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Health Care Reform Timeline

The health care reform bill, the Affordable Care Act (ACA), was signed into law on March 23, 2010. The ACA makes sweeping changes to the U.S. health care system. The ACA's health care reforms, which are focused on reducing the uninsured population and decreasing health care costs, are being implemented over a period of several years.

This Legislative Brief provides an implementation timeline of key ACA reforms that affect employers and individuals. Please contact Propel Insurance with questions about how you can prepare for the health care reform requirements.

2010

EXPANDED INSURANCE COVERAGE

- ***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, for plan years beginning before Jan. 1, 2014, grandfathered plans need not cover adult children who are eligible for other employer-sponsored coverage, such as coverage through their own employer.

  The ACA also added a new tax provision related to health insurance coverage for these adult children. As of March 30, 2010, amounts spent on medical care for an eligible adult child can generally be excluded from taxable income.

  Note: A "grandfathered plan" is one in which an individual was enrolled on March 23, 2010. A plan will retain its grandfathered status even if, after March 23, 2010, covered individuals renew their coverage, family members are added to coverage or new employees (and their families) enroll for coverage. A health plan will lose its grandfathered status if there are significant cuts to benefits or increases in participants' out-of-pocket spending. Grandfathered status is significant because many ACA reforms do not apply to grandfathered plans.

- ***Access to Insurance for Uninsured Individuals with Pre-existing Conditions***. The ACA created a temporary high-risk health insurance pool program, called the Pre-existing Condition Insurance Plan (PCIP), to provide health coverage to individuals who have been uninsured for at least six months because of a pre-existing condition. On Feb. 15, 2013, enrollment in the PCIP program was suspended due to limited funding. The enrollment suspension took effect immediately in 23 states where the federal government administered the program. However, state-based PCIPs could accept enrollment applications through March 2, 2013.

  The PCIP program was scheduled to continue until **Jan. 1, 2014**. However, HHS offered transitional coverage for a limited time period after Jan. 1, 2014, to PCIP enrollees who had not yet secured other health insurance. This transitional coverage was intended to allow PCIP enrollees more time to review Exchange options and enroll in a plan before open enrollment closed on March 31, 2014. See www.pcip.gov for more information.

  In addition, on April 24, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a bulletin that provides a **special enrollment period through the Exchange** for individuals who lose coverage through the PCIP once the program ends. In order to ensure that eligible individuals who are losing coverage through PCIP

because the program ended can avoid a lapse in coverage, CMS is providing a special enrollment period for enrollment in a qualified health plan (QHP) offered through the FFE in 2014. According to CMS, state-based Exchanges are adopting a similar special enrollment period.

- ***Identifying Affordable Coverage***. HHS established an Internet website—www.healthcare.gov—through which residents of any state may identify affordable health insurance coverage options in their 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 were precluded from listing their policies on this website.
- ***Reinsurance for Covering Early Retirees***. The ACA established a temporary reinsurance program to reimburse 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 was designed to end on Jan. 1, 2014, or earlier, if the $5 billion in funding was exhausted. Due the program's popularity and rapid use of funding, it stopped accepting applications as of May 5, 2011 and did not reimburse claims incurred after Dec. 31, 2011. The deadline for submitting ERRP reimbursement requests was July 31, 2013.

HEALTH INSURANCE REFORM

- ***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 applies to all employer plans and non-grandfathered plans in the individual market. This provision also applies to all enrollees effective for plan years beginning on or after Jan. 1, 2014.
- ***Coverage of Preventive Care Services***. Group health plans and health insurance issuers offering group or individual health insurance coverage must cover certain preventive care services without cost-sharing (for example, deductibles, copayments or coinsurance). Grandfathered plans are exempt from this requirement.
- ***Prohibiting Rescissions***. The ACA prohibits rescissions, or retroactive cancellations, of coverage, except in cases of fraud or intentional misrepresentation. Also, plans and issuers must provide at least 30 days' advance notice to the enrollee before coverage may be rescinded. This provision applies to all grandfathered and non-grandfathered plans.
- ***Lifetime and Annual Limits***. Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement for plan years beginning before Jan. 1, 2014. The annual limit waiver program closed to applications on Sept. 22, 2011. All annual dollar limits on essential health benefits are prohibited for plan years beginning on or after Jan. 1, 2014.

