PROTECTING THE CONSUMER'S FUTURE

NAHU

National Association of Health Underwriters

AMERICA'S BENEFITS SPECIALISTS

Healthcare Reform Timeline

Provisions That Will Impact Individuals & Employers

September 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.....

H E A L T H

"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, apply to all plans, whether or not they hold grandfathered status.

- Select small businesses became eligible for the small-business premium tax credit to help offset the cost of the small employer offering group health insurance benefits to employees. For tax years 2010 through 2013, the maximum credit was 35% of premiums for small-business employers and 25% for small tax-exempt employers. Effective January 1, 2014, employers will only be able to use this credit to purchase coverage through a state or federally facilitated Small Business Health Options (SHOP) exchange. Employers that provided 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 did not take effect until 2013.

- A temporary reinsurance programs for employers that 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, which covers people who cannot obtain individual health insurance coverage due to preexisting conditions, began. Employers were prohibited from sending individuals to the high-risk pool, with associated fines. PCIP is no longer accepting new applications for coverage but will continue to cover existing enrollees until health insurance exchanges become operational.

- The federal web health insurance information portal www.healthcare.gov was created. This portal has gone through a number of changes over the past several years and is now the main access point for the federal health insurance marketplace.

- 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. To date, 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 on the dollar value of plan benefits were only allowed through plan years beginning prior to January 1, 2014, and only on the 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. These waivers will expire at the conclusion of the 2014 benefit plan year or earlier.

- 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 who do not have another source of employer-sponsored coverage.

- All group and individual health plans had to start covering 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 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, all plans were required to 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.

2010

C A R E R E F O R M T I

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

- Fully insured health plans were subjected to medical loss ratio (MLR) 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.
- 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 of the law was formally repealed in December 2012.
- HHS, in conjunction with the 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 were required to include the cost of employer-sponsored health coverage for informational purposes for taxable years beginning after 2012, meaning on the forms issued in January 2013 and thereafter. Employers filing fewer than 250 W-2 forms may voluntarily report coverage cost information until the IRS issues further guidance.
- Group and individual health insurers (including grandfathered and self-funded plans) were required 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.
- All non-grandfathered group or individual plans were required to provide coverage for specified women's preventive care without any cost-sharing requirements.

2013

- Sponsors of self-insured group health plans and insurance carriers are required to begin paying a fee to fund the Patient-Centered Outcomes Research Institute (PCORI). The PCORI fee is to be collected for plan years ending on or after October 1, 2012, and before October 1, 2019, and must be paid by July 31 following the applicable plan year. Employers and insurers must report the fee on IRS Form 720. The fee applies to self-insured plans, insured plans, HRAs and retiree-only plans, among others.
- FSA contributions for medical expenses are limited to $2,500 per year, with the cap annually indexed for inflation for plan years 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 subject to the Fair Labor Standards Act are required to provide notices to their employees informing them of the existence of the health insurance exchange marketplaces no later than October 1, 2013, for current employees. Notices must be provided to each new employee at the time of hiring beginning October 1, 2013. Details of the content of such notices and a template were provided in temporary guidance issued by the DOL along with a new model COBRA notice amended to reflect the exchanges.
- On October 1, 2013, states will be required to have health benefit exchanges up and running to serve an open-enrollment period for 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. Exchange-based coverage will not be effective until January 1, 2014.

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 provisions of the law will take effect. They require all Americans to either obtain minimum essential health coverage through a private insurer or public program or face a tax penalty. There are specified exceptions, and violators will be subject to phased-in excise-tax penalties for noncompliance of either a flat-dollar amount per person or a percentage of the individual's income.

- Significant insurance-market reforms for all individual and fully insured group policies take effect. All plans must be offered on a guaranteed-issue basis. Preexisting-condition limitations, as well as annual and lifetime limits, will be prohibited, including for grandfathered plans. The size of a small-employer group will be redefined to one to 100 employees (although states may elect to keep the size of small groups at 50 employees until 2016). All fully insured individual and small groups 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. Experience rating will be prohibited. Small-group plans will be limited to annual deductibles of no more than $2,000.

- All non-grandfathered plans must adhere to annual out-of-pocket spending limits tied to the annual limits on contribution and out-of-pocket spending amounts for HSAs and for the high-deductible health plans required to be linked with HSAs; however, for plans with multiple benefit administrators, this requirement will not be fully effective until the 2015 plan year.

- Standards for qualified coverage, which will apply to all qualified health plans sold in the small-group and individual insurance markets both inside and outside the exchanges, begin.

- Catastrophic plans will be able to be offered both inside and outside the exchanges to individuals who are either under age 30 or who have received an exemption from the law's individual mandate for coverage affordability or financial hardship reasons. Premium tax credits will not be available for the purchase of catastrophic coverage.

- Cooperative plans will be allowed to be sold through state-based health insurance exchanges. At least two multistate national plans will also be offered to individuals and small employers through state exchanges. The multistate issuers must commit to offer plans in at least 60% of states and expand to all state exchanges within four years. Companies may also offer plans only in the individual markets and expand into the SHOP exchange markets over time and offer coverage only in certain service areas.

- Coverage offered through health insurance exchanges will become effective, and premium-assistance tax credits for qualified individuals and families with household incomes of between 100% and 400% of the Federal Poverty Level (FPL) will begin. These refundable and advanceable subsidies will be available only for people who do not have access to affordable and minimum-value employer coverage and may only be used to purchase a qualified individual health plan through an exchange.

- Expansion of the Medicaid program for all individuals who make up to 133% of the FPL is scheduled to begin. A number of states have either not made a determination about Medicare expansion or have chosen not to expand coverage. In expansions states, mandatory employer premium-assistance programs will begin for those eligible individuals who have access to qualified employer-sponsored coverage. States may 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 are pending

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- New-employee waiting periods of more than 90 days will be prohibited for all plans.

- A national premium tax on most fully insured health insurance issuers will take effect.

- All health insurance plans must pay transitional reinsurance fee annually from 2014 through 2016. The fee will be a flat amount based on the number of covered lives. By November 15, 2014, insurers, employers and TPAs must report their number of covered lives for the first nine months of the year to HHS, and HHS will communicate the amount due by December 15.

- Nondiscriminatory employer-sponsored health-contingent wellness programs rules for improve and employers may increase the value of workplace wellness incentives from 20% to 30% of premiums. Employers may further increase the maximum reward to as much as 50% for programs designed to prevent or reduce tobacco use. There will be a pilot expansion of wellness programs to individual-market consumers in 10 to-be-selected states.

"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)

2015 & 2016.....

2015:

- Employers of 200 or more employees will have to auto-enroll all new employees into any available employer-sponsored health insurance plan. 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.
- The federal Children's Health Insurance Program must be reauthorized.
- The employer-responsibility requirements will take effect for companies that employ more than 50 full-time-equivalent employees. Employers subject to the mandate that do not offer minimum essential 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 through the exchanges, will be fined beginning with plan renewals in 2015. Further guidance regarding the delay and the implications of it are expected soon.
- Employers will be required to report coverage information to the exchanges for the purposes of enforcing both the employer- and individual-mandate requirements.

2016:

- The definition of a small-employer group for health coverage purposes will automatically expand to one to 100 employees in all states.

2015 2016

2017 & 2018.....

2017:

- States may elect to allow large employers to purchase coverage through exchanges. If they do so, the market-reform provisions 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.

2018:

- The "Cadillac tax," a 40% excise tax on high-cost plans, will go 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.

2017 2018

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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