HEALTHCARE REFORM TIMELINE

Provisions That Will Impact Individuals & Employers

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PROTECTING THE CONSUMER'S FUTURE

NAHU

National Association of Health Underwriters

AMERICA'S BENEFITS SPECIALISTS

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Prologue

The changes to the American health insurance system that have occurred as a result of enactment of the Patient Protection and Affordable Care Act are many and profound. Since March 23, 2010, when the PPACA was signed by President Obama, health insurance professionals have been on a steep learning curve in an effort to understand the tens of thousands of pages of law, regulation and guidance necessary to assist individuals, employers and employees.

Several provisions of the PPACA have been delayed or, in some cases, repealed. Provisions that were repealed include the CLASS Act, which was found to be a fiscally unsustainable long-term-care program, the $2,000 deductible limit on small-employer group health plans and the requirement that employers with 200 or more employees provide auto-enrollment.

Changes that were implemented in the first years of implementation were numerous, including:

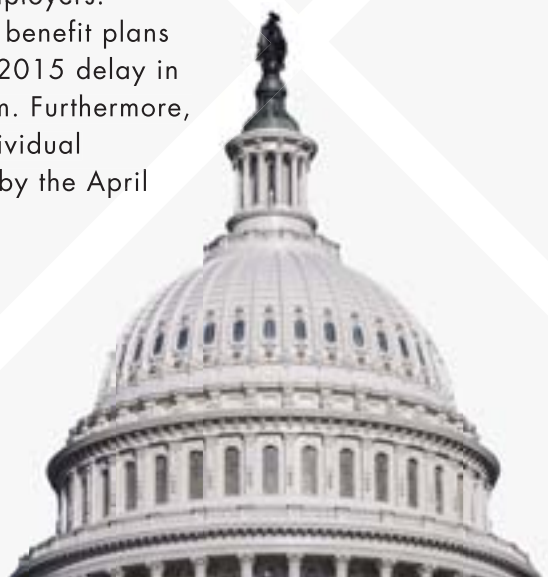
- Coverage for dependents to age 26.
- Elimination of lifetime and annual dollar limits on benefits.
- Coverage for pre-existing conditions.
- Coverage for specific preventive care services without cost-sharing.

Many ramifications of provisions that became effective in the first years of the PPACA continue to be felt today. The requirements for insurers to meet medical loss ratio requirements or provide rebates to customers have resulted in significant changes to broker compensation. Myriad tax provisions have also been implemented that have employers and insurers counting "belly buttons" to determine tax liability.

The years of 2013 and 2014 saw the implementation of the health insurance exchanges, or marketplaces, the expansion of Medicaid in many states and the availability of new federal premium tax credit subsidies for the purchase of health insurance for many low-income Americans. The health insurance exchange marketplaces were envisioned as a mechanism to simplify the shopping experience for health insurance for individuals and small employers. As with many of the PPACA's provisions, the exchanges are still in the "proof of concept" phase.

In 2015, many of the law's requirements for employers began to kick in. The law's shared responsibility requirements will become effective for many employers. Detailed reporting requirements for many employer-sponsored group benefit plans will be filed in 2016, for the 2015 calendar year. A late December 2015 delay in reporting deadlines will give employers much needed breathing room. Furthermore, all Americans will need to report their compliance with the law's individual mandate requirement on their 2015 tax returns, which must be filed by the April 2016 deadline.

A broker just starting his career today faces an industry and a marketplace that is vastly different than that of just a few years ago. This is both the challenge and the opportunity for veterans and newcomers in the insurance industry. The changes will continue this year and in the future, as this forward-looking timeline illustrates.



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2014

The $2,000 deductible limit requirement that was set to apply to small-group plans in 2014 was repealed retroactive to the January 2014 start date.

Expansion of the Medicaid program for all individuals who make up to 133% of the FPL began. A number of states have chosen not to expand coverage. In expansion states, mandatory employer premium-assistance programs began for those eligible individuals who have access to qualified employer-sponsored coverage. States may also create a separate non-Medicaid plan, called the Basic Health Plan, for those with incomes between 133% and 200% of FPL that do not have access to employer-sponsored coverage. Basic health plan rules were issued in March 2014.

All non-grandfathered (or grandmothered) plans must adhere to annual out-of-pocket spending limits tied to the annual limits on contribution, out-of-pocket spending amounts for HSAs and high-deductible health plans required to be linked with HSAs. However, for plans with multiple benefit administrators, this requirement will not be fully effective until the 2015 plan year.

Cooperative plans are allowed to be sold through state-based health insurance exchanges. At least two multi-state national plans are also offered to individuals and small employers through state exchanges, but this requirement is being phased in over several years. The multi-state issuers must commit to offer plans in at least 60% of states and expand to all state exchanges within four years. Companies may also offer plans only in the individual markets and expand into the SHOP exchange markets over time and offer coverage only in certain service areas.