HEALTH PLAN ADMINISTRATION

- ***Improved Claims and Appeals Process***. Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective process for benefit claims and appeals of coverage determinations. A plan's or issuer's internal claims and appeals process must comply with the claims procedure regulation issued by the Department of Labor (DOL) in 2001. In addition, the ACA requires plans and issuers to:
    - Have an internal claims and appeals process in effect that provides claimants with a full and fair review;
    - Provide information to claimants in a culturally and linguistically appropriate manner in some situations;
    - Comply with additional content requirements for denial notices; and

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3/10; BK 4/14

- Continue to provide coverage to a claimant pending the outcome of the appeals process.

A grace period for some of the ACA's additional claims and appeals requirements was available until plan years beginning on or after Jan. 1, 2012. Plans and issuers must also implement an external review process that meets applicable state or federal requirements.

- ***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 reform, which does not apply to grandfathered plans, 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, which will specify the new effective date.

MEDICARE/MEDICAID

- ***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 $2,850 in total drug costs ($2,960 for 2015), the participant is in the coverage gap. The coverage gap ends when the participant has spent $4,550 ($4,700 for 2015) out of pocket for drug costs in a calendar year. In 2010, the ACA provided a $250 rebate for all Medicare Part D enrollees who entered the donut hole. Starting in 2011, the ACA provides discounts on brand-name drugs and generic drug coverage in the donut hole. The donut hole gap will be filled by 2020.
- ***Medicaid Flexibility for States***. Under the ACA, states have the option to cover additional individuals under Medicaid. States will be able to cover parents and childless adults who have incomes up to 133 percent of the federal poverty level (FPL).

FEES AND TAXES

- ***Small Business Tax Credit***. The first phase of the small business tax credit for qualified small employers began in 2010. Eligible employers can receive a credit for contributions toward employees' health insurance. The credit is up to 35 percent of the employer's contribution. There is also up to a 25 percent credit for small tax-exempt organizations. The tax credits increased up to 50 percent of premiums in 2014, when the health insurance Exchanges became operational. However, the eligibility rules for the tax credit also changed in 2014 and require small employers to purchase insurance through an Exchange to be eligible for the credit.
- ***Indoor Tanning Services Tax***. The ACA imposed an additional 10 percent tax on amounts paid for indoor sun tanning services.

2011

EXPANDED INSURANCE COVERAGE

- ***Community Living Assistance Services and Supports Program (CLASS Act)***. The ACA created a voluntary, long-term care insurance program for disabled adults. Although the program was technically effective Jan. 1, 2011, significant portions were not required to be established until 2012. On Oct. 14, 2011, CLASS Act implementation was suspended due to concerns about the program's fiscal sustainability and affordability. On Jan. 2, 2013, the CLASS Act was repealed by legislation approved by Congress and signed by President Obama to avoid the "fiscal cliff."

HEALTH PLAN ADMINISTRATION

- ***Improving Medical Loss Ratios (MLRs)***. 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 MLRs.

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- ***Standardizing the Definition of Qualified Medical Expenses***. The ACA changed the definition of "qualified medical expenses" for health savings accounts (HSAs), health flexible spending accounts (FSAs) and health reimbursement arrangements (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.
- ***Cafeteria Plan Changes***. The ACA created 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/MEDICAID

- ***Medicare Part D Discounts***. To make prescription drugs more affordable for Medicare enrollees, the ACA provided a 50 percent discount on all brand-name drugs and biologics in the donut hole. Additional discounts on brand-name and generic drugs will also be phased in to completely fill the donut hole by 2020 for all Part D enrollees.
- ***Additional Preventive Care Services***. The ACA provided personalized prevention plan services and a free, annual wellness visit for Medicare beneficiaries. The ACA also eliminated cost-sharing for preventive care services beginning in 2011.

FEES AND TAXES

- ***Increased Tax on Withdrawals from HSAs and Archer MSAs***. The ACA 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.

