Health Care Reform

Implementation timeline for employees

2010

- Dependent coverage for adult children up to age 26
- Preventative services in network covered at 100%
- Elimination of pre-existing clause for children under age 19
- Elimination of lifetime and annual limits
- Small employer tax credits began
- No discrimination in favor of highly compensated employees (enforcement delayed)*

2011

- Prescription required for over-the-counter medication reimbursement for FSA/HSA/HRA
- Medical Loss Ratio standards go into effect (80% small group, 85% large group)

2012

- Expanded women's preventive care services covered at 100%*
- Summary of Benefits and Coverage (SBC) must be provided to employees
- 60-day notice of plan changes must be provided if off-renewal plan changes are made
- Medical Loss Ratio (MLR) rebates may be issued by group health carriers (for 2011)
- W-2 reporting requirements starts for companies with 250 or more W-2s
- Begin the Patient Centered Outcomes Research Institutes fee of $1 per participant per year

2013

- Medical FSA spending account contributions limited to $2,500 per year
- Employee notification of health insurance exchanges and premium subsidies
- Patient Centered Outcomes Research Institute fee increases to $2 per participant per year

2014

- Guaranteed issue access to health insurance and no pre-existing condition limitations
- Individual mandate to purchase health insurance
- Tax credits and subsidies for families to purchase insurance through the exchanges
- Employer mandates for employers who have 50+ Full Time Equivalents (FTEs)
- Employers with 200+ FTEs must auto-enroll employees into health benefits
- Nondiscrimination requirement enforced
- Limit any waiting period for coverage to 90 days
- Small group rating factor limited to age (3:1 ratio), tobacco use, geography, family tier*
- Small group deductibles cannot exceed $2,000 for individual or $4,000 for family*
- Out of pocket limits cannot exceed the OOP limits for HSA plans*
- Small group and individual health plans must cover Essential Health Benefits*
- Wellness rewards can increase from 20% to 30% for the cost of coverage
- Begin fees on the health insurers starting at $8 billion and increasing to $14.3 billion
- Begin reinsurance fee of $25 billion to stabilize the individual market
- Employers required to report information to the IRS annually
- Medicaid expansion

*DOES NOT APPLY TO GRANDFATHERED PLANS

Penalties for noncompliance

Employer "Play or Pay" Mandate

Employers with 50 or more Full Time Equivalents (FTEs) must offer health insurance coverage to all active full time employees or pay a penalty. Full Time Equivalents are defined as employees working 30 or more hours per week.

Health insurance coverage must meet minimum requirements:

- Provide 60% actuarial value – basically, this means the plan covers at least 60% of covered health costs
- Not cost more than 9.5% of the employee's average household income

Penalty for not providing coverage (opting out):

$2,000 annually multiplied by the total number of full-time employees (excluding the first 30 employees) if any full time employee receives premium assistance through an exchange.

Penalty for providing coverage, but the coverage does not meet the requirements:

The lesser of $3,000 annually for each full time employee who receives premium assistance through an exchange or $2,000 annually per full time employee (excluding the first 30 employees).

Individual Mandate

All US citizens are required to have "minimum essential coverage"

Tax for not having coverage:

2014: Greater of $95 per individual or 1% of income

2015: Greater of $325 per individual or 2% of income

2016 and after: Greater of $695 per individual or 2.5% of income