INSURANCE MANAGEMENT SERVICES

HEALTHCARE REFORM IMPLEMENTATION TIMELINE

September 2010 (Effective for all plans as they renew on September 23, 2010 and thereafter)

- No lifetime limits and only "restricted annual limits" on the value of the essential benefits*
- Annual or lifetime limits are allowed on non-essential benefits
- Prohibits cost sharing on preventive services and immunizations
- Requires Plans to maintain both internal and external appeals processes
- Prohibits the use of pre-existing condition exclusions on enrollees under age 19
- Rescissions (cancellations) are prohibited (except for fraud or intentional misrepresentation)
- Unmarried dependent coverage up to age 26. Self-funded plans do not have to provide coverage if dependent is eligible for other employer-sponsored coverage
- Requires coverage for Emergency Services without pre-authorization to be furnished as if in-network
- Prohibits plans from requiring authorization or referral for female patients seeking OB/GYN services

January 2011

- Employers are required to disclose costs of employer-sponsored health coverage on W-2
- Requires that non-taxable reimbursements from HSAs, HRAs and FSAs must be a prescribed medicine or insulin - no over the counter drugs without doctor's prescription will be allowed

January 2012

- Starting with all plans renewing on October 1, 2012, levies $1 per participant per year tax on all plans to fund Comparative Effectiveness Research. Levy is $2 per participant in 2013 through 2019

January 2013

- Limitation on Health FSA contributions to $2,500 per year
- Eliminates tax deductions for employers who maintain Rx plans to subsidize their Part D eligible retirees

January 2014

- Prohibits the use of pre-existing condition exclusions on all enrollees
- Prohibits the use of any annual maximums for Essential Benefits*
- Prohibits waiting periods greater than 90 days
- Employers with more than 200 employees must automatically enroll all eligible employees and each employee must be given the option to opt out of the plan
- Employer-sponsored vouchers begin. Vouchers are available for employees with income less than 400% of the FPL and employee contribution is between 8.0% and 9.8% of their annual income
- Employer Responsibility Mandates are established
- Prohibits dropping coverage or restricting routine care for participants in clinical trials
- If an employee buys insurance through the Health Insurance Exchange & receives subsidy, the employer pays $2000 per each Full-Time Equivalent
- States can provide premium assistance for Medicaid beneficiaries who are eligible for employer sponsor

January 2018

- 40% Excise Tax on "Cadillac" Plans

* Essential Benefits are benefits related to ambulatory patient services, emergency services, hospitalization, maternity & newborn care, mental health & substance abuse disorder services, prescription drugs, rehabilitation & habilitative services, laboratory services, preventive & wellness services and chronic disease management & pediatric services, including oral & vision care