PROTECTING THE CONSUMER'S FUTURE

NAHU

National Association of Health Underwriters

AMERICA'S BENEFITS SPECIALISTS

Healthcare Reform Timeline

Provisions That Will Impact Individuals & Employers

June 15, 2012

No one sees the direct results of the Patient Protection and Affordable Care Act (PPACA) like the health insurance professionals who work directly with American employers and individual consumers looking for affordable healthcare coverage.

2010.....

"It is essential that [policymakers] recognize and protect the indispensable role that licensed insurance professionals play in serving consumers."

- National Association of Insurance Commissioners

- Individuals and employer groups that wish to keep their current policy on a grandfathered basis can only do so if the plan changes made are to add or delete new employees and any new dependents. Many requirements of the new law do not apply to grandfathered plans and the new law does not require individuals to terminate coverage in which they were enrolled when the law was passed. A plan can maintain its grandfathered status even when family members or new employees join the plan.

- Select small businesses are eligible for phase one of the small business premium tax credit. Effective January 1, 2014, employers may only use this credit to purchase coverage through a state-based health insurance exchange.

- Employers that provide a Medicare Part D subsidy to retirees have to account for the future loss of the deductibility of this subsidy in 2010 on liability and income statements, although the elimination of the deductibility does not take effect until 2013.

- Temporary reinsurance programs for employers provide retiree health coverage for employees over age 55. However, the initial $5 billion appropriation for this program was exhausted, and applications are no longer accepted.

- The Pre-Existing Condition Insurance Plan (PCIP) or temporary high-risk pool program covers people who cannot obtain individual health insurance coverage due to preexisting conditions. Employers are prohibited from sending individuals to the high-risk pool, with associated fines.

- Federal web health insurance information portal, www.healthcare.gov, created.

- Non-grandfathered group plans are required to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals. The IRS announced it would not enforce this provision until the release of further guidance about how these provisions would apply to group health plans.

- Lifetime limits on the dollar value of benefits for any participant or beneficiary for all fully insured and self-funded groups and individual plans are prohibited.

- Annual limits are only allowed through plan years beginning prior to January 1, 2014, and only on HHS-defined non-essential benefits. Temporary waivers allow group benefit plans annual limits if compliance would result in a significant decrease in access to benefits or a significant increase in premiums.

- All group and individual plans have to cover dependents through age twenty-six. Dependents can be married and also be eligible for the group health insurance income tax exclusion.

- All group and individual health plans have to cover preexisting conditions for children 19 and under. If state law allows for the use of an open-enrollment period, one can be utilized.

- Health coverage rescissions are prohibited for all health insurance markets except for cases of fraud or intentional misrepresentation.

- All group and individual plans have to cover specific preventive care services with no cost-sharing. They also have to cover emergency services at the in-network level regardless of provider, allow enrollees to designate any in-network doctor as their primary care physician and have a coverage appeal process.

- Federal grant program for small employers providing wellness programs to their employees are to begin. However, funds have not been appropriated for this program, and applications are not currently being accepted.

CARE REFORM TI

2011..... 2012..... 2013.....

"Ninety percent of our time is spent servicing our clients...We do not sell—we educate and then we advise."

- Will Chapman, Baton Rouge, LA

2011

- Employers filing 250 or more W-2 Forms in 2011 must include the cost of employer sponsored health coverage on the forms beginning in the tax year 2012.
- Plans are subject to medical loss ratio requirements. Individual and small group insurers must adhere to an 80% MLR and large group insurers must adhere to an 85% MLR. Self-funded plans are exempt from this requirement.
- The tax on distributions from a Health Savings Account that are not used for qualified medical expenses increase from 10% to 20%.
- Over-the-counter drugs are no longer reimbursable under HSAs, medical FSAs, HRAs and Archer MSAs unless they are prescribed by a doctor.
- Small employers can adopt new "simple cafeteria plans."
- The CLASS Act provisions requiring participating employers to enroll employees in the new program are abandoned by HHS for fiscal insolvency.
- The Department of Health and Human Services, in conjunction with the Department of Labor, issues a study on the large group market, and the Department of Labor begins annual studies on self-funded plans using data collected from Form 5500.

2012

- Group and individual health insurers (including self-funded plans) have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees. It must be no more than four pages in length with print no smaller than 12-point font written in a culturally linguistically appropriate manner.
- Annual health coverage quality reporting requirements are submitted to the HHS secretary. There reports must state whether or not the benefits provided under their plans meet criteria established by HHS on improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors. HHS has yet to issue regulations on this reporting requirement.
- New regulations require insurers for most employer health plans to pay MLR rebates to the policyholder (usually the employer). First rebate payments are due on August 1, 2012.
- All non-grandfathered group or individual health insurance coverage must provide coverage for preventive care without any cost-sharing requirements, including contraceptives.

