CBIZ Health Reform Matrix

A Tool for Understanding the Impact of Health Care Reform

Patient Protection and Affordable Care Act (Public Law 111-148, enacted March 23, 2010) and the Health Care and Education Reconciliation Act (Public Law 111-152, enacted March 30, 2010)

The following matrix is divided into six categories:

Employer/Plan Sponsor Issues

Also see Reporting and Disclosure Issues, Taxes and Fees, and Insurance Issues

EMPLOYER/PLAN SPONSOR ISSUES*

(Also see Reporting and Disclosure, Taxes and Fees, and Insurance Issues)

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Temporary Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program (ERRP) began June 1, 2010, and was designed to encourage employers to establish or maintain health coverage for their early retirees (aged 55-64), and their eligible spouses and dependents. The purpose of the program was to provide reimbursement of certain expenses to plan sponsors of group health plans that provide retiree coverage. Certified plans are required to notify plan participants of the ERRP reimbursements. The Program has closed; no claims made on or after January 1, 2012 are accepted due to exhaustion of Program funds. The last day for submitting an ERRP reimbursement request was July 31, 2013; the last day for submitting an ERRP reopening request was December 31, 2013. The Program expired January 1, 2014.	All-sized employers	ERRP Program began 6/1/10; closed 1/1/14	▪ *Early Retiree Reinsurance Program (5/5/10)* ▪ *Early Retiree Subsidy – Initial Application Date is Approaching (6/11/10)* ▪ *Early Retiree Reinsurance Program Application Process Opened (6/29/10)* ▪ *Update: Early Retiree Reinsurance Program (9/1/10)* ▪ *Early Retiree Reimbursement Program Updates (10/5/10)* ▪ *ERRP Updates (4/4/11)* ▪ *ACA Updates: Increase in ERRP Cost Thresholds and Amounts (10/17/11)* ▪ *ERRP Closes (12/12/11)* ▪ *Early Retiree Reinsurance Program (5/9/13)*
Ban on Preexisting Condition Exclusions. Group health plans, including grandfathered plans, were prohibited from imposing preexisting condition exclusions (PCE) on individuals under age 19, beginning September 23, 2010. Beginning January 1, 2014, no PCE can be imposed on anyone. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Under age 19 PCE provision effective plan years beginning on or after 9/23/10 No PCE imposed on anyone effective plan years beginning on or after 1/1/14	▪ *Patient's Bill of Rights (6/23/10)*

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Extension of Dependent Coverage ▪ Group health plans that provide dependent coverage must continue to make such coverage available to an adult child up to age 26. ▪ For this purpose, a "*dependent*" includes a biological child, a step child, an adopted child or a foster child. Coverage must be available without regard to the child's marital status, or whether the child can be claimed as a dependent. ▪ Older-aged dependents cannot be subject to a surcharge, premium penalty, or any other plan differential, unless the differential is imposed on all dependents under the plan. An insurer is allowed to charge a differential for tiers of coverage (self, self + one, self + two, etc.). *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Health Reform's Coverage for Dependent Children Explained (5/10/10)* ▪ *Grandfathered Health Plan Rules (6/17/10)* ▪ *New Model Notices Issued (7/12/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Agencies Issue Additional PPACA Clarifications (12/23/10)*
Ban on Rescissions. Group health plans, including grandfathered plans, cannot rescind such plan or coverage once an enrollee is covered under the plan, except in the event of fraud or intentional misrepresentation of material fact. Cancellation can be retroactive for the failure to pay premium. Plans must provide 30 days advanced written notice to each participant who would be affected before coverage may be rescinded. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)*

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Ban on Annual and Lifetime Limits. Group health plans, including grandfathered plans, are prohibited from establishing lifetime limits and unreasonable annual limits on the dollar value of "essential health benefits". Plans can impose limits on non-essential benefits. A change in annual or lifetime limits could cause loss of grandfathered status. ***Mini-Med Plan Waivers***. Mini-med plans in existence prior to 9/23/10 could apply for waiver of annual limits. Waivers are not allowed after 1/2/14. Waiver only granted for one plan year at a time; plans must request a waiver for each subsequent plan year. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)* ▪ *Mini-Med Plan Relief from Annual Limit Restriction Offered (9/21/10)* ▪ *Relief for Stand-Alone Health Reimbursement Arrangements (8/23/11)* ▪ *Update: Mini-Med Plan Waivers (6/22/11)* ▪ *ACA Updates: What Are Essential Benefits? (10/17/11)* ▪ *See "Defining Essential Benefits" in the Year-end Wrap Up (12/21/11)*
Choice of Primary Care Provider. If a group health plan requires designation of a primary care provider (PCP), a participant must be allowed to designate a participating in-network PCP, who is available to accept him/her. A pediatrician can be designated as a child's PCP. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*
Direct Access to OB/GYN Services. Group health plans must provide direct access to OB/GYN providers, without prior authorization or a referral from the individual's primary care physician. Plans may require the OB/GYN provider to agree or adhere to the plan's policies and procedures relating to referrals, obtaining prior authorization, and providing services, pursuant to a treatment plan. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*

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Access to Emergency Room Services. Group health plans that provide coverage for hospital emergency room services must also cover emergency services without prior authorization, even if the emergency services are provided on an out-of-network basis. In addition, plans cannot impose limitations on coverage or greater cost sharing requirements for out-of-network emergency services than those that apply to in-network services. Out-of-network emergency services must be provided in an amount equal to the greater of: 1. The median negotiated amount with in-network providers for emergency services without regard to co-pays and co-insurance; 2. The amount the plan generally pays for out-of-network services (usual, customary and reasonable amounts) without regard to in-network co-pays or co-insurance and without reduction for the plan's usual cost-sharing applicable to out-of-network services; or 3. The amount that would be paid by Medicare Parts A and B, without regard to co-pays and co-insurance. Out-of network providers are permitted to balance bill participants for the difference between a provider's charges and the total amount collected by the provider, including payments from the plan and co-pays or co-insurance amounts from the participant. However, a reasonable amount must be paid before a participant becomes responsible for a balance billing amount. In establishing a reasonable amount, the greatest of the three amounts discussed above must be considered. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans)*	All-sized employers	Plan years beginning on or after 9/23/10	*Patient's Bill of Rights (6/23/10)*

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Coverage for Preventive Health Services. Group health plans must provide coverage for certain preventive health services, as well as recommended evidence-based items or services without imposing any cost sharing requirements when the services are delivered by in-network providers. Preventive services include: ▪ Blood pressure, diabetes, and cholesterol tests; ▪ Cancer screenings, including mammograms and colonoscopies; ▪ Counseling relating to smoking cessation, weight loss, healthy eating, depression and substance abuse; ▪ Regular well-baby and well-child visits, from birth to age 21; ▪ Routine vaccinations; ▪ Pregnancy counseling, screening, and vaccines; and ▪ Flu and pneumonia shots. ***Women's Health Preventive Services.*** Group health plans must also provide preventive health coverage for women's health services, including well-women visits, screenings, FDA-approved contraceptive methods, and counseling without additional cost-sharing requirement. Beginning on or after September 24, 2014 (January 1, 2015 for calendar year plans), coverage for certain medications for women who have a high risk for developing breast cancer, where applicable as part of a medical management regime, must also be covered without cost-share. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers *Entities exempt from providing contraceptive and related services:* ▪ Full exemption for religious employer: a church, its auxiliaries, or convention or association of churches ▪ Certain eligible organizations with religious objections to providing some or all of contraceptive services including non-profit entities with religious affiliations and for-profit closely held entities are exempt from providing such services if they self-certify their religious objections on EBSA Form 700 or HHS form.	▪ Preventive health services effective for plan years beginning on or after 9/23/10 ▪ Women's Health Preventive Services mandate effective for plan years beginning on or after 8/1/12	▪ *Preventive Health Services (7/15/10)* ▪ *Preventive Care Coverage Expanded to Include Women's Health Services (8/3/11)* ▪ *Preventive Health Services for Women: Limited Exception for Church Plans (2/13/12)* ▪ *Women's Preventive Services Update (3/21/12)* ▪ *Women's Preventive Services Update Impacting Religious Organizations (2/6/13)* ▪ *Women's Health Services Mandate Final Regulations – Exemption for Religious Employers and Non-Profit Religious Organizations (7/5/13)* ▪ *See First Dollar Coverage for Preventive Health Services: Contraceptive Coverage Mandate in Year-end Wrap Up (12/23/13)* ▪ *See Women's Preventive Health Services Expanded in Implementation Guidance FAQs (1/13/14)* ▪ *Preventive Services – Contraceptive Mandate (7/2/14)* ▪ *Implementation Update: Women's Preventive Health Services (8/28/14)* ▪ *Coverage of Preventive Services FAQs (5/20/15)*

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Independent Claims and Appeals, and External Review Process. Insured and self-funded group health plans must provide for an internal claim and appeals process, as well as an external review process, for coverage determinations and claims.	All-sized employers ***Note:*** *This provision applies to non-grandfathered plans, both those subject to ERISA and those exempt from ERISA; N/A to grandfathered plans.*	Plan years beginning on or after 9/23/10	▪ *Internal Claims and Appeals, and External Review Process (7/26/10)* ▪ *Federal External Claims Review: Interim Procedures and Model Notices (8/30/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Delay in Claims and Appeals Enforcement (3/22/11)* ▪ *Modifications to Claims and Appeals, and External Review Processes (7/11/11)* ▪ *90 Day Wait and Other Updates (3/26/13)* ▪ *See Internal Claims, Appeals and External Review: Update on Providing Culturally and Linguistically Appropriate Notices in Guidance and Updates (9/11/13)*
Salary-based Discrimination Rules Applicable to Insured Group Health Plans. Insured group health plans must comply with the nondiscrimination rules (IRC §105(h)) currently applicable to self-funded plans. Plans cannot discriminate in favor of highly compensated individuals as to eligibility and benefits. The consequence of a discriminatory insured plan is an excise tax equaling $100 a day, per affected employee, with a maximum penalty of $500,000.	All-sized employers *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	Plan years beginning on or after 9/23/10. ***(However, IRS Notice 2011-01 delays the effective date of these rules; no penalties will be imposed until after implementing regulations are issued)***	▪ *Salary-based Discrimination Rules Applicable to Fully Insured Group Health Plans (8/24/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Implementation of Salary-based Discrimination Rules Delayed (12/23/10)*

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Provision	**Impact**	**Effective Date 2011**	**Related CBIZ Health Reform Bulletin**
OTC Medications Are Not Qualified Expenses. FSAs, HRAs, Archer MSAs, and HSAs can no longer reimburse the cost of over-the-counter (OTC) medications, except for insulin or prescribed OTC medications. Debit cards for FSAs and HRAs can only be used for prescribed OTC medications, if certain conditions met.	Individuals	1/1/11	▪ *Over-the-Counter Medication Prohibition Clarified (9/7/10)* ▪ *Limited Relief for Debit Card Purchases of OTC Medications (1/10/11)* ▪ *Year-end Wrap Up (12/21/11)*
Minimum Loss Ratio (MLR) Rules. Insurers in the individual and group markets, including grandfathered plans, are required to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended on costs related to reimbursement for clinical services and activities that improve health care quality versus the total amount of premium revenue is less than: ▪ 85% for insurers in the large group market ▪ 80% for insurers in the small group or individual markets Beginning January 1, 2014, the MLR rebate amount is based on averages for each of the previous 3 years for the plan. Rebates received by employer-policyholders must be dispersed in accordance with plan document provisions and by the type of plan.	Plans in the large group, small group and individual markets, including grandfathered plans. MLR restrictions do not apply to self-insured plans.	1/1/11	▪ *Final Minimum Loss Ratio Rules Issued (12/12/11)* ▪ *ACA Updates: Minimum Loss Ratio Rules (5/17/12)* ▪ *Minimum Loss Ratio Rebates (7/10/12)*

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Simple Cafeteria Plans. An eligible small employer can establish a simple cafeteria plan that includes a safe harbor from the nondiscrimination requirements applicable to cafeteria plans and certain qualified benefits. These simple cafeteria plans must meet the following requirements: 1. ***Eligible Employer***. To be eligible to sponsor a simple cafeteria plan, the employer must have employed an average of 100 or fewer employees on business days during either of the 2 preceding years. 2. ***Minimum eligibility and participation requirements***. All employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate in the plan and may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan. 3. ***Contribution requirement***. The employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan, on behalf of each qualified employee.	Employers with 100 or fewer employees	Plan years beginning on or after 1/1/11	▪ *Simple Cafeteria Plans (9/1/10)*

