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Health Care Reform Implementation Timeline

With the recent enactment of the Patient Protection and Affordable Care Act ([P.L. 111-148](#)) and the Health Care and Education Reconciliation Act ([P.L. 111-152](#)), the president and Congress have set in motion a comprehensive reform of the nation's health care system. Together, these laws will expand coverage by roughly 30 million individuals.

Beginning in 2014, individuals will be responsible for maintaining coverage, and large employers will be responsible for offering coverage or paying a penalty if any of their full-time workers are eligible for, and receive, insurance subsidies. To meet these individual and employer responsibilities, the laws expand Medicaid, subsidize the purchase of private health coverage, and provide tax credits to assist small businesses in covering their employees. In order to finance these expansions, the two laws raise significant revenues through new taxes, improved efficiencies, and reduced reimbursements to stakeholders.

In addition to these coverage expansions, the laws will fundamentally transform the delivery of health care through: insurance market reforms with national rules that will be administered at the state level; the creation of state-based insurance exchanges; a federally defined essential health benefits package; restructuring of payments to Medicare Advantage (MA) plans; an Independent Payment Advisory Board that will recommend reductions in the growth of Medicare spending; Medicare hospital reimbursement based on quality measures; and expanding wellness programs and preventive coverage.

Implementation of these wide-ranging changes will take years, and given the level of rule-making authority delegated to executive branch officials, stakeholders will need to be vigilant in monitoring the administration of these reforms. The Department of Health and Human Services (HHS) and other agencies have already begun the difficult work of implementing the policies required by these laws. Below is a timeline that includes the effective dates for many of the laws' most significant provisions.

This *Alert* is intended as a summary only and is not to be relied upon for drawing legal conclusions or advising clients about specific issues.

2010

Insurance and Group Health Plan Reforms: For plan years beginning six months after the date of enactment, all existing *health insurance and group health plans* will be subject to new regulations that prohibit: lifetime limits; restrictive annual limits; rescissions; cost sharing for certain preventive and wellness benefits, and; excessive waiting periods. Group health plans that offer dependant coverage must

include in the offering coverage for adult children up to age 26 for adult children that are not eligible to enroll in their own employer-sponsored coverage. After 2014, these group health plans must offer dependent coverage for dependants up to age 26.

False Claims Act: Narrows the application of the False Claims Act's public disclosure bar and "original source" provisions.

Small Employer Tax Credit: The legislation provides a sliding scale tax credit to small employers with fewer than 25 employees on average.

Physician Ownership Interests in Hospitals: The Act effectively dismantles the so-called whole hospital exception to the physician self-referral law known as the Stark law. Going forward, physicians may not own interest in hospitals to which they refer unless those hospitals are operating and have a Medicare provider number by December 31, 2010. In addition, the aggregate percentage of physician ownership in physician-owned hospitals is capped at the percentage existing as of the law's enactment date (March 23, 2010).

High Risk Pools: Within 90 days of enactment, a temporary national high-risk pool will be created to provide coverage to adults with pre-existing conditions. This high risk pool will phase-out in 2014, when the new health insurance exchanges are operational.

Temporary Reinsurance Program: Within 90 days of enactment, and through 2013, a temporary reinsurance program will be established for retirees who are over age 55 but not eligible for Medicare.

2011

Medicare Advantage: Medicare Advantage payments are frozen for 2011. The HHS Secretary is required to adjust MA rates for coding pattern differences between MA and fee-for-service. Beginning in 2019, the annual minimum coding intensity adjustment is 5.7 percent.

Fee on Manufacturers and Importers of Branded Drugs: Fees will raise \$2.5 billion for 2011; \$3.0 billion per year for 2012-2016; \$3.5 billion for 2017; \$4.2 billion for 2018; and \$2.8 billion thereafter.

Physician Ownership Referral: Physicians are prohibited from self-referring to hospitals in which they have an ownership interest. There is a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

Enhanced Oversight for Initial Claims of DME Suppliers: Requires a 90-day period to withhold payment and conduct enhanced oversight in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers.

Funding to Fight Waste, Fraud and Abuse: Increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million over 10 years. Indexes funds to fight Medicaid fraud based on the increase in the CPI.

Market Basket and Productivity Adjustments: With varying effective dates, reduces annual market basket for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Also includes productivity adjustments.

Medical Malpractice Demonstration Grants: Five-year demonstration grants will be awarded to states to develop alternatives to tort litigation.

