PPi Benefit Solutions

# HEALTH CARE REFORM: EMPLOYER ACTION OVERVIEW

**This abbreviated health care reform timeline can help employers quickly understand what steps they should take for compliance.**

| MARCH 23, 2010 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Nursing Mothers –** Employers must provide a reasonable break time for non-exempt employees who are nursing mothers to express breast milk for a period of one year following the birth of the child. Bathrooms are not considered an appropriate place. Employers are not required to pay employee during break unless state mandated. | Yes, employers must establish an appropriate space for nursing mothers who are non-exempt employees. | |
| **Grandfathered Health Plans –** Group health plans and health insurance policies that were in existence on March 23, 2010, are excused from some of the health care reform requirements. Certain changes in plan terms can, however, cause a plan to lose its grandfathered status. | If the employer wants to maintain grandfathered status, the employer must provide the required annual notice and ensure any plan changes do not cause loss of grandfathered status. Available indefinitely | |

| SEPT. 23, 2010 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Adult Dependent Coverage –** Plans that offer dependent coverage must extend coverage up to age 26, regardless of marital status, residency, student status, etc. Grandfathered plans are no longer exempt if the dependent is eligible for other employer-sponsored coverage, effective Jan. 1, 2014. | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Provide required model notice. | |
| **Lifetime Dollar Limits –** Lifetime limits on the dollar value of essential benefits are prohibited for plans beginning on or after Sept. 23, 2010. | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Provide required model notice. | |

| SEPT. 23, 2010 CONT'D | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Annual Dollar Limits –** Annual limits on the dollar value of essential health benefits must meet the required minimums. The limits are graduated, with the minimum annual dollar limit for plan years beginning on or after Sept. 23, 2010, of $750,000; $1.25 million for plan years on or after Sept. 23, 2011; and $2 million for plan years beginning on or after Sept. 23, 2012. Annual limits on the dollar value of essential health benefits are prohibited after Jan. 1, 2014. | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Provide required model notice. | |
| **Prohibition on Pre-existing Condition Exclusions (PCE) –** PCEs are prohibited for children under 19 years. (In 2014 the PCE exclusion extends to all persons regardless of age.) | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Determine whether any children were previously denied for a pre-existing condition. | |
| **Rescissions –** Rescission of coverage (retroactive terminations) is prohibited unless there is evidence of fraud or material misrepresentation. | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Ensure coverage is not terminated retroactively, except in the limited conditions permitted. | |
| **Mandated Preventive Care Coverage –** Plans must provide coverage of certain preventive services with no cost sharing. Go to www.healthcare.gov for an updated list of mandated preventive services. Does not apply to grandfathered plans. | Yes, if the plan is not grandfathered, then communicate to employees during open enrollment and amend plan documents accordingly. | |
| **Emergency Services –** Coverage must be provided for emergency services at in-network cost levels, regardless of whether the provider is in or out of network. Does not apply to grandfathered plans. | Yes, if the plan is not grandfathered, amend plan documents and communicate to employees during open enrollment. Provide required model notice. | |
| **Primary Care Physician Designation –** Enrollees may designate any in-network primary care physician (PCP) as their PCP if one is required; a plan may not require a referral for OB/GYN services. Does not apply to grandfathered plans. | Primary Care Physician Designation – Enrollees may designate any in-network primary care physician (PCP) as their PCP if one is required; a plan may not require a referral for OB/GYN services. Does not apply to grandfathered plans. | |
| **Rate Review –** A new process requires insurers to justify rate increases. Carriers may be barred from participating in the state health insurance exchange if the state determines rate increases are unjustified. | Informational only. | |
| **Small Business Tax Credit –** Certain small employers are eligible for a tax credit, provided they contribute at least 50 percent toward their employees' health insurance. For tax-exempt small employers, themaximum credit is 25 percent (versus 35 percent for other employers) for tax years 2010 through 2013. | Yes, small employers should claim the credit starting with their 2010 annual income tax return if applicable. | |

