



AFFORDABLE CARE ACT: 2012 AND BEYOND

This timeline explains how and when the health care reform law will be implemented over the next few years.

2012

- **Uniform Summary of Benefits Coverage:** Under the Affordable Care Act (ACA), all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC) at the time of application, enrollment and yearly upon re-enrollment for plan or policy years beginning on or after Sept. 23, 2012. The SBC is a summary of the benefits and health coverage offered by a particular plan. The SBC is intended to provide improved information for consumers to understand the coverage they have and to compare coverage options across different types of plans and products. The SBC is completed using a government-designed template so that the SBC will be consistent across all health insurance plans and will include:
 - A description of the coverage
 - Exceptions, reductions or limitations of coverage
 - Cost-sharing provisions (including deductibles, coinsurance and copayments)
 - Coverage examples
 - A website and phone number for customer service and obtaining more information
- **Medical Loss Ratio (MLR) Rebates:** Starting August 2012, rebates are provided to enrollees if their insurer does not spend 80 (individual and small group market) to 85 (large group market) percent of premium dollars on medical care and health care quality improvement.
- **Patient-Centered Outcomes Research Institute (PCORI) Fee:** ACA established the nonprofit Patient-Centered Outcomes Research Institute for overseeing and conducting comparative clinical effectiveness research. The law requires sponsors of self-funded group health plans and insurers that offer health insurance coverage to pay an annual fee to help fund the research. The fee amount is \$1 times the average number of covered lives under the plan for policy or plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2013. The fee applies to plan or policy years ending after Sept. 30, 2012, and before Oct. 1, 2019.
- **Women's Preventive Services:** Federal regulatory agencies published regulations expanding preventive services for women. These additional guidelines must be included in the preventive services required to be provided without member cost-share (such as copayment, coinsurance or deductible) when using a network provider. This new coverage requirement is effective for plan/policy years beginning on or after Aug. 1, 2012.
- **Student Health:** Student health insurance plans would be required to have annual dollar limits on essential health benefits of no less than \$100,000 for policy years beginning on or after July 1, 2012, but before Sept. 23, 2012.

2013

- **W-2 Reporting:** Employers are required to report the cost of health insurance coverage on employees' W-2 forms.
- **FSA Changes:** Beginning on Jan. 1, 2013, contributions to FSAs will be capped at \$2,500 per year. The amount will be indexed annually.
- **Medical Expense Deductions:** As of Jan. 1, 2013, total medical expenses in excess of 10 percent of a person's adjusted gross income can be deducted as part of itemized deductions. People 65 and older can use the previous 7.5 percent threshold until 2017.

2013 (Continued)

- **Employer Notice Requirements:** Employers must provide employees written notice of the existence of the state health insurance exchange, which will become operative as of Jan. 1, 2014, of their potential eligibility for federal assistance if the employer's plan does not meet affordability and minimum value criteria and if employee household income is below certain thresholds, and that the employee may lose the employer's contribution to health coverage if they purchase health insurance through the state health insurance exchange. Employers are required to provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, the Department of Labor will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. With respect to employees who are current employees before Oct. 1, 2013, employers are required to provide the notice not later than Oct. 1, 2013.
- **Loss of Tax Exemption for Medicare Prescription Drug Subsidies:** Beginning Jan. 1, 2013, employers will no longer be permitted to take a tax deduction for the Medicare Part D retiree drug subsidies they receive from the federal government. ACA reverses an element of the Medicare Modernization Act of 2003, which established the Medicare Part D prescription drug benefit for seniors and provided a subsidy to employers that offer prescription drug coverage to retirees. Employers had received the subsidy tax-free and were able to deduct it from their corporate income taxes.
- **Annual Limits:** Plans that have restricted annual dollar limits on essential health benefits must increase the amount to \$2 million for the 2013 plan year.

