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Important Effective Dates for Employers and Health Plans

On March 23, 2010, President Obama signed the health care reform bill, or Affordable Care Act (ACA), into law. ACA makes sweeping changes to the U.S. health care system. ACA's health care reforms, which are primarily focused on reducing the uninsured population and decreasing health care costs, will be implemented over the next several years.

This Legislative Brief provides effective dates for key ACA reforms that affect employers and individuals. Please read below for more information.

2010	
EFFECTIVE DATE	**ACA PROVISION**
2010 Taxable Year	**Small Business Health Care Tax Credit** Eligible small employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small tax-exempt organizations. When the Exchanges are operational, the tax credits will increase, up to 50 percent of premiums.
March 30, 2010	**Tax-free Coverage to Children Under Age 27** Employer-provided accident or health plan coverage for an eligible adult child can generally be excluded from taxable income.
Plan years beginning on or after Sept. 23, 2010	**Prohibition on Lifetime and Annual Dollar Limits** Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement through HHS until Sept. 22, 2011. All annual limits will also be prohibited beginning in 2014.
	Appeals Process and External Review Requirements Enhanced internal claims and appeals requirements and external review procedures apply for group health plans and health insurance issuers, and insurers offering individual coverage (except for grandfathered health plans).
	Patient Protections ACA imposes three new requirements on group health plans and group or individual health insurance coverage that are referred to as "patient protections." These patient protections relate to the choice of a health care professional, access to obstetrical and gynecological care, and coverage for emergency services.
Plan years beginning on	**Dependent Coverage for Children Under Age 26**

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or after Sept. 23, 2010 (continued)	If a group health plan or insurer provides dependent coverage of children, the plan must make that coverage available until a child turns **age 26**. A limited exception applies for grandfathered health plans prior to Jan. 1, 2014.
	Eliminating Pre-existing Condition Exclusions for Children Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children **under age 19**. This provision applies to all employer plans and new plans in the individual market.
	Coverage of Preventive Care Services Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for certain preventive care services without cost-sharing (for example, deductibles, copayments or coinsurance). Grandfathered plans are exempt from this requirement.
	Rescissions Prohibition ACA prohibits rescissions, or retroactive cancellations, of coverage, except in cases of fraud or intentional misrepresentation. Also, plans and issuers must provide at least 30 days' advance notice to the enrollee before coverage may be rescinded. This provision applies to all grandfathered and non-grandfathered plans.

2011	
EFFECTIVE DATE	**ACA PROVISION**
Distributions after Dec. 31, 2010	**Increased Tax on Withdrawals from HSAs and Archer MSAs** ACA increased the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses also increased from 15 to 20 percent.
Beginning on Jan. 1, 2011	**Medical Loss Ratio (MLR) Requirements** Health insurance issuers offering coverage in the group or individual markets (including grandfathered health plans) must comply with medical loss ratio standards. Issuers must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.
	Simple Cafeteria Plans ACA created a simple cafeteria plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This plan is designed to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from certain nondiscrimination requirements applicable to highly compensated and key employees.
Taxable years on or after Jan. 1, 2011	**Over-the-Counter (OTC) Drug Restrictions** ACA changed the definition of "qualified medical expenses" for health savings accounts (HSAs), health flexible spending accounts (FSAs) and health reimbursement

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	arrangements (HRAs) to the definition used for the itemized tax deduction. This means that expenses for over-the-counter (OTC) medicines and drugs may not be reimbursed by these plans unless they are accompanied by a prescription. There is an exception for insulin. Also, OTC medical supplies and devices may continue to be reimbursed without a prescription.

2012	
EFFECTIVE DATE	**ACA PROVISION**
2012 Taxable Year	**Reporting Health Coverage Costs on Form W-2** ACA requires employers to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2. This requirement was effective, but optional, for the 2011 tax year and is mandatory for later years for most employers. This requirement is optional for small employers (those filing fewer than 250 Forms W-2) at least for the 2012 tax year and will remain optional until further guidance is issued. Employers that file at least 250 Forms W-2 must comply with this reporting requirement for 2012 (for Forms W-2 that must be issued by the end of January 2013) and future years.
Aug. 1, 2012	**Medical Loss Ratio (MLR) Rebates** Sponsors of fully insured plans will receive rebates by Aug. 1, 2012, if they qualify for a rebate from their health insurance issuers due to the MLR rules.
Plan years beginning on or after Aug. 1, 2012	**Coverage of Additional Preventive Care Services for Women** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for specific services for women, including contraceptives and contraceptive counseling, without cost-sharing. Grandfathered plans are exempt from this requirement. Exceptions to the contraceptive coverage requirement apply to religious employers.
Earlier of the plan's first open enrollment period or first plan year beginning on or after Sept. 23, 2012	**Uniform Summary of Benefits and Coverage** All health plans must provide a uniform summary of the plan's benefits and coverage to participants. The summary must be written in easily understood language and is limited to four double-sided pages. Any mid-year changes to the information contained in the summary must be provided to participants 60 days in advance.
Plan years ending on or after Oct. 1, 2012	**Patient-centered Outcomes Research Institute (PCORI) Fees** For plan years ending on and after Oct. 1, 2012, and before Oct. 1, 2019, self-insured plans and issuers must pay fees to fund health care research. The initial fee is $1 per covered life, increasing to $2 per covered life for plan years ending on or after Oct. 1, 2013 (and adjusted annually for later plan years). The first possible payments are due on **July 31, 2013**.
2013	
EFFECTIVE DATE	**ACA PROVISION**
Taxable years beginning	**Additional Medicare Tax for High-wage Workers**