| 2011 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **OTC Medicine –** Over-the-counter drugs are not eligible for reimbursement under health flexible spending arrangements (FSAs), health savings accounts (HSAs) and health reimbursement arrangements (HRAs) without a prescription. | Yes, communicate to employees during open enrollment and amend plan documents accordingly. Work with any third-party administrators to revise electronic payment cards. | |
| **Revised Claims and Appeal Procedures –** New claims and appeal procedures have been expanded to include, among other things, external review by an independent review organization. Does not apply to grandfathered plans. The new procedures are being implemented in three stages, with various effective dates. For example, the 72-hour initial Adverse Benefit Determination notice and the Culturally and Linguistically Appropriate notice were not effective until plan years beginning on or after Jan. 1, 2012. The non-English version of the Culturally and Linguistically Appropriate notice requirement must now be provided to certain participants upon request. | Yes, if the plan is not grandfathered, amend plan documents and communicate to employees during open enrollment. Develop new policies and procedures for internal and external appeals. Provide required model notice. | |
| **Cafeteria Plan Safe Harbor –** Small employers (100 or fewer employees) are allowed to adopt new "simple cafeteria plans." These plans are treated as meeting the nondiscrimination requirements. | Yes, small employer action is required if the employer would like to implement this plan design. Contact your advisor for more information. | |

| 2012 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Medical Loss Ratio Rebates –** Insurance carriers that fail to meet the medical loss ratio (MLR) standards must provide a rebate to policyholders by Aug. 1 following the MLR reporting year. | Yes, if the employer receives a rebate check, the employer should determine what portion of the rebate, if any, constitutes ERISA plan assets and distribute such assets according to fiduciary rules. There are separate requirements for distribution of rebates sent to non-ERISA plans. This is an ongoing requirement. | |
| **New Women's Preventive Care Mandate –** Effective for plan years on or after Aug. 1, 2012, group health plans must provide coverage for certain women's preventive care at no cost sharing. Mandated coverage includes well woman visits, HPV testing, contraceptives and more. Religious-based nonprofits had until Aug. 1, 2013, to comply**.** | Yes, if the plan is not grandfathered, then the employer should communicate the new coverage to employees during open enrollment and amend plan documents accordingly. This is an ongoing requirement. | |
| **Employer W-2 Reporting –** Employers must begin tracking the aggregate value of health coverage provided to employees for purposes of reporting on Form W-2s. The aggregate cost of health coverage includes major medical, employer contributions to a health FSA, retiree coverage (unless no W-2 is issued) and certain employee assistance programs and fixed- dollar coverage. There are several exclusions, including HRAs, HSAs and salary reduction contributions to health FSAs. There is an indefinite delay of implementation for employers that file fewer than 2 50 Form W-2s. | Yes, employers – in cooperation with their payroll vendors – need to quantify the value of health coverage to be included on Form W-2s beginning with 2012 compensation. This is an ongoing requirement. | Clients with access to Online bills can view a Cost of Coverage Report for their PPI-administered medical plans in their secure, ppibenefits.com portal. |

