

Legislative Brief

Health Care Reform Timeline



On March 23, 2010, President Obama signed into law the health care reform bill, the Patient Protection and Affordable Care Act. This legislation, along with the Health Care and Education Reconciliation Act of 2010, makes sweeping changes to the U.S. health care system. These changes will be implemented over the next several years.

This Legislative Brief provides a timeline of the implementation of key reform provisions that affect employers and individuals. Please read below for more information and contact NP Dodge Insurance with any questions about how you can prepare for health care reform.

2010

Expanded Insurance Coverage

The health care reform law contains some provisions designed to provide improvements in access to health care coverage this year.

- **Extended Coverage for Young Adults.** Group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children must make coverage available for adult children up to age 26. There is no requirement to cover the child of a dependent child. This requirement will apply to grandfathered and new plans.
The Reconciliation Act added a new tax provision related to health insurance coverage for these adult children. Effective March 30, 2010, amounts spent on medical care for an eligible adult child can be excluded from taxable income.
Note: a “grandfathered plan” is one in which an individual was enrolled on March 23, 2010, and to which there is no change to existing coverage. Many requirements of the new law do not apply to grandfathered plans and nothing in the law requires individuals terminate coverage in which they were enrolled when the law was passed. A plan can still be a grandfathered plan even if family members or new employees are allowed to join.
- **Access to Insurance for Uninsured Individuals with Pre-Existing Conditions.** The health care reform bill provides for the establishment of a temporary high risk health insurance pool program to provide health insurance coverage for certain uninsured individuals with pre-existing conditions. The program will end when the health insurance exchanges, set to be established in 2014, are operational.
- **Identifying Affordable Coverage.** The Secretary of Health and Human Services is required to establish an Internet website through which residents of any state may identify affordable health insurance coverage options in that state. The website will also include information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits, and other information of interest to small businesses. So-called “mini-med” or limited-benefit plans will be precluded from listing their policies on this website.
- **Reinsurance for Covering Early Retirees.** The new law requires the establishment of a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program will end on January 1, 2014.

Health Insurance Reform

The new law also imposes requirements on health insurance issuers to reform certain insurance practices and improve the coverage available.

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- **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. This provision will apply to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.
- **Coverage of Preventive Health Services.** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for preventive services. These plans also may not impose cost sharing requirements for preventive services.
- **Prohibiting Rescissions.** The health care reform law is designed to prohibit abusive rescissions of coverage by insurance companies when an individual gets sick as a way of avoiding covering the cost of the individual's health care needs. Group health plans and health insurance issuers offering group or individual insurance coverage may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be cancelled without prior notice to the enrollee. This provision applies to all new and existing plans.
- **Limits on Lifetime and Annual Limits.** In general, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or impose unreasonable annual limits on the dollar value of benefits for any participant or beneficiary. This requirement applies to all plans. Annual limits will also be prohibited beginning in 2014.

Health Plan Administration

In addition to any administrative changes required by the coverage improvements described above, health plans will be subject to increased administrative duties under health care reform.

- **Improved Appeals Process.** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, plans and issuers must:
 - have an internal claims process in effect;
 - provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist them with the appeals processes; and
 - allow enrollees to review their files, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

The internal claims process must initially incorporate the current claims procedure regulations issued by the Department of Labor in 2001. Plans and issuers must also implement an external review process that meets applicable state requirements and guidance that is to be issued.

- **Nondiscrimination Rules for Fully-Insured Plans.** Fully-insured group health plans will now have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This section does not appear to apply to grandfathered plans.

Medicare/Medicaid

The health care reform law will further affect individuals by making certain changes to Medicare and Medicaid.

