



## Health Care Reform Timeline

### 2010

**Dependent Coverage to age 26.** Young adults may stay on their parents' health plans to age 26. The provision applies to all health plans, both existing and new, effective for the first plan year beginning on or after September 23, 2010, and does not exclude young adults who are married.

**Prohibitions on Lifetime Limits and Restrictions on Annual Limits.** Plans providing group or individual coverage are prohibited from setting lifetime dollar limits and from setting unreasonable annual limits. These provisions apply to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. Annual limits will be banned completely in 2014.

**Prohibition on Preexisting Condition Exclusions for Children.** Children under 19 years old may not be excluded due to preexisting conditions. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

**Prohibition Against Coverage Rescissions.** Health plans cannot rescind coverage except in cases of fraud or intentional misrepresentation of material fact. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

**Preventive Care Without Cost Sharing.** Qualified health plans must provide, at a minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. This provision is

effective for the first plan year beginning on or after September 23, 2010, but does not apply to plans in existing on March 23, 2010.

**Other Coverage Requirements:** The following provisions will apply to employer sponsored plans effective for plan years on or after September 23, 2010:

- Plan participants may choose any participating primary care provider.
- No prior authorization or referral may be required for ob-gyn visits.
- Ob-gyn must be treated as a primary care provider.
- No prior authorization may be required for emergency care services. Cost sharing for emergency care services must be equal for both in and out of network.
- Costs for individuals participating in clinical trials must be covered.
- Mandatory internal and external claims appeal processes.

**Small Business Tax Credits.** For tax years beginning in 2010, a credit of up to 35 percent of premiums will be available to small businesses that offer health coverage. To qualify, businesses must have fewer than 25 employees and average annual wages of less than \$50,000.

**Reinsurance Program for Employers Providing Health Coverage to Retirees over Age 55.**

Available as of June 21, 2010, a temporary reinsurance plan for employers covering retirees who are not eligible for Medicare starts. \$5 billion in federal funding is allocated to this program. Reimbursements to plan sponsors will be made on a first-come, first-served basis. The plan ends in 2014, when state exchanges are available.

**Requirement to Report Medical Loss Ratio.** Insurers must annually report medical loss ratios effective for plan years beginning on or after March 23, 2010. Insurers must maintain a medical loss ratio of not less than 85 percent for large groups, or 80 percent for individual and small group markets. Those that do not meet the standard must pay rebates to policyholders.

**Nondiscrimination Testing.** Group health plans may not discriminate in favor of highly compensated employees, effective for plan years beginning on or after September 23, 2010.

**Grandfather Rules.** Grandfather Rules exempt group health plans that were in existence on March 23, 2010, from some of the new insurance mandates. Interim final rules issued by HHS on June 14, 2010, relay the changes that will cause a plan to lose grandfathered status. The reconciliation law substantially narrowed the grandfather protections and makes the following provisions applicable to both existing and new plans:

- Dependent coverage to age 26.
- No preexisting exclusions for children under age 19.
- No lifetime maximums.
- Restricted annual maximums.
- No rescissions of coverage.

**Temporary High-Risk Pool.** Creation of a high risk pool program available beginning on July 1, 2010, to help provide affordable health insurance coverage to people who are uninsured because of pre-existing conditions. States may choose whether and how they participate in the program, which is funded entirely by the federal government. People with preexisting conditions who have been uninsured for at least six months will be eligible for subsidized coverage. \$5 billion of federal funds is appropriated to support this program until the program ends on January 1, 2014.

## 2011

**Wellness Grants to Small Employers.** \$200 million is authorized to be appropriated over five years beginning in 2011 to fund grants to employers with fewer than 100 employees that provide their workers with access to comprehensive workplace wellness programs.

**Over-the-Counter Drugs No Longer Reimbursable under HRAs, HSAs, FSAs, and MSAs.** Over-the-counter drugs are no longer reimbursable under health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) or HSAs unless prescribed.

**HSA Excise Tax.** Effective for taxable years beginning after December 31, 2010, for consumer-directed health plans (CDHPs), the penalty for nonqualified distributions from a health savings account (HSA) increases from 10 to 20 percent.

**Medical Loss Ratio Reimbursement.** Beginning not later than January 1, 2011, plans in the individual and small group market must maintain a medical loss ratio (MLR) of 80 percent; plans in the large group market must maintain an MLR of 85 percent. Plans that exceed the MLR percentage limits must provide a rebate to each enrollee on a pro rata basis.

**Form W-2 Reporting.** Effective for tax years beginning after December 31, 2010, employers must disclose the value of employer-provided health benefits for each employee on the employee's annual Form W-2. The amount to be reported does not include amounts excluded from income through an HSA or salary reductions to a FSA. The first report must be released in 2012 for coverage provided in tax year 2011.

**Benefits Summary Requirement.** By March 23, 2011, HHS will issue national standards for compiling and providing comprehensive, accurate benefit summaries and coverage descriptions.

**CLASS Act.** The Community Living Assistance Services and Supports Act, which provides limited long-term care coverage through the workplace for employees, will take effect. Employers will be encouraged to participate in the CLASS Act and adopt automatic enrollment rules that default employees into the CLASS Act, starting January 1, 2011.