## 2012 CONT'D

| | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Summary of Benefits & Coverage (SBC) –** Plan sponsors must provide a new document that summarizes plan information for easier comparison. Information provided includes covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The SBC also provides information about how to access the Uniform Glossary. Effective for plan years beginning on or after Sept. 23, 2012. | Yes, the plan sponsor must provide the SBC during open enrollment, at renewal and upon request within seven days. An insurance carrier or third-party administrator will administer; however, the employer must ensure the information is complete. HHS requires that the SBCconform to the template provided. The SBC may be provided in paper or electronic form in compliance with Department of Labor (DOL) electronic delivery requirements. This is an ongoing requirement. | Clients of fully-insured medical plans receive an SBC specific to their plan and plan year from the insurance carrier. Carrier SBCs can be stored in the SelfEnroll Reference Center, for clients using employee self-service. A model SBC template is available for self-insured clients. |
| **Summary of Material Modification Notice –** This notice must be provided to enrollees 60 days prior to any material modification to the information provided on the most recent SBC. Notice must be provided only for only midyear material modifications. | Yes, if self-funded, the plan administrator or plan sponsor must provide the SBC timely. If fully insured, carrier will administer. The summary may be provided in paper or electronic form and must include certain required content. | Notice can be stored in the SelfEnroll Reference Center, for clients utilizing employee self-service. |
| **Patient Centered Outcomes Research (PCOR) Fee –** Issuers of certain health insurance policies and plan sponsors of self-insured group health plans must pay an excise tax of $1 per average number of covered lives to fund the Patient Centered Outcomes Research Institute. The tax increases to $2 the following year and will increase each year thereafter based on the projected per capita amount of national health expenditures. For the third year, the amount is $2.08 per covered life, and for the fourth year it is $2.17 per covered life. Effective for plan years ending after Oct. 1, 2012. Does not apply to HIPAA excepted benefits but does apply to retiree-only plans. | Employers with self-insured plans (including HRAs and self-insured prescription drug plans) must file Internal Revenue Service (IRS) Form 720 to pay the excise tax by July 31 each year. The fee stops applying for policy/plan years ending after Sept. 30, 2019. (For calendar-year policies/plans, that means the fees would apply for calendar policy/plan years 2012 through 2018.) | AutoEnroll houses the data required to complete the PCORI section of IRS form 720 for self-insured health plans via an integrated analytics tool. The participation analytics displays a point-in-time count of all enrolled members (employees and dependents). |

## 2013

| | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Health FSA Maximum Contribution Limit –** Employee contributions to health FSAs are limited to $2,500 annually, effective for plan years beginning in 2013 and 2014. For plan years beginning in 2015 and 2016, the limit is $2,550. Limit applies on a plan year basis. | Yes, employers should communicate change to employees during open enrollment and amend plan documents accordingly. Amendments must be adopted no later than Dec. 31, 2014, with a retroactive effective date. | AutoEnroll is a rule-based system that forces compliance with spending account contribution limits. |
| **Notice of Exchange –** Employers are required to provide a notice to employees informing them of the existence of the insurance exchanges that will serve as a marketplace to buy insurance coverage. The notice will also describe the availability of tax credits and premium subsidies for qualified individuals. | Yes, employers had until Oct. 1, 2013, to provide this notice to all employees, which coincided with the open enrollment period for exchanges. Employers must continue providing the notice within 14 days of a new employee's start date for employees hired after Oct. 1, 2013. | Sample employee notifications are available with the Health Reform kit on AutoEnroll and in the ppibenefits.com secure client portal.<br><br>Fulfillment service is available for a fee and can include delivery in a variety of mediums, from print and mail to Online or email. |

| 2014 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Waiting Periods –** Group health plans may not implement waiting periods longer than 90 days. | Yes, amend plan documents for first plan year beginning on or after Jan. 1, 2014, if existing waiting period exceeds 90 days. | AutoEnroll is a rule-based system that forces compliance with eligibility regulations. |
| **Annual Dollar Limits –** Annual dollar limits on essential health benefits are completely prohibited. Such limits are permissible for non-essential health benefits. | If plan is self-insured, amend plan design accordingly. Carrier will administer fully insured plan changes. All employers must amend plan documents for first plan year beginning on or after Jan. 1, 2014, to remove any remaining annual dollar limits on essential health benefits. | An *Annual Dollar Limits* handout is available in AutoEnroll in the PPI Health Reform Kit. |
| **Adult Dependent Coverage –** Grandfathered plans that offer dependent coverage were previously able to exclude those under age 26 who were eligible for other employer-sponsored coverage. This provision is no longer in effect. | Yes, grandfathered plans must revisit eligibility requirements and amend plan documents accordingly to remove eligibility exclusion for those dependents with other employer-sponsored coverage. | AutoEnroll is a rule-based system that forces compliance with eligibility regulations. |
| **Health Insurance Exchanges –** As of January 2014, a state-based or federally facilitated health insurance exchange is operational in each state. Health insurance coverage for individuals and small employer groups (groups of 50 or fewer) may be purchased through the exchanges. | No, informational only. | An exchange notification can be delivered for an additional fee.<br><br>Model Exchange Notices are available. |
| **Individual Mandate –** Citizens and legal residents are required to maintain "minimum essential coverage." Those without such coverage will be penalized in the form of a tax. Penalties will be phased in: $95 in 2014 or1 percent of household income; $325 or 2 percent of household income in 2015; and then $695 in 2016 or 2.5 percent of household income; and then adjusted by cost of living thereafter. | No, informational only. | |
| **Premium Tax Credits –** Premium tax credits are available to eligible individuals and families with incomes between 100 and 400 percent of federal poverty level (FPL) to purchase insurance through the health insurance exchanges. Individuals are eligible if they do not have affordable or qualified employer-sponsored coverage available to them. Cost-sharing subsidies are also available through the exchange for lower income individuals in order to reduce out-of-pocket costs. The exchanges will administer the premium tax credits and cost-sharing subsidies. | No, informational only. | |
| **Guaranteed Availability of Coverage and Renewability –** Each health insurance issuer that offers health insurance coverage in the large or small group market is required to accept every employer in the state that applies for coverage. Small groups not meeting minimum participation requirements may be limited to initial application and renewal during the annual open enrollment period. Large groups may be denied renewal for many reasons including failure to meet minimum participation. | No. Carriers will administer. | |

