AFFORDABLE CARE ACT TIMELINE

2010	2011	2013	2014	2015
Health plans that provide dependent coverage must make coverage available for dependents up to age 26	Medical loss ratio (MLR) rules apply to health insurer premium spending. Insurers with excessive ratios must pay consumer rebates each year starting in 2012	Improvements on HIPAA's electronic transaction rules start to be phased in	Individuals must obtain health insurance coverage or pay a penalty (some exemptions apply)	Applicable large employers with 100 or more FT and FTE employees must offer affordable, minimum value coverage to FT employees and their dependents or pay a penalty
Uninsured individuals with pre-existing conditions can obtain health insurance through a high-risk health insurance pool program	Employers must report health coverage costs on Form W-2 (optional for 2011; mandatory for later years; optional for small employers until further guidance)	Employers must provide a notice to employees regarding the insurance exchanges by Oct. 1, 2013	Health insurance Exchanges are available for individuals and small employers to purchase coverage	The employer shared responsibility rules will generally apply to employers with 50-99 FT and FTE employees starting in 2016
HHS established a website for individuals to identify affordable health insurance options in their state (www.healthcare.gov)	OTC medicine and drugs are "qualified medical expenses" for HSAs, FSAs and HRAs only if prescribed (except insulin)	Medicare Part D subsidy deduction eliminated	Health insurance companies may not discriminate against individuals based on health status	Limit on salary reduction contributions to health FSAs increases to $2,550, effective for plan years beginning on or after Jan. 1, 2015.
Early retiree reinsurance program provides reimbursement for a portion of the cost of providing health coverage for early retirees. Program was available for claims incurred before Jan. 1, 2012	Simple cafeteria plan provides small businesses with an easier way to sponsor a cafeteria plan	Income threshold for claiming itemized deduction for medical expenses increased	Health care tax credits available for eligible individuals with income below a certain threshold who purchase Exchange coverage	**2016**
Lifetime dollar limits on essential health benefits are prohibited. Annual dollar limits were restricted until 2014, when all annual dollar limits on essential health benefits are prohibited	Medicare Part D drug discounts start to be phased in for beneficiaries in the "donut hole" until the coverage gap is filled in 2020	Medicare hospital insurance tax rate for high wage workers increased	Health insurance providers fee and reinsurance fee take effect and increase annually (reinsurance fee effective 2014-2016) (providers fee will not be collected in 2017)	All applicable large employers must offer affordable, minimum value coverage to FT employees and their dependents or pay a penalty
Pre-existing condition exclusions are eliminated for children under age 19	Penalty tax increases on withdrawals from HSAs (prior to age 65) and Archer MSAs not used for qualified medical expenses	Medical device excise tax established (suspended for two years, in 2016 and 2017)	Health plans cannot impose waiting periods longer than 90 days	**2020**
Non-grandfathered health plans must cover certain preventive care services without cost-sharing	Free annual wellness visit for Medicare beneficiaries and elimination of cost sharing for preventive care services	Salary reduction contributions to health FSAs are limited to $2,500	No limits on annual dollar value of essential health benefits	High-cost plan excise tax established in 2020
Rescissions are prohibited in most cases; plan coverage may not be retroactively cancelled without prior notice to the enrollee	**2012**	By Dec. 31, 2013, employers must certify compliance with certain HIPAA transactions (deadline extended to Dec. 31, 2015)	Reforms related to the allocation of insurance risk through reinsurance, risk corridors and risk adjustment become effective	
Fully insured group health plans must satisfy nondiscrimination rules regarding participation and benefit eligibility (delayed until future regulations are issued)	Plans must provide SBC with the open enrollment period or plan year beginning on or after Sept. 23, 2012 (depending on type of enrollment)		Pre-existing condition exclusions prohibited for all enrollees	
Plans and issuers must adopt an improved internal claims and appeals process and comply with external review requirements (some rules were delayed until plan years	For plan years beginning on or after Aug. 1, 2012, plans and issuers must cover additional preventive care services for women without cost-sharing.		Insured plans in the small group and individual market must provide comprehensive benefits coverage (does not apply to	

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beginning on or after Jan. 1, 2012)	Exceptions to contraceptive coverage apply to religious employers		grandfathered plans)
First phase of the small business health care tax credit	For plan years ending on or after Oct. 1, 2012, issuers and self-insured health plans must pay PCORI fees		Some non-grandfathered health plans subject to cost-sharing limits (annual deductible limit repealed)
Rebates for the Medicare Part D "donut hole" sent to eligible enrollees			Second phase of small business tax credit

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