HEALTH CARE REFORM IMPACT: A TIMELINE

Timeline begins at March 27th bill signing date.

IMMEDIATELY

INDIVIDUALS AND EMPLOYER GROUP PLANS CAN KEEP THEIR CURRENT POLICY ON A GRANDFATHERED BASIS if the only plan changes made are to add or delete new employees and any new dependents. Once a plan loses its grandfathered status, it will be subject to all of the market reforms in the legislation when they take effect. But most of the market-reform provisions slated to take effect six months after the bill's signing will apply to all plans, including grandfathered ones.

Eligible **SMALL BUSINESSES** (those that have no more than 25 FTEs, pay average annual wages of less than $50,000 and provide qualified coverage) are eligible for phase one of the small business premium tax credit of up to 50 percent of premiums for up to two years.

Employers that provide a **MEDICARE PART D** subsidy to retirees will have to account for the future loss of the deductibility of this subsidy in 2013 on liability and income statements. While the elimination of the deductibility does not take effect until 2013, there could be an immediate accounting impact.

WITHIN 90 DAYS OF BILL SIGNING

Temporary reinsurance program for employers that provide retiree health coverage for **EMPLOYEES OVER AGE 55** begins.

Individuals that had previously been **DENIED COVERAGE DUE TO A PRE-EXISTING CONDITION** will be able to obtain coverage through a high-risk pool.

WITHIN 6 MONTHS

LIFETIME LIMITS on the dollar value of benefits for any participant or beneficiary are prohibited. Annual limits will be allowed only through plan years beginning before Jan. 1, 2014, only on federally-defined non-essential benefits, and after that be prohibited.

Small businesses that employ less than 50 people are eligible for **A TAX CREDIT EQUAL TO 35%** of their health insurance premiums. (50% by 2014.)

ALL GROUP AND INDIVIDUAL health plans will have to cover preexisting conditions for children 19 and under. Grandfathered status applies.

HEALTH COVERAGE RESCISSIONS WILL BE PROHIBITED, except for cases of fraud or intentional misrepresentation.

ALL GROUP AND INDIVIDUAL PLANS must cover specific preventive care services with no cost-sharing. They must also cover emergency services at the in-network level regardless of provider, allow enrollees to designate any in-network doctor as their primary care physician and have a coverage appeal process.

ALL GROUP AND INDIVIDUAL PLANS MUST COVER DEPENDENTS UP TO AGE 26. However, through 2014, grandfathered group plans will only have to cover dependents who do not have another source of employer-sponsored coverage.

FEDERAL GRANT PROGRAM FOR SMALL EMPLOYERS providing wellness programs to their employees begins.

ALL NEW HEALTH INSURANCE PLANS will have to comply with new regulations that lay out an appeals process for when claims are denied.

JAN 1, 2011

ALL EMPLOYERS MUST INCLUDE ON W2S the aggregate cost of employer-sponsored health benefits, for informational purposes.

The tax on distributions from a **HEALTH SAVINGS ACCOUNT** that are not used for qualified medical expenses increases to 20 percent.

OTC DRUGS WILL NO LONGER BE REIMBURSABLE under HSAs, medical FSAS, HRAs and Archer MSAs unless prescribed by a doctor.

SMALL EMPLOYERS (less than 100) will be allowed to adopt new "simple cafeteria plans."

ALL EMPLOYERS would be required to enroll employees in a new national public long-term care program, unless the employee opted out.

ALL BUSINESS OWNERS will be subject to new expanded federal income tax requirements on payments of fixed or determinable income or compensation.

A NEW TYPE OF CAFETERIA PLAN available for small employers that is similar to the SIMPLE retirement plan.

A VOLUNTARY FEDERAL LONG TERM CARE PLAN will be established.

SENIORS ENROLLED in Medicare Advantage or Prescription Drug Plan will receive a 50% discount on brand name drugs immediately with prescription discounts to follow.

A SMALL BUSINESS ALTERNATIVE to a cafeteria plan will be presented so they may offer tax free benefits without having to deal with administrative costs.

JAN 1, 2012

All group and individual plans and insurers must provide a **SUMMARY OF BENEFITS AND A COVERAGE EXPLANATION** that will require substantially more information than current summary plan descriptions. There is a $1,000-per-enrollee fine for willful failure to provide the information.

