for individual wages over $200,000 ($250,000 for couples filing jointly)	January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
f. Fees on Certain Plans / Insurers	Annual fee on a "covered entity" that provides health insurance. Excludes self-funded employer but does not specifically exclude fully insured plan	First payment due no later than September 30, 2014	
g. Reinsurance Fees Imposed on Self-Insured Group Health Plans and Insurers	Self-insured group health plans and insurers contribute to a reinsurance program for individual policies administered by a non-profit for high risk cases in state	January 1, 2014 (apparent sunset January 1, 2017)	

3. Tax Incentives / Penalties for Employers, TPAs and Insurers (Cont'd)			
2015			
	Summary of Change	**Effective Date**	**Comments**
h. Large Employers Must Provide Minimum Essential Coverage ("Pay or Play")	Employers with at least 50 full-time and full-time equivalent employees that do not offer to at least 95% of full-time employees (and dependents) "minimum essential coverage" under an "eligible employer-sponsored plan" are assessed a $2,000 annual fee (increased for growth of insurance premiums each year, determined on a month-to-month basis) for each full-time employee, provided at least one full-time employee receives a premium tax credit or cost-sharing reduction under a "qualified health plan" through an Exchange	Delayed to January 1, 2015 (originally to be effective January 1, 2014)	
	Summary of Change	**Effective Date**	**Comments**
i. Tax if Employer Offers Coverage but Employee Obtains Exchange Coverage ("Pay or Play")	Employer with at least 50 full-time and full-time equivalent employees that offers minimum essential coverage to at least 95% of full-time employees and dependents must pay a $3,000 annual fee (increased for growth of insurance premiums each year, determined on a month-to-month basis) for each full-time employee who: (i) enrolls in a "qualified health plan" through an Exchange; and (ii) receives a premium tax credit or cost-sharing reduction	Delayed to January 1, 2015 (originally to be effective January 1, 2014)	
2018			
	Summary of Change	**Effective Date**	**Comments**
j. "Cadillac Tax" on Certain High-Cost Plans	40% excise tax on excess benefit of high-cost employer-sponsored health	Tax years beginning January 1, 2018	

3. Tax Incentives / Penalties for Employers, TPAs and Insurers (Cont'd)			
	insurance (so-called "Cadillac tax"). Limit based on $10,200 annual limit for individual coverage and $27,500 annual limit for other than individual coverage. Numerous exceptions and adjustments based on states and job classifications		

4. Exchanges and Co-Ops			
	Summary of Change	**Effective Date**	**Comments**
a. Co-ops Created	Nonprofit co-ops created for individual and small employer market	Awards and grants provided by July 1, 2013	24 co-ops were funded through program; funding for additional co-ops virtually eliminated under 2012-2013 "fiscal cliff" legislation
b. State Exchanges	Establishes state exchange for individual and small employer market	No later than January 1, 2014	
c. Individual Policies Across State Lines	States can form "health care choice compacts" to allow purchase of individual policies across state lines	No earlier than January 1, 2016	
d. Large Employers Eligible for Exchange	Employers with average of 51 or more employees (and at least one current employee) allowed into exchange	2017	

5. Requirements, Taxes and Benefits for Individuals			
2010			
	Summary of Change	**Effective Date**	**Comments**
a. High-Risk Pools	A temporary insurance pool for uninsured individuals is created. Pools are expected to begin in 2010 and end on January 1, 2014	Generally July 2010	

5. Requirements, Taxes and Benefits for Individuals (Cont'd)			
2011			
	Summary of Change	**Effective Date**	**Comments**
b. HSA / Archer MSA Excise Tax	10% excise tax on HSA distributions (15% for Archer MSA distributions) for non-medical purposes is increased to 20%	Distributions beginning January 1, 2011	
2013			
	Summary of Change	**Effective Date**	**Comments**
c. Code Section 213 Medical Deduction Threshold Increases	Individuals who wish to deduct unreimbursed medical expenses will need to show that such expenses exceed 10% of income (up from 7.5%). Special transitional rule until 2017 if taxpayer or spouse is age 65	Taxable years beginning January 1, 2013	
d. 3.8% Tax on Unearned Income	A 3.8% tax will be applied to net investment income to the extent such income exceeds a specified threshold amount	January 1, 2013	
2014			
	Summary of Change	**Effective Date**	**Comments**
e. Individuals Must Maintain Minimum Essential Coverage	All individuals in U.S. must maintain "minimum essential coverage" through individual market, employer or certain other coverage (e.g., Medicare)	January 1, 2014	
f. Individual Credits and Reduced Cost-Sharing	Individuals can receive premium assistance credits if income between 100% and 400% of federal poverty level. Also, such individuals may be eligible for reduced cost-sharing requirements	January 1, 2014	

5. Requirements, Taxes and Benefits for Individuals (Cont'd)			
	Summary of Change	**Effective Date**	**Comments**
g. Penalties on Individuals	Individual noncompliance penalty is generally the greater of a flat dollar amount per adult in household or a percentage of household income ($95 or 1% in 2014; $325 or 2% in 2015; $695 or 2.5% in 2016; 2.5% or $695 (as indexed by a cost of living adjustment) for years after 2016), determined on a month-to-month basis. The applicable flat dollar amount is 1/2 for child under 18. Various exceptions and additional limits apply.	January 1, 2014	

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