Healthcare Reform Timeline

Updated September 2016

Effective Dates Uncertain

The effective date of the following provisions is uncertain. Final effective dates will be determined by regulatory guidance yet to be issued.

IRS Nondiscrimination Rules Applicable to Fully-Insured Health Plans

- Employers with fully-insured group health plans are prohibited from providing benefits which discriminate in favor of highly compensated employees, similar to Section §105(h) rules which already apply to self-insured group health plans.
- Effective date delayed - The IRS delayed the enforcement of these rules until plan years beginning some time after the release of regulatory guidance.

Health Plan Identification Number

- On 10/31/2014 the Centers for Medicare and Medicaid Services (CMS) announced an indefinite delay in the Health Plans ID (HPID) requirements applicable under HIPAA to self-funded employer-sponsored health plans. The corresponding certification requirements under the ACA (due 12/31/2015) are also delayed.

2012 - 2013

Summary of Benefits and Coverage (SBC)

- Plans required to provide a Summary of Benefits and Coverage (SBC) to all applicants and participants.
    - Requirements that apply to communications to participants during an annual enrollment period are effective for open enrollment periods that begin on or after 9/23/2012.
    - Requirements that apply to new enrollees other than during an open enrollment period are effective beginning on the first day of the first plan year that begins on or after 9/23/ 2012.
    - Amendments to the 2012 final rules generally apply to plan years beginning on or after 9/1/ 2015. A new template, instructions, and uniform glossary have been made available and must be used for plan years beginning on or after 4/1/17.

Clinical Effectiveness Research Fee ("PCORI" Fee)

- All health plans will pay a fee to fund clinical effectiveness research effective for plan years beginning 11/1/2011. The fee will equal $1 per year per participant for the first year, $2 for the second year, $2.08 for the third year, $2.17 for the fourth year (i.e. plan years ending after 9/30/2015 and before 10/1/2016) and indexed annually after that until it sunsets in 2018.
    - Health insurance companies will pay fee on behalf of fully-insured plans.
    - Plan sponsors of self-funded plans must pay fee by July 31 of the year following the end of the plan year using Form 720 (quarterly excise tax form).

Report Plan Cost on W-2

- Employers must report the value of employees' health coverage (including both employer and employee contributions) on their W-2. Reporting does not result in value of health insurance being treated as taxable income.
- Large employer reporting is mandatory for tax year 2012 (W-2s released January 2013).
- Smaller employers who file fewer than 250 W-2s in the prior year are not required to report.

Medicare Tax

- An additional Medicare tax of 0.9% applies to taxpayers with earned income above $200,000 (single return) or $250,000 (joint return). Employers are not required to match the increase.
- Employers must only withhold additional tax if employee's compensation from that employer exceeds $200,000.

Limit on Health FSA

- Employee annual pre-tax reductions for contribution to a §125 health FSA capped at $2,500 per year (then indexed annually to inflation) beginning with plan years starting on or after 1/1/2013. For 2016, the annual limit is $2,550.

Employee Notice Requirement

- Employers will be required to provide employees with a notice by 10/1/2013 which includes: information on health insurance exchanges, premium subsidies and if the employer's plan meets minimum coverage requirements.
- Employers are required to provide the notice to any new employees hired after 10/1/2013 within 14 days of hire.

2014

Health Benefit Exchanges

- States will establish an insurance Exchange to facilitate the offering of approved, qualified health plans. Exchange coverage initially offered only to individuals and small employers (50-100 employees, depending on the state).
- Federal government will establish an Exchange in states that choose not to implement a state run Exchange.

Individual Health Coverage Mandate

- Individuals who do not enroll in "minimum essential coverage" (MEC) will pay a tax starting at $95 or 1% of income in 2014, increasing to $695 or 2.5% of income per adult by 2016 (tax is half this amount for children) unless meeting one of the recognized exemptions or hardships.

