

*The following is a general overview of timelines for implementation of major aspects of a long and complicated bill with explanations and information about Colorado's implementation of the bill. Members of the LWVBC Health Care Committee are not experts on the bill. Most of the following information was compiled from websites listed at the end of the document titled "Outline of the Health Care Bill" on LWVBC website.*

## **The Federal Patient Protection and Affordable Care Act Timeline**

### **What's Changing and When**

#### **2010**

**January 1 – Provides Small Business Health Insurance Tax Credits** – The first phase of this credit has been implemented and is retroactive to January 1, 2010. Businesses with 25 or fewer employees and average annual wages of less than \$50,000 per employee will be eligible for a tax credit of up to 35% of the cost of their premiums. Small non-profits will be eligible to receive a tax credit of up to 25%. The second phase of this credit will be implemented in 2014.

**April 1 – Allows States to Cover More People on Medicaid** – Medicaid payments to Colorado medical providers are funded with 50% Federal dollars and 50% State dollars. States can now receive Federal matching funds for covering additional low-income individuals and families under Medicaid. Colorado passed HB09-1293, which became effective May 1, 2010, and expands coverage to parents of Medicaid eligible children with incomes under 100% of Federal Poverty Level (\$22,050 for family of 4) and children and pregnant women in families up to 250% of FPL (\$55,125 for family of 4). Children under the age of 6 can be covered in families with incomes up to 133% of FPL. In 2011, HB1293 will create a Medicaid buy-in for Coloradans with disabilities, and incomes up to 450% of FPL. In 2012, HB1293 will allow Colorado to expand Medicaid to adults without dependents and incomes under 100% of FPL.

**June thru Dec. – Provides Relief for Medicare Prescription Drug "Donut Hole"** – A onetime \$250 rebate will be paid to Medicare recipients in 2010, when the "donut hole" is reached. The "donut hole" is prescription expenses of more than \$2830 and less than \$6440. The first checks were mailed in June and will continue throughout 2010. The donut hole closes entirely by 2020.

**June 1 – Extends Coverage for Early Retirees** - Companies that provide benefits for retirees aged 55-64 can get financial help to continue insurance programs until Health Insurance Exchanges are available in 2014. The Act creates a temporary re-insurance program to help offset the costs of expensive health care premiums for employers who provide health benefits for these early retirees. As of the end of October, 29 Colorado companies enrolled in the Early Retiree Reinsurance Program.

**July 1 – Provides Access to Insurance for People with Pre-existing Conditions** - New coverage options will be available to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of implementing a state-wide plan, or

a plan will be established by the Department of Health and Human Services. Colorado's plan is called "GettingUSCovered", and is administered by Rocky Mtn. Health Plans and CoverColorado. Premiums will range from \$115 to \$601 per month for non-smokers. State plans will phase out in 2014, when discrimination is prohibited. Colorado received \$90 million in Federal money for this program.

**September 23 - Extends Coverage for Young Adults** – Effective for new plans only. Young adults can be covered on their parent's insurance plan up to age 26, regardless of marital or dependent status. They also don't have to be living with their parents. This doesn't apply if the young adult is offered insurance at his or her workplace. Individual insurance plan requirements may differ, so it's best to check with your insurance company for eligibility rules. This provision is one reason given for higher insurance premiums next year. Also, some insurers are now charging for every dependent, rather than including an unlimited number of dependents in a single family premium.

**Prohibits Extra Charges for Preventive Care in New Insurance Plans** - All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance.

**Prohibits Insurance Companies from Rescinding Coverage** - Insurers are prohibited from dropping policyholders when they get sick, except in cases of fraud. Rescissions are rare in the group market, but are estimated to occur about .15% in the individual market. This provision is expected to have a small effect on the cost of premiums.

**Creates Appeal Process for Insurance Company Decisions** - Insurers are required to implement in all new plans, a process that gives consumers a way to appeal coverage determinations or claims. This provision establishes an external review process.

**Eliminates Lifetime Limits on Insurance Coverage** - Insurers are prohibited from imposing lifetime limits on essential benefits, like hospital stays. According to national data, 63% of large employer plans, 52% of small employer plans, and 89% of individual plans had lifetime limits. Premium costs are expected to increase by .5% or less due to this provision.

**Regulates Annual Limits on Insurance Coverage** – Insurers are restricted from imposing annual limits on new plans in the individual market and all group plans. This provision will be phased in; requiring new plans to have annual limits no lower than \$750,000. The limits will increase to \$1.25 million in 2012, \$2 million in 2013, and be completely eliminated in 2014. Recently, 30 insurers were granted waivers by the Federal government, allowing them exemptions for one year.

