Health Care Overhaul Becomes the Law of the Land

Health Care Reform

The federal health care reform legislation, known as the Patient Protection and Affordable Care Act, signed by the President Obama with 20 pens on Tuesday, March 23, 2010 at ceremonies in the East Room of the White House, and the Health Care and Education Reconciliation Act approved by Congress, signed by the President, will expand the availability of health care coverage to millions of Americans. While some of the measures will be implemented this year, many do not take effect until 2014 and some extend out to 2020.

"The bill I'm signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see." President Obama.

Below is a high-level overview of the timeline. It is important to note that many of these reforms and their effective dates are subject to the rules and regulations process both at the state and federal levels – which could alter the intended timing of implementation.

2010

New Programs:
* Temporary retiree reinsurance program is established
* National risk pool is created, small business tax credit is established
* $250 rebate for Medicare members who reach the "doughnut hole"

Insurance Reforms:
* Prohibits lifetime benefit limits – based on dollar amounts
* Allows restricted annual limits on the dollar value of certain benefits
* Coverage rescissions/cancellations are prohibited (except for fraud or intentional misrepresentation)
* Cost-sharing obligations for preventive services are prohibited
* Dependent coverage up to age 26 is mandated
* Internal and external appeal processes must be established
* Pre-existing condition exclusions for dependent children (under 19 years of age) are prohibited
* New health plan disclosure and transparency requirements are created

2011

Insurance Reforms:
* Uniform coverage documents and standard definitions are developed
* Minimum medical loss ratios are mandated

Medicare Reforms:
* Medicare Advantage cost sharing limits effective
* Medicare beneficiaries who reach the doughnut hole will receive a 50% discount on brand name drugs
* A 10% Medicare bonus will be provided to primary care physicians and general surgeons practicing in underserved areas, such as inner cities and rural communities.
* Medicare Advantage plans would begin to have their payments frozen.

Other:
* Employers are required to report the value of health care benefits on employees' W2 tax statements.
* Annual industry fee for pharmaceutical manufacturers of brand name drugs.
* Voluntary long term care insurance program would be made available to provide cash benefit for assisting disabled individuals to stay in their homes or cover nursing home costs. Benefits would start five years after people begin paying a fee for coverage.
* Funding for community health centers would be increased to provide care for many low income and uninsured people.

2012

* Hospitals, physicians, and payers would be encouraged to band together in "accountable care organizations."
* Hospitals with high rates of preventable readmissions would face reduced Medicare payments.

2013

* Individuals making $200,000 a year or couples making $250,000 would have a higher Medicare payroll tax of 2.35% on earned income —up from the current 1.45%. A new tax of 3.8% on unearned income, such as dividends and interest, is also added.
* Medical expense contributions to flexible spending accounts (FSAs) limited to $2,500 a year—indexed for inflation. In addition, the thresholds for claiming itemized tax deduction for medical expenses rise from 7.5% to 10% of income.
* Medical device manufacturers would have a 2.9% sales tax on medical devices; devices such as eyeglasses, contact lenses, and hearing aids would be exempt.
* Eliminates deduction for expenses allocable to Medicare Part D subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

2014

Coverage Mandates & Subsidies:
* Individual and employer coverage responsibilities are effective.
* Individual affordability tax credits are created and small business tax credits are expanded.

Health Insurance Exchange & Insurance Reforms:
* State individual and small group health insurance exchanges operational.
* Guaranteed issue, guaranteed renewability, modified community rating and minimum benefit standards ("essential benefits" plan) effective.
* Lifetime and annual dollar limits are prohibited for essential benefits.
* Pre-existing condition exclusions are prohibited.

Taxes & Fees:
* Addition of new taxes on health insurers

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% required for Medicare Advantage plans

2018

Taxes & Fees:
* Tax ("Cadillac tax") imposed on employer sponsored health insurance plans that offer policies with generous levels of coverage.

2020

Medicare Reform:
* Doughnut hole coverage gap in Medicare prescription benefit is fully phased out. Seniors continue to pay the standard 25% of their drug costs until they reach the threshold for Medicare catastrophic coverage.

