

EMPLOYER-SPECIFIC TIMELINE

as of June 30, 2010

DATE	REFORM PROVISION
2010	
2010	<p>Small Employer Health Insurance Credit: For tax years beginning in 2010, 2011, 2012, and 2013, small employers with 25 or fewer “full-time equivalent” employees and average annual wages of no more than \$50,000 may be eligible for a tax credit of 35% (25% for tax-exempt small employers) of the employer’s contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. The full credit is available to employers with 10 or fewer employees and wages less than \$25,000, and phases out up to the maximum of 25 full-time employees.</p>
1/1/2010	<p>Medicare Part D Donut Hole: Medicare Part D beneficiaries who reach the donut hole are offered a one-time rebate of \$250.</p>
3/23/2010	<p>Determination of Grandfathered Plan Status: Health plans and health insurance coverage in which individuals were enrolled by March 23, 2010 may be recognized as having grandfathered plan status and may be exempted from conforming with certain subsequent requirements. Plans governed by collective bargaining agreements (“CBA”) that were ratified prior to March 23, 2010 are also grandfathered until the expiration of the current CBA, although coverage offered under a newly ratified agreement can continue to enjoy grandfathered plan status if the health insurance coverage does not make any of the prohibited changes. Certain changes made to a grandfathered health plan after March 23, 2010 will forfeit this status, including: the elimination of all or substantially all benefits to diagnose or treat a particular condition (including a condition that is not an essential health benefit); increases in any percentage cost-sharing requirement; increases in any fixed-amount cost-sharing requirement above a certain amount; decreases in the employer contribution rate to more than 5% below the contribution rate in effect on March 23, 2010; decreases in an existing overall annual limit; imposing an annual limit if no such annual or lifetime limit is in place on March 23, 2010; imposing an annual limit that is lower than an existing lifetime limit; and changes in insurance carriers or offering a new policy (changes to a self-insured employer’s third party administrator or administrative services only provider will not jeopardize grandfathered status). Grandfathered plans may make voluntary changes to increase benefits, may conform to required legal changes, and may voluntarily adopt other health care reform requirements.</p> <p>A grandfathered plan must disclose its status by including a statement in any plan materials provided to a participant or beneficiary, and must maintain records documenting the terms of the plan that were in effect on March 23, 2010 for as long as the plan takes the position that it is a grandfathered plan.</p>
3/23/2010	<p>Automatic Enrollment for Employees of Large Employers: Employers with more than 200 full-time employees and that offer one or more health benefits plans, must automatically enroll new full-time employees in one of the plans offered. Employees have the right to decline such enrollment. This provision is not effective until a date to be determined under regulations to be issued.</p>
	<p>Temporary Reinsurance for Early Retirees: A temporary reinsurance program is established to</p>

6/23/2010	pay for a portion of health benefits provided by employment-based plans to retirees not yet eligible for Medicare and their eligible dependents. A plan must apply to and be approved by the Secretary of HHS to be eligible for this reinsurance. The reimbursement is equal to 80% of the amount of valid retiree claims that exceed \$15,000 and are no greater than \$90,000 indexed for changes in the medical CPI. The program ends on January 1, 2014. \$5 billion is appropriated for this program.
9/23/2010	Adult Dependents: Group health plans and health insurance issuers who offer dependent coverage are required to continue coverage for dependent children who have not attained age 26. The participant will not be required to include the value of the coverage in income. This applies to grandfathered plans, except when the dependent is eligible to enroll in an eligible employer-sponsored health plan other than the grandfathered health plan.
9/23/2010	No Lifetime or Annual Limits: Group health plans and insurance issuers may not impose lifetime limits on essential health benefits. Prior to January 1, 2014, restricted annual limits may be imposed on certain essential health benefits; after January 1, 2014, no annual limits may be imposed on essential health benefits. Lifetime and annual limits may be imposed on specific, non-essential health benefits without restriction. For plan years beginning on or after September 23, 2010, but before September 23, 2011, the restricted annual limit threshold is \$750,000 per individual. Any individual who lost coverage under a group health plan when he exceeded the plan's lifetime limit and who would be eligible for coverage under the plan or coverage option but for exceeding the lifetime limit, must be permitted to reenroll in the group health plan. The rules on lifetime limits and annual limits apply to plans regardless of their grandfathered status, although the annual limits apply to grandfathered plans that are group health plans.
9/23/2010	Prohibition on Preexisting Condition Exclusions: Group health plans and insurers may not impose any preexisting condition exclusions on children under the age of 19. This prohibition extends to all participants for plan years beginning on or after January 1, 2014. Plans and insurers cannot deny participants coverage of specific benefits associated with a preexisting condition or exclude an individual from the plan or coverage altogether based on a preexisting condition. This applies to all group plans regardless of their grandfathered status. (A preexisting condition exclusion is a limitation or exclusion of benefits based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was received before that date.)
9/23/2010	Patient Protections: Group health plans and insurers must comply with certain rules governing choice of primary care providers, obstetrical and gynecological care, and access to emergency services. A plan or issuer that requires or provides for participant designation of a primary care physician must permit each participant to select any available participating primary care provider (or pediatrician if for a child) who is part of the plan's network. A plan or issuer may not require a female participant who seeks coverage for obstetrical or gynecological care to obtain authorization or a referral for care provided by a participating health care professional who specializes in obstetrics and gynecology. Notice must accompany any summary plan description, or other description of benefits, informing the participant of the plan terms regarding designation of a primary care provider. Any plan or issuer that provides emergency services must do so (1) without requiring prior authorization, even when the services are provided out-of-network, (2) without regard to whether the particular health care provider is a participating network provider with respect to the services, (3) without imposing any administrative requirement or limitation on coverage for out-of-network services that is more restrictive than that which applies to in-network services, and (4) by

