HEALTH CARE POLICY & REFORM TIMELINE

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2010 — Health care reform begins.

2011 — Health care reform implementation continues.

2012 — Women's preventive care and Summary of Benefits Coverage requirements take effect.

2013 — Employers are required to submit W-2 reporting and individuals receive their first notice of health insurance exchanges.

2014 — Second wave of health coverage mandates begins. Individuals are required to have qualifying health insurance coverage and public health insurance exchanges are open to small businesses and individuals.

2015 — The employer shared-responsibility penalty begins to phase in.

2016 — The employer shared-responsibility payment is phased in completely, and employers must complete IRS reporting requirements. State option to expand "small group" definition.

2017 — Marketplace expansion option. IRS enforcement of employer-shared responsibility penalty begins. Health insurer's fee is suspended.

2018 — Original effective date for Cadillac tax. The tax, which never went into effect, was delayed twice before it was repealed in 2019.

2019 — Individuals are no longer required to have health insurance or pay a tax penalty. Health insurers fee is suspended for 2019, but continues to apply in 2020. As part of Congress' year-end spending legislation, the Cadillac tax and other Affordable Care Act taxes are repealed. The Patient Centered Outcomes Research Institute fee is extended.

2020 — The Families First Coronavirus Relief Act and the Coronavirus, Aid, Relief and Economic Security Act are signed into law.

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2010

Health care reform begins. The Affordable Care Act is signed into law on March 23, 2010.

- **Availability of small-business tax credits:** Businesses with fewer than 25 full-time workers (or 50 part-time workers), may be eligible for the Small Business Health Care Tax Credit.
- **Dependent coverage to age 26:** Group health plans that make dependent coverage available must make such coverage available until a child turns age 26.
- **Grandfathered plans:** Companies with plans that covered employees on March 23, 2010, became eligible for grandfathered status. Grandfathered plans are exempt from a number of mandates and reporting requirements but also cannot make significant changes to benefits or costs.
- **Online resources for consumers:** Health insurance companies are required to make health plan options available for consumers online. This requirement applies only to fully insured individual policies and small-group plans.
- **Appeals and external review:** For plan years beginning on or after Sept. 23, 2010, all Nongrandfathered individual and group health plans must have an effective appeals process for coverage determinations and claim decisions. The law requires plans and issuers to offer an external review process meeting minimum requirements.
- **Prohibition on discrimination in favor of highly compensated individuals.** New nondiscrimination rules for Nongrandfathered fully insured group plans (based on the existing rules for self-funded plans) were scheduled to go into effect. However, the new nondiscrimination rules have been delayed indefinitely until such time as the IRS issues regulations.
- **Temporary high-risk pools:** Temporary high-risk pools gave health insurance to people with pre-existing conditions who have not had insurance for at least six months. These pools were made available until state exchanges began operating and selling insurance in 2014.
- **Medical loss ratio requirement for insurers:** Major medical insurers that do not meet new medical loss ratio requirements will be required to pay rebates to policyholders.
- **No unreasonable premium increases:** Every year the federal government will review plan premium increases. Health and Human Services is establishing a process to review unreasonable increases. This provision applies only to Nongrandfathered fully insured individual policies and small-group plans.
- **Cancellation of coverage (rescissions):** Coverage cannot be retroactively canceled on any plan.
- **Doctor choice:** People select their choice of primary care physicians, pediatrician and OB-GYN with Nongrandfathered plans.
- **Dollar limits on essential health benefits:** Lifetime limits on essential health benefits are no longer allowed. Restricted annual limits on essential health benefits are permitted until 2014.
- **Emergency care:** Nongrandfathered plans must generally cover emergency services on the same basis regardless of whether the provider is in-network or out of network.
- **No pre-existing condition limitations for enrollees under 19:** Nongrandfathered plans cannot deny benefits and coverage to dependent children under 19 with pre-existing conditions. No pre-existing condition limitations were extended to everyone in 2014.
- **Preventive services/immunizations without cost share:** Nongrandfathered plans must cover certain preventive services and immunizations at no cost to the enrollees.
- **Early retiree reinsurance program:** This program started June 1, 2010, and ended Jan. 1, 2014. It paid employers for part of the cost of health benefits they pay for retired employees age 55 and over, their spouses and dependents.

