# Health Reform Timeline


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*The Patient Protection and Affordable Care Act signed into law in 2010 will make health insurance available and attainable for millions of United States citizens and legal residents who currently lack coverage. It provides for sweeping changes that are phased in over the next eight years. Because of the legislation's complexity and long phase-in period, Butzel Long's Health Reform team created this timeline to illustrate when specific provisions become effective. For questions or more information, please contact one of our Health Reform team members.*

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# Health Reform Timeline

2010 2011 2012 2013 2014 2015 2016 2017 2018

| MEDICARE | MEDICAID | QUALITY INITIATIVES | SHARED RESPONSIBILITY | ORAL HEALTH | RESIDENTS | TAX |
|---|---|---|---|---|---|---|
| 1. Medicare Part D (Prescription Drugs): "doughnut hole" created by original statute for Part D will be plugged. September 23, 2010: individuals affected by the "doughnut hole" will receive $250 rebate; 50% of "doughnut hole" will be eliminated in 2011. Entire "doughnut hole" will be eliminated by 2020. Medicare premium subsidy will be reduced for those with incomes above $85,000 for individuals and $170,000 for couples effective January 1, 2011. July 1, 2010: many drugs will be furnished, subject to a 50% discount.<br>2. Claims submission within 12 months.<br>3. Coordination for dual eligibles (people who qualify for both Medicare and Medicaid).<br>4. Ban on new physician-owned hospitals (with some grandfathering).<br>5. Creation of a 15-member Medicare Advisory Board to advise Congress on proposals to reduce costs and improve quality of care. Proposals will take effect unless Congress passes an alternative measure. No proposals for rationing care, raising taxes or Part B premiums, changing Medicare benefit eligibility, or cost-sharing standards will be permitted. | 1. Medicaid coverage for family planning.<br>2. Drug rebate percentage increased.<br>3. State option to cover childless adults.<br>4. States are required to maintain their current eligibility standards for the Children's Health Insurance Plan (CHIP). The Maintenance of Effort (MOE) requirements apply to children until December 30, 2019. This means that states cannot adopt changes in eligibility rules and procedures that would make someone ineligible for CHIP coverage that would have been eligible for CHIP on March 23, 2010. States are required to extend funding for CHIP through 2015. Beginning in 2015, states will receive in increase in the CHIP match up to a cap of 100%. CHIP-eligible children who are subject to state caps (currently only in Arizona) will be eligible for tax credits in the state exchanges.<br>5. Medicaid cost containment provisions in the Act include a 23.1% increase in the Medicaid drug rebate percentage for name brand drugs, with certain exceptions; a 13% increase in the Medicaid average wholesale price rebate for non-innovator, multiple source drugs; and extension of the drug rebate program to Medicaid managed care plans. | 1. Comparative effectiveness research.<br>2. National emergency changes.<br>3. Amend Indian Healthy Care Improvement Act. | | *Also see Workforce Development*<br>1. Title VII provisions to expand and educate oral health workforce.<br>2. Grants to support school-based health clinics.<br>3. Establishes an oral health care prevention education campaign at the CDC that focuses on preventive measures and targeting key populations including children and pregnant women.<br>4. Grant program for entities to demonstrate effectiveness of research-based dental caries disease management.<br>5. Expands federal grant program for school-based sealants program.<br>6. Investment in oral health infrastructure and surveillance<br>7. Directs HHS Secretary to develop programs and efforts to improve oral health monitoring and data collection. | 1. Secretary directed to redistribute residency positions that have been unfilled for training for primary care physicians. | 1. Tax on nonprofits of $50,000 if don't meet requirements.<br>2. Limits deduction of executive compensation pay for health insurance to $500,000.<br>3. 10% tax on indoor tanning.<br>4. Application of economic substance doctrine.<br>5. The maximum exclusion for employer-provided adoption assistance increases to $13,170 for 2010 from $12,170, subject to indexing after 2010 and a sunset after 2011.<br>6. Qualified health benefits provided by Tribal Governments excluded from gross income.<br>7. Increased estimated tax payments.<br>8. Tax credits for small businesses. |