	<p>complying with cost-sharing requirements for out-of-network services.</p> <p>Plans cannot impose copayments or coinsurance requirements on out-of-network emergency services that are greater than those imposed on in-network emergency services.</p> <p>Grandfathered plans do not need to comply with these rules.</p>
9/23/2010	<p>Prohibition on Rescission: Group health plans and a health insurance issuers offering group or individual health insurance coverage are prohibited from rescinding coverage for a covered enrollee except in cases where an enrollee commits fraud or makes an intentional misrepresentation of a material fact. An inadvertent omission of information on a medical history questionnaire or a mistake made by the plan or insurer do not meet the criteria for rescinding coverage. Rescissions are only permitted to the extent that the individual’s actions leading to the rescission are prohibited by the terms of the plan. Notice must be given in writing at least 30 days in advance of any rescission of coverage. This prohibition applies to all plans regardless of their grandfathered status. (A rescission is any cancellation or discontinuance of coverage with a retroactive effect, however, coverage may be withdrawn retroactively to the extent that it is attributable to the participant’s failure to pay premiums or contribution amounts in a timely manner.)</p>
9/23/2010	<p>Preventive Services: Group health plans must provide first dollar coverage for certain preventive services. Grandfathered plans are exempt from this requirement. Guidance on what constitutes preventive services is forthcoming.</p>
9/23/2010	<p>Nondiscrimination: Fully insured group health plans must comply with non-discrimination rules similar to those applicable to self-insured plans under Section 105(h) of the tax code. Grandfathered plans are exempt from this requirement. Under current guidance, it is unclear what the scope of penalties will be to employers and employees.</p>
9/23/2010	<p>Appeals: Group health plans and insurers must each maintain internal appeals procedures for denied claims, and comply with any applicable state-established external review procedures. Group health plans and insurers must provide “culturally and linguistically appropriate” notification of the availability of the appeals processes.</p>
10/1/2010	<p>Wellness Programs: Employers with a maximum of 100 employees who work 25 hours or more per week are eligible to compete for grant funding to implement wellness programs (funding is available through FY 2015).</p>
2011	
1/1/2011	<p>Rebate from Insurers: Health insurers (including grandfathered plans) must begin providing a rebate to each enrollee if the amount the insurer spends on clinical services provided to enrollees and activities that improve health care quality is less than 85% of premium revenue for large groups (80% for small groups).</p>
1/1/2011	<p>Medicare Part D Donut Hole Closing: Medicare Part D “donut hole” coinsurance for generic drugs is reduced to 93% (from 100% in 2010).</p>
1/1/2011	<p>Increased Penalties on Nonqualified HSA and Archer MSA Distributions. The tax on distributions from an HSA or an Archer MSA that are not used for qualifying medical expenses is increased from 10% for HSAs and 15% for Archer MSAs to 20% for both.</p>