- **Rebates for the Medicare Part D "Donut Hole."** Currently, there is a gap in Medicare prescription drug coverage. The coverage gap falls between \$2,830 and \$6,440 in total drug spending. The health care reform bill provides a \$250 rebate check for all Medicare Part D enrollees who enter the "donut hole." Beginning in 2011, a 50 percent discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The donut hole gap will be filled by 2020.
- **Medicaid Flexibility for States.** States are given a new option under the health care reform law to cover additional individuals under Medicaid. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

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Fees and Taxes

With a total estimated cost of over \$900 billion dollars, the reform of the nation's health care system comes with additional costs and fees. These fees will also be implemented over the next several years. However, health care reform also includes some subsidies, in the form of tax credits, to help individuals and businesses pay for coverage.

- **Small Business Tax Credit.** The first phase of the small business tax credit for qualified small employers begins in 2010. These 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 nonprofit organizations. When health insurance exchanges are operational, tax credits will increase, up to 50 percent of premiums.
- **Indoor Tanning Services Tax.** One additional tax imposed by the health care reform law is a 10 percent tax on amounts paid for indoor sun tanning services.

2011

Expanded Insurance Coverage

- **Voluntary Long-Term Care Insurance Options.** The health care reform law creates a long-term care insurance program for adults who become disabled. Participation will be voluntary and the program is to be funded by voluntary payroll deductions to provide benefits to adults who become disabled.

Health Plan Administration

- **Improving Medical Loss Ratios.** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.
- **Reporting Health Coverage Costs on Form W-2.** Beginning in 2011, employers will be required to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2.
- **Standardizing the Definition of Qualified Medical Expenses.** The health care reform law conforms the definition of "qualified medical expenses" for HSAs, FSAs and HRAs to the definition used for the itemized tax deduction. Amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses. Costs for over-the-counter medications obtained without a prescription would not qualify.
- **Cafeteria Plan Changes.** The new law creates 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 pension plan nondiscrimination requirements applicable to highly compensated and key employees.

Medicare/Medicaid

- **Medicare Part D Discounts.** In order to make prescription drug coverage more affordable for Medicare enrollees, the new law will provide a 50 percent discount on all brand-name drugs and biologics in the "donut hole." It also begins phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for all Part D enrollees.
- **Additional Preventive Health Coverage.** The new law provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for preventive services beginning in 2011.

Fees and Taxes

- **Increased Tax on Withdrawals from HSAs and Archer MSAs.** The health care reform law will increase 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 would increase from 15 to 20 percent.

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Health Plan Administration

- **Administrative Simplification.** Beginning in 2013, health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.
- **Limiting Health Flexible Savings Account Contributions.** The new health care law will limit the amount of contributions to health FSAs to \$2,500 per year, indexed by CPI for subsequent years.

Fees and Taxes

- **Eliminating Deduction for Medicare Part D Subsidy.** Currently, employers that maintain prescription drug plans for their Medicare Part D eligible retirees are entitled to a tax deduction. This deduction will be eliminated in 2013.
- **Increased Threshold for Medical Expense Deductions.** The health care reform law increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.
- **Additional Hospital Insurance Tax for High Wage Workers.** The new law increases the hospital insurance tax rate by 0.9 percentage points on wages over \$200,000 for an individual (\$250,000 for married couples filing jointly). The tax is also expanded to include a 3.8 percent tax on net investment income in the case of taxpayers earning over \$200,000 (\$250,000 for joint returns).
- **Medical Device Excise Tax.** The law also establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are excepted from the tax.

2014

Coverage Mandates

- **Individual Coverage Mandates.** The health care reform legislation requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at \$95 per person for 2014 and increase each year. The penalty amount increases to \$325 in 2015 and to \$695 (or up to 2.5 percent of income) in 2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of \$2,250 per family. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.
- **Employer Coverage Mandates.** Employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if one employee receives a government subsidy for health coverage. The penalty amount is up to \$2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits, will be subject to a fine of \$3,000 for each worker receiving a tax credit, up to an aggregate cap of \$2,000 per full-time employee. Employers will be required to report to the federal government on health coverage they provide.

Health Insurance Exchanges

The health care reform legislation provides for **health insurance exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. Large employers with over 100 employees are to be allowed into the exchanges in 2017. Workers who qualify for an affordability exemption to the coverage mandate, but do not qualify for tax credits, can use their employer contribution to join an exchange plan.

