EXPERT UPDATE

Compliance Headlines from Henderson Brothers:

- Health Care Reform Timeline

HENDERSON BROTHERS

Health Care Reform Timeline

This Henderson Brothers Summary provides a timeline of the of key reform provisions that affect employers and individuals. This timeline starts with 2010 requirements and ends at 2018. Please feel free to contact your HBI representative if you would like more detail regarding any of these Affordable Care Act reform provisions.

Key Health Reform Provisions in Place Already –

2010

- ***Extended Coverage for Young Adults.*** Group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child or spouse of a dependent child. This requirement applies to grandfathered and non-grandfathered plans. However, grandfathered plans need not cover adult children who are eligible for

other employer-sponsored coverage, such as coverage through their own employer, until 2014.

- ***Access to Insurance for Uninsured Individuals with Pre-Existing Conditions.*** The health care reform law provided for the establishment of a temporary high risk health insurance pool program to provide health insurance coverage for certain uninsured individuals with pre-existing conditions. The program will end in 2014, when the health insurance exchanges are set to be operational.

- ***Affordable Coverage.*** As required, the Secretary of Health and Human Services (HHS) has established an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website also includes information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits, and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans will be precluded from listing their policies on this website.

- ***FLSA Amendment***. New requirement to furnish "reasonable" breaks to mothers to express milk for their infants who are up to one year old.

- ***Reinsurance for Covering Early Retirees.*** The new law established a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program is designed to end on Jan. 1, 2014, or earlier, if the $5 billion in funding is paid out.

  Due to the program's popularity, it closed to new applications effective May 5, 2011. In early December 2011, HHS announced that, because the program has already provided more than $4.5 billion in reimbursements, it will not accept reimbursement requests for claims incurred after **Dec. 31, 2011**.

- ***Eliminating Pre-Existing Condition Exclusions for Children.*** Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children under age 19. This provision will apply to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.

- ***Coverage of Preventive Health Services.*** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost sharing requirements for preventive services. Grandfathered plans are exempt from this requirement.

- ***Prohibiting Rescissions.*** The health care reform law prohibits rescissions, or retroactive cancellations, of coverage. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.

- ***Limits on Lifetime and Annual Limits.*** In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the dollar value of benefits for any participant or beneficiary. This requirement applies to all plans, although plans may request a waiver of the annual limit requirement. The annual limit waiver program will be close to applications effective Sept. 22, 2011. Annual limits will also be prohibited beginning in 2014.

- ***Addition of Patient Protections***. Group health plans must permit participants to designate their own primary care physician and young children must be permitted to designate a pediatrician as their primary care provider. Referrals or authorizations must not be required for a female participant seeking care at a provider who specializes in obstetrics or gynecology. Additional provisions have been included to regulate how insurers address emergency room services, including the requirement to provide coverage regardless of network status, removal of any administrative requirements or coverage limitations that are greater for non-network providers, etc.

- ***Improved Appeals Process.*** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:

    - Have an internal claims process in effect;
    - Provide information to claimants in a culturally and linguistically appropriate manner in some situations; and
    - Allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

- ***Nondiscrimination Rules for Fully Insured Plans.*** Fully insured group health plans will have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor

of highly compensated individuals. This section does not apply to grandfathered plans. This provision was set to take effect for plan years beginning on or after Sept. 23, 2010. However, it has been delayed indefinitely pending the issuance of regulations. The regulations will specify the new effective date.

- ***Rebates for the Medicare Part D "Donut Hole."*** Currently, there is a coverage gap, or "donut hole," in most Medicare Part D plans. Once the plan and participant have paid $2,840 in total drug costs ($2,930 for 2012), the participant is in the coverage gap. The coverage gap ends when the participant has spent $4,550 ($4,700 for 2012) out of pocket for drug costs in a calendar year. Health care reform provides a $250 rebate check for all Medicare Part D enrollees who enter the donut hole. Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.

- ***Medicaid Flexibility for States.*** States are given a new option under the health care reform law to cover additional individuals under Medicaid. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

- ***Small Business Tax Credit.*** The first phase of the small business tax credit for qualified small employers began in 2010. These employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations. When health insurance exchanges are operational, tax credits will increase, up to 50 percent of premiums.

- ***Indoor Tanning Services Tax.*** One additional tax imposed by the health care reform law is a 10 percent tax on amounts paid for indoor sun tanning services.

2011

- ***Suspended - Community Living Assistance Services and Supports Program (CLASS Act).*** The health care reform law creates a long-term care insurance program for adults who become disabled. Participation will be voluntary and the program is to be funded by voluntary payroll deductions to provide benefits to adults who become disabled. Although the program was technically effective Jan. 1, 2011, significant portions are not required to be established until 2012. ***Note: Implementation of the CLASS Act was suspended on Oct. 14, 2011 due to concerns on fiscal sustainability and affordability.***

- ***Repealed - Free Choice Vouchers.*** This provision would have required employers to pay for a voucher for exchange coverage if the employee was required to contribute towards health plan premiums an amount between 8% and 9.8% of their annual household income. The voucher would have been used to purchase Exchange coverage.