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| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
|---|---|---|---|---|---|---|---|
| 1. Beginning in 2010, qualified small employers (employers who have no more than 25 full-time employees and with average annual compensation levels not exceeding $50,000) may elect a tax credit up to 35% (which will reach up to 50% by 2014) of their employee health care coverage expenses. This credit is to be phased out as employer size and employee compensation increases.<br>2. Employers are now required to provide "reasonable break time" to an employee for one year after a child's birth each time the employee has a need to express breast milk. The employer is required to provide a private, shielded place other than a restroom for the mother to express the breast milk. The employer has the option whether to compensate the employee during the break time or not. Employers with fewer than 50 employees are exempt if obeying the requirement would impose an undue hardship on the employer. The Act does not provide an effective date for this requirement.<br>3. Effective for plan years that begin 6 months after the implementation of the Act, fully-insured group health plans must comply with the nondiscrimination requirements, as well.<br>4. ERISA is amended to prohibit anyone from making a false statement or false representation of fact to any employer, employee, employee organization, or beneficiary regarding a Multiple Employer Welfare Arrangement (MEWA). The Department of Labor (DOL) may issue a cease-and-desist (ex parte) order if it appears that the conduct of a MEWA is fraudulent or creates an immediate danger to the public safety or welfare with the burden of proof being on the MEWA to show cause why it should be set aside. The DOL can also adopt regulations providing that state fraud laws apply to MEWAs. MEWAs that provide medical care benefits must register with the DOL.<br>5. Health flexible spending arrangements, health reimbursement arrangements, health spending accounts, and Archer MSAs are not permitted to reimburse for any expenses incurred for any medicine or drug after December 31, 2010, other than a prescribed drug or insulin. | | 1. Must guarantee issue/renewability and not based on gender. Prohibits exclusion for pre-existing conditions or other discrimination based on health status. Also prohibits rescissions except in cases of fraud or misrepresentation.<br>2. Prohibits rescissions except for fraud.<br>3. Requires coverage of preventative health services recommended by Health Resources and Services Administration without cost sharing.<br>4. All plans in the individual and group markets are required to provide coverage for children up to age 26.<br>5. Premium variance allowed for participation in health promotion and disease prevention programs.<br>6. All insurers operating in the exchange must offer the following minimum benefits: preventative and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy and metal health and substance abuse series that meet minimum standards set by federal and state laws.<br>7. The HHS Secretary is required to establish a temporary reinsurance pool which will provide reimbursement until January 1, 2014 to certain qualifying employer-based plans, for retirees age 55 and older and not eligible for Medicare, their spouses, surviving spouses, and dependents. The pool will provide employers 80% reimbursement of claims in excess of $15,000 but not greater than $90,000 (as adjusted for cost of living). The amounts received by the plans are to be used to reduce premium costs, co-payments, deductibles, or other out-of-pocket costs, etc. | | 1. Allocation of funds to investigate Comparative Effectiveness Research (CER).<br>2. Establishes a Regular Corps and a Ready Reserve Corps of highly-qualified public health professionals for national emergencies. | 1. Creates a Workforce Advisory Committee to develop national workforce strategy (appointments to be made by September 30, 2010).<br>2. Graduate Medical Education programs will be increased, with priorities on primary care.<br>3. Awards grants for up to 15 demonstration programs to train or employ alternative dental health providers to increase access to dental care. | 1. Sense of the Senate: to reform the medical malpractice and medical liability insurance and states should be encouraged to develop and test alternative models to the existing civil litigation system and Congress should consider state demonstration projects to evaluate. | 1. Increased provider screening.<br>2. HHS to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. All providers and suppliers are subject to license checks. Additional screening measures such as fingerprinting, criminal background checks, multistate database inquiries, and random or unannounced site visits would be permitted. Application fees of $200 for individuals and $500 for institutions would be used to cover the costs of screening. Reverification would occur every five years.<br>3. Secretary is authorized to impose additional screening measures such as fingerprinting, criminal background checks, multistate database inquires, and random unannounced visits. Application fees would be imposed.<br>4. All providers are required to have compliance plans.<br>5. Requires CMS to include in the Integrated Data Repository (IDR) claims and payment data from Medicare, Medicaid, CHIP, Veterans Affairs, Department of Defense, Social Security, and Indian Health Service (IHS).<br>6. Data sharing agreement with the Commissioner of Social Security, the Director of IHS, the Secretary of Veterans' Affairs, and the Secretary of the Department of Defense.<br>7. HHS, OIG, and DOJ are granted access to the IDR.<br>8. Overpayments are required to be reported within 60 days from the date that overpayment was identified, or by the date the corresponding cost report was due, whichever is later.<br>9. Secretary to issue regulations mandating that all Medicare, Medicaid, and CHIP providers must provide their National Provider Identifier (NPI) on enrollment applications.<br>10. Providers and suppliers are subject to exclusion for providing false information on any application to enroll or participation in federal health care program.<br>11. Expands the use of civil monetary penalties.<br>12. Secretary must take into account the volume of billing of a Durable Medical Equipment (DME) supplier or home health agency when determining the size of the surety bond.<br>13. Payments to a provider may be suspended pending a fraud investigation.<br>14. Secretary must identify and submit a report to Congress regarding the promotion of correct coding to control improper coding under Medicaid.<br>15. Requires states to implement fraud, waste, and abuse programs.<br>16. Requires Secretary to establish a nationwide program for national and state background checks on direct patient access employees of certain long-term care facilities or providers and to provide federal matching funds to states.<br>17. Physicians must notify patients in writing at the time of referral that they may receive CT, MRI, or PET scans at alternative sites. |

