

Implementation Timeline for Federal Health Reform Legislation

On March 23, 2010, the President signed into law a comprehensive health reform measure, the Patient Protection and Affordable Health Care Act, PPACA (P.L. 111-148). In addition, on March 30, 2010, the President signed a corrections measure, the Health Care and Education Reconciliation Act (P.L. 111-152) which makes several major changes to the main bill.

There are a number of immediate deadlines that will impact states. In addition, states will need to begin planning soon for many of the longer term initiatives envisioned in the pending Senate bill. In a few instances, the law references dates that have already passed, since enactment occurred later than anticipated. The budget reconciliation process limited the scope of corrections that could be included, including amending effective dates. Going forward there may need to be additional corrections to the dates or the Administration may issue guidance for implementation dates based on congressional intent.

The following timeline reflects provisions in the main law and corrections measure and is intended to assist states as they plan for implementation. It highlights many of the key federal and state deadlines and options that will directly impact states but is not intended to be a comprehensive summary of the new law. For purposes of provisions that are based on “date of enactment,” this date is March 23, 2010. Please note that additional deadlines for several implementation pieces may be established as the federal agencies develop their own implementation timelines and regulations.

2010

- Retroactive to January 1, 2010 the minimum drug rebate level for most brand name products is increased from 15.1 to 23.1 percent. Minimum rebate levels for generics would increase from 11 to 13 percent. Any savings that accrue from the incremental increase in the minimum rebate levels – the bands between 15.1 to 23.1 and 11 to 13 percent – accrue to the federal government only and would not be shared with states. Supplemental rebates negotiated above 23.1 would be split according to the regular state FMAP.¹
- Upon enactment, a state would be subject to a maintenance of effort (MOE) on Medicaid eligibility standards, methodologies, and procedures until an Exchange is operational in the state.² States also would be subject to a MOE on eligibility

¹ There has been conflicting information regarding the effective date of this provision (whether it is January 1, 2010 or March 23, 2010) and its application to states that have negotiated supplemental rebates above the new federal minimum levels. The information reflected here is based on NGA conversations with congressional staff on March 26, 2010.

² A limited exception is permitted for the period January 1, 2011 through December 31, 2013 for a state that certifies it has or projects a budget deficit. The exception would apply for eligibility policies applying to optional non-pregnant, non-disabled adults with income above 133 percent of the FPL.

standards, methodologies, and procedures for all children in Medicaid and in the Children's Health Insurance Program (CHIP), until September 30, 2019.

- Upon enactment, the Medicaid prescription drug rebate is extended to Medicaid managed care organizations for generic and brand name drugs. Similar to the rebate provisions for fee-for-service enrollees discussed above, the federal government recaptures the savings for MCO enrollees for the incremental increase in the minimum rebate levels – the bands between 15.1 to 23.1 and 11 to 13 percent.³
- By March 1, 2010, HHS is required to establish a federal Coordinated Health Care Office to promote integration between Medicare and Medicaid and improve coordination between states and the federal government.
- As of April 1, 2010, there is a state option to expand Medicaid to the new expansion population up to 133% FPL without a waiver. States could phase-in the expansion. Funding for this optional expansion would be at the state's regular FMAP during the period April 1, 2010 through December 30, 2013. States will still be eligible for the new enhanced FMAP for this population once the mandatory expansion takes effect on January 1, 2014.
- Within 90 days of enactment, HHS must establish a temporary high-risk health insurance pool program, funded at \$5 billion. HHS will work with states to establish a high risk pool or an alternative program that serves the same purpose. A federal fallback exists if a state chooses not to operate such a program.⁴
- Within 90 days of enactment, HHS must establish a temporary re-insurance program for reimbursement to participating employment-based plans to cover 80% of the cost for claims for retirees ages 55-64, including employees of state and local government.
- By July 1, 2010, HHS, in consultation with states, will establish a mechanism, including a website, to facilitate information for consumers and small businesses on coverage options, including public and private options, in each state. Within 60 days of enactment HHS will develop a standardized format for presenting coverage options.
- HHS is to immediately begin to develop standards for establishing and operating state-based Exchanges for individuals and standards for a state-based Small Business Health Options Program (SHOP) Exchange. For a SHOP Exchange, a small employer is defined as having one to 100 employees.⁵ Beginning in 2010 and through 2014,

³ *Ib.*

⁴ States may apply for grants to create or expand their high risk pool program or a similar alternative program. The statute does not create an entitlement to coverage through this program for qualifying individuals.

⁵ While the small employer is defined as having one to 100 employees, until the year 2016, states can limit the small-group market to firms with 50 or fewer employees.