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Summary of Benefits and Coverage (SBC) and Uniform Glossary. Plans are required to provide participants and beneficiaries a standardized disclosure document (SBC) explaining certain aspects of their health benefit coverage. The SBC must also include a statement about whether the plan meets minimum essential coverage standards and the minimum value standard. Generally, for insured plans, SBCs are provided by insurer and plan administrator; this is a joint obligation.. If the insurer is providing the SBC, then the plan administrator has an obligation to monitor compliance. For self-funded plans, the plan administrator (generally, the plan sponsor unless the plan indicates otherwise) is responsible for issuing SBCs. In addition, insurers and group health plans must make a uniform glossary of insurance terms available upon request by participants. There are 5 specific timeframes for providing both the SBC and glossary: upon application; by the first day of coverage; within 90 days of enrollment by special enrollees; upon contract renewal; and upon request. Further, individuals residing in a particular county where 10% or more of its population are literate in a non-English language must be provided the SBC and glossary in the appropriate non-English language. *Note: In addition to this requirement, plans subject to ERISA must continue complying with all existing ERISA disclosure requirements. Plans exempt from ERISA are subject to the SBC requirement.*	All-sized employers Plans exempt from SBC requirement include: ▪ HSA (however, underlying HDHP plan may not be exempt) ▪ HIPAA-excepted plans: excepted FSA, limited scope dental and vision plans, and stand alone retiree-only plans ▪ Stand-alone HRA ▪ Wellness and EAPs unless they provide medical benefits ▪ Expatriate health plans ▪ Medicare Advantage plans offered as separate benefit package	First open enrollment period occurring on or after 9/23/12 *Model SBC templates for use on or before 1/1/17 are available on DOL and HHS websites*	▪ *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary (8/18/11)* ▪ *More ACA Updates: Summary of Benefits and Coverage: Required When? (11/28/11)* ▪ *ACA Updates: Final Rules – Summary of Benefits and Coverage (2/11/12)* ▪ *ACA Updates: Summary of Benefits & Coverage (5/17/12)* ▪ *Updated Summary of Benefits and Coverage (SBC) Guidance and New FAQs (4/25/13)* ▪ *Proposed SBC Changes (1/8/15)* ▪ *Final Summary of Benefits and Coverage Rules (6/22/15)*
Advanced 60-Day Notice of Material Modification of Benefits. A notice of any material change in any plan terms or coverage affecting SBC content not reflected in the most recently provided SBC (other than in connection with renewal or reissuance of coverage) must be provided to plan participants no later than 60 days *prior to* the effective date of the change. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers *Note: In addition to this requirement, plans subject to ERISA must continue complying with all existing ERISA disclosure requirements. Plans exempt from ERISA are subject to this new requirement.*	Plan years beginning on or after 9/23/12	▪ *Agencies Issue Additional PPACA Clarifications (12/23/10)* ▪ *See Notice of Material Modification, Final Rules: Summary of Benefits and Coverage, ACA Updates (2/10/12)*

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Patient-Centered Outcome Research Fee. Insured and self-funded group health plans must pay a fee based on the average number of lives covered under the plan. The purpose of these fees is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research. Amount of fees is indexed accordingly: ▪ For policy/plan years ending after 9/30/12 and before 10/1/13, the applicable dollar amount is $1 per covered life. ▪ For policy and plan years ending after 9/30/13 and before 20/1/14, the applicable dollar amount is $2 per covered life. ▪ For policy and plan years ending after 9/30/14 and before 10/1/15, the applicable dollar amount is $2.08 per covered life The fee is to be paid by the insurer for a fully insured plan, by the plan sponsor for a self-funded plan. PCOR fees are paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*: ▪ For insured plans, Form 720 due by July 31st following the close of the policy year ▪ For self-funded plans, Form 720 due by July 31st of the calendar year following the plan year end	▪ Insurers of all-sized fully-insured plans ▪ All-sized employers of self-funded plans ***Also applies to:*** ▪ Retiree-only plans ▪ COBRA and state continuation coverage ▪ Non-integrated health reimbursement arrangements (HRA) ▪ Medical flexible spending accounts (FSA) subject to HIPAA **Plans *not subject* to the fees include:** ▪ HIPAA-excepted benefit plans such as limited scope dental and vision plans ▪ FSAs excepted from HIPAA ▪ Employee assistance programs, disease management programs, and wellness programs that do not provide significant benefits in medical care or treatment ▪ Expatriate group health plans primarily covering employees who work and reside outside U.S. (however, foreign nationals working in U.S. *are* counted in calculation of the fee) ▪ Stop loss and indemnity reinsurance policies	Plan years ending after 9/30/12 *No fee assessed for policy/plan years ending after 9/30/19 (for calendar year plans, this means the 2018 plan year)*	▪ *Year-end Wrap Up (12/21/11)* ▪ *Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund (4/18/12)* ▪ *Final Regulations Issued: Patient-Centered Outcomes Research Fees and Medical Device Tax (12/11/12)* ▪ *Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *See Patient-Centered Outcomes Research Fee in Sub-Regulatory Guidance and FAQs Issued (1/25/13)* ▪ *Reporting and Paying PCOR Fees: Revised Form 720 Issued (6/4/13)* ▪ *Year-end Wrap Up (12/23/13)* ▪ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)*

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Provision	Impact	Effective Date 2013	Related CBIZ Health Reform Bulletin
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500 (indexed for 2014; $2,550 for 2015).	All-sized employers with FSA plan	Plan years beginning on or after 1/1/13	*Year-end Wrap Up (12/21/11)* *Guidance Issued Relating to $2,500 FSA Salary Reduction Cap (5/31/12)*
Retiree Prescription Drug Coverage. An employer's deduction for retiree prescription drug expenses is reduced by the amount of the Medicare Part D tax-free subsidy.	All-sized employer sponsored health plans claiming Medicare Part D retiree drug subsidy	1/1/13	
Automatic Enrollment in Health Plan. Employers who offer their employees enrollment in one or more health benefit plans are required to automatically enroll new full-time employees in one of their plans offered, subject to any waiting period.	Employers subject to Fair Labor Standards Act who employ 200+ full-time employees	*Employers are not required to comply with the automatic enrollment provisions until implementing regulations are issued.*	*ACA Updates: Automatic Enrollment in Health Plans (2/10/12)*
Effective 2014			
90-Day Waiting Period Restriction. Group health plans are prohibited from imposing waiting periods exceeding 90 calendar days, including weekends and holidays. Health coverage must be made available no later than the 91st day. If individuals are required to satisfy certain job criteria, such as achieving a particular job classification or job-related licensure requirement, the 90-day clock begins when the eligibility conditions are satisfied. *Orientation Period*. An optional one-month orientation period to determine whether an individual has met the requisite qualifications, licensure or other job standards may be imposed prior to the beginning of a waiting period. The orientation period is measured forward from employee's date of hire by adding one calendar month and subtracting one calendar day; after which time, the maximum 90-day wait would commence.	Virtually all-sized employer sponsored group health plans including insured and self-funded plans, whether grandfathered or not, and without regard to plan size.	Plan years beginning on or after 1/1/14	*ACA Updates: 90-Day Waiting Period Limitation (2/10/12)* *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee (9/06/12)* *90 Day Wait and Other Updates (3/26/13)* *See 90-day Waiting Period in Guidance and Updates (9/11/13)* *Final Rules – 90-Day Waiting Period (2/24/14)* *Final Rules Address Orientation Period (6/26/14)*

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Reward for Participation in Wellness Program. A wellness program that is part of a health plan can be designed as a participation-only program, or as a contingent program. A *participation-only program* is one based strictly on taking part in the program. A *contingent program* can take one of two forms: it can either be an *activity-only program* or an *outcome-based program*. Both types of contingent programs require compliance with five standards; one of which permits up to a 30% financial incentive reward of the cost of single coverage (or family coverage, if applicable) and up to 50% as a tobacco free incentive. *[Note: Proposed EEOC rules would cap the total reward to 30% of the total cost of employee-only coverage when a participation-only program involves a medical exam, disability-related inquires, or the collection of medical information. These rules would also cap tobacco-related incentives to 30% unless the program does not require disability-related inquiries or medical tests.]* If a participant's health care provider determines that an outcome-based program is not advised for the individual and recommends an activity-only program, the individual can explore any available alternative options for achieving the goal that is appropriate for him/her. A plan is required to include a notice of available alternative options in its plan materials of how to qualify for a reward if an alternative option is recommended by his/her health care provider, or is otherwise available through the wellness program.	All-sized employers *The wellness program rules apply to both grandfathered and non-grandfathered group health plans, whether insured or self-funded.*	Plan years beginning on or after 1/1/14	▪ *Proposed Regulations: Wellness Programs, Essential Health Benefits and Rating Restrictions, Guaranteed Issue and Renewal Rules (11/28/12)* ▪ *Final Rules Issued: Nondiscriminatory Wellness Programs and Small Business Health Options Program (6/3/13)* ▪ *See 'Wellness Programs' in Implementation Guidance FAQs (1/13/14)* ▪ *Wellness Programs: EEOC Proposed Rules and Tri-Agency Guidance (5/12/15)*
Coverage for Individuals Participating in Approved Clinical Trials. Individual and group health plans cannot deny individual participation in approved clinical trials and must cover routine costs in approved clinical trials. Insurers are not required to cover: ▪ The investigational item, device or service; ▪ Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or ▪ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	All-sized employers	Plan years beginning on or after 1/1/14	

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Certification of Compliance with Electronic Transaction Requirements. The ACA modifies certain aspects of HIPAA electronic transaction rules to require a controlling health plan (CHP) and any subhealth plan (SHP) to obtain a unique health plan identifier (HPID). The CHP or SHP would then be required to certify compliance with certain standards for electronic transactions and operating procedures for purposes of processing: ▪ Eligibility for health plan transactions; ▪ Health care claim status transactions; and ▪ Health care electronic funds transfers and remittance advice transactions. Certification would be accomplished by either obtaining a certification seal for Phase III CAQH CORE Operating Rules by CAQH CORE; or a HIPAA credential.	▪ Insured Plans ▪ Self-Funded Plans	*On October 31, 2014, CMS indefinitely suspended the requirement to obtain an HPID and certify compliance*	▪ ***Certification of Compliance with Electronic Transaction Requirements (1/23/14)***

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Shared Responsibility Requirements for Health Coverage. Employers employing ≥50 full-time employees (working ≥30 hours per week) must either provide adequate coverage at an affordable rate, or pay an excise tax. There are two separate potential non-deductible excise taxes that could be assessed: 1. The **'No Coverage' excise tax penalty [IRC §4980H(a)]** applies if an employee working ≥30 hours per week is offered no coverage, or coverage that is less than minimum essential coverage ("MEC"), and if the employee qualifies for premium assistance, i.e., the individual falls below 400% of the federal poverty level and is not eligible for MEC. MEC includes most types of employer coverage, as well as government-sponsored coverage, such as Medicaid or Medicare, among others. *Calculating the No Coverage Excise Tax Penalty* If employer fails to offer MEC to minimum 95% (70% for 2015) of its full-time employees (FTE) (employees + dependents* beginning 2015) for any calendar month and employs at least one credit employee**, the excise tax penalty is calculated monthly as: (Number of FTEs – 30 [- 80 for 2015]) X $166.67*** (indexed) (~$2,000/yr***). **Dependents include employee's son or daughter through end of month of his/her 26th birthday. Does not include step or foster children, certain non-US citizen children, or spouse.* *** A credit employee is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through a marketplace.* **** Penalties are indexed beginning in 2015. The excise tax penalty under IRC §4980H(a) is projected to increase to $2,080 for 2015; $2,160 for 2016.*	▪ Applies to all public and private employers who employ ≥50 full-time employees (FTE) plus full-time equivalent employees (FTEE) on business days during preceding calendar year ▪ A FTEE is determined by dividing the aggregate number of hours worked by part-time employees in a month by 120. Employees working ‹30 hours per week are considered part-time employees and are not counted for penalty assessment purposes. ▪ For counting purposes, IRC control group rules apply (IRC §414 (b), (c), (m), (o)). *[Penalties assessed separately to individual entity]*	January 1, 2015 *(Note: This provision was initially to take effect 1/1/14. Both the penalties and reporting requirements delayed until 1/1/15)* ▪ **Employers employing 100+ employees:** Subject to employer shared responsibility provision beginning 1/1/15 (transition relief available for non-calendar year plans) ▪ **Employers employing 50 to 99 employees** become subject to shared responsibility provision on plan anniversary occurring in 2016, if certain criteria is certified.	▪ *ACA Updates: Shared Responsibility Requirement (2/10/12)* ▪ *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee (9/06/12)* ▪ *A Primer on ACA's Variable Employee Rules (11/5/12)* ▪ *Shared Responsibility Guidance (1/9/13)* ▪ *Individual Minimum Essential Coverage and 2) Affordability Standard (2/6/13)* ▪ *Final Essential Health Benefit Regulations and Determining Actuarial Value & Minimum Value in Plans (2/25/13)* ▪ *Minimum Value and Affordability; Shortened Exchange Application (5/7/13)* ▪ *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations (7/3/13)* ▪ *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements (7/10/13)* ▪ *See Employer Shared Responsibility in Year-end Wrap Up (12/23/13)*