Health Insurance Reform

Additional **health insurance reform** measures will be implemented beginning in 2014. Specifically, health insurance companies will not be permitted to:

- Refuse to sell or renew policies due to an individual's health status;
- Exclude coverage for treatments based on pre-existing health conditions

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- Charge higher rates due to health status, gender or other factors (premiums will be able to vary based only on age (no more than 3:1), geography, family size, and tobacco use);
- Impose annual limits on the amount of coverage an individual may receive; or
- Drop 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.

Fees and Taxes

- **Individual Health Care Tax Credits.** The new law makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- **Small Business 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.
- **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.

2018

High-Cost Plan Excise Tax

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance (also known as a "Cadillac tax"). 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. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

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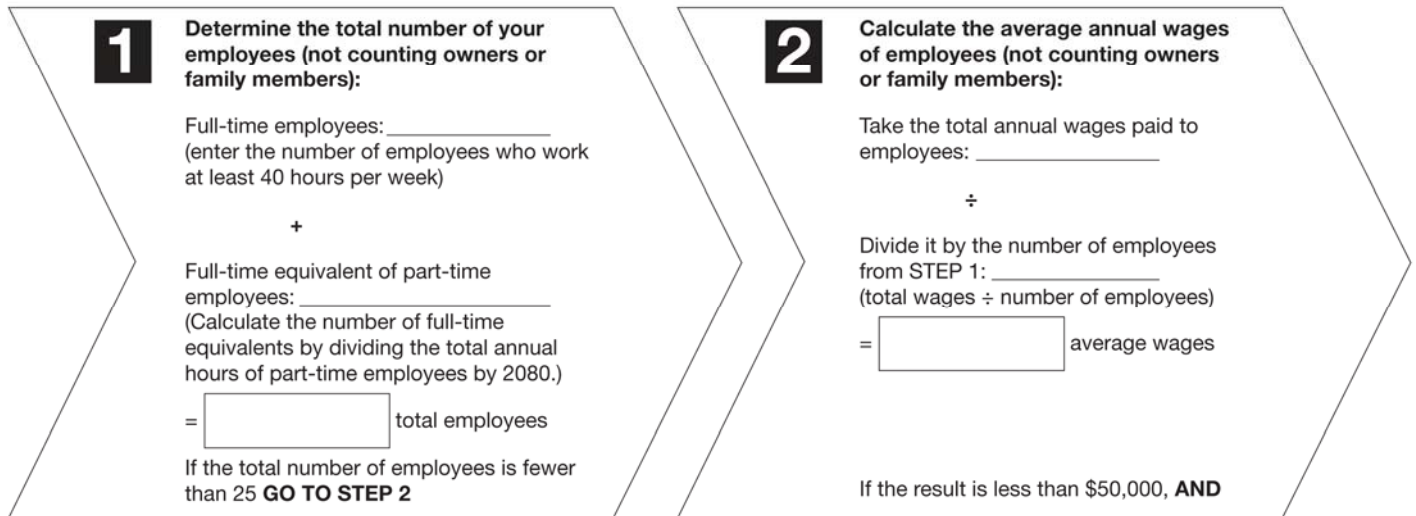
Small Business Health Care Tax Credit: Steps to Determine Eligibility



Determine if you may qualify for the Small Business Health Care Tax Credit by following these three simple steps from the IRS.

3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:



3 You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then

» you may be able to claim the **Small Business Health Care Tax Credit**.
Find out more information at **IRS.gov**

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Health Care Reform: Grandfathered Plans



EXECUTIVE SUMMARY

In March 2010, President Obama signed sweeping health care legislation into law. The health care reform law contains many provisions that will affect your business and your employees. The extent of the impact will depend, in part, on whether you maintained a health care plan on March 23, 2010, the date the primary legislation was enacted. If your company sponsored a plan on that date, it is considered a “grandfathered” plan.

- Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, the date of enactment of the legislation.
- These plans can avoid many of the new health care reform provisions.
- The “grandfathered” protections still apply even if family members join current coverage or new employees join a current plan.