| 2014 CONT'D | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Cost-sharing Limits –** Non-grandfathered group health plans must limit the maximum out-of-pocket limits to $6,350 for self-only and $12,700 for family coverage in 2014. These limits will be adjusted annually for inflation. Effective for plan years beginning in 2014. | Yes, amend plan documents and coverage accordingly. | |
| **Essential Health Benefits (EHB) Package –** Effective for plan years beginning on or after Jan. 1, 2014, individual and small group health coverage must include the EHB package, which means providing EHB, setting limits on cost sharing and providing coverage at specific actuarial levels of coverage. | No. Carriers will administer. | |
| **Prohibition on Pre-existing Condition Exclusions (PCE) –** Group health plans are prohibited from imposing PCEs on any individuals, effective for plan years beginning on or after Jan. 1, 2014. | Review plan documents and amend accordingly to reflect required coverage. Employers and insurers must continue to provide a Certificate of Creditable Coverage until Dec. 31, 2014, regardless of plan year. | |
| **Reinsurance Fee –** Beginning in 2014, each state that operates an exchange is required to establish a temporary reinsurance program for the individual market, to which health insurers and group health plans are required to contribute. The reinsurance program will be in operation from 2014 to 2016. There will be a national uniform contribution rate of $63 per covered life per year ($5.25 per month) payable in 2014 for major medical coverage, including for retiree-only plans and COBRA coverage. The rate decreases to $44 in 2015 and $27 in 2016. For fully insured major medical coverage, insurers are liable for the contributions. They will presumably pass along the cost as part of premiums or other fees. For self-insured plans, the plan is ultimately liable for the contributions, although a third-party administrator can be used to remit the contributions on the plan's behalf. | Self-insured employers and fully insured insurers will report the number of covered lives to HHS by Nov. 15. HHS will then notify the employer of its contribution by Dec. 15. The contribution will be due within 30 days after the employer or insurer receives the contribution notice. | Clients can run a Dependent Census Benefit Report from AutoEnroll to capture the total number of covered lives in the medical plan. |
| **Small Business Tax Credit –** The available tax credit increases for certain small businesses, provided they contribute at least 50 percent toward their employees' health insurance. For tax-exempt small employers, the maximum credit is 35 percent (versus 50 percent for other employers) beginning in 2014. Coverage must be purchased within the Small Business Health Options Program (SHOP) exchange. | Yes, although small employers purchasing coverage through the SHOP exchange are limited to claiming the increased tax credit amounts for two consecutive years. | |

