

PPACA IMPLEMENTATION TIMELINE

2010

Insurance Reforms

Provide dependent coverage for adult children up to age 26 for all individual and group plans.

Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary of HHS. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children under the age of 19.

For plan years beginning on or after September 23, 2010 (so January 1, 2011 for calendar year plans), require qualified health plans to 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.

Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees.

Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)

Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)

Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases.

Quality Improvement

Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.

2011

Long-term Care

Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Prevention/Wellness

Provide grants for up to five years to small employers that establish wellness programs.

Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.

Medicare

Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

Quality Improvement

Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

Tax Changes

Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.

Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses from 10% to 20% of the disbursed amount.

2012

Tax Changes

Employers issuing 250 or more W-2s for the 2011 tax year (issued in January, 2012), must begin reporting the aggregate cost of health care coverage on employees' W-2 forms.

2013

Insurance Reforms

Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)

Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)

Tax Changes

Limit the amount of contributions to a health care flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.

Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).

Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.

Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.

Reduce the out-of-pocket limits for those with incomes up to 400% of the federal poverty level (FPL) to the following levels:

100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family);

200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family);

300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family).

Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.

Limit any waiting periods for coverage to 90 days.

Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.

Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

Require qualified health plans to meet new operating standards and reporting requirements.

Prevention/Wellness

Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

2015 and later

Insurance Reforms

Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)

Tax Changes

Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018)