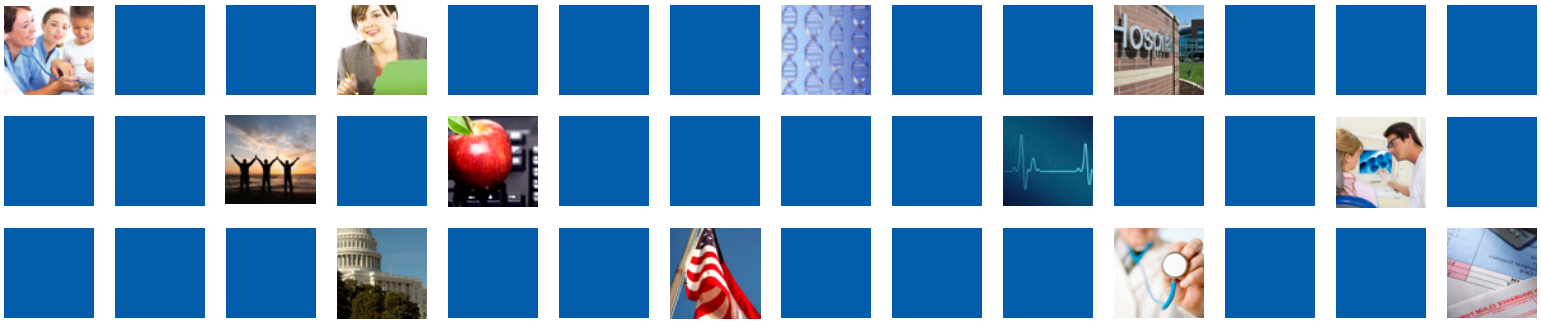
CONNER STRONG

MAY2010

National Health Insurance Reform

Impact Year by Year



With the passage of National Health Insurance Reform it is crucial that employers and plan sponsors have clear information about the impact of the laws and how they will affect group health plans. To assist in understanding what will need to happen and when, Conner Strong has prepared the following 'Year by Year' summary of the various provisions of the law and when they will take effect.

Conner Strong will continue to evaluate and review the details of the health reform changes and the guidance being issued. As always, if you have any questions regarding the latest on national health insurance reform, visit the **health reform section on our website** or contact your Conner Strong account representative at 1-877-861-3220.

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2010	CY2010	For tax years beginning in 2010, 2011, 2012, and 2013, small employers with 25 or fewer "full-time equivalent" employees and average annual wages of no more than $50,000 may be eligible for a **small employer tax credit** of 35% (25% for tax-exempt small employers) of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. Full credit available to employers with 10 or fewer employees and wages less than $25,000.
	CY2010	Employers must provide a "reasonable" break time for employees to nurse a child or express milk for 1 year after the child's birth in a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public. Employers are not required to compensate employees for "reasonable" break time for nursing. Employers with less than 50 full-time employees are exempt if this requirement results in "undue hardship" by causing the employers significant difficulty or expense in relation to the size, financial resources, nature, or structure of employer's businesses.
	CY2010	Employers that receive federal retiree drug subsidies (RDS) must include the additional accounting charge in their 1st Quarter 2010 earnings reports.
	1/1/2010	The dollar limitation for the credit for qualified adoption expenses and for the tax exclusion from gross income for such expenses paid under an employer's adoption assistance program increases from $10,000 to $13,170, adjusted for inflation after 2010.
	3/23/2010	States must establish and implement for plan year 2010 a process for reviewing insurance premium increases, and insurers must justify unreasonable increases in premiums prior to implementation.
	6/23/2010	**Early retiree temporary reinsurance program** is established to pay for a portion of health benefits provided by employment-based plans to pre-Medicare eligible retirees and their eligible dependents. The program ends on January 1, 2014. $5 billion is appropriated for this program.
	7/1/2010	10% service tax imposed on indoor tanning.
	10/1/2010	Employers with 100 employees or fewer who work 25 hours or more per week are eligible to compete for grant funding to implement wellness programs (funding is available through 2015).

