



HEALTH CARE REFORM TIMELINE

YEAR	PROVISION	DESCRIPTION
Effective 1/1/2010	Small business tax credit	<ul style="list-style-type: none"> Tax credits of up to 35% (25% non-profit) of employer's contribution for coverage if employer contributes at least 50% of premium. Credits phase out starting at <25 employees & annual average wages <\$50,000; full credit if <10 employees & <\$25,000 in annual wages.
Effective 6/23/2010	Temporary retiree reinsurance program	<ul style="list-style-type: none"> Federal government to reimburse early retiree health plans for up to 80% of "cost of claims" between \$15k and \$90k for early retirees age 55 – 64. Funds must be used to lower retiree cost of coverage. Program ends January 1, 2014, or earlier if funds are exhausted.
	National high-risk pool	<ul style="list-style-type: none"> High-risk pool will be established for individuals uninsured for 6 months with preexisting conditions. Expires 1/1/2014.
Effective Plan Years on/after 9/23/2010	Dependent coverage up to age 26*	<ul style="list-style-type: none"> Requires plans to allow married and unmarried dependent children to remain covered under their parents' health plan up to age 26, if the plan offers dependent coverage. Full-time student status not required. Contributions are tax-free. Grandfathered plans: adult children up to age 26 are ineligible for coverage on parent's plan if eligible for their own employer-sponsored coverage.
	Preventive services	<ul style="list-style-type: none"> Plans must cover certain preventive care services. Prohibits cost sharing for required preventive care services.
	Annual limits*	<ul style="list-style-type: none"> Restricted annual limits on essential benefits permitted through 2013 (scope of restrictions to be determined by Secretary of Health and Human Services). Annual limits prohibited completely effective 2014.
	Lifetime benefit limits*	<ul style="list-style-type: none"> Lifetime benefits limits on essential benefits are prohibited.
	Rescissions / cancellations prohibited*	<ul style="list-style-type: none"> Health plans are prohibited from rescinding coverage once an individual is enrolled, unless due to fraud or material misrepresentation.
	Appeal process	<ul style="list-style-type: none"> Internal appeals process required for fully-insured plans. External appeals process required for self-funded plans (HHS to set standards).
	Pre-existing condition exclusions for dependent children (under age 19) prohibited*	<ul style="list-style-type: none"> Plan cannot impose a pre-existing condition limitation for a dependent child under the age of 19.
	Prohibition Discrimination**	<ul style="list-style-type: none"> Fully insured group health plans may not discriminate in favor of highly compensated employees with regards to eligibility or benefits (must now satisfy self-insured plans nondiscrimination rules of Code Section 105(h)(2)).
	Increased limit for Adoption Assistance	<ul style="list-style-type: none"> The Annual limit on the tax-free reimbursement to employees for adoption expenses increased from \$10k to \$13,170.

* Certain provisions are subject to grandfathering, which may either delay or remove the effective date of compliance. Effective dates are preliminary and may be subject to change based on final regulations and guidance from HHS. Employer compliance will typically be required at the beginning of the plan year following the effective date of the provision.

** Enforcement delayed until regulations are published.



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Effective 1/1/2011	Summary of benefits**	<ul style="list-style-type: none"> Employers are required to distribute a summary of benefits to all enrollees prior to enrollment or re-enrollment and 60 days prior to any material modifications. The benefits summary is to be uniform, as developed by the HHS Secretary.
	Medicare rebate for “donut hole”	<ul style="list-style-type: none"> Provides a \$250 rebate to Medicare beneficiaries who reach the Medicare Part D coverage gap (“donut hole”). Phase down the coinsurance rate from 100% to 25% by 2020.
	Minimum medical loss ratios	<ul style="list-style-type: none"> Large group insurance issuers are required to spend at least 85% of premium on clinical services and activities that improve healthcare quality. Individual and small market insurance issuers are required to spend at least 80% of premium on clinical services and activities that improve healthcare quality. Insurers are required to rebate premiums if loss ratios do not meet the minimum thresholds.
	Long-term care program (CLASS)	<ul style="list-style-type: none"> Voluntary long term care insurance program available.
	Over-the-counter medications not reimbursable	<ul style="list-style-type: none"> Over-the-counter medications (not prescribed by a physician) are not reimbursable through a Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Archer Medical Savings Account (MSA).
	Increased excise tax for Health Savings Accounts	<ul style="list-style-type: none"> Excise tax increases from 10% to 20% for non-qualified distributions from an HSA.
Effective 1/1/2013	Increased Medicare payroll tax	<ul style="list-style-type: none"> 2.35% payroll tax for individuals who earn more than \$200k (\$250k for joint filers). 3.8% assessment on “unearned” income (interest, dividends, annuities, royalties, and rents) for individuals who earn more than \$200k (\$250k for joint filers).
	W-2 reporting of value of health care	<ul style="list-style-type: none"> The aggregate cost of employer-sponsored health coverage (including dental & vision) must be reported on the employee’s annual Form W-2.
	FSA’s limited to \$2,500 a year	<ul style="list-style-type: none"> Tax free contributions to a health FSA limited to \$2,500 per year. Limits will be adjusted annually for inflation.
	Medical device sales tax imposed	<ul style="list-style-type: none"> 2.3% sales tax on medical devices for medical devices manufacturers.
	Medicare Part D subsidy deduction eliminated	<ul style="list-style-type: none"> Discontinues existing tax subsidies for employers providing Medicare part D drug coverage to retirees.
Effective 1/1/2014	Waiting period restrictions	<ul style="list-style-type: none"> Prohibits an employer from applying a medical plan waiting period in excess of 90 days.
	“Essential benefits” plan effective	<ul style="list-style-type: none"> Secretary of HHS to specify minimum benefits and cost sharing for Essential Benefits, that include: (1) Ambulatory patient services; (2) Emergency services; (3) Hospitalization; (4) Maternity and newborn care; (5) Mental health and substance use disorder services, including behavioral health treatment; (6) Prescription drugs; (7) Rehabilitative and habilitative services and devices; (8) Laboratory services; (9) Preventive and wellness services and chronic disease management; (10) Pediatrics.

