

December 1, 2010

## Timeline for Implementing ObamaCare

### 2010

- Federal officials authorized to review and investigate health insurance premium increases. This provision encroaches on state authority and imposes a costly burden on insurers.
- FDA authorized to approve “follow-on” biologics.
- Increase brand-name pharmaceutical Medicaid rebate (from 15.1% to 23.1%).
- Medicare payments to physicians in primarily rural areas increase (2 years).
- Deny “black liquor” eligibility for cellulosic bio-fuel producer’s credit.
- Tax credits provided to certain small employers for healthcare-related expenses. Dan Danner, the President of the National Federation of Independent Businesses (NFIB), wrote in a [Wall Street Journal op-ed](#) that these credits are not designed to be useful to small businesses.
- Increase adoption tax incentives for 2 years.
- Codify economic substance doctrine and impose penalties for underpayments (transactions beginning on 3/23/10).
- Provide income exclusion for specified Indian tribe health benefits provided after 3/23/10.
- Temporary high-risk pool and high-cost union retiree reinsurance pool (\$5 billion for each pool for 3.5 years, Total Cost: \$35 billion) (takes effect on 6/23/10).
- Impose 10% tax on indoor UV tanning (takes effect on 7/1/10).
- Medicare cuts to inpatient psych hospitals (takes effect on 7/1/10).
- Prohibits lifetime and annual benefit spending limits (plan years beginning 9/23/10). The result of limiting lifetime and annual benefits will be that private [health insurance companies](#) will be forced out of business.
- Prohibits non-group plans from canceling coverage (rescissions) (plan years beginning 9/23/10).
- Requires plans to cover - at no charge to the policyholder - most preventive care (plan years beginning 9/23/10). As Michael Cannon at CATO explains, there is no such thing

as a free lunch. Cannon writes [here](#) that the result of this government requirement will be higher premiums.

- Allows dependents to stay on parents' policies through age 26 (plan years beginning 9/23/10).
- Provides limited protections to children with pre-existing conditions (plan years beginning 9/23/10).
- Hospitals in "Frontier States" (ND, MT, WY, SD, UT) receive higher Medicare payments for up to five years. After these higher reimbursement rates are discontinued, these states will be forced to find additional funds for Medicaid in their state budgets.
- Hospitals in "low-cost" areas receive higher Medicare payments for 2 years. This provision will create a "funding cliff" because hospitals will become more dependent on federal Medicare reimbursements, which disappear after two years.

## 2011

- Medicare Advantage (MA) cuts begin. These cuts are already affecting millions of seniors and are [causing cancellations of MA](#) plans across the country.
- No longer allowed to use FSA, HSA, HRA, Archer MSA distributions for over-the-counter medicines. This new regulation will diminish the usefulness of consumer-driven plans.
- Medicare cuts to home health begin.
- Wealthier seniors (\$85k/\$170k) begin paying higher Part D premiums (not indexed for inflation in Parts B/D).
- Medicare reimbursement cuts when seniors use diagnostic imaging like MRIs, CT scans, etc.
- Medicare cuts begin to ambulance services, ASCs, diagnostic labs, and durable medical equipment.
- Impose new annual tax on brand name pharmaceutical companies.
- Americans begin paying premiums for federal long-term care insurance (CLASS Act).
- Health plans required to spend a minimum of 80% of premiums on medical claims.
- Physicians in "Frontier States" (N.D., MT., WY, S.D., UT) receive higher Medicare payments. This provision will create a funding cliff, leaving these states with huge budget shortfalls, or extreme benefit cuts.
- Prohibition on Medicare payments to new physician-owned hospitals. [As John Goodman notes](#), entrepreneurial doctors have a better track record of running hospitals than government bureaucrats.
- Penalties for non-qualified HSA and Archer MSA distributions double (to 20%)
- Seniors prohibited from purchasing power wheelchairs unless they first rent for 13 months.

- Brand name drug companies begin providing 50% discount in the Part D “donut hole.”
- 10% Medicare bonus payment for primary care and general surgery (5 years)
- Employers required to report value of health benefits on W-2.
- Steps towards health insurance administrative simplification (reduced paperwork, etc) begins (five year process).
- Additional funding for community health centers (funding lasts five years).
- Seniors who hit Part D “donut hole “in 2010 receive \$250 check (3/15/11).
- New Medicare cuts to long-term care hospitals begin (7/1/11).
- Additional Medicare cuts to hospitals and cuts to nursing homes and inpatient rehab facilities begin (fiscal 2012).
- New tax on all private health insurance policies to pay for comparative efficient research (plan years beginning fiscal 2012).

