

Health Insurance Reform at a Glance Implementation Timeline

2010

Access to Insurance for Uninsured Americans with a Pre-Existing Condition. Provides uninsured Americans with pre-existing conditions access to coverage. The temporary high-risk pool will serve as a bridge to when the new health insurance Exchanges are up and running, at which point insurance companies will no longer be able to deny coverage based on pre-existing conditions. *Effective 90 days after enactment.*

Small Business Health Insurance Credit. Provides a tax credit for qualified small businesses to help them afford insurance coverage for their workers. The credit is up to 35 percent of the employer's contribution to the employees' health insurance. There is also up to a 25 percent credit for small nonprofit organizations. *Effective taxable year 2010.* (In 2014, when health insurance Exchanges are operational, tax credits will be up to 50 percent of premiums, and up to 35 percent for non-profits.)

No Discrimination Against Children With Pre-Existing Conditions. Prohibits new health plans in all markets and grandfathered group health plans from denying access to and coverage of children with preexisting conditions up to age 19. *Effective 6 months after enactment.* ** (Beginning in 2014, or upon expiration of the current union contract, collectively bargained group plans will not be allowed to deny coverage for pre-existing conditions for all individuals.)

Relief for Seniors Who Hit the Medicare Part D 'Donut Hole.' Provides a \$250 rebate check for Part D enrollees who hit the gap in prescription drug coverage known as the 'donut hole.' Currently, the coverage gap falls between \$2,830 and \$6,440 in total drug spending. *Effective calendar year 2010.* (Beginning in 2011, seniors who reach the donut hole will get a 50 percent discount on brand-name drugs and gradually increasing discounts on generic drugs. A typical senior who hits the donut hole will save over \$700 in 2011, and over \$3,000 by 2020. ** The donut hole coverage gap in the Medicare prescription drug benefit will be closed completely by 2020. Seniors continue to pay the standard 25 percent of drug costs until they reach the threshold for Medicare catastrophic coverage, when their co-payments drop to five percent.

Prohibits Dropping Coverage When People Get Sick. Prevents insurance companies from withdrawing coverage when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs. ** (In the first plan year after September 2010, or upon expiration of the current union contract, whichever is later, collectively bargained plans will not be allowed to rescind coverage.) *Effective six months after enactment and applying to all plans.*

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Eliminating Lifetime Limits on Insurance Coverage. Prohibits insurers from imposing lifetime limits on benefits. ******(In the first plan year after September 2010, or upon expiration of the current union contract, whichever is later, collectively bargained plans will not be allowed to have lifetime limits.) *Effective six months after enactment and applying to all plans.*

Prohibits the use of restrictive annual limits. ****** (In the first plan year after September 2010, or upon expiration of the current union contract, whichever is later, annual limits will be restricted. Beginning in 2014 or upon expiration of the current union contract, whichever is later, collectively bargained group plans will not be allowed to have annual limits.)

Covering Preventive Health Services. All new plans must cover preventive services at no charge by exempting these benefits from deductibles and other cost-sharing requirements. *Effective six months after enactment.*

Improving Preventive Health Benefits. Requires State Medicaid programs to cover tobacco cessation services for pregnant women. *Effective Fiscal Year 2011.*

Extending Coverage for Young Adults. Requires health plans that provide coverage for children to continue to make that coverage available until the child turns 26 years of age. ******In the first plan year after September 2010, or upon expiration of the current union contract, whichever is later, adult children up to age 26 must be allowed to enroll in their parent's plan if they have no employer offer of coverage. Beginning in 2014 or upon expiration of the current union contract, whichever is later, adult children up to age 26 must be allowed to enroll in their parent's plan, regardless of whether they have an employer offer of coverage. *Effective for plans starting six months after enactment.*

Bringing Down the Cost of Health Care Coverage. With the exception of employers that self-insure, all health plans must report on the share of premium dollars spent on medical care versus other expenses, such as salaries and administrative costs – their medical loss ratio (MLR). Beginning not later than January 1, 2011, plans that spend too much on overhead must provide consumer rebates if they fail to meet the MLR standard. *Reporting requirement effective for plan years starting 6 months after enactment; consumer rebate requirement begins not later than January 1, 2011.*

Reducing the Cost of Covering Early Retirees. Creates a new temporary reinsurance program (until 2014 when the health insurance Exchanges are available) to help offset the costs of expensive premiums for employers and retirees for health benefits for retirees age 55-64. *Effective 90 days after enactment.*

Holding Insurance Companies Accountable for Unreasonable Rate Hikes. Creates a grant program to support States in requiring health insurance companies to submit justification for requested premium increases, and insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges. *Starting in plan year 2011.*

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Reducing Barriers to Providing Home and Community-Based Services (HCBS) in Medicaid. Gives States more flexibility to provide HCBS and to extend full Medicaid benefits to individuals receiving these services. *Effective the first day of the quarter after the date of enactment, or April 1, 2010.*