This NP Dodge Insurance Legislative Brief provides information to help you understand what makes a plan “grandfathered.” It also describes the provisions that do not apply to grandfathered plans, as well as major provisions that do apply. Please read below for more information.

HOW HEALTH CARE REFORM AFFECTS GRANDFATHERED PLANS

Grandfathered Plans

The new health care reform law provides that certain provisions of the law will not apply to group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, the date the legislation was passed. The legislation refers to these plans as “grandfathered health plans.” The law states that a grandfathered plan will retain its grandfathered status even if the covered individual renews the coverage after March 23, 2010, family members are allowed to enroll or new employees (and their families) are allowed to enroll.

Regulations issued by the Departments of Health and Human Services (HHS), Labor and Treasury on June 14, 2010, clarify which additional changes can be made to grandfathered plans. The regulations essentially state that plans will lose their grandfathered status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers. Losing grandfathered status means that a plan would have to comply with the health care reform requirements that do not apply to grandfathered plans, such as first-dollar coverage of recommended prevention services and patient protections such as guaranteed access to OB-GYNs and pediatricians.

Specifically, the prohibited changes include the following:

- **Significantly Cutting or Reducing Benefits.** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- **Raising Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20 percent of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Significantly Raising Co-Payment Charges.** Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points.
- **Significantly Raising Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000 or \$1,500 a year). Compared with the deductible required as of March

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Health Care Reform: Grandfathered Plans

23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points.

- **Significantly Reducing Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 25%).
- **Adding or Tightening an Annual Limit.** If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- **Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan. This does not apply when employers that provide their own insurance to their workers switch plan administrators or to collective bargaining agreements.

Health Care Reform Rules that Do Not Apply to Grandfathered Plans

The grandfathering provision of the health care reform law specifically exempts grandfathered plans from certain requirements of the law. Grandfathered health plans are exempt from the following requirements:

- **Coverage of Preventive Health Services.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for certain preventive health services without imposing cost-sharing requirements.
- **Patient Protections.** Effective for plan years beginning on or after September 23, 2010, the health care reform law puts the following rules in place for patients:
 - Group health plans and health insurance issuers offering group or individual health insurance coverage that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).
 - Group health plans and health insurance issuers offering group or individual health insurance coverage that provide emergency services may not impose preauthorization or increased cost-sharing for emergency services (in or out of network).
 - Group health plans and health insurance issuers offering group or individual health insurance coverage that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.
- **Nondiscrimination Rules for Fully-Insured Plans.** Effective for plan years beginning on or after September 23, 2010, fully insured plans must satisfy the requirements of Internal Revenue Code section 105(h)(2). That section provides that a plan may not discriminate in favor of highly compensated individuals as to eligibility to participate and that the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.
- **Quality of Care Reporting.** Within two years of the date of enactment, reporting requirements will be developed for group health plans and health insurance issuers offering group or individual health insurance coverage. The reports will relate to benefit and reimbursement structures that are designed to improve health outcomes, prevent hospital readmissions, improve patient safety, reduce medical errors and implement health and wellness activities.
- **New Appeals Process.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims.

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- **Insurance Premium Restrictions.** Effective for plan years beginning on or after January 1, 2014, premiums charged for health insurance coverage in the individual or small group market may not be discriminatory and may vary only by individual or family coverage, rating area, age and tobacco use, subject to certain restrictions.
- **Guaranteed Issue and Renewal of Coverage.** Effective for plan years beginning on or after January 1, 2014, 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 in force the coverage at the option of the plan sponsor or the individual.
- **Nondiscrimination Based on Health Status.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may not establish rules for eligibility or continued eligibility based on health status-related factors. Wellness programs must meet nondiscrimination requirements.
- **Nondiscrimination in Health Care.** Effective for plan years beginning on or after January 1, 2014, 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. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.
- **Comprehensive Health Insurance Coverage.** Effective for plan years beginning on or after January 1, 2014, health insurance issuers that offer health insurance coverage in the individual or small group market must provide the essential benefits package required of plans sold in the health insurance exchanges.
- **Limits on Cost-Sharing.** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose cost-sharing or out-of-pocket costs in excess of certain limits. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs and deductibles may not exceed \$2000 (single coverage) or \$4000 (family coverage). These amounts are indexed for subsequent years.
- **Coverage for Clinical Trials.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual insurance coverage must permit certain enrollees to participate in certain clinical trials, must cover routine costs for clinical trial participants and may not discriminate against participants.

