the bottoms group
SINCE 1947 BENEFITS · INSURANCE · COMMUNICATION

Health Care Reform

Employer Action Overview

Immediate	Employer Action Required	Notes
Nursing Mothers – Employers must provide a reasonable break time for 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.	

June 30, 2010	Employer Action Required	Notes
Federal Retiree Reinsurance Program – This program pays 80 percent of claims incurred for retirees (age 55-64) between $15,000 and $90,000. Payments must be used to lower costs for retirees. Applies to self-insured and fully insured retiree plans.	Applications may no longer be submitted to the Department of Health and Human Services (HHS) for the Retiree Reinsurance Program.	
National High-Risk Pool – This pool is for individuals who have not obtained insurance within the past six months due to a pre-existing condition. This pool will end on Jan. 1, 2014, when market reforms take effect that prohibit pre-existing condition exclusions and require guarantee issue.	No, informational only.	

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 exempt if the dependent is eligible for other employer-sponsored coverage.	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.	

Continued

Sept. 23, 2010 *cont'd*	Employer Action Required	Notes
Annual limits on the dollar value of essential 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.	
Annual Dollar Limits – Annual limits on the dollar value of essential 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.	
Pre-existing Condition Provisions – Pre-existing condition limitations are prohibited for children under 19 years. (In 2014 this prohibition will extend 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) are 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 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.	Yes, if the plan is not grandfathered, amend plan documents and communicate to employees during open enrollment. Provide required model notice.	

Continued

2010	Employer Action Required	Notes
Rate Review – A new process was established that 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 will be eligible for a tax credit, provided they contribute at least 50 percent toward their employees' health insurance. For tax-exempt small employers, the maximum credit is 25 percent (versus 30 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 no longer eligible for reimbursement under flexible spending accounts (FSAs), health saving 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.	
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.	
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 are not effective until plan years beginning on or after Jan. 1, 2012. After that date, the non-English version of the Culturally and Linguistically Appropriate notice requirement must 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) will be allowed to adopt new "simple cafeteria plans." These plans will be 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.	

Continued

2011 *cont'd*	Employer Action Required	Notes
HSA Penalty Increase – PPACA increased the additional tax on HSA distributions that are not used for qualified medical expenses to 20 percent for distributions made after Dec. 31, 2010.	Informational only.	

2012	Employer Action Required	Notes
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. The first rebate checks must be sent by August 2012.	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.	
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 have 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.	
Employer W-2 Reporting – Employers must begin tracking the aggregate value of health coverage provided to employees for purposes of reporting on 2012 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 many exclusions, including HRAs, HSAs and salary reduction contributions to FSAs. There is an indefinite delay of implementation for employers that file fewer than 250 W-2s.	Yes, employers – in cooperation, with their payroll vendors – will need to quantify the value of health coverage to be included on W-2s beginning with 2012 compensation.	
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 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 the SBC conform to the template provided. The SBC may be provided in paper or electronic form in compliance with Department of Labor (DOL) electronic delivery requirements.	

Continued

2012 *cont'd*	Employer Action Required	Notes
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 for only mid-year 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.	
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 guidance has been released.	Yes, self-insured employers will have to provide appropriate reports. Insurance carriers will administer for fully insured plans. Guidance forthcoming.	
Comparative Effectiveness Research Fee (PCOR) – 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. 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. 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.)	

2013	Employer Action Required	Notes
Increased Tax On High Wage Earners – There is a tax increase of 3.8 percent for high wage earners on passive income (investment income, capital gains, rent, etc.) and a 0.9 percent increase in Medicare payroll tax on earned income above certain thresholds. Threshold amounts are $200,000 advised gross income for individuals and $250,000 for families.	Optional. Employers may want to communicate information to employees. Work with payroll vendor to ensure compliance.	
Health FSA Maximum Contribution Limit – Employee contributions to health FSAs are limited to $2,500 annually, effective for plan years beginning after Dec. 31, 2012.	Yes, employers should communicate change to employees during open enrollment and amend plan documents accordingly.	

Continued

2013 *cont'd*	Employer Action Required	Notes
Notice of Exchange – In 2013, 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. Additional guidance is forthcoming.	Yes, employers have until late summer or fall of 2013 to provide this notice, which will coincide with the open enrollment period for exchanges. The Department of Labor delayed the original effective date of March 1, 2013 in guidance issued on Jan. 24, 2013.	