2014

- **Individual Requirement to Have Insurance:** Nearly all U.S. citizens and legal residents are required to maintain qualifying health coverage or pay a penalty.
- **Employer Shared Responsibility:** Employers with an average of at least 50 full-time or full-time equivalent employees who don't offer coverage or whose employee contributions exceed a certain percentage of the employee's income or do not provide minimum value could be subject to a penalty starting in 2014, if any full-time employee receives a premium tax credit toward purchasing his or her own coverage through an exchange.
- **Guaranteed Availability and Renewability:** All carriers in the individual and group markets will be required to offer all products approved for sale in a particular market and accept any individual or group that applies for any of those products. Plans and policies are guaranteed renewability. In the case of a plan sponsor in the small group market that is unable to comply with employer contribution or group participation rules, a carrier may limit the availability to an annual enrollment period of November 15 through December 15 of each year.
- **Health Insurance Exchanges:** State individual and small group health insurance exchanges become operational on Jan. 1, 2014. For states that do not establish a state-based exchange, a federally facilitated exchange will be operated in that state or a state may elect to establish a state/federal partnership exchange.
- **Essential Health Benefits (EHB):** Certain health benefits that are deemed "essential" must be offered by non-grandfathered individual plans and non-grandfathered fully insured small group plans offered both on and off the exchange in 2014. The final rule released by the U.S. Department of Health and Human Services (HHS) provides additional details including the *benchmark plan for each state*.
- **Annual Limits:** For plan years on or after Jan. 1, 2014, restricted annual limits on essential health benefits are no longer permitted.
- **Deductible Limits for Essential Health Benefits:*** For plan years beginning on or after Jan. 1, 2014, non-grandfathered, fully insured small group plans must limit deductibles to \$2,000 for individuals and \$4,000 for families. This applies only to in-network essential health benefits (EHBs). A health plan may exceed the deductible limit if it cannot reasonably reach a given level of coverage (metallic level) without doing so.
- **Out-of-Pocket Limits for Essential Health Benefits:*** For plan years beginning on or after Jan. 1, 2014, all non-grandfathered plans that cover essential health benefits (EHBs) must limit annual out-of-pocket member expenses for in-network EHBs. Expenses for EHBs including coinsurance, deductibles, copays and similar charges cannot exceed 2014 out-of-pocket limits set by the IRS for High Deductible Health Plans (HDHPs). The 2014 out-of-pocket limits for EHBs will be \$6,350 for self-only coverage and \$12,700 for family coverage. There are exceptions under a safe harbor for 2014.

2014 (Continued)