1/1/2011	Limitations on Health FSAs: Reimbursement for over-the-counter drugs will no longer be permitted from health FSAs, HSAs, and Archer MSAs.
1/1/2011	National Voluntary Insurance Program for Purchasing Community Living Assistance Services and Support (CLASS program). Employers who chose to participate may automatically enroll qualified individuals in the CLASS program in the same manner as the employer may elect to automatically enroll employees in a 401(k), 403(b) or 457 plan. Qualified individuals must have attained age 18, be actively employed, and receive taxable wages. Individuals may opt out of the program. (The CLASS program will provide assistance and support to certain individuals with functional limitations to enable them to live in the community.)
1/1/2011	Inclusion of Cost of Employer-Sponsored Health Coverage on W-2: An employer is required to include the aggregate cost of applicable employer-sponsored health insurance coverage, except for the amount of any salary reduction contributions to FSAs, on employees' annual form W-2s.
9/23/2011	Phase in of Restriction on Annual Limits: A plan (including grandfathered group health plans) may only impose a restricted annual limit of up to \$1,250,000 on the dollar value of essential health benefits for any participant or beneficiary.
2012	
1/1/2012	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 86% (from 93% in 2011).
1/1/2012	Modification of Itemized Deduction for Medical Expenses. For taxpayers who itemize deductions, the "floor" for deducting unreimbursed medical expenses is raised from 7.5% to 10% of AGI. (This is not effective until January 1, 2017 for individuals over the age of 65.)
3/23/2012	Requirements for a Uniform Summary of Benefits: Health insurance issuers, group health plans (including grandfathered plans), and sponsors and administrators of self-insured plans are required to use uniform explanation of coverage documents developed by the Secretary of HHS by this date. The summary of benefits coverage must be no longer than four pages and with print no smaller than 12-point type and must be provided to applicants, enrollees, and policyholders. Willful failure to provide a summary that complies with regulations promulgated by the Secretary will result in a \$1,000 fine per failure. A failure can occur with regard to an applicant at the time of application, an enrollee prior to enrollment or reenrollment, and a policyholder at the time a policy is issued. Once written, a plan benefits summary must be maintained and reflect material modifications to the plan.
9/23/2012	Phase in of Restriction on Annual Limits: A plan (including grandfathered group health plans) may only impose a restricted annual limit of up to \$2,000,000 on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits.
2013	
1/1/2013	Limitations on Health FSAs under Cafeteria Plans: Annual salary contributions to health FSAs will be limited to \$2,500 a year (indexed by the Consumer Price Index for taxable years beginning after December 31, 2013).
1/1/2013	Elimination of Incentives for Employer Contributions to Medicare Part D Prescription Drug

	Plans: The deduction for expenses allocable to the Medicare Part D subsidy received by employers is eliminated.
1/1/2013	Medicare Part D Donut Hole Closing: Medicare Part D “donut hole” coinsurance for generic drugs is reduced to 79% (from 86% in 2012).
3/1/2013	Notice of Coverage Options: Employers must provide written notice to all new hires and current employees describing the state-based exchange, explaining the premium tax credit and cost-sharing subsidies (if the employer’s plan pays less than 60% of costs of benefits) and, if the employer does not offer a free choice voucher, that the employee may lose the employer contribution toward employer-sponsored coverage if he or she elects coverage through the Exchange (described below).
2014	
1/1/2014	State-Based Exchanges: State-based exchanges become available; only individuals and small employers (less than 100 employees) are initially eligible to participate. Beginning in 2017, states may allow (but not require) health insurance issuers in the large group markets to offer qualified health plans through an Exchange.
1/1/2014	Individual Mandate: Most U.S. citizens and legal residents must either maintain “minimum essential coverage” (which can be satisfied by, among other things, participating in an employer sponsored plan or purchasing individual coverage) or pay a monthly “shared responsibility” penalty. These penalties phase in gradually starting in 2014 at \$95 per adult or \$47.50 per child with a family maximum of \$285, or 1% of household income in excess of the federal income tax return filing threshold, and increasing in 2015 to \$325 per adult or \$162.50 per child, with a family maximum of \$975, or 2% of household income in excess of the federal income tax return filing threshold, before reaching the full amount on January 1, 2016. Starting January 1, 2017, the penalties will be indexed to cost-of-living increases. These penalties do not apply to certain individuals, including those for whom the cost of coverage is deemed unaffordable.
1/1/2014	Certification of Health Plans: Health plans seeking certification must submit to the Exchange, State, and Secretary of HHS, and make publicly available, certain information, including claims payment policies, and data on enrollment and denied claims.
1/1/2014	Premium Tax Credit: Affordability premium credits and cost-sharing credits are provided to non-Medicaid eligible individuals who are not enrolled in an affordable employer-sponsored plan and who have household incomes between 133% and 400% FPL to purchase coverage through an Exchange. An employer may not terminate an employee based on eligibility for a premium tax credit or cost-sharing assistance.
1/1/2014	Reporting of Health Insurance Coverage: Each employer providing minimum essential coverage to an employee must file an information return with the IRS (1) describing the coverage, (2) stating the employer’s name, address, and employer identification number, (3) stating the portion of the premium paid by the employer, and (4) for coverage in the small group market offered through an Exchange, any information required by the Secretary of Treasury to administer the credit for employee health insurance expenses of small employers. In addition, on or before the January 31 following the calendar year of this return, the employer is required to furnish to each listed employee a written statement containing the name, address, and the contact information of the employer and employee-specific information reported on the return.