Strengthening Community Health Centers. Provides funds to build new and expand existing community health centers. *Effective Fiscal Year 2011.*

Strengthening the Primary Care Workforce. Expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas participating in the National Health Service Corps. *Effective Fiscal Year 2011.*

Ensuring An Effective Appeals Process for a Denial of Coverage. Requires new plans to implement an effective internal and external appeals process for coverage determinations and claims. *Effective six months after enactment.*

Improving Consumer Information through the Web. Requires the Secretary of Health and Human Services to establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State. *Effective not later than July 1, 2010.*

Improving Consumer Assistance. Requires the Secretary of Health and Human Services to award grants to States to establish health insurance consumer assistance or ombudsman programs to receive and respond to inquiries and complaints concerning health insurance coverage. *Effective upon enactment.*

Cracking Down on Health Care Fraud. Requires enhanced screening procedures for health care providers to reduce fraud and waste in Medicare, Medicaid, and CHIP. *Many provisions are effective on the date of enactment.*

Improving Public Health Prevention Efforts. Creates an interagency council to promote healthy living and establishes a Prevention and Public Health Fund with \$15 billion in funding over ten years to provide an expanded and sustained national investment in prevention and public health programs. *Interagency council must submit first Report on its activities and progress by July 1, 2010 and funding appropriations begin in Fiscal Year 2010.*

Extending Payment Protections for Rural Providers. Extends Medicare payment protections for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients, but play a vital role in their communities. *Effective calendar year 2010.*

Ensuring Medicaid Flexibility for States. A new option will take effect allowing States to cover individuals up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance Percentage (FMAP). *Effective April 1, 2010.*

Expanding the Adoption Credit and Adoption Assistance Program. Increases the adoption tax credit and adoption assistance exclusion by \$1,000, makes the credit refundable,

and extends the credit through 2011. *Effective for tax years beginning after December 31, 2009.*

Encouraging Investment in New Therapies. A two-year temporary credit subject to an overall cap of \$1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. *Available for qualifying investments made in 2009 and 2010.*

Providing Tax Relief for Doctors, Nurses, and Other Health Professionals with State Loan Repayment. Excludes from taxable income payments made under any State loan repayment or loan forgiveness program that is intended to increase the availability of health care services in underserved or health professional shortage areas. *Effective for amounts received by an individual in taxable years beginning after December 31, 2008.*

Establishing a National Health Care Workforce Commission. Establishes an independent National Commission to provide comprehensive, objective information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs. *Effective not later than September 30, 2010.*

Strengthening the Health Care Workforce. Expands and improves low-interest student loan programs, scholarships, and loan repayments for health students and professionals to increase and enhance the capacity of the workforce to meet the range of patients' health care needs. *Effective calendar year 2010.*

Special Requirements for Blue Cross Blue Shield (BCBS). Requires that non-profit BCBS organizations devote 85 percent or more of their premium dollars to patient care in order to take advantage of the special tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves. *Effective for tax years beginning after December 31, 2009.*

2011

Discounts in the Part D 'Donut Hole.' Provides a 50 percent discount on all brand-name drugs and biologics in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for Part D enrollees. *Effective January 1, 2011.*

Improving Medicare Preventive Health Coverage. Provides a free, annual wellness visit and personalized prevention plan services and zero cost-sharing for certain preventive services. *Effective January 1, 2011.*

Increasing Reimbursement for Primary Care Practitioners. Provides a 10 percent Medicare bonus payment to primary care practitioners for primary care services, and provides a 10 percent Medicare bonus payment to general surgeons for major surgical procedures provided in health professional shortage areas. *Effective for services provided from January 1, 2011 up to January 1, 2016.*

Improving Health Care Quality and Efficiency. Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals. *Effective January 1, 2011.*

Providing New, Voluntary Options for Long-Term Care Insurance. Creates a long-term care insurance program to be financed by voluntary payroll deductions to provide cash benefits to adults who become disabled. *Effective January 1, 2011.*

Improving Transitional Care for Medicare Beneficiaries. Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries following hospital discharge. *Effective January 1, 2011.*

Transitioning to Reformed Payments in Medicare Advantage. Establishes greater financial parity between Medicare Advantage (MA) and traditional Medicare coverage while better aligning MA payments with the local costs of health coverage. Provides for quality bonus payments to high-quality plans in all areas, so that Medicare beneficiaries and taxpayers are paying for greater value and quality, rather than merely subsidizing the profits of insurance companies. *Effective January 1, 2011.*

Increasing Training Support for Primary Care Doctors. Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites. *Effective July 1, 2011.*

Increasing Access to Home and Community Based Services. Establishes a new Community First Choice Option, which allows States to offer home and community based services to disabled individuals through Medicaid rather than institutional care. *Effective October 1, 2011.*

Strengthening Health Care Quality. Directs HHS to develop a national quality strategy and support quality measure development and endorsement for Medicare, Medicaid and CHIP quality improvement efforts. *Strategy submitted not later than January 1, 2011.*

Continuing Innovation and Lower Health Costs. Establishes an Independent Payment Advisory Board of medical experts to develop and submit proposals to Congress and the private sector aimed at extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care.