2012

HEALTH INSURANCE REFORM

- ***Additional Preventive Care Services 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 care services without cost-sharing requirements. Effective for **plan years beginning on or after Aug. 1, 2012**, the required preventive care services include specific services for women, including contraceptives and contraceptive counseling. Exceptions to the contraceptive coverage requirement apply to religious employers.

EXPANDED INSURANCE COVERAGE

- ***Community Living Assistance Services and Supports Program (CLASS Act)***. As noted above, the CLASS Act, which would have created a voluntary long-term care insurance program for disabled adults, was technically effective Jan. 1, 2011. However, significant parts of the program, such as enrollment and premium payment rules, were to be established in 2012. CLASS Act implementation was suspended on Oct. 14, 2011, due to concerns on fiscal sustainability and affordability. The CLASS Act was repealed on Jan. 2, 2013.

HEALTH PLAN ADMINISTRATION

- ***Uniform Summary of Benefits and Coverage***. All health plans (grandfathered and non-grandfathered) must provide a uniform summary of the plan's benefits and coverage to participants. The summary must be

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written in easily understood language. Any material mid-year changes to the information contained in the summary must be provided to participants 60 days in advance. The ACA indicated that plans would be required to start providing the summary by March 23, 2012, but this deadline was pushed back. Plans and issuers were required to start providing the summary by the following deadlines:

  - Issuers were required to provide the summary to health plans effective **Sept. 23, 2012**;
  - Plans and issuers were required to 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 have provided the SBC 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 must disclose the value of the health coverage they provide to each employee on the employee's annual Form W-2. This requirement was effective, but optional, for the 2011 tax year and is mandatory for later years for most employers. Form W-2 reporting is optional for small employers (those filing fewer than 250 Forms W-2) until further guidance is issued. However, employers that file at least 250 Forms W-2 must comply for 2012 and future years.
- ***Medical Loss Ratio (MLR) Rebates***. Sponsors of fully-insured plans may qualify for a rebate from their health insurance issuers due to the MLR rules. The MLR rules require insurance companies to spend a certain percentage of premium dollars on medical care and health care quality improvement, rather than administrative costs. Any portion of a rebate that is a plan asset must be used for the exclusive benefit of the plan's participants and beneficiaries. This may include, for example, reducing participants' premium payments.

FEES AND TAXES

- ***Patient-centered Outcomes Research Institute (PCORI) Fees***. Effective for plan years ending on or after Oct. 1, 2012, issuers and sponsors of self-insured health plans must pay PCORI fees to fund health care research. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. Thus, for calendar year plans, the PCORI fees will be effective for the 2012 through 2018 plan years. For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the fee is **$1 multiplied by the average number of lives covered under the plan**. The fee goes up to **$2** for plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, and will be indexed for future years. PCORI fees must be reported and paid by July 31 of each year. The first due date for paying PCORI fees was July 31, 2013.

2013

HEALTH PLAN ADMINISTRATION

- ***Administrative Simplification***. In 2013, health plans must adopt and implement uniform standards and operating rules for electronic exchange of health information to reduce paperwork and administrative burdens and costs. For example, effective Jan. 1, 2013, health plans must comply with HHS's operating rules for electronic health care transactions regarding eligibility for health plan coverage and health care claim status.
- ***Limiting Health FSA Contributions***. Effective for plan years beginning in 2013, the ACA limits the amount of salary reduction contributions to health FSAs to **$2,500 per year**. On Oct. 31, 2013, the IRS announced that the health FSA limit will remain at $2,500 for taxable years beginning in 2014. However, the $2,500 limit potentially will be indexed for cost-of-living adjustments for later years.

  Employee Notice of Exchanges. Employers must provide a notice to employees about the Exchanges. The original deadline, set for March 1, 2013, was delayed. On May 8, 2013, the DOL announced a compliance

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deadline of **Oct. 1, 2013**. The DOL also issued model language for employers that do not offer a health plan and model language for employers who offer a health plan to some or all employees. On Sept. 11, 2013, the DOL issued an FAQ announcing that there are **no fines or penalties under the ACA for failing to provide the notice**. Thus, employers cannot be fined for failing to notify employees about the ACA's Exchanges.