| 2015 | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Employer Mandate –** Applicable large employers with at least 100 full- time employees (including equivalents) during a six-month consecutive period determined by the employer in 2014 may be assessed a penalty under the employer mandate if at least one full-time employee (e.g., one working 30 or more hours/week) receives a premium tax credit in the state exchange. Employees qualify for a premium tax credit if their income is 100–400 percent of FPL and their coverage is unaffordable or does not meet minimum value.<br><br>There are two types of potential penalties: (1) Penalty A applies to employers that do not offer any coverage; and (2) Penalty B applies to employers that offer coverage that is "unaffordable" (using one of three safe harbor methods ensuring coverage is not greater than 9.56 percent for 2015 (9.66 percent for 2016) of household income) or does not meet minimum value (defined as 60 percent actuarial value). For 2015, Penalty A equals $2,080 ($2,160 for 2016) times the number of full-time employees, less the first 80. For 2015, Penalty B equals $3,120 ($3,240 for 2016) times the number of full-time employees receiving the premium tax credit. Penalty B is capped at the amount paid under Penalty A. Neither penalty is tax deductible.<br><br>Transition relief is provided until 2016 for employers with 50–99 full-time employees and equivalents who meet specific requirements to delay compliance. Non-calendar-year plans may be eligible for an additional delay if certain requirements are satisfied. | Applicable large employers must identify and offer coverage to all full-time employees. In addition, large employers must report to the IRS on their employer mandate compliance obligations (see next section "Reporting on Health Insurance Coverage"). The IRS will use this information to administer the employer mandate penalty. Speak to your advisor to calculate affordability of your plan in light of employee compensation and adjust contribution levels as necessary to avoid the penalty. Consider the long-term impact of compensation and composition of workforce (full time vs. part time). Draft employment policy concerning retaliation against individuals receiving premium tax credit. | The ACA StatusTracker℠, powered by Businessolver and available on AutoEnroll allows clients to configure measurement, stability and administrative periods, track overlapping new hire and ongoing employee periods, and apply determined eligibility status directly to employees' records within the same platform. *Charges and fees apply.*<br><br>AutoEnroll tracks when an employee waives coverage. Waive reasons are reportable in AutoEnroll, providing proof of offered coverage, including a time and date stamp of any waived coverage.<br><br>Calculation tools are also are available on HR360, accessible through AutoEnroll and ppibenefits.com. |
| **Reporting on Health Insurance Coverage –** Any person who provides "minimum essential coverage" to an individual must report certain health insurance coverage information to the IRS. There are two types of reports: One applies to insurers and plan sponsors of self-insured plans; the other applies to applicable large employers and offering employers. Reporting is required for 2015 and beyond.<br><br>For 2015, IRS filings are due by May 30 (for paper filings) and June 30, 2016 (for electronic filing). For 2015, employee statements must be distributed by March 31, 2016.<br><br>For 2016 reporting and beyond, employee statements must be distributed by Jan. 31 of the following year, and IRS filings are due by the last day of February (for paper filings) and last day of March (for electronic filings) of the following year. | Yes. Under so-called "6056 reporting", applicable large employers must report to the IRS on whether they offered coverage to all full-time employees and their dependents. This is accomplished by completing and filing Forms 1094-C and 1095-C (Parts I and II). In addition, employers must submit a relevant report of health insurance coverage to the IRS and must also furnish a written statement (or copy of Form 1095-C) to each full-time covered employees.<br><br>Under so-called "6055 reporting", self-insured employers of any size must report to the IRS on all individuals covered under the self-insured plan, This is accomplished on Forms 1094-B and 1095-B, although large self-insured employers can combine 6055 and 6056 reporting by completing Parts I, II and III on Form 1095-C. Self-insured employers must also furnish covered individuals with a statement or a copy of either Form 1095-B or 1095-C. | *PPI will offer support for 6055/6056 reporting. For clients with medical coverage, services can include:*<br>*-Data Collection*<br>*-Final report preparation and filing of Forms 1094 and 1095 (electronic or paper)*<br>*-1095-C Employee Fulfillment*<br><br>*Charges and fees apply.*<br><br>*Accurate data assumes that information in PPI systems is current and accurate, and verified on a regular basis throughout the year.* |