Individual Mandate:

Starting in 2014, require that most Americans have a minimum level of health insurance or else pay a penalty.

Senate bill

Penalty: In 2014, $95 a year or 0.5 percent of a household's income, whichever is greater; in 2015, $495 or 1 percent of income; in 2016, $750 or 2 percent of income (with a maximum of $2,250 for a family). The penalty would be adjusted for inflation after 2016.

Exemptions: American Indians; people with religious objections; people who can show financial hardship; people without coverage for less than three months; households with income below 100 percent of the poverty level ($22,050 for a family of four in 2009); households that would pay more than 8 percent of their income on premiums for the cheapest available health plan.

Reconciliation bill

Would revise the penalty for some years: In 2014, $95 a year or 1 percent household's income; in 2015, $325 or 2 percent of income; in 2016, $695 or 2.5 percent of income (with a maximum of $2,085 for a family).

Instead of using the poverty threshold to exempt low-income people, the bill would exempt households with incomes below the tax-filing threshold — $9,350 for individuals and $18,700 for couples in 2009.

Insurance Exchange:

Create health insurance marketplaces, where individuals and employers can shop for insurance and compare prices and benefits, by 2014.

Senate bill

States would form their own exchanges. Several states could join together to form a regional exchange.

Open to people who do not have qualifying coverage through an employer or a public program.

Open to employers with 100 or fewer workers. Starting in 2017, states could allow employers with more than 100 employees to participate in the exchange.

Reconciliation bill

No major changes.

Public Plan:

Would not create a new government insurance plan to compete with private insurers.

Senate bill

The federal Office of Personnel Management, which provides health benefits to federal employees, would sign contracts with insurers to offer at least two national health plans to individuals, families and small businesses. The new plans would be separate from the program for federal employees, and premiums would be calculated separately. At least one of the plans would have to operate on a nonprofit basis.

Reconciliation bill

No major changes.

Subsidies for individuals:

Starting in 2014, provide tax credits to low- and middle-income people to help them buy insurance through the exchange.

Senate bill

Would provide tax credits, on a sliding scale, to people with incomes up to 400 percent of the federal poverty level ($88,200 for a family of four) to help pay insurance premiums and out-of-pocket costs like co-payments and deductibles.

Households in the lowest income group — those below 150 percent of the poverty level ($33,075 for a family of four) — would pay 2 percent to 4.6 percent of their income on premiums. Health plans would cover 90 percent of the cost of the benefits.

Households in the highest income group eligible for subsidies — those between 350 percent and 400 percent of the poverty level ($77,175 to $88,200 for a family of four) — would pay 9.8 percent of their income on premiums. Health plans would cover 70 percent of the cost of the benefits.

Subsidies would increase at the same rate as the increase in premium contributions from the previous year.

Reconciliation bill

Would offer more generous subsidies to lower income groups. Households below 150 percent of the would pay 2 percent to 4 percent of their income on premiums. Health plans would cover 94 percent of the cost of benefits.

Employer contribution:

Starting in 2019, the subsidies would grow at a slower rate than under the Senate bill.

Would not explicitly require employers to offer coverage. Starting in 2014, penalize some employers if low- and middle-income workers use federal subsidies to buy insurance.

Senate bill

Employers with 50 or more full-time workers would pay a penalty if they do not offer health benefits and if any of the workers obtain subsidized coverage through the new health insurance exchanges.

Penalty: $750 for each full-time worker in the company.

Employers with more than 50 workers that offer coverage would also pay a penalty if any of the workers obtain subsidies to buy insurance. In this case, the penalty would be $3,000 for each employee who receives subsidized coverage, or $750 for each full-time worker in the company, whichever is lesser.

Employers who offer coverage would be required to provide vouchers — equal to what the employer would have paid under the company's plan — to low- and middle income workers to obtain insurance on their own through the exchanges. These firms would not be subject to penalties if any of the employees receive subsidies. People with incomes up to 400 percent of the federal poverty level ($88,200 for a family of four) would be eligible for the vouchers if they spend between 8 and 9.8 percent of their income on premiums.

