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ADP RESOURCE®

Affordable Care Act Timeline

2012

Internal and External Review and Appeals
Health Care Reform requires group health plans to maintain an internal claim and appeal process that meets certain standards and to provide for an external appeal process. By **July 1, 2012**, self-insured group health plans must contract with at least three Independent Review Organizations (IROs).These plans were required to have contracted with two IROs by January 1, 2012. Other requirements related to internal and external claims processes generally went into effect in part for plan years beginning on or after July 1, 2011 and in part for plan years beginning on or after January 1, 2012.

Medical Loss Ratio (MLR Rebates)
If an insurer's MLR is less than 80% (or 85% in the large group market), insured group health plans must receive MLR rebates. Plan sponsors must distribute rebates in compliance with ERISA plan asset rules.

Preventive Health Services for Women
For plan years beginning on or after **August 1, 2012**, group health plans must provide women's preventive health services with no cost-sharing requirements.*

Summary of Benefits and Coverage (SBC)
Insurers and plan sponsors must provide SBCs for annual enrollments beginning on or after September 23, 2012 and for other enrollments and upon request for plan years beginning on or after **September 23, 2012.** Group health plans must notify enrollees of material mid-year changes to a plan at least 60 days in advance, for plan years beginning on or after September 23, 2012.

Patient-Centered Outcomes Research Institute (PCORI) Fee
For policy or plan years ending on or after **September 30, 2012**, insurers and self-insured employers sponsoring group health plans must pay a fee of $1 per covered life per year. The fee adjusts to $2 per covered life for policy or plan years beginning October 1, 2013. For policy or plan years beginning October 1, 2014, the dollar amount in effect for such policy or plan year will be adjusted by the Secretary of Treasury based on the percentage increase in the projected per capita amount of national health expenditures. The fee will no longer apply to policy or plan years beginning October 1, 2019.

2013

Flexible Spending Account (FSA) Annual Limit on Salary Reductions
For plan years beginning on or after **January 1, 2013**, $2,500 limit applies to salary reduction contributions to a health care FSA.

Medicare Tax Increase
For high income earners, Medicare tax increases by 0.9% for any wages earned over $200,000 for single filers, $250,000 for joint filers and $125,000 for individuals who are married but filing separately, and a new 3.8% Medicare tax will be imposed on unearned income.

Itemized Deductions for Medical Expenses
The threshold for itemizing and deducting unreimbursed medical expenses increases from 7.5% of adjusted gross income to 10% of adjusted gross income; the increase is waived for individuals age 65 and older for tax years 2013 through 2016.

Tax Deduction for Retiree Prescription Drug Expenses
Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Reporting Value of Health Care Coverage on Form W-2
Employers must include the value of group health coverage provided to employees on Form W-2, beginning with the Forms W-2 issued for the **2012 tax year**. (Requirement does not apply to employers who issued fewer than 250 Forms W-2 in preceding calendar year.)

Employee Notice of Exchanges and Subsidies
Employers must provide current employees with notice describing the availability of exchange coverage no later than **October 1, 2013.** Notice must also be provided within 14 days of hire for employees hired on or after the effective date October 1, 2013.

2014

Annual Dollar Limits/Pre-existing Condition Exclusions
For plan years beginning on or after **January 1, 2014**, employer group health plans may not impose annual dollar limits on essential health benefits or impose pre-existing condition exclusions for any enrollees.

Limit on Waiting Periods
Employers may not impose more than a 90 day waiting period on benefits eligibility.

Coverage for Adult Children Expanded for Grandfathered Plans
Grandfathered health plans may no longer deny coverage to children who are age 26 based on eligibility for other employment-provided coverage.

2014 (continued...)

Coverage for Clinical Trials
Plans will be required to cover routine costs for care in connection with clinical trials.*

Wellness Incentives
For plan years beginning on or after January 1, 2014, employer wellness incentives may increase from 20% of the cost of coverage to 30%.

Small Group Coverage Reform
Fully insured small group health plans will be allowed to vary rates only based on whether the policy covers an individual or family, geographic area, age, and tobacco use. In addition, deductibles for small group health plans can be no greater than $2,000 for single coverage and $4,000 for family coverage and out of pocket maximums may not exceed that allowed for a high deductible health plan offered alongside a health savings account.* Fully insured health plans offered in the small group markets (both inside and outside of the Exchange) must offer a comprehensive package of items and services, known as "essential health benefits."*

Health Insurance Exchanges
The state and federal health insurance exchanges will begin operation for individual coverage and employers in the small group market.

Cafeteria Plans Permitted for Exchange Coverage
Employers that offer coverage through the Exchange to their employees may permit employees to make pre-tax contributions through their cafeteria plan for such coverage.

"Play or Pay" Individual Mandate
Most individual taxpayers must have minimum essential coverage or be subject to a penalty.

Health Insurer Fee
Insurers will pay an annual fee which is allocated by market share to fund insurance exchange subsidies that are to be made available to qualifying individuals purchasing health insurance coverage on the Exchanges beginning 2014.

Reinsurance Fee
A fee will be imposed on both fully insured and self-insured group health plans in order to help fund a reinsurance program for the individual market.

2015-2018

"Play or Pay" Employer Shared Responsibility
Employers with 50 or more full-time employees (including full-time equivalents) may be subject to a penalty if they do not offer coverage to their full-time employees or they offer coverage that is deemed unaffordable or insufficient and one or more full-time employee receives subsidized coverage through an Exchange.

Employer Annual Reporting of Employee Coverage
Employers subject to the Shared Responsibility provision will be required to report coverage information to enrollees and the Internal Revenue Service.

Increased Penalties on Individual Mandate
Beginning in 2015, the individual mandate penalty will increase.

Insurance Exchanges May Be Expanded
As of January 1, 2017, states may allow large employers to participate in the Exchange.

Excise Tax on High-Cost Plans ("Cadillac Tax")
For taxable years beginning after December 31, 2017: If coverage under a group health plan exceeds certain thresholds (anticipated in 2018 to be $10,200 for single coverage and $27,500 for family coverage, each to be adjusted for inflation), an insurer, plan administrator or employer will be subject to 40% excise tax on amount of excess benefit.

PENDING:

The following Health Care Reform provisions have been delayed until further guidance is issued:

- ## Quality of Care Reporting
  An annual report must be provided by employer group health plans to disclose information of plan benefits and reimbursement structures that improve health outcomes.
- ## Automatic Enrollment
  Employers with more than 200 full-time employees must automatically enroll new employees in the employer's group health plan.
- ## Nondiscrimination Rules for Fully-Insured Plans
  Fully-insured employer group health plans will be subject to additional nondiscrimination rules.*

**Does not apply to grandfathered group health plans.*

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