Frontier State Hospitals: The law establishes a hospital wage index and geographic practice floor for hospitals in states where 50 percent of counties are frontier counties. This provision would apply to hospitals in North Dakota, South Dakota, Montana, Utah, and Wyoming.

2012

Medicare Advantage (MA): A new system of blended benchmarks will be phased-in. Payments will be linked to county benchmarks, which will vary based on the county's fee-for-service costs. Bonuses will be available to high-performing plans.

2013

FSA Limits: Places an annual limit of \$2,500 on contributions that can be made to health FSA arrangements; indexed to CPI-U after 2013.

Medical Device Tax: 2.3 percent excise tax on manufacturers and importers of certain medical devices.

Elimination of Deduction for Part D Subsidy: The existing employer tax deduction for the Part D subsidy is eliminated.

Broadening of Medicare Hospital Insurance Tax Base: Imposes additional surtax of 0.9 percent on earned income in excess of \$200,000/\$250,000 (unindexed) and a 3.8 percent surtax on investment income for taxpayers with AGI in excess of \$200,000/\$250,000 (unindexed).

Medicaid Reimbursements to Primary Care Physicians: Requires that Medicaid payment rates to primary care physicians furnishing primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014. Provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

2014

Health Insurance Exchanges: States must establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Qualified individuals (individuals who are not incarcerated and who are lawfully residing in a state) can enroll in a qualified health plan through a State Exchange. Small employers can offer a choice of plans to their employees through the Exchange.

Individual Obligation: Other than individuals who meet a hardship exemption, individuals will be required to carry eligible health coverage. The fully phased-in penalty for not having health insurance is the greater of \$695 or 2.5 percent of income.

Employer Obligation: Employers with 50 or more full time equivalent (FTE) employees face a number of coverage obligations. Those that do not provide health coverage would be assessed \$2,000 for each full-time employee in their workforce. These employers would not be assessed a penalty for the first 30 full-time employees. Employers that provide coverage that is deemed unaffordable would be assessed the lesser of \$3,000 for each full-time employee who obtains a premium credit in a health insurance exchange or \$2,000 for all FTE employees. Mitigating these obligations, employers would be permitted to have waiting periods of up to 90 days without being subject to penalties. Furthermore, part-time employees would be considered when calculating employer size for the purpose of determining employer coverage responsibility requirements (i.e. 2 employees working 15 hours each per week equal 1 FTE employee). Penalties, however, would be assessed only on behalf of full-time employees who work 30 or more hours per week.

Annual Fee on Health Insurance Providers: Fees will raise \$8 billion in 2014; \$11.3 billion in 2015 and 2016; \$13.9 billion in 2017; \$14.3 billion in 2018; and indexed to medical cost growth thereafter.

Pre-existing condition exclusions: Prohibits pre-existing condition exclusions for group health plans.

Prohibition on Annual Limits: Prohibits annual limits for group health plans.

Medicare DSH Cuts: Reductions in Medicare DSH payments begin. The cost of these reductions is roughly \$22 billion between 2014 and 2019. DSH payments are initially reduced by 75 percent and then subsequently increased based on the size of the uninsured population and the amount of uncompensated care.

Medicaid DSH Cuts: Reductions in DSH allotments begin. The cost of these reductions is roughly \$14 billion between 2014 and 2019. DSH allotments will be reduced depending on a state's use of allotments between 2004 and 2008, whether it is a low DSH state, and the rate of the uninsured.

2015

IPAB: Establishes an Independent Payment Advisory Board (IPAB), charged with recommending reductions in Medicare spending. Congress must either adopt the IPAB's proposed cuts or pass an alternative with equivalent savings. The IPAB will first propose cuts in 2014 for implementation in 2015.

2016

Interstate Health Choice Compacts: Under these compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's state.

2017

Large Employer Participation in Exchanges: States may allow large employers to offer coverage to their employees through the exchanges.

2018

High premium excise tax: Imposes a 40 percent excise tax on health coverage in excess of \$10,200/\$27,500 and increased thresholds of \$1,650/\$3,450 for over age 55 retirees or certain high-risk professions, both indexed for inflation by CPI-U plus one percent; adjustment based on age and gender profile of employees; vision and dental excluded from excise tax.

2019/2020

Indexing of Premium Subsidies: To slow the growth of these premium subsidies, beginning in 2019, the indexing of these subsidies is adjusted if premiums are growing faster than CPI.

Indexing of High Premium Tax Thresholds: Beginning in 2020, the thresholds for the high premium tax will be reindexed to the general rate of inflation.

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