Healthcare Reform Timeline Updated April 26, 2011

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Please note: *This document is designed to provide a high-level overview of the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act. It is not comprehensive and does not constitute legal or tax advice for healthcare reform implementation. Please consult a professional benefit advisor or legal counsel regarding how the law may impact your specific benefit plan.*

Introduction

Healthcare reform legislation will have a broad and far-reaching impact. To help you better understand and plan for how the new law will affect your benefit plan, your employees and your business, this timeline provides a high-level overview of the major provisions and areas of responsibility for implementation.

The legislation passed in two parts. First, President Obama signed into law the *Patient Protection and Affordable Care Act (PPACA)* on March 23, 2010. That law was then modified by the *Health Care and Education Reconciliation Act*, signed on March 30. For that reason, we have based the timeline on March 23 as a start date. So provisions with effective dates six months following enactment would go into effect on or around September 23, 2010.

However, the law is highly complex, with many provisions that must be further defined by additional rules and regulations at both the federal and state levels. This will take time and involve some uncertainty. We will work to keep you updated as the situation changes and we gain more clarity around specific elements of the legislation and its implementation.

Note on Grandfathered Plans:
Grandfathered health plans are exempt from some of the provisions of PPACA. Grandfathered group health plans are those (including self-insured plans) that were in effect on the date of PPACA enactment (March 23, 2010) that have not been altered in a manner prohibited by the regulations addressing grandfathered plans.

Healthcare Reform Impacts on Grandfathered Plans

For plan years beginning six months on or after enactment:

- No lifetime limits on essential health benefits.
- Restrictions on annual limits on essential health benefits. (No annual limits on essential benefits after Jan. 1, 2014.)
- May not rescind coverage except in cases of fraud or intentional misrepresentation
- Must extend coverage for young adults until age 26, if the plan offered dependent coverage. (Prior to 2014, only if the individual is not eligible for employment-based health coverage.)
- Pre-existing condition exclusions and limitations are prohibited for covered dependent children up to age 19 (and for all enrollees after Jan. 1, 2014).

Healthcare Reform Key Provisions Timeline

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Date	Provision	Requirements
January 1, 2010	**Small business health insurance tax credit**	Available to employers who contribute at least 50% of the cost of coverage, have less than 25 equivalent FTEs with an average annual salary < $50,000. Credit is up to 35% of employer contribution until 2014, and increases to a maximum of 50% in 2014.
March 23, 2010	**Federal rate review**	HHS Secretary, in conjunction with the States, is responsible for developing process for review of "unreasonable" premium increases. No final rule issued as of April 11, 2011.
+60 Days @ May 23, 2010	**Internet portal**	HHS Secretary to develop standardized format for presentation of coverage options.
+90 Days @ July 1, 2010	**Internet portal**	Portal up and running.
	National high-risk pool	HHS Secretary creates temporary high-risk pool to help individuals with pre-existing conditions get coverage if they have been uninsured for at least six months.
	Early retiree reinsurance	HHS to establish temporary reinsurance program for employers that provide coverage for retirees over age 55 who are not eligible for Medicare. Reimburses 80% of retiree claims between $15,000 and $90,000, through 2013. Employers must apply, and be accepted, for participation in the program. HHS is not accepting new applications after May 5, 2011.

Date	Provision	Requirements
+6 Months @ September 23, 2010	**Coverage Mandates**	
	- Lifetime limits	No lifetime limits on essential benefits.
	-Annual limits	Restrictions on annual limits, as determined by HHS Secretary.
	-Rescissions	Prohibited except in cases of fraud or intentional misrepresentation.
	-Preventive services	New policies may not impose any cost-sharing requirements for in-network preventive services, screenings and immunizations as described in the PPACA.
	-Coverage for young adults	For plans that offer dependent coverage, coverage must be extended to adult children up to age 26.
	-Pre-existing condition exclusions	No pre-existing condition exclusions for enrollees under age 19.
	-Emergency services	No prior authorization required and copays and coinsurance applied same as if in-network.
	-Ob-gyn	No authorization or referral required.
	Other Provisions	
	-Nondiscrimination rules	Fully insured plans cannot discriminate as to eligibility or benefits in favor of highly compensated employees in accordance with section 105(h)(2) of the Internal Revenue Code. Enforcement delayed pending further guidance as of April 11, 2011.
	-Appeals	Establish new internal and external processes.
	-Reporting	Health plans must report spending on clinical services, activities that improve health care quality and other costs. No guidance issued to date, as of April 11, 2011.