Special Effective Date for Collectively Bargained Plans

The regulations provide special rule for insured plans that are maintained pursuant to one or more collective bargaining agreements in place before March 23, 2010. These plans are considered grandfathered until the last collective bargaining agreement terminates, even if there is a change in insurers or one of the other changes that would otherwise terminate a plan's grandfathered status. This rule does not apply to self-funded collectively bargained plans. They will need to comply with the restrictions on grandfathered plans right away.

Contrary to what many expected, this special rule does not provide a delayed effective date for collectively bargained plans to comply with the health care reform requirements. Rather, it extends the time these plans can be considered grandfathered. Also, these plans are not exempted from complying with the rules that apply to grandfathered plans. After the last collective bargaining agreement expires, whether the plan is grandfathered will be determined by comparing the plan in existence on the expiration date with the plan as it existed on March 23, 2010.

Major Health Care Reform Rules that Do Apply to Grandfathered Plans

The Health Care and Education Reconciliation Act of 2010 (the Reconciliation Bill) repealed some of the exemptions that were originally intended for grandfathered plans. Therefore, the provisions described below apply to both grandfathered *and* new health plans. Keep in mind that this is a description of major provisions that affect health plans, not an exhaustive list of how health care reform might affect your company.

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Health Care Reform: Grandfathered Plans

- **Extension of Dependent Coverage.** Effective for plan years beginning on or after September 23, 2010, group health plans must provide coverage for adult dependent children up to age 26 if the child is not eligible to enroll in other employer-provided coverage (other than in a grandfathered plan). Effective March 30, 2010, employer-provided health insurance coverage provided to these adult children is tax-free to employees.
- **Elimination of Lifetime and Annual Limits.** Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers offering group or individual health coverage may not establish lifetime limits on the dollar value of essential benefits. Group health plans may also not establish unreasonable annual limits. In 2014, all annual limits are eliminated.
- **Elimination of Pre-existing Condition Exclusions.** Effective for plan years beginning on or after September 23, 2010, pre-existing condition exclusions may not be applied to enrollees under age 19. Pre-existing condition exclusions are eliminated for all enrollees in 2014.
- **Limits on Rescissions.** Effective for plan years beginning on or after September 23, 2010, coverage may not be rescinded, except in the case of fraud or intentional misrepresentation of material fact. Policyholders must be notified prior to cancellation.
- **Limits on Waiting Periods.** Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers offering group or individual health insurance coverage may not require a waiting period of more than 90 days.
- **Summary of Benefits.** Beginning 24 months after enactment of the health care reform law, insurers and plans sponsors of self-funded plans must provide a summary of benefits to participants and applicants. The law sets out specific content and format guidelines.
- **Reporting Medical Loss Ratio.** Effective for plan years beginning on or after September 23, 2010, health insurance issuers offering group or individual health insurance coverage must annually report the percentage of premiums spent on non-claim expenses. Beginning January 1, 2011, insurers must provide rebates if more than the applicable percentage is spent on non-claims costs.

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Health Care Reform: Extension of Dependent Coverage



On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. This legislation, along with the Health Care and Education Reconciliation Act of 2010, makes sweeping changes to the U.S. health care system, including an extension of health insurance coverage to young adult children up to age 26. On May 13, 2010, an interim final rule was published to implement this extension of health insurance coverage to young adult children. Though many of the changes will be implemented over the next several years, the extension of coverage to young adult children takes effect in as little as six months from enactment.

