

Pennsylvania Association of Health Underwriters

Advisors and Advocates for Employers, Employees and Health Care Consumers

Timeline for Health Care Reform

Updated May 28, 2010

The Patient Protection and Affordable Care Act and The Health Care and Education Affordability Reconciliation Act of 2010 are now law. While these laws addressed some needs, many believe that these new laws missed an opportunity to directly address health care costs. **Unless one addresses reducing the cost of health care there is no real Health Care Reform.** That being said, let's look at the timeline of what was actually passed.

Immediate

Insurance Industry Requirements

1. **Grandfathered Policies** (in existence March 2010) must be in full compliance with new healthcare reform law.

Government Programs

1. **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.
2. **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.
3. **States must have ombudsman program.**

Taxes, Subsidies, and Grants

1. **Tax credits for small employers** (phase one) begins now.
 - Provide small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit.
 - For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.
 - The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - The credit phases-out as firm size and average wage increases.
 - Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.

Health Care Provider Issues

1. **Cracking Down on Health Care Fraud;** requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.
2. **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.
3. **Non-Profit Hospitals;** establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments.

4. **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.*
5. **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. *Effective for amounts received by an individual in taxable years beginning after December 31, 2008.*
6. **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.*
7. **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.*
8. **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.*

July 2010

Insurance Industry Requirements 7/10

1. **Creates a Temporary Reinsurance** program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
2. **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. *Effective 90 days after enactment.* See High Risk Pool under government.

Government Programs 7/10

1. **Requires the states and the Secretary of DHHS** to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage, and existing state high-risk pool options.
2. **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.*
3. **Create a temporary "High-Risk Pool"** for people who cannot obtain current individual coverage due to preexisting conditions. In the case of Pennsylvania, \$160 million has been allocated. Program ends January 2014

Taxes, Subsidies, and Grants 7/10

1. **Extends the tax exclusion** for employer provided health coverage to a person who is eligible for coverage under the employer's plan and who is not a spouse or dependent.
2. **Imposes 10% tax on indoor tanning services.** Indoor tanning services are services that use an electronic product with one or more ultraviolet lamps to induce skin tanning.

October 2010

Insurance Industry Requirements 10/10

1. **Eliminating Pre-Existing Condition Exclusions for Children;** bars health insurance companies from imposing pre-existing condition exclusions on children's coverage. (This provision will apply to all people in 2014).
2. **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.
3. **Eliminating Lifetime Limits;** prohibits insurers from imposing lifetime limits on benefits.
4. **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. (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.)
5. **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.
6. **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.
7. **Covering Preventive Health Services;** all new group health plans and plans in the individual market must provide first dollar coverage for preventive services.
8. **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. (*Note: Many carriers have adapted this provision as of June 1 with the stipulation that the affected dependent was on the plan May 2010.*) The only planned open enrollment is the first scheduled group renewal after September 23, 2010.
9. **Federal review** of health insurance premium rates
10. **Creates a temporary reinsurance program** for employer health plans providing coverage for non-Medicare eligible retirees aged 55-64 and their families.
11. **Annual benefit limits** on coverage would be limited to DHHS-defined non-essential benefits.
12. **Mandated coverage of emergency services** at in-network level regardless of provider
13. **Prohibits discrimination** in coverage or premium based on salary
14. **Appeals Process;** requires plans to have coverage appeals processes
15. **Summary of Coverage;** requires that a summary of coverage be provided to applicants and enrollees
16. **Report Medical Loss Ratios;** requires insurance companies to report medical loss ratios.

Government Programs 10/10

1. **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.)
2. **Establish an office of health insurance consumer assistance** or ombudsman program to advocate for people with private coverage in the individual and small group markets.
3. **Authorizes FDA to approve FOBs** (follow-on biologics).
4. **Establishes Patient-Centered Outcomes Research Institute.**

Taxes, Subsidies, and Grants 10/10

1. **Medicare Part D;** \$250 rebate to Medicare beneficiaries reaching Part D coverage gap in 2010; phases out rebate and replaces with 25% coinsurance program after 2010.
2. **Cost Shift** - Cuts \$130 Billion from Medicare Advantage and \$70 Billion from regular Medicare.
3. **Creates grants for small employer-based wellness programs.**

Health Care Provider Issues 10/10

1. **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. *Effective not later than September 30, 2010.*

January 2011

Insurance Industry Requirements 1/11

1. **Minimum loss ratio requirements** for insurers in all markets.
2. **Rebates Related to Medical Loss Ratios;** requires insurance companies to begin providing rebates related to medical loss ratios.
3. **Employers must start reporting** the value of health benefits on W-2 forms.
4. **Develop Standards for Insurers** to use in providing information on benefits and coverage.
5. **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.