Reconciliation bill

Would increase the penalty to $2,000 for each full time worker in the company, but would exempt the first 30 employees while calculating the penalty. For example, an employer with 53 workers would pay the penalty for 23 workers, or $46,000.

Subsidies for employers:

Starting in 2010, provide tax credits to small businesses that want to offer coverage. Subsidize employer plans that cover early retirees ages 55 to 64.

Senate bill

Employers with 25 or fewer workers and average wages of $50,000 or less could qualify for tax credits. Employers with 10 or fewer workers and average wages of less than $25,000 can get the full credit — up to 35 percent of premium costs between 2010 and 2013 and 50 percent thereafter. The credit would phase out as firm size and average wage increases.

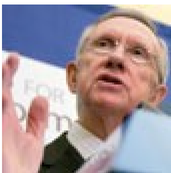
The federal government would cover 80 percent of the cost of a retiree's medical claims of more than $15,000 through 2013, with a cap at $90,000 — at which point the employer's plan would pay the rest.

Reconciliation bill

No major changes.

Expand Medicaid:

Starting in 2014, expand Medicaid to cover millions of additional people, including parents and childless adults who are not eligible under current rules.

**Senate bill**

Would cover everyone with incomes less than 133 percent of the poverty level ($29,327 for a family of four).

Estimated number of new recipients: 16 million.

From 2014 to 2016, the federal government would pay all of the costs for covering the newly eligible. The share of federal spending would vary somewhat from year to year after 2016, but would average about 90 percent by 2019, according to the Congressional Budget Office. Currently, the federal government pays about 57 percent, on average, of the costs of Medicaid benefits. Nebraska is the only state that would receive 100 percent of the cost of expanding Medicaid.

Reconciliation bill

Would take away the exemption for Nebraska and increase the share of federal spending for covering newly eligible people. The federal government would pay all of the costs until 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent thereafter. Some states that already insure childless adults under Medicaid would receive more federal money for covering that group through 2018.

Would increase Medicaid payment rates to primary care doctors to match Medicare payment rates, which are higher, in 2013 and 2014.

Medicare drug benefits:

Would close a gap in Medicare coverage of prescription drugs, known as the doughnut hole, by 2020.

Senate bill

Would increase the amount of drug costs covered by Medicare by $500 in 2010. And beginning on July 1, 2010, drug makers would provide 50 percent discounts on brand-name drugs and biologics that low- and middle-income beneficiaries have to pay for themselves once the coverage gap begins. Currently, older Americans in the coverage gap pay 25 percent of the cost of their drugs up to $2,830 in out-of-pocket spending, then the full cost of drugs up to $6,300 — a $3,470 “doughnut hole” — after which Medicare catastrophic coverage kicks in and seniors pay only 5 percent of the cost of additional drugs.

Reconciliation bill

Would give a one-time, $250 rebate to people who face the coverage gap in 2010 (instead of the $500 increase).

The 50 percent discount on brand-name drugs would begin in 2011. By 2020, the government would pay to provide up to 75 percent discount on brand-name and generic drugs, eventually closing the coverage gap.

Defining benefits:

Require insurance plans to offer a minimum package of health insurance benefits, to be defined by the federal government.

Senate bill

The basic plan would cover 60 percent of the cost of the benefits. The proposal would limit out-of-pocket costs at $5,950 year for an individual and $11,900 for a family.

The exchanges would offer three other benefit plans, covering 70 percent to 90 percent of costs. A plan for catastrophic coverage would be available to people up to the age of 30 and those who are exempt from the requirement to obtain insurance.

Reconciliation bill

No major changes.

Insurance regulations:

Prohibit insurers from denying coverage or charging higher premiums because of a person's medical history or health condition.

Senate bill

People with pre-existing conditions who have been turned down for health insurance could sign up for a high-risk insurance pool that would be available within 90 days and remain available until 2014. Within six months, insurers would be prohibited from denying coverage to children based on pre-existing medical conditions, from placing lifetime dollar limits on coverage and from rescinding coverage when a person becomes sick or disabled. The ban on exclusion based on pre-existing conditions would be extended to every one when the exchanges are operational in 2014.