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## MEDICARE

1. CLASS Act establishes a new national voluntary program for purchasing community living assistance services and supports effective January 1, 2011. All working adults enrolled unless they opt out.
2. Allots primary care practitioners, as well as general surgeons practicing in health professional shortage areas with a 10% Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across the board reduction in all other services.
3. Part B premiums frozen from 2011-2019.
4. Pharmaceutical manufacturers required to provide 50% discount on brand name prescriptions billed under Part D
5. Create innovation center.

## MEDICAID

1. Prohibit federal payments to states for health care acquired conditions.
2. Creates a new Medicaid state plan option that permits Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a "health home."
3. Creates a State Balancing Incentive Program to increase non-institutionally-based long-term care services.

## QUALITY INITIATIVES

1. Requires Secretary to annually establish and update national strategy to improve the delivery of health care services, patient health outcomes, and population health. To be established by January 1, 2011: a Federal health care quality website.

## SHARED RESPONSIBILITY

## ORAL HEALTH

## RESIDENTS

1. Incentives for training primary care physicians; encouragement of medical residency training in non-hospital settings.

## TAX

1. An annual fee is imposed on branded prescription pharmaceutical manufacturers and importers in the amount of $2.8 billion.
2. No more Part D deduction for employers receiving Part D subsidy
3. The Act creates a simple cafeteria plan that can be adopted by businesses with an average of 100 or fewer employees. The Plan requires either a minimum 2% employer contribution or a minimum matching contribution and establishes minimum eligibility requirements.
4. The Act incorporates by reference into the Internal Revenue Code and ERISA, various provisions of the Public Health Service Act ("PHSA") for the purpose of imposing the Code's excise tax on failure of a plan to comply with the requirements of the PHSA (e.g., the requirements of no lifetime or annual limits, coverage of preventive health services, extension of dependent coverage, etc.) and applying the ERISA civil enforcement mechanisms to violations of these PHSA requirements. If there is a conflict between the Code or ERISA and the PHSA, the PHSA applies.
5. The tax on distributions not used for qualified medical expenses from an HSA or Archer MSA is increased to 20% (from 10%) of the disbursed amount.

