ACA Mandates by Year Through 2015

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ACA News: What's happened so far - provisions that took effect 2010-2014

March 17, 2015

The Affordable Care Act (ACA or health care reform law) changed how health care plans work and how people can get coverage. It also changed the way we do business and the way you serve your clients. Now more than ever, it's important to stay on top of what's changed, and prepare for what's ahead. That's why we bring you this first article in a series about health care reform — where we've been and where we're going from here. This article breaks down what happened and when, as health care reform rolled out.

As you know, not all parts of the law affect every line of business (Individual, Small Group, Large Group) or funding type (fully insured, self-funded). Also, not all laws were put in place at the same time. To help show the impact of health care reform, we've updated this easy-to-reference chart which details those provisions which have already been implemented as well as some which have been proposed for the future. The chart also includes a page which explains how the laws differ for plans sold on and off the exchange.

If a word, phrase or heading is highlighted in color and underlined, click on it for more details. Or check out the Library section on our health care reform website.

2010:

Children up to age 19 can't be denied coverage

This group can't be denied health care coverage due to health issues they've had in the past.

Young adults can stay on their parents' plans up to age 26

Teens and young adults can stay under their parents' health care plans up to age 26.

Annual and lifetime dollar limits are gone

Health care plans can't set a lifetime dollar limit on members' benefits – or an annual limit on certain types of benefits.

Changes to how claims are handled

If a health claim is denied, members can now challenge the decision.

Most plans cover preventive care at 100%

Certain checkups, generic drugs, shots and tests are covered – at no cost to members.

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2011:

Medical loss ratio (MLR)

Medical loss ratio is the percentage health insurance companies must spend on medical care. They must spend at least 85% of premiums on medical care in the fully insured large group market and 80% in the fully insured small group and individual markets. (States that got waivers to have a lower threshold for the individual markets are required to meet the percentage in the waiver.) In 2012 the first MLR rebate checks were sent. Self-funded, or ASO, plans are exempt.

Emergency care (ER) costs

Members don't need special approval (prior authorization) for ER care. They also won't pay a higher copay or coinsurance for out-of-network ER care.

2012:

Summary of Benefits and Coverage (SBC)

All insurance companies now send the same type of easy-to-understand coverage summary to help people better understand their health benefits. Learn about the different parts of the SBC.

2013:

A new fee to pay for research

Health plan issuers and sponsors pay a comparative effectiveness research fee. This fee helps the government better understand the effectiveness, risks and benefits of treatments. This began for plan years ending October 1, 2012, and later. See all fees in this chart.

Limits to flexible spending accounts

Workers can only add up to $2,500 per year to their accounts for qualified medical expenses.

Notices to workers

Businesses must tell workers about the Health Insurance Marketplace (also known as the exchange). It is one more way for workers to compare and buy health care plans. Businesses must also tell workers how to get help with costs through subsidies and tax credits.

W-2 reporting of health care plans

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Businesses must report the value of their health care plans on W-2 forms. This was optional in 2012. In 2013, employers were required to report the value if they had 250 W-2s. Employers with less than 50 W-2s had until 2014 to show the value. Although employers must report this, the value is not taxed.

2014:

Individual mandate kicked in

The law says all legal U.S. residents must have basic health coverage, if they can pay for it.

Employers must offer "minimum essential coverage"

By 2014, businesses had to offer "minimum essential coverage" if they have 50 or more full-time workers. The U.S. Chamber of Commerce developed this penalty calculator to help determine whether companies must offer coverage and what the penalty might be based on the number of full-time employees. Penalties were delayed until 2015. Employers with 50 to 99 full-time workers do not have to offer minimum value, affordable health insurance until 2016, if they meet certain conditions.

New fees impact coverage

The insurer fee is built into the cost of fully insured coverage but doesn't apply to self-funded plans. This fee funds premium subsidies and Medicaid expansion. Another fee called the reinsurance fee applies to both fully insured and self-insured plans. It aims to stabilize premiums for coverage in the individual market and lower the effects of adverse selection. See all fees in this chart.

No bias for workers

Health care plans can't be better for highly paid workers. Health care plans can't be based on eligibility, the level of benefits or on a worker's wage.