Premiums for older people cannot be more than three times the premium for young adults.

Insurers competing in the new exchanges would be required to justify rate increases and those who raise prices excessively could be barred from the exchanges.

Insurers would be required to spend more of their premium revenues — between 80 to 85 cents of every dollar — on medical claims. According to a recent Senate Commerce Committee analysis, the largest for-profit insurance companies spend about 74 cents out of every dollar on medical care in the individual market.

Reconciliation bill

Would extend the ban on lifetime limits and rescission of coverage to all existing health plans within six months.

Would extend the ban on exclusion based on medical condition and annual limits to all employer-sponsored health plans by 2014.

Dependent coverage:

Within six months, require health plans, including employer-sponsored plans, to cover children of policyholders up to a certain age.

Senate bill

Would allow children to stay on their parents' insurance plans until they turn 26. Currently, states set the age at which adults can no longer be covered by their parents' insurance.

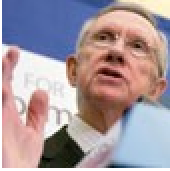
Reconciliation bill

Would apply the requirement to cover children to all existing plans within six months, not just new plans.

Before 2014, only children who do not have a choice of coverage from an employer can stay on their parents' plan.

Long-term care:

Starting in 2011, establish a voluntary federal program to provide long-term care insurance and cash benefits to people with severe disabilities.



Senate bill

The program would be financed with premiums paid by participants, through voluntary payroll deductions, with no federal subsidy. People could qualify for lifetime benefits if they became disabled after paying premiums for at least five years and working for three of those years. Individuals who have substantial cognitive impairments or are unable to perform two or three “activities of daily living,” like eating, bathing or dressing, would qualify.

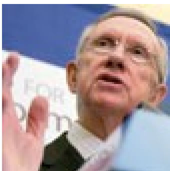
The amount of benefits would vary, depending on the degree of a person’s disability, but could not average less than $50 a day. The Congressional Budget Office assumes that premiums would be $123 a month for benefits expected to average $75 a day, or about $27,000 a year. The amount of benefits would vary, depending on the degree of a person’s disability. The secretary of health and human services could increase premiums to ensure “the financial solvency” of the program over 75 years.

Reconciliation bill

No major changes.

Abortion:

Prohibit use of federal money for abortions, except as allowed by current law — in cases of rape or incest or if the life of a pregnant woman was in danger.



Senate bill

Health plans could choose whether to cover abortion or not. But states could prohibit the coverage of abortions by health plans that are offered for sale through the new insurance exchanges.

People who receive federal subsidies to buy insurance could enroll in health plans that cover abortion. But subscribers of health plans that cover abortion would have to make two separate monthly premium payments: one for all insurance coverage except abortion and one for abortion coverage.

Health plans that offer abortion coverage and receive federal subsidies would be required to segregate the federal money into separate accounts and use only the premium money and co-payments contributed by consumers to cover the procedure. State insurance commissioners would police the “segregation of funds.”

Reconciliation bill

No major changes. Reconciliation is used only for budget-related issues, which means the abortion provisions can’t be changed.

Illegal immigrants:

Limit access to the exchange and federal subsidies for illegal immigrants.

Senate bill

Could not buy insurance from the exchanges, even if they were able to pay the full cost themselves, without federal subsidies.

Reconciliation bill

No major changes. Reconciliation is used only for budget-related issues, which means the immigration provisions can’t be changed.

Children of the poor:

Changes to the Children’s Health Insurance Program, which benefits children of the working poor.

Senate bill

Children now enrolled in CHIP would continue to receive coverage through the program. The bill would provide money to extend the program for two more years, through 2015.

States would be required to maintain current coverage levels for children enrolled in CHIP and Medicaid until 2019.

Beginning in 2014, states would receive higher federal reimbursement for the program’s beneficiaries, increasing from an average of 70 percent to 93 percent.