This Legislative Brief provides a summary of the provisions of the law requiring the extension of dependent health insurance coverage. Please read below for more information and contact NP Dodge Insurance with any questions.

What Does The Law Require?

Group health plans and health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children must make coverage available for adult children up to age 26, regardless of the child's marital status. The regulations clarify that a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency, residency with the participant or with any other person, student status, employment, or any combination of those factors.

Parents can decide whether to add adult children to their plan. There is no requirement, however, to cover the child of a dependent child. The mandate applies to plans in existence on the date the law was passed ("grandfathered plans") and new plans. The cost of coverage, as well as reimbursement of medical expenses, is not taxable to the employee or the child with dependent coverage. The law also allows self-employed people who buy their own insurance to deduct the cost of covering adult children up to age 26.

Though the coverage requirement ends on the child's 26th birthday, employers can continue to offer this benefit until the end of the plan year with preferential tax treatment on the extension. The regulations provide that the terms of the plan or health insurance coverage providing dependent coverage of children, including the premiums charged, cannot vary based on age (except for children who are age 26 or older). The regulations also provide a transitional rule for young adult children whose coverage ended or who were denied or not eligible for coverage because the availability of coverage ended before age 26, and who become eligible or are required to become eligible for coverage on the first day of the first plan year on or after September 23, 2010.

To Whom Does The Law Apply?

Insurers and all health plans that provide dependent coverage of children will be required to permit an adult child to stay on family policies until age 26. "Child" means an individual who is a son, daughter, stepson, stepdaughter or eligible foster child of the taxpayer/employee.

What Is The Effective Date Of The Law?

The extension of dependent coverage provision takes effect for plan years beginning on or after **September 23, 2010** though it can be adopted earlier. That means that for October plans, the start date would be October 1, 2010. Plans that run on a calendar-year basis must cover an employee's dependent child up to age 26 starting on January 1, 2011. Plans that begin July 1 must cover dependents up to age 26 starting on July 1, 2011.

For grandfathered plans, before January 1, 2014, the provision will apply only with respect to dependent children not eligible for coverage under another employer's health plan. On and after January 1, 2014, the provision applies to all plans regardless of a dependent child's eligibility for coverage under another employer health plan

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Health Care Reform: Extension of Dependent Coverage

What If State Laws Differ From Federal Law?

More than two-thirds of states have passed laws that require insured group health plans to cover dependents after they turn 18 years old, often into their mid to late 20s and in some cases later. For example, in New Jersey, unmarried children can stay on a parent's plan until they are 31 years old. Such state mandates, including those requiring coverage past age 26, will continue to apply.

What Are the Tax Effects Of State Laws Which Require Coverage Longer Than The Federal Law?

The Health Care and Education Reconciliation Act of 2010 amended federal tax law so that employers can offer tax-free health insurance coverage to adult children of employees during those taxable years in which the children are age 26 or under for the entire taxable year. It does not matter whether those children are tax dependents for federal income tax purposes. Often, adult children that obtain coverage pursuant to state law are not tax dependents for federal income tax purposes. In the event state laws mandate coverage past age 26, federal tax law requires employers to impute as income, to employees covering children who are not tax dependents, the fair market value of health insurance coverage provided to such non-tax dependents for those taxable years in which a covered child turns 27 or older, or that employees pay for it on an after tax basis.

Since the change in the federal tax code is not retroactive, the fair market value of coverage provided between January 1, 2010 and March 30, 2010 for a child who was not a tax dependent continues to be taxable income. Employers will still need to treat such coverage as imputed taxable income to the employee for this time period and must report it as such on the employee's Form W-2, unless it was paid for on an after tax basis.

What Should Employers Do Now?

