

Effective Dates of Proposed Health Care Reforms

The health care legislation being considered by the House of Representatives and the Senate have a rolling series of effective dates starting immediately upon passage of the legislation and running all the way into 2018. The following chart has been assembled to provide an overview on what becomes effective when.

Effective 2010:

- House provisions
 - The time health plans can look back for pre-existing conditions is reduced from 6 months to 30 days
 - Insurers must disclose new health premium rate increases
 - Individuals may maintain COBRA coverage until Health Exchange is in effect
 - Plans must pay for reconstructive surgery for children with deformities
 - Employers prohibited from reducing retiree health benefits for retirees, unless the same reduction is made to active employees' benefits
 - So called CLASS ACT is implemented in order to provide public long-term disability insurance, which would supplement Medicaid or private LTD benefits
 - Funding to community health centers significantly increased
 - Funding for preventative health services at local or community level
 - Primary care physicians and training for nurses expanded
 - Grants for employer wellness programs established
 - States to receive grants for immediate health care reform initiatives
 - Consumer Operated and Oriented Program (CO-OP) created to facilitate the establishment of a non-profit, member run health insurance cooperative through the Exchange
 - States can extend Medicaid coverage to HIV infected individuals
 - Reimbursement rate for Medicaid begins to be raised up to Medicare levels for primary care physicians
 - States required to provide 12-month continuous eligibility for children in CHIP
 - HHS Secretary required to set standards for expanding Medicare accountable organizations and medical home pilot programs and to test such programs in a variety of settings and regions

- Senate provisions
 - The use of some annual coverage limits prohibited
 - Plans must provide first dollar coverage for preventative care
 - Plans must annually report the share of premium dollars spent on health care and provide rebates to participants for excessive loss ratio (2010-2013)
 - Process to be established for reviewing health coverage premium increases
 - Consumer Operated and Oriented Program (CO-OP) created to facilitate the establishment of a non-profit, member run health insurance companies in all 50 states and DC
 - Insured plans must establish an effective appeals process for coverage determinations and claim denials with states to set standards for effective appeals process
 - Community First Choice Option established to permit states to offer home and community based services to disabled through Medicaid
 - New quality requirements established for nonprofit hospitals
 - Non-profit Blue Cross & Blue Shield required to have a medical loss ratio of 85 percent or higher to take advantage of tax benefits under Section 833
 - Medicare payment protections established to increase reimbursements for health care providers in rural areas
 - HHS to receive additional resources to develop a national quality strategy
 - HHS Secretary to establish website through which residents of any state may find affordable coverage options in the state
 - \$2.3 billion non-deductible annual fee imposed on the pharmaceutical manufacturing industry and is to be allocated by market share
 - \$2 billion non-deductible annual fee imposed on the medical device manufacturing sector and is to be allocated by market share
 - \$6.7 billion non-deductible annual fee imposed on the health insurance sector and is to be allocated by market share
 - 10 percent tax imposed on indoor tanning

- House and Senate provisions
 - Insurance policies prohibited from being rescinded when an individual gets sick
 - Uses new discounts from drug manufacturers to provide a 50 percent discount on brand name drugs in the “donut hole” under Medicare Part D
 - Lifetime dollar limits for coverage prohibited
 - Individuals up to age 26 (Senate) and 27 (House) not otherwise covered may remain on parents coverage
 - Temporary reinsurance assistance established for employers providing early retiree health benefits (ages 55-64)

- \$5 billion fund created to finance immediate insurance for uninsured due to pre-existing conditions
- Standards for financial and administrative transactions adopted to promote simplification

Effective January 1, 2011:

- House provisions
 - Low-income individuals to have more access to subsidies for Part D drug benefits
 - Cost-sharing for services in Medicare Advantage limited to that of traditional Medicare services
 - Health Benefits Advisory Committee to submit report on recommended essential benefits package to HHS Secretary
 - 5.4 percent tax imposed on high income individuals
 - 2.5 percent excise tax imposed on the first taxable sale of medical devices
 - The implementation of the worldwide interest allocation repealed
 - Second generation biofuel producer tax credit restricted

- Senate provisions
 - Employers must report the value of health care benefit provided on each employee W-2
 - Tax penalty increased to 20 percent for non-qualified expenses under health savings tax vehicles such as Health Savings Accounts
 - The amount of contribution to Flexible Spending Accounts limited to \$2,500
 - Employer deductions eliminated for subsidies currently received for providing prescription drug plans for Medicare Part D retirees
 - 10 percent Medicare reimbursements paid to primary care and surgeons
 - New CMS Innovation Center established to test payment and service delivery models
 - Medicare coverage for annual wellness visit and cost sharing for prevention is prohibited
 - Community Care Transitions Program established to provide transition to high-risk Medicare recipients
 - Access to primary care and nursing increased through Medicare Graduate Education Program
 - Small business tax credit to begin for qualified employers purchasing health care for their employees
 - Simple Cafeteria Plans established and available for small businesses
 - Transition to competitive bidding process for insurers in Medicare Advantage

