



Waterstone Benefit Administrators

Affordable Care Act Timeline

The federal health care reform legislation enacted in March 2010 raises many issues for employers, large and small, as well as other health plan sponsors. The vast majority of changes will affect employers and plan sponsors for plan years beginning on or after September 23, 2010. However, there are many provisions that become effective on different dates over a period of time.

Below is an overview of the effective dates for some of the provisions that apply to self-insured group plans. Please be aware, exceptions to these effective dates and limitations on these provisions may change over time. While there are many provisions in the legislation, the below timeline is directed to self-insured plans. Waterstone will notify our groups when we are made aware of any changes or updates.

APPLIES TO	EFFECTIVE 2010 PROVISIONS	COMMENTS/CLARIFICATIONS	SECTION/ PAGE OF LEGISLATION
Dependent	Provide dependent coverage for dependents up to the age of 26. Plans must implement after September 23, 2010 in conjunction with their plan year. Plans may deny coverage to any child who is eligible for other employment-based health coverage up until 2014. At that point you must cover dependent children up to the age of 26.	Adult dependents are to be covered up to age 26 if the child is not eligible for an employer-sponsored health plan.	HR 3590 Sec. 1001, 2714 Page 14 HR 4872: Sec. 2301 Page 145
Employee/ Dependent	Prohibition of lifetime limits.		HR 3590 Sec.1001, 2711 Page 13 HR 4872: Sec.2301 Page 144
Plan Sponsor	Prohibition or recessions - Plan cannot rescind coverage unless in the instances of fraud. Plans must implement after September 23, 2010 in conjunction with their plan year.	Most self-funded plans do not have an issue with this provision	HR 3590 Sec. 2712 Page 13 HR 4872: Sec. 2301 Page. 144
Plan Sponsor	Prohibition on preexisting conditions. No Health plan can impose any pre-existing condition exclusion or discriminate against enrollees under the age of 19 who have been sick in the past. Plans must implement after September 23, 2010 in conjunction with their plan year.	Effective January 1, 2014 preexisting is prohibited for all enrollees.	HR 3590 Sec. 1201, 2704 Page 36 HR 4872: Sec. 2301 Page 145
Plan Sponsor	Prohibition of annual limits- Plans may eliminate or restrict annual limits on the dollar value of "essential benefits". Annual limits are being phased out over the next three years: For plan years beginning on or after September 23, 2010 - \$750,000.00 For plan years beginning on or after September 23, 2011 - \$1.25 million For plan years beginning on or after September 23, 2012 - \$2 million	Essential benefits have not been established as of yet. Plans may have annual dollar limits on non-essential benefit components. HHS is charged with defining essential health benefits and must include but not limited to: Ambulatory patient services, Emergency services, Hospitalizations, Maternity and newborn care, Mental Health and substance abuse, Rx, Rehabilitative and habilitative services and devices, Laboratory service, Preventive and wellness, and Pediatric service. After 2014 All annual limits are excluded.	HR 3590 Sec. 10101, 2711 Page 765 HR 4872: Sec. 2301 Page 144

Essential Health Benefit Update

On December 16th, 2011, the Center for Consumer Information and Insurance Oversight proposed a benchmark standard to define essential health benefits. Under the proposal, states would choose a benchmark plan from:

- The largest plan by enrollment in any of the three largest small group insurance products in the state;
- Any of the largest three state employee benefit plans;

- Any of the largest three national Federal Employee Health Benefits program plans; or
- The largest commercial HMO in the state.

If a state failed to choose a benchmark, the default plan would be the largest plan by enrollment in the small group market. Of course, any benchmark plan would need to include the 10 statutorily-required areas of essential health benefits.