1/1/2014	<p>Reporting of Employer Health Insurance Coverage: Employers with 50 or more full-time employees must file an information return in a form to be established by the Secretary of Treasury (1) stating the employer's name, employer identification number, and the date, (2) certifying whether the employer offers minimum essential coverage to its full-time employees (and their dependents) under an eligible employer-sponsored plan, and describing certain terms of such plan, (3) the number of full-time employees for each month during the calendar year (not the plan year), (4) the name, address, TIN, and monthly coverage status of each full-time employee during the calendar year and the months, and (5) any other information required by the Secretary. In addition, on or before the January 31 following the calendar year of this report, the employer must provide each listed full-time employee with a statement containing the name and contact information of the person filing the return and the employee-specific information reported.</p>
1/1/2014	<p>Small Employer Health Insurance Credit: The small business tax credit is increased to 50% for for-profit small business (35% to tax-exempt small businesses) of the employer's contributions for qualified health plans offered by the employer through an Exchange, or contributions that the employer would have made if its employees had enrolled in an Exchange plan. The credit fully phases out for firms with average wages equal to or greater than \$50,000.</p>
1/1/2014	<p>Prohibition on Preexisting Condition Exclusions: This prohibition is extended to apply for all participants under group health plans (not just children under the age of 19). This applies to all plans, including grandfathered plans.</p>
1/1/2014	<p>Rate Variations: Rates may only vary for insurance offered in the small group market (or if permitted in a given state, the large group market) based on age, individual versus family coverage, geographic area, and tobacco use. Rates may not vary based on health status, but they may be reduced by up to 30% based on participation in a wellness program</p>
1/1/2014	<p>No Excessive Waiting Periods: Waiting periods under a group health plan may not exceed 90 days. This applies to all plans, including grandfathered group plans.</p>
1/1/2014	<p>Employer Penalties: If any employer with 50 or more full-time employees <u>does not</u> offer minimum essential coverage, and one or more of the employer's full-time employees qualifies for the premium tax credit or for the benefits of a cost-sharing reduction, then the employer will be required to pay a fee of \$2,000 per year (\$166.67 per month) per each full-time employee, excluding the first 30 full time employees. This penalty is calculated based on the total number of full-time employees and not the number of employees qualifying for the credit.</p> <p>If any employer with 50 or more full-time employees <u>does</u> offer minimum essential coverage, and one or more of the employer's full-time employees qualifies for the premium tax credit or for the benefits of a cost-sharing reduction, then the employer will be required to pay a fee of \$3,000 on an annualized basis (assessed at \$250 per month) per each full-time employee who receives a credit or reduction. The penalty under this section is capped for any month at an amount equal to \$166.67 per month times the number of full-time employees, excluding the first 30 full-time employees. The penalty will not apply if the actuarial value of the employer's cost of the plan is at least 60% of the full value of the benefits provided by the plan unless an employee cannot afford the employee share and he or she enrolls in coverage offered through an Exchange and receives the premium tax credit.</p>
	<p>Free Choice Vouchers. Employers who offer minimum essential coverage and who pay a portion of the premiums are required to offer free choice vouchers in the amount of the employer</p>