Effective January 1, 2012:

- House provisions
 - Personal asset limits for Medicare Savings Program and Part D increased
 - Limitations on Medicare coverage for drugs for kidney transplants lifted
- Senate provisions
 - Businesses paying providers of property or services of \$600 or more per year required to file reports with IRS and providers specifying the amounts paid
 - Deductibility of executive compensation under Section 162(m) limited to \$500,000 for insurance providers if 25 percent or more of gross income comes from health plans that meet the minimum creditable coverage requirements
 - Physician payment reforms implemented to increase payment for primary care physicians
 - Hospital value-based purchasing program established to provide incentives to acute care hospitals for quality outcomes
 - CMS tracks hospital readmission rates certain high cost conditions and hospitals with the highest readmission rates to be penalized
 - Funding for community health centers increased

Effective January 1, 2013:

- House provisions
 - All individuals required to obtain acceptable health care coverage or pay penalty of 2.5 percent of their income
 - Contribution amount to Flexible Spending Arrangement limited to \$2,500
 - Employers required to offer health coverage to employees (and families) with minimum contributions and standards or pay an 8 percent payroll tax; employers with annual payrolls below \$500,000 are exempt from the employer mandate
 - Small businesses that provide health coverage to employees are eligible for a tax credit up to 50 percent of the amount paid for coverage (credit lasts 2 years)
 - Insurance companies prohibited from refusing to sell or renew policies on the basis of an individual's health
 - Exclusion of coverage because of pre-existing conditions is prohibited
 - Insurance companies cannot charge higher premiums based on health status, gender, etc., and premiums can vary only on age (no more than 2:1), geography, and family size

- Coverage through the Health Insurance Exchange provided to the uninsured and to employees of employers with 25 or fewer employees
- Public health plan option established and is only available in the Health Insurance Exchange
- Health Insurance Affordability Credits to purchase insurance in the Exchange provided to individuals with income above Medicaid eligibility and below 400 percent of poverty who are not offered acceptable health coverage
- Access to Medicaid expanded to all individuals under 65 with incomes up to 150 percent of poverty
- Medicaid coverage provided for up to 60 days for newborn babies without proof of insurance
- Senate provisions
 - 40 percent excise tax imposed on so called “Cadillac health plans”
 - Income threshold increased from 7.5 to 10 percent in order for individuals to deduct medical expenses
 - Medicare hospital insurance tax rate increased by .05 percent on individuals earning \$200,000 (\$250,000 for married filed jointly)
 - Physician value-based payment program implemented for treatment of Medicare beneficiaries
 - Standards for electronic exchange of health information is adopted
 - National pilot program on payment bundling established to encourage physicians, hospitals, and post-acute care providers to work together in order to create savings for Medicare
- House and Senate provisions
 - Tax deduction for employers for the subsidy that they receive for continuing to provide a qualified retiree drug benefit is eliminated

Effective January 1, 2014:

- House provisions
 - Individuals offered employer-sponsored coverage may opt-in to the Health Insurance Exchange if the employer’s premium is equal to or greater than 12 percent of family income
 - Health Insurance Exchange expanded to include employers with 50 or fewer employees
 - Medicare Advantage program must spend at least 85 percent of premium on health care

- Senate provisions
 - Individuals required to obtain acceptable health care coverage or pay an annual tax penalty of \$95 graduated up to \$750 by 2016
 - Employers with 50 or more employees must offer health coverage to employees (and families) or pay an annual \$750 penalty for each full-time employee
 - Employers with more than 200 employees must automatically enroll employees into employer-sponsored plans although employees may opt out
 - Employers with eligibility waiting periods over 60 days must pay \$600 annually for each full-time employee subject to the waiting period
 - Health Insurance Exchanges created in each state
 - Insurance companies prohibited from refusing to sell or renew policies on the basis of an individual's health
 - Exclusion of coverage because of pre-existing conditions is prohibited
 - Insurance companies cannot charge higher premiums based on health status, gender, etc. and premiums can vary only on age (no more than 3:1), geography, and family size
 - Tax credits to purchase insurance through the Exchange are provided to individuals with income above Medicaid eligibility limit and between 100- 400 percent of poverty who are not offered acceptable coverage
 - Access to Medicaid expanded to all individuals under 65 with incomes up to 133 percent of poverty level
 - Competitive bidding process completed for insurers in Medicare Advantage
 - Temporary reinsurance program (2014-2016) established to collect payments from health insurers to provide payments to plans in the individual market that cover high-risk individuals

Effective January 1, 2015:

- House provisions
 - Health Insurance Exchange expanded to employers with 100 or fewer employees
- Senate provisions
 - Independent Medicare Advisory Board established to submit proposals to Congress regarding the solvency of Medicare

Effective January 1, 2017:

- Senate provisions
 - States may permit businesses with more than 100 employees to purchase coverage in the Health Insurance Exchanges

Effective January 1, 2018:

- House provisions
 - Employer-sponsored plans must meet the acceptable coverage standards (grace period ends)