**Prohibits Denying Coverage of Children with Pre-Existing Conditions** – Exclusions of children with pre-existing conditions are eliminated for those under the age of 19. This applies to new plans and grandfathered group plans, but does not apply to existing individual plans. As of October 1, several Colorado insurers dropped child-only plans, even though there are no regulations about how much they can charge. The insurers claimed parents would wait until a child is sick before enrolling. The Colorado Division of Insurance issued emergency regulations requiring specified open enrollment dates in child-only plans, but so far

these insurers haven't re-entered the market. Child-only plans are still being offered by Kaiser Permanente and Rocky Mountain Health Plans.

**Various Dates -Holds Insurance Companies Accountable for Unreasonable Rate Hikes -** \$250 million in new Federal grants will be available to states that require insurance companies to justify premium increases. Insurance companies with excessive or unjustified increases will be barred from participating in the new health insurance Exchanges in 2014. Colorado was awarded \$1 million recently, enabling the expansion of their review process. Unjustified increases can be denied or refunded to policy holders.

**Provides New Incentives to Rebuild the Primary Care Workforce -** Scholarship funding and tax relief will be provided for student loans incurred after 12/31/08. \$320 million is available to benefit doctors, nurses and physician assistants working in underserved or health professional shortage areas. The law establishes a National Health Care Workforce Commission that will make recommendations to Congress and the Administration about how best to align primary care workforce resources with national needs. Dr. Richard Krugman, dean of the University of Colorado School of Medicine, was recently named to serve on the commission.

**Funds Prevention of Disease and Illness –** Establishes a Prevention and Public Health Fund of \$15 billion to be distributed over 10 years, for investments in prevention and public health programs. The Surgeon General will chair an inter-agency council to promote healthy living. Colorado agencies will receive over \$1 million in grants to support public health and prevention programs.

**Strengths Community Health Centers -** New Federal funding will be available to support construction and expansion of services at community health centers. This will allow for nearly doubling the number of patients seen by the centers over the next 5 years. Health centers in three Colorado cities, Alamosa, Englewood, and Lafayette, will receive a total of \$18.6 million in grants.

**Increases Payments for Rural Healthcare Providers –** Increased Federal funding is aimed at attracting and retaining medical professionals in rural communities. Medicare payment protections are extended to rural facilities with a low-volume of Medicare patients.

## 2011

**January 1 – Creates Prescription Drug Discounts –** Provides a 50% discount on Medicare Part D covered **brand name** drugs for seniors who reach the coverage gap or “donut hole”. Over the next 10 years additional discounts on brand name and generic drugs will be phased in, until the “donut hole” is completely eliminated by 2020.

**Prohibits Extra Charges for Medicare Preventive Care –** Requires that free annual wellness visits be available to seniors, and no co-payments or deductibles for most preventive care. This is similar to the 9/23/10 regulation for new insurance plans, but applies to Medicare.

**Reduces Cost of Health Care Premiums** – The law establishes a medical loss ratio, which means that insurers will be required to spend 85% of large group and 80% of small group and individual plan premiums on health care. Insurance companies that do not meet these thresholds must provide rebates to policyholders.

**Addresses Medicare Advantage Overpayments to Insurance Companies** – Medicare Advantage plans are private insurance plans through which Medicare recipients receive their Medicare benefits. Medicare pays the private insurance company a set amount each month for each member. The aim is for greater uniformity in payments to Medicare Advantage insurance plans and traditional Medicare coverage. Now payments are on average over \$1000 more per patient to Medicare Advantage insurers. Bonus payments will be available to Medicare Advantage plans that provide high quality care. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits. Premiums for Medicare Advantage Plans are projected to go down by 1%, while enrollment is expected to increase by 5%. In October, the Colorado Department of Regulatory Agencies was awarded \$100,000 to fight Medicare fraud.

**Creates New Center for Medicare and Medicaid Innovation** – The purpose of the Center is to begin testing new ways of delivering care to patients. Expectations are to improve the quality of care and reduce the rate of growth in health care costs for these programs, including CHIP. The law directs Health and Human Services to submit a national strategy for quality improvement measures by January 1, 2011.

**Creates Community Care Transitions Program** – The program will be designed to help high-risk Medicare beneficiaries, following hospital discharge, avoid unnecessary re-admissions by coordinating care and connecting patients to community services.

**Creates New Voluntary Public Long-Term Care Insurance Program** – This is a new optional employee program, called Community Living Assistance Services and Support, or CLASS. The program will be financed by voluntary payroll deductions and provide benefits to adults who are actively employed and become disabled. The program will have a five year vesting period.

**October 1 – Develops New Innovations to Bring Down Medicare Costs** – Establishes an Independent Payment Advisory Board of medical experts that will develop proposals for extending the solvency of the Medicare Trust Fund. The board will focus on ways to target waste in the system and improve patient outcomes.

**Provides Improved Access to Home and Community Based Services** – Establishes a new Community First Choice Option, that allows states to offer home and community based services to disabled individuals, through Medicaid rather than institutional care.