HHS could award grants to states for planning and implementation of a state-based Exchange.⁶

- Beginning with a 2010 plan year HHS, in collaboration with states, will review any unreasonable increases in premiums for health insurance. Health insurance issuers would be required to submit to HHS and the state a justification for an unreasonable premium increase prior to the implementation of the increase and would have to post this information on their website. Beginning October 1, 2009 and for a five year period, HHS will award grants to states to assist them with the review and meeting related standards.⁷
- Six months after enactment, several new federal insurance rules will take effect including: a prohibition on insurers from imposing lifetime limits on benefits, restrictions on the use of annual limits, and a prohibition on insurers from rescinding coverage. All health insurance plans would be required to cover recommended preventive services and immunizations. Unmarried children could remain on their parent's health plan until age 26.
- Beginning six months after enactment, health insurance plans will be required to report medical loss ratio and HHS will make the information public.
- Within 180 days of enactment, HHS will be required to issue regulations concerning a program that will allow states to apply for a waiver from the individual mandate or certain other requirements of the bill if they can demonstrate that they have another way of meeting federal coverage requirements. The state waiver program could begin in plan year 2017.
- Beginning in 2010 through 2013, employers with fewer than 25 employees will be eligible to receive a federal tax credit to offset 35 percent of their health insurance costs as long as the employer contributes at least half of the premium.
- States must make MMIS methodologies compatible with the federal National Correct Coding Initiative (NCCI.) The NCCI standard will go into effect for claims filed on or after October 1, 2010.
- As of October 1, 2010, states must cover tobacco cessation services for pregnant women enrolled in Medicaid.

2011

- Medical loss ratio requirements will take effect beginning with a 2011 plan year. Insurers will be required to spend 85 percent of their revenue from premiums (80 percent for insurers covering small businesses) on medical claims.

⁶ Amount of grants and requirements will need to be provided by HHS.

⁷ The definition of unreasonable increases is not defined in statute and is expected to be defined in regulation by HHS, with input from NAIC.

-
- Medicaid will be required to cover tobacco cessation services for pregnant women.
- Effective July 1, 2011, the Medicaid FMAP for territories is increased to 55 percent from 50 percent. In addition, there is \$6.3 billion to proportionally increase the caps for territories and Puerto Rico from July 1, 2011 through September 30, 2019.
- Operating rules for eligibility for a health plan and health claim status transactions are required to be adopted by July 1, 2011.
- Effective October 1, 2011, there will be a new state Medicaid option to offer home and community-based services to disabled individuals through Medicaid rather than institutional care. States would be eligible for enhanced federal funding but would have to meet several federal requirements, including a MOE for state expenditures for certain programs for individuals with disabilities.

2012

- By January 1, 2012, HHS is required to establish procedures for determining eligibility for the Community Living Assistance and Supports (CLASS) program, a new national voluntary insurance program for purchasing community living assistance services and supports. By October 1, 2012, HHS must publish regulations concerning the standards for a CLASS Independence Benefit Plan.
- Operating rules for electronic funds transfers and health care payment and remittance advice transactions are to be adopted by July 1, 2012.

2013

- Prior to January 1, 2013, states must notify HHS if they intend to establish and operate a state-based Exchange, according to federal standards. In addition, HHS will make a determination that the state is making sufficient progress towards having the state-run Exchange operational by January 1, 2014. If the state chooses not to establish an Exchange or is not making sufficient progress, HHS will plan for a federally established/operated Exchange in the state. Territories have the option to establish an Exchange and a limited amount of funding is allocated for this purpose.
- By July 1, 2013, HHS is required to issue regulations for the creation of health care choice compacts whereby two or more states may agree to allow health insurers to sell products across state lines. Health choice compacts may not take effect prior to January 1, 2016.

- The deadline for complying with operating rule for health plan and health claim transactions would be 2013. (See 2011 timelines)
- By January 1, 2013, state Medicaid agencies are required to conduct an assessment of the capacity for entities, such as providers of home care, home health services, etc, to serve as fiscal agents for personal care attendants who provide services to people receiving benefits through the Community Living Assistance Services and Supports (CLASS) Act. States must also designate or create such entities to serve as fiscal agents.
- As of January 1, 2013, states that cover certain evidence-based preventive services and vaccines with no cost sharing for Medicaid eligible adults will be eligible for a one percentage point increase in their FMAP for such services.

2014

Unless otherwise noted, the following 2014 reforms begin January 1, 2014.

- Individuals will be required to maintain minimum essential health coverage or pay a penalty.
- Employers with 50 or more full-time employees that do not offer affordable coverage will be required to pay a fee if they do not offer coverage and if any employee receives a subsidy – in the form of a tax credit – to purchase health insurance through a state-based Exchange. The employer will be subject to a fee for every full-time employee, regardless of how many employees receive a subsidy, up to a capped amount. If the employer offers coverage, but the employee obtains subsidized coverage, the employer is still subject to a fee.
- Several federal health insurance reforms will take effect, including: guaranteed issue whereby insurers are required to accept every employer and individual applying for coverage; Adjusted Community Rating which prohibits insurers from using any factors in setting premiums, including health status and gender, other than limited use of age (3:1), family size, geography and tobacco use; a prohibition on denying coverage based on preexisting health conditions.
- Launch of the state-based Exchanges for individuals and SHOP Exchanges for small business. States may combine these exchanges. The state exchange would have to comply with certain federal standards and perform functions specified in the statute.
- Sliding scale subsidies will be available for eligible low and moderate income individuals below 400% FPL that cap the cost of health insurance premiums and cost-sharing at a percentage of household income.
- All insurance plans will be required to provide, at a minimum, coverage for specified categories of services and coverage of preventive services without cost-sharing.