Reconciliation bill

No major changes.

Total cost and coverage:

10-year estimates of the cost of the legislation from the Congressional Budget Office.

Senate bill

$871 billion. Expected to reduce projected federal budget deficits by $132 billion.

31 million people would gain coverage, leaving 23 million uninsured.

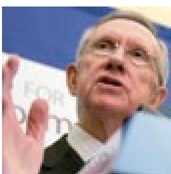
Reconciliation bill

About $940 billion. Expected to reduce deficits by $138 billion.

32 million people would gain coverage, leaving 22 million uninsured.

Paying for the proposals:

Impose new fees and taxes. Curb Medicare payments to hospitals and many other health care providers.


Senate bill

TAX ON HIGH-COST HEALTH PLANS: Starting in 2014, would impose a 40 percent excise tax on high-cost employer-sponsored group health plans with premiums over $8,500 for individual coverage and $23,000 for family. The thresholds would rise each year by the inflation rate plus one percentage point. The bill would provide a special dispensation to police officers, firefighters, miners and construction workers, who have high premiums because they work in high-risk occupations.

MEDICARE PAYROLL TAX: Starting in 2013, would increase tax rate — from 1.45 percent to 2.35 percent – for individuals earning more than $200,000 a year and families earning more than $250,000.

FEES FROM HEALTH CARE SECTOR: Would impose annual fees, allocated by market share, on health care companies. Starting in 2010, drug makers would pay $2.3 billion a year. Manufacturers of medical devices would pay $2 billion in 2011 and $3 billion after 2017. For insurance companies, the fee would start at $2 billion in 2011 and gradually increase to $10 billion a year in 2017. Nonprofit insurance companies could be exempt if they spent a large share of their premiums on medical care rather than administrative costs.

FLEXIBLE SPENDING ACCOUNTS: Starting in 2011, would place a $2,500 annual limit on what people can set aside from their paychecks before paying taxes to use for health care expenses.

TANNING TAX: Would impose a 10 percent tax on indoor tanning services starting in 2010.

MEDICARE SAVINGS: Squeeze roughly $500 billion out of the projected growth in Medicare over 10 years, including $116 billion in cuts to federal subsidies for privately offered Medicare Advantage plans.

Reconciliation bill

TAX ON HIGH-COST HEALTH PLANS: Would delay the application of the tax until 2018 and would increase the thresholds to $10,200 for individual coverage and $27,500 for family. Beginning in 2020, the thresholds would be rise by the inflation rate.

MEDICARE PAYROLL TAX: Would impose an additional 3.8 percent tax on capital gains, dividends, interest and other “unearned income.”

FEES FROM HEALTH CARE SECTOR: Would delay the implementation of all fees by one to three years. Drug makers would pay $2.5 billion in 2011, $3 billion from 2012 to 2016, $3.5 billion in 2017, $4.2 billion in 2018, and $2.8 billion in 2019 and thereafter. For insurance companies, the fee would start at $8 billion in 2014 and rise to $14.3 billion in 2018, after which point the fee would rise yearly by the rate of premium growth. Medical device manufacturers would pay 2.9 percent excise tax on devices sold (excluding eyeglasses, contact lenses, and hearing aids).

FLEXIBLE SPENDING ACCOUNTS: Would delay the provision until 2013.

MEDICARE SAVINGS: Would imposes an additional $16 billion in cuts to Medicare Advantage plans, which now cost the government more on average than traditional Medicare, for a total of $132 billion in reductions

Health Care: A Brief Glossary

Benefit package – The list of services and products that a health plan covers. Typically, the more expansive the benefit package is, the more expensive the health insurance coverage is.

Capitation – A system of paying doctors and health providers a set amount per patient per year regardless of how much health care that person uses. In theory, this creates incentives to keep people healthy and avoid using expensive services.

Cherry-picking – A process where an insurer tries to cover only the healthiest people with the lowest risk of using health services.

Community rating – This rule would require insurance companies to set premium rates based only on geography and not health status. Sometimes gender and age also are considered in rate setting.