2011

Health care reform implementation continues.

- **Availability of simple cafeteria plans:** Simple cafeteria plans are a new way for small businesses with 100 or fewer employees to take advantage of tax savings. Similar to traditional cafeteria plans, the simple cafeteria plan removes the obstacle of nondiscrimination requirements, applicable to highly compensated and key employees, which impact many small employers. There are, however, a number of other rules that apply, including contribution requirements for the employer. These plans offer the same tax benefits as traditional cafeteria plans. Thus, these plans allow employees to pay their portion of health insurance premiums and other eligible benefits, such as contributions to flexible spending accounts, with pretax dollars. As an employer, you can take advantage of this option to save on the employer portion of FICA, FUTA and workers' compensation insurance premiums.
- **Restriction on reimbursement of OTC medicines:** Tax-favored plans, including health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs), cannot be used to reimburse over-the-counter medicines unless the medicine is prescribed by a medical practitioner.
- **Health savings account distribution tax penalty:** The additional tax on distributions from Health Savings Accounts that are not used for medical expenses increases from 10 percent to 20 percent.
- **Eliminate the Medicare Part D coverage "Donut Hole":** Health care reform reduces coinsurance for generic drugs over time, from 100 to 25 percent.

2012

Women's preventive care and Summary of Benefits Coverage Requirements take effect.

- **Women's preventive care requirements:** Nongrandfathered group health plans are required to offer preventive coverage to women without cost sharing for plan years beginning on or after Aug. 1, 2012. Under regulations, certain employers are exempt from the requirement to offer contraceptive coverage.
- **Medical loss ratio rebate distribution:** Major medical insurers that did not meet the new medical loss ratio (MLR) requirements were required to issue rebates to policyholders by Aug. 1, 2012. In most cases, it is the employer's responsibility to distribute the participant portion within three months of receiving the rebate. The details on distribution depend on the type of plan offered (e.g., church plan, ERISA, etc.). In the future, any rebate due must be paid by Aug. 1, and for 2014 and later years, Sept. 30.
- **Encouraging integrated health systems:** Health care reform creates incentives for doctors to form accountable care organizations (ACOs). These organizations allow doctors and other health care professionals to better coordinate patient care to help prevent disease and illness and reduce unnecessary hospital admissions or re-admissions.
- **Quality of care reporting:** The Department of Health and Human Services is developing rules for how plans report on benefits and how they pay health care providers to improve the quality of care and reduce costs.
- **Reducing paperwork and administrative costs:** Health plans are required to adopt rules for the secure, confidential and electronic sending of health information. Standard documents could reduce paperwork and administrative duties, lower costs and decrease medical errors.

2012

- **New summary of benefits and coverage (SBC)** Major medical insurers began sending all benefits enrollees and applicants a new summary of benefits booklet and coverage notice to explain their benefit plans and coverage. Self-funded plans were required to provide the new summary for annual enrollment periods on or after Sept. 23, 2012, as well as all other enrollments for plan years beginning on or after Jan. 1, 2013.
- **Patient-Centered Outcomes Research Institute (PCORI) fee:** Starting with plan years ending on or after Oct. 1, 2012, issuers and plan sponsors are required to pay a new fee for the number of lives covered under each plan or policy subject to the fee, with the fee going to the PCORI fund. The funds will help contribute to research that evaluates and compares health outcomes and clinical effectiveness as well as the risks and benefits of two or more medical treatments and/or services. Since the fee is treated as an excise tax, it is filed through IRS Form 720. The PCORI fee is $1 per covered beneficiary for the first year and is due July 31, 2013, for the first year. The fee is temporary and does not apply to plan years ending on or after Oct. 1, 2019.

2013

Employers are required to submit W-2 reporting and individuals receive their first notice of health insurance exchanges.