- Beginning with a 2014 plan year, HHS, in conjunction with the states, would monitor premium increases of health insurance coverage offered through a state-based Exchange and outside of an Exchange.
- State Medicaid programs will be required to cover certain non-pregnant, non-elderly individuals with income up to 133% FPL. The cost of services for the expansion population will be fully federally funded in calendar years 2014, 2015, and 2016.⁸ States are required to apply a 5% income disregard when determining Medicaid eligibility, effectively further increasing the new Medicaid minimum eligibility level. States will be required to use modified adjusted gross income to determine eligibility.⁹
- The Medicaid eligibility MOE for non-pregnant, nondisabled adults would expire once HHS has determined a state-based Exchange is fully operational. The bill's provisions call for state Exchanges to be operational by January 1, 2014.
- State Medicaid programs will be required to implement several statutorily defined procedures concerning enrollment simplification and coordination with state-based Exchanges and CHIP. States must implement specific procedures outlined in legislation and that will be further defined via regulation.
- State Medicaid programs will be required to offer premium assistance for employer-sponsored insurance.
- Beginning in fiscal year 2014, there will be reductions in the disproportionate share hospital program funding. The law requires total reductions in DSH funding of \$14.1 billion.¹⁰ HHS will develop the methodology for applying the reductions.
- HHS would have the authority to allow states to establish alternative programs for low-income individuals. Instead of offering coverage through a state-based Exchange, states could negotiate directly with health insurers to establish a basic health program which offers at least one standard health plan providing at least the essential health benefits for certain non-Medicaid eligible individuals with income between 133 and 200% FPL.

⁸ In calendar year 2017, the state share will vary based on whether the state is an early adopter state or not. Early adopter states are: AZ, DE, HI, ME, MA, MN, NY, PA, VT, WA, and WI. Early adopter states will receive an increase in their FMAP for certain childless adults that they currently cover (not parents). Other states will receive an increase for the expansion population (parents and certain childless adults) as follows: 95% FMAP in 2017, 94% FMAP in 2018, 93% FMAP in 2019, and 90% FMAP in 2020 and beyond.

⁹ There are certain exceptions for using MAGI to determine eligibility, for example, individuals may still qualify for Medicaid via SSI.

¹⁰ The law requires specific reductions of: \$500 million in FY 2014, \$600 million in FYs 2015-2016, \$1.8 billion in FY 2017, \$5 billion in FY 2018, \$5.6 billion in FY 2019, and \$4 billion in FY 2020..

- State Medicaid programs will be prohibited from excluding coverage for barbiturates, benzodiazepines, and tobacco cessation products.
- Expiration of authorization for the Medicare Special Needs Plans (SNPs).
- States will have to adopt state law or regulation and establish at least one reinsurance entity.
- Deadline for adopting operating rules for electronic funds transfers and health care payment and remittance advice transactions.
- Operating rules for health claims/encounter information in a health plan, premium payments, and certification and authorization are to be adopted by July 1, 2014.

2015

- Beginning January 1, 2015, state-based Exchanges must be self-sustaining. Exchanges may charge assessments or user fees.
- Beginning January 1, 2015, state Medicaid programs will be required to begin annual Medicaid enrollment reporting.
- Beginning October 1, 2015 through September 30, 2019, states will be eligible for a 23 percentage point increase in the regular CHIP match up to 100 percent.
- Federal funding for the CHIP program expires September 30, 2015. If a state allotment is insufficient to meet the need, CHIP-eligible children could receive tax credits to obtain coverage through the state-based Exchange. HHS would be required to certify plans in the exchange that provide comparable benefits for low-income children.

2016

- Beginning January 1, 2016, health care choice compacts may take effect.

2017

- Beginning January 1, 2017 states that have obtained a waiver from HHS may operate an alternative program in lieu of certain federal health coverage reforms.
- States will begin to pay a share of the new mandatory Medicaid expansion.¹¹

¹¹ The state share of the cost of covering the Medicaid expansion population varies by state. See footnote 7.

- Beginning in 2017, a state may allow large companies (with at least 101 employees) to participate in the state-based Exchange.

2018

- Implementation of an excise tax on insurers of employer sponsored health plans with aggregate values exceeding certain thresholds, including on state and governmental plans, often referred to as “Cadillac plans.”
-