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after Dec. 31, 2012	ACA increases the Medicare hospital insurance tax rate by 0.9 percentage points for high-income individuals. Employers must withhold the additional taxes on wages paid in excess of $200,000.
Plan years beginning after Dec. 31, 2012	**Health Flexible Savings Account (FSA) Contribution Limits** ACA limits the amount of salary reduction contributions to health FSAs to **$2,500 per year**, indexed by CPI for subsequent years.
Beginning in 2013	**Administrative Simplification** Health plans must adopt and implement uniform standards and operating rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs. For example, effective Jan. 1, 2013, health plans must comply with HHS's operating rules for electronic health care transactions regarding eligibility for health plan coverage and health care claim status.
July 31, 2013	**Patient-centered Outcomes Research Institute (PCORI) Fee Payments** The first possible PCORI fee payments are due.
Oct. 1, 2013	**Employee Notice of Exchanges** Employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. ACA required employers to provide the Exchange notice by March 1, 2013, but the DOL delayed this deadline. Employers must provide the notice to each current employee by **Oct. 1, 2013**. For new employees, employers must provide the notice at the time of hiring beginning Oct. 1, 2013. For 2014, the DOL will allow the notice to be provided within **14 days** of an employee's start date.
Dec. 31, 2013	**HIPAA Certification** Employers with group health plans must certify that their plans comply with certain HIPAA rules on electronic transactions.

2014	
EFFECTIVE DATE	**ACA PROVISION**
Calendar years beginning after Dec. 31, 2013	**Health Insurance Provider Fee** The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.
Delayed for one year, until 2015	**Employer Coverage Requirements** See 2015 section below. The employer mandate penalties and related reporting requirements have been delayed for one year, until 2015.
Jan. 1, 2014	**Individual Coverage Mandates** ACA requires most individuals to obtain acceptable health insurance coverage or pay a penalty. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.

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	Individual Health Insurance Subsidies ACA makes federal subsidies available through the Exchanges, in the form of premium tax credits and cost-sharing reductions, for low-income individuals who are not eligible for or offered other acceptable coverage.
	Health Insurance Exchanges ACA calls for the creation of state-based competitive marketplaces, known as Affordable Health Insurance Exchanges (Exchanges), for individuals and small businesses to purchase private health insurance.
	Reinsurance Payments Health insurance issuers and third-party administrators (TPAs) will be required to make contributions based on a federal contribution rate established by HHS. States may collect additional contributions on top of the federal contribution rate.
Plan years beginning on or after Jan. 1, 2014	**Employer Wellness Programs** Under health care reform, the potential incentive for employer wellness programs increases to 30 percent of the premium for employee participation in the program or meeting certain health standards. Employers must offer an alternative standard for those employees whom it is unreasonably difficult or inadvisable to meet the standard. Following a governmental study on wellness programs, the incentive may be increased to as much as 50 percent.
	Annual Limits Prohibited Plans and issuers may not impose annual limits on the coverage of essential health benefits.
	Guaranteed Issue and Renewability Health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual. Grandfathered plans are exempt from this requirement.
	Pre-existing Condition Prohibition Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for anyone.
Plan years beginning on or after Jan. 1, 2014 (continued)	**Nondiscrimination Based on Health Status** Group health plans and health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.
	Nondiscrimination in Health Care Group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. It also does not apply to grandfathered plans. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.

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	Insurance Premium Restrictions Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to heath status, gender or other factors. Premiums will be able to vary based only on age, geography, family size and tobacco use. The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to offer large group coverage through the state exchange. Also, these restrictions do not apply to grandfathered coverage.
	Excessive Waiting Periods Prohibited Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.
	Coverage for Clinical Trial Participants Non-grandfathered group health plans and insurance policies will not be able to terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.
	Comprehensive Benefits Coverage Health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance exchanges. This requirement does not apply to grandfathered plans.
	Limits on Cost-sharing Non-grandfathered group health plans will be subject to limits on cost-sharing or out-of-pocket costs. ACA's annual deductible limit applies *only* to insured health plans offered in the small group market, whereas ACA's out-of-pocket maximum limit applies to *all* non-grandfathered health plans.
Coverage provided on or after Jan. 1, 2014	**Reporting of Health Insurance Coverage** ACA requires any person who provides "minimum essential coverage" to an individual during a calendar year to report certain health insurance coverage information to the IRS. The first information returns will be filed in 2015.
Taxable years beginning in 2014	**Small Business Health Care Tax Credit** The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
After 2014 (delayed)	**Automatic Enrollment** ACA requires employers with more than 200 full-time employees that offer health coverage to automatically enroll new employees (and re-enroll current employees) in one of the employer's health plans, subject to any permissible waiting period. Employers will not be required to comply with the automatic enrollment requirements until final regulations are issued and a final effective date is specified.

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Jan. 1, 2015	**Employer Coverage Requirements** Employers with 50 or more employees will be subject to penalties if they do not provide health coverage to full-time employees, or if the coverage they provide is not affordable or does not provide minimum value. A full-time employee is an employee who was employed on average at least 30 hours of service per week. The employer mandate penalties and related reporting requirements have been **delayed for one year, until 2015**. Therefore, these payments will not apply for 2014. No other provisions of the ACA are affected by the delay.

2018	
EFFECTIVE DATE	**ACA PROVISION**
Jan. 1, 2018	**High Cost Plan Excise Tax** A 40 percent excise tax (also known as a "Cadillac tax") is to be imposed on the excess benefit of high-cost employer-sponsored health insurance. The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider," which can be the insurer, the employer or a third-party administrator.

Please contact Hickok & Boardman HR Intelligence with any questions about how you can prepare for any of the health care reform requirements.

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