Nondiscriminatory employer-sponsored health-contingent wellness programs rules improve, and employers may increase the value of workplace wellness incentives from 20% to 30% of premiums. Employers may further increase the maximum reward to as much as 50% for programs designed to prevent or reduce tobacco use. There will be a pilot expansion of wellness programs to individual-market consumers in 10 to-be-selected states.

Standards for qualified coverage, which will apply to all qualified health plans sold in the small-group and individual insurance markets both inside and outside the exchanges, begin.

New employee waiting periods of more than 90 days are prohibited for all plans.

2014

The individual mandate tax penalty provisions of the law took effect. They require all Americans to obtain minimum essential health coverage through a private insurer or public program or face a tax penalty. There are specified exceptions, and violators will be subject to phased-in excise tax penalties for noncompliance of either a flat-dollar amount per person or a percentage of the individual's income. Individuals are required to document their compliance on their 2014 tax returns.

A national premium tax on most fully insured health insurance issuers took effect.Legislation enacted into law in December 2015 provides a one-year suspension of this tax for the year 2017.

All plans must be offered on a guaranteed-issue basis. Preexisting condition limitations as well as annual and lifetime limits will be prohibited, including for grandfathered plans. The size of a small-employer group will be redefined to one to 100 employees (although states may elect to keep the size of small groups at 50 employees until 2016). All fully insured individual and small groups will have to 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. Experience rating in the individual and small group markets will be prohibited.

Coverage offered through health insurance exchanges is effective, and premium assistance tax credits for qualified individuals and families with household incomes of between 100% and 400% of the federal poverty level (FPL) began. These refundable and advanceable subsidies are available only for people who do not have access to affordable and minimum value employer coverage and may only be used to purchase a qualified individual health plan through an exchange.

Catastrophic plans can be offered both inside and outside the exchanges to individuals who are either under age 30 or who have received an exemption from the law's individual mandate for coverage affordability or financial hardship. Premium tax credits are not available for the purchase of catastrophic plans..

All health insurance plans must pay transitional reinsurance fees annually from 2014 through 2016. The fee is a flat amount based on the number of covered lives. By November 15, 2014, insurers, employers and TPAs must report their number of covered lives for the first nine months of the year to HHS, and HHS will communicate the amount due by December 15.

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2015 2016 2017 2020

2015

Employers, insurers and exchanges will be required to report coverage information to the IRS and to covered individuals for the purposes of enforcing both the employer- and individual-mandate requirements.These reports of coverage offered in 2015 are due in 2016.

The federal Children's Health Insurance Program (CHIP) was set to expire in 2015. A two-year extension was enacted into law. Absent further Congressional action, CHIP will expire in 2017.

The employer responsibility requirements will take effect for companies that employ 50 or more full-time-equivalent employees. Such employers that do not offer minimum essential coverage to full-time employees and their dependent children, or do not offer them coverage that meets minimum value and affordability standards and have employees who obtain subsidized coverage though the exchanges,will be fined beginning with plan renewals in 2015. Mid-size employers with 50-99 FTE employees that meet transition-rule requirements may qualify for a delayed effective date for the employer-responsibility requirements. Qualifying employers will be exempt for 2015 and for the rest of a plan year that begins in 2015 and ends in 2016. Large employers may also qualify for transition relief that provides for the employer-responsibility requirements to apply upon a plan's renewal in 2015 instead of on January 1, 2015, and penalty triggers are slightly altered for the 2015 plan year.

2016

The definition of a small-employer group for health coverage purposes in all states which was to automatically expand to groups up to 100 employees was revised by the PACE Act, which was passed by Congress on October 1, 2015. The PACE Act allows each state to continue to determine if and when to expand the definition of the small group health marketplace.

2017

The Health Insurance Tax (HIT) applicable to health insurers will be suspended for this year as a result of Congressional action in December 2015.

The medical device tax, a 2.3% tax on medical devices that began in 2013, will be suspended until December 31, 2017.

States may elect to allow large employers to purchase coverage through exchanges. If they do so, the market-reform provisions will be applied to all fully insured plans offered in the state regardless of group size or whether or not the plan was purchased inside or outside the exchange.

CHIP, the federal Children's Health Insurance Program will expire absent Congressional reauthorization.

2020

The "Cadillac tax," a 40% excise tax on high-cost plans, will go into effect for all group plans. The tax is paid by the insurer in the case of a fully insured group—or the TPA in a self-funded arrangement—but is passed on directly to the employer. The value of stand-alone vision and dental plans is excluded, and the tax does not apply to accident, disability, long-term care and after-tax indemnity, or specified disease coverage. The amount of a high-cost plan for purposes of the tax is indexed for inflation and will vary annually.This tax was originally slated to go into effect in 2018 but was delayed as a part of the budget bill passed in 2015.

Members of the National Association of Health Underwriters (NAHU) service the health insurance needs of large and small employers as well as people seeking individual health insurance coverage. As such, one of NAHU's primary goals is to do everything we can to promote access to affordable health insurance coverage for all Americans. Visit www.nahu.org for more information.