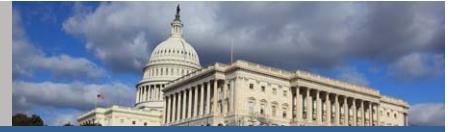
Employers face a myriad of issues related to the requirement to extend health insurance coverage to adult children. Some of the issues of which employers should be aware and should consider taking immediate action include:

- Confirming coverage changes, including possible early implementation, with TPAs, insurers and stop-loss providers;
- Determining whether there is a cost impact to the employer (e.g., whether the plan will charge for adding additional persons to the plan's coverage so long as it is without regard to age);
- Revising plan documents, enrollment materials, SPDs and other employee communications;
- Reviewing payroll practices for imputing income and withholding taxes, and making necessary adjustments;
- Considering establishing who is and who is not a tax dependent (e.g., employee certification);
- Reviewing vendor agreements to determine the need to coordinate communication and notice responsibilities with insurers; and
- Reviewing COBRA treatment of individuals, especially in states where extended coverage is optional.

The interim final rule implementing this new mandate will likely be amended after the public comment period ends on August 11, 2010. NP Dodge Insurance will keep on top of developments regarding this and other legislative initiatives and will work to keep you informed.

This NP Dodge Insurance Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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Health Care Reform: The Who, What and When

Here is a look at some of the major health care reform provisions that you will see over the next decade.

2010

Employers: Small businesses can receive tax credits if purchasing insurance for employees.

Insurers: Cannot impose pre-existing condition exclusions on coverage for children. Must cover preventive services without copays. Cannot remove coverage when a person becomes ill. Cannot impose lifetime coverage limits.

Uninsured: Individuals with pre-existing conditions receive immediate access to coverage through a high-risk pool. Dependent children can remain on parents' plans until age 26.

Early retirees: Employers will be able to participate in a reinsurance program to help provide coverage for retirees and their spouses, surviving spouses and dependents over age 55 and not eligible for Medicare.

Medicare Part D enrollees: A \$250 rebate check received for those entering the "doughnut hole" gap in coverage in 2010. Rebate payable by April 1, 2011.

2011

Insurers: Required to spend at least 80 percent of premiums on medical services.

Medicare Part D enrollees: Receive a 50 percent discount on brand-name prescription drugs when in doughnut hole coverage gap.

Those with health care savings accounts: Federal tax on those who spend health care savings

account money on ineligible medical expenses increases to 20 percent.

Over-the-counter drugs: Except for insulin, OTC drugs without a prescription are not reimbursable from an FSA or HRA, and are not a tax-free reimbursement from an HSA.

W-2: The value of your health coverage must be disclosed on your W-2 form.

2012-2013

Taxpayers: Medicare payroll taxes increase to 2.35 percent for individuals earning more than \$200,000 and families earning more than \$250,000.

Those with flexible savings accounts: A federal limit of \$2,500 for individual pretax contributions per year.

2014

Employers: Companies with 50 or more employees must provide affordable coverage or pay a penalty.

Insurers: Prohibited from refusing to sell or renew policies. Cannot deny coverage for adults with pre-existing conditions. Limits ability to set prices on the basis of sex, health status or other factors. Prohibited from imposing annual limits.

Uninsured: Most Americans required to buy health insurance or pay fines of \$95 per individual and up to \$285 per family. Families will pay half the amount for children. Families can receive subsidies to buy insurance if they earn no greater than four times the federal poverty level (about \$88,000 per year for a family of four). Individuals and small

businesses can buy packages through state exchanges.

2015

Uninsured: Penalties for not carrying insurance increase to \$325 per individual and up to \$975 per family. Families will pay half the amount for children.

2016

Uninsured: Penalties for not carrying insurance increase to \$695 per individual and up to \$2,250 per family or 2.5 percent of taxable family income – whichever is greater. Families will pay half the amount for children.

2018

Taxpayers: A 40 percent excise tax imposed on high-cost employer-provided policies (\$10,200 for individual coverage or \$27,500 for family coverage).

2020

Medicare Part D Enrollees: Prescription drug coverage gap eliminated.

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Health Care Reform: Extension of Dependent Coverage to Age 26

The recently passed health care reform legislation makes sweeping changes to the U.S. health care system, including an extension of health insurance coverage to young adult children up to age 26.

Who is Eligible?