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# Health Reform Timeline

2010 2011 2012 2013 2014 2015 2016 2017 2018

| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
|---|---|---|---|---|---|---|---|
| 1. Required to report value of employer-provided health insurance.<br>2. Group health plans (other than self insured plans) cannot establish eligibility rules for full-time employees that are based upon total hourly or annual salary or otherwise establish eligibility rules that discriminate in favor of higher wage earners. It is permissible to have lesser contribution requirements for lower wage earners. (Existing law already prohibits such discrimination in self-insured plans.) This requirement does not apply to grandfathered plans.<br>3. A plan (other than a grandfathered plan) must have an appeals process for appeals of coverage determinations and claims which includes an internal appeals process, a notice to enrollees of the internal and external appeals processes, and the availability of government assistance through an ombudsman program or otherwise, allow an enrollee to review his file, present evidence and testimony and provide an external review process that, at a minimum, includes certain consumer protections spelled out in the Acts and is binding on the plan. During the appeals process, the enrollee is entitled to receive continued coverage. The Acts do not specify whether the continued coverage provided during the appeals process can be retroactively denied if the enrollee loses his appeals. | | 1. A plan may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as determined by the Secretary; provided, however, that all annual limits are prohibited after 2013. However, if the plan is not required to provide essential health benefits, it can include such limits if otherwise permitted by law.<br>2. A plan cannot rescind coverage for an enrollee once he is covered, except if he commits fraud or makes an intentional misrepresentation of material fact. A plan may not be canceled except with prior notice to the enrollee and in compliance with applicable law.<br>3. A plan (other than a grandfathered plan) must provide coverage for certain preventative health services specified in the Act and may not impose any cost sharing requirements for such services, including at least the following:<br>• Ambulatory patient services<br>• Emergency services<br>• Hospitalization<br>• Maternity and newborn care<br>• Mental health and substance use disorder benefits, including behavioral health<br>• Prescription drugs<br>• Rehabilitative and habilitative services and devices<br>• Laboratory services<br>• Preventative and wellness services and chronic disease management<br>• Pediatric services, including oral and vision care. | 1. Grants to state and trauma centers to strengthen the nation's trauma system. | 1. Provides Medicare beneficiaries access to health risk assessment.<br>2. Establishes for up to 5 years for small employers that establish wellness programs.<br>3. Develops material strategy to improve nations health.<br>4. Requires chain restaurants and vending machine food to disclose nutritional content.<br>5. Improves access to care by increasing funding for community health centers and The National Health Service Corps over 5 years; establishes school-based health centers and nurse-managed health clinics. | | | 1. Increases funding by $250 million for fiscal years 2011-2020.<br>2. Secretary to maintain a national health fraud and abuse data collection program for reporting certain adverse actions against providers, suppliers, and practitioners and submit information to National Practitioner Data Bank. Termination of HIPDB (Health Integrity and Protection Data Bank).<br>3. Requires states to establish contracts with Recovery Audit Contractors (RACs).<br>4. Requires Secretary to expand RAC to Medicare Parts C and D.<br>5. Requires states to terminate individuals and entities from Medicaid if terminated from Medicare or another state's Medicaid program.<br>6. Prohibits payments for items or services provided under Medicaid to any financial institution or entity outside of the U.S.<br>7. Requires states to use National Correct Coding Initiative for Medicaid (NCCI). |

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# Health Reform Timeline

2010 2011 2012 2013 2014 2015 2016 2017 2018

## MEDICARE

1. Adopts Accountable Care Organization concept (ACO).
2. Creates the Independence at Home demonstration program.
3. Annual market basket updates are reduced, but adjusted for productivity for hospitals, home health agencies, skilled nursing facilities, hospices, and other providers with various effective dates.
4. Hospital value-based purchasing program is to be created to pay hospitals for performance based on quality measures; also to be implemented for nursing homes, home health agencies, and ambulatory surgery center
5. Bonus payments to high-quality Medicare Advantage Plans.
6. Reduce rebates for Medicare Advantage Plans.