Insurance Market Reforms

- Insurers in the individual and small-group markets subject to various rating and underwriting rules. Rules apply to small group and individual health insurance plans sold both inside and outside an Exchange.
    - Guarantee issue and renewable basis, no health underwriting, no preexisting condition exclusions and limits on permissible premium rating bands
    - Premium rates can only vary premium according to specific criteria including individual or family coverage, rating area and age.

No Lifetime Limits, Restricted Annual Limits on Essential Health Benefits

- Plans may not impose lifetime limits.
- Restrictions on annual limits began in 2012, with no annual limits permitted beginning in 2014.

Cost-Sharing Limitations

- Out-of–pocket (OOP) maximum on essential health benefits limited to those applicable to HSA qualified high deductible health plans in 2014.
- In 2015, OOP maximum on essential health benefits increased to $6,600/$13,200, in 2016 increased to $6,850/$13,700, and in 2017 will increase to $7,150/$14,300. NOTE – these limits differ from HSA OOP limits.
- The preamble to the final HHS Notice of Benefit and Payment Parameters for 2016 set forth a clarification that cost-sharing for an individual covered under a family coverage cannot exceed the individual out-of-pocket maximum amount, even if the plan imposes a higher family out-of-pocket maximum.

Limits on Waiting Periods

- Plan years beginning on or after 1/1/2014 - plan generally cannot impose any waiting period that exceeds 90 calendar days. Exceptions for initial measurement periods that follow Section 4980H requirements, 1-month orientation periods, 1200 cumulative hours of service, and achievement of licensures or certifications

Fees on Certain Plans/Insurers

- Annual fee on health insurance "issuers" (health insurance companies). Does not apply to self-funded plans.

Comprehensive Health Insurance Coverage (Essential Health Benefits)

- A health Insurance issuer offering coverage in the individual or small group market must offer those essential health benefits that are required to be offered on the state exchanges. Employers offering self-funded health plans are not required to cover essential health benefits; however, they must: 1) select an approved state benchmark plan; and 2) ensure that any benefits they cover that are included in that benchmark plan (and that are therefore essential health benefits) comply with the essential health benefits requirements.

Wellness Incentives

- HIPAA limits on financial incentives for participation in health-contingent wellness programs will increase to 30% of the total cost of coverage (but tobacco-related incentives may be 50%).
- Final EEOC rules issued in May 2016 limit incentives for any wellness programs that include disability-related inquiries and/or medical examinations to 30% of the total cost of self-only coverage. This limitation goes beyond existing HIPAA limits and would apply to both participatory and health-contingent wellness programs and also apply regardless of whether or not the incentive is tied to the group health plan. The final rules also permit employers to offer an incentive of up to 30% of the self-only rate for spouses who are asked to provide information about the manifestation of a disease or disorder as part of a wellness program.

Federal Premium Subsidies and Cost Sharing Reductions for Low and Middle-Income Individuals

- Premium subsidies and reduced cost-sharing will be provided to individuals earning between 100-400% of federal poverty level (FPL) who purchase individual health insurance through an Exchange. Individuals eligible for minimum value, affordable employer-sponsored health insurance are not eligible.

Coverage for Clinical Trials; No Discrimination

- Plan cannot deny participation in approved clinical trials or otherwise discriminate based on participating in trials.

Transitional Reinsurance Program

- Fully-insured and self-funded plans (including non-profit) will be responsible to pay a temporary fee from 2014 to 2016, approximated at $63/covered individual for 2014, $44/ covered individual for 2015, and $27/ covered individual in 2016 by the Department of Health and Human Services, to offset high-cost medical claims from the individual market during the first THREE YEARS of the individual mandate's operation.
    - Self-funded, self-administered group health plans are exempt in 2015 and 2016 (but not 2014)
- Self-funded employers must submit via www.pay.gov the number of covered employees to HHS by November 15 (generally based on January-September data) and the payment amount will be provided. The payment may be made in one installment by January 15 or in two installments (e.g.$33 by 1/15/2016 and $11 by 11/15/16).
    - Carriers/Insurers will take care of the submission of enrollment count and payment of fees on behalf of fully-insured plan.