2012

Encouraging Integrated Health Systems. Implements physician payment reforms that enhance payment for primary care services and encourage physicians to join together to form “accountable care organizations” to gain efficiencies and improve quality.

Linking Payment to Quality Outcomes. Establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Also, requires the Secretary to submit a plan to Congress by the beginning of fiscal year 2012 on how to move home health agencies and skilled nursing facilities and ambulatory surgical centers into a value-based purchasing payment system.

Reducing Avoidable Hospital Readmissions. Directs CMS to track hospital readmission rates for certain high-cost conditions and implements a payment penalty for hospitals with the highest readmission rates.

Reducing Paperwork and Administrative Costs. Requires health plans to adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

2013

Improving Preventive Health Coverage. Creates financial incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing.

Encouraging Provider Collaboration. Establishes a national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.

Increasing Medicaid Payment for Primary Care Doctors. Requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services, and fully federally fund any additional state costs.

Limiting Executive Compensation. Limits the deductibility of executive compensation under the tax code for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements. The deduction is limited to \$500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. This provision is effective beginning in 2013 with respect to services performed after 2009.

2014

Reforming Health Insurance Regulations. Implements strong health insurance reforms that prohibit insurance companies from refusing to sell coverage or renew policies based on an individual's health status. Insurers can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Premiums can vary only by age (no more than 3:1), geography, family size, and tobacco use.

Eliminating Annual Limits on Insurance Coverage. Prohibits new plans in the individual market and all employer plans from imposing annual limits on the amount of coverage an individual may receive.

Ensuring Coverage for Individuals Participating in Clinical Trials. Prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

Establishing Health Insurance Exchanges. Opens health insurance Exchanges in each State to the individual and small group markets. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and qualifies individuals for tax credits that make coverage more affordable.

Ensuring Choice through a Multi-State Option. Provides a choice of coverage through at least two multi-State plans offered through the Exchange, available nationwide, and offered by private insurance carriers under the supervision of the Office of Personnel Management.

Providing Premium Tax Credits and Cost-Sharing Reductions. Makes premium tax credits and cost-sharing reductions available through the Exchanges to help people obtain affordable coverage. Premium credits are available for people with incomes above 100 percent and below 400 percent of poverty (\$88,000 for a family of four) who are not eligible for or offered other qualified coverage. The premium credits and cost-sharing reductions aim to ensure that no family faces bankruptcy due to medical expenses again.

Ensuring Choice through Free Choice Vouchers. Workers who qualify for an affordability exemption to the individual responsibility policy can take their employer contribution and purchase an Exchange plan.

Promoting Individual Responsibility. Requires most individuals who can afford it to obtain acceptable health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, they will be eligible for an exemption.

Increasing Access to Medicaid. Medicaid eligibility will increase to 133 percent of poverty for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive 100 percent federal funding for the first three years of this coverage expansion.

Additional Funding for the Children's Health Insurance Program (CHIP). States will receive two more years of funding (in FY 2014 and FY 2015) to continue coverage for children not eligible for Medicaid.

Small Business Tax Credit. Implements the second phase of the small business tax credit for qualified small businesses. The credit is up to 50 percent of the employer's contribution to provide health insurance for employees. There is also up to a 35 percent credit for small nonprofit organizations.

Quality Reporting for Certain Providers. Places certain providers – including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, PPS-exempt cancer hospitals, and hospice providers – on a path toward value-based purchasing by requiring the Secretary to implement quality measure reporting programs in these areas and also pilot test value-based purchasing for each of these providers in subsequent years.

2015

Continuing Innovation and Lower Health Cost. Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector aimed at extending the solvency of Medicare, lowering health care costs, improving health outcome for patients, promoting quality and efficiency, and expanding access to evidence-based care.

Paying Physicians Based on Value Not Volume. Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

2018

Excise Tax on High Cost Employer-Sponsored Health Coverage. This bill levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan with an annual premium that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage. The revenue collected by the tax is reduced by 80 percent as compared to the original Senate-passed bill. The tax is effective in 2018 and applies to the amount of the premium in excess of the dollar threshold. The tax applies to self-insured plans and plans sold in the group market, and does not apply to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals.) Stand-alone dental and vision plans are disregarded in applying the tax. An additional threshold amount of \$1,650 for single coverage and \$3,450 for family coverage applies for retired individuals age 55 and older and for plans that cover employees engaged in high-risk professions. The dollar amount thresholds are automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office Estimates in 2010. Employers with age and gender demographics that result in higher premiums are allowed to value the coverage provided to employees using the rates that would apply using a national risk pool. The dollar thresholds are indexed to inflation.

2020

****Ends the doughnut hole coverage gap in the Medicare prescription drug benefit. Seniors continue to pay the standard 25 percent of drug costs until they reach the threshold for Medicare catastrophic coverage, when their co-payments drop to five percent.**

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