- ***HIPAA Certification***. By Dec. 31, 2013, group health plans must certify that they comply with certain HIPAA rules on electronic transactions. On Dec. 31, 2013, HHS issued a proposed rule that **extends the initial certification deadline to Dec. 31, 2015**.

FEES AND TAXES

- ***Eliminating Deduction for Medicare Part D Subsidy***. In the past, employers that received the Medicare Part D retiree drug subsidy were permitted to take a tax deduction for their prescription drug costs, including costs attributable to the subsidy. The deduction for the retiree drug subsidy was eliminated in 2013.
- ***Increased Threshold for Medical Expense Deductions***. The ACA 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 may claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- ***Additional Medicare Tax for High Wage Workers***. The ACA increases the Medicare 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 ACA established a 2.3 percent excise tax on the first sale for use of medical devices. 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 exempted from the tax.
- ***PCORI Fees***. For plan years ending on and after Oct. 1, 2012 and before Oct. 1, 2019, self-insured plans and issuers must pay fees per covered life. The initial fee is $1 per covered life, increasing to $2 per covered life for plan years ending on or after Oct. 1, 2013 (and adjusted annually for later plan years). The first possible payments were due on July 31, 2013.

2014

COVERAGE MANDATES

- ***Individual Coverage Mandate***. The ACA requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty starts at $95 per person for 2014. 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 pay half the penalty amount for children, up to a cap of three times the adult penalty for that year. Individuals may be eligible for an exemption from the penalty in certain circumstances (for example, if they cannot afford coverage).
- ***Employer Coverage Mandate***. See the 2015 section below. The employer mandate provisions were set to take effect on Jan. 1, 2014, but have been delayed for one year, until 2015. Employers with 50-99 full-time employees may qualify for an additional one-year delay, until 2016.

HEALTH INSURANCE EXCHANGES

The ACA requires each state to establish a **health insurance Exchange** (or Marketplace) in 2014. Individuals and small employers are eligible to shop for insurance through the Exchanges.

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- ***Small Business Health Options Program (SHOP)***. The Exchange for small employers is called the Small Business Health Options Program (SHOP). Small employers are those with up to 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. However, states may limit employers' participation in the Exchanges to businesses with up to 50 employees until 2016. States may allow large employers with over 100 employees to participate in the Exchanges in 2017.
- ***State Options***. States have three main options with respect to their Exchange. They can:
    - Establish and run a **state-based Exchange**;
    - Have HHS establish a **federally-facilitated Exchange (FFE)** for their residents; or
    - **Partner with HHS** so that some FFE functions can be performed by the state.

  A state may also elect to partner with HHS so that the state runs the SHOP Exchange and HHS runs the individual market Exchange.
- ***SHOP Employee Choice Model***. On June 4, 2013, HHS delayed implementation of the employee choice model as a requirement for all SHOPs for one year, until 2015. The federally-facilitated SHOP (FF-SHOP) will not provide the employee choice model for small employers until 2015. For 2014 plan years, the FF-SHOP will assist employers in choosing a single QHP to offer their qualified employees. Beginning in 2014, many state-operated Exchanges offer the employee choice model, including California, New York and Colorado, among others.

  Also, HHS has proposed an additional one-year transition policy for the employee choice model for certain SHOPs. The proposal would allow a state's insurance regulators to recommend that, in 2015, a SHOP not provide the employee choice model to employers if:
    - Making the employee choice option available would result in significant adverse selection in the state's small group market, resulting in market disruptions that could not be addressed by the premium stabilization programs or single risk pool; or
    - There would be insufficient issuers of QHPs or qualified stand-alone dental plans to allow for meaningful choice between plans.