## 2016

| | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Employer Mandate –** Employer Mandate – Transition relief for employers with 50–99 full-time employees and equivalents ends. Such employers must comply with the previously described employer mandate requirements as of the first plan year beginning on or after Jan. 1, 2016. | Applicable large employers must report to the IRS on their employer mandate compliance obligations. The IRS will use this information to administer the employer mandate penalty. Speak to your advisor to calculate affordability of your plan in light of employee compensation and adjust contribution levels as necessary to avoid the penalty. Consider the long-term impact of compensation and composition of workforce (full time vs. part time). Draft employment policy concerning retaliation against individuals receiving premium tax credit. | |
| **Health Insurance Exchanges –** The state-based and federally facilitated health insurance exchange will be expanded to allow groups between 51 and 100 employees to purchase coverage in 2016 (if state allows). | Yes, employers must submit a relevant report of health insurance coverage to the IRS and must also furnish a written statement to covered employees. | |

## 2017

| | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Health Insurance Exchanges –** The state-based and federally facilitated health insurance exchange will be expanded to allow groups over 100 to purchase coverage in 2017 (if state allows). | No, informational only. | |

## 2020

| | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Cadillac Tax Plans –** Beginning in 2020, there will be a 40 percent excise tax on certain plans imposed on insurers and administrators of self-insured plans. To avoid the excise tax, the aggregate value of a health plan may not exceed $10,200 for single coverage and $27,500 for family coverage. (These have been informally estimated by the Congressional Budget Office as $10,800 and $29,100, although those numbers are not yet official.) The total aggregate value is equal to the reimbursement for FSAs or HRAs, employer contributions to HSAs and medical plans. If health care costs increase more than expected, the initial threshold will automatically adjust upward. | Yes, review current plans to determine potential applicability of Cadillac tax and make adjustments to plan design as required prior to 2020. Consider compensation adjustments accordingly. | A Cadillac Tax Modeling Tool is available in the PPI Health Reform Kit on ppibenefits.com and is designed to show the amount of excise tax under PPACA that is likely to be imposed in 2018 on a plan with certain assumptions.<br><br>The model includes easy to use instructions, a worksheet for standard groups, and a worksheet for retired and high-risk professions. |

| COMPLIANCE DATE UNKNOWN | EMPLOYER ACTION REQUIRED | NOTES |
|---|---|---|
| **Auto-enrollment –** Employers with more than 200 full-time employees must automatically enroll new full-time employees in one of the employer's health benefit plans and continue the enrollment of current employees, unless they opt out of coverage. This compliance requirement was repealed. Included here for informational purposes only. | No. This requirement has been repealed. | |
| **Nondiscrimination –** Section 105(h) nondiscrimination requirements are currently applicable to self-insured plans and have been extended to govern fully insured plans under PPACA. This law prohibits employers from establishing eligibility and benefit rules in favor of the highly compensated individuals. Does not apply to grandfathered plans. Enforcement against fully insured plans is delayed until further guidance is released. | Yes, if the plan is not grandfathered, determine whether any of the plan's eligibility rules have the effect of discriminating in favor of highly compensated employees. Change plan design as necessary when guidance is released. | |
| **Quality of Care Reporting –** Group health plans and health insurance issuers must submit an annual report to HHS addressing coverage benefits and provider reimbursement structures that may affect the quality of care in certain specific ways. The effective date is unknown. The Secretary of HHS was required to develop the reporting requirements no later than March 23, 2012, but no formal guidance has been released. | Yes, self-insured employers will have to provide appropriate reports. Insurance carriers will administer for fully insured plans. Guidance forthcoming. | |

**About PPI**

Founded in the 1960's, PPI Benefit Solutions integrates insurance product distribution, benefits technology and support for brokers selling to smaller, mid-market employers. Clients look to PPI Benefit Solutions to simplify, consolidate, and automate enrollment and eligibility, billing, COBRA administration, and compliance. We pride ourselves on delivering the best service and support to our broker, employer, and carrier partners. PPI is a subsidiary of National Financial Partners Corporation®.

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