

# Health reform timeline

## 2010

- Temporary high risk pool
- Early retiree reinsurance program (ERRP)
- Small business tax credit
- Adult child coverage until age 26
- No pre-existing conditions for kids until age 19
- Rescissions prohibited except for fraud or non payment
- Lifetime dollar limits prohibited
- Annual dollar limits restricted
- Preventive services with no cost sharing <sup>G</sup>
- Pediatricians as PCPs, direct access to OB/GYNs <sup>G</sup>
- ER coverage as in-network, no prior authorization <sup>G</sup>
- Initial appeals review standards <sup>G</sup>
- Medicare Part D rebate for beneficiaries in the gap
- Online consumer information at [healthcare.gov](http://healthcare.gov)

## 2011

- Annual rate review process
- Appeals ombudsmen and process documentation <sup>G</sup>
- Minimum medical loss ratio (MLR): 85% for large group; 80% for small group and individual
- HSAs/HRAs/FSAs: limitations for OTC medications
- Increase penalty for non-qualified HSA withdrawals
- Small business wellness grants
- Annual fee on pharmaceutical manufacturers begins
- Discounts in Medicare Part D “donut hole”
- Non discrimination rules apply to insured plans (implementation delayed until regulations are released) <sup>G</sup>
- Auto-enrollment for Groups with 200+ FTEs (implementation delayed until regulations released)

## 2012

- Appeals provision fully implemented <sup>G</sup>
- Uniform explanation of coverage and standard definitions
- 60 day advance notice of material modification
- Accountable Care Organization requirements
- Quality bonus begins for Medicare Advantage plans
- Comparative effectiveness fee (\$1 per member/year)
- Administrative simplification begins
- 1<sup>st</sup> medical loss ratio rebates to be paid by August

## 2013

- Employee notification of access to Exchanges
- Employers to report value of employer-sponsored health benefits on W2s
- FSA contributions limited to \$2,500
- High earner tax begins
- Annual fee on medical device sales begins
- Deduction for expenses allocable to the Part D subsidy for “qualified prescription drug plans” eliminated
- Comparative effectiveness fee increases to \$2 per member/year
- ICD-10 code adoption

## 2014

- Health benefit exchanges
- Guaranteed issue and renewal rules <sup>G</sup>
- No annual limits
- No pre-existing condition exclusions
- Rating restrictions <sup>G</sup>
- Individual & employer mandates
- Tax credits and subsidies for individuals and small employers
- Standardized essential health benefits
- Waiting period limits
- Mandatory coverage for clinical trials <sup>G</sup>
- Annual insurance industry tax
- OOP limits must comply with OOP limits for HSA qualified plans <sup>G</sup>
- Deductible caps cannot exceed \$2k for individual and \$4k for family <sup>G</sup>
- Coverage for all adult children until age 26 including those that have employer coverage (formerly not covered for grandfathered plans)

## 2015 & beyond

- States can open Exchange to all employers (2017) and CHIP eligibles (2015)
- High-value plan excise tax begins (2018)
- Insurance industry tax through 2018
- Medicare Part D “Donut hole” closed by 2020

<sup>G</sup> Grandfatherable provision

Note: some provisions apply only to fully insured business (e.g., MLR and guarantee issue)