Healthcare Reform Implementation Timeline

Reflecting the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act

2010

Immediate Access to Insurance for Individuals who are Uninsured for 6 or more months 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 new Exchanges are operational. Effective 90 days after enactment.

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 up to a 25 percent credit for small nonprofit organizations. *Effective calendar year 2010.* (Later, when Exchanges are operational, tax credits will be up to 50 percent of premiums.)

Eliminating Pre-Existing Condition Exclusions for Children. Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage. *Effective six months after enactment and applying to all employer plans and new plans in the individual market.* (This provision will apply to all people in 2014).

Rebates for the Medicare Part D "Donut Hole." Provides a $250 rebate check for all Part D enrollees who enter 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, institutes a 50 percent discount on brand-name drugs and begins generic coverage in the donut hole; fills the donut hole by 2020.)

Prohibiting Rescissions. Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs. *Effective six months after enactment and applying to all new and existing plans.*

Eliminating Lifetime Limits. Prohibits insurers from imposing lifetime limits on benefits. *Effective six months after enactment and applying to all plans.*

Regulating Use of Annual Limits. Tightly regulates plans' use of annual limits to ensure access to needed care in all group plans and all new individual plans. These tight restrictions will be defined by the Secretary of Health and Human Services. *Effective six months after enactment and applying to new plans in the individual market and all employer plans.* (When the Exchanges are operational in 2014, the use of annual limits will be banned for new plans in the individual market and all employer plans.)

Covering Preventive Health Services. All new group health plans and plans in the individual market must provide first dollar coverage for preventive services. *Effective six months after enactment.*

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

Extending Coverage for Young Adults. Requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available until the child turns 26 years of age. *Effective six months after enactment.*

Bringing Down the Cost of Health Care Coverage. Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care and provide consumer rebates for excessive medical loss ratios. *Effective January 1, 2011*

Reducing the Cost of Covering Early Retirees. Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 offset the expensive cost of that coverage. *Effective 90 days after enactment.*

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 undeserved areas participating in the National Health Service Corps. *Effective Fiscal Year 2011.*

Improving Consumer Assistance. Requires that any new group health plan or new plan in the individual market implement an effective appeals process for coverage determinations and claims. *Effective six months after enactment.*

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. The website will also include information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits, and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans will be precluded from listing their policies on this website. *Effective not later than July 1, 2010.*

Improving Consumer Assistance. Requires the Secretary of Health and Human Services (HHS) 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 eliminate fraud and waste in the health care system. *Many provisions are effective on the date of enactment.*

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. *Effective not later than July 1, 2010.*

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. *Strategy submitted not later than January 1, 2011.*

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.*

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

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. *Effective April 1, 2010.*

Non-Profit Hospitals. Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments. *Effective on the date of enactment.*

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.*

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 undeserved or health professional shortage areas. *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. *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, non-biased 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 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. *Effective for tax years beginning after December 31, 2009.*

Indoor Tanning Services Tax. Imposes a ten percent tax on amounts paid for indoor tanning services. Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning. *Effective for services on or after July 1, 2010.*

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 all Part D enrollees. *Effective January 1, 2011.*

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

Increasing Reimbursement for Primary Care. Provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons .Effective *January 1, 2011.*

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 programs to be financed by voluntary payroll deductions to provide 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. *Effective January 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 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas with higher benchmarks for high-quality plans. Changes are phased-in over three, five or seven years, depending on the level of payment reductions. *Effective January 1, 2011.*

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. *Effective July 1, 2011.*

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. *Effective July 2011.*

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. *Effective October 1, 2011.*

Reporting Health Coverage Costs on W-2 Form: 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 W-2 Form. *Effective for tax years beginning after December 31, 2010.*

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. *Effective for tax years beginning after December 31, 2010*.

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. *Effective for tax years beginning after December 31, 2010.*

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 pension plan nondiscrimination requirements applicable to highly compensated and key employees. *Effective for tax years beginning after December 31, 2010.*

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. *Effective for tax years beginning after December 31, 2010.*

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 incentive 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-cost conditions and implements a payment penalty for hospitals with the highest readmission rates.

Uniform Summary of Benefits. Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. People will receive the summary when shopping for coverage, enrolling in coverage, at each new plan year, and within seven business days of requesting a copy from their health insurance issuer or group health plan.

New Women's Preventive Care with No Cost-Sharing. On Aug. 1, 2011, the Department of Health and Human Services (HHS) released new health plan coverage guidelines that will require health insurance plans to cover women's preventive services such as well-woman visits, domestic violence screening, and U.S. Food and Drug Administration (FDA)-approved contraception, without charging a copayment, coinsurance or a deductible.

W-2 Reporting. Under PPACA, employers are required to report the aggregate cost of applicable employer sponsored group health plan coverage on each employees W-2 Form. The employer must report the cost of coverage on a calendar-year basis, regardless of the plan year used for the health plan. Generally speaking, all employers, including private companies, governmental entities, church organizations and tax-exempt organizations, are required to provide informational reporting of the value of health benefits provided to employees. There is a small employer exception for employers who filed fewer than 250 W-2 Forms for 2011.

2013

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

Administrative Simplification. Health plans must adopt and implement uniform standards and business rules for 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.

Increasing Medicaid Payment for Primary Care. Requires states to pay primary care physicians the same rate Medicare pays, and federal funding will fully cover any additional state costs.

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 wages over $200,000 for an individual ($250,000 for married couples filing jointly). Expands the tax to include a 3.8 percent tax on 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 first sale for use of a medical device. Excepted 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. 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 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 insurers 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 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 nationwide, and offered by private insurance carriers 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 $2,000 per full-time employee. On July 2, 2013, the U.S. Department of the Treasury, in a blog post by Mark J. Mazur, the assistant secretary for tax policy, announced that penalties under the employer mandate and associated reporting requirements would be delayed for one year, until 2015. We will update the timeline accordingly, once further instructions have been released.

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.

Small Business Tax Credit. Implements 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.

Individual Health Insurance Mandate. The new health care reform law will implement an individual health insurance mandate. When the mandate goes into effect, most Americans will be required to purchase health insurance or will have to pay a fine.

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

High-Cost Plan Excise Tax. Imposes an excise tax of 40 percent on insurance companies and plan administrators for any health insurance plan that is above the threshold of $10,200 for self-only coverage and

$27,500 for family plans. The tax would apply to the amount of the premium in excess of the threshold. The threshold would be indexed at CPI-U plus one percentage point for 2019 and CPI for years thereafter. An additional threshold amount of $1,650 for singles and $3,450 for families is available for retired individuals over the age of 55 and for plans that cover employees engaged in high risk professions. Employers with higher costs on account of the age or gender demographics of their employees when compared to the age and gender demographics nationally may adjust their thresholds even higher.