Health Care Reform Timeline

2010

New Programs

- National risk pool launched
- Small business tax credit
- Medicare members who reach the "donut hole" receive a $250 rebate

Insurance Reforms

- No lifetime dollar limits on essential benefits
- Allowed restricted yearly limits on the dollar value of certain benefits
- No coverage rescissions/cancellations except for fraud or intentional misrepresentation
- No cost-sharing for preventive services in network
- Dependent coverage, if provided, required up to age 26
- Enhanced internal and external appeal processes and requirements
- No pre-existing condition exclusions for enrollees under 19 years of age

2011

Insurance Reforms

- Must meet minimum loss ratios
    - 85% for Individuals and Small Business (2-50)
    - 80% for groups of 51+
- Rate reviews begin

Medical Reforms

- Medicare Advantage cost-sharing limits take effect
- Medicare beneficiaries who reach the "donut hole" get a 50% discount on brand-name drugs
- Primary care doctors and general surgeons practicing in underserved areas, such as inner cities and rural communities, get a 10% Medicare bonus
- Medicare Advantage plans begin restructuring of payments and freeze 2011 payments at 2010 levels

Other

- The voluntary long-term care insurance program starts
    - Provides a cash benefit to help those with disabilities stay in their homes or pay nursing home costs. Benefits start five years after paying the coverage fee
- Increased funding for community health centers to provide care for many low-income and uninsured people.
- Costs for over-the-counter drugs not prescribed by a doctor excluded from being reimbursed through an HSA or FSA.
- Employers may report the value of health care benefits on employee W2 tax statements (optional for 2011 tax year; mandatory thereafter).
    - Small employers (e.g. employers filing fewer than 250 Forms for the previous calendar) are exempt.
- Start of new annual fees on pharmaceutical manufacturing sector

2012

Health System Changes

- Hospitals, doctors, and payers encouraged to join forces in "accountable care organizations"
- Hospitals with high rates of preventable readmissions facing reduced Medicare payments
- Administrative simplification rules required under ACA begin to phase in

Insurance Reforms

- Women's Wellness benefits (August, 2012)
- Summary of Benefits and Coverage (SBC's)
- MLR reporting (Rebates issued by August, 2012 based on 2011 data)
- Quality of Care Reporting
- **Patient-Centered Outcomes Research Fee – from 2012 to 2019 (see Taxes and Fees below)**
- Wellness Incentives –
    - A 5 year/$200 billion grand program available to small employers (less than 100 employees that did not provide a wellness program as of March, 2010

2013

Taxes/Deductions

- Individuals making $200k a year or couples making $250k have a higher Medicare payroll tax of 2.35% on earned income - up from the current 1.45%. A new 3.8% tax on unearned income, such as dividends and interest also added
- Contributions to flexible spending accounts (FSAs) limited to $2,500 per year - indexed for inflation
- The threshold for deducting medical expenses on taxes goes from 7.5% to 10% of income
- Medical device manufacturers have a 2.9% sales tax on medical devices, with exemptions for some, like eyeglasses, contact lenses and hearing aids

- No more deduction for expenses allocable to Medicare Part D subsidy for employers who maintain prescription drug plans for their Medicare Part D-eligible retirees

Administrative Simplification

- Eligibility verification standards on how health plans must verify each individual's health plan eligibility and what that person's financial responsibility might be for specific services either prior to or at the end of service
- Claim status transactions outline required timeframes by which health plans must respond to claim status inquiries from providers, including the adjudication and appeals processes

2014

Coverage Mandates & Subsidies

- New individual and employer coverage responsibilities
- New individual affordability tax credits and expanded small business tax credits

Health Insurance Exchange & Insurance Reforms

- California individual and small group health insurance exchanges operational
    - Small Group is 2-50 unless state chooses to go to 2-100
- Guaranteed issue, guaranteed renewability, modified community rating and minimum benefit standards (essential benefits) effective
- No more lifetime or annual dollar limits for essential benefits.
- No more excessive waiting periods (more than 90 days)
- No pre-existing condition exclusions
- New health plan disclosure and transparency requirements
- New uniform insurance rating reforms (age, geography, family status, tobacco user)
- Provider non-discrimination requirements

New taxes on health Insurers (See taxes and fees below)

Medicaid and Medicare Reform

- Medicaid expanded to cover low-income individuals under age 65 up to 133% of the federal poverty level - about $28,300 for a family of four
- Minimum medical loss ratio of 85 percent required for Medicare Advantage plans.

Administrative Simplification

- Electronic Fund Transfer (EFT) standards for automated reconciliation of payment to remittance advice
- Claim payment/remittance standards when health plans process electronic payments
- Health plan certification required by health plans for eligibility verification, claim status, electronic fund transfer and claim payment/remittance compliance.
- Health plan identifier (HPID) and unique identification of health plans in order to facilitate routing of electronic transactions between the plan and providers

Taxes and Fees

Patient-Centered Outcomes Research Fee (also known as the Comparative Effectiveness Fee)

- Beginning in late 2012 to 2019, insured and self-funded plans will be assessed new ACA-mandated, federal taxes and fees.
    - Patient centered outcomes Research Fee (also known as the Comparative Effectiveness Fee)
        - Assessed on both self-funded and insured health plan membership
            - $1/member ending on or after October, 2012 and before October, 2013 and $2/member ending on or after October, 2013 and before October, 2014.
            - Fee is subject to adjustment for projected increases

Transitional Reinsurance Program Contribution

- Fees in place for plan years 2014-2016, to fund state non-profit reinsurance entities for the purpose of establishing a high-risk pool for the individual market
- The government plans to collect $25 billion in per capita fees from health insurers and from third-party administrators, on behalf of self-funded group health plans, over the three year period. States may choose to collect additional funds through higher contribution rates
- Estimated to be approximately $73 to $78 per member per year

Health Insurer Fee

- Health insurers will have to pay an annual fee to help pay for premium subsidies and tax credits to be made available to qualifying individuals purchasing health insurance coverage on the exchanges beginning in 2014
- The fee begins in 2014 and has not end
- The ACA calls for the government to collect a set total from health insurers each year:
    - $8 billion in 2014, growing to $14.3 billion in 2018 and increasing by the rate of premium growth after that
- The Secretary of the Treasury will determine the amount of the fee due by each health insurer, based on net premiums for US-based lives, and bill each issuer annually
- The fee is assessed only on fully insured health risks and not self-funded plans
- Estimated to be approximately 2-3% of premium

High Cost Employer-Sponsored Health Coverage Excise Tax

- Often called the “Cadillac tax,” this is a tax worth 40% of the aggregate cost exceeding a certain threshold (more than $10,200 for individual coverage and $27,500 for self and spouse or family coverage)
- The thresholds apply nationally and there is no market or regional indexing for area cost differentials. It applies to both fully insured and self-funded medical plans.