UPMC HEALTH PLAN

Health Care Reform: Timeline of Key Dates for Employers

2012

W-2 Reporting

Employers are required to report the aggregate cost of group health plan benefits on employees' Forms W-2 for the 2012 calendar year (for which Forms W-2 must be distributed by the end of January 2013).

Uniform Summary of Benefits and Coverage

Individual and group health plans must distribute a uniform Summary of Benefits and Coverage (SBC) to all plan participants and beneficiaries beginning on the first day of the first open enrollment period that began on or after September 23, 2012. The goal of the SBC is to help consumers compare and understand health insurance coverage options. This obligation is imposed upon insurers and self-funded plans. In some cases, third-party administrators (TPA) may agree to prepare SBC documents on behalf of plans.

Patient-Centered Outcomes Research Trust Fund Fees

For plan years ending on or after October 1, 2012, through September 30, 2013, both fully insured and self-funded health plans will be assessed a $1 per covered life fee to fund research regarding patient-centered outcomes for medical treatment. The fee increases to $2 per covered life for plan years ending on or after October 1, 2013, through September 30, 2014, and then is subject to projected increases in National Health Expenditures for years 2014-19.

Quality of Care Reporting

Health plans will be required to collect and submit information on an annual basis to both the U.S. Department of Health and Human Services (HHS) and plan members (both current and prospective) about how the health plan's benefits and provider reimbursement policies satisfy new requirements and improve the quality of care for members. This new reporting requirement applies to all individual, group, fully insured, and self-funded plans; grandfathered plans are exempt from this provision. Implementing regulations have not yet been issued.

2013

FICA Medicare Tax Increase

For tax years beginning in 2013, an increased Medicare tax applies to high-income individuals. The employee portion of the Medicare tax, which is a part of the Federal Insurance Contributions Act (FICA), will be increased by 0.9 percent for individuals earning more than $200,000 individually and $250,000 if married filing jointly.

Health Flexible Spending Account Limits

For plan years beginning on or after January 1, 2013, allowable employee contributions to health flexible spending accounts (FSA) are limited to $2,500, increased annually by the cost of living adjustment.

Notice of Health Insurance Exchanges

(Effective date pending issuance of final regulations; anticipated late summer/fall 2013.)

Employers must provide all employees and new hires with a written notice of the upcoming availability of the Health Insurance Exchanges (to be established by all states in 2014). The notice must also inform employees that they may be eligible for a premium tax credit or a cost-sharing reduction through the Exchanges in certain circumstances.

2014

Annual Limits

Plans are restricted from imposing any annual limits on Essential Health Benefits (see below).

Automatic Enrollment *(Effective date pending issuance of final regulations; anticipated 2014.)*

Employers with more than 200 full-time employees must automatically enroll new employees in one of their health plans with adequate notice and opportunity to opt out.

Employer Pay-or-Play Mandate

Employers with 50 or more full-time equivalent (FTE) employees must pay penalties if at least one of their full-time (FT) employees (working 30+ hours per week) obtains a premium credit/cost-sharing reduction through an Exchange. An individual may be eligible for a premium credit/cost-sharing reduction either because the employer does not offer health care coverage or the employer offers coverage that is either not "affordable" (the employee's annual premium for self-only coverage must not exceed 9.5 percent of household income) or does not provide "minimum value" (the plan's share of allowed costs under the plan must be at least 60 percent). If no coverage is offered to FT employees (and their dependents), the penalty is $2,000 per FT employee in excess of 30 FT employees. If coverage is offered to FT employees (and their dependents) but is unaffordable or does not meet "minimum value," the penalty is whatever is less: $3,000 per FT employee on an Exchange plan or $2,000 per FT employee in excess of 30 FT employees.

Enhanced Small Business Health Care Tax Credit

For tax years 2010 through 2013, the maximum small business health care tax credit is 35 percent for small business employers and 25 percent for small tax-exempt employers, such as charities. Beginning January 1, 2014, the rates will generally increase to 50 percent and 35 percent, respectively, and is only available for coverage purchased through an Exchange. To be eligible, an employer must cover at least 50 percent of the cost of single health care coverage for each of its employees. It must also have fewer than 25 full-time equivalent employees, and those employees must have average wages of less than $50,000 a year.

Essential Health Benefits

Plans in the individual and small group markets, both inside and outside of the Exchanges, must offer a comprehensive package of items and services known as Essential Health Benefits (EHB) within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Guaranteed Issue

Individual, small group health plans, and the Exchanges are required to guarantee issue and renewability of health insurance regardless of health status. Rating variation is only permitted based on age (limited to a 3:1 ratio), geographic area, family composition, and tobacco use (limited to 1.5:1 ratio).

Health Insurance Exchanges

States are required to establish Health Insurance Exchanges through which individuals and small groups may purchase coverage. The Exchanges will have a single application form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs. Until the year 2016, states can limit the small group market to groups with 50 or fewer employees, and Pennsylvania will enforce this limit until 2016.

Individual Mandate

Most U.S. citizens and legal residents are required to have qualifying health coverage. Those without coverage must pay a tax penalty which will be phased in from 2014 to 2016 as follows:

- 2014: $95 per adult and $47.50 per child (maximum of $285 for a family) or 1 percent of family income, whichever is greater.
- 2015: $325 per adult and $162.50 per child (maximum of $975 for a family) or 2 percent of family income, whichever is greater.
- 2016: $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5 percent of family income, whichever is greater.

After 2016, penalty amounts will be increased annually by the cost of living.

Insurer Fee

Beginning in 2014, a fee will be imposed upon insurers that offer fully insured plans, including employer-sponsored coverage. The fee is based on each insurer's market share. Implementing regulations have not yet been issued.

Preexisting Condition Exclusions

Plans may not impose preexisting condition exclusions on any participant.

Reinsurance Fee

Health insurers and self-funded plans must make contributions to the transitional reinsurance program, which is designed to help stabilize the individual market. Proposed regulations indicate the estimated fee for calendar year 2014 is $5.25 per enrollee per month, plus an 11-cent annual administrative fee.

Waiting Periods

Plans are not permitted to have eligibility waiting periods greater than 90 days.

Wellness Incentives

Current wellness regulations under the Health Insurance Portability and Accountability Act permit wellness incentives of up to 20 percent for employers to offer employees rewards for participating in wellness programs and meeting certain health-related standards. The Affordable Care Act increases the wellness incentive limit to 30 percent of the cost of coverage, potentially increasing to 50 percent.

2015

Reporting of Health Insurance Coverage

Employers and other entities that provide health coverage must file annual returns to the IRS reporting specific information on that coverage and the individuals covered. The first information returns are due January 31, 2015, for coverage provided on or after January 1, 2014.

2016

Expansion of Health Insurance Exchanges

In 2016, Exchanges must be open to employers with up to 100 employees.

2017

Continued Expansion of Health Insurance Exchanges

In 2017, states will have the option to permit large groups (with 100 or more employees) to purchase coverage through the Exchanges.

2018

Cadillac Tax

Beginning January 1, 2018, a 40 percent excise tax will be imposed on high-cost health care premiums in excess of $10,200 for single coverage and $27,500 for family coverage.

CAUTION: This document was prepared in February 2013 based on then-available regulatory guidance. The information contained herein is based in part on proposed regulations or intended approaches to implementation of the Employer Shared Responsibility requirements. Such regulations and guidance are explicitly subject to change. This document is offered for informational purposes only and should not be relied upon as a source of tax, legal, or other professional advice.

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