<http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>

PROVISIONS TO NON-GRANDFATHERED PLANS			
Plan Sponsor	Requirement for coverage of certain preventive health services and immunizations without cost-sharing for services provided by In-network providers. Plans may impose cost-sharing or not cover services for out of network providers.	This does not apply to current self-funded plans. However plans will have to cover specific preventive care services with no cost-sharing. Specific types of coverage are mandated.	HR 3590 Sec. 1001, 2713 Page 13
Plan Sponsor	Requirements to provide patient protections regarding emergency services, choice of primary care provider and access to gynecological/obstetric services	This does not apply to current self-funded plans	HR 3590 Sec. 2719A Page 770
Plan Sponsor	Requirement for Internal and External Appeals Processes Update: DOL issued T.R. 2010-02 specifically setting forth an enforcement grace period until July 1, 2011 for specific provisions. However, T.R. 2011-01 extends the enforcement grace period set for in T.R. 2010-02 until plan years beginning on or after January 1, 2012 To view T.R. 2010-02 and T.R. 2011-01 please refer to the following websites: http://www.dol.gov/ebsa/newsroom/tr10-02.html http://www.dol.gov/ebsa/newsroom/tr11-01.html	Requirements apply to non-grandfathered plan year beginning on or after September 23, 2010.	HR 3590 Sec. 1001, 2719 Page 19
APPLIES TO	EFFECTIVE 2011 PROVISIONS	COMMENTS/CLARIFICATIONS	SECTION/ PAGE OF LEGISLATION
Plan Sponsor	Reporting of Value of Health Benefits on W-2 (optional for 2011)	W-2's issued on or before Jan 31, 2012 must report the value of health benefits provided in 2011. Although the value of health benefits must be reported, it will not be subject to federal income tax.	HR 3590 Sec.9002 Page 735
Plan Sponsor	Change of Expenses Reimbursable from a Flexible Spending Account, Health Savings Account, or Health Reimbursement Account, e.g., <i>no reimbursement for over-the-counter medications unless prescribed.</i>	May require amendments to spending account programs.	HR 3590 Sec.9003 Page 736
Plan Sponsor	HSA: the penalty for non-qualifying distributions increases to 20%, in addition to the inclusion in income.		HR 3590 Sec.9004 Page 736
APPLIES TO	EFFECTIVE 2012 PROVISIONS	COMMENTS/CLARIFICATIONS	SECTION/ PAGE OF LEGISLATION
Plan Sponsor	Reporting of Value of Health Benefits on W-2 To view IRS FAQ's on the Form W-2 Reporting provision click the below link http://www.irs.gov/pub/irs-drop/n-12-09.pdf	W-2's issued on or before Jan 31, 2013 must report the value of health benefits provided in 2012. Although the value of health benefits must be reported, it will not be subject to federal income tax.	
Plan Sponsor	Uniform Summary of Benefits and Coverage (SBC) for enrollment or re-enrollment that occurs on and after March 23, 2012. Update: The effective date has been delayed for six (6) months. The Effective date is now for Plan Years beginning on or after September 23, 2012.	HHS must issue a set of standards that all medical plans will use to describe their benefits no later than March 23, 2011. Update February 9, 2012: Final Regulations have been issued.	HR 3590 Sec. 1001, 2715 Page 14
Plan Sponsor	Group Health Plans must notify enrollees of material changes to the coverage described in the uniform explanation no less than 60 days before the change is effective.	Effective 24 months from date of enactment, March 23, 2012	HR 3590 Sec. 1001, 2715 (4) Page 16
Plan Sponsor	PATIENT-CENTERED OUTCOME RESEARCH TRUST FUND - A fee equal to \$2 (\$1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan will be imposed. Update April 17, 2012: Proposed Rules issued. http://www.gpo.gov/fdsys/pkg/FR-2012-04-17/pdf/2012-9173.pdf	Beginning 2014, indexed.	HR 3590 Sec.4376 Page 626
APPLIES TO	EFFECTIVE 2013 PROVISIONS	COMMENTS/CLARIFICATIONS	SECTION/ PAGE OF LEGISLATION
Employee	Health Flexible Spending Cap, \$2500.00; indexed.	Employer Plan Redesign Required	HR3590 Sec. 9005 Page 736 HR4872 Sec. 1403 Page 95
Plan Sponsor	Employers become subject to notification requirements regarding insurance exchanges and subsidies. (Effective March 1, 2013)	This effective date is in advance of the provision. Plan Sponsors should be prepared to give notification prior to the Exchange effective date January 1, 2014.	HR 3590 Sec. 1512 Page 134

