These days it seems like even our elected officials can't agree if federal health reform legislation is dead, alive, on a back burner or on life support. No matter what your best guess is as to what will happen, the fact remains that both the U.S. House of Representatives and the U.S. Senate have passed their own pieces of comprehensives health reform legislation. These two bills will remain on the table, and could be acted on at any time, for the remainder of the 111th Congress. And the 111th Congress is not slated to adjourn until December of 2010.

If either bill or some variation thereof, were to pass both houses of Congress and be signed into law, some of the reforms would take effect right away. Others would be phased in over the next three to four years. The following timeline shows the health insurance market reforms included in both the House and Senate-passed bills, and how and when they would impact private health insurance coverage.

Timeline of Health Insurance Reforms in the House and Senate-Passed Reform Bills that Would Impact Private Health Insurance Coverage

Proposed Reform	Effective Date	House Bill	Senate Bill
No lifetime limits on health plan coverage	Immediately House/within six months Senate	☑	☑
Raises the age of a dependent for health plan coverage to 26 (Senate) and 27 (House)	Immediately House/within six months Senate	☑	☑
Restricts rescissions of health plan coverage in all insurance markets	Immediately House/within six months Senate	☑	☑
Federal review of health insurance premium rates	Immediately House/within six months Senate	☑	☑
Minimum loss ratio requirements for insurers in all markets	Immediately House/2011 Senate	☑	☑
High-risk pool coverage for people who cannot obtain current individual coverage due to preexisting conditions	Immediately House/within six months Senate	☑	☑
Creates a temporary reinsurance program for employer health plans providing coverage for non-Medicare eligible retirees aged 55-64 and their families.	Immediately House/within six months Senate	☑	☑
Creates grants for small employer-based wellness programs.	Immediately House/2011 Senate	☑	☑
Creates a new public long-term care program and requires all employers to enroll employees, unless the employee elects to opt out.	Immediately House/January 1, 2014 Senate	☑	☑
Eventual elimination of employer deductible subsidy under Medicare Part D (January 1, 2011 Senate; January 1, 2013 House) would have immediate impact on	Immediately	☑	☑

Proposed Reform	Effective Date	House Bill	Senate Bill
employers' liability and income statements.			
Mandates coverage of reconstructive surgery for children with congenital or developmental deformities	Immediately	☑	
Eliminates preexisting exclusions based on conditions resulting from domestic violence	Immediately	☑	
COBRA coverage time-frames would be eliminated until the Health Insurance Exchange became operational	Immediately	☑	
Extends the tax exclusion for employer provided health coverage to a person who is eligible for coverage under the employer's plan and who is not a spouse or dependent.	Immediately	☑	
Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.	Within 90 days of enactment		☑
Annual benefit limits on coverage would be limited to DHHS-defined non-essential benefits.	Within six months of enactment		☑
Mandated coverage of specific preventive services with no cost sharing	Within six months of enactment		☑
Mandated coverage of emergency services at in-network level regardless of provider	Within six months of enactment		☑
Allows enrollees to designated any in-network doctor their primary care physician (including OB/GYN and pediatrician)	Within six months of enactment		☑
Prohibits discrimination in coverage or premium based on salary	Within six months of enactment		☑
Requires plans to have coverage appeals processes	Within six months of enactment		☑
Requires that a summary of coverage be provided to applicants and enrollees	Within six months of enactment		☑
Makes available tax credits for qualified small employer contributions to purchase coverage for employees. Would apply to small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for their employees.	In 2010		☑
Requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.	By July 1, 2010		☑
Mandatory federal study on the impact the market reforms in the bill will have on the large group market	Within a year of enactment	☑	☑
Mandatory annual studies by the federal Department of labor on self-funded plans	Within a year of enactment		☑
Prohibits over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs	January 1, 2011	☑	☑
Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).	January 1, 2011	☑	☑
Limits FSA contributions for medical expenses to $2,500	January 1, 2011	☑	☑

Proposed Reform	Effective Date	House Bill	Senate Bill
per year.	Senate/January 1, 2013 House		
The annual 5.4% income surtax on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000 would begin.	January 1, 2011	☑	
Annual fees on private health insurers based on net premiums written after December 31, 2008 and third-party agreement fees received after December 31, 2008 begin. $2 billion in 2011, $4 billion in 2012, $7 billion in 2013, $9 billion in 2014-2016, and $10 billion in 2017 and thereafter. **Does NOT apply to self-insured plans.**	January 1, 2011		☑
Freezes the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduces the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.	January 1, 2011		☑
Employers must start reporting of value of health benefits on W-2 forms.	January 1, 2011		☑
New federal premium tax on fully-insured and self-insured group health plans to fund comparative effectiveness research program begins.	January 1, 2012	☑	☑
Applies the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets	January 1, 2013	☑	
For all individual and fully insured group plans, regardless of size, imposes strict modified community rating standards consisting of variances only by family enrollment, geographic, and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insured to a ratio of 2:1	January 1, 2013	☑	
Requires all health plans, whether fully insured or self-funded, to issue coverage regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits	January 1, 2013	☑	
Existing individual policies would only be able to be retained if the only change to the policy was to add or delete a dependent. New individual policies would have to be purchased through the exchange. Group plans would be allowed to phase in reform requirements over 5 years, eventually these plans would have to change to meet the terms of the proposed individual and employer mandates.	January 1, 2013	☑	
Coverage, including a government-run public plan option, begins to be offered by a national Health Insurance Exchange to be administered by a new federal Agency, the “Health Choices Administration,” governed by a Commissioner to be appointed by the President. All individual coverage would be offered through the Exchange. The categories of people and businesses qualified to purchase coverage through the Exchange would be	January 1, 2013-January 1, 2016	☑	

