Health Care Reform ...

What’s Happening — When

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Insurance Reforms
- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the HHS secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers, including local governments, providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until Jan. 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective Jan. 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.
- HHS secretary begins to set standards for establishing and operating state-based Exchanges for individuals and standards for a state-based Small Business Health Options Program (SHOP) Exchange. For a SHOP Exchange, a small employer is defined as having one to 100 employees. States can limit SHOP exchange to employers with 50 employees until 2016. Beginning in 2010 and through 2014, HHS could award grants to states for planning and implementation of a state-based Exchange.

Medicare
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.
- Medicaid
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- States subject to a maintenance of effort (MOE) on Medicaid eligibility, standards, methodologies and procedures until an Exchange is operational in the state. States are also subject to a MOE on eligibility standards, methodologies and procedures for all children in Medicaid and in the Children’s Health Insurance Program (CHIP), until Sept. 30, 2019. An exception to the MOE is permitted for eligibility policies applying to optional non-pregnant, non-disabled adults with incomes above 133 percent of the FPL for the period Jan. 1, 2011 through Dec. 31, 2013 if the state certifies it has run projects a budget deficit.

Quality Improvement
- Support comparative effectiveness research by establishing a nonprofit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce
- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

Tax Changes
- Impose additional requirements on nonprofit hospitals to provide charity care, and to conduct and implement a community health needs assessment in consulta
tion with community leaders and public health experts. Impose a tax of $50,000 per year for failure to meet these requirements.
- Impose a tax of 10% on the amount paid for indoor tanning services.

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Long-term Care
- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice
- Award five-year demonstration grants to states to develop, implement and evaluate alternatives to current tort litigations.

Public Health, Prevention and Wellness
- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the U.S. Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation’s health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare
- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians, and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Reduce annual market basket updates for Medicare providers beginning in 2011.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid
- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutional based long-term care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement
- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Tax Changes
- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
Where will health care be five years from now?

2012

Medicaid
- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective Jan. 1, 2012 through Dec. 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective Jan. 1, 2012 through Dec. 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective Oct. 1, 2011 through Dec. 31, 2015).

Quality Improvement
- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability, status, and for underserved rural and frontier populations.

2013

Insurance Reforms
- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)

- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective Jan. 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective Jan. 1, 2013), and health claims and equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective Jan. 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Medicaid
- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement
- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals and medical supplies.

Tax Changes
- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.

2014

Individual and Employer Requirements
- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms
- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or nonprofit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee-issue and renewability, and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
  - 100–200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
  - 200–300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
  - 300–400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a nonprofit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create Basic Health Plans for uninsured individuals with incomes up to 133–200% FPL based on modified adjusted gross income (MAGI) with 100% FMAP for newly eligible.
- Require qualified health plans to cover high-risk individuals.
- Reduce states’ Medicaid DSH allotments by $600 million in 2015; $600 million in 2016; $1.8 billion for 2017; $5 billion for 2018; $5.6 billion for 2019 and $4 billion for 2020.

Prevention/Wellness
- Permit employers to offer employee rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes
- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. (Effective Jan. 1, 2018)

2015

Medicaid
- Expand Medicaid to all individuals under age 65 (children, pregnant women, parents and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) with 100% FMAP for newly eligible.
- Reduce states’ Medicaid Disproportionate Share Hospital (DSH) allotments by $500 million.

Prevention/Wellness
- Potential savings of $40 billion over 10 years through Dec. 31, 2015)

Tax Changes
- Impose fees on the health insurance sector.

Medicaid
- 100% FMAP for newly eligible in 2015 and 2016; 95% in 2017; 94% in 2018; 93% in 2019 and 90% in 2020 and each year thereafter.
- Reduce states’ Medicaid DSH allotments by $600 million in 2015; $600 million in 2016; $1.8 billion for 2017; $5 billion for 2018; $5.6 billion for 2019 and $4 billion for 2020.

Sources
- The Patient Protection and Affordable Care Act (H.R. 3590)
- The Kaiser Commission on Medicaid and the Uninsured and the Health Care Market Place Project. Publication Number: 8060, March 25, 2010
- National Governors Association, Implementation Timeline for Federal Health Reform Legislation (Discussion Draft), March 17, 2010