Guaranteed issue – This rule would require insurance companies to offer health coverage to any one willing and able to pay regardless of health status or pre-existing conditions.

Comparative effectiveness research – Research that compares two or more drugs, treatments or medical interventions to see which is most effective for which type of patient. In theory, insurance providers, whether it is the government or a private company, would use this research to guide decisions on which medical treatments to cover.

Employer mandate – A requirement that businesses offer their employees health insurance. It may only pertain to businesses of a certain size. Massachusetts, for example, requires businesses with 10 or more employees to provide coverage or to pay a set amount on their behalf to purchase coverage.

Fee-for-service – The traditional and most widespread method of paying doctors and health care providers for each service provided.

Health insurance cooperative – A nonprofit health plan owned and operated by a collection of small businesses or individuals that group together to purchase health insurance so they have greater negotiating power.

Health insurance exchange – A marketplace where people can buy insurance. An exchange could be set up in many ways at the state, regional or national level. The government could regulate what plans are offered, how much insurers charge and set other rules insurers must follow. Sometimes called a “connector,” it often is compared to a menu of insurance options people can choose among similar to what is available to federal government employees. Its primary users likely would be small businesses and people buying individual insurance.

High-risk pool – Some states have insurance pools for people who insurance companies will not cover due to pre-existing conditions or poor health status.

Individual mandate – A requirement that all individuals purchase health insurance coverage. Proponents say an individual mandate is necessary to achieve universal coverage and to avoid a system where only the elderly and unhealthy purchase insurance. Opponents say it infringes on personal freedoms and is unenforceable.

Medicaid – The government health insurance program for the poor. The $333-billion program is paid for through a combination of federal and state funding, but administered by states. In 2007, about one in five people in the U.S. were enrolled in Medicaid.

Medicare – The government health insurance program for people who are 65 and older, blind or permanently disabled. In 2008, the $460-billion program provided health coverage to about 45 million people.

Medicare Advantage – This program allows Medicare beneficiaries to enroll in a private HMO or other health plan to receive their benefits.

Medical underwriting – An insurance process of evaluating an individual’s health status to decide if they should be offered insurance and how much they should pay in premiums. Underwriting is not used in the employer-sponsored insurance market only the individual market.

Pay for performance – A system that would pay doctors, hospitals and health care providers based on how well they take care of patients and not just on how much care they provide to patients.

Pre-existing condition – A prior health condition that may make people ineligible for health insurance coverage in the individual market.

Premium – The amount an insurance company charges to provide coverage. In 2008, the average annual premium for a family was $12,680 – more than twice the cost in 1999.

Public plan – The government could offer a public plan similar to Medicare as one of choice in the health insurance exchange to compete with private insurers. Republicans strongly oppose creating a public plan.

Purchasing pool – Health insurers lump the premiums people pay together to pay for health care services. In this pool, people who use few health services subsidize the costs of people who use many. This ability to "spread risk" gives large employers an advantage over small employers when buying health insurance.

SCHIP – The State Children's Health Insurance Program was created in 1997 to provide health coverage to children not poor enough to qualify for Medicaid. The program is funded by the federal and state governments, but each state operates its program differently. In 2008, the $10-billion program provided health coverage to about 4.5 million children.

Single-payer system – A health care system in which all the funding comes from one source, usually the government. Private insurance, however, can and does exist in countries with a single-payer system, such as Canada and the United Kingdom.

Socialized medicine – A health system in which the government provides the health insurance coverage, owns the hospitals, and employs the doctors. The Veterans' Administration health system is an example of socialized health care.

Uncompensated care – Care that doctors and hospitals provide to patients for which they never receive payment.

Underinsured – A term describing people who have insurance but are still considered financially vulnerable to high health expenses because of the limitations or cost-sharing of their plans.

Please note that the precise coverage afforded is subject to the terms, conditions, and exclusions of the policy as issued. This explanation is intended only as a guideline. This information is not intended to be considered investment, tax or legal advice. It is provided, for your education only. This is not a health care contract. All terms and coverage are defined solely by your policy.

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