  State regulators would submit their recommendations to the SHOP (or to HHS for FF-SHOPs). The SHOP would evaluate the state's recommendation and determine whether the state's small group market would be significantly adversely affected by the implementation of employee choice in 2015. In the FF-SHOPs, HHS would seek public comment on the state's request regarding employee choice before making this determination. HHS expects that SHOPs would reach a decision about employee choice no later than early Fall 2014.
- ***Free Choice Voucher***. The ACA provided that workers who qualified for an affordability exemption to the individual mandate, but did not qualify for tax credits, could use their employer contribution to enroll in an Exchange plan. This requirement is known as the "free choice voucher" provision. The federal appropriations bill, enacted on April 15, 2011, eliminated the free choice voucher provision.

HEALTH INSURANCE REFORM

Additional health insurance reform measures are effective in 2014.

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

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3/10; BK 4/14

Health Care Reform Timeline

- ***Pre-existing Condition Exclusions***. Effective for plan years beginning on or after 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 in the individual and small group markets may not charge higher rates due to heath status, gender or other factors. Premiums may vary based only on age (no more than 3:1), geography, family size and tobacco use. The rating limitations will not apply to health insurance issuers in the large group market unless the state elects to offer large group coverage through the state Exchange (beginning on or after 2017). Also, these restrictions do not apply to grandfathered coverage.
- ***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 are permitted until 2014. However, for plan years beginning in 2014, plans and issuers may not impose annual dollar limits on the coverage of essential health benefits.
- ***Excessive Waiting Periods***. Group health plans and health insurance issuers offering group or individual health insurance coverage may not require a waiting period of more than 90 days.
- ***Coverage for Clinical Trial Participants***. Non-grandfathered group health plans and insurance policies may not 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 must 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 are subject to limits on cost-sharing or out-of-pocket costs for essential health benefits. The cost-sharing limits include both an overall annual limit (or an out-of-pocket maximum) and an annual deductible limit.

  On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, which **repeals the ACA's annual deductible limit**, effective as of the date that the ACA was enacted (March 23, 2010). Due to the actuarial value exception provided under the final rule, this repeal may not significantly impact small employers. However, it will give small employers with insured plans more flexibility to offer higher deductible health plans (which typically have lower premiums). The repeal of the annual deductible limit did not impact the out-of-pocket maximum, which remains in effect for all non-grandfathered health plans.

  The deductible limit applied only to non-grandfathered insured plans in the small group market. The out-of-pocket limit applies to all non-grandfathered health plans. The final rule allowed a health plan to exceed the ACA's deductible limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier—bronze, silver, gold or platinum) without exceeding the limit.

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For 2014, the out-of-pocket maximum limit is $6,350 for self-only coverage and $12,700 for family coverage. The deductible limit was $2,000 for self-only coverage and $4,000 for family coverage. On March 5, 2014, HHS announced the cost-sharing limits for 2015 in the 2015 Notice of Benefit and Payment Parameters Final Rule. The 2015 deductible limit was set at $2,050 for self-only coverage and $4,100 for family coverage. The 2015 out-of-pocket maximum limit is $6,600 for self-only coverage and $13,200 for family coverage.

- ***Risk-spreading Mechanisms***. The ACA includes reforms related to insurance risk allocation in 2014, through reinsurance, risk corridors and risk adjustment. These reforms are intended to protect against risk selection and market uncertainty as insurance changes and the Exchanges are implemented. The reinsurance program, which operates from 2014 through 2016, requires health insurance issuers and self-insured plans to make contributions based on a federal contribution rate. States may collect additional contributions on top of the federal contribution rate. For the 2015 and 2016 benefit years, self-insured plans that do not use a third party administrator for their core administrative functions are exempt from paying reinsurance fees.

EMPLOYER WELLNESS PROGRAMS

Under the ACA, nondiscrimination rules for employer wellness programs are changed slightly. Existing wellness rules under HIPAA allow wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. In 2014, the ACA increases the potential incentive to 30 percent of the premium for employee participation in the program or meeting certain health standards. The ACA also increases the maximum reward for wellness programs designed to prevent or reduce tobacco to 50 percent of the cost of health coverage. Employers must offer an alternative standard to employees for whom it is unreasonably difficult or inadvisable to meet the standard.

