Health Care Reform Provisions by Year 2011 – 2018

2011(21)

- Minimum Medical Loss Ratio for Insurers

Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers if the share of the premium spent on clinical services and quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

Implementation: Requirement to report medical loss ratio effective for 2010; requirement to provide rebates effective beginning January 1, 2011

- Closing the Medicare Drug Coverage Gap

Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

Implementation: January 1, 2011

- Medicare Payments for Primary Care

Provides a 10% Medicare bonus payment for primary care services; also, provides a 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas.

Implementation: January 1, 2011 through December 31, 2015

- Medicare Prevention Benefits

Eliminates cost-sharing for Medicare-covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waives the Medicare deductible for colorectal cancer screening tests; authorizes Medicare coverage for a personalized prevention plan, including a comprehensive health risk assessment.

Implementation: January 1, 2011

- Center for Medicare and Medicaid Innovation

Creates the Center for Medicare and Medicaid Innovation to test new payment and delivery system models that reduce costs while maintaining or improving quality.

Implementation: Center established by January 1, 2011

- ## Medicare Premiums for Higher-Income Beneficiaries

Freezes the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels resulting in more people paying income-related premiums, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.

Implementation: January 1, 2011

- ## Medicare Advantage Payment Changes

Restructures payments to private Medicare Advantage plans by phasing-in payments set at increasingly smaller percentages of Medicare fee-for-service rates; freezes 2011 payments at 2010 levels; and prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.

Implementation: January 1, 2011

- ## Medicaid Health Homes

Creates a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the option with 90% federal matching payments for two years for health home-related services.

Implementation: January 1, 2011

- ## Chronic Disease Prevention in Medicaid

Provides 3-year grants to states to develop programs to provide Medicaid enrollees with incentives to participate in comprehensive health lifestyle programs and meet certain health behavior targets.

Implementation: January 1, 2011

- ## CLASS Program

Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Implementation: January 1, 2011

- National Quality Strategy

Requires the Secretary of the federal Department of Health and Human Services to develop and update annually a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.

Implementation: Initial strategy due to Congress by January 1, 2011

- Changes to Tax-Free Savings Accounts

Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a Health Reimbursement Account or health Flexible Spending Account and from being reimbursed on a tax-free basis through a Health Savings Account or Archer Medical Savings Account. Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the amount used.

Implementation: January 1, 2011

- Grants to Establish Wellness Programs

Provides grants for up to five years to small employers that establish wellness programs.

Implementation: Funding authorized beginning in fiscal year 2011

- Teaching Health Centers

Establishes Teaching Health Centers and provides payments for primary care residency programs in community-based ambulatory patient care centers.

Implementation: Funding appropriated for five years beginning in fiscal year 2011

- Medical Malpractice Grants

Authorizes $50 million for five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Implementation: Authorizes funding beginning fiscal year 2011

- Funding for Health Insurance Exchanges

Provides grants to states to begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges, which facilitate the purchase of insurance by individuals and small employers.

Implementation: Grants awarded starting March 23, 2011; enrollment in Exchanges begins January 1, 2014

- ## Nutritional Labeling

Requires disclosure of the nutritional content of standard menu items at chain restaurants and food sold from vending machines.

Implementation: By March 23, 2011

- ## Medicaid Payments for Hospital-Acquired Infections

Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections.

Implementation: July 1, 2011

- ## Graduate Medical Education

Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots and promotes training in outpatient settings.

Implementation: July 1, 2011

- ## Medicare Independent Payment Advisory Board

Establishes an Independent Advisory Board, comprised of 15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds targeted growth rates.

Implementation: Funding available October 1, 2011; first recommendations due January 15, 2014

- ## Medicaid Long-Term Care Services

Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Implementation: October 1, 2011

2012(10)

- Accountable Care Organizations in Medicare

Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

Implementation: January 1, 2012

- Medicare Advantage Plan Payments

Reduces rebates paid to Medicare Advantage plans and provides bonus payments to high–quality plans.

Implementation: January 1, 2012

- Medicare Independence at Home Demonstration

Creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home.

Implementation: January 1, 2012

- Medicare Provider Payment Changes

Adds a productivity adjustment to the market basket update for certain providers, resulting in lower rates than otherwise would have been paid.

Implementation: Begins calendar, fiscal, or rate year 2012, as appropriate

- Fraud and Abuse Prevention

Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare.

Implementation: January 1, 2012

- Annual Fees on the Pharmaceutical Industry

Imposes new annual fees on the pharmaceutical manufacturing sector.

Implementation: January 1, 2012

- ### Medicaid Payment Demonstration Projects

Creates new demonstration projects in Medicaid for up to eight states to pay bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost-savings.

Implementation: January 1, 2012 through December 31, 2016

- ### Data Collection to Reduce Health Care Disparities

Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

Implementation: March 23, 2012

- ### Medicare Value-Based Purchasing

Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and requires plans to be developed to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

Implementation: October 1, 2012

- ### Reduced Medicare Payments for Hospital Readmissions

Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.

