

Implementation Timeline for Federal Health Reform

Oregon has already begun taking steps toward implementing many of the key tenets of federal reform, including planning for a health insurance exchange. Federal reform may also affect laws already in place in Oregon, including state authority to regulate insurance rates.

This timeline includes both the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act

2010 *By July*

- **High-risk pool:** Creates a temporary high-risk pool for individuals who cannot obtain health insurance. Funded with \$5 billion. The federal government may operate the pool itself or contract with states like Oregon that already operate a high-risk pool.
- **Reinsurance:** Creates a temporary re-insurance program to reimburse employers 80 percent of the cost of claims for retirees ages 55 to 64 in employment-based health plans. States and local governments will be eligible to receive the reimbursement.
- **Comparative effectiveness:** Establishes a private, nonprofit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.
- **Medical innovation:** Creates a two-year temporary credit (subject to an overall cap of \$1 billion) to encourage investment in new therapies to prevent, diagnose, and treat acute and chronic diseases. Available for qualifying investments made in 2009 and 2010.
- **Tax relief for health professional state loans:** Excludes from gross income payments made under any state loan repayment or loan forgiveness program that is intended to provide increased availability of health care services in underserved areas or health professional shortage areas. Effective for amounts received by an individual in taxable years beginning Jan. 1, 2009.
- **Indian tribal health:** Excludes from gross income the value of specified Indian tribal health benefits.
- **Community needs assessment:** A tax-exempt hospital must conduct a community health needs assessment (CHNA) at least once during any three-year period. The hospital must then adopt an implementation strategy to meet the needs identified in the CHNA and make the CHNA widely available to the public. In performing the assessment, the hospital is required to obtain input from members of the community it serves, including those with special knowledge or expertise in public health. The assessment must be made widely available to the public and the hospital must adopt an implementation strategy to meet identified community needs.

By October

- **New federal insurance rules** take effect, including:
 - No lifetime limits on benefits
 - Restricted annual limits on benefits
 - Insurers cannot rescind coverage except in case of fraud
 - Certain preventive services and immunizations will be required to be covered
 - Unmarried children can remain on their parents' health plan until age 26
 - Children cannot be denied coverage on employment-based plans for preexisting conditions. This rule will apply to all people in 2014.

- A new state Medicaid option will be created for individuals with disabilities to receive home and community-based services. Oregon already has a waiver to cover a portion of those services under Medicaid.

By the end of 2010

- **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.
- **Health insurance exchanges:** The federal government will start setting standards for state-based individual and small business exchanges. Grants will be awarded to states between 2010 and 2014 for planning/implementation of health insurance exchanges. An exchange is a government-regulated marketplace where consumers would shop for insurance, compare benefits and prices, and choose a plan that best suits their needs. The Oregon Health Policy Board has already started planning for the creation of a health insurance exchange in Oregon, and it may now qualify for additional funding to do so.
- **Insurance rate review:** Federal and state governments will review health insurance premium increases to ensure they are not unreasonable and may deny unreasonable rate increases. Grants may be awarded to states to assist with the review of premiums.
- **Tax credits:** Initiates the first phase of a small business tax credit for employer contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There's also up to a 25 percent credit for small nonprofit organizations. Later, when exchanges are operational, tax credits will be up to 50 percent of premiums.
- **National Summit on Geographic Variation, Cost, Access and Value in Health Care:** Conducted by Secretary of Health and Human Services Kathleen Sebelius.
- **Geographic variation study:** Completion of the first Institute of Medicine study on data and factors related to geographic variation in Medicare payments and allowable changes to the Medicare physician payment and hospital wage index rates.

Medicare payments adjusted (details pending)

- **Rebates for the Medicare Part D donut hole:** A \$250 rebate will be available for the 4 million individuals who are in the Medicare drug coverage gap area and pay for drugs out-of-pocket. Currently, the coverage gap falls between \$2,830 and \$6,440 in annual drug spending per person per year. Beginning in 2011, a 50 percent discount on brand-name drugs will be implemented. The gap is expected to be filled by 2020.
- **Medicare preventive care:** Cancer screening and other preventive care will be free of copayments and deductibles.

