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HEALTH CARE REFORM IMPLEMENTATION TIMELINE

Sep 27, 2012

We recently held a health care reform roundtable where our clients and friends were able to share ideas about their preparations for upcoming Patient Protection and Affordable Care Act compliance. Below is an implementation timeline that we shared with those in attendance. We hope you find it useful as well.

Health Care Reform: Moving Forward From 2012 to 2018

Implementation Timeline

2012	January 1, 2012	Employers begin tracking information necessary to report the aggregate cost of each employee's health coverage on Forms W-2 for 2012 and thereafter.
	August 1, 2012	First rebates from insurers due under medical loss ratio requirement. Plan sponsors must allocate rebates consistent with DOL rules.
	Plan years beginning on or after August 1, 2012	Non-grandfathered plans must begin providing FDA-approved contraceptives to women at no-cost.
	First open enrollment period or first plan year beginning on or after September 23, 2012, whichever is earlier	Provide a summary of benefits and coverage (SBC) to eligible employees and participants. Plans must provide 60-day advance notice of any material changes to the SBC.
	Plan years beginning on or after September 23, 2012 (January 1, 2013 for calendar year plans)	Any annual limit on essential health benefits cannot be less than $2,000,000.[a]
	Plan years ending on or after October 1, 2012 (December 31, 2012 for calendar year plans)	Choose method for calculating the average number of covered lives for purposes of determining the plan sponsor's required annual fee to fund the Patient-Centered Outcomes Research Institute.
2013	Cafeteria plan years beginning after December 31, 2012	The annual health FSA limit on salary reduction contributions cannot exceed $2,500 (subject to annual cost-of-living adjustments). Plans must be amended by December 31, 2014.
	January 31, 2013	Issuance of employees' Forms W-2 reporting the aggregate cost of health coverage (2012 as the first reporting year).
	March 1, 2013	Employers must provide new hires and current employees with written notice about the health exchange and the consequences of purchasing coverage through an exchange in lieu of any employer-provided coverage.

	July 31, 2013	Payment of the first annual Patient-Centered Outcomes Research Institute Fee is due. Report fee using IRS Form 720, Quarterly Federal Excise Tax Return.
	Beginning January 1, 2014	Pay or Play: Employers with an average of at least 50 full-time & full-time equivalent employees during the preceding year may be subject to a penalty tax for (i) failing to provide health care coverage to all full-time employees and their dependents; or (ii) offering minimum essential coverage that is either not affordable or under which the plan's share of the total allowed cost of benefits is less than 60% of the actuarial value.Individual Mandate: Individuals are subject to a tax penalty for each month in which they do not possess minimum essential coverage.
2014		Insurers and third-party administrators, on behalf of self-insured medical plans, must begin making contributions to support reinsurance payments through 2016. First payment due January 15, 2014.
		Grandfathered plans must extend eligibility to dependent children without regard to whether they are eligible for other employer-provided coverage.
	Plan years beginning on or after January 1, 2014	Waiting period in excess of 90 days is prohibited.
		Pre-existing condition exclusions prohibited (even for grandfathered plans).
		Annual limits on essential health benefits are prohibited.

[a] Regulations have yet to be issued defining "essential health benefits", but we know that they include items and services in the following general categories: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) maternity and newborn care; (v) mental health and substance use disorder services, including behavioral health treatment; (vi) prescription drugs; (vii) rehabilitative and habilitative services and devices; (viii) laboratory services; (ix) preventive and wellness services and chronic disease management; and (x) pediatric services, including oral and vision care.

2014		
	Plan years beginning on or after January 1, 2014	Annual out-of-pocket maximums for a non-grandfathered plan may not exceed the limits for high deductible health plans and deductibles may not be greater than $2,000 for individual coverage and $4,000 for family coverage.
		Non-grandfathered insured plans must provide comprehensive health insurance coverage that: ▪ covers essential health benefits; ▪ limits cost sharing; and ▪ covers at least 60% of the actuarial value of covered benefits.
		Non-grandfathered plans are prohibited from:

- denying any qualified individual of the right to participate in a clinical trial;
- denying, limiting or imposing additional conditions on the coverage for routine patient costs for items and services furnished in connection with participation in the clinical trial; and
- discriminating against any qualified individuals who participate in a clinical trial.

With respect to any participation or coverage, a non-grandfathered plan may not discriminate against any health care provider acting within the scope of his or her license or certification.

Non-grandfathered plans may offer financial incentives of up to 30% for participation in a wellness program.

AUTOMATIC ENROLLMENT: Employers that: (i) are subject to the Fair Labor Standards Act; (ii) have more than 200 full-time employees; and (iii) have at least one health benefit plan must automatically enroll full-time employees in one of the health benefit plans (subject to any waiting period) and provide "adequate notice" to employees (with an opportunity for employees to opt out of coverage).However, the DOL has indicated that employers are not required to comply with this requirement before final regulations are issued, which is not expected in time to implement by 2014.

ADDITIONAL REPORTING: Non-grandfathered group health plans are subject to the following additional reporting requirements:

- § Annual report filed with HHS addressing whether plan or coverage benefits (and provider reimbursement structures) satisfy various criteria related to the cost and quality of health care, such as whether the plan or coverage: (i) improves health outcomes for treatment or services through certain activities; (ii) implements activities to prevent hospital re-admissions; (iii) improves patient safety and reduces medical errors through best clinical practice, evidence-based medicine, and health information technology; and (iv) implements wellness and health promotion activities. However, a due date by which the first report must be submitted to HHS has not yet been specified.
- § Transparency in coverage reporting in which plans must disclose to HHS and the state insurance commissioner (and make available to the public) the following information: (i) claims payment policies and practices; (ii) periodic financial disclosures; (iii) data on enrollment and disenrollment; (iv) data on the number of claims denied; (v) data on rating practices; (vi) information on cost-sharing and payments regarding any out-of-network coverage; (vii) information on enrollee and participant rights under Title I of PPACA; and (viii) other information as determined by HHS. Plans subject to this reporting requirements must also provide certain cost-sharing information upon request from an individual. Although this requirement was effective beginning for plan years after September 23, 2010, it is unlikely to be enforced before state exchanges are effective in 2014.

ELECTRONIC TRANSACTION RULES: Health care reform expanded HIPAA's electronic transaction rules. Beginning in 2013, electronic eligibility and claims status transactions must be conducted in accordance with the standards and operating rules adopted by HHS. In 2014, the standards and operating rules for electronic funds transfer (EFT) and remittance advice will apply. The standards and operating rules for health claims or equivalent encounter information, enrollment and disenrollment, health plan premium payments, referral certification and authorization and health claims attachments are scheduled to be effective January 1, 2016.

2015	Filing deadline TBA	Filing of first annual information return by: (i) sponsors of self-insured plans; (ii) large employers; and (iii) employers offering minimum essential coverage reporting certain plan information, including whether minimum essential coverage is provided to full-time employees and their dependents. A written statement must be provided to each full-time employee whose name was required to be included in

		such report on or before January 31 of the year following the calendar year for which the information was reported.
2018	Taxable years beginning January 1, 2018	Employer must pay nondeductible 40% excise tax on the amount, if any, by which the monthly value/cost of health coverage provided to an individual exceeds $10,200 for an individual and $27,500 for a family, as such amounts are indexed for inflation.