Hollis Companies

Employee Benefits Specialists

Health Care Reform Impact and Timeline

Effective 2010-2011

New Regulation	Current Status / Action Item
Requires health plans to maintain dependent coverage for children up to the age of 26, regardless of marriage or school status. (Louisiana law made this effective October 1, 2010. **Until 2014, grandfathered plans are only required to extend coverage if the adult child is not eligible for another qualified employer-sponsored plan.**	Fully Implemented
Prohibits insurers from excluding coverage for pre-existing conditions for children up to the age of 19.	Fully Implemented
Prohibits lifetime dollar limits on insurance policies.	Fully Implemented
Prohibits coverage rescissions except in limited acts of fraud or intentional misleading representation of facts.	Fully Implemented
Over-the-counter drugs no longer reimbursable under FSAs, HRAs or HSAs unless prescribed by a doctor. (Effective January 1, 2011)	Fully Implemented
Requires employers to enroll employees in a new national Long-Term Care Program unless employee opts out. Employees must contribute for minimum of five years to become eligible for payments.	House of Representatives repealed February 1, 2012. Deferred as unaffordable and not expected to be implemented.
Tax penalty for distributions from a Health Savings Account that are not used for qualified medical expenses increases from 10% to 20%.	Fully Implemented
Minimum Loss Ratio requirements established of 80% for small group plans and 85% for large group plans (over 100 lives). Carrier will have to issue a premium rebate to individuals for plans that fail to meet the minimum MLR requirements.	Fully Implemented
Mandates coverage of specific preventive services with no cost sharing. *	Fully Implemented for Non-Grandfathered health plans.
Must allow emergency services without pre-authorization and treat as in-network. *	Fully Implemented for Non-Grandfathered health plans.
Must allow individuals to choose a pediatrician for a child's primary care provider and must allow females to choose a gynecologist or obstetrician without referral. **	Currently allowed.
No discrimination in favor of highly compensated individuals (Code Sec. 105-H) *	Currently applies to self-funded plans only. Would significantly impact a Management Carve-out Group. Enforcement delayed until regulations issued. Once issued, will not apply until plan year following issuance.
Must provide internal review and external appeals process. *	Fully Implemented for Non-Grandfathered health plans.

Effective 2012

Requires employers to report the value of health care benefits on employees' W-2s.	IRS has given transitional relief to those employers who file fewer than 250 Forms W-2 to further notice. However, employers who file 250 or more Forms W-2 are required to report for 2013 W-2s issued in January 2014.
Preventive Services for Women are expanded to cover well woman exams, contraceptives, and additional screenings and counseling at no cost sharing for plan years beginning on or after August 1, 2012. *	Plan document amended to cover the additional services.

Effective 2013

Increases employee portion of Medicare payroll tax from 1.45% to 2.35% and expands to 3.8% on interest, dividends and other unearned income for singles earning greater than $200,000 annually and joint filers earning greater than $250,000 annually.	Current Medicare tax of 1.45% deducted from paycheck and applied to earned income only. New tax expansion effective January 1, 2013.
Assesses a premium tax of $1.00 on each covered life to fund a comparative effectiveness research program. Fee doubles to $2.00 in 2014.	Fees should be paid by the insurance company for insured plans and by the "plan sponsor" for self-funded plans.
Must create Summary of Benefits and Coverage (SBC) using uniform DHHS definitions. SBC must be provided when Open Enrollment materials are distributed. If coverage automatically continued for the next year, the SBC must be provided at least 30 days before the beginning of the new plan year or within 7 business days after the earlier of: a) the date the policy or certificate is issued; or b) receipt of written confirmation of intent to renew.	Both health insurance issuer and plan administrator are required to furnish an SBC to plan participants, however, this obligation is satisfied if one party furnishes the SBC to participants as long as it is timely and complete.
Employers must inform employees/members of certain material changes to health benefit plans 60 days in advance of when the change becomes effective when making mid-year changes.	Mid-Year changes are rarely implemented so very little impact.
Employers must notify all employees no later than October 1st, 2013 of the state insurance exchanges which will be operational in 2014. Information must include right to purchase coverage on the exchange, possible eligibility for government subsidies and possible loss of employer subsidy.	Notification must be sent to current employees and all new hires.