Employer Requirements 1/11

1. **Reporting Health Coverage Costs on Form W-2;** requires employers to disclose the value of the health insurance benefit provided by the employer for each employee on their annual Form W-2. *Effective for tax years beginning after December 31, 2010.*
2. **Elimination of employer deductible subsidy under Medicare Part D** (2013) will have an immediate impact on employers' liability and income statements. FAS109 requires employers to immediately take a charge against current earnings to reflect the higher anticipated tax costs and higher FAS 106 liability.

Government Programs 1/11

1. **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.
2. **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.
3. **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.
4. **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.
5. **Improving Transitional Care for Medicare Beneficiaries;** establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.
6. **Improving Prevention Health Coverage;** requires State Medicaid programs to cover tobacco cessation services for pregnant women.
7. **Medicare Part D;** begin phase-in of subsidies of 75% of generic drug cost for prescriptions filled in the Part D Coverage gap.
8. **Revised payments to Medical Assistance Begin;** phased in over 3 years.
9. **CMS;** Creates payment innovation center within Center for Medicare Services.
10. **(Class Act)** Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out. (see taxes)

Taxes, Fees, Subsidies, and Grants 1/11

1. **Increases the tax on distributions from a health savings account** that are not used for qualified medical expenses to 20% (from 10%).
2. **Freezes the threshold for income-related Medicare Part B premiums** for 2011 through 2019, and reduces the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
3. **Imposes \$2.5 billion fee on pharmaceutical manufacturing sector.**
4. **Increases funding to community health centers** by \$11B over five years.
5. **Excise tax on brand name drugs begins.**
6. HSA. HRA. FSA; permit only prescribed drugs to be reimbursable through a HSA, Archer MSA, HRA, or FSA for medical expenses.
7. **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.
8. **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.
9. **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 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.
10. **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.
11. **Providing New, Voluntary Options for Long-Term Care Insurance;** creates a long-term care insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become disabled. This was put under taxes as it is intended to raise revenue for Health Care Reform

Provider Issues 1/11

1. **Transitioning to Reformed Payments in Medicare Advantage;** Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition, and then 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.
2. **Strengthening Community Health Centers;** provides funds to build new and expand existing community health centers.
3. **Strengthening the Primary Care Workforce;** expands funding for scholarships and loan repayments for primary care practitioners working in underserved areas participating in the National Health Service Corps.
4. **Increasing Reimbursement for Primary Care;** provides a 10 percent Medicare bonus payment for primary care physicians and general surgeons.

March 2011

Government Programs 3/11

- Mandatory federal study on the impact the market reforms in the bill will have on the large group market
- Mandatory annual studies by the federal Department of labor on self-funded plans
- Repeal implementation of Worldwide Interest Allocation Disclosures to facilitate identification of individuals likely to be ineligible for low income subsidies under the Medicare Prescription Drug program to assist Social Security Administration's outreach to eligible individuals.

July 2011

Provider Issues 7/11

1. **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.
2. **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. This ensures that public health challenges are adequately addressed.

October 2011

Insurance Industry Requirements 10/11

1. **Rules adopted for simplifying health insurance administration** by adopting a single set of operating rules for eligibility verification and claims status.

Government Programs 10/11

1. **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.

January 2012

Taxes, Fees, Subsidies, and Grants 1/12

1. **New federal premium tax** on fully-insured and self-insured group health plans to fund comparative effectiveness research program begins. Applies the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets
2. **Reduce Medicare payments for preventable hospital readmissions**

Provider Issues 1/12

1. **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.
2. **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.
3. **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.

