

Health Care Reform Overview - Upcoming Changes - REVISED

Note: Chart has been reorganized from the original chart to reflect the revised effective dates.

Note: The changes listed below generally apply to all group health plans, including both fully insured and self-insured plans. However, the changes marked with an asterisk (*) will **not** apply to “grandfathered” plans.

“Grandfathered Plans” are defined as those health plans (both fully insured and self-insured) that were in effect as of the date of enactment of the initial health care reform law, i.e., March 23, 2010. If a plan qualifies as a “grandfathered” plan, it will not have to comply with some of the health insurance reforms included in these laws. A plan may lose its grandfathered status in a number of ways, including change in coinsurance levels, change (above a certain threshold) in deductibles, copays, and/or out-of-pocket limits, and change (above a certain threshold) in percentage of employer contribution to premium.

Provision	Details	Effective Date
Provisions In Effect Now		
Tax Credits for Small Employers	<ul style="list-style-type: none"> - Applies to employers with 25 or fewer employees (FTEs) and average annual wages of \$50,000 or less - Employers must provide health insurance to employees - Tax credits available on a sliding scale - Full tax credit (equal to 35% of employer contribution towards health insurance premium) available to employers with 10 or fewer employees with average annual wages of \$25,000 or less 	Immediately
Reinsurance Program for Non-Medicare Retirees	<ul style="list-style-type: none"> - Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare - Program will reimburse a portion (up to 80%) of the cost of coverage for individual retirees’ claims between \$15,000 and \$90,000 - HHS is responsible for creation of this temporary reinsurance pool - Update: Applications are no longer be accepted due to depletion of available funding. 	6/1/2010
Interim High-Risk Pool	<ul style="list-style-type: none"> - Provides access to insurance for those who are uninsured because of a pre-existing condition through a temporary high-risk pool - Phased out once state health insurance Exchanges are operational in 2014 	7/1/2010
Rescission	<ul style="list-style-type: none"> - Health plans will not be allowed to rescind (cancel) coverage, except in the case of fraud or intentional misrepresentation - Coverage can only be canceled with proper prior notice for non-payment of premiums or termination of the plan - Applies to all plans, including self-insured plans and those with grandfathered status 	First day of new plan year on or after 9/23/2010

Provision	Details	Effective Date
Coverage for Dependent Children	<ul style="list-style-type: none"> - Extended to age 26, regardless of the child's status as a full-time student - Child may be married or unmarried - Child cannot be eligible to enroll as an employee in an employer-sponsored group health plan (this provision is only effective for grandfathered plans, and only through 12/31/2013) - Does not include coverage for the dependent child's spouse and/or children - IRS rules amended to allow coverage for children to be available tax-free through the end of the calendar year in which the child turns age 26; the value of the child's coverage will not be imputed to the employee's income 	First day of new plan year on or after 9/23/2010
Lifetime Maximum Benefits	<ul style="list-style-type: none"> - Lifetime limits may not be imposed on the dollar value for "essential health benefits" - Lifetime limits may apply to non-essential benefits - "Essential benefits" will be defined by the Department of Health and Human Services (HHS), but generally include those benefits covered by most health plans, including hospitalization, physician services, and prescription drugs 	First day of new plan year on or after 9/23/2010
Annual Maximum Benefits	<ul style="list-style-type: none"> - Annual limits may only apply to "essential benefits" as approved by HHS: for plan years beginning from 9/23/2010 - 9/22/2011 - \$750,000; for plan years beginning from 9/23/2011 - 9/22/2012 - \$1.25 million; for plan years beginning from 9/23/2012 - 12/31/2013 - \$2 million - No annual limits on "essential benefits" will be allowed effective 1/1/2014 - Annual limits may apply to non-essential benefits - "Essential benefits" include ambulatory patient services, emergency services, hospitalization, maternity/newborn care, pediatric services, mental health/substance abuse services, prescription drugs, rehab services, lab services, preventive/wellness services, disease management - 	First day of new plan year on or after 9/23/2010
Pre-Existing Condition Exclusions	<ul style="list-style-type: none"> - Pre-existing condition restrictions or exclusions may not be imposed for dependent children under age 19 - Will be extended to include adults effective 1/1/2014 	First day of new plan year on or after 9/23/2010
Coverage of Preventive Health Services *	<ul style="list-style-type: none"> - Requires group health plans to cover certain preventive services without any member cost-sharing (i.e., cover at 100%) - Applies to all preventive services rated A ("strongly recommends") or B ("recommends") by the U.S. Preventive Services Task Force - Covered services include immunizations and screenings for infants, children and adolescents; and breast cancer screenings and mammograms for women 	First day of new plan year on or after 9/23/2010 Does not apply to grandfathered plans
Nondiscrimination - Insured Plans *	<ul style="list-style-type: none"> - Prohibits insured plans from establishing eligibility rules that discriminate in favor of highly compensated individuals - Self-insured plans are already subject to similar rules, under IRS Code Section 105(h) 	First day of new plan year on or after 9/23/2010. Does not apply to grandfathered plans

