



Health Care Reform Implementation Timeline

The following timeline covers areas of the new health care reform statute that have direct implications on small businesses, their employees and their families. For a more comprehensive timeline that includes other provisions, such as changes to Medicare or the myriad new taxes on health insurers and others, please visit the [resources section](http://HealthReformToday.org) of HealthReformToday.org.

Began March 23, 2010:

1. Provides Medicare patients who face a gap in prescription drug coverage would receive a one-year, \$250 rebate to help pay for medication.
2. Allows individuals and groups to keep their “grandfathered” health plan status as long as the only changes made to the policy is adding or deleting employees or dependents.

By June 21, 2010:

1. Creates a \$5 billion temporary reinsurance program for employers to provide coverage for retirees over the age of 55 who are not eligible for Medicare (expires January 1, 2014).
2. Creates a \$5 billion temporary high-risk insurance pool for individuals with pre-existing medical conditions who have been uninsured for at least six months (expires Jan. 1, 2014).

By July 1, 2010:

1. Requires states and the Secretary of Department of Health and Human Services (DHHS) to develop information portal options consumers to gather uniform information on sources of affordable coverage, including an Internet site. Information must provide options for private health insurance, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.

Health Plan Years Beginning On or After September 17, 2010:

1. Insurance market reforms:
 - a. Bars rescissions (except for fraud or intentional misrepresentation), insurers from denying coverage to children under age 19 with pre-existing conditions, and lifetime caps on coverage.
 - b. Requires insurers to allow individuals to stay on their parents' policies until they turn 26.
 - c. Requires health insurance plans to cover preventive services with no co-pays, such as immunizations for children and cancer screenings for women.
2. Enacts new health plan disclosure and transparency requirements.

3. Plans can no longer discriminate in favor of highly compensated individuals. Subject to IRC Section 105(h).

October 1, 2010:

1. Creates \$200 million of grants for small employer-based wellness programs for FY 2011-2015.

Tax years 2010-2013:

1. Businesses with 10 or fewer full-time-equivalent employees earning less than \$25,000 a year on average will be eligible for a tax credit of 35 percent of health insurance costs for tax years 2010-2013. Companies with between 11 and 25 workers and an average wage of up to \$50,000 are eligible for partial credits. A modified tax credit will be available for two years beginning in 2014 through the exchange. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25 percent of the employer's contribution toward the employee's health insurance premium.

January 1, 2011:

1. Requires individual and small group market plans to spend 80 percent of premium dollars on medical services. Large group plans would have to spend at least 85 percent.
2. Increases the federal tax penalty on individuals who spend money from health-care savings accounts on ineligible medical expenses to 20 percent (from 10 percent).
3. Creates a voluntary long-term care program mirrored from the Community Living Assistance Services and Support (CLASS) Act. After at least five years of contributions, enrollees would be entitled to a \$50-a-day cash benefit to pay for long-term care. Employers would be required to automatically enroll employees wishing to participate.
4. Drug companies would provide a 50 percent discount on brand name prescription drugs for seniors who face a gap in drug coverage (i.e., the Medicare "doughnut hole"). More subsidies would be phased in through 2020, when the coverage gap would be closed.
5. Requires employers to report the aggregate cost of employer-provided health benefits on employees W-2s. If employee receives health insurance coverage under multiple plans, the employer must report the aggregate value, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.
6. Limits FSA contributions for medical expenses to \$2,500 per year and indexes the cap for inflation.
7. HRAs, FSAs and MSAs cannot be used to purchase over the counter medications unless they are physician prescribed.
8. Small employers will be allowed to adopt new "simple cafeteria plans." A new safe harbor from the nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained

by eligible employers to the extent certain requirements are met, such as (i) all “nonexcludable” employers are eligible to participate and (ii) certain minimum contributions requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two preceding years (provided it is a full year).

January 1, 2012:

1. Requires businesses to complete 1099 forms for every business-to-business transaction of \$600 or more. Extends reporting to include payments made to corporations other than corporations exempt from income tax under section 501(a). Also expands the kinds of payments subject to reporting to include reporting of the amount of gross proceeds paid in consideration for property or services.

January 1, 2013:

1. Limits the amount individuals can contribute to flexible savings accounts, which let people set aside money tax free for health costs, at \$2,500.
2. Increases the threshold for deducting itemized expenses for unreimbursed medical expenses from 7.5 percent of adjusted gross income to 10 percent.
3. The Medicare Hospital Insurance (HI) tax rate would increase by 0.9 percentage points -- from 1.45 percent to 2.35 percent -- on earnings over \$200,000 for individuals and \$250,000 for families (amounts not indexed). This does not change the employer HI tax obligation; however, self-employed individuals are not permitted to deduct any portion of the additional tax. Also, for the first time, a 3.8 percent Medicare HI tax would be imposed on unearned income for individuals making over \$200,000 and families making over \$250,000 (amounts not indexed).

