

Health Care Reform Timeline 2010-2015

Big Changes Taking Effect in 2010

EXPANDED COVERAGE

- By the end of June, a temporary national high-risk pool will provide coverage to adults with pre-existing conditions.
- Also by the end of June, a temporary reinsurance program will assist employers in providing coverage to retirees over age 55 who aren't eligible for Medicare.
- By the end of September, covered dependents must be allowed to stay on health policies until age 26.

INSURANCE REGULATION

- By the end of September, health plans will be barred from placing lifetime limits on coverage; from rescinding coverage, except in cases of fraud; and from excluding coverage for children who have pre-existing conditions.
- Health plans must begin reporting annually how much premium income goes for clinical services, quality improvements and non-claim costs.

MEDICARE

- New physician-owned hospitals are barred from participating in Medicare
- Medicare coverage is expanded to individuals who have developed certain health conditions as a result of exposure to environmental health hazards.

MEDICAID

- Creation of the Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services is intended to improve care coordination for seniors eligible for both programs.

PRESCRIPTION DRUGS

- Medicare beneficiaries who reach the Part D prescription drug coverage gap in 2010 will be given a \$250 rebate, and the "donut hole" will be closed gradually over the next decade.

- The Food and Drug Administration is authorized to approve generic versions of biologic drugs.

- The rebate percentage for drugs provided under Medicaid will be increased.

HEALTH CARE QUALITY

- By the end of September, a nonprofit Patient-Centered Outcomes Research Institute is to be created, managed by a board whose members are mostly appointed by the Comptroller General. The institute is to conduct research into the comparative effectiveness of medical treatments, and it will be financed by fees on health insurance policies.

MEDICAL WORKFORCE

- The secretary of Health and Human Services (HHS) is authorized to make grants to create or expand primary care residency programs.

- The secretary is authorized to award grants to provide scholarships for mid-career health care professional training.

- By the end of September the Comptroller General is to appoint a commission to advise Congress on future health care workforce needs.

TAXES

- Nonprofit hospitals are subject to a tax of \$50,000 per year if they fail to meet certain requirements.

- Health insurance companies are permitted to deduct up to \$500,000 per employee per year for compensation.

- An excise tax of 10 percent is imposed on the price of indoor tanning services.

Big Changes Taking Effect in 2011

MEDICARE

- By Jan. 1, 2011, the HHS secretary is to create a Center for Medicare and Medicaid Innovation to test both payment and health care delivery techniques.

- Medicare Part B physician premiums and Part D drug premiums will increase for some people, based on incomes.

- Annual increases in hospital payments will begin to be limited to account for productivity gains.

MEDICAID

- Payments to states under Medicaid will be prohibited for so-called health care-acquired conditions related to treatment.
- A new state plan for treating low-income patients with more than one chronic condition would increase federal payments to states in cases where care is coordinated through so-called health homes.

PRESCRIPTION DRUGS

- Pharmaceutical makers are to give a 50 percent discount on brand-name drugs purchased through Medicare Part D.
- Federal subsidies would phase in for generic drugs purchased through Medicare Part D while a patient is caught in the “donut hole” coverage gap.

HEALTH CARE QUALITY

- By Jan. 1, 2011, the HHS secretary is to submit to Congress a plan to establish a national strategy for improving health care delivery, patient outcomes and overall population health.
- The HHS secretary is authorized to make grants to community-based networks of hospitals and health centers to improve coordination of services to low-income people.

WELLNESS

- The president is to establish a National Prevention, Health Promotion and Public Health Council, chaired by the surgeon general, to promote general improvements to the nation’s health.
- By the end of March 2011, the HHS secretary is to issue regulations requiring chain restaurants and vending machines to report the nutritional value of what they sell.
- In an effort to improve preventive medicine, Medicare is to begin paying only for proven preventive services and to increase payments for certain preventive medical treatments.

MEDICAL MALPRACTICE

- Beginning in fiscal 2011, the HHS secretary is authorized to spend \$50 million over five years on grants to states intended to design alternative methods of resolving medical malpractice claims, and to encourage more detailed and complete reporting of medical errors.

TAXES

- Over-the-counter drugs that aren't prescribed by a physician may no longer be purchased using tax-advantaged set-asides such as Flexible Spending Accounts, Health Savings Accounts or Archer Medical Savings Accounts.

- By Sept. 30, 2011, the secretary of the Treasury is to impose an annual fee on pharmaceutical manufacturers based on annual sales of brand-name drugs.

Big Changes Taking Effect in 2012

INSURANCE EXCHANGES

- By July 1, The HHS secretary will set regulations for initial open enrollment in state-managed exchanges where people who have no employer-provided health insurance can purchase coverage.

MEDICARE

- On Oct. 1, hospitals that meet certain performance standards are to become eligible for value-based incentive payments allotted by fiscal year.

- The HHS secretary is to adjust the Medicare physician fee schedule to reflect variety in operating expenses for medical practices in different geographic areas.

- Providers that qualify as accountable care organizations are to share in cost savings they achieve for Medicare.

- The HHS secretary is to establish a demonstration program to test payment incentives for home-based primary care.

- Medicare payments to hospitals are to be reduced to account for preventable hospital readmissions.

- High-quality Medicare Advantage plans are to begin receiving bonus payments.

MEDICAID

- The HHS secretary must issue a core set of health quality measures for Medicaid-eligible adults.