EMPLOYER/PLAN SPONSOR ISSUES*

(Also see Reporting and Disclosure, Taxes and Fees, and Insurance Issues)

** As a general statement, wherever a provision refers to employer-sponsored or group health plan, unless otherwise indicated, the provision applies to both insured and self-funded plans. The IRC control group rules apply for purposes of determining employer size.*

Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Shared Responsibility Requirements for Health Coverage, con't			*Continued from page 16:*
2. The '**Inadequate or Unaffordable' excise tax penalty [IRC §4980H(b)]** would apply if an employer offers health coverage to at least 95% (70% for 2015) of its full-time employees and employs at least one credit employee*, and coverage fails to meet minimum value standard or is unaffordable. This penalty would also apply if the employer offers coverage to at least 95% (70% for 2015) of its FTEs, and a credit employee is *not* offered coverage. ▪ Coverage meets *minimum value standard* if it covers minimum 60% of total allowed cost of benefits expected to be incurred under the plan. The 3 options used to determine minimum value are an IRS/HHS minimum value calculator, designed-based safe harbor checklists, or obtain actuarial certification. ▪ Coverage under employer-sponsored plan (based on self-only coverage cost) is deemed *affordable* if the employee's required contribution is less than 9.5% employee's household income (modified AGI) for taxable year. The 3 safe harbors that can be used to determine *affordability* (based on self-only coverage cost) are Form W-2 wages (Box 1), a rate of pay method or a Federal poverty line (FPL) standard. *Calculating the Inadequate or Unaffordable Excise Tax Penalty.* If an employer offers health coverage to at least 95% (70% for 2015) of its FTEs and employs at least one credit employee*, and coverage fails to meet minimum value standard or is unaffordable, then the monthly excise tax penalty is the lesser of: ▪ Number of credit employees* multiplied by $250** (~$3,000/yr**); or ▪ (Number of FTEs – 30 [- 80 for 2015]) X $166.67** (indexed)(~$2,000/yr**) **A credit employee is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through a marketplace.* ***Penalties are indexed for 2015. The excise tax penalty under IRC §4980H(b) is projected to increase to $3,120 in 2015; $3,240 in 2016*			▪ *Final Rules Addressing the Employer Shared Responsibility Requirement (2/12/14)* ▪ *Exploring the Final Employer Shared Responsibility Regulations (3/10/14)* ▪ *Employer Shared Responsibility: Change in Employment Status Proposals (10/6/14)* ▪ *See Employer Shared Responsibility Requirement in Year-end Wrap Up (12/11/14)*

EMPLOYER/PLAN SPONSOR ISSUES*

(Also see Reporting and Disclosure, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Shared Responsibility Requirements for Health Coverage, con't ***Reporting and Disclosure Requirement.*** IRC §6056 obligates employers subject to the employer shared responsibility rules (known as "applicable large employer" or "ALE") to report certain information annually to the IRS, as well as provide related benefit statements to employees (see *Employer Health Insurance Reporting Requirement* on page 25).	Employers subject to the ACA's shared responsibility provisions (see pages 15-16)	Beginning in 2015, the Forms 1094 and 1095 are required to be filed with the IRS no later than February 28th of each year (or March 31st of each year if filed electronically), reflecting information for prior calendar year	▪ *IRS Final Rules – IRC Sections 6055 and 6056 (3/14/14)* ▪ *IRS Releases Draft Section 6055 and 6056 Reporting Forms (8/5/14)* ▪ *IRS Releases Draft Instructions for ACA Shared Responsibility Reporting (9/15/14)* ▪ *Finalized ACA Reporting Forms (2/16/15)* ▪ *IRS Draft Versions of 1094/1095 Series Forms (6/22/15)*
Effective 2018			
Excise Tax on High Cost Employer-Sponsored Health Coverage. A 40% excise tax will be imposed on the value of high cost employer sponsored health coverage ("Cadillac" health plans) exceeding certain threshold limits. The type of coverage subject to the Cadillac tax would generally include all health coverage, whether insured or self-funded; but would generally not include excepted benefits. Applicable coverage is projected to include employer contributions and salary contributions to flexible medical spending accounts, health savings accounts and medical savings accounts; but would not include after-tax contributions to such plans. It is anticipated that the COBRA methodology would be used to calculate the cost of coverage. The annual statutory limit to which the Cadillac tax would be imposed is individual coverage exceeding $10,200, or $27,500 for family coverage. However, these numbers are only placeholders, as there would be various calculations that could increase these annual figures. Specifically, in 2018, the first year the tax would be imposed, a health cost adjustment percentage would be applied to the baseline dollar limit. In 2019 and beyond, a cost of living adjustment would be imposed.	All-sized employers	1/1/18	▪ *Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Preview of Cadillac Tax Implementation (3/3/15)*

Reporting and Disclosure Issues

Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Notice of Rescission of Coverage. Group health plans, including grandfathered plans, must provide 30 day-advanced written notice of a rescission of coverage to each affected individual, prior to rescinding coverage.	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)*
Notice of Grandfathered Health Plan Status. All grandfathered health plans, whether insured or self-funded, are required to provide a Notice to covered individuals of the plan's grandfathered status. The Notice must be included in any plan materials provided to participants and beneficiaries and must include the plan's contact information for questions and complaints.	Grandfathered plans, whether insured or self-funded	No later than the first day of the first plan year beginning on or after 9/23/10; and continuing as long as the plan maintains grandfathered status	▪ *Grandfathered Health Plans Rules (6/16/10)* ▪ *New Model Notices Issued (7/12/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Grandfathered Status & ERRP Update (4/4/11)* ▪ *Year-end Wrap Up (12/21/11)*
Notice of Choice of Primary Care Provider. If a group health plan requires designation of a primary care provider (PCP), a participant must be allowed to designate a participating in-network PCP, who is available to accept him/her. A pediatrician can be designated as a child's PCP. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*
Notice of Right to Direct Access to OB/GYN Services. Group health plans must provide direct access to OB/GYN providers, without prior authorization or a referral from the individual's primary care physician. Plans may require the OB/GYN provider to agree or adhere to the plan's policies and procedures relating to referrals, obtaining prior authorization, and providing services, pursuant to a treatment plan. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Independent Claims and Appeals, and External Review Process As part of the requirements applicable to independent claims and appeals, and external review process, the plan or insurer must provide claimants with the following document(s), in writing, to the affected individual(s): ▪ Notice of Adverse Benefit Determination ▪ Notice of Final Internal Adverse Benefit Determination ▪ Notice of Final External Review Decision. There are specific content and timeframes for providing these notices, depending on whether the issue relates to an urgent care or life-threatening matter, or whether it relates to a non-urgent matter. In addition, there are specific methods of distribution of the various notices in urgent and non-urgent instances.	Non-grandfathered group health plans. These rules apply to ERISA plans and non-ERISA plans, such as governmental plans and church plans. Plans subject to ERISA must also to continue to comply with all existing ERISA claims and appeal disclosure requirements.	Plan years beginning on or after 9/23/10	▪ *Internal Claims and Appeals, and External Review Process (7/26/10)* ▪ *Federal External Claims Review: Interim Procedures and Model Notices (8/30/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Delay in Claims and Appeals Enforcement (3/22/11)* ▪ *Modifications to Claims and Appeals, and External Review Processes (7/11/11)* ▪ *90 Day Wait and Other Updates (3/26/13)* ▪ *See Internal Claims, Appeals and External Review: Update on Providing Culturally and Linguistically Appropriate Notices in Guidance and Updates (9/11/13)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2011	Related CBIZ Health Reform Bulletin
Form W-2 Reporting – Aggregate Cost of Health Coverage. Employers are required to disclose the aggregate cost of any employer-sponsored health insurance coverage on the Form W-2, including both the employer's and employee's share. The cost is reported in Box 12 of the W-2 using Code DD. The aggregate cost can be calculated in one of several ways: the insurance premium method, the COBRA method, or, a modified COBRA method. Plans *excluded* from the reporting requirement include: ▪ Stand-alone, non-integrated dental or vision plans; ▪ Contributions to HSAs*, Archer MSAs, HRAs, or salary reduction contributions to FSA; ▪ Certain non-health benefit plans such as LTC, disability income, liability, work comp, auto medical payment, specified disease or illness, fixed indemnity; and multiemployer plans; ▪ Coverage under an EAP, wellness program, or on-site clinic unless the program qualifies as a 'health plan' and premiums are charged to individuals on COBRA or comparable continuation coverage; ▪ Hospital indemnity or fixed dollar plan coverage for which the employer makes no contribution, and the employee pays coverage on an after-tax basis; ▪ Self-funded plans exempt from federal COBRA (such as a self-funded church plan); ▪ Government-sponsored plans maintained for military members and their families; ▪ Federally-recognized Indian tribal government plans; ▪ Post-employment (retiree) health plans unless employer obligated to provide W-2 to retirees. **<u>Important Note about HSA contributions</u>: Employer contributions (including employee contributions via IRC §125 cafeteria plan) to an HSA must still be reported in Box 12 of the Form W-2 using Code W. Employer contributions to an HSA that are not excludable from the income of the employee must continue to be reported in Boxes 1, 3, and 5.*	▪ All-sized employers required to file a Form W-2 (*IRC control group rules do not apply*) ▪ Employers exempt from electronic W-2 filing requirement, i.e., file fewer than 250 Form W-2s per year, are exempt until future guidance issued	▪ *Voluntary* reporting for 2011 tax year ▪ *Mandatory* reporting for 2012 tax year and thereafter	▪ *See "IRS Pronouncements" in Agencies Issue Additional PPACA Clarifications (12/23/10)* ▪ *IRS Issues Interim Guidance on W-2 Reporting (3/30/11)* ▪ *Additional IRS Guidance on W-2 Reporting Requirement (1/6/12)* ▪ *Reminder: Fast Approaching Form W-2 Reporting Requirement (11/1/12)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2012	Related CBIZ Health Reform Bulletin
Summary of Benefits and Coverage (SBC) and Uniform Glossary. Plans are required to provide participants and beneficiaries a standardized disclosure document (SBC) explaining certain aspects of their health benefit coverage. The SBC must also include a statement about whether the plan meets minimum essential coverage standards and the minimum value standard. Generally, for insured plans, SBCs are provided by insurer and plan administrator; this is a joint obligation. The final regulations affirm that compliance by one entity is deemed compliance by the other. If the insurer is providing the SBC, then the plan administrator does have an obligation to monitor compliance. For self-funded plans, the plan administrator (generally, the plan sponsor unless the plan indicates otherwise) is responsible for issuing SBCs. In addition, insurers and group health plans must make a uniform glossary of insurance terms available upon request by participants. There are 5 specific timeframes for providing both the SBC and glossary: upon application; by the first day of coverage; within 90 days of enrollment by special enrollees; upon contract renewal; and upon request. Further, individuals residing in a particular county where 10% or more of its population are literate in a non-English language must be provided the SBC and glossary in the appropriate non-English language. *In addition to the SBC requirement, plans subject to ERISA must continue complying with all existing ERISA disclosure requirements. Plans exempt from ERISA are subject to the SBC requirement.*	All-sized employers Plans exempt from SBC requirement include: ▪ HSA (however, underlying HDHP plan may not be exempt) ▪ HIPAA-excepted plans: excepted FSA, limited scope dental and vision plans, and stand alone retiree-only plans ▪ Stand-alone HRA ▪ Wellness and EAPs unless they provide medical benefits ▪ Expatriate health plans ▪ Medicare Advantage plans offered as separate benefit package	First open enrollment period occurring on or after 9/23/12 *Model SBC templates for use on or before 1/1/17 are available on DOL and HHS websites*	▪ *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary (8/18/11)* ▪ *More ACA Updates: Summary of Benefits and Coverage: Required When? (11/28/11)* ▪ *ACA Updates: Final Rules – Summary of Benefits and Coverage (2/12/12)* ▪ *ACA Updates: Summary of Benefits & Coverage (5/17/12)* ▪ *Updated Summary of Benefits and Coverage (SBC) Guidance and New FAQs (4/25/13)* ▪ *Proposed SBC Changes (1/8/15)* ▪ *Final Summary of Benefits and Coverage Rules (6/22/15)*
60-day Advanced Notice of Material Modification of Benefits. A notice of any material modification of plan terms or coverage that affects SBC content not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage must be provided to plan participants no later than 60 days prior to the effective date of the change.	All-sized employers *Note: In addition to this requirement, plans subject to ERISA must continue complying with all existing ERISA disclosure requirements. Plans exempt from ERISA are subject to this new requirement.*	Plan years beginning on or after 9/23/12	▪ *Agencies Issue Additional PPACA Clarifications (12/23/10)* ▪ *See Notice of Material Modification, Final Rules: Summary of Benefits and Coverage, ACA Updates (2/10/12)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2012	Related CBIZ Health Reform Bulletin
Quality of Care Reporting Requirement. Insured and self-funded group health plans are required to submit a quality of care report to HHS. The type of information included in the report are details about coverage benefits, health care provider reimbursement structures, any improvement of health outcomes, and implementation of any wellness or prevention activities. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	*By law, this report was to be developed by March 23, 2012; however, it has not been released by the governing agencies, nor has any implementation guidance been issued thus far.*	
Effective Date 2013			
Notice of Marketplace (Exchange) Coverage. Employers are required to provide information about the marketplace (exchange) options to their employees without regard to coverage status. This written notice informs employees of the existence and options available through Marketplace, whether the employer's plan provides minimum value and affordability, and a description of the government assistance that may be available for purchasing coverage via the Marketplace. The DOL provides two model notices: one to be used by employers offering health coverage and the other for employers who do not.	All-sized employers subject to Fair Labor Standards Act	Initial notice required to be distributed to all employees by 10/1/13. Thereafter, the Notice must be provided to all new hires within 14 days of hire	▪ *Sub-Regulatory Guidance and FAQs Issued (1/25/13)* ▪ *Notice to Employees of Coverage Options; Updated COBRA Model (5/10/13)* ▪ *October 1st Deadline Reminder: Notice to Employees of Marketplace Coverage Options (8/28/13)* ▪ *See Distribution of Marketplace Notice to Employees in Guidance and Updates (9/11/13)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Health Insurance Reporting Requirement ***Reports to IRS.*** IRC §6056 obligates employers subject to the ACA's employer shared responsibility provisions, specifically employers employing ≥ 50 employees (known as "applicable large employer" or "ALE"), to annually report certain information to the IRS. From these reports, the IRS determines who is entitled to premium assistance and whether an employer might be at risk for an IRC §4980H(a) no-coverage tax or IRC §4980H(b) inadequate or unaffordable tax (see pages 15-17). The IRS Form 1095-C (employee statement) and a Form 1094-C (transmittal) are the designated forms to be used for Section §6056 reporting. ***Benefit Statements to Employees.*** The employees listed in the Form 1094-C must be furnished the Form 1095-C to assist them in satisfying proof of MEC for purposes of the individual shared responsibility requirement.	All public and private employers who employ 50+ full-time (plus full-time equivalent "FTEE") employees on business days during preceding calendar year	Applies to coverage provided on or after 1/1/15 ▪ Forms 1094 and 1095 must be filed with IRS by February 28th of each year (or by March 31st of each year if filed electronically), reflecting information from prior calendar year ▪ Form 1095-C must be provided to individuals listed in Form 1094-C by January 31st of each year	▪ *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations (7/3/13)* ▪ *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements (7/10/13)* ▪ *Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage (9/18/13)* ▪ *IRS Final Rules – IRC Sections 6055 and 6056 (3/14/14)* ▪ *IRS Releases Draft Section 6055 and 6056 Reporting Forms (8/5/14)* ▪ *IRS Releases Draft Instructions for ACA Shared Responsibility Reporting (9/15/14)* ▪ *Finalized ACA Reporting Forms (2/16/15)* ▪ *IRS Draft Versions of 1094/1095 Series Forms (6/22/15)*