The extension of dependent coverage applies to plans in existence on the date the health care reform legislation was passed (grandfathered plans) and new plans. Coverage must be made available to qualifying young adults up to age 26 whose parents carry private group or non-group health coverage. Qualifying young adults include sons, daughters, stepsons, stepdaughters, adopted children or eligible foster children of the parent, regardless of the qualifying young adult's marital status. It does not matter whether the qualifying young adults are tax dependents for federal income tax purposes. Parents may decide whether to add adult children to their plan, but there is no requirement to cover the child of a dependent child.

Tax-Free Coverage

Effective March 30, 2010, health coverage provided for an employee's children under 27 years of age is generally tax-free to the employee. Although the coverage requirement ends on the child's 26th birthday, employers can continue to offer the benefit on a tax-advantaged basis until the end of the taxable year in which the child turns 26.

The Internal Revenue Service announced that these changes immediately allow employers with cafeteria plans – plans that allow

employees to choose from a menu of tax-free benefit options and cash or taxable benefits – to permit employees to begin making pretax contributions to pay for the expanded benefit. This guidance also applies to health FSAs and health reimbursement arrangements (HRAs).

When Does the Dependent Coverage Extension Begin?

The extension of dependent coverage provision takes effect for plan years beginning on or after September 23, 2010. That means that for October plans, the start date would be October 1, 2010. Plans that run on a calendar-year basis must cover an employee's young adult child up to age 26 starting on January 1, 2011. Plans that begin July 1 must cover dependents up to age 26 starting on July 1, 2011. Some insurers have said that they will begin to extend dependent coverage prior to September 23, 2010, for individuals who would otherwise lose coverage.

For grandfathered plans, before January 1, 2014, the extension of coverage will apply only with respect to dependent children not eligible for coverage under another employer's health plan. On and after January 1, 2014, the provision applies to all plans regardless of a dependent child's eligibility for coverage under another employer health plan.

How Much Will it Cost?

The provision does not specify how a parent's premium costs will be affected by having a qualified young adult remain on their policy. Although, any qualified individual

must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status. The qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status.

What if My State Already Extends Coverage to Young Adults?

More than two-thirds of states already have laws that require insured group health plans to cover dependents past age 18, often into their mid to late 20s and in some cases later. For example, in New Jersey, unmarried children can stay on a parent's plan until age 31. Such state mandates, including those requiring coverage past age 26, will continue to apply. Also, the favorable tax treatment applies only for adult children through the tax year in which they turn 26 and does not vary depending on state requirements. Employees in states that extend coverage past age 18, but not all the way to age 26, will now be able to take advantage of the federal extension.

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Legislative Guides

The screenshot displays the MyWave HR Human Resources Center interface. At the top left is the logo for MyWave HR, with the text "Human Resources Center" below it. To the right of the logo are navigation links for "Home", "Help", and "Close". Below the logo is a green banner with the text "Provided by Awesome Agency, powered by MyWave(R)". To the right of this banner are four tabs: "HealthShop", "Documents on Command", "Compliance", and "Resources". Below the banner is a dark blue header bar with the text "Becky Smith : ABC Company".

The main content area is divided into three sections:

- Legislative Guides >**: A sidebar menu with the following items:
 - COBRA** [open >](#)
 - FMLA** [open >](#)
 - Health Care Reform**
 - [Common Questions](#)
 - [Forms](#)
 - [Quick Reference](#)
 - HIPAA** [open >](#)
 - HIPAA Privacy** [open >](#)
 - Medicare Part D** [open >](#)
 - Section 125** [open >](#)
- Health Care Reform Content**: A text block stating: "Health care reform is now a reality and there is a lot of information out there on the new law. It can take a long time to find the information you need. The Legislative Guide to Health Care Reform makes your job easier. Just point and click to find answers to common questions about Health Care Reform, and how it affects your business and employees."
- Search Legislative Guides**: A search box with a "Search" button. Below the search box are two dropdown menus:
 - Search in: **All Legislative Guides** (dropdown arrow)
 - Restrict results to: **All Categories** (dropdown arrow)