Healthcare Reform: Examining the Implementation Timeline

Exhibit 1: Healthcare Implementation Timeline 2010-2011 – Selected Provisions

Year	Item	Short Description
2010	**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.
	Small Business Tax Credit	Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35% of the employer's contribution to provide health insurance for employees. There is also up to a 25% credit for small nonprofit organizations. The second phase of the small business tax credit for qualified small employers occurs in 2014.
	Medical Loss Ratio Provisions	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.
	Temporary Reinsurance Program	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.
	Rebates for the Part D "Donut Hole"	Provides a $250 rebate for all Part D enrollees who enter the donut hole. Currently, the coverage gap falls between $2,700 and $6,154 in total drug costs.
	New Therapies Tax Credit	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. The credit would be available for qualifying investments made in 2009 and 2010.
2011	**Center for Medicare & Medicaid Innovation Created**	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. How authority for this center is defined will be critical.
	Medicare Advantage Payments Changed	Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.
	MLR floor	Minimum Medical Loss Ratio of 85% for Large Group Plans; 80% for Small Group/Individual Plans
	Payment Rate Reduction	Home Health base rates reduced by 2.5 percentage points; market basket reduced by 1 percentage point.
	Revised Payment Classification System	Implementation of RUG IV will be delayed to Oct.1, 2011 at the earliest.
	Discounts in the Part D "Donut Hole"-	Provides a 50% discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.
	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.

Source: H.R. 4872, other Government reports, press reports, Credit Suisse Research

Exhibit 2: Healthcare Implementation Timeline 2012-2014 – Selected Provisions

Year	Item	Short Description
2012	**Payment to Acute Care Hospitals Linked 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.
	Hospital Readmissions Study and Payment Modification	Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions and uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.
	Home Health Payment Rate Reduction	Market basket reduced by 1 percentage point.
	Skilled Nursing Facilities Therapy Payment	Concurrent therapy payment restructuring and MDS 3.0 may be implemented and productivity adjustment begins
2013	**Pilot Program on Payment Bundling**	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.
	Employer Part D Subsidy Deduction Ends	Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.
	Hospital Insurance Tax for High Wage Workers Raised	Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married filing jointly). Moreover, net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns) will also be taxed.
	Medical Device Excise Tax	Establishes a 2.3% 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.
	Patient Centered Outcomes Research Trust Funds Starts Collecting Fees	Annual fee becomes effective on insured and self-insured plans to fund the patient centered outcomes research trust fund. . Beginning of the funding program for comparative research under the legislation.
2014	**Out-Of-Pocket Drug Costs Cost Growth Curbed**	The cost threshold for out-of-pocket prescription drug costs is reduced by .25% in 2014 and 2015 and by the Consumer Price Index-Urban (CPI-U) plus 2 percentage points for 2016-2019.
	Health Insurance Regulations	Prohibits insurance companies from engaging in practices that enable them to refuse to sell or renew policies due to an individual's health status. Health plans can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to heath status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use.
	Payment Rate Reduction	Home Health payment rebasing begins
	Health Insurance Exchanges Created	Opens health insurance Exchanges in each State to individuals and small employers that will allow for comparison shopping among standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.
	Multi-State Option Begins	Provides a choice of coverage through a multi-State plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

Source: H.R. 4872, other Government reports, press reports, Credit Suisse Research

Exhibit 3: Healthcare Implementation - Items to take effect in 2014-2018

Year	Item	Short Description
2014 (cont)	**Health Care Tax Credits for Insurance Purchased on Exchanges**	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% 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.
	Individual Mandate Begins	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% 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 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.
	Employer Mandate Begins	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. 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 $2000 per full-time employee.
	Medicaid Eligibility Increases	Medicaid eligibility will expand to 133% of poverty for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and appropriate manner. States will receive increased federal funding to cover these new populations.
	Health Insurance Provider Fee	Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.
2015	**Independent Payment Advisory Board Created**	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.
	Medicare Physician Payment Based on Value Not Volume	Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.
2018	**Excise Tax on High Cost Plans (aka Cadillac Plan Tax) Begins**	Tax is on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (single coverage), increased to $30,950 (family) and $11,850 (single) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

Source: H.R. 4872, other Government reports, press reports, Credit Suisse Research