March 2012

Insurance Industry Requirements 3/12

1. **Group plans must report to HHS** reimbursement structures that improve patient safety, wellness etc.

Employer Requirements 3/12

1. **Employers must provide a four-page summary** of benefits and coverage explanation; any changes to be notified to employees within 60 days after plan change (penalties).
2. **Requires all employers provide notice to their employees** informing them of the existence of an Exchange.

July 2012

Government Programs 7/12

1. **Electronic funds transfer** and health care payment and remittance rules adopted

January 2013

Insurance Industry Requirements 1/13

1. **Limits FSA Contributions** for medical expenses to \$2,500
2. **Limit the Deductibility of Executive and Employee Compensation** to \$500,000 per applicable individual for health insurance providers. (Applies to deferred compensation going back to 2009).
3. **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.

Government Programs 1/13

1. **Medicare Pilot Program** begins to test bundled payments.
2. **Improving Preventive Health Coverage**; creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing.

Taxes, Fees, Subsidies, and Grants 1/13

1. **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.
2. **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.
3. **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.
4. **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).
5. **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.
6. **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.

Provider Issues 1/13

1. **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.
2. **Increasing Medicaid Payment for Primary Care;** requires states to pay primary care physicians the same rate Medicare pays, and fully federally funds any additional state costs.

July 2013

Government Programs 7/13

1. **Create the Consumer Operated and Oriented Plan (CO-OP)** program. Appropriate \$6 billion to finance program and award loans and grants to establish CO-OPs.
2. **States must ensure Medicaid pays primary care providers at least 100% of Medicare reimbursement.** Additional Federal funding available to comply.

January 2014

Insurance Industry Requirements 1/14

1. **Requires all individual health insurance policies** and all fully insured group policies to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances.
2. **Coverage must be offered on a guarantee issue** basis in all markets and be guaranteed renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited in all markets.
3. **Prohibits any annual limits or lifetime limits** in group or individual plans
4. **Redefines small group coverage** as 1-100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016. Pennsylvania has opted to use the 50 employee threshold.
5. **Grandfathered Policies;** Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement. Grandfathered group plans may only impose annual limits as determined by HHS. Must eliminate pre-existing condition exclusions for adults.
6. **Establishes standards for qualified coverage,** including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. Allows catastrophic-only policies for those 30 and younger.
7. **Documentation Requirement;** Health plans, including self-funded employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.
8. **Codifies and improves upon the HIPAA** bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums.
9. **Require risk adjustment** in the individual and small group markets.
10. **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. This applies to all clinical trials that treat cancer or other life-threatening diseases.

Employer Requirements 1/14

1. **Employer mandate begins.** Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of \$2,000 per year for each full time employee they don't cover (First 30 employees exempt from coverage. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.

2. **Require employers to give a voucher** to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.
3. **Waiting Periods;** An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$600 for any full-time employee subject to more than a 60-day waiting period.
4. **Auto-enrollment;** Requires employers of 200 or more employees to auto-enroll all new employees into any available employer sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.
5. **Reporting Requirements;** Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.

Individual Requirements 1/14

1. **Insurance Mandate;** Requires all American citizens and legal residents to purchase qualified health insurance coverage. Exceptions are provided for religious objectors, individual's not lawfully present and incarcerated individuals, those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year. **Violators** are subject to an excise tax penalty of 1% of household income in 2014 and 2% of household income in 2015, and 2.5% of household income in 2016 (capped at the annual cost of the average bronze level premium plan (60%) offered through the exchanges). There is a fixed dollar alternative tax phasing in at \$325 in 2015 and \$695 in 2016.