REPORTING AND DISCLOSURE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Insurance Issues)

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Health Insurance Coverage Reporting by Insurers and Sponsors of Self-Insured Plans ***Reports to IRS*** Insurers, self-funded plans and other providers of minimum essential coverage ("MEC") are required to report certain information to the IRS, known as IRC §6055 reporting. This requirement applies without regard to plan size. The IRS Form 1095-B (employee statement) and a Form 1094-B (transmittal) are the designated forms to be used for Section §6055 reporting. A self-funded plan sponsor subject to the employer shared responsibility requirements (see pages 15-17) can accomplish its obligation by completing Part III of the Form 1095-C. ***Benefit Statements to Covered Individuals*** The employees listed in the Form 1094-B must be furnished the Form 1095-B to assist them in satisfying proof of MEC for purposes of the individual shared responsibility requirement.	▪ Insurers ▪ Sponsors of Self-funded Plans	Applies to coverage provided on or after 1/1/15 ▪ Forms 1094 and 1095 must be filed with IRS by February 28th of each year (or by March 31st of each year if filed electronically), reflecting information from prior calendar year ▪ Form 1095-B must be provided to individuals listed in Form 1094-B by January 31st of each year	▪ *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations (7/3/13)* ▪ *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements (7/10/13)* ▪ *Information Reporting by Employers on Health Coverage and Reporting of Minimum Essential Coverage (9/18/13)* ▪ *IRS Final Rules – IRC Sections 6055 and 6056 (3/14/14)* ▪ *IRS Releases Draft Section 6055 and 6056 Reporting Forms (8/5/14)* ▪ *IRS Releases Draft Instructions for ACA Shared Responsibility Reporting (9/15/14)* ▪ *Finalized ACA Reporting Forms (2/16/15)* ▪ *IRS Draft Versions of 1094/1095 Series Forms (6/22/15)*

Taxes and Fees

Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues & Insurance Issues

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Small Business Tax Credit (SBTC). Small businesses and tax-exempt employers that provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit. ▪ ***Eligible Employers***. To be eligible, the employer must employ fewer than 25 full-time equivalent employees whose average annual wages are less than $50,000 (indexed; $50,800 for both 2014 and 2015). Employers employing 10 or fewer full-time equivalent employees whose average annual wages are less than $25,000 (indexed; $25,400 for 2014; $25,800 for 2015) also qualify for the SBTC. In addition, the small employer must cover at least 50% of the cost of single (not family) health care coverage for each employee. ▪ ***Qualifying Coverage***. The credit is only available for qualified health plan (QHP) coverage and/or stand-alone dental coverage purchased through the Small Business Health Options Program (SHOP) and is only available for 2 consecutive year period. ▪ ***Amount of Credit.*** For tax years beginning in 2014 and beyond, the maximum credit is 50% of premiums paid by small business employer; 35% for premiums paid by small tax-exempt employers. The SBTC is limited to the average premium in the rating area in which the employee enrolls. ▪ ***Uniform Contribution Requirement***. To be eligible to take the SBTC, the employer must make a uniform contribution toward health coverage. ▪ ***Claiming the Credit.*** Calculation and claiming the credit is accomplished on IRS Form 8941, *Credit for Small Employer Health Insurance Premiums*. A tax-exempt employer would include the amounts on its Form 990-T, *Exempt Organization Business Income Tax Return*.	▪ Employers who employ ‹25 full-time employees whose average annual wages are ‹ $50,800 (indexed for both 2014 and 2015). ▪ Employers employing ≤10 full-time equivalent employees whose average annual wages are ‹$25,400 (indexed for 2014; $25,800 for 2015) also qualify for the SBTC	1/1/10	▪ *The Small Business Health Care Tax Credit (5/20/10)* ▪ *Additional Guidelines to the Small Business Tax Credit (12/22/10)* ▪ *See Small Business Tax Credit (SBTC) Updates in Guidance and Updates (9/11/13)* ▪ *Small Business Tax Credit Final Regulations (8/5/14)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Adult Dependent Children Coverage. The cost of employer-provided health coverage of dependent children under the age of 27 (as of the end of the tax year) is excluded from employee's gross income, and is not included in employment taxes. Self-employed individuals may deduct premiums paid on dependent coverage. The exclusion of health expenses from the employee's taxable income extends to reimbursements and premiums paid by employers.	All-sized employers	3/30/10	*IRS Guidance: Tax-Favored Status of Dependent Coverage (4/28/10)* *State Tax Treatment of Older-aged Dependent Coverage (12/16/10)*
Economic Substance Doctrine. The economic substance judicial doctrine has been codified. Transactions are treated as having economic substance, and therefore, respected for tax purposes, only if the transaction results in a meaningful change to a taxpayer's economic position, and the taxpayer has a substantial purpose for entering into the transaction (apart from Federal income tax effects). Significant penalties apply to transactions that fail these requirements.	All-sized employers	Transactions entered into after 3/30/10	*Tax Shelter Aftermath: Congress Codifies the Economic Substance Doctrine*
Excise Tax on Indoor Tanning Services. A 10% tax is imposed on the cost of indoor tanning services.	Individuals	7/1/10	
Effective Date 2011			
Increased Penalty for Nonqualified HSA or Archer MSA Distributions. Penalties on nonqualified HSA distributions increase from 10% to 20%. The penalty for nonqualified distributions from Archer MSAs increases from 15% to 20%.	Individuals	1/1/11	
Fees on Pharmaceutical Manufacturers and Importers. An annual nondeductible fee is imposed by the IRS on pharmaceutical manufacturers and importers of certain branded prescription drugs or biologics offered for sale in the U.S. Collected fees will be credited to the Medicare Part B trust fund. The annual fee collected by IRS for the pharmaceutical manufacturing and importing industry is $2.5 billion for 2011; $3 billion for 2012 to 2016; $4 billion for 2017; $4.1 billion for 2018; $2.8 billion for 2019 and subsequent years.	Fees apply to both domestic and foreign manufacturers and importers. Potential impact on group health plans if pharmaceutical entities pass the cost to insurers.	The first payment of fees for 2011 due September 2012	*IRS Provides Guidance for Fee Imposed on Sales of Branded Prescription Drugs* *IRS Releases Guidance on Branded Prescription Drug Fee for 2014*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2013	Related CBIZ Health Reform Bulletin
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500 (indexed for 2014; $2,550 for 2015).	All-sized employer sponsored flexible medical spending account (FSA) plans	Plan years beginning on or after 1/1/13	▪ *Year-end Wrap Up (12/21/11)* ▪ *Guidance Issued Relating to $2,500 FSA Salary Reduction Cap (5/31/12)*
Excise Tax on Sales of Medical Devices. An excise tax is imposed on manufacturers, producers or importers of certain medical devices. The tax is equal to 2.3% of the price for which the medical device is sold. For this purpose, medical device refers to any FDA-approved device intended for humans. Certain items are exempt from the medical device tax, such as eyeglasses, hearing aids and common items purchased on a retail basis.	Manufacturers, producers or importers of certain medical devices Affected entities report sales on Form 720 and pay tax to IRS	Excise tax applies to sales beginning January 1, 2013	▪ *Final Regulations Issued: Medical Device Tax (12/11/12)*
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased (by 0.9%), from 1.45% to 2.35%, to the extent an individual's wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ Employer must withhold on all wages >$200,000 ▪ Employee liable regardless of employer withholding ▪ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Implementation Guidance on Medicare Tax (6/27/12)* ▪ *Additional Medicare Tax - Clarifications and Proposed Regulations Issued (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals, equal to 3.8% of the lesser of an individual's: ▪ "Net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities); or ▪ Modified AGI in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ No employer withholding requirement ▪ Counted for estimated tax payments ▪ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Additional Medicare Tax - Clarifications and Proposed Regulations Issued (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2013	Related CBIZ Health Reform Bulletin
Retiree Prescription Drug Coverage. An employer's deduction for retiree prescription drug expenses is reduced by the amount of the Medicare Part D tax-free subsidy.	All-sized employer sponsored health plans claiming Medicare Part D retiree drug subsidy	1/1/13	
Modification of Itemized Deduction for Medical Expenses. The threshold for deductibility of unreimbursed medical expenses is increased from 7.5% to 10% of AGI. The 7.5% threshold is retained through 2016 for individuals who are at least 65 years old by year end.	Individuals	1/1/13	
Effective Date 2014			
Annual Fee – Health Insurers. The ACA imposes an annual fee upon "covered entities" (insurers) who engage in providing health insurance for U. S. health risks. The assessed fees are apportioned amongst all applicable covered entities (insurers) based on a ratio of net premiums for insuring U. S. risks during the preceding calendar year as compared to the aggregate net premiums for that same year. The fee is assessed when net premiums covering US risks exceed $25 million for the previous year.	Insurers writing health insurance covering US citizens. *Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders. Certain expatriate plans and plans sponsored by non-profit entities, such as a VEBA, are not subject to these fees.*	Annual fee is required to be paid each calendar year beginning 1/1/14 *Net premiums written during the prior year are reported by filing the Form 8963 with IRS by April 15th of the year in which the fee is due (by May 1st for the initial 2014 filing report).*	▪ *Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *See Health Insurance Provider Fees in Year-end Wrap Up (12/23/13)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Premium Assistance Tax Credit. Individuals and families whose household income for the year is between 100% and 400% of the federal poverty level (FPL) and whose employer fails to offer minimum essential coverage at an affordable rate (see Employer Shared Responsibility, below), are entitled to a tax credit for coverage purchased through the marketplace. The amount of the credit is based upon premium cost and family income. The credit is refundable, payable in advance, and remitted directly to the insurer; or the credit can be claimed during the annual income tax filing with the IRS. Individuals eligible for the premium tax credit must purchase coverage through the marketplace, have household income that falls within a certain range, cannot obtain affordable employer-sponsored coverage providing minimum value and are ineligible for coverage through a government program (Medicaid, Medicare, CHIP or TRICARE). Individuals seeking a premium tax credit receive the Form 1095-A by January 31st from the marketplace to allow them to claim the premium tax credit, and to reconcile the credit on their returns with advance payments of the premium tax credit.	Individuals with family income between 100% and 400% of the Federal Poverty Level	1/1/14	▪ *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary (8/18/11)* ▪ *Individual Minimum Essential Coverage and 2) Affordability Standard (2/6/13)* ▪ *Final Exchange Regulations (7/3/13)* ▪ *See Individual Shared Responsibility Mandate in Year-end Wrap-up (12/11/14)* ▪ *See Taxpayer Assistance for Individuals (1/8/15)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Premium Stabilization – Mechanisms for Allocating Risk Mechanisms implemented to stabilize the insurance marketplace by spreading the risk more broadly across all insurers. The three components of the Premium Stabilization Program are a transitional reinsurance program, a temporary risk corridor program and a permanent risk adjustment program.			
1. The **transitional reinsurance program** is intended to stabilize premiums in the individual market due to immediate enrollment of higher risk individuals beginning in 2014. The reinsurance money will be used to offset the expenses of the newly eligible individuals. States that operate a marketplace are required to establish a transitional reinsurance pool, to be in effect for the 3-year period of 2014 through 2016. In the absence of a state establishing a reinsurance pool, the federal government will do so. Both insured plans, through their insurers, and self-funded plans must contribute to the reinsurance pool. For a self-funded plan, the contributing entity is the plan sponsor/employer. The plan can contract with a third party administrator (TPA) to calculate the premium and submit the payment, but ultimately the plan sponsor/employer is responsible for funding it. The specific rates are set annually by HHS. For 2014, the contribution rate is $5.25 per covered life per month, or approximately $63, annually. The annual reinsurance contribution rate to be collected in 2015 is $44 per covered life ($3.66 per covered life per month). In 2016, the annual reinsurance contribution rate to be collected is $27 per covered life.	▪ Insurers of all-sized fully-insured plans ▪ All-sized employers of self-funded plans *Also applies to:* ▪ Post-employment plans that are primary to Medicare, such as early retiree plans ▪ COBRA continuation *Plans not subject to fees include:* ▪ HIPAA excepted benefit plans such as limited scope dental and vision plans ▪ HRAs integrated with comprehensive insured or self-funded group coverage ▪ Flexible medical spending account plans (FSA) ▪ Health savings accounts (HSA) except an HDHP used in conjunction with HSA is considered major medical insurance and thus, subject to reinsurance contributions	1/1/14	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)* ▪ *See 'Transitional Reinsurance Fee' in 'Proposed Benefit and Payment Parameters in 2015' in Year-end Wrap Up (12/23/13)* ▪ *HHS Benefit and Payment Parameters for 2015 (3/14/14)* ▪ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)* ▪ *Completing the Transitional Reinsurance Fee Form (10/28/14)* ▪ *Proposed Benefit and Payment Parameters for 2016 in Year-end Wrap Up (12/11/14)* ▪ *Transitional Reinsurance Fee Refund Requests (4/17/15)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Transitional Reinsurance Program, con't An insurer, or plan sponsor through its TPA, is required to submit an annual enrollment count of the average number of covered lives to HHS by November 15th of each year. The process for reporting and payment of the fees is accomplished through the pay.gov website. Reporting entities complete the *ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*, upload supporting enrollment documentation, and schedule payment of the fees in one or two installments. HHS will then notify the insurer or plan sponsor/TPA of its contribution amount no later than December 15th of the reporting year. The insurer or plan sponsor/TPA must then remit payment to HHS within 30 days of receiving the HHS notification of the amount due.	*Plans not subject to fees, con't:* ▪ Employee assistance plans, disease management programs, and wellness programs that do not provide significant benefits in the nature of medical care or treatment. ▪ Post-employment plans where Medicare is primary to group plan ▪ Stand-alone prescription drug plans ▪ TRICARE or other military benefit plans ▪ Certain Indian Tribal benefit programs ▪ Certain expatriate plans		
2. **A temporary risk corridor program**. Qualified health plan (QHP) issuers are required to establish and administer a temporary risk corridor program for a 3-year period from 2014 through 2016. QHP issuers receive payment from HHS in certain circumstances when a QHP's allowable costs for any benefit year exceed the target amount. The regulations permit QHPs to include profits and taxes within its risk corridors calculations. This program is intended to protect QHP issuers in the individual and small group market against inaccurate rate setting and uncertainty in the marketplace by limiting the extent of issuer losses and gains.	Issuers of Qualified Health Plans via Marketplace	1/1/14	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure Issues, and Insurance Issues)