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2010	2010 Plan years beginning on or after 9/23/2010	Applies to grandfathered plans in which an individual or group was enrolled on the date of enactment: ■ Prohibits exclusion based on pre-existing conditions initially for children up to age 19 (applies to all adults as of 1/1/2014); ■ Plans are prohibited from rescinding coverage with respect to a participant once covered, except in the event of fraud or intentional misrepresentation; ■ Plans can have no annual or lifetime maximum dollar limits, in general, on overall benefits; until 2014 plans may have "restricted" annual dollar limits on "essential benefits" (to be defined by HHS) that are not "unreasonable"; ■ Plans with **dependent coverage extended to 26th birthday** (regardless of student status or marital status; unless dependent children are eligible for other employer coverage). Beginning with the first plan year on or after 1/1/2014, plans must also cover dependents to age 26 even if they are offered other employer-sponsored coverage (applies to grandfathered group plans before 2014, and all plans beginning in 2014). Does not apply to grandfathered plans: ■ Prohibits prior authorization for emergency care services or OB/GYN care; ■ Insurers that require designation of a primary care provider must permit designation of any participating primary care provider; ■ Insurers required to adopt specified internal claims and appeals procedures; ■ Plans must provide coverage for certain preventive services; ■ Plans must meet annual reporting requirements regarding quality of care; ■ Plans must provide information to Secretary and to participants as requested regarding the amount of cost-sharing and other provisions; ■ Fully-insured group health plans must comply with the non-discrimination rules under the tax codes.
2011	1/1/2011	Health insurers (including grandfathered plans) must begin providing a rebate to each enrollee if the amount the insurer spends on clinical services provided to enrollees and activities that improve health care quality is less than 85% of premium revenue for large groups (80% for small groups).
	1/1/2011	Individuals can no longer use flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), or health savings accounts (HSAs) to pay for over-the-counter (OTC) medications, unless prescribed by a physician or for insulin.
	1/1/2011	The tax on distributions from HSAs for nonqualified medical expenses is increased from 10% to 20%. The tax on distributions from Archer MSAs for nonqualified medical expenses is increased from 15% to 20%.

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2011	1/1/2011	Secretary must designate a plan to create a long-term care insurance program (the CLASS program) to be financed by voluntary payroll deductions. Employers can choose to voluntarily auto-enroll employees in the program and begin deducting monthly premiums from paychecks of likely $65 per month at most but as little as $5 for certain low-income earners. Program to pay $50 per day to those unable to perform 2 or 3 activities of daily living after year 5 to purchase nonmedical services and supports need to maintain independence at home or in a community residential setting.
	1/1/2011	An employer that employed on average 100 or fewer employees in the preceding two years is permitted to establish a "Simple Cafeteria Plan" by complying with the contribution, eligibility, and participation requirements established for "Simple Cafeteria Plans."
	1/1/2011	Secretary is authorized to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs. An employer is eligible if it employs less than 100 employees who work 25 hours or greater per week and did not provide a wellness program prior to March 23, 2010. $200 million has been appropriated for these grants for fiscal years 2011 through 2015.
	2/1/2011	Secretary is required to study and report to Congress regarding the fully-insured and self-insured group health plan markets.
	3/23/2011	Secretary of Labor is required to report information regarding self-insured group health plans (derived from Department of Labor Annual Return/Report of Employee Benefit Plan) and self-insured employers (derived from financial filings) to Congress.
	3/23/2011	Deadline for the Secretary to develop uniform explanation of coverage documents to be used by insurers, including otherwise grandfathered plans.
2012	1/1/2012	Threshold for itemized deductions for medical expenses is increased from 7.5% to 10% of adjusted gross income (not effective until Jan. 1, 2017 for individuals over the age of 65).
	1/1/2012	Employers must report the aggregate value of health benefits on all employees' W-2 forms for 2011 annual earnings (includes both employer and employee contributions for certain coverages). Employer to determine the aggregate value of health benefits using employees' applicable COBRA rates (minus the 2% administrative fee if charged).

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2012	3/23/2012	If a plan makes any material modification in any of the terms of the plans or coverage that is not reflected in the most recently provided summary of benefits and coverage, the plans or issuers must provide notice of these modifications to enrollees no later than 60 days before the date when they take effect.
	3/23/2012	CDC is required to conduct, at regular intervals, a national worksite health policies and programs survey to assess employer-based health policies and programs.
	Plan years ending after 9/30/2012	Plans (self and fully insured) will be assessed a tax of $2 ($1 in the case of plan years during fiscal year 2013) per average number of insured lives to finance a comparative effectiveness research program. This tax will be paid by the plan sponsor, will be indexed annually, and will sunset for plan years ending after September 30, 2019.
2013	1/1/2013	Annual salary contributions to health FSAs will be limited to $2,500 a year and will be indexed by the Consumer Price Index for taxable years beginning after December 31, 2013.
	1/1/2013	Additional 0.9% Medicare hospital insurance (FICA) tax imposed on wages above $200,000 for individual filers, $125,000 for married filing separate filers, and $250,000 for joint filers. The increase applies only to the employee-paid FICA taxes. Although this tax does not apply to the employer-paid FICA taxes, employers will still be responsible for the withholding and reporting obligations with respect to this increase in employee-paid FICA taxes.
	1/1/2013	For taxable years after December 31, 2012, deduction eliminated for expenses allocable to Medicare Part D subsidy received by employers.
	3/1/2013	Employers must provide written notices to employees regarding the exchange at the time of hire for new employees and for all other employees by March 1, 2013. The notice must inform the employee of: the existence of an exchange, its services, and how to contact the exchange; that if the employer plan's share of the total allowed costs of benefits under the plan is less than 60% of such costs, that the employee may be eligible for a premium tax credit or a cost sharing reduction through the exchange; and that if the employee purchases a plan through the exchange, the employee will lose the employer contribution (if any) to any health plan offered by the employer and that all or a portion of such contribution may be excludable from federal income taxes.
	3/23/2013	Plans must provide a summary of benefits and coverage explanation (in addition to the SPD) that accurately describes benefits and coverage under the group health plan to participants prior to enrollment. The Secretary is required to provide standards for developing this summary by March 23, 2011.

