

## 2010

### What

### Who

### When

**Federal Tax Credits Begin for Small Employers** – In this first phase, the credit for qualified small employers is up to 35 percent of the employer’s contribution to provide health insurance for employees. To qualify, employers must have 25 or fewer full-time employees, average annual wages of less than \$50,000, they must purchase health insurance for employees and must contribute at least 50 percent of the premium. (Full credits will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.)

Small employers

The entire 2010 tax year payable in 2011.

**Rebates to Seniors Who Reach the Coverage Gap** – Seniors who reach the Medicare prescription drug coverage gap receive a \$250 rebate.

Medicare beneficiaries

June 2010 – January 1, 2011

**Early Retiree Reinsurance Program (ERRP) Established** – This temporary program helps companies that provide health insurance to early retirees ages 55-64. It reimburses 80 percent of certain claims costs. To qualify for the program, employers must apply to the Department of Health and Human Services (HHS).

Employers

June 2010 – January 1, 2014

Note: Effective May 6, 2011, the ERRP is no longer accepting new applications.

**Health Insurance for Individuals with a Pre-Existing Condition** – Health coverage is available through State High Risk Pools that don’t exclude individuals due to pre-existing health conditions.

Uninsured eligible individuals

June 21, 2010 – January 1, 2014

**Consumer Website Created** – HHS must establish an easy-to-use website where consumers can compare health coverage options in their state. Visit the website at HealthCare.gov.

Individuals  
Small employers

July 1, 2010

**No Pre-Existing Condition Exclusions for Enrollees Under Age 19** – Health insurance companies can’t deny coverage to enrollees under age 19 due to a pre-existing health condition.

Individuals  
Fully insured groups  
Self-funded groups  
Grandfathered group plans

Plan years beginning on or after September 23, 2010

**Restrictions Placed on Annual Limits** – The use of annual dollar limits on essential benefits is restricted until 2014, when annual limits will be prohibited.

**Coverage Extended for Young Adults** – Any group or individual health plan that offers dependent coverage must provide coverage until the child turns age 26. In Illinois, coverage may continue through the last day of the month the dependent turns age 26. (Until 2014, this requirement does not apply to grandfathered group plans if the dependent is eligible for other employer-sponsored coverage.)

Individuals  
Fully insured groups  
Self-funded groups  
Grandfathered plans

Plan years beginning on or after September 23, 2010

**Rescissions Prohibited** – Insurance companies can't retroactively cancel coverage after enrollment, except in the event of fraud or intentional misrepresentation.

**Lifetime Limits Eliminated** – There can't be lifetime dollar limits on essential benefits.

**Coverage for Preventive Health Services** – Plans must provide first-dollar coverage at no cost for certain preventive services, immunizations, child preventive services and women's preventive care and screenings.

Individuals  
Fully insured groups  
Self-funded groups

**Revised Internal Appeals Procedures and New External Review Procedures** – Any new individual or group health plan must implement an effective internal appeals process that provides notice about external and internal review procedures. Plans must provide an external review process that includes, at minimum, the protections in the National Association of Insurance Commissioners (NAIC) model.

Note: Illinois and Iowa law implemented the NAIC model law effective July 1, 2011.

**Protection for Emergency Services** – Emergency services must be covered without preauthorization and must be covered the same out-of-network as they're covered in-network.

**Choice of PCP from Any Available Participating PCP** – Members can choose any available Primary Care Physician from the plan's list of participating providers, including pediatricians and OB/GYNs.

**Direct Access to OB/GYN** – Authorizations and referrals to see a participating OB/GYN are prohibited.

**No Discrimination in Favor of Highly Compensated Individuals (delayed)** – Extends similar rules currently applied to self-funded employers, to fully insured employers specifying that the plan can't have eligibility rules or levels of coverage that discriminate in favor of higher-wage employees.

Employers

**Consumer Advocate Grants to States** – States that apply receive federal grants to set up or expand offices to help consumers navigate the health insurance system.

State governments will receive the grants

Grants awarded October 2010

**Automatic Enrollment of Employees (delayed)** – Employers with more than 200 employees must automatically enroll all full-time employees as soon as they're eligible. Employers must also provide adequate notice and the opportunity for employees to opt out.