- ***Medical Loss Ratio Standards.*** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.

- ***Standardizing the Definition of Qualified Medical Expenses.*** The health care reform law conforms the definition of "qualified medical expenses" for HSAs, FSAs and HRAs to the definition used for the itemized tax deduction. This means that expenses for over-the-counter (OTC) medicines and drugs may not be reimbursed by these plans unless they are accompanied by a prescription. There is an exception for insulin. Also, OTC medical supplies and devices may continue to be reimbursed without a prescription.

- ***Over the Counter Drug Restrictions***. Reimbursements for over-the-counter medicines or drugs will be treated as a reimbursable expense only if the medicine or drug is prescribed by a physician.

- ***Cafeteria Plan Changes.*** The new law creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax free benefits to their employees. This plan is designed to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from certain nondiscrimination requirements applicable to highly compensated and key employees.

- ***Medicare Part D Discounts.*** In order to make prescription drug coverage more affordable for Medicare enrollees, the new law will provide a 50 percent discount on all brand-name drugs and biologics in the "donut hole." It also begins phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for all Part D enrollees.

- ***Additional Preventive Health Coverage.*** The new law provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for preventive services beginning in 2011.

- ***Increased Tax on Withdrawals from HSAs and Archer MSAs.*** The health care reform law increased the additional tax on HSA withdrawals prior to age 65 that

are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses also increased from 15 to 20 percent.

- ***Repealed*** - ***Expanded 1099 Tax Reporting Requirements***. This was to begin for payments made after December 31, 2011. This requirement applied not only to contract workers and independent contractors, but to any individual or corporation from which they buy more than $600 in goods or services in a tax year.

- ***Wellness Grants for Small Businesses***. PPACA creates a grant program to assist "eligible employers" to provide comprehensive workplace wellness programs. $200 million has been appropriated for five years, starting in 2011. HHS has yet to release details as to how employers can apply for these grants.

What is happening Now ---

2012

- ***Expanded Preventive Care for Women.*** Beginning in 2010, non-grandfathered group health plans and health insurance issuers offering group or individual non-grandfathered health insurance coverage were required to provide coverage for preventive services with no cost-sharing requirements. Effective for plan years beginning on or after August 1, 2012, the required preventive services include specific services for women, including contraceptives and contraceptive counseling. Exceptions to the contraceptive coverage requirement apply to certain religious employers.

- ***Fees to Fund Research on Patient-Centered Outcomes.*** Fees are payable for policy/plan years ending after September 30, 2012, and stop applying for policy/plan years ending after September 30, 2019. The annual fee is $1.00 per average covered life for policy years ending on or after October 1, 2012, and **before** October 1, 2013. The fee is increased to$2.00 for policy years that end on or after October 1, 2013. For plan years ending on or after October 1, 2014, the $2.00 fee will be increased based on increases in the projected per capita amount of National Health Expenditures. Insurers are responsible for reporting and remitting the fee for fully-insured health plans. Self-insured health plan sponsors are responsible for payment of the fee for self-insured plans. Insurers and plan sponsors will report these fees by July 31 of each year.

- ***Uniform Summary of Benefits and Coverage (SBC).*** All non-grandfathered and grandfathered health plans will be required to provide a uniform summary

of the plan's benefits and coverage to participants. The summary will have to be written in easily understood language and will be limited to four pages. Any mid-year changes to the information contained in the summary will have to be provided to participants 60 days in advance. Originally the health care reform law indicated that plans would be required to start providing the summary by March 23, 2012. However, on Nov. 17, 2011, the Department of Labor (DOL) issued guidance that delayed the deadline for plans to begin providing the summary until after the release of final regulations. On Feb. 9, 2012, HHS, the DOL and the Treasury Department issued final regulations on the summary of benefits and coverage requirement.

The final guidance provides that plans and issuers must start providing the summary by the following deadlines:

- Issuers must provide the summary to health plans effective **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants and beneficiaries who enroll or re-enroll during an open enrollment period starting with the first day of the first **open enrollment period** that begins on or after **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants who enroll for coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first **plan year** that begins on or after **Sept. 23, 2012**.

- ***Reporting Health Coverage Costs on Form W-2.*** Employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2. This requirement has been delayed for MEWAs and is optional for small employers (those filing fewer than 250 Form W-2s) at least for the 2012 tax year.

