



Health Care Reform Action Plan

PHASE 1 (2010-2011)

**Effective at plan renewal after 9/23/10 unless otherwise indicated.*

Plan Administration / Design Considerations

1. Determine if the plan will be grandfathered (Grandfathered status as of 3/23/10). **See KTB Resource "Grandfathered Health Plans"*
2. Evaluate new plans and eligibility to ensure non-discrimination requirements are met in compliance with IRS Section 105 (self-insured plans already subject to this requirement, which is now being extended to fully-insured plans). **See KTB Resource "Non-Discrimination Rules"*
3. Review appeals process and amend if necessary to comply with new requirements. **See KTB Resource "Appeals Process Requirements"*
4. EMPLOYERS WITH 200+ EMPLOYEES: Establish method to auto-enroll new full-time employees in the plan and to provide adequate notice of auto-enrollment as well as an opt-out option. The regulations specify no effective date, but are presumed effective when regulations are issued by the Department of Labor (DOL).
5. Develop "Lactation Accommodation" policy and establish private space for lactation (effective 3/23/10). If an employer has fewer than 50 employees and establishment of a private space would pose an undue hardship, that employer may not be required to comply. **See KTB Resource "Lactation Accommodation" and "Lactation Accommodation Sample Policy"*
6. Non-retaliation provisions take effect (effective 3/23/10). Employers may not discriminate or retaliate against an individual who makes a complaint about noncompliance with the Reform laws, receives any subsidy, or participates in the Exchanges.

Coverage Requirements

1. Evaluate new plans to ensure required benefits are included whether grandfathered or not:
 - a. Uniform summary of benefits
 - b. No lifetime caps or annual coverage limits
 - c. Limits on rescissions of coverage (except for fraud)
 - d. No pre-existing conditions exclusions for children under age 19
 - e. 90 day maximum waiting period for benefits (effective 2014)

- f. Dependent to age 26 coverage (if grandfathered, the plan can limit coverage if other employer-provided coverage available) **See KTB Resources “Early Extension of Dependent to Age 26 Coverage – Participating Carriers” and “Early Extension of Dependent to Age 26 Coverage – Sample Template for Employee Communication”*
2. Evaluate new plans to ensure required benefits are included unless grandfathered:
 - a. Enrollees may designate any in-network primary care physician as their primary care physician
 - b. Preventive services must be covered with no cost-sharing
 - c. Emergency services must be covered at the in-network rates regardless of provider.
3. If medical FSA, HSA or HRA offered, exclude over-the-counter drugs unless prescription is provided and update plan documents. Update any HSA plan documents to reflect the increased penalty for non-qualified disbursements.

Recordkeeping and Reporting

1. Develop system to track cost of employer-sponsored coverage each year; work with payroll to include the cost in W-2 reporting. (Applies to benefits provided during tax years after 12/31/10). **See KTB Resource “W-2 Reporting”*
2. Prepare for annual reporting to the Secretary of the Treasury to include: whether employer offers minimum essential coverage; any waiting period for coverage; monthly premium for lowest cost option in each enrollment category under the plan; employer’s share of the total allowed cost of benefits provided; number of full-time employees during each month; name, address and TIN of each full-time employee and months they were covered by the employer’s plan; and other information as determined by the Secretary (regulations on method of reporting and specific information required pending).
3. Determine if employer will participate in the federal long-term care coverage program (CLASS Act) and establish auto-enrollment and opt-out process. **See KTB Resource “CLASS Act Limited Long-Term Care Coverage”*

Notice Requirements

1. Develop Uniform Summary of Benefits. Health and Human Services (HHS) will develop standards and model notice by 3/23/11.
2. Update any plan documents and summary plan descriptions to reflect changes made as a result of the reform, such as dependent definitions and allowable FSA expenses.
3. If grandfathered, include grandfathered health plan status disclosure in plan materials. **See KTB Resource “Grandfathered Health Plan Status Disclosure Template”*

Taxes

1. Calculate per-head fees for each plan year beginning after 9/30/12 to fund federal comparative effectiveness research (regulations pending on how to pay this tax). For the first year the fee is \$1 per enrollee and increases to \$2 per participant for each year thereafter, ending for plan years beginning after 9/30/19.

PHASE 2 (2012-2013) **Regulations needed to fully develop action plan.*

1. Payment of the per-head fees begins for each plan year beginning after 9/30/12 to fund federal comparative effectiveness research (regulations pending). \$1 per enrollee in the first year and \$2 per enrollee each year thereafter, ending for plan years beginning after 9/30/19.
2. If medical FSA offered, annual limit on the maximum election is set at \$2,500 beginning in 2013; update plan documents to reflect the new limit.
3. Develop employee notice to be distributed to current employees by 3/1/13 regarding the exchanges, premium credits, minimum essential benefits, and availability of subsidies. Notice required for new employees on or after 3/1/13 at time of hire.
4. Increase payroll tax withholdings for Medicare for families with annual gross annual incomes higher than \$250,000 in 2013.
5. 1099 tax forms required not just for contract workers but also to any individuals or corporations from which a company purchases more than \$600 in goods or services in a year (regulations expected in 2011).

PHASE 3 (2014-2017) **Regulations needed to fully develop action plan.*

1. All plans must provide minimum essential benefits unless grandfathered (to be determined by HHS).
2. No pre-existing conditions exclusions for anyone (whether plan is still grandfathered or not).
3. Determine if coverage will be purchased through the exchange or on the private market (cost-analysis determination of potential penalties and fees for not providing coverage versus cost of providing coverage).
4. Employers who offer coverage must provide "Free Choice Voucher" to employees meeting certain income requirements if that employee purchases coverage through exchange. Failure to do so will result in the employer paying the penalties for that employee.
5. Evaluate wellness programs for compliance with new requirements. Determine eligibility for grant program and apply if applicable.
6. Calculate and pay the "play or pay" penalties if coverage not offered.
7. Individual mandates take effect.
8. Plan changes must be communicated to participants at least 60 days before taking effect.

PHASE 4 (2018 and beyond) **Regulations needed to fully develop action plan.*

1. Employers with high-end "Cadillac" health plans: determine the amount of excess premium; calculate and pay taxes as required.
2. The per-head fees that started in 2012 no longer apply to plan years ending after 9/30/19.