## MEDICAID

1. Creates demonstration projects to pay bundled payments for episodes of care.
2. Allows pediatric accountable care organizations (ACOs) to share in cost savings.
3. Provides Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (Oct. 1, 2011-Dec. 31, 2015).

## QUALITY INITIATIVES

1. Enhanced collection and reporting of data.

## SHARED RESPONSIBILITY

## ORAL HEALTH

## RESIDENTS

## TAX

1. Beginning January 1, 2012, the Medicare tax is increased by 0.9% of wages on joint returns for those earning $250,000 and for single filers for those earning $200,000 or more. A new 3.8% tax will be assessed on unearned income of taxpayers earning $250,000 or more and for single filers earning $200,000 or more.
2. 3.8% tax on unearned income.

## EMPLOYER RESPONSIBILITY

1. Enrollees must be provided a summary of benefits and a coverage explanation in a uniform format not in excess of four pages in length that meets standards prescribed by the Secretary.
2. If a plan makes any material modification in any terms of the plan or coverage, the plan shall provide participants notice not later than 60 days prior to the date on which the modification shall become effective.

## EXCHANGES

## INSURANCE

## TRAUMA CARE

## PUBLIC HEALTH

## WORKFORCE DEVELOPMENT

## LIABILITY REFORM

## PROGRAM INTEGRITY

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## MEDICARE

1. National Medicare Pilot Program to evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

## MEDICAID

1. Increased payment for primary care services.

## QUALITY INITIATIVES

1. Required disclosure of financial relationships among health entities.
2. Public reporting of physician performance.

## SHARED RESPONSIBILITY

## ORAL HEALTH

## RESIDENTS

## TAX

1. Itemized deduction threshold to increase from 7.5% to 10% with minor exceptions.
2. **Flexible Spending Accounts & Health Savings Accounts**
   a. Preparing for tax years after December 31, 2012 limits the amount of contributions to FSA for medical expenses to $2500 per year. Also, over the counter medications are excluded.
   b. Increases the tax on distributions from HSA (prior to age 65) that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount.
3. Establishes a 2.3% medical device excise tax after December 31, 2012 on sales of medical devices. Does not apply to Class I or Class II products that are primarily sold to consumers at retail for not more than $100 per unit.

## EMPLOYER RESPONSIBILITY

1. The Secretary is to establish new operating rules for electronic exchange of information on eligibility and health claim status, electronic funds transfer, health care payments, and remittance advice. Health plans must certify that they are in compliance with these rules by December 31, 2013, subject to a penalty for noncompliance.

## EXCHANGES

1. Creation of the Consumer Operated and Oriented Plan (CO-OP) to encourage creation of non-profit, member-run health insurance companies in all fifty (50) states and D.C. to offer qualified plans in individual and small group market. To receive funds, (1) this must be a new organization or sponsored by a state or local government; (2) governing documents incorporate ethics and conflict of interest standards protecting against unaware industry involvement; (3) substantially all activities must consist of issuance of qualified health benefit plans; (4) majority vote of members must govern its affairs; (5) strong consumer focus; (6) profits must be used to lower premiums, improve benefits or improve health quality of members; (7) compliance with state insurance laws; and (8) representatives of federal, state or local government may not be a Board Member. Six Billion and 00/100 ($6,000,000,000.00) Dollars is provided to finance the program and to award loans and grants to establish CO-OPs by July 1, 2013.
2. Employers must provide each employee upon hire or not later than March 1, 2013, a notice of the existence of a health care exchange (the "Exchange"), whether the employee may be eligible for a premium tax credit and/or a cost-sharing reduction if the employee buys coverage through the Exchange and that the employee will lose any employer contribution towards coverage if the employee buys coverage through the Exchange.