- ***Establishment of Co-Ops***. Health care reform launched a Consumer Operated and Oriented Plan (CO-OP) program designed to provide loans to nonprofit organizations to establish consumer-governed, member-run health insurers that offer qualified health plans (QHPs) in the individual and small group markets. The purpose of the program is to create at least one of these health insurers, called a CO-OP, in every state in order to expand the number of plans with a focus on integrated care and greater plan accountability.

Preparing for Next Year ---

2013

- ***Administrative Simplification.*** Beginning in 2013, health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.
- ***Limiting Health Flexible Savings Account Contributions.*** The health care law will limit the amount of salary reduction contributions to health FSAs to $2,500 per FSA PLAN year, indexed by CPI for subsequent years.
- ***Eliminating Deduction for Medicare Part D Subsidy.*** Currently, employers that receive the Medicare Part D retiree drug subsidy may take a tax deduction for their prescription drug costs, including costs attributable to the subsidy. The deduction for the retiree drug subsidy will be eliminated in 2013.
- ***Increased Threshold for Medical Expense Deductions.*** The health care reform law increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- ***Additional Hospital Insurance Tax for High Wage Workers.*** The new law increases the hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).
- ***Medical Device Excise Tax.*** The law also establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are excepted from the tax.
- ***Employers Must Provide Exchange Notice.*** Employers must provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.

The Big Changes --

2014

- ***Individual Coverage Mandates.*** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of $2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
    - Legal challenges to the health care reform law have focused on whether Congress had the constitutional authority to enact the individual coverage mandate.
    - On June 28, 2012, the U.S. Supreme Court addressed these legal challenges and upheld the individual coverage mandate as constitutional. This means that the mandate will go into effect in 2014 as planned, unless it is repealed by Congress.
- ***Employer Coverage Requirements.*** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage. The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.
- ***Automatic Enrollment***. The automatic enrollment requirement applies to employers that are subject to the FLSA, have more than 200 full-time employees, and have one or more health benefit plans. Employers must provide "adequate notice" to employees, and employees must be given an opportunity to opt out of coverage. Health care reform does not specify an effective date for the automatic enrollment requirement. However, the DOL has indicated that employers are not required to comply with this requirement until final regulations are issued and applicable—and that such regulations are not expected to be promulgated in time to implement the automatic enrollment provisions by 2014.
- ***Excessive Waiting Periods***. Effective as of plan years beginning on or after January 1, 2014, group health plans and insurers are prohibited from applying a

waiting period that exceeds 90 days. The prohibition on excessive waiting periods applies to group health plans and insurers (as defined by applicable provisions of the PHSA, ERISA, or the Code) but not to certain "excepted benefits".

- ***Health Exchanges.*** The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. Large employers with over 100 employees are to be allowed into the exchanges in 2017. The health care reform legislation provided that workers who qualified for an affordability exemption to the coverage mandate, but did not qualify for tax credits, could use their employer contribution to join an exchange plan. This requirement is known as the "free choice voucher" provision. The federal appropriations bill signed by President Obama on April 15, 2011, **eliminated the free choice voucher provision from health care reform.**

- ***Guaranteed Issue and Renewability***. Health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual.

- ***Pre-existing Condition Exclusions***. Effective Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age.

- ***Insurance Premium Restrictions***. Health insurance issuers will not be permitted to charge higher rates due to heath status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size, and tobacco use.

- ***Nondiscrimination Based on Health Status***. Group health plans and health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.

- ***Nondiscrimination in Health Care***. Group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. It also does not apply to grandfathered plans. Plans and issuers

also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.

- ***Annual Limits***. Restricted annual limits will be permitted until 2014. However, in 2014, the plans and issuers may not impose annual limits on the amount of coverage an individual may receive.

- ***Excessive Waiting Periods***. Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.

- ***Coverage for Clinical Trial Participants***. Non-grandfathered group health plans and insurance policies will not be able to terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

- ***Comprehensive Benefits Coverage***. Health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance exchanges. This requirement does not apply to grandfathered plans.

- ***Limits on Cost-Sharing***. Non-grandfathered group health plans will be subject to limits on cost-sharing or out-of-pocket costs. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs and deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage). These amounts are indexed for subsequent years. Further guidance on which plans will have to apply these limits would be helpful.

- ***Employer Wellness Programs***. Under health care reform, the rules for employer wellness programs will be changed slightly. Existing wellness regulations under HIPAA permit wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. Under health care reform, the potential incentive increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. Following a governmental study on wellness programs, the incentive may be increased to as much as 50 percent.

- ***Individual Health Care Tax Credits***. The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below

400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.

- ***Small Business Tax Credit***. The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
- ***Health Insurance Provider Fee***. The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2018

- ***Excise Tax***. A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as a "Cadillac tax." The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer, or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.