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2014	1/1/2014	State-based exchanges become available; only individuals and small employers are initially eligible to participate. A small employer can offer qualified health plan coverage to its full-time employees through an exchange. An employer in the small group market generally must have between one and 100 employees during the preceding year, applying the controlled group rules. However, for plan years beginning before 1/1/2016, a state can elect to limit the small group market to employers with no more than 50 employees. An employer providing coverage through an exchange that outgrows the parameters for the small group market is permitted to continue to offer coverage through the exchange until such time as the employer discontinues coverage. Beginning in 2017, states may elect to permit employers in the large group market to offer insurance through an exchange.
	1/1/2014	Deadline for the Secretary to develop guidelines for Exchange plans concerning improving health outcomes, preventing hospital readmissions, improving patient safety, implementing wellness and health promotion activities, and reducing health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
	Plan years beginning on or after 1/1/2014	Beginning with the first plan year on or after January 1, 2014, plans must cover dependents to age 26 even if they are offered other employer-sponsored coverage (applies to grandfathered group plans before 2014, and all plans beginning in 2014).
	1/1/2014	Imposition of new tax penalty on individuals who do not purchase coverage, and tax penalty on employers with over 50 employees that have at least one employee receiving a subsidy to purchase through the exchange.
	1/1/2014	Employers that provide minimum essential coverage are required to file a report with the IRS by January 31 of the following year that provides information about the employees who are covered by the minimum essential coverage, the portion of the premium (if any) required to be paid by the employer, and such additional information as may be required if the minimum essential coverage is offered through an exchange. The employer must provide to each employee included in the report a statement showing the information reported with respect to that employee. The purpose of this reporting requirement is to assist the IRS in its determination of whether individuals are meeting their obligations to have coverage and to determine whether such individuals are eligible for a premium tax credit or cost sharing reduction.

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2014	1/1/2014	Large employers (for purposes of applying the employer penalties) are required to file a report with the IRS by January 31 of the following year that provides certification as to whether the employer offers full-time employees the opportunity to enroll in minimum essential coverage through an eligible employer-sponsored health plan, and if so, information on the length of waiting periods imposed, costs of premiums, total cost paid by the employer, number of full-time employees, and information on each full-time employee and the months covered under the plan. The information required to be reported must also be provided in a statement to each full-time employee. The purpose of this reporting requirement is to provide the IRS with the information necessary to determine whether the employer may be subject to a penalty.
	1/1/2014	Small business tax credit increased to 50% for for-profit small business (35% to tax-exempt small businesses) of the employer's contributions for qualified health plans offered by the employer through an Exchange, or contributions that the employer would have made if its employees had enrolled in an Exchange plan. The credit, which is available for two consecutive years, fully phases out for firms with average wages equal to or greater than $50,000.
	1/1/2014	Imposition of new tax penalties on employers with 50 or more employees who do not provide insurance (and have at least one employee who qualifies for a premium tax credit) or who do not provide affordable insurance.
	1/1/2014	For grandfathered plans in which an individual or group was enrolled on the date of enactment: ■ Extends prohibition on pre-existing condition exclusions to all individuals under group health plans; ■ Prohibits any waiting period that exceeds 90 days for group coverage; ■ All private coverage must include the essential health benefits package
	1/1/2014	Plans can not have "restricted" annual dollar limits or lifetime limits on "essential health benefits"; plans may have annual and lifetime per beneficiary limits on certain specific benefits that are not "essential health benefits".
	1/1/2014	Employers may provide premium discounts, rebates or other rewards to employees who participate in wellness programs.
2015	3/23/2015	Deadline for GAO to submit to Congress a study on the affordability of health insurance coverage, including the effect of the tax credit, the availability of affordable health plans, and the ability of individuals to keep essential health benefits coverage.

YEAR	EFFECTIVE DATE	AFFORDABLE CARE ACT PROVISION
2016	1/1/2016	Multistate plans may be offered in the Exchange through health care choice compacts.
2017	1/1/2017	States may permit businesses with more than 100 employees to purchase coverage in the exchanges.
2018	1/1/2018	A tax is imposed on the coverage provider of high-cost health plans equal to 40 percent of the "excess benefit" ($10,200 single, 27,500 family). There is a higher dollar threshold for qualified retirees and high risk professions, and adjustments are made for age and gender. Any coverage provided under a group health plan that is excludable from an employee's gross income under Code section 106 is included in the cost calculation, including employer and *employee* pre-tax contributions to flexible spending accounts, health reimbursement accounts, and employer contributions to health savings accounts.

The above summary is based on publicly available information contained in the U.S. Patient Protection and Affordable Care Act (H.R. 3590) and the U.S Health Care and Education Affordability Reconciliation Act (H.R. 4872). The above summary is subject to change and does not constitute legal advice. For legal advice, employers and plan sponsors should contact their counsel.