## INSURANCE

## TRAUMA CARE

## PUBLIC HEALTH

## WORKFORCE DEVELOPMENT

## LIABILITY REFORM

## PROGRAM INTEGRITY

2014 2015 2016 2017 2018

# Health Reform Timeline

2010 2011 2012 2013 2014 2015 2016 2017 2018

## MEDICARE

1. Reduces the out-of-pocket amount that qualifies enrollee for catastrophic coverage in Part D (through 2019).
2. Establishes Independent Medicare Advisory Board to submit recommendations to reduce Medicare spending if spending exceeds targets.
3. Requires Medicare Advantage Plans to have medical loss ratios no lower than 85%.

## MEDICAID

1. Expands Medicaid to all non-Medicare-eligible adults under 65 and adults with dependent children who are at incomes of up to 133% of the federal poverty level (FPL). States have the option to provide coverage to such individuals above 133% of the FPL through a state plan amendment.
2. Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments.

## QUALITY INITIATIVES

1. Requires individuals to have qualifying health coverage.

## SHARED RESPONSIBILITY

1. All U.S. citizens and legal residents will be required to have qualifying health coverage by 2014, except for those covered by hardship exemptions. Those that do not comply will have a tax maximum penalty of 2.5% of household income or $695, whichever is greater per adult per year. This will be phased in by 2016. After 2016, penalties will be increased by annual cost of living adjustments.

## ORAL HEALTH

1. Medical plans in exchanges must include pediatric oral health services. Stand alone dental coverage will also be offered.
2. No minimum level of coverage specified.

## RESIDENTS

## TAX

1. Health insurance providers will pay an annual fee starting at $8 billion. Self-insured and governmental plans are exempt. Third party administrators are covered.

## EMPLOYER RESPONSIBILITY

1. Employers offering coverage to their employees are required to provide a "free choice voucher" to all employees with incomes less than 4 times the federal poverty level ($18,310 for a family of 3), and whose share of the premium exceeds 8% but is less than 9.8% of their income and chose to enroll in the Exchange (although the Act did not provide a specific effective date, it is likely the effective date will be January 1, 2014). The amount of the voucher must equal the portion of the cost of the plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. The amount must equal the amount the employer would pay for an employee with self-only coverage, unless the employee elects family coverage.
2. Employers with 50 or more employees that do not offer coverage and have one full-time employee who receives a premium tax credit pays $2,000 per full-time employee excluding first 30 employees from the assessment.
3. Employers with 50 or more employees that offer coverage, but have one or more full-time employee receiving tax credit, will pay lesser of $3,000 for each employee receiving credit or $2,000 for each full-time employee excluding first 30 employees from the assessment.
4. Employers with more than 200 employees are required to enroll employees in health insurance plans offered by employer. Employees may opt out of coverage.
5. An employer is deemed to provide affordable coverage if the employer pays more than 60% of the cost of the coverage and the employee's share of the premium does not exceed 9.5% of the employee's income. Employees who are offered affordable coverage by their employers are not eligible for a premium assistance credit or a cost sharing subsidy.

## EXCHANGES

1. Creates state-based exchanges for individual market and "small business health options program" (SHOP) exchanges for small group market to be operational by 2014.
2. Creates four benefit categories of plans plus a separate "young invincible plan" to be offered throughout the exchange and in the individual and small group markets. Allows states to contract with one or more standard health plans for low-income individuals (those below 200% of the federal poverty level) who are not eligible for Medicaid.
3. Minimum benefits required.