## 2012

- Medicare cuts to dialysis treatment begin.
- Require information reporting on payments to corporations.
- Medicare to reduce spending by using an HMO-like coordinated care model (Accountable Care Organizations).
- Medicare Advantage plans with a 4 or 5 star rating receive a quality bonus payment.
- New Medicare cuts to inpatient psychiatric hospitals (7/1/12).
- Hospital pay-for-quality program begins (fiscal 2013).
- Medicare cuts to hospitals with high readmission rates begin (fiscal 2013).
- Medicare cuts to hospice begin (fiscal 2013).

## 2013

- Impose \$2,500 annual cap on FSA contributions (indexed to CPI).
- Increase Medicare wage tax by 0.9% and impose a new 3.8% tax on unearned, non-active business income for those earning over \$200,000 or \$250,000 for families (not indexed to inflation).
- Generally increases (7.5% to 10%) threshold at which medical expenses, as a percentage of income, can be deductible.
- Eliminate deduction for Part D retiree drug subsidy employers receive.
- Impose 2.3% excise tax on medical devices. The result of this tax will be fewer innovative and life-saving medical devices, as [this article](#) demonstrates.

- Medicare cuts to hospitals which treat low-income seniors begin.
- Post-acute pay for quality reporting begins.
- CO-OP Program: Secretary of Health and Human Services awards loans and grants for establishing nonprofit health insurers.
- \$500,000 deduction cap on compensation paid to insurance company employees and officers.
- Part D “donut hole” reduction begins, reaching a 25% reduction by 2020.

## 2014

- Individuals without government-approved coverage are subject to a tax of the greater of \$695 or 2.5% of income.
- Employers who fail to offer “affordable” coverage would pay a \$3,000 penalty for every employee that receives a subsidy through the Exchange.
- Employers who do not offer insurance must pay a tax penalty of \$2,000 for every full-time employee.
- More Medicare cuts to home health begin.
- States must have established Exchanges.
- Employers with more than 200 employees can auto-enroll employees in health coverage, with opt-out.
- All non-grandfathered and Exchange health plans required to meet federally mandated levels of coverage.
- States must cover parents /childless adults up to 138% of poverty on Medicaid, receive increased FMAP.
- Tax credits available for Exchange-based coverage, amount varies by income up to 400% of poverty.
- Insurers cannot impose any coverage restrictions on pre-existing conditions (guaranteed issue/renewability). The danger here is that people will wait until they are sick to obtain health insurance policies, which will ultimately cause private health insurance companies to be unable to offer new plans.
- Modified community rating: individual or family coverage; geography; 3:1 ratio for age; 1.5:1 for smoking.
- Insurers must offer coverage to anyone wanting a policy and every policy has to be renewed.
- Limits out-of-pocket cost-sharing (tied to limits in HSAs, currently \$5,950/\$11,900 indexed to COLA).

- Insurance plans must include government-defined “essential benefits ” and coverage levels. The result of this mandate will be fewer consumer choices and higher prices for these comprehensive plans.
- OPM must offer at least two multi-state plans in every state.
- Employers can offer some employees free choice vouchers for health insurance in the Exchange.
- Government board (IPAB) begins submitting proposals to cut Medicare.
- Impose tax on nearly all private health insurance plans.
- Medicare payment cuts for hospital-acquired infections begin (fiscal 2015).

## **2015**

- More Medicare cuts to home health begin.

## **2016**

- States can form interstate insurance compacts if the coverage with HHS approval (2016).

## **2017**

- Physician pay-for-quality program begins for all physicians.
- States may allow large employers and multi-employer health plans to purchase coverage in the Exchange.
- States may apply to the HHS Secretary for a limited waiver from certain federal requirements.

## **2018**

- Impose “Cadillac tax on “high cost” plans, 40% tax on the benefit value above a certain threshold: (\$10,200 individual coverage, \$27,500 family or self-only union multi-employer coverage).