AFFORDABLE HEALTH CARE FOR AMERICA

HEALTH INSURANCE REFORM AT A GLANCE

IMPLEMENTATION TIMELINE

2010

Immediate Access to Insurance for Uninsured Individuals with a Pre-Existing Condition. Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when Exchanges are operational.

Small Business Tax Credit. Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also a credit of up to 25 percent for small nonprofit organizations.

Eliminating Pre-Existing Condition Exclusions for Children. Bars all employer plans and new plans in the individual market from imposing pre-existing condition exclusions on children's coverage.

Prohibiting Rescissions. Prohibits abusive practices whereby health plans rescind existing health insurance policies when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs.

Eliminating Lifetime Limits and Restricting Use of Annual Limits. Prohibits all health plans from placing lifetime limits on coverage, and prohibits the use of restrictive annual limits in all employer plans and new plans in the individual market.

Covering Preventive Health Services. All new group health plans and plans in the individual market must provide first dollar coverage for preventive services.

Extending Dependent Coverage. Requires all plans in the individual market and new employer plans that provide dependent coverage for children to continue to make that coverage available up to age 26; for existing employer plans, this applies only to young people not offered their own employer-provided coverage.

Reducing the Cost of Covering Early Retirees. Creates a new temporary reinsurance program (until the Exchanges are available) to help offset the costs of expensive claims for employers and retirees, for health benefits for retirees age 55-64.

New, Independent Appeals Process. Requires that any new group health plan or new plan in the individual market implement an effective internal and external appeals process for coverage determinations and claims.

Improving Consumer Assistance. Provides aid to states in establishing offices of health insurance consumer assistance in order to help individuals with the filing of complaints and appeals.

Improving Consumer Information through the Web. Requires the Secretary of HHS to establish an Internet website through which residents of any State may identify affordable health insurance coverage options in that State.

Cracking Down on Health Care Fraud. Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

Rebates for the Part D "Donut Hole". Provides a $250 rebate for all Part D enrollees who enter the donut hole. Currently, the coverage gap falls between $2,700 and $6,154 in total drug costs.

Improving Public Health Prevention Efforts. Creates an interagency council to promote healthy policies at the federal level and establishes a prevention and public health investment fund to provide an expanded and sustained national investment in prevention and public health programs.

Strengthening the Quality Infrastructure. Additional resources provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid and CHIP quality improvement programs.

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 an important role in their communities.

Establishing a Patient-Centered Outcomes Research Institute. Establishes a private, non-profit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.

Ensuring Medicaid Flexibility for States. A new option allowing States to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance Percentage (FMAP) will take effect.

Non-Profit Hospitals. Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments.

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. The enhancements are 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. The credit would be available for qualifying investments made in 2009 and 2010.

Tax Relief for Health Professionals with State Loan Repayment. Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

Excluding from Income Health Benefits Provided by Indian Tribal Governments. Excludes from gross income the value of specified Indian tribal health benefits. The provision is effective for benefits and coverage provided after the date of enactment.

Establishing a National Health Care Workforce Commission. Establishes an independent National Commission to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for aligning federal health care workforce resources with national needs.

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 patients' health care needs.

Special Deduction for Blue Cross Blue Shield (BCBS). Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher 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.

Indoor Tanning Services Tax. Imposes a ten percent tax on amounts paid for indoor tanning services in lieu of the tax on cosmetic surgery. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. The tax would be effective for services on or after July 1, 2010.

Holding Insurance Companies Accountable for Unreasonable Rate Hikes. Creates a grant program to support States in requiring health insurance companies to submit justification for unreasonable premium increases starting in plan year 2010, and insurance companies with excessive or unjustified premium increases between 2010 and 2014 could be prohibited from participating in the new Health Insurance Exchanges.

2011

Bringing Down the Cost of Health Care Coverage. Health insurers, including grandfathered plans, must annually report on the share of premium dollars spent on medical care as opposed to profits or administration and provide consumer rebates where less than 80 to 85 percent of dollars are used for benefits.