Effective 2014

Pre-Existing condition exclusions on adults are prohibited.	All pre-existing condition limitations have been removed from medical policy.
Prohibits waiting periods in excess of 90 days.	
Annual benefit limits are prohibited on essential benefits	Fully Implemented upon anniversary.
Group health plans must provide annual certification of compliance with various PPACA requirements such as minimum essential benefits, length of waiting period, employer's contribution, total number and names of employees receiving health coverage, etc.	Reporting requirements delayed until 2015.
"Temporary" fee of $5.25 PMPM ($63 PMPY) levied to help cover people with pre-existing conditions. Fee meant to decline then cease after 3 years.	Fee paid by insurance carrier for fully-insured plans. Fee paid by employer for self-funded plans.

States create health insurance exchanges for individuals and small businesses to buy coverage. Certain penalties will apply to employers with more than 50 employees who do not offer coverage if any of their workers get coverage through the exchange and receive a tax credit.	While the health insurance exchanges (marketplace) were activated on January 1, 2014, penalties on employers with 100 or more FTE employees are delayed until 2015 and penalties are delayed for employers with 50-99 FTE employees until 2016.
Employers with more than 50 Full Time Equivalent (FTE) employees that don't offer coverage to at least 95% of their full-time employees face a penalty of $2,000 per FTE (excluding the first 30) if at least one FTE receives a government subsidy to buy coverage on an exchange. Employees with household income up to 400% of the federal poverty level ($92,200 in 2012-2013) could be eligible for subsidies on the exchange if the employee's share of the premium exceeds 9.5% of their household income or the plan pays for less than 60% on average of covered health care expenses. Employers fined $3000 for each employee who applies for and receives a subsidy. Employer implementation and penalties are delayed until 2015. Transition Rule: In 2015, the 30 employee reduction in computing the penalty is increased to 80 employees and the requirement to offer coverage to 95% of full-time employees is reduced to 70%. In 2016 and beyond, the 30 employee reduction and 95% of full-time employee's coverage requirement would apply.	Employer contribution must be structured to ensure that employee's share of premium does not exceed 9.5% of household income. (The use of an employee's W-2 income will be considered in compliance.) Employer implementation and penalties are delayed until January 2015.
Requires citizens to have health insurance except in case of financial hardship or pay a fine to the IRS. Employers with 200+ employees required to auto-enroll employees into employer's health plan. Employees are allowed to opt out if they demonstrate coverage from another source.	Individual Mandate in place but Large Employer Mandates and auto-enroll delayed until 2015.
Annual fee levied on health insurers. The fee would be $8 billion rising to $14.3 billion in 2018 then adjusted for inflation in subsequent years. Would be apportioned among carriers based on a ratio of net health insurance premiums written to the total market share of U.S. health insurance business.	Fee paid by insurance carriers.
All employee cost share (deductibles, copays and coinsurance) must accrue to the annual out-of-pocket maximum. *	Fully Implemented for Non-Grandfathered health plans.
No discrimination against an individual participating in a clinical trial including denying, limiting or imposing additional conditions on the coverage of items or services furnished in connection with participation in the approved clinical trial. *	Fully Implemented for small Non-Grandfathered health plans.
Insurers offering coverage in a particular state must, with limited exceptions, offer any individual, small or large group all products that are approved for sale in the market, and accept any individual or employer that applies for any of those products. *	Fully Implemented for Non-Grandfathered health plans.
Small group markets limited when varying specific premium rates to using age (3:1 limit), tobacco use (1.5:1 limit), individual or family coverage, and geographic area as rating factors. No other rating factors such as health status, claims experience or gender allowed.*	Fully Implemented for small Non-Grandfathered health plans.