Employers

Effective upon issuance of U.S. Department of Labor rules

# 2011

## What

## Who

## When

**Reporting of Health Coverage Costs Required on W-2 (delayed)** – On the annual W-2 form, employers must disclose the value of the benefit provided for each employee's health coverage. The Internal Revenue Service (IRS) delayed enforcement action of this requirement in 2011 to give employers time to comply.

Employers (doesn't apply to Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs) or Flexible Savings Accounts (FSAs))

Plan years beginning after December 31, 2010

Note: Employers are not required to report the cost of coverage on any forms required to be furnished to employees prior to January 1, 2013.

**Over-the-Counter Medications Not a Qualified Medical Expense** – A standard definition for qualified medical expenses is used for HSAs, FSAs and Health Reimbursement Accounts (HRA). The definition means costs for over-the-counter medications obtained without a prescription will not be considered a qualified medical expense. There is an exception for over-the-counter medications obtained with a prescription—these costs still qualify as medical expenses.

Individuals  
Employers

**Tax Increase for Withdrawals from HSAs and Archer MSAs for Non-Qualified Medical Expenses**

– The tax increases from 10 to 20 percent for HSA withdrawals prior to age 65 that are not used for qualified medical expenses. The tax for Archer MSA withdrawals not used for qualified medical expenses increases from 15 to 20 percent.

Individuals

**Changes to Cafeteria Plans** – Simple cafeteria health plans are created for employees that ease participation restrictions to provide a way for small employers to offer tax-free benefits. Cafeteria plans may no longer reimburse for over-the-counter medications unless they're prescribed.

Small employers

**Conditions Established for Wellness Programs –**

The reward for such programs is increased to 30 percent of the cost of employee-only coverage.

Employers

Plan years beginning after December 31, 2010

**Minimum Medical Loss Ratios** – For large employer plans, at least 85 percent of premium dollars must be spent on health care services and quality improvement. For individual and small employer plans, this minimum is 80 percent. Insurance companies must provide rebates to consumers if they don't meet these requirements.

Individuals  
Employers

January 1, 2011

**Prescription Drug Discounts for Seniors** – Seniors who reach the Medicare prescription drug coverage gap receive a 50 percent discount on brand-name drugs.

Medicare  
beneficiaries

**Free Preventive Care for Seniors** – Those age 65 and older won't pay for most preventive services like mammograms and cancer screenings. They also receive a free annual wellness visit.

**Grants to Small Employers for Wellness Programs –**

Small employers that establish wellness programs and meet certain requirements can receive grants for up to five years.

Small employers

2011-2015

# 2012

## What

## Who

## When

**Health Plans Pay a Fee per Participant to Fund Patient-Centered Outcomes Research**Self-funded groups  
Fully insured groupsPlan years after  
September 30, 2012

**Reduce Paperwork and Administrative Costs** – Health plans must adopt and implement standards and business rules for electronically exchanging health information to reduce paperwork and administrative costs.

Health plans

2012-2016

**Uniform Summary of Benefits** – Prior to enrollment, health plans must provide a new explanation of coverage document including standard definitions of insurance and medical terms, plus examples to illustrate common benefit scenarios. A summary plan description is also required. (There must be a 60-day advance notice of mid-year changes to materials.)

Individuals  
Fully insured groups  
Self-funded groups  
Grandfathered plans

March 23, 2012

**Employer Annual Reporting Requirements** – Annual reports must be provided to HHS and participants describing plan benefits designed to improve quality of care, including wellness activities. This does not apply to grandfathered plans.

Individuals  
Fully insured groups  
Self-funded groups

# 2013

## What

## Who

## When

### **Elimination of Tax Deduction for Employers Who Receive Medicare Part D Retiree Drug Subsidy Payments**

Employers

Effective for tax years after December 31, 2012

**Employers Send Notice about Insurance Exchange** – Employers must provide written notice to each employee regarding the insurance exchange, including a description of services and contact information.

Employers

March 1, 2013

**Limits to Health FSA Contributions** – The amount of contributions to health FSAs is limited to \$2,500 per year, indexed for inflation.