January 1, 2014:

1. Employer Responsibilities:
 - a. Small businesses with less than 50 or less employees are exempt from any penalties associated with the free-rider statute. However, small businesses with more than 50 employees can be subject to the “free-rider” statute as followed:
 - i. If an employer with more than 50 employees offers qualified coverage to their employees and at least one employee qualifies for premium assistance based on income and receives the subsidy through the Exchange, the employer will be required to pass the lesser of \$3,000 for each of those employees receiving the premium subsidy in the Exchange or \$2,000 for each full-time employee.
 - ii. If an employer with more than 50 employees does not offer qualified coverage to their employees and at least one employee qualifies for premium assistance based on income and receives the subsidy through the Exchange, the employer will be required to

pay \$2,000 per full-time employee, excluding the first 30 employees from the assessment.

- b. An employer must provide “free-choice vouchers” to each employee who is required to contribute between 8 percent and 9.8 percent of their household income toward the cost of coverage, if the employee’s household income is less than 400 percent of the federal poverty line and the employee does not enroll in the employer’s coverage (i.e., the employee goes to the Exchange). The voucher’s value must be equal to the amount the employer would have otherwise provided towards the employees health coverage. The voucher must be used in the Exchange.
 - c. Businesses with 10 or fewer full-time-equivalent employees earning less than \$25,000 a year on average will be eligible for a tax credit of 50 percent of health insurance costs for two years. Companies with between 11 and 25 workers and an average wage of up to \$50,000 are eligible for partial credits. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35 percent of the employer’s contribution toward the employee’s health insurance premium.
 - d. Employers with more than 50 full-time employees are prohibited from requiring waiting periods in excess of 90 days for employee coverage.
 - e. Employers with more than 200 employees are required to automatically enroll employees into their health plan. Employees may opt out.
 - f. March 1, 2013 – Employers are required to provide notice to their employees informing them of the existence of an Exchange.
2. Individual Responsibilities:
- a. All American citizens and legal residents are required to purchase qualified health benefits.
 - i. Exceptions are provided based on religious objections, those who cannot afford the coverage (i.e., the offered coverage is more than 8 percent of an individual’s income), taxpayers with income under 100 percent of poverty, members of Indian tribes, those that can present hardship waivers, or those not covered for a period of less than three months during the year.
 - ii. Penalties for noncompliance are phased-in and would be either a flat dollar amount per person or a percentage of the individual’s income, whichever is higher.
 - iii. By 2016, the penalty structure would be the greater of \$695 per year up to a maximum of three times that amount (\$2,085 per family or 2.5 percent of household income).
3. Insurance market reforms:
- a. All coverage must be guaranteed issued and renewable. Exclusions based on preexisting conditions would be banned in all markets.
 - b. Modified community ratings standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions.

- c. Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
 - d. Small group market is redefined to 1-100 employees. States can reduce the number to 1-50 for plan years prior to January 1, 2016.
 - e. Requires each state to create American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges to facilitate the sale of qualified benefit plans, including the federally administered multi-state plans and non-profit co-operative plans. States can blend the SHOP exchange with the individual market or apply for other modifications with the DHHS.
 - f. Requires a catastrophic only policy to be offered in the Exchange for individuals 30 years and younger.
 - g. Establishes standards for an “essential benefits package,” which include mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60 percent.
4. Government Responsibility
- a. Creates a sliding-scale premium assistance tax credit for non-Medicaid eligible individuals with incomes up to 400 percent of the federal poverty line to buy coverage in the Exchange.
 - b. Medicaid eligibility is expanded in all states to 133 percent of the federal poverty line. Federal government picks up the entire cost of expansion until 2016 then begins phasing out.
 - c. Requires states to offer Medicaid wrap-around benefits to qualified individuals who receive employer sponsored health insurance, if cost effective.

January 1, 2015

- 1. States may form “health care choice compacts” and allow insurers to sell policies in any state participating in the compact. However, compacts may not take effect before January 1, 2016.

January 1, 2017

- 1. States may choose to allow large groups (over 100) to purchase coverage through the Exchanges.

January 1, 2018:

- 1. Imposes a 40 percent excise tax on insurers of employer-provided health plans with total values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs. Dental and vision benefits are excluded from the calculation. Starting in 2018, the aforementioned total value amounts will be indexed to inflation.