## INSURANCE

1. Waiting period for coverage is not to exceed 90 days.
2. Creates an "essential health benefits package."
3. Gives states the option to create a basic health plan for the uninsured.
4. Allows State to merge individual and small group markets.
5. Prohibits plans from establishing lifetime or unreasonable annual limits on dollar value of benefits.
6. No pre-existing conditions exclusion.
7. A plan is not required to furnish abortion services. State laws regarding abortion are not preempted.
8. A three-year reinsurance program is required to be established in each state. Administrative and other costs for the reinsurance are to be collected from insured and self-insured plans for the plan years beginning in 2014, 2015 and 2016, based on the cost of providing benefits to enrollees, or a specified amount per enrollee, and may be required to be paid in advance or periodically during the year. The monies will support a high-risk pool for the individual and small group market.

## TRAUMA CARE

## PUBLIC HEALTH

## WORKFORCE DEVELOPMENT

## LIABILITY REFORM

## PROGRAM INTEGRITY

| MEDICARE | MEDICAID | QUALITY INITIATIVES | SHARED RESPONSIBILITY | ORAL HEALTH | RESIDENTS | TAX |
|---|---|---|---|---|---|---|
| 1. Directs Secretary of HHS to develop and implement budget-neutral payment system that adjusts Medicare physician payments based on quality and cost of the care delivered. Measures will be risk-adjusted and geographically standardized. New payment systems will be phased in over 2 year period beginning in 2015. | | | | | | |

| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
|---|---|---|---|---|---|---|---|
| 1. An employer is deemed to provide affordable coverage if the employer pays more than 60% of the cost of the coverage and the employee's share of the premium does not exceed 9.5% of the employee's income. Employees who are offered affordable coverage by their employers are not eligible for a premium assistance credit or a cost-sharing subsidy. | 1. After 2014, if employers purchase coverage through a state exchange, there is a tax credit of up to fifty (50%) percent of the employer's contribution if employer contributes fifty (50%) percent of total premium cost. The credit is available for employers with ten or fewer employees and average annual wages of less than $25,000.00. Tax exempt and small businesses that meet requirements are eligible for tax credits up to thirty-five (35%) percent of the premium contributed to by employer. | | | | | | |

# Health Reform Timeline

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| MEDICARE | MEDICAID | QUALITY INITIATIVES | SHARED RESPONSIBILITY | ORAL HEALTH | RESIDENTS | TAX |
|---|---|---|---|---|---|---|
| | | | 1. The penalties for not having health insurance increase by the cost of living. | | | |

| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
|---|---|---|---|---|---|---|---|
| | 1. Creates American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges. These will be administered by a government agency or a non-profit organization. Employers with 100 employees or less will be able to purchase qualified coverage. States will be able to allow employers with more than 100 employees to participate in SHOP after 2016. Exchanges are to serve a specific geographic area, but may have more than one in a state; states may have regional exchanges. Funding will be available within one year of enactment and until 2015. | | | | | | |

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| MEDICARE | MEDICAID | QUALITY INITIATIVES | SHARED RESPONSIBILITY | ORAL HEALTH | RESIDENTS | TAX |
|---|---|---|---|---|---|---|
| | | | | | | 1. Individuals begin paying a penalty to the IRS if they do not maintain minimum health insurance coverage. |

| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
|---|---|---|---|---|---|---|---|
| | 1. A large employer may be eligible to use the Exchange in a State that so authorizes. | | | | | | |

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|---|---|---|---|---|---|---|
| | | | | | | 1. EXCISE TAX ON HIGH-COST HEALTH PLANS<br>After December 31, 2017, revenue from a new excise tax of 40% on insurance companies and plan administrators for any plan that is above the threshold of $10,200 for single coverage and $27,500 for family coverage with limited exception of certain high-cost states and for high-risk employees or those installing or repairing electrical or telecommunication lines where the cap is increased. High risk professions include police and fire emergency medical care outside the hospital and individuals engaged in construction; mining, agriculture, forestry, and fishing industries. |

| EMPLOYER RESPONSIBILITY | EXCHANGES | INSURANCE | TRAUMA CARE | PUBLIC HEALTH | WORKFORCE DEVELOPMENT | LIABILITY REFORM | PROGRAM INTEGRITY |
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