Date	Provision	Requirements
January 1, 2011	**Medical loss ratios (MLRs)**	- 85% MLR for large group mandated - 80% MLR for small group and individual health plans (or provide rebates to enrollees)
	Employer reporting	Some employers required to report cost of Employer-sponsored health coverage on W-2. Reporting delayed until 2012 W-2 form year.
	HSAs, HRAs & FSAs	May no longer be used for over-the-counter medications unless prescribed by a doctor. Increased tax on non-qualified withdrawals.
	CLASS Act (Long-term Care)	HHS to begin development of national voluntary program to purchase community living assistance services coverage.
	Small-group wellness grants	Congress may use appropriated funds for grants for up to 5 years for small employers that establish qualified wellness programs approved by HHS.
	Tax/fee changes	Imposition of an annual fee on pharmaceutical manufacturers.
March 23, 2011	**Self-funded and large group market study**	HHS Secretary reports on findings of study of self-funded and large group market.
	Uniform explanation of benefits	NAIC and HHS establish uniform coverage documents and standard definitions.
March 23, 2012	**Uniform explanation of benefits**	Health plans and plan sponsors must begin using uniform summary of benefits and coverage explanation.
	Health Plan reporting requirements	HHS Secretary to develop reporting requirements with respect to plan benefits and provider reimbursement that promotes quality of care.
October 1, 2012	**Comparative effectiveness fee**	Fee on individual and group health plans (insured and self-funded) to fund comparative effectiveness research. - $1 per participant in Fiscal Year 2013 - $2 per participant in Fiscal Years 2014 through 2019

Date	Provision	Requirements
January 1, 2013	**CO-OP Program**	Funds allocated to foster creation of non-profit, member-run, health insurers to offer qualified plans to individuals and small businesses.
	Administrative simplification	Plans must adopt uniform rules for eligibility verification, claim status, electronic payment, enrollment and other administrative procedures.
	Tax changes	- 2.3% tax on medical device sales begins. - FSA contributions limited to $2,500 per year.
December 31, 2013	**Employer reporting requirements**	HHS Secretary to develop method for large employers to report required information on health insurance coverage.
January 1, 2014	**Coverage Mandates**	
	-Pre-existing condition exclusions	Health plans can no longer impose pre-existing condition exclusions for any person.
	-Guarantee issue/renewal	Health insurers must accept every employer or individual who applies for/renews coverage.
	-Annual limits	No annual limits on essential benefits.
	-Small group and individual rating	Rating variation based only on age (limited to 3 to 1 ratio) premium rating area, family composition and tobacco use.
	-Clinical trials	Plans must cover routine costs for a qualified individual's participation in approved clinical trials.
	-Deductible limits	Small-group plan deductibles limited to $2,000 for self-only/$4,000 for family unless offset by a flexible spending arrangement.
	-Cost-sharing limits (Exchange only)	- Group health plans may not impose cost sharing greater than the current HSA amount. - Out of pocket further limited for those with incomes less than 400% of FPL. 100-200% FPL=one-third HSA limit 200-300% FPL=one-half HSA limit 300-400% FPL=two-thirds HSA limit
	-Waiting periods	Cannot exceed 90 days.
	-Essential benefits	Mandates the level of benefits offered in the exchange and for individuals and small groups outside the exchange. Includes pediatric oral and vision services.
	Exchanges	State-based American Health Benefit Exchanges and Small Business Health Options Program established, through which individuals and businesses with up to 100 employees can purchase coverage.
	Rate monitoring	Allows states to merge the individual and small-group markets.

Date	Provision	Requirements
January 1, 2014 (continued)	**Merged markets**	HHS Secretary, in conjunction with the states, monitors premium increases both in and outside the exchanges.
	Auto-enroll	Employers with more than 200 full-time employees must automatically enroll all eligible employees, but employees may opt out.
	Coverage responsibility -Individual	- Greater of $95 or 1% of income rising to $695 or 2.5% in 2016 and thereafter. - Half penalty for children and cap of $2,085.
	-Employer	- Employers with equivalent of 50 or more FTEs that do not offer minimum essential coverage but have at least one FTE receiving a premium tax credit must pay $2,000 per FTE, excluding the first 30 employees. - Employers with more than 50 FTEs that do offer coverage but have at least one FTE receiving a premium tax credit must pay the lesser of $3,000 per employee receiving the credit or $2,000 for each FTE, excluding the first 30 employees.
	Wellness	Employers may offer employees rewards of up to 30% of total coverage costs (up to 50% with HHS approval) for participating in a wellness program and meeting specific health-related standards.
	Premium Tax	Premium tax on insurers begins at $8 billion, rising to $14.3 billion in 2018 and increasing in proportion to premium growth thereafter.
April 1, 2014	**Administrative simplification**	HHS to assess penalties on health plans that have failed to meet certain administrative simplification requirements.
January 1, 2017	**Exchanges expanded**	States have the choice to open exchanges to large employers.
January 1, 2018	**"Cadillac" Plan Tax**	Excise tax on high-value plans of 40% for amounts over $10,200 for individuals and $27,500 for family plans.