Provision	Details	Effective Date
Patient Protections *	<ul style="list-style-type: none"> - Group health plans with in-network benefits must allow each plan member to designate any participating primary care provider able to accept that person as a patient - Emergency care services must be covered (where applicable) without requiring prior authorization, and regardless of whether the provider is a participating network provider - Group health plans must have internal and external review and appeals processes in place - Group health plans will be required to submit to HHS, and make available to plan members, information on claims payment policies, rating practices, and other information as required by HHS 	First day of new plan year on or after 9/23/2010 Does not apply to grandfathered plans
Small Group Wellness Program Grants	<ul style="list-style-type: none"> - Creates grants for small employer-based wellness programs 	10/1/2010
HSA Penalty Taxes	<ul style="list-style-type: none"> - The penalty tax on HSA distributions that are used for other than qualified medical expenses will increase from 10% to 20% 	1/1/2011
Over the Counter (OTC) Medications	<ul style="list-style-type: none"> - Nonprescription medications other than insulin will not be eligible for reimbursement under health reimbursement arrangements (HRAs), health savings accounts (HSAs), or health flexible spending accounts (FSAs), unless prescribed by a physician 	1/1/2011
Federal Study on Self-Insured Plans	<ul style="list-style-type: none"> - Mandates annual studies by the DOL using data collected from Form 5500 returns - Studies to include general info on self-insured group health plans, as well as data from financial filings of self-insured employers 	By March 2011
Provisions Yet To Be Implemented		
Medicare Part D Annual Enrollment Period	<ul style="list-style-type: none"> - The annual enrollment period for Medicare Part D and Medicare Advantage plans has been changed. Plan sponsors that provide prescription drug coverage to Medicare-eligible individuals are required to provide Notice of Creditable (or Non-Creditable) Coverage. Previously notice needed to be provided by November 15, now notices need to be provided prior to October 15. 	October 15, 2011
Advance Notice Requirements	<ul style="list-style-type: none"> - Insurance companies and self-insured group health plans must provide 60 days advance notice before any material modifications are made to the plan - Updated: Interim rules were released 8/22/11. Effective 3/1/12. Will not apply to changes made during annual enrollment. 	Proposed effective date is March 2012
Summary of Benefits	<ul style="list-style-type: none"> - Plan must provide standard, understandable summary of health plan benefits (in addition to SPD) - Updated: Interim regulations issued on 8/22/11 including template summary form. Effective 3/1/12. 	By March 2012
Women's Preventive Healthcare Services* (New)	<ul style="list-style-type: none"> - Preventive health care services further defined to include Women's Preventive Health Care services. Include birth control methods. Expands the list of services previously addressed. These services are required to be covered at 100%. More clarity needed on elements of this requirement. 	First plan year on or after 8/1/2012