- The HHS secretary is to establish a demonstration project to evaluate bundled payments for Medicaid beneficiaries who have episodes that include hospitalization.

HEALTH CARE QUALITY

- No later than two years after enactment, federal agencies managing health programs and conducting surveys will have to start collecting statistics by demographic characteristics such as race, ethnicity, sex, language and disability status by narrow geographic areas to determine quality of and access to health care.

LONG-TERM CARE

- By Oct. 1, 2012, The HHS secretary is supposed to designate a long-term care plan to which individuals can subscribe to meet their long-term care needs under the new Community Living Assistance Services and Supports (CLASS) program.

Big Changes Taking Effect in 2013

INSURANCE REGULATION

- By July 1, 2013, the HHS secretary is to award \$6 billion in loans and grants to foster establishment of nonprofit, member-run health insurance companies.
- By July 1, 2013, the HHS secretary is to issue regulations, in consultation with the National Association of Insurance Commissioners, on compacts between states allowing insurance plans to cross state lines.

MEDICARE

- The HHS secretary is to establish a Medicare pilot program to evaluate bundled payments for episodes of care.

MEDICAID

- As of Oct. 1, 2013, federal payments to so-called Disproportionate Share Hospitals, which treat large numbers of indigent patients, are to be reduced and subsequently allowed to rise based on the percentage of the population that is uninsured in each state.

PRESCRIPTION DRUGS

- Federal subsidies are to begin for brand-name drugs purchased through Medicare Part D while a patient is caught in the “doughnut hole” coverage gap.

HEALTH CARE PROVIDERS

- Hospitals must have a process in place for physicians to disclose any financial interest in the hospital to patients.

TAXES

- An excise tax of 2.3 percent is to be levied on manufacturers and importers of certain medical devices.
- Taxpayers with earned incomes in excess of \$200,000 for individuals and \$250,000 for couples will pay higher Medicare hospital insurance taxes on their income, including non-wage earnings.
- Flexible spending accounts are to be capped at \$2,500, indexed annually to a cost-of-living adjustment.
- The tax deduction for employers who receive Medicare Part D subsidy payments will be eliminated.
- Taxpayers who itemize deductions will be limited to reducing their taxable incomes by the amount they spend on medical care in excess of 10 percent of income, up from 7.5 percent.

Big Changes Taking Effect in 2014

INSURANCE EXCHANGES

- By Jan. 1, 2014, all states must have established a state health insurance exchange to aid in the purchase of health insurance for individuals and small businesses.
- The Office of Personnel Management is to ensure that each exchange offers at least two multi-state qualified health care plans.
- The HHS secretary is to ensure that each state exchange offers at least one plan that doesn't provide coverage for abortion services.
- All new policies are required to conform with essential benefits standards determined by the HHS secretary.

EXPANDED COVERAGE

- States may create a basic, low-cost health plan sold outside the exchanges that provides essential benefits for individuals who cannot qualify for Medicaid,

but have incomes lower than 200 percent of the federal poverty level, and who would otherwise be eligible to receive premium subsidies through an exchange.

INDIVIDUAL MANDATE

- Individuals are required to have qualifying health insurance or face a tax penalty.
- Those with incomes between 133 percent and 400 percent of the federal poverty level are to begin receiving premium credits and cost-sharing subsidies to purchase insurance through the exchanges.

EMPLOYER MANDATE

- Employers with 50 or more workers are subject to fees if they don't offer health coverage or if any employee receives subsidized coverage through an exchange.
- Employers with more than 200 workers who provide health insurance are required to enroll their employees automatically in a health plan, giving them the opportunity to opt out.

INSURANCE REGULATION

- Insurance companies are prohibited from setting premiums that discriminate based on factors other than age, geography, family composition and tobacco use.
- Annual deductibles for health plans in the small-group market are to be capped at \$2,000 for individuals and \$4,000 for families.
- Health plans are to reduce out-of-pocket limits by specified amounts for individuals and families with incomes of up to 400 percent of the federal poverty level.

MEDICARE

- Beginning on Jan. 15, 2014, a new Independent Payment Advisory Board appointed by the president may begin submitting advisory reports to Congress regarding Medicare spending.

MEDICAID

- Medicaid will be expanded to cover all individuals under age 65 with incomes up to 133 percent of the federal poverty level.

WELLNESS

- Employers may offer rewards of up to 30 percent of the cost of a health insurance plan to employees who participate in a wellness program and meet certain health-related standards.

TAXES

- An annual fee is to be imposed on health insurance providers (totalling \$8 billion in 2014 and growing to \$14.3 billion in 2018, and indexed to medical cost growth in following years).

Big Changes Taking Effect in 2015 and later

INSURANCE REGULATION

- Beginning Jan. 1, 2016, health care compacts that enable insurance plans to be sold across state lines are allowed to take effect.

MEDICARE

- On Jan. 1, 2015, CMS will begin using the Medicare fee schedule to give larger payments to physicians who provide high-quality care compared with cost.

CHILDREN

- Beginning Oct. 1, 2015, a state may shift children eligible for care under the Children's Health Insurance Program (CHIP) to health care plans sold on its exchange, as long as HHS approves.
- States must maintain current CHIP eligibility rules through Sept. 30, 2019.

TAXES

- Beginning Jan. 1, 2018, an excise tax equal to 40 percent of the excess benefit is to be imposed on high-cost health insurance plans.

Source: Congressional Quarterly Staff