Implementation: October 1, 2012

2013(13)

- ### State Notification Regarding Exchanges

States indicate to the Secretary of HHS whether they will operate an American Health Benefit Exchange.

Implementation: January 1, 2013

- ## Closing the Medicare Drug Coverage Gap

Begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand-name discount).

Implementation: January 1, 2013

- ## Medicare Bundled Payment Pilot Program

Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Implementation: January 1, 2013

- ## Medicaid Coverage of Preventive Services

Provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations.

Implementation: January 1, 2013

- ## Medicaid Payments for Primary Care

Increases Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding).

Implementation: January 1, 2013 through December 31. 2014

- ## Itemized Deductions for Medical Expenses

Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income; waives the increase for individuals age 65 and older for tax years 2013 through 2016.

Implementation: January 1, 2013

- ## Flexible Spending Account Limits

Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by the cost of living adjustment.

Implementation: January 1, 2013

- ## Medicare Tax Increase

Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers.

Implementation: January 1, 2013

- ## Employer Retiree Coverage Subsidy

Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Implementation: January 1, 2013

- ## Tax on Medical Devices

Imposes an excise tax of 2.3% on the sale of any taxable medical device.

Implementation: January 1, 2013

- ## Financial Disclosure

Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Implementation: Report to Congress due April 1, 2013

- ## CO-OP Health Insurance Plans

Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies.

Implementation: CO-OPs established by July 1, 2013

- ## Extension of CHIP

Extends authorization and funding for the Children's Health Insurance Program (CHIP) through 2015 (current authorization is through 2013).

Implementation: Fiscal year 2013

2014(20)

- ## Expanded Medicaid Coverage

Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL and provides enhanced federal matching payments for new eligibles.

Implementation: January 1, 2014 (states have the option to expand coverage to childless adults beginning April 1, 2010)

- ## Presumptive Eligibility for Medicaid

Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations.

Implementation: January 1, 2014

- ## Individual Requirement to Have Insurance

Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions).

Implementation: January 1, 2014

- ## Free Choice Vouchers

Requires employers that offer coverage to their employees to provide a free choice voucher to certain employees. Vouchers are available to employees with incomes less than 400% of the federal poverty level whose share of the premium under the employer-sponsored coverage exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in a health insurance Exchange.

Implementation: January 1, 2014

- ## Health Insurance Exchanges

Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Exchanges will have a single form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs.

Implementation: January 1, 2014

- Health Insurance Premium and Cost Sharing Subsidies

Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals. Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges, while cost sharing subsidies are available to those with incomes up to 250% of the poverty level.

Implementation: January 1, 2014

- Guaranteed Availability of Insurance

Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.

Implementation: January 1, 2014

- No Annual Limits on Coverage

Prohibits annual limits on the dollar value of coverage.

Implementation: January 1, 2014

- Essential Health Benefits

Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits ($5,950/individual and $11,900/family in 2010). Creates four categories of plans to be offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover.

Implementation: January 1, 2014

- Multi-State Health Plans

Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.

Implementation: January 1, 2014

- Temporary Reinsurance Program for Health Plans

Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

Implementation: January 1, 2014 through December 31, 2016

- Basic Health Plan

Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.

Implementation: January 1, 2014

- Employer Requirements

Assesses a fee of $2,000 per full-time employee, excluding the first 30 employees, on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees.

Implementation: January 1, 2014

- Medicare Advantage Plan Loss Ratios

Requires Medicare Advantage plans to have medical loss ratios no lower than 85%.

Implementation: January 1, 2014

- Wellness Programs in Insurance

Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-

related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Implementation: Changes to employer wellness plans effective January 1, 2014; 10-state pilot programs established by July 1, 2014

- ## Fees on Health Insurance Sector

Imposes new fees on the health insurance sector.

Implementation: January 1, 2014

- ## Medicare Independent Payment Advisory Board Report

Establishes an Independent Advisory Board, comprised of 15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate.

Implementation: First recommendations due January 15, 2014 (Funding available October 1, 2011)

- ## Medicare Disproportionate Share Hospital Payments

Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided.

Implementation: October 1, 2014

- ## Medicaid Disproportionate Share Hospital Payments

Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary to develop a methodology for distributing the DSH reductions.

Implementation: October 1, 2014

- ## Medicare Payments for Hospital-Acquired Infections

Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%.

Implementation: Fiscal Year 2015

2015(1)

- Increase Federal Match for CHIP

Provides for a 23 percentage point increase in the Children's Health Insurance Program (CHIP) match rate up to a cap of 100%.

Implementation: October 1, 2015

2016(1)

- Health Care Choice Compacts

Permits states to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.

Implementation: January 1, 2016

2018(1)

- Tax on High-Cost Insurance

Imposes an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed $10,200 for individual coverage and $27,500 for family coverage.

Implementation: January 1, 2018

Source: The Henry J. Kaiser Family Foundation

http://healthreform.kff.org/