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Premium Stabilization – Mechanisms for Allocating Risk, con't 3. **A permanent risk adjustment program**. An on-going permanent risk adjustment program is intended to provide adequate payments and reduce risk premium to insurers that attract high-risk populations, such as individuals with chronic conditions; as well as stabilize premiums in the individual and small group markets once the ACA's insurance market reforms are implemented. The program provides a process for transferring funds from plans with lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. HHS has established the criteria and methodology to be used by states in determining the actuarial risk of plans within a state that are offered both in and outside the marketplace.	Non-grandfathered individual and small group market plans, in and outside the marketplace	Benefit year 2015 *(transitional policy for Benefit year 2014)*	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure, and Insurance Issues)

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Shared Responsibility Requirements for Health Coverage. Employers employing ≥50 full-time employees (working ≥30 hours per week) must either provide adequate coverage at an affordable rate, or pay an excise tax. There are two separate potential non-deductible excise taxes that could be assessed: 1. The **'No Coverage' excise tax penalty [IRC §4980H(a)]** applies if an employee working ≥30 hours per week is offered no coverage, or coverage that is less than minimum essential coverage ("MEC"), and if the employee qualifies for premium assistance, i.e., the individual falls below 400% of the federal poverty level and is not eligible for MEC. MEC includes most types of employer coverage, as well as government-sponsored coverage, such as Medicaid or Medicare, among others. *Calculating the No Coverage Excise Tax Penalty* If employer fails to offer MEC to minimum 95% (70% for 2015) of its full-time employees (FTE) (employees + dependents* beginning 2015) for any calendar month and employs at least one credit employee**, the excise tax penalty is calculated monthly as: (Number of FTEs – 30 [- 80 for 2015]) X $166.67*** (indexed) (~$2,000/yr***). **Dependents include employee's son or daughter through end of month of his/her 26th birthday. Does not include step or foster children, certain non-US citizen children, or spouse.* *** A credit employee is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through a marketplace.* **** Penalties are indexed beginning in 2015. The excise tax penalty under IRC §4980H(a) is projected to increase to $2,080 for 2015; $2,160 for 2016.*	▪ Applies to all public and private employers who employ ≥50 full-time employees (FTE) plus full-time equivalent employees (FTEE) on business days during preceding calendar year ▪ A FTEE is determined by dividing the aggregate number of hours worked by part-time employees in a month by 120. Employees working <30 hours per week are considered part-time employees and are not counted for penalty assessment purposes. ▪ For counting purposes, IRC control group rules apply (IRC §414 (b), (c), (m), (o)). *[Penalties assessed separately to individual entity]*	January 1, 2015 *(Note: This provision was initially to take effect 1/1/14. Both the penalties and reporting requirements delayed until 1/1/15)* ▪ **Employers employing 100+ employees:** Subject to employer shared responsibility provision beginning 1/1/15 (transition relief available for non-calendar year plans) ▪ **Employers employing 50 to 99 employees** become subject to shared responsibility provision on plan anniversary occurring in 2016, if certain criteria is certified.	▪ *ACA Updates: Shared Responsibility Requirement (2/10/12)* ▪ *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee (9/06/12)* ▪ *A Primer on ACA's Variable Employee Rules (11/5/12)* ▪ *Shared Responsibility Guidance (1/9/13)* ▪ *Individual Minimum Essential Coverage and 2) Affordability Standard (2/6/13)* ▪ *Final Essential Health Benefit Regulations and Determining Actuarial Value & Minimum Value in Plans (2/25/13)* ▪ *Minimum Value and Affordability; Shortened Exchange Application (5/7/13)* ▪ *Employer Shared Responsibility Reporting Requirements Delayed and Final Exchange Regulations (7/3/13)* ▪ *IRS Guidance on Delay of Employer Shared Responsibility Reporting Requirements (7/10/13)* ▪ *See Employer Shared Responsibility in Year-end Wrap Up (12/23/13)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure, and Insurance Issues)

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Provision	Impact	Effective Date 2015	Related CBIZ Health Reform Bulletin
Employer Shared Responsibility Requirements for Health Coverage, con't			*Continued from page 36:*
2. The '**Inadequate or Unaffordable' excise tax penalty [IRC §4980H(b)]** would apply if an employer offers health coverage to at least 95% (70% for 2015) of its full-time employees and employs at least one credit employee*, and coverage fails to meet minimum value standard or is unaffordable. This penalty would also apply if the employer offers coverage to at least 95% (70% for 2015) of its FTEs, and a credit employee is *not* offered coverage. ▪ Coverage meets *minimum value standard* if it covers minimum 60% of total allowed cost of benefits expected to be incurred under the plan. The 3 options used to determine minimum value are an IRS/HHS minimum value calculator, designed-based safe harbor checklists, or obtain actuarial certification. ▪ Coverage under employer-sponsored plan (based on self-only coverage cost) is deemed *affordable* if the employee's required contribution is less than 9.5% of employee's household income (modified AGI) for taxable year. The 3 safe harbors that can be used to determine *affordability* (based on self-only coverage cost) are Form W-2 wages (Box 1), a rate of pay method or a Federal poverty line (FPL) standard. *Calculating the Inadequate or Unaffordable Excise Tax Penalty.* If an employer offers health coverage to at least 95% (70% for 2015) of its FTEs and employs at least one credit employee*, and coverage fails to meet minimum value standard or is unaffordable, then the monthly excise tax penalty is the lesser of: ▪ Number of credit employees* multiplied by $250** (~$3,000/yr**); or ▪ (Number of FTEs – 30 [- 80 for 2015]) X $166.67** (indexed)(~$2,000/yr**) **A credit employee is one who works at least 30 hours per week and who is eligible for a premium tax credit or cost sharing assistance for buying insurance through a marketplace.* *** Penalties are indexed beginning in 2015. The excise tax penalty under IRC §4980H(b) is projected to increase to $3,120 in 2015; $3,240 in 2016.*			▪ *Final Rules Addressing the Employer Shared Responsibility Requirement (2/12/14)* ▪ *Exploring the Final Employer Shared Responsibility Regulations (3/10/14)* ▪ *Employer Shared Responsibility: Change in Employment Status Proposals (10/6/14)* ▪ *See Employer Shared Responsibility Requirement in Year-end Wrap Up (12/11/14)*

TAXES AND FEES*

(Also see Employer/Plan Sponsor Issues, Reporting and Disclosure, and Insurance Issues)

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Provision	Impact	Effective Date 2018	Related CBIZ Health Reform Bulletin
Excise Tax on High Cost Employer-Sponsored Health Coverage. A 40% excise tax will be imposed on the value of high cost employer sponsored health coverage ("Cadillac" health plans) exceeding certain threshold limits. The type of coverage subject to the Cadillac tax would generally include all health coverage, whether insured or self-funded; but would generally not include excepted benefits. Applicable coverage is projected to include employer contributions and salary contributions to flexible medical spending accounts, health savings accounts and medical savings accounts; but would not include after-tax contributions to such plans. It is anticipated that the COBRA methodology would be used to calculate the cost of coverage. The annual statutory limit to which the Cadillac tax would be imposed is individual coverage exceeding $10,200, or $27,500 for family coverage. However, these numbers are only placeholders, as there would be various calculations that could increase these annual figures. Specifically, in 2018, the first year the tax would be imposed, a health cost adjustment percentage would be applied to the baseline dollar limit. In 2019 and beyond, a cost of living adjustment would be imposed.	All-sized employers	1/1/18	▪ *Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Preview of Cadillac Tax Implementation (3/3/15)*