1/1/2014	contribution to any employee who does not participate in the employer's plan if the employee has household income for the taxable year not exceeding 400% of the federal poverty level, and the required contribution under the plan is between 8 and 9.8% (both percentages indexed for the rate of premium growth) of the employee's household income. If the amount of the voucher exceeds the cost of the premiums for the Exchange plan selected by the employee, then the employee may retain this excess amount. Employees are only taxed on the value of the vouchers to the extent that the value exceeds the amount paid for a qualified health plan. Employers may treat the amount of a free choice voucher as a deductible expense.
1/1/2014	Mandated Coverage for Clinical Trials: Coverage for routine care provided to an individual enrolled in a clinical trial cannot be denied. This does not apply to grandfathered plans.
1/1/2014	Wellness Programs: Incentives employers may offer under a wellness program increase from 20% to 30% of the cost of group health plan coverage. Wellness programs must comply with certain restrictions if they are based in part on health status.
1/1/2014	Adult Dependents: Grandfathered plans must extend coverage to adult dependent children up to age 26, without regard to whether an adult child is eligible to enroll in any other coverage.
1/1/2014	No Annual Limits: Health plans may not place annual limits on essential health benefits. This applies to all plans, including grandfathered group health insurance plans.
1/1/2014	Limitations on Health FSAs under Cafeteria Plans: Annual salary contributions to health FSAs will be indexed by the Consumer Price Index for taxable years.
1/1/2014	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 72% (from 79% in 2013).
2015	
1/1/2015	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 65% (from 72% in 2014). Medicare Part D "donut hole" coinsurance for most brand-name drugs is reduced to 45% (down from 47.5% in 2013-2014), including a 50% rebate from Medicare Coverage Gap Discount Program, for 2015-2016.
1/1/2015	Individual Mandate: The penalty imposed on individuals who do not purchase insurance coverage increases to \$325 per adult or \$162.50 per child, with a family maximum of \$975, or 2% of household income in excess of the federal income tax return filing threshold. The threshold for exemption from the shared responsibility payment will change from 8% of modified adjusted gross household income to the "percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period."
2016	
1/1/2016	Individual Mandate: The penalty imposed on individuals who do not purchase insurance coverage increases to the full amount, which will equal the lesser of (1) the national average premium for coverage provided through a health care Exchange or (2) the greater of (a) \$695 per adult individual and \$347.50 per child under 18 (to a maximum of \$2,085 per family) or (b) 2.5% of household income in excess of the federal income tax return filing threshold.
1/1/2016	State-Based Exchanges: Plans may be offered in the Exchange through health care choice compacts.

1/1/2016	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 58% (from 65% in 2015).
2017	
1/1/2017	Individual Mandate: The penalty imposed on individuals who do not purchase insurance coverage will be indexed to cost-of-living increases.
1/1/2017	State-Based Exchanges: States may permit businesses with more than 100 employees to purchase coverage in the Health Insurance Exchanges.
1/1/2017	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 51% (from 58% in 2016). Medicare Part D "donut hole" coinsurance for most brand-name drugs is reduced to 40% (down from 45% in 2015-2016), including a 50% rebate from Medicare Coverage Gap Discount Program.
1/1/2017	Modification of Itemized Deduction for Medical Expenses. For taxpayers who itemize deductions, the "floor" for deducting unreimbursed medical expenses is raised from 7.5% to 10% of AGI for individuals over the age of 65. (This provision applies to individuals under the age of 65 as of 1/1/2012.)
2018	
1/1/2018	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 44% (from 51% in 2017). Medicare Part D "donut hole" coinsurance for most brand-name drugs is reduced to 35% (down from 40% in 2017), including a 50% rebate from the Medicare Coverage Gap Discount Program.
1/1/2018	Cadillac Tax: An excise tax is imposed on insurers if the aggregate value of employer-sponsored health insurance coverage for an employee exceeds \$10,200 for individuals and \$27,500 for family coverage (indexed for increases in health care costs). The tax imposed is 40% of the excess amount.
2019	
1/1/2019	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 37% (from 44% in 2018). Medicare Part D "donut hole" coinsurance for most brand-name drugs is reduced to 30% (down from 35% in 2018), including a 50% rebate from the Medicare Coverage Gap Discount Program.
2020	
1/1/2020	Medicare Part D Donut Hole Closing: Medicare Part D "donut hole" coinsurance for generic drugs is reduced to 25% in 2020 and each year thereafter (from 37% in 2019). Medicare Part D "donut hole" coinsurance for most brand-name drugs is reduced to 25% (down from 30% in 2019), including a 50% rebate from the Medicare Coverage Gap Discount Program, for 2020 and each year thereafter.