Provision	Details	Effective Date
Tax on Group Health Plans to Fund Comparative Effectiveness Research	<ul style="list-style-type: none"> - Federal premium tax equal to \$2 annually for each covered person. - Financing mechanism to fund Patient Centered Outcome Research 	First plan year ending after 9/30/2012; through 2019
W-2 Reporting	<ul style="list-style-type: none"> - Employers will be required to report the aggregate cost of employer-sponsored health insurance coverage on employees' W-2 forms - Revised – Employers filing fewer than 250 W-2 forms won't have to report until the IRS issues further guidance, which is likely to be for calendar year 2013. Large employers, filing more than 250 W-2 forms, will be subject to reporting beginning in calendar year 2012. 	Delayed until tax year 2012 with first reports due January 2013 (<i>large employers</i>)
CLASS Act – Long Term Care	<ul style="list-style-type: none"> - Establishes a new public insurance program for purchasing long term care insurance through employer payroll deductions - Requires employers to automatically enroll eligible employees, unless the employee opts out - Voluntary for employers to participate - Secretary of HHS has until 2012 to finalize plan details, determine premium rates, and benefit levels 	Delayed until late 2012.
FSA Limit	<ul style="list-style-type: none"> - Maximum contribution for pre-tax medical reimbursement plan \$2,500 per year (indexed for inflation) 	Taxable years beginning after 12/31/2012
Increased Medicare Tax	<ul style="list-style-type: none"> - Increased Medicare payroll tax for individuals earning over \$200,000 and joint filers earning over \$250,000; additional 0.9% Medicare Hospital Insurance tax - Does not change employer Hospital Insurance tax obligation - New 3.8% Medicare contribution tax on certain unearned income for high earners 	1/1/2013
Employer Subsidy of Medicare Part D Premiums	<ul style="list-style-type: none"> - Phase out of corporate deduction for subsidized Medicare Part D payments - FAS 109 requires employers to immediately take a charge against current earnings to reflect higher FAS 106 liability and higher anticipated tax costs 	1/1/2013; however, immediate accounting impact
Pre-Existing Conditions Exclusions	<ul style="list-style-type: none"> - Pre-existing condition restrictions or exclusions may not be imposed for adults as well as for children 	1/1/2014
Waiting Period Requirements	<ul style="list-style-type: none"> - Prohibits waiting periods in excess of 90 days for all plans, including grandfathered plans. 	1/1/2014
Employer Wellness Plans	<ul style="list-style-type: none"> - Expands HIPAA bona fide wellness program rules - Increases the value of workplace wellness program incentives to 30% of premium - Cap on incentives possibly increased to 50% (HHS) 	For plan years beginning on or after 1/1/2014

Provision	Details	Effective Date
Coverage Documentation and Reporting	<ul style="list-style-type: none"> - Health plans (including self-insured plans) will be required to provide coverage documentation to covered individuals and the IRS - Must provide report to HHS and enrollees on whether plans include certain specified components, including quality reporting measurements - HHS will make reports available via Internet; can impose penalties for noncompliance 	1/1/2014
Definition of “Small Group” and Community Rating Requirements	<ul style="list-style-type: none"> - “Small group” coverage will be defined as including groups with 1-100 employees (although states may choose to reduce this number to 50 employees for plan years prior to 1/1/2016) - All fully insured groups of 100 or fewer lives will be required to follow strict modified community rating standards, with limited premium variations allowed - Experience rating to be prohibited for groups with 100 or fewer employees 	1/1/2014
State-Based Exchanges	<ul style="list-style-type: none"> - Each state will be required to create an Exchange through which qualified benefit plans may be sold (as well as “catastrophic” plan for individuals age 30 and younger) - Four levels of qualified benefit plans, with standardized benefits - Includes some mandated benefits, cost-sharing requirements, and out-of-pocket limits, as well as minimum actuarial value of 60% (these requirements do not apply to employer-sponsored plans offered outside of the Exchange) - Insurance coverage may be purchased through the Exchange by individuals and small employers (100 or fewer employees) <p>Updated: The Maine legislature held over 2 bills from the 2011 session, and passed a resolve to form a committee to study the creation of an Exchange in Maine. The committee will report to the legislature in fall of 2011.</p>	1/1/2014
Tax Credits for Lower Income Individuals	<ul style="list-style-type: none"> - Non-Medicaid eligible individuals with income up to 400% of FPL may be provided with premium assistance tax credits (sliding scale) to buy coverage through the Exchange 	1/1/2014
Employee Free Choice Requirements (Revised)	<ul style="list-style-type: none"> - Repealed (Had it remained in effect, it would have required employers who offer employer subsidized health insurance coverage to offer a voucher for employees to purchase coverage through a health care exchange when certain income conditions were met.) 	Repealed