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Effective 1/1/2014	Insurance exchange	<ul style="list-style-type: none"> • State-based insurance Exchanges allowing small businesses (employers with 50 or fewer employees) and individuals to purchase coverage established by 2014. • Employers will be required to notify employees of the Exchanges and any potential eligibility for premium assistance (effective 2013). • Provides awards and grants to create non-profit co-ops for small employer and individual markets (effective 2013). • Federal subsidies for individuals with incomes of up to 400% of the Federal poverty level (would be \$88k in 2009 for a family of four).
	Employer mandate	<ul style="list-style-type: none"> • Employers are not mandated to provide coverage, but employers with more than 50 FT/FTE employees (> 30 hours +) may be subject to penalties if an employee receives subsidized individual coverage through an Exchange. • If an employer does not provide coverage: penalty is \$2k per employee, applied to the total number of FT employees minus 30. • If employer does provide coverage: penalty is \$3k per FT employee who receives subsidized individual coverage -OR- \$2,000 per FT employee in entire workforce; whichever is less. • Requires employers with 200 or more employees to automatically enroll employees into a health insurance plan.
	Free choice voucher	<ul style="list-style-type: none"> • Employers required to provide a “free choice voucher” to employees with household incomes less than 400% the Federal poverty level whose contribution for employer health coverage is between 8% and 9.5% of household income for a tax year. The voucher can be used to purchase coverage through an Exchange. • The voucher amount is equal to the cost the employer would have paid for coverage under the employer’s plan. • The employee may retain any excess voucher amounts that exceed the cost of the plan in the Exchange, tax-free, and this amount is deductible by the employer. • Employers providing vouchers are exempt from penalties for employees that receive premium subsidies in the Exchange.
	Individual mandate	<ul style="list-style-type: none"> • All US citizens and legal residents must have qualifying health insurance coverage. • Exemptions for religious objections and financial hardship. • Penalty for non compliance is: greater of 1.0% or \$95 in 2014; greater of 2.0% or \$395 in 2015; greater of 2.5% or \$695 in 2016 and indexed for inflation thereafter.
	Quality of Care Reporting	<ul style="list-style-type: none"> • Health plans are required to report on whether they satisfy quality-of-care standards developed by the Secretary. • Report submitted annually to plan participants and the government.
	Premium rates	<ul style="list-style-type: none"> • Small employers (<50 FTE) & individual premium rates may not vary based on gender. • Age based premium rates may not vary by more than 3:1 (oldest relative to youngest). • Tobacco user premium rates may not be more than 1.5 times non-tobacco rates.



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Effective 1/1/2014	Employer reporting requirements	<ul style="list-style-type: none"> Employers are required to report details regarding the health coverage provided to employees to the government and to plan participants. Details included in government reporting include but are not limited to: whether employer offers minimum essential coverage, the names of employees and dependents covered by the plan, the number of full-time employees, the length of any waiting period, the monthly premium of the lowest cost option and the employer's contribution.
	Pre-existing condition exclusions prohibited for all	<ul style="list-style-type: none"> Preexisting condition exclusion prohibited for all.
	Annual dollar limits prohibited on "essential benefits"	<ul style="list-style-type: none"> Annual limits on non-essential benefits may still be permitted. Additional rulemaking needed.
	Enhancement to Wellness Program incentives	<ul style="list-style-type: none"> Increases maximum permissible incentives for wellness programs from 20% to 30% of premium. Permissible award may be increased to 50% by Secretary of HHS for 2014. Incentives may be applied for participation or meeting certain health-related standards if alternative standards are allowed for those with medical conditions that prevent achievement of the health-related standard. Includes grants for small employers to establish programs. Requires chain restaurants (20 locations) and vending machines to display nutritional content.
Effective 1/1/2018	"Cadillac tax"	<ul style="list-style-type: none"> 40% excise tax applied to the value of employer-sponsored health coverage in excess of \$10,200 for individual coverage and \$27,500 for family coverage (\$11,850/\$30,950 for high-risk workers and retirees age 55 or older). Cost thresholds will be indexed to the consumer price index. Cost thresholds include reimbursement by health FSA or HRA, and employer contributions to an HSA, but excludes stand-alone dental and vision plans.

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