**Simple Cafeteria Plans for Small Employers.** As of January 1, 2011, IRS Code Sec. 125 is amended to provide for simple cafeteria plans for small businesses that employ an average of 100 or fewer employees during either of the 2 preceding years. The simple cafeteria plans will allow certain small employers to avoid the nondiscrimination rules of traditional cafeteria plans.

## 2012

**Benefits Summary Requirement.** By March 23, 2012, a summary of benefits and coverage explanation that meets national standards must be provided to applicants at the time of application, to the enrollee prior to the time of enrollment or reenrollment, and to a policyholder or certificate holder at the time of policy issuance or certificate delivery.

**Comparative Effectiveness Research.** The Patient Centered Outcomes Research Institute will be created to perform comparative effectiveness research. The institute will examine data collected from comparative clinical effectiveness research, which will analyze and compare the health outcomes and the clinical effectiveness, risks and benefits of medical treatments. It is payable by insurers and self-insured plans. Institute to be funded by tax on insured and self-funded plans of \$1/plan participant in year one; \$2/plan participant second year; indexed thereafter.

## 2013

**FSA Contribution Limit.** Effective January 1, 2013, FSA contributions are capped at \$2,500 per year, increased annually by COLA.

**Medicare Tax.** Effective January 1, 2013, employees' share of the Medicare tax on wages in excess of \$200,000 (or \$250,000 for joint tax filers) increases from 1.45 percent to 2.3 percent. Also, a 3.8 percent Medicare tax will be assessed on investment income from interest, dividends, royalties, rents, gross income from a trade or business and net gain from property disposition for individuals earning over \$200,000 and families earning over \$250,000.

**Elimination of Tax Deduction for Part D Subsidy Payment.** Effective January 1, 2013, employers will no longer be permitted to take an income tax deduction for the Medicare Part D retiree drug subsidies they receive from the federal government.

**Employer to Inform Employees of Coverage Options.** Effective March, 2013, employers must provide written notice to all employees of state health insurance exchanges, whether the employer's plan meets minimum coverage requirements and how to access information regarding premium subsidies that may be available for exchange-based coverage.

## 2014

**Individual Mandate.** Effective in 2014, individuals must purchase health insurance. Any employee who earns less than four times federal poverty level and pays more than 8 percent of their income for the employer-sponsored coverage will have the option of purchasing health insurance through health care exchanges.

**Employer Pay or Play Mandate.** Effective in 2014, the following Employer mandates are implemented:

- Employers with 50 or more employees that do not offer health coverage and that have one full-time employee receiving a subsidy will pay a penalty of \$2,000 per each full-time employee (minus the first 30 employees).
- Employers with 50 or more employees that do offer health coverage and have one full-time employee opting out of that coverage and instead receiving a federal subsidy will pay a penalty of \$2,000 per employee.
- Employers that offer health coverage must offer a free choice voucher for employees who choose to purchase coverage through exchanges. The voucher must be equal to the amount paid to provide coverage to participants in the company health plan.

**Large Employer Automatic Enrollment Requirement.** Employers with 200 or more employees that offer coverage must auto-enroll workers in the lowest cost health care plan. Any auto enrollment program must include adequate notice and the opportunity for an employee to opt out.

**Minimum Benefit Package.** Effective for plan years beginning on or after January 14, 2014, coverage offered in the individual or small group market must provide "minimum essential benefits" (with such minimum essential benefits to be defined by HHS).

**Plan Prohibitions and Limits.** Effective for plan years beginning on or after January 1, 2014, all plans must comply with the following coverage provisions:

- No annual dollar limits on coverage.
- Waiting periods over 90 days are prohibited.
- Preexisting conditions exclusions are prohibited.
- Maximum out-of-pocket limits cannot exceed those out-of-pocket limits of those that apply to HSA compatible High Deductible Health Plans.

**Wellness Incentives.** Effective for plan years beginning on or after January 14, 2014, employers may offer wellness program incentives/penalties of up to 30 percent of premium to employees. The amount can increase to 50 percent after government agencies conduct a study on wellness programs. Health risk assessments may not include questions on gun ownership.

**State Health Insurance Exchanges.** By 2014, states must create Small Business Health Options Programs or “SHOP Exchanges.” Individuals and small employers (with up to 100 employees) may purchase coverage through an Exchange plan. (In 2017, large employers may purchase plans through the Exchange.)

**Guaranteed Issue and Renewability.** Effective January 1, 2014, insurers are required to guarantee issue and renewability.

**Rating Variation.** Effective January 1, 2014, plans in the individual and small group markets and the Exchanges may only implement rating variation based on age (limited to 3-to-1 ratio); geographic area, family composition. A 50% surcharge for tobacco use will be permitted.

## 2017

**State Health Insurance Exchanges.** Effective in 2017, states may begin to allow large employers to provide coverage through an Exchange plan.

## 2018

**“Cadillac Plan” Excise Tax.** Effective January 1, 2018, an excised tax will be imposed on insurers of employer-sponsored health plans:

- 40% tax on plan values that exceed \$10,200 for individual coverage/\$27,500 for family coverage.
- Indexed at CPI-U for 2019.
- CPI-U only after 2019.