2015

Employer "Play or Pay" Mandate

- Applies to employers with 50 or more full-time equivalents (FTEs), defined as "applicable large employers" (ALEs)
    - Average total FTEs from the previous calendar year are used to determine status as an ALE. Part-time employees are counted on a pro-rated basis to determine if employer is subject to the penalty, but employers are not required to offer coverage to part-time employees.
    - Employers with 50-99 FTEs that meet certain transition relief criteria are not required to comply until 2016
- Employers who do not offer minimum essential coverage (MEC) to at least 95% (70% for 2015 only) of full-time employees may be liable for a monthly penalty of approximately $180 multiplied by the total full-

time employees minus 30 (80 in 2015 only) if at least one full-time employee purchases subsidized individual coverage through a public Exchange.

- Employers who fail to offer coverage that is affordable and provides minimum value may be liable for a monthly penalty of approximately $260 for any full-time employee receiving subsidized individual coverage through a public Exchange.
- Proposed rules provided in early 2016 indicate that while offering a cash opt-out option is allowed, for purposes of determining affordability for potential penalty risk under §4980H(b) and reporting on Line 15 of Form 1095-C, "unconditional" opt-out payments will increase what is considered to be the employee contribution, while "conditional" opt-out payments (i.e. those provided only upon proof of other coverage) meeting certain requirements will not.

2016

Reporting to Government on Plan Coverage

- Section 6055 requires employers offering self-funded minimum essential coverage to report to the IRS about health coverage, including the name and SSN of each covered individual (including dependents) covered by the plan. Such employers will report this data to the IRS using either Forms 1094-B and 1095-B or 1094-C and Part III of 1095-C, and furnish statements (usually copies of Form 1095-B or C) to covered individuals.
- Section 6056 requires applicable large employer (ALE) members to report to the IRS about health coverage offered to full-time employees. ALE members must file Form 1095-C and Form 1094-C with the IRS, and furnish statements (usually copies of Form 1095-C) to full-time employees.
- Reporting timeframes are the same as those for Form W-2 filing (i.e. individual statements due by January 31st and reporting to the IRS due by February 28th (or March 31st if filing electronically).
    - For 2015 only, reporting was delayed. Statements to full-time employees and covered individuals (usually copies of Form 1095-B or 1095-C) were due by 3/31/2016 and reporting to the IRS was due by 5/31/2016 (6/30/2016 if filing electronically).

Exchange Appeal Notices to Employers

- Public Exchanges are required to send notices to employers who have employees that have been approved for tax subsidies toward coverage through the public Exchange. Employers who believe such subsidy was approved in error (i.e. because the employer offered minimum value, affordable coverage) have the option to appeal within 90 days of receiving the notice.

2017

Large Employers and Exchanges

- Beginning in 2017, states may permit large employers (more than 100 FTEs) to purchase coverage through the Small Business Health Options Program (SHOP) Exchanges.

Innovation Waivers

- States may apply for a waiver from certain ACA requirements (e.g., employer shared responsibility, establishment of qualified health plans (QHPs), individual mandate, etc.) for plan years beginning on or after 1/1/2017.

Section 1557 Nondiscrimination Rules

- Covered entities (health programs and activities that receive federal financial assistance administered by HHS) are required for plan years beginning on or after 1/1/17 to provide expanded coverage for transgender services, provide notice to individuals of their rights under Section 1557 nondiscrimination rules generally, and also put appropriate grievance procedures in place.

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2020

Excise Tax on High-Cost Health Plans ("Cadillac Tax")

- A 40% excise tax will apply to the cost of employee health coverage that exceeds $10,200 annually for single coverage and $27,500 for family coverage. (This tax was originally set to take effect in 2018; recent legislation delayed it until 2020.)

FRENKEL BENEFITS
350 Hudson Street, 4th Floor, New York, NY 10014
P: (212) 488-0200 | F: (212) 488-0263 | www.frenkelbenefits.com