- **EHB Out-of-Pocket Limits for Carve Outs:*** For plan years beginning on or after Jan. 1, 2014, all non-grandfathered plans that cover essential health benefits (EHBs) administered by multiple service providers (i.e. prescription drug and medical) must cap the total of all member annual out-of-pocket expenses for EHBs at the limits set by the IRS for High Deductible Health Plans (HDHPs). However, a safe harbor for the 2014 plan year allows groups and issuers to maintain separate out-of-pocket maximums for EHBs administered by more than one service provider -- as long as they individually do not exceed \$6,350 for individual coverage and \$12,700 for family coverage. Member EHB expenses for medical/surgical and mental health/substance use disorder benefits must still cross-accumulate up to single out-of-pocket as required under federal mental health parity law.
- **Actuarial Value (Metal Levels):** Beginning in 2014, non-grandfathered health plans in the individual and small group markets will be measured in a way that allows consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider participation, and other factors, would help the consumer make an informed decision. This measurement is called the Actuarial Value (AV), or metal level. For example, if a plan has an AV of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of all covered benefits. The actuarial values are defined using metal levels: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan and 90 percent for a platinum plan. In addition, issuers may offer catastrophic-only coverage with lower AV for eligible individuals.
- **Pre-existing Conditions:** Beginning on the policy/plan date on or after Sept. 23, 2010, pre-existing condition limitations were waived for all enrollees up to age 19. Beginning on plan years on or after Jan. 1, 2014, pre-existing condition limitations will be eliminated for enrollees of all ages.
- **Waiting Periods:** Waiting periods for employees eligible for group coverage cannot be longer than 90 days for plan years starting on or after Jan. 1, 2014.
- **PCORI Fee:** The Patient-Centered Outcomes Research Institute fee increases to \$2 multiplied by the average number of lives covered under the plan or policy for plan or policy years ending on or after Oct. 1, 2013, and before Oct. 1, 2014.
- **Provider Non-discrimination:** Health care providers will not be prevented from participation in an insurer's provider network if willing to abide by the terms and conditions for participation and are acting within the limits of their medical license or certification.
- **Coverage for Clinical Trials:** For plan years beginning on or after Jan. 1, 2014, if a "qualified individual" is in an "approved clinical trial," the plan cannot deny coverage for related services. This only applies to non-grandfathered plans.
- **Tax Credits:** ACA increases the small business tax credit to 50 percent of employer cost for providing employee health coverage (35 percent for tax-exempt employers). Credits will only be available on plans offered through health insurance exchanges and will expire after an employer has received the credit for two years. Premium tax credits are also provided to qualifying individuals purchasing coverage on the exchanges.
- **Community Rating:** Health insurance issuers will only be allowed to vary rates based on geographic area, family size, age and tobacco use. State rating rules will still apply. Applies only to individual plans and small groups plans unless large group coverage is offered through the Health Insurance Exchange.
- **Insurer Fee:** The Health Insurer Fee is designed to help fund premium tax credits and/or cost-sharing subsidies for eligible individuals purchasing a qualified health plan through the exchange. This annual fee will be determined by the federal government and will be based on a health insurer's premiums from the previous year. Therefore, 2014 fees (due by Sept. 30, 2014) will be based on 2013 premiums. Exemptions exist for Medicare, self-funded groups, long-term care and others.
- **Dependent to Age 26 for Grandfathered Plans:** ACA requires group health plans and insurers that offer health insurance for dependent children to make coverage available for children (married or unmarried) until age 26. This provision is already effective under most policies; however, it does not fully apply to grandfathered group health plans until Jan. 1, 2014. For plan years beginning on or after Jan. 1, 2014, a grandfathered group health plan that offers dependent coverage for children may no longer exclude an adult child under age 26 from coverage if the child is eligible for another employer-sponsored health plan other than that of a parent. Note for BCBSIL insured groups: Due to the applicability of the Illinois Dependent Age Expansion requirement on an Illinois insured group, the group -- regardless of

2014 (Continued)

grandfathering – is already unable to restrict coverage to dependents that have coverage available through another employer-sponsored health plan.

- **Wellness Incentive Increases:** ACA changes the maximum reward that can be provided under HIPAA's health factor-based wellness program from 20 to 30 percent. The reward under such a program can be up to 30 percent of the cost of employee coverage. Additionally, the secretaries of Health and Human Services, Labor and Treasury can expand the reward up to 50 percent of cost of coverage if deemed appropriate.
- **The 3Rs:** Beginning in 2014, ACA will create three risk-mitigation programs (Transitional Reinsurance, Temporary Risk Corridors and Risk Adjustment) intended to stabilize premiums in the market as insurance reforms and exchanges are implemented. The benefits of these programs are targeted to the insured individual and small group markets; however, the cost of the Transitional Reinsurance program will impact the entire market for both fully insured and self-funded groups.
- **Transitional Reinsurance** is a temporary program (2014–2016) that provides partial reinsurance coverage for issuers that incur high claims costs for individual market enrollees. It will require all issuers and third-party administrators (on behalf of self-funded groups) to make contributions to a reinsurance entity to support payments to non-grandfathered individual market plans.
- **Risk Corridors** is a temporary program (2014–2016) that protects the uncertainty in rate setting by limiting health issuers' gains and losses in excess of 3 percent of target premiums. Issuers share the risk with the government and will receive either a portion of the gain or a subsidy for loss.
- **Risk Adjustment** is a permanent program that transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees (such as individuals with chronic conditions). The Risk Adjustment calculation will result in payments between insurance issuers. Risk Adjustment applies to individual and small group insured markets, on and off the exchange, for non-grandfathered plans.

2015

2016

2017

- **Public Exchanges Opened to Large Group:** Large Group (100+) may be allowed to use exchange beginning in 2017 if a state allows it.

2018

- **“Cadillac Plan” Tax:** ACA imposes a 40% excise tax on high-cost employer sponsored health coverage, or plans with an annual cost exceeding \$10,200 for individuals or \$27,500 for a family.

* This information is based on our current interpretation of the existing government rules and guidance. It is subject to change based on the availability of new information.

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