Proposed Reform	Effective Date	House Bill	Senate Bill
phased in over three year's time to up to 100 employees and the Commissioner has the authority to expand the exchange to larger groups after that.			
Sliding-scale affordability tax credits made available to non-Medicaid eligible individuals with incomes up to 400% of FPL through the exchange who do not have access to qualified employer-sponsored coverage	January 1, 2013	☑	
Ends CHIP program block grants and makes subsidized coverage available to CHIP-eligible people through the Exchange	January 1, 2013	☑	
Medicaid eligibility level is increased to 150% FPL	January 1, 2013	☑	
All employers, except for exempt small employers, must offer qualified coverage. Employers would be required to pay 72.5% of the cost of acceptable coverage for individuals and 65% for family coverage, and part-time employees must be covered on a pro-rated basis based on average hours worked. In lieu of paying for coverage, the employer could pay 8% of wages to the Commissioner and their employees would be eligible for coverage through the national Exchange. Small employers with annual payroll up to $500,000 will be exempt from the requirement. Employers with $500,001-$585,000 in annual payroll would pay a fee of 2%, employers with annual payroll of $585,001-$670,000 would pay a fee of 4%, and employers with annual payroll of $670,001-$750,000 would pay a fee of 6% for non-compliance.	January 1, 2013	☑	
Requires all individuals to maintain qualified coverage with a federal income tax penalty equal to 2.5% of the excess of the taxpayer's adjusted gross income over the threshold amount or the average premium in the exchange, whichever is less. Hardship waivers will be available.	January 1, 2013	☑	
All employers providing qualified coverage to individuals must provide them with annual documentation of coverage.	January 1, 2013	☑	
Federal approval required of all self-funded health plans (similar to the requirement for retirement plans under ERISA)	January 1, 2013	☑	
Establishes standards for qualified coverage, including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 70%	January 1, 2013	☑	
Creates health insurance tax credit for small businesses, equal to 50 % of the cost of coverage for firms where the average employee compensation is less than $20,000 for the first two years the employer provides coverage.	January 1, 2013	☑	
Amends ERISA to require all group health plans to add a provision that expressly bars post-retirement reductions	January 1, 2013	☑	

Proposed Reform	Effective Date	House Bill	Senate Bill
in benefits that may be provided to retirees or their beneficiaries unless the reduction is also made with respect to active participants.			
The 40% excise tax on insurers of employer-sponsored health plans (both fully-insured and self-insured) with aggregate values that exceed $8,500 for individual coverage and $23,000 for family coverage (indexed annually by CPI plus 1%) would begin. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs; also includes coverage for dental, vision, and other supplementary health insurance coverage.	January 1, 2013		☑
The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of AGI to 10% of AGI for regular tax purposes. The increase would be waived for individuals age 65 and older for tax years 2013 through 2016 (Effective January 1, 2013).	January 1, 2013		☑
Requires all individual health insurance policies and all fully insured group policies to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances.	January 1, 2014		☑
Coverage must be offered on a guarantee issue basis in all markets and be guarantee renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited in all markets.	January 1, 2014		☑
Prohibits any annual limits or lifetime limits in group or individual plans	January 1, 2014		☑
Redefines small group coverage as 1-100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.	January 1, 2014		☑
Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.	January 1, 2014		☑
Requires each state to create an Exchange to facilitate the sale of qualified benefit plans to individuals, including the federally administered multi-state plans and non-profit co-operative plans. A catastrophic-only policy would be available for those 30 and younger. In addition the states must create “SHOP Exchanges” to help small employers purchase such coverage. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange. States can also apply for a modification waiver from DHHS.	January 1, 2014		☑
Require employers to give a voucher to use in the	January 1, 2014		☑

Proposed Reform	Effective Date	House Bill	Senate Bill
individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.			
Establishes standards for qualified coverage, including mandated benefits, cost-sharing requirements, out-of-pocket limits and a minimum actuarial value of 60%. Allows catastrophic-only policies for those 30 and younger.	January 1, 2014		☑
Creates sliding-scale premium assistance tax credits for non-Medicaid eligible individuals with incomes up to 400% of FPL to buy coverage through the exchange	January 1, 2014		☑
Medicaid eligibility level is increased to 150% FPL	January 1, 2014		☑
Requires states to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost-effective to do so, under terms outlined already in current law.			
Gives states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer-sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars	January 1, 2014		☑
Allows states to apply for a waiver for up to 5 years of requirements relating to qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers, provided that they create their own programs meeting specified standards.	January 1, 2014		☑
Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of $750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than $250,000.	January 1, 2014		☑
An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay $600 for any full-time employee subject to more than a 60-day waiting period.	January 1, 2014		☑

Proposed Reform	Effective Date	House Bill	Senate Bill
An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit or $750 for each of their full-time employees total.	January 1, 2014		☑
Requires all American citizens and legal residents to purchase qualified health insurance coverage. Exceptions are provided for religious objectors, individuals not lawfully present and incarcerated individuals, those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year. Violators are subject to an excise tax penalty of up to $750/person or up to 2 percent of income (capped at the annual cost of the average bronze level premium plan offered through the exchanges).	Phased in beginning January 1, 2014		☑
Health plans, including self-funded employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.	January 1, 2014		☑
Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.	January 1, 2014		☑
Requires all employers provide notice to their employees informing them of the existence of an Exchange.	January 1, 2014		☑
Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.	January 1, 2014		☑
Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums.	January 1, 2014		☑
Establishes a 10-state pilot program to apply the rules to HIPAA bona fide wellness program rules the individual market in 2014-2017 with potential expansion to all states after 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.	January 1, 2014-2017		☑
CHIP program must be reauthorized.	2015		☑
States may choose to allow large groups (over 100) to purchase coverage through the exchanges.	January 1, 2017		☑