Strengthening Community Health Centers and the Primary Care Workforce. Provides funds to build new and expand existing community health centers, and expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas.

Increasing Reimbursement for Primary Care. Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons.

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

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.

Improving Preventive Health Coverage. Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and requires new plans to cover preventive services with little to no

cost sharing. Creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing, and requires coverage of tobacco cessation services for pregnant women.

Improving Transitional Care for Medicare Beneficiaries. Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

Expanding Primary Care, Nursing, and Public Health Workforce. Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce. Ensures that public health challenges are adequately addressed.

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

Transitioning to Reformed Payments in Medicare Advantage. Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.

Discounts in the Part D "Donut Hole": Provides a 50 percent discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.

Reporting Health Coverage Costs on Form W-2: Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Standardizing the Definition of Qualified Medical Expenses. Conforms the definition of qualified medical expenses for HSAs, FSAs, and HRAs to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Increased Additional Tax for Withdrawals from Health Savings Accounts and Archer Medical Savings Account Funds for Non-Qualified Medical Expenses. Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses would increase from 15 to 20 percent.

Cafeteria Plan Changes. Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees. This would ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from nondiscrimination requirements applicable to highly compensated and key employees.

Pharmaceutical Manufacturers Fee. Imposes an annual, non-deductible fee on the pharmaceutical manufacturing industry allocated according to market share and not applying to companies with sales of branded pharmaceuticals of $5 million or less.

2012

:ouraging 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 2012 on how to move home health and nursing home providers into a value-based purchasing payment system.

Reducing Avoidable Hospital Readmissions. Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions and uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

2013

Payments to Primary Care Physicians. Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014. Provides 100% federal funding for the incremental costs to States of meeting this requirement.

dministrative Simplification. Health plans must adopt and implement uniform standards and business rules r the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

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.

Limiting Health Flexible Savings Account Contributions. Limits the amount of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Eliminating Deduction for Employer Part D Subsidy. Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Increased Threshold for Claiming Itemized Deduction for Medical Expenses. Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10 percent. Individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Additional Hospital Insurance Tax for High Wage Workers. Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married filing jointly). Expands the taxable base to include net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).

Medical device excise tax. Establishes a 2.3 percent excise tax on the sale of a medical device by a manufacturer or importer. Exempted from the tax are eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.

Limiting Executive Compensation. Limits the deductibility of executive compensation under Section 162(m) 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.

Fee for patient-centered outcomes research. Annual fee becomes effective on insured and self-insured plans to fund the patient-centered outcomes research trust fund.

2014

Reforming Health Insurance Regulations. Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. Health plans 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 heath status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use.

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

Ensuring Coverage for Individuals Participating in Clinical Trials. Prohibits new health plans 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 individuals and small employers. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.

Ensuring Choice through a Multi-State Option. Provides a choice of coverage through a multi-State plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

Providing Health Care Tax Credits. Makes premium tax credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for or offered other acceptable coverage. They apply to both premiums and cost-sharing 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 but do not qualify for tax credits can take their employer contribution and join an Exchange plan.

Promoting Individual Responsibility. Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of $95 for 2014, $325 for 2015, $695 for 2016 (or, up to 2.5 percent of income in 2016), up to a cap of the national average bronze plan premium. Families will pay half the amount for children, up to a cap of up to a cap of $2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized.

Promoting Employer Responsibility. Requires employers with 50 or more employees who do not offer coverage to their employees to pay $2,000 annually for each full-time employee over the first 30 as long as one of their employees receives a tax credit. Precludes waiting periods over 90 days. Requires employers who offer coverage but whose employees receive tax credits to pay $3,000 for each worker receiving a tax credit up to an aggregate cap of $2000 per full-time employee.

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 increased federal funding to cover these new populations.

Small Business Tax Credit. Continues the second phase of the small business tax credit for qualified small employers.

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.

Health Insurance Provider Fee. Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2015

Continuing Innovation and Lower Health Costs. 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 outcomes 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-provided health plans becomes effective. Tax is on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (single coverage), increased to $30,950 (family) and $11,850 (single) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.