## 2012

**January 1 – Encourages Creation of Integrated Health Systems** – The law provides incentives for physicians to join together to form “Accountable Care Organizations”. The purpose is to gain efficiencies and improve quality, by coordinating patient care. In 2014, these

co-op non-profit organizations will participate in the new Health Insurance Exchanges. Grand Junction's healthcare system is an "Accountable Care Organization". We'll talk more in depth about Grand Junction later in our presentation.

**March – Funds Research to Examine Healthcare Disparities** – Requires any ongoing or new Federal health program to report racial, ethnic and language data, to help identify and reduce disparities.

**October 1 – Reduces Paperwork and Administrative Costs** – This provision institutes changes to standardize billing. It requires health plans to implement uniform standards and rules for the secure, confidential, electronic exchange of health information.

**Links Traditional Medicare Payments to Quality Outcomes** – Creates a hospital "pay for performance" program called Value-Based Purchasing (VBP). Financial incentives will be offered to hospitals to improve the quality of care. Hospital performance will be required to be publicly reported, and poor performance may result in payment penalties.

## 2013

**January 1 – Improves Preventive Health Coverage for Medicaid Patients** – Provides new funding to state Medicaid programs that cover evidence-based preventive services at little or no cost to the patient.

**Increases Medicaid Payments for Primary Care Doctors** – Requires states to pay primary care physicians no less than 100% of Medicare payment rates in 2013 and 2014.

**Expands Authority to Bundle Medicare Payments** – Establishes a national pilot program of "payment bundling", to encourage hospitals, doctors and other providers to work together to achieve savings for Medicare. With "payment bundling", hospitals, doctors, and other providers are paid a flat rate for an episode of care, such as surgery, instead of separately. This should increase collaboration, improve coordination of patient care, and improve patient outcomes.

**October 1 – Extends Funding for the Children's Health Insurance Program (CHIP)** – States will receive two more years of Federal funding to continue coverage for low income children not eligible for Medicaid.

## 2014

**January 1 – Establishes Health Insurance Exchanges** – Requires health insurance marketplaces or exchanges to be set up in each state. Exchange plans will be available to individuals if their employer doesn't offer insurance or if they qualify for an affordability exemption. Those who qualify for an affordability exemption can get a voucher for the employer portion of insurance, to help them purchase coverage in an Exchange plan. Some small businesses can also qualify to participate. A choice of coverage will be ensured by allowing multi-state plans. Congress will be getting their insurance through an Exchange plan in 2014. Colorado is currently working on its Exchange program and has received close to \$1 million

from the U.S. Department of Health and Human Services to fund exchange planning. More funding will be awarded in the coming years.

**Promotes Individual Responsibility** – Most individuals will be required to have health insurance. Exceptions for people with low incomes, Native Americans, and religious reasons will be allowed. Penalties for not having insurance will be phased in. In 2016 the penalty will be \$695 per person, with a maximum of \$2085 for a family, or 2.5% of income, whichever is greater. Nobody will go to jail for not obtaining insurance.

**Increases Access to Medicaid** – Medicaid eligibility will increase to 133% of poverty level for non-elderly individuals, funded by the Federal government for the first 3 years. Medicaid will move to being based on income eligibility only. The current structure requires that a person has to be both low income **and** fall into one of several categories of eligibility (i.e. parent of Medicaid eligible child, aged, blind, disabled).

**Makes Health Care More Affordable** – Tax credits and cost-sharing reductions (e.g. copayments, coinsurance, and deductibles) will be provided for people with incomes above 133% and below 400% of poverty level, who are not eligible for or offered other qualified coverage and will purchase insurance through the new Exchanges. In 2010 that translates to a maximum income of \$43K for an individual, and \$88K for a family of 4. The credits are refundable, so you don't have to have a tax liability to qualify.

**Ensures Coverage for Individuals Participating in Clinical Trials** – Prohibits insurers from dropping or limiting coverage when an individual participates in a clinical trial. This applies to all clinical trials that treat cancer or other life-threatening diseases.

**Eliminates Annual Limits on Insurance Coverage** – Prohibits new individual plans and all employer plans from imposing annual limits. This expands upon restrictions that took effect on 9/23/10.

**Bans Discrimination Due to Pre-Existing Conditions or Gender** – Insurance companies will be banned from refusing to sell or charging higher rates based on pre-existing conditions or gender. Premiums can vary only by age (no more than 3:1), geography, family size, and tobacco use.

**Increases Small Business Health Insurance Tax Credit** – The law implements the second phase of the small business tax credit. Qualified businesses will be eligible for up to 50% of the employer's insurance costs. The credit for small non-profits is increased to 35% of insurance costs.

## 2015

**January 1 – Pays Physicians Based on Value Not Volume** – This aims to tie physician payments under Medicare to the quality of care provided. Those physicians providing higher value care will receive higher payments.

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