2013

- Premium tax on fully insured and self-funded group health plans to fund comparative effectiveness research program begins. The IRS asked for comments in 2011, but rules have not yet been released.
- FSA contributions for medical expenses are limited to $2500 per year, with the cap annually indexed for inflation. IRS guidance issued in June 2012 clarified that the cap applies on a plan year basis. For example, a plan with the plan year beginning September 2012 will not be subject to the $2500 cap until the plan renews in September 2013. NAHU sought additional guidance to address plans that had already renewed in 2012 with the new cap in place. Unless further relief is provided, the IRS will not allow plans to revise their 2012 plan limits to take advantage of the clarified cap information.
- The Medicare payroll tax increase goes into effect. In addition, there is a new 3.8% Medicare contribution on certain unearned income from high-income individuals.
- For those who itemize their federal income taxes, the threshold for deducting unreimbursed medical expenses increases from 7.5% of AGI to 10% of AGI. The increase is waived for those 65 years and older through 2016.
- All employers are required to provide notices to their employees informing them of the existence of the state-based exchanges. Details of the content of such notices and a template have not been released.

M E L I N E

2014.....

"As the vice president of finance for a busy small business, I don't have the time to monitor the constant changes in health insurance. [My agent] knows [his] business, which lets me focus on mine."

- Ann A., Lafayette, CA

- The individual mandate requirement takes effect. There are specified exceptions, and under current law, violators will be subject to a phased-in excise tax penalty for noncompliance of either a flat-dollar amount per person or a percentage of the individual's income.

- States are required to have health benefit exchanges up and running to serve their individual and small employer markets. If a state fails to create a federally certified exchange, HHS will step in and operate an exchange for the state.

- Significant insurance market reforms for all individual market and fully insured group market policies take effect. All plans must be offered on a guaranteed-issue basis, prohibit preexisting condition limitations, disallow annual and lifetime limits, and redefine the size of small-employer groups. Fully insured individuals and small groups must abide by strict modified community rating standards, and experience rating will be prohibited.

- Standards for qualified coverage, including the essential health benefits standards, begin.

- Cooperative plans are allowed to be sold through state-based health insurance exchanges. Multistate national plans will be offered to individuals and small employers through state exchanges.

- Premium assistance tax credits for individuals and families making up to 400% of FPL begin. These subsidies are available only for individual coverage purchased through the exchange.

- Expansion of the Medicaid program for individuals making up to 133% of the FPL begins. Mandatory state-by-state employer premium-assistance programs begin for eligible individuals. States can also create a non-Medicaid plan for qualified individuals without access to employer-sponsored coverage.

- The employer responsibility requirements take effect for companies that employ more than 50 full-time employees. Coverage must meet a minimum standard in order to be considered compliant with the mandate, but that standard has yet to be defined. A final exchange regulation describes who will be eligible to receive the premium tax credit, how to compute the credit and employer responsibilities relative to the credit.

- For employers that have a waiting period for coverage for new employees, waiting periods of more than 90 days are prohibited for all plans.

- Employers of 200 or more employees have to auto-enroll all new employees into any available employer-sponsored health insurance plan.

- Premium taxes on most private health insurers based on premium volume take effect, which can be passed directly to fully insured plan consumers.

- Employer-sponsored wellness program rules for all employer group plans under HIPAA improve and employers can increase the value of workplace wellness incentives.

2015.....

"I was totally overwhelmed with the amount of material to read and absorb. It was such a relief to have [my agent] explain in a simple way the different options and to help me decide on the very best coverage for me."

- Robin H. (PA)

- The federal Children's Health Insurance Program is reauthorized.

2017 & 2018.....

- States may elect to allow large employers to purchase coverage through exchanges. If they do so, the market reform provisions—like modified community rating and others that apply to individual and small group policies—will be applied to all fully insured plans offered in the state regardless of group size or place of purchase.

- Cadillac tax goes into effect for all group plans. The tax is paid by the insurer in the case of a fully insured group or the TPA in a self-funded arrangement but is passed on directly to the employer. The value of stand-alone vision and dental plans are excluded, and does not apply to accident, disability, long-term care, and after-tax indemnity or specified disease coverage.

Members of the National Association of Health Underwriters (NAHU) service the health insurance needs of large and small employers as well as people seeking individual health insurance coverage. As such, one of NAHU's primary goals is to do everything we can to promote access to affordable health insurance coverage for all Americans. Visit www.nahu.org for more information.

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