2011

- **Medicaid expansion:** States may begin expanding Medicaid to certain non-elderly individuals up to 133 percent FPL at the current federal reimbursement rate until 2014.
- **Medical-loss ratio regulation:** Insurers will be required to spend 80 to 85 percent of their revenue from premiums on medical claims.
- **Medicare Advantage benefits,** such as free glasses, will be reduced.
- **Medicare drug costs** for individuals paying out-of-pocket will be reduced by 50 percent.
- **Strengthening community health centers:** Provides funds to build new and expand existing community health centers.
- **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.
- **Requires state Medicaid** programs to cover tobacco cessation services for pregnant women.
- **Strengthening the quality infrastructure:** Additional resources will be provided to HHS to develop a national quality strategy and support the development and endorsement of quality measures for the Medicare, Medicaid and CHIP quality improvement programs.
- **Improving transitional care for Medicare beneficiaries:** Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

2013

- **CHIP:** States may be eligible for a 23 percent increase in regular CHIP match up to 100 percent.
- **Medicare payroll tax** increase will go into effect for individuals earning more than \$200,000 and couples earning more than \$250,000.
- **Tax on unearned income,** such as dividends and interest, over a certain amount.
- **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.
- **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.
- **Increasing Medicaid payment for primary care:** Requires states to pay primary care physicians the same rate Medicare

pays, and federally funds any additional state costs in full.

- **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.
- **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.
- **Increasing the threshold 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.
- **Hospital insurance tax for high-wage workers:** Increases the hospital insurance tax rate by 0.9 percent 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).
- **Medical device excise tax:** Establishes a 2.3 percent excise tax on the first sale for use of a medical device. Exempt 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.

2014

- **Mandatory individual coverage:** All individuals will be required to carry insurance or will pay a penalty. The penalty will start at \$95 or 1 percent of income, whichever is higher.
- **Employer penalty:** Employers with more than 50 employees must offer health insurance or pay a fee if any of their employees receive a government subsidy for health care.
- **Preexisting conditions:** Insurers must accept all applicants, whether an individual or employer. You cannot be denied coverage for preexisting conditions and there will be no annual limit on the benefits you receive.
- **Community rating:** Insurers are prohibited from using health status, gender, family size, geography or tobacco use in setting premiums. They'll have a limited use of age in setting premiums.
- **State-based health insurance exchanges** will be launched by Jan. 1, 2014: The exchanges must be available for individuals and small businesses.
- **Individual subsidy:** Individuals up to 400 percent FPL will receive a sliding-scale subsidy that will cap premiums and out-of-pocket expenses.
- **Essential benefits package:** Insurers must provide a basic set of minimum benefits to all individuals who are not subject to copayments or deductibles, including preventive care.
- **Premium assistance:** Offered for employers that provide insurance to Medicaid-eligible individuals.
- **Business subsidy:** For small businesses that pay for at least half of their employees' premiums, the subsidy will be increased to 50 percent of the cost of insurance.
- **State health plan:** States may be allowed to establish a health insurance plan, which would be negotiated by the state for non-Medicaid eligible individuals between 133 percent to 200 percent of FPL.
- **Re-insurance:** States must establish at least one re-insurance entity.
- **Second geographic variation study:** A second Institute of Medicine study on variation in the volume and intensity of services and health care spending completed. The study will recommend ways to incorporate quality and value metrics into the Medicare reimbursement system. Depending on the results of both studies and the recommendations by IOM, CMS and IPAB could make recommendations to increase payments.

2015

- **Health insurance exchanges** must be self-sustaining: Beginning in 2015, exchanges can charge a fee for use.
- **Tax credit:** Available for children to obtain insurance through an exchange.

2016-18

- **2016:** Insurance can be offered across state lines if the states agree.
- **2017:** States begin to pay a share of the Medicaid expansion.
- **2017:** States may allow large companies (over 100 employees) to participate in exchanges.
- **2018:** Implementation of an excise tax on high-cost plans beginning 2018 for insurers of employer-sponsored health plans, setting the threshold for the tax at \$10,200 for individual coverage and \$27,500 for family coverage.

For additional information:

Andi Easton, director of advocacy | aeaston@oahhs.org | 503-479-6007

Robin Moody, director of policy | rmoody@oahhs.org | 503-479-6013

www.oahhs.org/health-reform