Insurance Issues

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Individual Responsibility)

INSURANCE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Individual Responsibility)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Extension of Dependent Coverage ▪ Health plans that provide dependent coverage must continue to make such coverage available to an adult child up to age 26. ▪ For this purpose, a "*dependent*" includes a biological child, a step child, an adopted child or a foster child. Coverage must be available without regard to the child's marital status, or whether the child can be claimed as a dependent. ▪ Older-aged dependents cannot be subject to a surcharge, premium penalty, or any other plan differential, unless the differential is imposed on all dependents under the plan. An insurer is allowed to charge a differential for tiers of coverage (self, self + one, self + two, etc.).	Individual and Group Plans ▪ *The extension of dependent coverage does not apply to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.* ▪ *Grandfathered Plan Exception: Older-aged dependent coverage must be available to an adult child up to age 26, unless he/she has access to other employer-provided coverage (exception expires for plan years beginning on or after 1/1/14)*	Plan years beginning on or after 9/23/10	▪ *Health Reform's Coverage for Dependent Children Explained (5/10/10)* ▪ *Grandfathered Health Plan Rules (6/17/10)* ▪ *New Model Notices Issued (7/12/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)* ▪ *Agencies Issue Additional PPACA Clarifications (12/23/10)*
Ban on Rescissions. Group health plans, including grandfathered plans, cannot rescind such plan or coverage once an enrollee is covered under the plan, except in the event of fraud or intentional misrepresentation of material fact. Cancellation can be retroactive for the failure to pay premium. Plans must provide 30 days advanced written notice to each participant who would be affected before coverage may be rescinded. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *Agencies Issue PPACA Clarifications (10/12/10)*
Choice of Primary Care Provider. If a group health plan requires designation of a primary care provider (PCP), a participant must be allowed to designate a participating in-network PCP, who is available to accept him/her. A pediatrician can be designated as a child's PCP. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Ban on Annual and Lifetime Limits. Group health plans, including grandfathered plans, are prohibited from establishing lifetime limits and unreasonable annual limits on the dollar value of "essential health benefits". Plans can impose limits on non-essential benefits. A change in annual or lifetime limits could cause loss of grandfathered status. ***Mini-Med Plan Waivers***. Mini-med plans in existence prior to 9/23/10 could apply for waiver of annual limits. Waivers are not allowed after 1/2/14. Waiver only granted for one plan year at a time; plans must request a waiver for each subsequent plan year. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)* ▪ *Mini-Med Plan Relief from Annual Limit Restriction Offered (9/21/10)* ▪ *Relief for Stand-Alone Health Reimbursement Arrangements (8/23/11)* ▪ *Update: Mini-Med Plan Waivers (6/22/11)* ▪ *ACA Updates: What Are Essential Benefits? (10/17/11)* ▪ *See "Defining Essential Benefits" in the Year-end Wrap Up (12/21/11)*
Direct Access to OB/GYN Services. Health plans must provide direct access to OB/GYN providers, without prior authorization or a referral from the individual's primary care physician. Plans may require the OB/GYN provider to agree or adhere to the plan's policies and procedures relating to referrals, obtaining prior authorization, and providing services, pursuant to a treatment plan.	Individual and Group Plans *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)* ▪ *New Model Notices Issued (7/12/10)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Ban on Preexisting Condition Exclusions. Group health plans, including grandfathered plans, were prohibited from imposing preexisting condition exclusions (PCE) on individuals under age 19, beginning September 23, 2010. Beginning January 1, 2014, no PCE can be imposed on anyone. *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	Individual and Group Plans	▪ **Under age-19** provision effective for plan years beginning on or after 9/23/10 ▪ **Beginning 1/1/14,** no PCEs can be imposed on anyone	▪ *Patient's Bill of Rights (6/23/10)*
Access to Emergency Room Services. Group health plans that provide coverage for hospital emergency room services must also cover emergency services without prior authorization, even if the emergency services are provided on an out-of-network basis. In addition, plans cannot impose limitations on coverage or greater cost sharing requirements for out-of-network emergency services than those that apply to in-network services. Out-of-network emergency services must be provided in an amount equal to the greater of: 1. The median negotiated amount with in-network providers for emergency services without regard to co-pays and co-insurance; 2. The amount the plan generally pays for out-of-network services (usual, customary and reasonable amounts) without regard to in-network co-pays or co-insurance and without reduction for the plan's usual cost-sharing applicable to out-of-network services; or 3. The amount that would be paid by Medicare Parts A and B, without regard to co-pays and co-insurance. Out-of network providers are permitted to balance bill participants for the difference between a provider's charges and the total amount collected by the provider, including payments from the plan and co-pays or co-insurance amounts from the participant. However, a reasonable amount must be paid before a participant becomes responsible for a balance billing amount. In establishing a reasonable amount, the greatest of the three amounts discussed above must be considered.	Individual and Group Plans *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	Plan years beginning on or after 9/23/10	▪ *Patient's Bill of Rights (6/23/10)*

INSURANCE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Individual Responsibility)

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Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Coverage for Preventive Health Services. Group health plans must provide coverage for certain preventive health services, as well as recommended evidence-based items or services without imposing any cost sharing requirements when the services are delivered by in-network providers. Preventive services include: ▪ Blood pressure, diabetes, and cholesterol tests; ▪ Cancer screenings, including mammograms and colonoscopies; ▪ Counseling relating to smoking cessation, weight loss, healthy eating, depression and substance abuse; ▪ Regular well-baby and well-child visits, from birth to age 21; ▪ Routine vaccinations; ▪ Pregnancy counseling, screening, and vaccines; and ▪ Flu and pneumonia shots. ***Women's Health Preventive Services.*** Group health plans must also provide preventive health coverage for women's health services, including well-women visits, screenings, FDA-approved contraceptive methods, and counseling without additional cost-sharing requirement. Beginning on or after September 24, 2014 (January 1, 2015 for calendar year plans), coverage for certain medications for women who have a high risk for developing breast cancer, where applicable as part of a medical management regime, must also be covered without cost-share. *(N/A to grandfathered plans, HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	All-sized employers *Entities exempt from providing contraceptive and related services:* ▪ Full exemption for religious employer: a church, its auxiliaries, or convention or association of churches ▪ Certain eligible organizations with religious objections to providing some or all of contraceptive services including non-profit entities with religious affiliations and for-profit closely held entities are exempt from providing such services if they self-certify their religious objections on EBSA Form 700 or HHS form.	▪ Preventive health services effective for plan years beginning on or after 9/23/10 ▪ Women's Health Preventive Services mandate effective for plan years beginning on or after 8/1/12	▪ *Preventive Health Services (7/15/10)* ▪ *Preventive Care Coverage Expanded to Include Women's Health Services (8/3/11)* ▪ *Preventive Health Services for Women: Limited Exception for Church Plans (2/13/12)* ▪ *Women's Preventive Services Update (3/21/12)* ▪ *Women's Preventive Services Update Impacting Religious Organizations (2/6/13)* ▪ *Women's Health Services Mandate Final Regulations – Exemption for Religious Employers and Non-Profit Religious Organizations (7/5/13)* ▪ *See First Dollar Coverage for Preventive Health Services: Contraceptive Coverage Mandate in Year-end Wrap Up (12/23/13)* ▪ *See Women's Preventive Health Services Expanded in Implementation Guidance FAQs (1/13/14)* ▪ *Preventive Services – Contraceptive Mandate (7/2/14)* ▪ *Implementation Update: Women's Preventive Health Services (8/28/14)* ▪ *Coverage of Preventive Services FAQs (5/20/15)*

INSURANCE ISSUES*

(Also see Employer/Plan Sponsor Issues, Taxes and Fees, and Individual Responsibility)

** As a general statement, wherever a provision refers to employer-sponsored or group health plan, unless otherwise indicated, the provision applies to both insured and self-funded plans. The IRC control group rules apply for purposes of determining employer size*

Provision	Impact	Effective Date 2011	Related CBIZ Health Reform Bulletin
Minimum Loss Ratio (MLR) Rules. Insurers in the individual and group markets, including grandfathered plans, are required to provide an annual rebate to each enrollee if the ratio of the amount of premium revenue expended on costs related to reimbursement for clinical services and activities that improve health care quality versus the total amount of premium revenue is less than: ▪ 85% for insurers in the large group market ▪ 80% for insurers in the small group or individual markets Beginning January 1, 2014, the MLR rebate amount is based on averages for each of the previous 3 years for the plan. Rebates received by employer-policyholders must be dispersed in accordance with plan document provisions and by the type of plan.	Plans in the large group, small group and individual markets, including grandfathered plans. MLR restrictions do not apply to self-insured plans.	1/1/11	▪ *Final Minimum Loss Ratio Rules Issued (12/12/11)* ▪ *ACA Updates: Minimum Loss Ratio Rules (5/17/12)* ▪ *Minimum Loss Ratio Rebates (7/10/12)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2012	Related CBIZ Health Reform Bulletin
Patient-Centered Outcome Research Fee. Insured and self-funded group health plans must pay a fee based on the average number of lives covered under the plan. The purpose of these fees is to fund a Patient-Centered Outcome Research Trust Fund. This Trust Fund, in turn, supports a Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing comparative clinical effectiveness research. Amount of fees is indexed accordingly: ▪ For policy/plan years ending after 9/30/12 and before 10/1/13, the applicable dollar amount is $1 per covered life. ▪ For policy and plan years ending after 9/30/13 and before 20/1/14, the applicable dollar amount is $2 per covered life. ▪ For policy and plan years ending after 9/30/14 and before 10/1/15, the applicable dollar amount is $2.08 per covered life The fee is to be paid by the insurer for a fully insured plan, by the plan sponsor for a self-funded plan. PCOR fees are paid once a year in connection with IRS Form 720, *Quarterly Federal Excise Tax Return*: ▪ For insured plans, Form 720 due by July 31st following the close of the policy year ▪ For self-funded plans, Form 720 due by July 31st of the calendar year following the plan year end	▪ Insurers of all-sized fully-insured plans ▪ All-sized employers of self-funded plans ***Also applies to:*** ▪ Retiree-only plans ▪ COBRA and state continuation coverage ▪ Non-integrated health reimbursement arrangements (HRA) ▪ Medical flexible spending accounts (FSA) subject to HIPAA **Plans *not subject* to the fees include:** ▪ HIPAA-excepted benefit plans such as limited scope dental and vision plans ▪ FSAs excepted from HIPAA ▪ Employee assistance programs, disease management programs, and wellness programs that do not provide significant benefits in medical care or treatment ▪ Expatriate group health plans primarily covering employees who work and reside outside U.S. (however, foreign nationals working in U.S. *are* counted in calculation of the fee) ▪ Stop loss and indemnity reinsurance policies	Plan years ending after 9/30/12 *No fee assessed for policy/plan years ending after 9/30/19 (for calendar year plans, this means the 2018 plan year)*	▪ *Year-end Wrap Up (12/21/11)* ▪ *Fees on Health Insurance Policies & Self-Insured Plans: Patient-Centered Outcome Research Trust Fund (4/18/12)* ▪ *Final Regulations Issued: Patient-Centered Outcomes Research Fees and Medical Device Tax (12/11/12)* ▪ *Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *See Patient-Centered Outcomes Research Fee in Sub-Regulatory Guidance and FAQs Issued (1/25/13)* ▪ *Reporting and Paying PCOR Fees: Revised Form 720 Issued (6/4/13)* ▪ *Year-end Wrap Up (12/23/13)* ▪ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
90-Day Waiting Period Restriction. Group health plans are prohibited from imposing waiting periods exceeding 90 calendar days, including weekends and holidays. Health coverage must be made available no later than the 91st day. If individuals are required to satisfy certain job criteria, such as achieving a particular job classification or job-related licensure requirement, the 90-day clock begins when the eligibility conditions are satisfied. *Orientation Period*. An optional one-month orientation period to determine whether an individual has met the requisite qualifications, licensure or other job standards may be imposed prior to the beginning of a waiting period. The orientation period is measured forward from employee's date of hire by adding one calendar month and subtracting one calendar day; after which time, the maximum 90-day wait would commence.	Virtually all-sized employer sponsored group health plans including insured and self-funded plans, whether grandfathered or not, and without regard to plan size.	Plan years beginning on or after 1/1/14	▪ *ACA Updates: 90-Day Waiting Period Limitation (2/10/12)* ▪ *Guidance Issued Relating to 90-day Waiting Period and Defining Full-time Employee (9/06/12)* ▪ *90 Day Wait and Other Updates (3/26/13)* ▪ *See 90-day Waiting Period in Guidance and Updates (9/11/13)* ▪ *Final Rules – 90-Day Waiting Period (2/24/14)* ▪ *Final Rules Address Orientation Period (6/26/14)*
Coverage for Individuals Participating in Approved Clinical Trials. Individual and group health plans cannot deny individual participation in approved clinical trials and must cover routine costs in approved clinical trials. Insurers are not required to cover: ▪ The investigational item, device or service; ▪ Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or ▪ A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.	Individual and Group Plans *(N/A to HIPAA-exempt programs, limited scope dental and vision plans, and stand alone retiree-only plans.)*	Plan years beginning on or after 1/1/14	