2014	Employer Action Required	Notes
Waiting Periods – Group health plans may not implement waiting periods longer than 90 days.	Yes, amend plan documents if existing waiting period exceeds 90 days.	
Lifetime / Annual Dollar Limits – Lifetime and annual dollar limits on essential benefits are completely prohibited. Such limits are permissible for non-essential benefits.	If self-funded plan, amend plan documents accordingly. Carrier will administer fully insured plan changes.	
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. Effective date unknown. The DOL has indicated that employers are not required to comply with this requirement until final regulations are issued and applicable — and that such regulations are not expected to be promulgated in time to implement the automatic enrollment provisions by 2014.	Not at this time. When final regulations are released, revise enrollment procedures as necessary.	

Continued

2014 *cont'd*	Employer Action Required	Notes
Employer Mandate – If a large employer (at least 50 full-time equivalents) has at least one full-time employee (e.g., working 30 or more hours / week) receiving a premium tax credit in the state exchange, the employer will be subject to a penalty. Employees qualify for a premium tax credit if their income is between 133 percent - 400 percent of federal poverty level (FPL) and their coverage is unaffordable or not qualified (as defined below). There are two types of potential penalties: (1) the first applies to employers that do not offer coverage and (2) the second applies to employers that offer coverage that is "unaffordable" (defined as greater than 9.5 percent of household income) or not "qualified" (defined as 60 percent actuarial value). If the employer offers no coverage, the penalty equals $2,000 times the number of full-time employees, less the first 30. If the employer offers unaffordable or unqualified coverage, the employer's penalty equals $3,000 times the number of full-time employees receiving the premium tax credit. The second penalty is capped at the amount paid under the first penalty. Penalties are not tax deductible.	Certain employers must report to the IRS whether they offer their full-time employees the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan. The IRS will use this information to administer the employer mandate penalty (also referred to as the share responsibility payment). 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 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 – Beginning in January 2014, a state-based or federally facilitated health insurance exchange will be operational in each state. Health insurance coverage for individuals and small employer groups (groups of 50, or groups to 100, depending on state's decision) may be purchased through the exchanges. Groups over 100 will be permitted to purchase coverage in 2017 if state allows.	Sponsors of self-insured plans must report to the IRS information about minimum essential coverage provided to an individual. This information will be used for purposes of the individual mandate and premium tax credits.	
Individual mandate – Citizens and legal residents are required to maintain "minimum essential coverage." Those without such coverage will be taxed the greater of $695 per year up to a maximum of $2,085 per family or 2.5 percent of household income. Penalties will be phased in: $95 in 2014 or 1 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.	Informational only.	
Premium Tax Credits – Premium tax credits are available to eligible individuals and families with incomes between 100 and 400 percent of 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 (as described under Employer Mandate section). 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.	Informational only, unless future regulations concerning employer notice about exchanges require otherwise. Employers will be subject to an employer mandate penalty if its employees qualify for a premium tax credit or cost-sharing subsidy. See Employer Mandate for more information.	

Continued

2014 *cont'd*	Employer Action Required	Notes
Guaranteed Availability of Coverage and Renewability – Each health insurance issuer that offers health insurance coverage in the individual or group market (regardless of whether the coverage is offered in the large or small group market) is required to accept every employer and individual in the state that applies for coverage and desires renewal.	No. Carriers will administer.	
Cost-sharing Limits – Group health plans must limit cost sharing to the maximum out-of-pocket expense limits for self-only and family coverage for HSA-compatible high-deductible health plans. In addition, the deductible cannot exceed $2,000 for a single coverage plan, or $4,000 for any other plan. It is unclear whether the annual deductible limit applies only to the small group market or also applies to the large group market. Guidance is forthcoming. Grandfathered group health plans are not required to comply. Effective for plan years beginning in 2014.	Yes, amend plan documents and coverage accordingly.	
Essential Health Benefits Package – Effective for plan years beginning on or after Jan. 1, 2014, individual and small group health coverage must include the essential health benefits package, which means providing essential health benefits, setting limits on cost sharing and providing coverage at specified actuarial levels of coverage.	No. Carriers will administer.	
Prohibition on Pre-existing Condition Exclusions (PCE) – Group health plans are prohibited from imposing any PCEs (previously applied to individuals under age 19), effective for plan years beginning on or after Jan. 1, 2014.	Review plan documents and amend accordingly to reflect required coverage.	
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. More guidance to follow.	Yes, employers must submit a relevant report of health insurance coverage to the IRS and must also furnish a written statement to covered employees.	
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 annually. 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.	The employer 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 receives the contribution notice.	

Continued

2018	Employer Action Required	Notes
Cadillac Tax Plans – Beginning in 2018, 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. 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 2018. Consider compensation adjustments accordingly.	

94975 1/11 (BP-15587-13) Revised 1/13