- **Health flexible spending arrangement contribution limit:** The ACA limits the amount of participant pretax dollars that can be used to cover health expenses through flexible spending accounts (FSAs).
- **W-2 reporting requirement:** All employers that issued at least 250 Form W-2s in 2011 will need to report the value of health care coverage that employees participated in during the 2012 plan year on the employee's Form W-2. Some items, such as stand-alone dental, vision and health savings account contributions, are excluded from this reporting requirement. Although the value must be reported, it is not taxable for the business or employee.
- **Medicare retiree drug subsidy tax deduction eliminated:** Employers will no longer be able to deduct retiree drug expenses for which they receive a Medicare Part D retiree drug subsidy payment.
- **Increased Medicare Part A tax on wages and investment income:** Health care reform imposes an additional 0.9 percent hospital insurance tax and a separate 3.8 percent net investment income tax on higher income individuals to help fund Medicare Part A.
- **Expanded authority to bundle payments:** Health care professionals collaborate to improve coordination and quality of care.
- **Notice about the health insurance marketplace:** Employers subject to the Fair Labor Standards Act are required to notify employees of the health insurance marketplace and potential eligibility for premium credits. The first notice was required by Oct. 1, 2013. Learn more.
- **HHS provides transition relief for "grandmothered" plans:** HHS provided temporary relief from some of the second wave of health reform requirements that go into effect in 2014. Relief is provided, if permitted under state law, for individual and small group policies renewed between Jan. 1, 2014 and Oct. 1, 2014. The transition relief was subsequently extended through Dec. 31, 2017.

2014

Second wave of health coverage mandates begins. Individuals are required to have qualifying health insurance coverage and public health insurance exchanges are open to small businesses and individuals.

- **Individual mandate:** Health care reform requires almost all Americans to have qualifying health coverage (QHC) that offers minimal essential coverage (MEC), or pay a penalty. The mandate is repealed in 2019.
- **Small Business Health Options Program (SHOP) and individual health insurance marketplace:** Effective 2014, small businesses and individuals will have the opportunity to participate in the federal- and state-facilitated health insurance marketplace. Specific information by state can be found at healthcare.gov.
- **Required contribution to the temporary reinsurance program:** During the first-three years of insurance market reforms (2014-2016), a temporary reinsurance program for the individual insurance market will be funded by a required contribution from all group major medical plans. The per capita amount is paid for each enrollee by the insurer or the self-funded plan.
- **Small-business tax credit changes:** Small-business tax credits will expand to 50 percent of a small business's premium costs for two consecutive years. These credits are available to businesses with average wages between $25,000 and $50,000, that have fewer than 25 full-time workers (or 50 part-time workers) and that offer health insurance through the Small Business Health Options Program (SHOP) marketplace.
- **Updated COBRA notices:** Updated model notices inform eligible employees about government marketplace options. Learn more.
- **Clinical trials:** Nongrandfathered health care plans must not discriminate against a policyholder because of a clinical trial and can't deny people from participating in clinical trials. They can't limit coverage of routine patient costs for items and services in connection with the trial.
- **Health insurance industry fee:** This fee on health insurers, including HMOs, is based on each insurer's share among all health insurers of U.S. health risks. It starts at $8 billion in 2014 and increases year over year before reaching $14.3 billion in 2018. In December 2015, the Health Insurance Industry Fee was suspended for 2017. The fee is suspended for 2019 .... and later repealed in 2020.
- **Wellness program incentives:** Maximum reward is 30 percent of costs or 50 percent for programs related to tobacco use.
- **Second wave of health insurance reforms:**
  - Pre-existing condition exclusions will no longer be permitted. Applies to both grandfathered and Nongrandfathered plans; however it does not apply to grandfathered plans in the individual market.
  - There will be no annual dollar limits on essential health benefits. Does not apply to grandfathered plans in the individual market.
  - Limits will be placed on out-of-pocket expenses (does not apply to grandfathered plans).
  - Small-group fully insured plans will have limits on deductibles (does not apply to grandfathered plans).
  - Health insurers will be subject to modified community ratings and guaranteed-issue requirements.
  - Waiting periods in excess of 90 days will be prohibited.
  - Nongrandfathered individual market and small group health plans must meet metal tier requirements based on the percentage of costs the plan is expected to cover: 60 percent Bronze; 70 percent Silver; 80 percent Gold; 90 percent Platinum.

2015

The employer shared-responsibility penalty begins to phase in.

