

**ALERT:
HEALTH CARE REFORM BILL**

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**WHAT DO
WE DO NOW?
HEALTH CARE
REFORM
TIMELINE**

Federal health care reform is now law, and employers want to know what plan changes are needed to comply and when those changes must be made. This is a lengthy and complicated law, and we will be sorting out how the various provisions work and interact over the next several months or years. Our answers to questions about the law are likely to change as we go forward due to regulatory guidance, additional legislation, court cases and actual experience under the new law. Information about health care reform obligations must therefore be provided with the caveat that health care reform is and will remain a work in progress for many months.

Employee benefits veterans have learned from experience that employers generally are best-served by waiting for as much guidance as possible before investing time and attention on the details and implementation of new legislation. To provide a compact overview of health care reform obligations and help you determine how long you can wait for guidance on them, the timeline below notes the effective dates of the federal health care reform provisions that most directly affect employers. Willis' National Legal & Research Group will be providing detailed compliance information on these requirements as their effective dates approach.

MARCH 23, 2010

- Date of enactment

- Plans in effect on this date are “grandfathered plans,” which get some exemptions from compliance

WITHIN 90 DAYS

- Availability of reimbursement for large claims under early retiree coverage

SEPTEMBER 23, 2010

- Group health plans – including, for most items, self-insured plans – start becoming subject to “insurance” reforms (see items listed for January 1, 2011) as of the dates their plan years begin

JANUARY 1, 2011

- Group health plans – including, for most items, self-insured plans – that are calendar year plans become subject to “insurance” reforms:
 - Lifetime dollar limits on essential benefits prohibited
 - Annual dollar limits on essential benefits prohibited (subject to exceptions defined by HHS)
 - Rescissions prohibited except in cases of fraud or intentional misrepresentation
 - Preexisting condition exclusions prohibited for children under age 19
 - Coverage for dependent children must remain available until age 26 (until 2014, grandfathered plans may exclude children who are eligible for other employment-based coverage)
 - Benefits provided to children under age 26 for whom plans are required to make coverage available are nontaxable regardless of dependent status
 - Cost sharing on preventive care expenses prohibited (grandfathered plans exempt)
 - Insured plans become subject to nondiscrimination rules that currently apply only to self-insured plans (grandfathered plans exempt)

- Plans must allow participants to choose any primary care provider available to accept them (grandfathered plans exempt)
 - Choice of pediatrician as a child's primary care provider must be allowed (grandfathered plans exempt)
 - Access to emergency services must be provided (grandfathered plans exempt)
 - Access to obstetrical and gynecological care must be provided (grandfathered plans exempt)
 - Internal and external appeals procedures must be implemented (grandfathered plans exempt)
- Health insurers must report medical loss ratios to HHS and provide rebates to enrollees if medical loss ratio is less than 85% (80% for small groups)
 - Unless prescribed by a provider, over-the-counter medications are not qualifying medical expenses for purposes of health flexible spending accounts (FSAs), health reimbursement arrangements and health savings accounts (HSAs)
 - Penalty for using HSA or Archer MSA funds for items other than qualifying medical expenses increases to 20%
 - Employers with fewer than 25 employees may qualify for a tax credit if they provide health insurance
 - Qualifying small employers may establish "simple cafeteria plans"

MARCH 23, 2011

- Deadline for HHS to establish standards for uniform explanations of coverage

JANUARY 31, 2012

- W-2s issued for 2011 earnings must report value of health coverage

MARCH 23, 2012

- Deadline for group health plans to provide uniform explanations of coverage
- Group health plans must notify enrollees of material changes no less than 60 days before effective date
- Deadline for HHS to develop standards for annual reports to enrollees and HHS on plan benefits that improve health

SEPTEMBER 30, 2012

- For policy years ending after this date, a fee of \$1 times the average number of covered lives is required for both insured and self-insured coverage

SEPTEMBER 30, 2013

- For policy years ending after this date, the fee noted at September 30, 2012 increases to \$2 times the average number of covered lives

JANUARY 1, 2013

- Annual salary reduction contributions to a health FSA may not exceed \$2,500
- Subsidy for employers that provide certain retirees with coverage equivalent to Medicare Part D is no longer deductible

- 1.45% Medicare payroll tax increases to 2.35% on wages over \$200,000 (\$250,000 for joint return filers)

JANUARY 1, 2014

- Employers with 50 or more full-time employees may incur “free rider” penalties if they offer no coverage or coverage that is unaffordable or insufficient
- Employers must offer free choice vouchers to certain employees
- Individuals who do not have qualifying coverage must pay an excise tax (coverage under any grandfathered plan satisfies requirement)
- Plans must report coverage information to enrollees and the IRS
- Group health plans – including, for most items, self-insured plans – become subject to additional “insurance” reforms when their 2014 plan year begins:
 - Preexisting condition exclusions prohibited for all enrollees
 - All annual dollar limits on essential benefits prohibited
 - Grandfathered plans lose the ability to deny coverage to employees’ children who are under age 26 based on eligibility for other employment-based coverage
 - Plans must cover routine patient costs for care in connection with clinical trials (grandfathered plans exempt)
 - Discrimination against providers prohibited as long as they act within the scope of their licenses (grandfathered plans exempt)
 - Out-of-pocket maximum can be no greater than that allowed for a high-deductible health plan offered in connection with a health savings account (grandfathered plans exempt)
 - Deductibles can be no greater than \$2,000 for single coverage and \$4,000 for family coverage (grandfathered plans exempt)

- Wellness incentives up to 30% of individual COBRA rate permitted (federal agencies may allow additional increases up to 50%)

- Employers with 200 or more full-time employees become subject to automatic enrollment requirements

- Employers become subject to notification requirements regarding insurance exchanges and subsidies

- State health insurance exchanges begin operation for individuals and small employers

- Employers that offer coverage through an exchange may permit pre-tax contributions through their cafeteria plans

JANUARY 1, 2016

- State health insurance exchanges must be available for employers with up to 100 employees

JANUARY 1, 2017

- States may allow employers of any size to access coverage through health insurance exchange

JANUARY 1, 2018

- Excise tax applies to high-cost coverage

JANUARY 1, 2020

- Fee noted at September 30, 2012 and September 30, 2013 sunsets

Not every employer-related provision with an early effective date is listed here, nor does the list include any provisions that may indirectly affect employers through their effect on health care providers and the health care delivery system.

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