FEES AND TAXES

- ***Individual Health Care Subsidies***. The ACA makes subsidies available through the Exchanges to ensure that people can obtain affordable coverage. Subsidies 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 subsidies apply to both premiums and cost-sharing.
- ***Small Business Tax Credit***. The second phase of the small business tax credit for qualified small employers is implemented in 2014. Eligible small employers that purchase group health coverage through an Exchange may receive a tax credit for health insurance contributions. In 2014, the maximum credit increases to 50 percent of premiums paid for taxable small employers, and 35 percent of premiums paid for tax-exempt small employers. Beginning in 2014, the credit is only available to an employer for two consecutive taxable years.
- ***Health Insurance Providers Fee***. The ACA 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.

2015

EMPLOYER COVERAGE MANDATE

Applicable large employers (ALEs) with **50 or more full-time employees** (including full-time equivalent employees, or FTEs) that do not offer health coverage to their full-time employees (and dependents) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a subsidy for coverage through an Exchange. These requirements are known as the "employer shared responsibility" or "pay or play" provisions.

On Feb. 12, 2014, the Treasury published final rules implementing the employer mandate. The final rules include **transition relief** to help ALEs comply with the new requirements.

- ***Effective Date Delay***. The employer mandate was set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury delayed the employer mandate penalties and related reporting requirements for one year,

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3/10; BK 4/14

until 2015. Therefore, **these payments will not apply for 2014**. On July 9, 2013, the IRS issued Notice 2013-45 to provide more formal guidance on the delay. No other ACA provisions were affected by the delay.

ALEs with **100 or more full-time employees** (including FTEs) will be subject to the employer mandate starting in 2015. However, the final rules delay implementation for eligible medium-sized employers for an additional year. Under this transition rule, ALEs with **fewer than 100 full-time employees** (including FTEs) will generally have an additional year, **until 2016**, to comply with the employer mandate.

- ***Transition Relief for Penalties***. The final rules also include transition relief for determining an employer's liability for a penalty for 2015. The penalty amount for not offering health coverage to substantially all full-time employees (and dependents) is $2,000 annually for each full-time employee, excluding the first 30 full-time employees. For 2015, instead of excluding the first 30 employees, an ALE with at least 100 full-time employees (including FTEs) may exclude the first 80 full-time employees under this calculation.

  Also, under the final rules, an ALE will satisfy the requirement to offer coverage to substantially all of its full-time employees for 2015 if it offers coverage to at least **70 percent** of its full-time employees. In 2016 and beyond, to meet this requirement, an ALE must offer coverage to all but five percent (or, if greater, five) of its full-time employees and dependents.

  ALEs who offer health coverage, but whose employees receive subsidies because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of up to $3,000 annually for each full-time employee receiving a subsidy, with a maximum annual fine of $2,000 per full-time employee, excluding the first 30 employees (80 employees for 2015 for ALEs with 100 or more full-time employees).

EMPLOYER REPORTING REQUIREMENTS

Internal Revenue Code section 6056 requires ALEs subject to the employer mandate to report certain information on the health plan they offer to the IRS. Related statements must also be provided to employees. These reporting requirements were also delayed for one year, until 2015. In preparation for the application of the employer mandate in 2015, the IRS is encouraging affected entities to voluntarily comply for 2014 with the reporting rules and to maintain or expand health coverage in 2014.

On March 5, 2014, the IRS issued final rules on the section 6056 reporting requirements, which apply for **calendar years beginning in 2015**. The final rules provide a general method and alternative methods for reporting, designed to simplify and reduce the cost of reporting. The first returns are due in 2016 for coverage provided in 2015.

HEALTH PLAN ADMINISTRATION

- ***HIPAA Certification***. The ACA requires group health plans to certify that they comply with certain HIPAA rules on electronic transactions. The ACA included an initial certification deadline of Dec. 31, 2013. However, on Dec. 31, 2013, HHS issued a proposed rule that extends the initial certification deadline to **Dec. 31, 2015**.

2018

TAXES AND FEES

- ***High-cost Plan Excise Tax***. Beginning in 2018, the ACA imposes a 40 percent excise tax on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as the "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.

This Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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3/10; BK 4/14