- **Shared-responsibility payment phase I:** Employers with at least 100 full-time equivalent employees must offer affordable, minimum value health coverage to at least 70 percent of their full-time employees and their dependents, unless the employer qualifies for 2015 dependent coverage transition relief, or face a penalty.
- **Supreme Court ruling on King v. Burwell:** On June 25, 2015, the Supreme Court ruled on an important issue affecting health insurance in the U.S. The decision upheld a key part of the Affordable Care Act by affirming an eligible individual's ability to obtain subsidized health insurance through a federal exchange.

2016

The employer shared-responsibility payment is phased in completely, and employers must complete IRS reporting requirements. State option to expand "small group" definition.

- **Shared-responsibility payment phase II:** Employers with at least 50 full-time equivalent employees must offer affordable, minimum-value health coverage to at least 95 percent of their full-time employees and their dependents, or face a penalty.
- **Small-business definition:** Most states define small businesses as those with 50 or fewer employees, but the Affordable Care Act was originally set to expand the definition in 2016 to include those with 51 to 100 employees, including full-time equivalents (FTEs). The president signed a bill on Oct. 7, 2015, that no longer requires states to expand their definition. Instead, states can use their own discretion. The new law is meant to help curb premium hikes in the small-group market. Learn more.
- **IRS reporting requirements for employers:** Businesses are required to report information regarding the health coverage of your employees, including basic employee data, dates and type of coverage; cost-sharing; and any other information required by the IRS. These requirements apply to coverage offered on or after Jan. 1, 2015, but the first report will not be due until 2016.
- **New individual out-of-pocket rules:** Non-grandfathered family plans must have an "embedded" individual out-of-pocket maximum.
- **Presidential election – Nov. 8, 2016.**

2017

Marketplace expansion option. IRS enforcement of employer-shared responsibility penalty begins.

» **Marketplace expansion option:** With approval from Health and Human Services (HHS), states will have an option to open their public marketplace to any size employer.

» **Executive order:** The President signs an executive order directing federal regulatory agencies to develop rules to minimize the economic and regulatory burden of the Patient Protection and Affordable Care Act and to prepare to afford states more flexibility and control of health care markets.

2019

Individuals are no longer required to have health insurance or pay a tax penalty. Health insurers fee is suspended 2019, but still applied in 2020.

Congress' fiscal year 2020 spending package repeals the Cadillac tax and other ACA taxes, as well as extends the Patient Centered Outcomes Research Institute fee.

» **Cadillac plan tax repealed:** The Cadillac plan tax, which never went into effect, was a 40% excise tax on the cost of certain employer-sponsored health coverage in excess of a specified dollar threshold. The tax was originally scheduled to go into effect in 2018 but was delayed twice. Even with the delayed effective date, some employers started to modify their health insurance plans to avoid triggering the tax, including increasing deductibles and copays. The push for repeal grew as many policymakers increasingly viewed the tax as having an effect on middle-class workers.

» **Health insurance tax repealed:** The HIT is imposed on health insurers based on their relative market share of premiums for major medical plans and certain other health insurance plans. Although the tax was imposed on the health insurance company, it generally passed through to consumers as part of the premium. The tax went into effect in 2010 and was suspended in 2017, went back into effect in 2018 and was again suspended in 2019. The tax applied for 2020 but is repealed starting in 2021.

» **Medical device tax repealed:** The medical device tax was a 2.3 percent excise tax on gross sales of medical devices used by humans such as x-ray machines and hospital beds. It was implemented in 2013, but was suspended in 2015. The 2019 year-end legislation repeals the tax effective 2020.

» **Patient Centered Outcomes Research Institute fee extended:** Congress' end-of-year legislation extends the PCORI fee for 10 years, so that it applies to plan years beginning on or after Oct. 1, 2012 and ending before Oct. 2029.

2020

The Families First Coronavirus Relief Act and the Coronavirus, Aid, Relief and Economic Security Act are signed into law.

» As amended by the Coronavirus, Aid, Relief and Economic Security (CARES) Act, the Families First Coronavirus Relief Act requires most health plans to cover certain COVID-19 testing and related services without cost sharing, effective March 18, 2020, for the duration of the COVID-19 public health emergency.

The CARES Act also also accelerates the time that any COVID-19 preventive care services are covered by the ACA preventive care mandate to 15 days after the United States Preventive Services Task Force or the Centers for Disease Control and Prevention recommends such services as preventive care.

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