All group and individual plans and insurers must **SUBMIT ANNUAL REPORTS** to the federal government and plan participants on whether the benefits provided under their plans meet federal criteria on improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors.

EXISTING HEALTH INSURANCE PLANS will now be subject to a rule that preventative care may not be subject to co-pay.

The complete core mechanism of universal coverage starts in 2014.

When insurance companies recognized that reform was picking up momentum, America's Health Insurance Plans (AHIP) made sure carriers had a seat at the table by offering a key concession—universal coverage regardless of pre-existing conditions and other factors.

AHIP demanded an enforceable individual coverage mandate to ensure that young, healthy people did not abandon the risk pool and leave insurers with an older, sicker and more expensive client base to cover.

Carriers say that while restrictions on them will be tight, the penalties on individuals who drop coverage will be ineffective, leading to higher rates for everyone else.

JAN 1, 2013

NEW FEDERAL PREMIUM TAX ($2 on each covered individual) begins on group health plans to fund comparative effectiveness research program.

CONTRIBUTIONS for medical expenses will be limited to $2,500 per year, with the cap annually indexed for inflation.

MEDICARE PAYROLL TAX INCREASES 0.9 PERCENT on self-employed individuals and employees with AGI of more than $200,000 for individuals ($250,000 for joint filers). The income eligibility levels for the tax are not indexed for inflation.

NEW 3.8 PERCENT MEDICARE TAX begins on investment income from individuals with AGI exceeding $200,000 ($250,000 for joint filers). This includes taxable annuity proceeds.

JAN 1, 2014

The individual mandate **REQUIREMENT TO PURCHASE HEALTH INSURANCE** for all citizens and legal residents takes effect. Violators will be subject to a phased-in excise tax penalty for noncompliance.

PREMIUM ASSISTANCE TAX CREDITS for individuals and families making up to 400 percent of FPL begin. These subsidies are available only for individual coverage purchased through the exchange, not employer-sponsored coverage.

THE EMPLOYER RESPONSIBILITY REQUIREMENTS TAKE EFFECT FOR COMPANIES that employ more than 50 FTEs. If an employer does not provide coverage to its FTEs and at least one employee receives a premium-assistance tax credit to buy coverage through the exchange, the employer must pay a fine of $2,000 per year for each full-time employee. The first 30 employees are exempted from the fine calculation. An employer with more than 50 employees that does offer qualified coverage but has at least one FTE receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit, or $2,000 for each of its full-time employees total.

ALL STATES ARE REQUIRED to have health insurance exchanges established for individuals and small employers with up to 100 employees to purchase coverage.

ALL PLANS MUST BE OFFERED ON A GUARANTEED-ISSUE BASIS, preexisting condition limitations will be prohibited, annual and lifetime limits will be prohibited. All fully insured individual and small groups (and large groups purchasing through the exchange) must abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions, to be defined by the states, and experience rating would be prohibited.

EMPLOYERS OF 200 OR MORE EMPLOYEES MUST AUTO-ENROLL ALL new employees into any available employer-sponsored health insurance plan.

PREMIUM TAXES ON MOST PRIVATE HEALTH INSURERS BASED ON PREMIUM VOLUME TAKE EFFECT. The amount of the total assessed tax on the industry will start at $8 billion in 2014, rising to $14.3 billion in 2018. After 2018, the fee would be indexed to the annual amount of premium growth in subsequent years.

EXPANSION OF THE MEDICAID PROGRAM FOR ALL INDIVIDUALS, including childless adults, making up to 133 percent of the FPL begins.

AN ANNUAL HEALTH INSURANCE PROVIDER FEE will be imposed on insurers whose total premiums exceed $25 million.

JAN 1, 2018

CADILLAC TAX GOES INTO EFFECT for all group plans, including self-insured plans. The new law establishes a **40 PERCENT EXCISE TAX** on plans with values that exceed $10,200 for individual coverage and $27,500 for family coverage, with higher thresholds for retirees over age 55 and employees in certain high-risk professions. When determining the values of health plans, reimbursements from FSAs, HRAs and employer contributions to HSAs will be included. Also excluded would be the value of stand-alone vision, dental, accident, disability, long-term care plans and after-tax indemnity or specified disease coverage.

SOURCE: National Association of Health Underwriters