Government Programs 1/14

1. **Requires each state to create an Exchange** to facilitate the sale of qualified benefit plans to individuals, including the federally administered multi-state plans and non-profit co-operative plans. A catastrophic-only policy would be available for those 30 and younger. In addition the states must create "SHOP Exchanges" to help small employers purchase such coverage. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange. States can also apply for a modification waiver from DHHS.
2. **Medicaid Expansion:**
 - To finance the coverage for the newly eligible (those who were not previously eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), establishes that the federal government will pay 100% of the cost of the new expansion population until 2016, not 2017. Starting in 2017, all states except for the expansion states (including Nebraska), will then have to begin to have to pay a phased in amount of the cost of covering the expansion population, so that the federal government's match is 90% in 2020 and the out-years.
 - For states that already cover adults with incomes above 100%, the law reduces the amount the States are currently paying to cover this population by 50% in 2014 and gradually increases the amount of the federal share, so that by 2019, all states are paying the same amount for the non-pregnant adult Medicaid population.
3. **Medicaid eligibility** level is increased to 150% FPL
4. **Requires states to offer premium assistance** and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost effective to do so, under terms outlined already in current law.

5. **Gives states the option of establishing a federally-funded non-Medicaid state plan** for people between 133-200% FPL who do not have access to affordable employer sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars
6. **Allows states to apply for a waiver** for up to 5 years of requirements relating to qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers, provided that they create their own programs meeting specified standards.
7. **Establishes a 10-state pilot program** to apply the rules to HIPAA bona fide wellness program rules the individual market in 2014-2017 with potential expansion to all states after 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.
8. **Creates essential health benefits package.** All health plans except grandfathered individual and employer-sponsored plans, required to offer at least the essential health benefits package.
9. **Allow states the option of merging the individual and small group markets.**
10. **States permitted to create a Basic Health Plan** for uninsured individuals between 133-200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchange.
11. **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.

Taxes, Fees, Subsidies, and Grants 1/14

1. **Annual fees on private health insurers** based on net premiums and third party agreement fees received will be \$8 billion in 2014-2016, and \$13.9 billion in 2017 \$14.3 billion in 2018 and indexed to the amount of premium growth in subsequent years. Does NOT apply to self-insured plans.
2. **Creates sliding-scale premium assistance** tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL to buy coverage through the exchange
3. **Small Employer Tax Credit Phase II;** For tax years 2014 and beyond, small employer tax credit Phase II begins.
4. **Appropriates \$1 billion** to DHHS to implement Health Care Reform.
5. **Appropriates \$11 Billion** dollars in additional funding for community health centers over 5 years.
6. **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.
7. **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.
8. **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 \$2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized.
9. **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. This 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.

Provider Issues 1/14

1. **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.

July 2014

Government Programs 7/14

1. Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, plan premium payments and referral certification and authorization rules adopted.

2015

Government Programs 1/15

1. CHIP program must be reauthorized.
2. Creates state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges for individuals & small businesses with up to 100 employees.

Taxes, Fees, Subsidies, and Grants 1/15

1. Imposes \$11.3 billion fee on insurance sector through 2016.

Provider Issues 1/15

1. **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.
2. **Paying Physicians Based on Value Not Volume;** creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

2016

Government Programs (2016)

1. Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, plan premium payments and referral certification and authorization rules.
2. States may allow businesses with more than 100 employees to purchase coverage in the SHOP exchange.

Taxes, Fees, Subsidies, and Grants (2016)

1. Imposes \$3.5 billion fee on pharmaceutical manufacturing sector.
2. Imposes \$13.9 billion fee on insurance sector.

2017

Government Programs (2017)

1. States may choose to allow large groups (over 100) to purchase coverage through the exchanges.

2018

Government Programs (2018)

1. IPAB recommendations submitted if Medicare per capita spending exceeds GDP per capita plus 1%.

Taxes, Fees, Subsidies, and Grants (2018)

1. **(Cadillac Tax)**The 40% excise tax on insurers of employer-sponsored health plans (both fully-insured and self-insured) with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (indexed annually by CPI) would begin. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs. Stand alone dental and vision coverage is exempt from the tax.
2. Imposes \$4.2 billion fee on pharmaceutical manufacturing sector.
3. Imposes \$14.3 billion fee on insurance sector.

2019

Taxes, Fees, Subsidies, and Grants (2019)

1. Imposes \$2.8 billion fee on pharmaceutical manufacturing sector.
2. Failsafe mechanism - Individual Subsidies could be reduced if aggregate amount exceeds .504 percent of GDP.

This summary is intended to inform our clients, business partners, and friends with guidance on the new health reform law. This summary, however, does not constitute legal advice.