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin

Ban on Discriminatory Premium Rates. Health insurance premiums in the individual, small and large group market can only be based on:
▪ Family size (individual or family coverage)
▪ Geography
▪ Age. Following are permitted age-bands:
  ▪ Child age bands. A single age band for individuals aged 0-20.
  ▪ Adult age bands. One-year age bands for individuals aged 21-63.
  ▪ Older adult age bands. A single age band for individuals aged 64 and older.
▪ Tobacco use. Such rate band cannot vary by more than 1.5:1 and may only be applied with respect to individuals who legally use tobacco, as permitted under federal and state law.
	▪ Individual policies
	▪ Small insured group plans covering ≤100 employees, including non-grandfathered plans
	▪ Large insured group health plans offered via marketplace
		Plan years beginning on or after 1/1/14	▪ *Proposed Regulations: Rating Restrictions, Guaranteed Issue and Renewal Rules (11/28/12)*
			▪ *Final Health Insurance Market and Rate Review Rules (2/28/13)*

Guaranteed Availability: Ban on Discrimination Based on Health Status. Insurers are prohibited from imposing discriminatory eligibility rules based on any of the following health status-related factors, relating to the covered individual or his/her dependent: ▪ Health status; ▪ Medical condition including both physical and mental illnesses; ▪ Claims experience; ▪ Receipt of health care; ▪ Medical history; ▪ Genetic information; ▪ Evidence of insurability, including conditions resulting from domestic violence; ▪ Disability; or ▪ Any other health status-related factor determined discriminatory by HHS.	▪ Individual policies ▪ All sized insured non-grandfathered group health plans	Plan years beginning on or after 1/1/14	▪ *Proposed Regulations: Rating Restrictions, Guaranteed Issue and Renewal Rules (11/28/12)* ▪ *Final Health Insurance Market and Rate Review Rules (2/28/13)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Guaranteed Renewability of Coverage. Similar to the rules imposed under HIPAA, individual policies and contracts issued to both small and large groups are subject to guaranteed renewability provisions. Under ACA, renewal of contracts can only be denied in the following circumstances: ▪ Failure to pay premium ▪ Fraud or intentional misrepresentation by the employer or employee ▪ Material noncompliance with contract terms such as contribution or participation requirement. ▪ The insurer terminates the plan, i.e., ceases to do business within a geographic area ▪ In the case of a network plan, there are no enrollees residing or working within the network service area ▪ An employer's membership in a bona fide association ceases but only if coverage is terminated uniformly without regard to any health status related factor relating to any covered individual.	▪ Individual policies ▪ All sized insured, non-grandfathered group health plans	Plan years beginning on or after 1/1/14	▪ *Proposed Regulations: Rating Restrictions, Guaranteed Issue and Renewal Rules (11/28/12)* ▪ *Final Health Insurance Market and Rate Review Rules (2/28/13)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Health Insurance Marketplace. By 2014, states were to either establish a marketplace, or enter into a Federal-State partnership for establishing a marketplace, or if the state failed to act, then it would utilize a federally-established marketplace. A marketplace is intended to be a one stop marketplace available to individuals and certain employers for the purchase of health coverage. Eligible employers are able, but not obligated, to buy coverage through the marketplace. There are two types of marketplaces: state-based marketplaces available to individuals and Small Business Health Options Program (SHOP) marketplaces available to small employers. *Employer Size Defined* ▪ *Small Employers*: Employs at least 1 but not more than 100 employees. ▪ *Large Employers:* Employs at least 101 employees. ▪ For plan years starting before 1/1/16, states may elect to define small employers as one with 1-50 employees; large employers as one with 51+ employees. Insurers are permitted to offer plans to qualified individuals and qualified employers outside of the marketplace. *Qualified Health Plans* The marketplace is responsible for certifying qualified health plans (QHPs) offered through the marketplace. QHPs must meet certain benefit design standards, such as provide essential health benefits and cost-share requirements, and meet the bronze, silver, gold, or platinum actuarial levels of benefits and coverage. States have significant discretion in defining the essential benefits package which provides a standardized framework of benefit coverage that must be included in QHPs offered through marketplaces beginning in 2014.	▪ Insurers in the Individual and Small Group Markets *Note:* In 2014 and 2015, "small employer" is defined by state law. Beginning in 2016, a small employer is one with 100 or fewer employees. ▪ Beginning in 2017, large groups may be allowed to participate in the marketplace (if a state legislature so provides).	1/1/14 for Individual and Small Group Plans 2017 for Large Group Plans (If a State Legislature so provides).	▪ *Proposals on Exchanges, Premium Assistance and Uniform Benefit Summary (8/18/11)* ▪ *Overview of Final Exchange Regulations (3/28/12)* ▪ *Final Essential Health Benefit Regulations (2/25/13)* ▪ *Final Rules Issued: Small Business Health Options Program (6/3/13)* ▪ *Final Exchange Regulations (7/3/13)* ▪ *Small Business Health Options Program (SHOP) Updates (10/31/13)* ▪ *See 'Proposed Benefit and Payment Parameters in 2015' and 'Online SHOP Enrollment Delayed' in Year-end Wrap Up (12/23/13)* ▪ *See Cost Sharing Requirement in Implementation Guidance FAQs (1/13/14)* ▪ *HHS Benefit and Payment Parameters for 2015 (3/14/14)* ▪ *Elimination of Deductible Limits in Small Employer Sponsored Plans (4/4/14)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Health Insurance Marketplace, (continued) ***Cost-Share Requirements.*** QHPs available through the marketplace are subject to cost-share requirements on essential health benefits. The cost-share amount must equate to qualified high deductible health plan (HDHP) coverage. For out-of-pocket purposes, cost-sharing includes deductibles, coinsurance, and co-pays (but no premium). OUT-OF-POCKET LIMITS (applicable to insured plans offered via marketplace, and insured and self-funded plans offered outside marketplace): ▪ For 2015, the annual out-of-pocket limit is $6,600 for self-only coverage and $13,200 for other than self-only coverage. ▪ For 2016, the out-of-pocket limit increases to $6,850 for self-only coverage; $13,700 for other than self-only coverage For plan years beginning January 1, 2016, an individual cannot be subject to more than the individual statutory out-of-pocket limit on EHBs, even if the individual is covered by a family plan. The out-of-pocket limits only apply to in-network benefits. A plan can, but is not required to, impose the out-of-pocket limit on other network benefits. For plan years beginning on or after January 1, 2015, the out of pocket limit on essential health benefits must be satisfied, even if the plan uses different service providers. ***Other QHP Standards*** Insurers offering QHPs are subject to standards relating to rate and participation, accreditation, transparency of coverage, network provider adequacy, as well as rules relating to enrollment, termination of coverage, payment of premium, notices and applications, prescription drug distribution and cost reporting, termination of coverage, marketing, and plan certification renewals.			*Marketplace-related HRBs, cont'd* ▪ *Implementation Guidance (5/7/14)* ▪ *See Cost Share Limits in Year-end Wrap-Up (12/11/14)* ▪ *Employer Appeals to Marketplace Determinations (2/16/15)* ▪ *HHS Benefit and Payment Parameters for 2016 (3/3/15)*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Health Insurance Marketplace, (continued) ***Open Enrollment Period.*** The open enrollment period for 2015 coverage began November 15, 2014 and extended through February 15, 2015. For the 2016 plan year, the annual open enrollment period for obtaining coverage through the marketplace or the Small Health Options Program (SHOP) will run from November 1, 2015 through January 31, 2016. ***Special Enrollment Periods***. Outside of the open enrollment period, individuals experiencing a 'qualifying life change' or 'qualifying circumstance' may be eligible for a special enrollment period (SEP). Most SEPs last 60 days from the date of the qualifying life change in the individual marketplace; 30 days in the SHOP marketplace. Individuals who fail to enroll within this period may have to wait until the next annual open enrollment period. ***Small Business Health Options Program (SHOP).*** The SHOP is the marketplace specific to small employers. A small employer, for SHOP purposes, is one who employs 50 or fewer full-time equivalent employees (FTEs), including part-time employees. Beginning January 1, 2016, the SHOP will be available for employers with 100 or fewer FTEs. A qualified small employer is eligible to purchase coverage through a SHOP if such employer elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and either has its principal business address in the marketplace service area and offers coverage to all its employees through that SHOP; or offers coverage to each eligible employee through the SHOP service area where the employee's primary worksite is located. A SHOP differs from a state-based marketplace with regard to such matters as enrollment and eligibility functions, a uniform level of coverage availability for all employees, premium payment administration, QHP certification, uniform rate restrictions, uniform group participation rules and initial, annual and special enrollment periods.			

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Premium Stabilization – Mechanisms for Allocating Risk Mechanisms implemented to stabilize the insurance marketplace by spreading the risk more broadly across all insurers. The three components of the Premium Stabilization Program are a transitional reinsurance program, a temporary risk corridor program and a permanent risk adjustment program.			
1. The **transitional reinsurance program** is intended to stabilize premiums in the individual market due to immediate enrollment of higher risk individuals beginning in 2014. The reinsurance money will be used to offset the expenses of the newly eligible individuals. States that operate a marketplace are required to establish a transitional reinsurance pool, to be in effect for the 3-year period of 2014 through 2016. In the absence of a state establishing a reinsurance pool, the federal government will do so. Both insured plans, through their insurers, and self-funded plans must contribute to the reinsurance pool. For a self-funded plan, the contributing entity is the plan sponsor/employer. The plan can contract with a third party administrator (TPA) to calculate the premium and submit the payment, but ultimately the plan sponsor/employer is responsible for funding it. The specific rates are set annually by HHS. For 2014, the contribution rate is $5.25 per covered life per month, or approximately $63, annually. The annual reinsurance contribution rate to be collected in 2015 is $44 per covered life ($3.66 per covered life per month). In 2016, the annual reinsurance contribution rate to be collected is $27 per covered life.	▪ Insurers of all-sized fully-insured plans ▪ All-sized employers of self-funded plans *Also applies to:* ▪ Post-employment plans that are primary to Medicare, such as early retiree plans ▪ COBRA continuation *Plans not subject to fees include:* ▪ HIPAA excepted benefit plans such as limited scope dental and vision plans ▪ HRAs integrated with comprehensive insured or self-funded group coverage ▪ Flexible medical spending account plans (FSA) ▪ Health savings accounts (HSA) except an HDHP used in conjunction with HSA is considered major medical insurance and thus, subject to reinsurance contributions	1/1/14	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)* ▪ *See 'Transitional Reinsurance Fee' in 'Proposed Benefit and Payment Parameters in 2015' in Year-end Wrap Up (12/23/13)* ▪ *HHS Benefit and Payment Parameters for 2015 (3/14/14)* ▪ *PCOR Fees and Transitional Reinsurance Fees (6/18/14)* ▪ *Completing the Transitional Reinsurance Fee Form (10/28/14)* ▪ *Proposed Benefit and Payment Parameters for 2016 in Year-end Wrap Up (12/11/14)* ▪ *Transitional Reinsurance Fee Refund Requests (4/17/15)*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Transitional Reinsurance Program, con't An insurer, or plan sponsor through its TPA, is required to submit an annual enrollment count of the average number of covered lives to HHS by November 15th of each year. The process for reporting and payment of the fees is accomplished through the pay.gov website. Reporting entities complete the *ACA Transitional Reinsurance Program Annual Enrollment Contributions Submission Form*, upload supporting enrollment documentation, and schedule payment of the fees in one or two installments. HHS will then notify the insurer or plan sponsor/TPA of its contribution amount no later than December 15th of the reporting year. The insurer or plan sponsor/TPA must then remit payment to HHS within 30 days of receiving the HHS notification of the amount due.	*Plans not subject to fees, con't:* ▪ Employee assistance plans, disease management programs, and wellness programs that do not provide significant benefits in the nature of medical care or treatment. ▪ Post-employment plans where Medicare is primary to group plan ▪ Stand-alone prescription drug plans ▪ TRICARE or other military benefit plans ▪ Certain Indian Tribal benefit programs ▪ Certain expatriate plans		
2. **A temporary risk corridor program**. Qualified health plan (QHP) issuers are required to establish and administer a temporary risk corridor program for a 3-year period from 2014 through 2016. QHP issuers receive payment from HHS in certain circumstances when a QHP's allowable costs for any benefit year exceed the target amount. The regulations permit QHPs to include profits and taxes within its risk corridors calculations. This program is intended to protect QHP issuers in the individual and small group market against inaccurate rate setting and uncertainty in the marketplace by limiting the extent of issuer losses and gains.	Issuers of Qualified Health Plans via Marketplace	1/1/14	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)*

