PROTECTING THE CONSUMER'S FUTURE

NAHU

National Association of Health Underwriters

AMERICA'S BENEFITS SPECIALISTS

Healthcare Reform Timeline

Provisions That Will Impact Individuals & Employers

February 2013

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

- Individual and group health plans that existed on or before March 23, 2010, had the option to choose grandfathered status once health reform was enacted. Individuals and employer group plans that elected to keep their current policy on a grandfathered basis can only do so if they maintain essentially the same benefits and follow strict rules that limit yearly increases to employee out-of-pocket costs. The only substantive plan changes a grandfathered plan can make are those required by a preexisting collective bargaining agreement or to add or delete new employees and dependents. An amendment to the grandfathered plan rules issued in November 2010 allows all group health plans to switch insurance companies and shop for the same coverage at a lower cost and maintain their grandfathered status, as long as the structure of the coverage doesn't violate one of the other rules for maintaining grandfathered status. Furthermore, many of the market-reform provisions slated to take effect in plan years beginning on or after September 23, 2010, will apply to all plans, whether or not they hold grandfathered status.

- Select small businesses became 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 had to account for the future loss of the deductibility of this subsidy beginning in 2010 on liability and income statements, although the elimination of the deductibility does not take effect until 2013.

- Temporary reinsurance programs for employers who provide retiree health coverage for employees over age 55 began. 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 began. Employers are prohibited from sending individuals to the high-risk pool, with associated fines. On February 16, 2013, HHS announced that PCIP would cease accepting new applications for coverage, but would continue to cover existing enrollees until health insurance exchanges become operational on January 1, 2014.

- The federal web health insurance information portal www.healthcare.gov created.

- Non-grandfathered insured group plans were required to comply with the Internal Revenue Section 105(h) rules that prohibit discrimination in favor of highly compensated individuals. However, the IRS announced it would not enforce this provision until the release of further guidance about how these provisions would apply to insured group health plans and no guidance has been issued.

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

- Annual limits are only allowed through plan years beginning prior to January 1, 2014, and only on the Department of Health and Human Services (HHS)-defined non-essential benefits. HHS issued rules to allow for temporary waivers from the annual limit requirements if it was found that compliance would result in a significant decrease in access to benefits or a significant increase in premiums. The waiver application period closed in September of 2011. All waivers expire as of January 2, 2014.

- All group and individual plans had to begin covering dependents to age 26. Dependents can be married and also be eligible for the group health insurance income tax exclusion. However, through 2014, grandfathered group plans will only have to provide coverage to dependents that do not have another source of employer-sponsored coverage.

- All group and individual health plans had to start covering pre-existing 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 were prohibited for all health insurance markets except for cases of fraud or intentional misrepresentation.

- If an individual or group health plan provides any benefits with respect to services in an emergency department of a hospital, the plan must cover out-of-network emergency services as if they were in-network. Plans must also allow enrollees to designate any in-network doctor as their primary care physician and have a coverage appeal process.

- All group and individual plans without grandfathered status had to begin covering specific preventive care services with no cost-sharing.

- The federal grant program for small employers providing wellness programs to their employees was to begin. However, funds were never appropriated for this program, and applications are not currently being accepted.

CARE REFORM TI

2011.....

"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

- Fully insured health plans were subjected 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. Plans that do not meet this requirement each year will have to pay policy holders rebates by August of the following year. Rules proposed in January 2013 would change the rebate due date to September 30 effective with 2014 MLR reporting.
- The tax penalty on distributions from Health Savings Accounts (HSAs) that are not used for qualified medical expenses increased from 10% to 20%.
- Reimbursements for over-the-counter drugs under HSAs, medical FSAs, HRAs and Archer MSAs were prohibited without a prescription.
- Small employers were allowed to adopt new "simple cafeteria plans."
- HHS determined that it could not meet the fiscal sustainability requirements in the law relative to the Class Act public long term care program. This provision was repealed as a part of the "fiscal cliff" legislation enacted in December 2012.
- HHS, in conjunction with the Department of Labor (DOL), issued a study on the large-group market, and the DOL began annual studies on self-funded plans using data collected from Form 5500.

2012.....

