




Patient Protection and Affordable Care Act

> Timeline of Significant Impacts on Self-Funded Plans As of March 2011

-  New plan/coverage requirements
-  New requirements for employers
-  External/government actions

July 2010

- Establish a temporary National Risk Pool to provide coverage for people who have been uninsured for six months and have a pre-existing condition
- Create temporary reinsurance program for early retirees. No new applications accepted after May 5, 2011.

September 2010

New mandates for plan years beginning after 9/23/10:

- Coverage required for emergency services at in-network cost-sharing level with no prior authorization*
- No lifetime dollar limits for essential health benefits
- Restrictions on annual dollar limits for essential health benefits
- Dependent coverage must be provided for adult children up to age 26; for grandfathered plans, only if other employer-sponsored coverage is not available
- No cost-sharing on preventive services and immunizations*
- No rescissions (except for fraud or intentional misrepresentation)
- Plans required to maintain both internal and external appeals processes*
- No pre-existing condition exclusions on covered enrollees (under age 19)
- Hospitals required to publicize a list of standard charges for the items and services they provide
- Grants provided to states to collect reimbursement information and to make information available to all

* Provision does not apply to "grandfathered" plans, defined as plans in existence on 3/23/10

2011

- Some employers are required to disclose costs of employer-sponsored health coverage on W-2. Reporting delayed to 2012 of W-2 Form year.
- Over-the-counter drugs that are not prescribed by a doctor no longer qualify for tax-free reimbursement under FSAs, HSAs and HRAs
- Tax on non-qualified HSA distributions increases to 20%
- HHS is required to develop a national healthcare quality improvement strategy
- Congress may use appropriated funds for grants provided to small employers to establish wellness programs

2012

- Plans renewing on or after October 1, 2012 must pay a tax of \$1 per covered life to fund Comparative Effectiveness Research. This tax rises to \$2 per covered life for plans renewing on or after October 1, 2014 and stays in place at this level until September 30, 2019
- Medicare payments to hospitals are reduced to account for excess (preventable) hospital re-admissions

2013

- FSA contributions limited to \$2,500 per year
- Tax deductions are eliminated for employers who maintain pharmacy plans to subsidize Part D eligible retirees
- Internet program must be implemented to compare physician performance

2014




- Pre-existing condition exclusions are prohibited
- Annual dollar maximums prohibited for essential health benefits
- Waiting periods greater than 90 days are prohibited
- Prohibitions on dropping coverage or restricting routine care for participants in clinical trials
- Employers with more than 50 FTEs that do not offer coverage and have at least one full-time employee who receives a premium tax credit must pay a fee of \$2,000 per employee, excluding the first 30 employees
- Employers with more than 50 employees that offer coverage but have at least one full-time employee who receives a premium tax credit must pay a fee of \$3,000 per employee receiving a tax credit, capped at \$2,000 for each FTE equivalent
- Employer-sponsored "Free Choice" vouchers equal to employer's contribution toward coverage made available to employees with income less than 400% of FPL with a contribution between 8.0% and 9.8% of their annual income
- Employers with more than 200 employees must automatically enroll all eligible employees in plan, and must provide an option to opt out of the plan
- All U.S. citizens and legal residents are required to have qualifying health coverage (phase-in tax penalty for those without coverage)
- Health Insurance Exchanges established in each state for individual and small group markets (sliding scale federal subsidies available for those under 400% of FPL)
- \$8.0 billion annual fees levied on U.S. health insurance plans (increases to \$11.3 billion in 2015, \$13.9 billion in 2017 and \$14.3 billion in 2018)
- Non-elderly who earn 133% or less of FPL become eligible for Medicaid

2017

- States may opt to allow large employers to purchase coverage through Health Insurance Exchanges

2018

- Excise tax (40%) levied on high-value "Cadillac" Plans

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-  New requirements for employers
-  External/government actions

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.