APPLIES TO	EFFECTIVE 2014 PROVISIONS	COMMENTS/CLARIFICATIONS	SECTION/PAGE OF LEGISLATION
Plan Sponsor	Waiting Periods longer than 90 days prohibited.	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not apply any waiting period that exceeds 90 days.	HR 3590 Sec. 2708 Page 43
Employee	Mandates individuals to purchase insurance coverage	Individuals will be fined /taxed if they do not purchase coverage	HR 3590 Sec. 1501 Page 124
Plan Sponsor	Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit (employees who make less than 400% of the federal poverty level, today = \$44,000) will be imposed a fee of \$2,000 per full time employee, excluding the first 30 employees.	Some material refers to the fine of being \$750 versus \$2,000. The fine increased from \$750 to \$2,000 after the reconciliation process.	HR 3590 Sec. 1513 Page 135 HR 4872: Sec. 1003, Page 10
Plan Sponsor	Employers with more than 50 employees that offers coverage but has at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 fine for each employee receiving such premium credit or \$2,000 fine for each full-time employee	Some material refers to the fine of being \$750 versus \$2,000. The fine increased from \$750 to \$2,000 after the reconciliation process.	HR 3590 Sec. 1513 Page 135 HR 4872: Sec. 1003, Page 10
Plan Sponsor	Section 1511 requires employers with more than 200 employees to automatically enroll into health insurance plans offered by the employer. The employee may opt out of coverage. Update February 9, 2012: On December 22, 2010, DOL issued FAQ's on section 18A of the Fair Labor Standards Act, which noted that the statute provides that employer compliance with the automatic enrollment provisions of section 18A of the FLSA shall be carried out "in accordance with regulations promulgated by the Secretary of Labor." The FAQ also stated that it is the view of the DOL that, until such regulations are issued, employers are not required to comply with section 18A. Finally, the FAQ indicated that the DOL intends to complete this rulemaking by 2014. http://www.dol.gov/ebsa/faqs/faq-aca5.html	Employers must provide adequate notice to their employees of their enrollment.	HR 3590 Sec.1511 Page 134
Plan Sponsor	Free Choice voucher - Employees who are required to pay between 8 and 9.8% of the employee's household income toward the cost of coverage and if their household income is less than 400% of the federal poverty level are allowed the opportunity for a free choice voucher to use to purchase coverage through the exchange. The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage under the employer's health plan. Update April 14, 2011: As part of the spending bill agreed to that will fund the government for the remainder of the Fiscal Year, the Free Choice Vouchers Provision will be struck from the PPACA law.	The cost of the voucher will not count as taxable income for any recipient and the cost of any vouchers to an employer is deductible for such employer.	HR 3590 Sec. 1401 Page 95 HR 4872: Sec. 1001 Page 4
Plan Sponsor	Plans must report coverage information to enrollees and the IRS		HR 3590 Sec. 1514, 6056 Page 138
Plan Sponsor	Employers that offer coverage through an exchange may permit pre-tax contributions through their cafeteria plans.		HR 3590 Sec. 1515 Page 140
Plan Sponsor	Access to Clinical Trials – All non-grandfathered self-insured health plans (and all other non-grandfathered group health plans) that provide coverage to an individual who meets the qualifications to participate in a clinical trial dealing with the treatment of a life-threatening disease, may not: 1) deny the participation in the clinical trial; 2) deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; 3) discriminate against the individual on the basis of the individual's participation in a clinical trail	"Approved Clinical Trial" means phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in HR 3590, Section 2709(d) page 776-777	HR 3590 Sec. 2709 Page 774

*HR 3590 "The Patient Protection and Affordable Care Act"

* HR 4872 "Health Care and Education Reconciliation Act of 2010"

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