Individuals  
Employers

**New Tax on Unearned Income** – A new 3.8 percent tax begins on unearned income, such as dividends and interest.

Individuals

**Medicare Part A Tax Incease for Some** – Individuals making \$200,000 a year (or couples making \$250,000) will have a higher Medicare payroll tax on earned income.

Individuals making \$200,000 a year (or couples making \$250,000)

2013

# 2014

## What

## Who

## When

**No Pre-Existing Condition Exclusions** – You can't be denied health coverage or eligibility due to a pre-existing health condition.

Individuals  
Fully insured groups  
Self-funded groups  
Grandfathered plans

2014

**Guaranteed Issue and Guaranteed Renewal** – Health plans must allow you to enroll in a plan and renew a plan regardless of your age, gender, health status or other factors like pre-existing conditions that may predict your use of health services.

**Annual Limits Eliminated** – Annual dollar limits on the amount of coverage an individual may receive are not allowed.

**Coverage Ensured for Individuals Participating in Clinical Trials** – Plans can't eliminate coverage for individuals enrolled in a clinical trial (for cancer and other life-threatening diseases) and can't deny coverage for routine care otherwise provided by the plan. This does not apply to grandfathered plans.

Individuals  
Fully insured groups  
Self-funded groups

**Annual Out-of-Pocket Maximum Limited** – The annual out-of-pocket maximum is limited to the maximum for an HSA. For example, for 2010 limits, out-of-pocket expenses couldn't be more than \$5,950 for an individual or \$11,900 for a family.

Individuals  
Fully insured groups  
Self-funded groups

2014

**Deductible Limits Set** – Deductible limits are set at \$2,000 for an individual and \$4,000 for a family.

**Individuals Required to Obtain Coverage** – Most individuals will be required to obtain health insurance coverage or pay a fee.

Individuals

**Employer Coverage Responsibility** – Employers that have 50 or more employees and don't offer coverage to their employees will pay a penalty of \$2,000 annually for each full-time employee if one or more employees receives a tax credit. Employers who offer coverage and have one or more employees receive a tax credit, pay the lesser of \$3,000 for each employee receiving a tax credit or \$2,000 for each full-time employee.

Employers

**Cost-Sharing Requirements** – Health plans provided by employers must meet certain cost-sharing requirements or the employer will pay a fee.

**No Waiting Periods Longer than 90 Days** – Employers can't impose a waiting period of longer than 90 days before enrolling eligible employees.

**Employer Notice of Health Insurance Coverage to IRS** – Employers that provide health coverage that meets what's considered minimum essential coverage must report this information by January 31 of the following year.

**Federal Tax Credits Continue for Small Employers** – In this second phase the credit for qualified small employers is up to 50 percent of the employer's contribution to provide health insurance for employees.

Small employers

**Health Insurance Exchanges Open** – Health insurance exchanges are operational, serving as a marketplace where individuals and small employers can shop for and buy health insurance.

Individuals  
Small employers

**Premium Rating Requirements** – Health insurers are only allowed to base premium amounts on certain factors such as specific age bands, tobacco use and whether the plan provides coverage for an individual or a family. (Premium rates can't be based on gender.)

Individuals  
Fully insured groups

**Multi-State Option Ensures Choice** – Consumers can choose to get their coverage through a multi-state plan available nationwide and offered by private insurance companies, supervised by the Office of Personnel Management.

Individuals  
Fully insured small groups

**Coverage for Essential Benefits Required** – Essential benefits are to be further defined within these broad 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; pediatric services, including oral and vision care.

Individuals  
Fully insured small groups  
Self-funded small groups

2014

# 2018-2020

## What

## Who

## When

**New Tax for High-Cost Plans** – A new excise tax of 40 percent is imposed on insurance companies and plan administrators for any high-cost health plans. These plans are those that cost more than \$8,500 for single coverage of an individual or \$23,000 for a family plan.

Health insurance companies  
Plan administrators

2018

**Medicare Coverage Gap Closes** – The Medicare prescription drug coverage gap is phased out.

Medicare beneficiaries

2020

