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Health-Care Reform: Timeline

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The Patient Protection and Affordable Care Act (ACA) was signed into legislation in March of 2010. Many of the law's provisions are implemented over several years. The following timeline describes when some of the major provisions take effect. Some provisions of the ACA apply to individual and group plans in effect prior to the enactment of the law (grandfathered plans); other provisions apply only to new plans. Unless otherwise indicated, each provision noted below applies to all plans.

2010	• Plans cannot impose lifetime limits on the dollar value of coverage nor may they rescind coverage except in cases of fraud. • Children (under age 19) cannot be denied coverage based on pre-existing medical conditions, nor can policies include exclusions for pre-existing conditions (not applicable to grandfathered individual plans). • Plans must extend dependent coverage to adult children up to age 26 (exception for grandfathered group plans where child has group coverage available through another employer). • Requires new health plans (not grandfathered individual or group plans) to offer minimum coverage without cost sharing for certain enumerated preventive services, recommended immunizations, preventive care for children, and preventive care and screenings for women. • Provides a $250 rebate to Medicare Part D (drug coverage) beneficiaries in the coverage gap (donut hole). • Creates a temporary program to provide insurance coverage to individuals with pre-existing conditions who have been uninsured for at least six months. • Establishes the requirement that a process be implemented to review insurance premium increases. • Institutes a plan to provide tax credits to small employers with 25 or fewer employees with annual average wages of less than $50,000 who provide health insurance for their employees. • Imposes a tax of 10% on fees paid for indoor tanning services.
2011	• Medicare Part D beneficiaries in the coverage gap (donut hole) receive a 50% discount on brand-name prescriptions. • Medicare deductible is waived for certain preventive services, and coverage must include a personalized prevention plan and a comprehensive health risk assessment. • The income threshold for income-related Medicare Part B premiums is frozen through 2019 at 2010 levels, resulting in more participants paying income-related premiums. • The Medicare Part D premium subsidy for participants with incomes above $85,000 for individuals and $170,000 for married couples filing jointly is reduced. • Over-the-counter drugs not prescribed by a doctor can no longer be reimbursed through a health reimbursement arrangement (HRA), a health flexible spending account (FSA), a health savings account (HSA), or an Archer medical savings account (MSA). The ACA also increases the tax to 20% on distributions from an HSA or MSA not used for qualified medical expenses. • Requires that most chain restaurants and food sold through vending machines disclose the nutritional content of standard menu items.
2012	• All plans must provide a uniform summary of benefits and coverage to all applicants and plan participants, enabling consumers to compare health insurance coverage options. • Participants reaching the Medicare Part D coverage gap (donut hole) receive a 50% discount on brand-name prescription drugs and a 14% discount on generic drugs at the time of purchase. • First medical loss ratio rebates are required to be issued by August 1. Insurers must provide a rebate if the percentage of their premiums spent on medical claims for plans is less than 80% in the small group and individual markets or 85% in the large group market.

2013	• States must notify the Department of Health and Human Services as to whether they will operate American Health Benefit Exchanges. • Participants reaching the Medicare Part D coverage gap (donut hole) receive a 52.5% discount on brand-name prescription drugs and a 21% discount on generic drugs at the time of purchase. • The threshold for the itemized deduction for unreimbursed medical expenses is increased from 7.5% to 10% of adjusted gross income beginning in tax year 2013. The increase is waived for individuals age 65 and older until 2016. • Contributions to health (FSAs) are limited to $2,500 per year, subject to cost-of-living adjustments. • The Medicare Part A (hospital) tax rate increases by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individuals and $250,000 for married couples filing jointly. In addition, the ACA assesses a new Medicare tax of 3.8% on some or all of the unearned income of individuals, estates, and trusts that have income above statutory limits. • The tax deduction for employers who receive Medicare Part D retiree drug subsidy payments is eliminated. • Creates the Consumer Operated and Oriented Plan (CO-OP) for the establishment of nonprofit, member-run health insurance companies.
2014	• Requires most U.S. citizens and resident aliens to have qualifying health insurance, subject to a phased-in tax penalty for noncompliance. • A penalty is assessed on employers with more than 50 full-time employees (or the equivalent) that do not offer health insurance to their employees and have at least one full-time employee who receives a premium tax credit. Employers that do offer coverage but have at least one full-time employee receiving a premium tax credit will also be subject to a penalty. • Implements state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. • Exchanges must offer four categories of plans (Bronze, Silver, Gold, and Platinum) based on different percentages of covered medical costs. • Plans in the individual and small group market must offer, at a minimum, essential health benefits as defined by the Department of Health and Human Services. Cost sharing is limited to HSA limits for individuals and families. • Tax credits and cost-sharing subsidies are available to eligible individuals and families to aid in the purchase of qualifying health insurance. • Insurers cannot deny coverage based on pre-existing health conditions for new plan applicants (guaranteed issue) or renewing subscribers (guaranteed renewability), and issuers are allowed rating variations based only on age, geographic area, family composition, and tobacco use. • Plans cannot exclude coverage for care or services related to pre-existing health conditions (does not apply to grandfathered individual plans). • Plans cannot impose annual limits on the dollar value of coverage (does not apply to grandfathered individual plans). • Plan waiting periods for coverage cannot exceed 90 days.

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