2015 - New transition rules

Fiscal Year Plans. Fiscal year (non-calendar year) plans that were in existence on December 27, 2012, and for which the plan year was not subsequently modified will not have to comply until the beginning of their plan year that begins in 2015 if certain conditions are met. Coverage that is affordable and has minimum value must be offered to full-time employees on the first day of the 2015 plan year according to the eligibility rules that were in effect on February 9, 2014.	New transition rule
Large Employer Status. Large employer status for 2015 may be determined by using a six-month period in 2014 (rather than the full calendar year).	New transition rule
Full-Time Status. A six-month measurement period in 2014 may be used to determine full-time status of an employee for 2015, but not for later years. The measurement period may start as late as July 1, 2014, and must end no earlier than 90 days before the first day of the plan year that begins on or after January 1, 2015.	New transition rule
Offers of Coverage. An employer will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once for each plan year, or if the employee does not have an effective opportunity to decline to enroll unless the offered coverage has minimum value and costs less than 9.5% of the federal poverty level (on a monthly basis). An evergreen election of coverage is permitted unless the employee affirmatively opts out. Employers do not have to get signed declinations of coverage to prove coverage was offered. The general substantiation and recordkeeping requirements must be met. Offers can be made electronically according to the Internal Revenue Code's electronic media rules.	Change to final regulations
Monthly Measurement Method. An employee's full-time status could be determined using the monthly measurement method, instead of the look-back measurement method. The employer must use the same method for all employees within certain categories of employees. An employer using the monthly measurement method is not subject to the section 4980H(a) ($2,000 annualized) penalty with respect to the first three full calendar months in which an individual is an eligible employee (other than satisfying the waiting period) if the employee is offered coverage on the first day of the next calendar month. The section 4980H (b) ($3,000 annualized) penalty can be avoided for those months only if the offered coverage has minimum value.	Change to final regulations
Look-back Measurement Method. The initial measurement period for newly hired variable hour and seasonal employees may start the first day of the following month (or, if later, the first day of the next pay period). As a result, only 12 groups of new hires would need to be tracked during the year.	Change to final regulations
Rehired employees. The final regulations reduce from 26 weeks to 13 weeks (except for educational organizations) the absence that will allow a rehired employee to be treated as a new employee. There was no change to the rule of parity under which an employee may be treated as a new employee if his period with no hours is more than the greater of four weeks or the employee's length of service before the break.	Change to final regulations

Seasonal Employees. Seasonal employees are defined as those whose customary annual employment is six months or less, and this period should begin at about the same time each year. This six- month rule does not apply to seasonal workers for determining large employer status.	Change to final regulations
Volunteers. Hours worked by bona fide volunteers of government and tax exempt entities will not be counted to cause them to be full-time employees	Change to final regulations

2018 – Effective 10/1/18

Imposes an excise tax equal to 40% of the aggregate value of employer-sponsored coverage that exceeds $10,200 for an individual policy and $27,500 for a family policy. There are slightly higher thresholds for "high-risk professions" and individuals in 17 "high cost states" as determined by the DHHS Secretary.	Not currently required.

*** "Grandfathered Plans" are exempt from those provisions with an asterisk. Grandfathered plans are those in effect as of March 23, 2010. Grandfathered plans will lose their grandfather status if they:**

- **Significantly cut or reduce benefits for a particular condition**
- **Increase coinsurance levels**
- **Significantly raise copayments (defined as no more than the greater of $5.00 or a percentage equal to medical inflation plus 15%) ****
- **Significantly raise deductibles (defined as no more than a percentage equal to medical inflation plus 15%). ****
- **Significantly lower the employer contribution towards any tier of coverage (defined as by more than 5 percentage points).**
- **Add or tighten an annual limit.**
- **Change insurance companies. (Repealed November 17, 2010)**

* The government is using an average medical inflation rate of 4-5% which is well below the inflation/trend rate used by the insurance industry.