Provision	Details	Effective Date
Employer Mandate	<ul style="list-style-type: none"> - Applies to employers with average of 50 or more FTEs in prior calendar year - FTE is defined as an employee working on average 30 or more hours per week (added to chart) - Employers must offer minimum essential coverage - Penalty calculated based on number of full-time employees, excluding the first 30 employees - Penalty applied on PEPM basis - Amount of penalty depends on whether employer offers coverage - If no coverage, and one or more employees obtain coverage through Exchange: annual penalty = \$2,000 per employee - If coverage, but one or more employees obtain coverage through Exchange: annual penalty = lesser of \$2,000 per employee, or \$3,000 per employee covered through Exchange 	1/1/2014
Individual Mandate	<ul style="list-style-type: none"> - Individuals must have qualifying health insurance coverage or be assessed a penalty - Qualifying coverage includes both employer-sponsored and individual coverage - Penalty is the greater of flat dollar amount (starting with \$95 in 2014, increasing to \$695 in 2016) or percentage of taxable household income (starting with 1% in 2014, increasing to 2.5% in 2016) 	1/1/2014
Medicaid Expansion	<ul style="list-style-type: none"> - Medicaid eligibility expanded to 133% of FPL - Federal government will pay 100% of the cost of this expansion until 2017, then will phase in states' contributions - For 2020 and after, federal government's match will be 90% of cost 	1/1/2014
Large Groups in Exchange	<ul style="list-style-type: none"> - Employers with >100 employees will be allowed to join the Exchange 	1/1/2017
Cadillac Tax	<ul style="list-style-type: none"> - 40% excise tax on "excess value" of high cost employer-provided insurance - Tax applies to plans with aggregate annual value in excess of \$10,200 (individual) / \$27,500 (family) - Higher limits for retirees over age 55, and employees in certain high-risk professions, as well as 17 identified high-cost states (as determined by HHS based on average premium costs in 2012) 	1/1/2018
Auto-Enrollment by Employers	<ul style="list-style-type: none"> - Requires employers with 200 or more employees to auto-enroll all new employees into any existing employer-sponsored health insurance plan - Employees may opt out if they have other coverage 	Unclear

Note: We have included those provisions that we feel may have an impact on our clients' health insurance programs, benefits, and costs. There are many other provisions included as part of the health care reform laws (for example, tax on tanning salons; tax on medical devices; etc.) that may not be listed in this summary. We would be happy to provide further information if requested.

Sources:

- *Health Care Reform – Impact on Employers and Employer-Sponsored Health Plans, Kilpatrick Stockton LLP, Legal Alerts, 3/30/2010*
- *Stat! Health Reform Weekly – Summary of the Patient Protection and Affordable Care Act, Segal Company, 3/29/2010*
- *Affordable Health Care for America, Key Provisions That Take Effect Immediately, Prepared by House Ways & Means Committee, 3/22/2010*
- *Affordable Health Care for America, Implementation Timeline, Prepared by House Ways & Means Committee, 3/18/2010*
- *Health Care Reform At-A-Glance, Buck Consultants, 3/29/2010*
- *Focus on Health Reform, Summary of New Health Reform Law, Kaiser Family Foundation, 3/26/2010*
- *Focus on Health Reform, Health Reform Implementation Timeline, Kaiser Family Foundation, 4/27/2010*
- *U.S. Senate, The Patient Protection and Affordable Care Act, Immediate Benefits*
- *National Association of Health Underwriters, Timeline of Health Insurance Reforms that Will Impact Private Health Insurance, 4/1/2010*
- *National Association of Insurance Commissioners, Patient Protection and Affordable Care Act of 2009: Immediate Health Insurance Market Reforms, Updated 4/20/2010*
- *Demystifying Health Care Reform, Eric Altholz, Verrill Dana, 4/29/2010*
- *Health Reform: Implications for Maine, Andrew Coburn, USM Muskie School, 5/12/2010*
- *Capital Checkup, June 29, 2011, “Medicare Part D Annual Enrollment Period Pushed Forward to October 12.”*
- *Health Resources and Services Administration; Women’s Preventive Services: Required Health Plan Coverage Guidelines, August 1, 2011.*

Some Government Resources, for more info:

- *The White House <http://www.whitehouse.gov/healthreform>*
- *Health and Human Services Web pages <http://www.healthcare.gov>*
- *Department of Labor Web page <http://www.dol.gov/ebsa/healthreform/>*
- *Internal Revenue Service Web page <http://www.irs.gov/newsroom/>*