- Employers filing 250 or more W-2 Forms in 2012 must include the cost of employer-sponsored health coverage for informational purposes on the forms beginning in the tax year 2013.
- Group and individual health insurers (including grandfathered and self-funded plans) have to provide a summary of benefits and a coverage explanation (referred to as an SBC) that meets specified criteria to all enrollees and applicants when they apply, enroll or reenroll, when a policy is delivered and when a material change is made outside a policy renewal period.
- Group insurers and self-funded plans will have to begin submitting quality reports to HHS. These 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.
- All non-grandfathered group or individual health insurance coverage must provide coverage for specified women's preventive care service 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.
- 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 beginning after December 31, 2012.
- The Medicare payroll tax increase of 0.9% goes into effect for individual filers with incomes over $200,000 and joint filers with incomes over $250,000. 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. The notices which were to be provided by March 1, 2013 were delayed pending further guidance from the Department of Labor. The DOL announced the delay on January 24, 2013.

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 tax penalty takes effect. There are specified exceptions, and 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. HHS will also allow a state to elect a hybrid state/federal partnership model overseen by HHS.

- 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, preexisting condition limitations will be prohibited, annual and lifetime limits will be fully prohibited, including for grandfathered plans, and the size of a small-employer group will be redefined to one to 100 employees (although states may elect to keep the size of a small groups at 50 employees until 2016). In addition, all fully insured individual and small groups up to 100 employees (although states may elect to keep the size of small groups at 50 employees until 2016) will have to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions, to be defined by the states, and experience rating will be prohibited.

- Standards for qualified coverage, which will apply to all fully insured small group and individual products to be sold both inside and outside the exchanges, begin. These include the essential health benefits standards that will cover specific mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%.

- 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 between 100-400% of the federal poverty level (FPL) begin. These refundable and advanceable subsidies will be available only for people who qualify to purchase individual coverage through an exchange. The subsidies are available in the individual exchange irrespective of whether the exchange is a state-based exchange or a federally-facilitated exchange.

- Expansion of the Medicaid program for all individuals, including childless adults, who make up to 133% of the FPL is scheduled to begin. The ruling by the Supreme Court in *NFIB v. Sebelius* prohibits the federal government from withholding other federal Medicaid funds if the state refuses to expand their Medicaid programs. Mandatory state-by-state employer premium-assistance programs will begin for those eligible individuals who have access to qualified employer-sponsored coverage. States can also create a separate non-Medicaid plan, called the Basic Health Plan, for those with incomes between 133% and 200% of FPL that do not have access to employer-sponsored coverage. Basic Health Plan rules had not been issued as of February, 2013.

- The employer responsibility requirements take effect for companies that employ more than 50 full-time equivalents. Calculation of the number of full-time equivalent employees is complicated. Counting of seasonal employees was partially addressed in proposed rules issued on January 2, 2013, but more guidance is required to address all situations. Coverage must meet a minimum value standard in order to be considered compliant with the mandate. Coverage must also meet affordability requirements. Employers who do not offer coverage to full-time employees and their dependent children or do not offer them coverage that meets minimum value and affordability standards and have employees who obtain subsidized coverage though the exchanges will be fined.

- 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. The effective date of this provision was originally assumed to be January 1, 2014, but an effective date was actually not specified in the law. The DOL has issued guidance that this provision will not be enforced until regulations are issued and that such regulations are not expected until after 2014.

- A national premium tax on most private health insurers based on premium volume takes 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. There will be a pilot expansion of wellness programs to individual market consumers in 10 to-be-selected states.

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 must be 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 inside or outside the exchange.

- The "Cadillac tax," a 40% excise tax on high-cost plans, 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 the tax does not apply to accident, disability, long-term care, and after-tax indemnity or specified disease coverage. The amount of a high-cost plan for purposes of the tax is indexed for inflation and will vary annually. The excise tax will apply to plans with values that exceed $10,200 for individual coverage and $27,500 for family coverage, with higher thresholds for retirees over age 55 and employees in certain high-risk professions.

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.

1212 New York Avenue, N.W., Suite 1100 • Washington, D.C. 20005
202-552-5060 • www.nahu.org