INSURANCE ISSUES*

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Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Premium Stabilization – Mechanisms for Allocating Risk, con't 3. **A permanent risk adjustment program**. An on-going permanent risk adjustment program is intended to provide adequate payments and reduce risk premium to insurers that attract high-risk populations, such as individuals with chronic conditions; as well as stabilize premiums in the individual and small group markets once the ACA's insurance market reforms are implemented. The program provides a process for transferring funds from plans with lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. HHS has established the criteria and methodology to be used by states in determining the actuarial risk of plans within a state that are offered both in and outside the marketplace.	Non-grandfathered individual and small group market plans, in and outside the marketplace	Benefit year 2015 *(transitional policy for Benefit year 2014)*	▪ *Premium Stabilization Program Proposals and 2) Chart of Health Plan Fees and Taxes (12/18/12)* ▪ *Implementation Guidance (3/12/13)*

INDIVIDUAL RESPONSIBILITY

(ALSO SEE TAXES AND FEES, INSURANCE ISSUES, AND MEDICARE ISSUES)

INDIVIDUAL RESPONSIBILITY
(Also see Taxes and Fees, Insurance Issues, and Medicare Issues)

Provision	Impact	Effective Date 2010	Related CBIZ Health Reform Bulletin
Temporary High Risk Pool. HHS established a temporary, national high-risk pool to assist individuals who have been denied insurance coverage due to a preexisting condition. Coverage was provided through a Pre-existing Condition Insurance Plan ("PCIP"). The PCIP program became effective on June 21, 2010 and sunset on January 1, 2014, at which point, coverage is obtainable via the marketplaces. However, certain PCIP participants whose coverage had been cancelled prior to January 1, 2014 are given a transitional extension to replace their PCIP coverage with new marketplace coverage through March 31, 2014.	Individuals	6/21/10 PCIP Program closed 1/1/14	▪ *Pre-existing Condition Insurance Plan ("PCIP") (8/19/10)*
Effective Date 2011			
OTC Medications Are Not Qualified Expenses. FSAs, HRAs, Archer MSAs, and HSAs can no longer reimburse the cost of over-the-counter (OTC) medications, except for insulin or prescribed OTC medications. Debit cards for FSAs and HRAs can only be used for prescribed OTC medications, if certain conditions met.	Individuals	1/1/11	▪ *Over-the-Counter Medication Prohibition Clarified (9/7/10)* ▪ *Limited Relief for Debit Card Purchases of OTC Medications (1/10/11)* ▪ *Year-end Wrap Up (12/21/11)*
Increased Penalty for Nonqualified HSA or Archer MSA Distributions. Penalties on nonqualified HSA distributions increase from 10% to 20%. The penalty for nonqualified distributions from Archer MSAs increases from 15% to 20%.	Individuals	1/1/11	

INDIVIDUAL RESPONSIBILITY

(Also see Taxes and Fees, Insurance Issues, and Medicare Issues)

Provision	Impact	Effective Date 2013	Related CBIZ Health Reform Bulletin
FSA Cap. The maximum amount of salary contributions to a flexible medical spending account is capped at $2,500 (indexed for 2014; $2,550 for 2015).	Individuals participating in an employer-sponsored FSA plan	Plan years beginning on or after 1/1/13	▪ *Year-end Wrap Up (12/21/11)* ▪ *Guidance Issued Relating to $2,500 FSA Salary Reduction Cap (5/31/12)*
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased (by 0.9%), from 1.45% to 2.35%, to the extent an individual's wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ Employer must withhold on all wages >$200,000 ▪ Employee liable regardless of employer withholding ▪ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Implementation Guidance on Medicare Tax (6/27/12)* ▪ *Additional Medicare Tax - Clarifications and Proposed Regulations Issued (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals equal to 3.8% of the lesser of an individual's (1) "net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities); or, (2) modified adjusted gross income in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ No employer withholding requirement ▪ Counted for estimated tax payments ▪ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Additional Medicare Tax Clarifications and Proposed Regulations Issues (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*
Modification of Itemized Deduction for Medical Expenses. The threshold for deductibility of unreimbursed medical expenses is increased from 7.5% to 10% of AGI. The 7.5% threshold is retained through 2016 for individuals who are at least 65 years old by year end.	Individuals	1/1/13	

INDIVIDUAL RESPONSIBILITY

(Also see Taxes and Fees, Insurance Issues, and Medicare Issues)

Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Individual Shared Responsibility Mandate Beginning in 2014, virtually all individuals residing in the U.S. must maintain a minimum level of coverage, or risk a shared responsibility payment. Minimum essential coverage must be maintained by the taxpayer for him or herself and his/her dependents. For these purposes, dependents are those as defined by IRC Section 152, including the taxpayer's biological child, step child, adopted child or foster child, up to age 26, as well as a dependent who meets the definition of qualifying child or qualifying relative of the taxpayer. The taxpayer would be liable for the shared responsibility payment attributable to the dependent's lack of coverage regardless of whether the taxpayer claims the individual as a dependent on a Federal income tax return for the taxable year. Spouses who file their taxes jointly are likewise generally responsible for maintaining this minimum level of coverage. Following are the potential penalties for failure to maintain minimum essential coverage: ▪ **2014**: Greater of $95 per adult and $47.50 per child (up to $285 for a family); ***or*** 1.0% of family income ▪ **2015**: Greater of $325 per adult and $162.50 per child (up to $975 for a family) ***or*** 2.0% of family income ▪ **2016 and Beyond**: Greater of $695 per adult and $347.50 per child (up to $2,085 for a family) ***or*** 2.5% of family income	All U.S. citizens *Exemptions:* ▪ Conscientious religious member ▪ Health care sharing ministry member ▪ Federally-recognized Indian tribal member ▪ Household income ▪ Short gap in coverage ▪ Hardship ▪ Cost of coverage exceeds 8% (indexed for 2014; 8.05% for 2015; 8.1% for 2016) of household income ▪ Incarceration ▪ Non-U.S. citizen, U.S. national or alien lawfully present in U.S.	1/1/14 *Transition Relief. An individual who is eligible for an employer plan for which the anniversary is different from the calendar year will not be subject to individual shared responsibility requirement until the plan anniversary occurring on or after January 1, 2014.*	▪ *Individual Minimum Essential Coverage (2/6/13)* ▪ *See Individual Shared Responsibility – Final Regulations in Guidance and Updates (9/11/13)* ▪ *See Individual Shared Responsibility in Year-end Wrap Up (12/23/13)* ▪ *See Individual Shared Responsibility in Implementation Updates (8/5/14)* ▪ *See Individual Shared Responsibility Mandate in Year-end Wrap Up (12/11/14)* ▪ *Taxpayer Assistance for Individuals (1/8/15)* ▪ *HHS Benefit and Payment Parameters for 2016 (3/3/15)*

INDIVIDUAL RESPONSIBILITY
(Also see Taxes and Fees, Insurance Issues, and Medicare Issues)

Provision	Impact	Effective Date 2014	Related CBIZ Health Reform Bulletin
Individual Shared Responsibility Mandate, con't To facilitate maintenance of minimum essential coverage (MEC), certain individuals whose income falls between 100 and 400% of the federal poverty level (FPL) are entitled to government assistance unless he/she is exempt. MEC generally includes coverage under: ■ Employer-sponsored group health plans, whether insured or self-funded, and grandfathered plans, as well as COBRA coverage (if actually elected) and retiree coverage. It also includes group health coverage sponsored by non-profit and for-profit entities, and governmental entities, including local governments. HIPAA-excepted coverage that is not integrated with a group plan such as limited scope dental, vision or long term care, or other types of limited benefit plan coverage, non-coordinated benefits or specific disease coverage, and supplemental benefit coverage do not qualify as MEC. ■ Government-sponsored plans such as Medicare, Medicaid, Children's Health Insurance Program (CHIP), TRICARE, and various Veteran's health programs ■ Individual health policies, including a qualified health plan offered by a marketplace. ■ Certain third party coverage offered through PEO, leasing company or multi-employer plan ■ Certified self-funded student health plans, AmeriCorp plans and state high risk pools ■ Other similar types of comprehensive health coverage recognized as MEC by HHS			

INDIVIDUAL RESPONSIBILITY (Also see Taxes and Fees, Insurance Issues, and Medicare Issues)			
Provision	**Impact**	**Effective Date 2014**	**Related CBIZ Health Reform Bulletin**
Individual Shared Responsibility Mandate, con't ***Premium Assistance Tax Credit.*** To assist individuals meet their shared responsibility requirement, government assistance is available to help them. Taxpayers with family income between 100% and 400% of the federal poverty level (FPL) and whose employers fail to offer minimum essential coverage at an affordable rate, are entitled to a tax credit for coverage purchased through a marketplace. The amount of the credit is based upon premium cost and family income, but starts at the amount by which premiums exceed 2% of family income if the income is at or below 100% of FPL. At 400% of FPL the credit is the amount by which premiums exceed 9.5% (indexed for 2014) of the employee's household income (modified AGI) for taxable year. *The household income threshold percentage increases to 9.56% for 2015; it is proposed to increase to 9.66% for 2016*. To be eligible for premium assistance, the individual must meet the following criteria: 1. Health insurance is purchased via the marketplace; 2. The individual is ineligible for coverage through an employer or government plan; 3. The individual meets certain income limits; 4. The individual files a joint return, if married; and 5. The individual cannot be claimed as a dependent by another person. Individuals who meet the above criteria can have some or all of the estimated credit paid in advance directly to the insurer to lower their out-of-pocket amounts on the monthly premiums during the tax year; or wait to get the credit when they file their annual tax return.	Taxpayers whose income ≥100% but less than 400% of the FPL for the size of family involved	1/1/14	

MEDICARE ISSUES

MEDICARE ISSUES

Provision	Impact	Effective Date 2011	Related CBIZ Health Reform Bulletin
Medicare Coverage Gap Discount Program. In order to have their drugs covered by Medicare Part D, pharmaceutical manufacturers must provide a 50% discount off the negotiated price for brand name drugs under plan formularies for beneficiaries who enter the coverage gap. Beneficiaries would be eligible for the discount if they don't qualify for low-income subsidies, do not have employer-sponsored coverage, or do not pay higher, income-related Medicare premiums under Parts B or D.	Medicare Part D Enrollees	1/1/11	
Effective Date 2013			
Increased Medicare (Hospital Insurance) Tax on High-Income Individuals. The Medicare portion of an individual's FICA tax is increased (by 0.9%), from 1.45% to 2.35%, to the extent an individual's wages exceed $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ Employer must withhold on all wages >$200,000 ▪ Employee liable regardless of employer withholding ▪ Counted for estimated tax payments	Individuals with wages of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Implementation Guidance on Medicare Tax (6/27/12)* ▪ *Additional Medicare Tax – Clarifications and Proposed Regulations Issued (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*

MEDICARE ISSUES			
Provision	Impact	Effective Date 2013	Related CBIZ Health Reform Bulletin
Unearned Income Medicare Contribution. A Medicare tax is imposed on high income individuals equal to 3.8% of the lesser of an individual's (1) "net investment income" (capital gains, interest, dividends, annuities, rent and gross income from passive activities); or, (2) modified adjusted gross income in excess of $250,000 for married filing jointly, $200,000 for single taxpayers, or $125,000 for married filing separately. ▪ No employer withholding requirement ▪ Counted for estimated tax payments ▪ Net investment income excludes income from a qualified retirement plan and amounts subject to self-employment taxes.	Individuals with net investment income and modified AGI of $250,000 (married filing jointly), $200,000 (single), or $125,000 (married filing separately)	1/1/13	▪ *Additional Medicare Tax Clarifications and Proposed Regulations Issues (12/10/12)* ▪ *2013 Final Net Investment Income, Additional Medicare Tax Regulations (12/11/13)*