



The Affordable Care Act Key Provisions and Status

Year	Provision	Status
2010	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> • \$5 billion for individuals with preexisting conditions to access high-risk pools (by June 23, 2010). • Insurance market reforms (eliminates lifetime limits, pre-existing condition exclusions for children's coverage, and rescissions) (by September 23, 2010). 	<ul style="list-style-type: none"> • April 30, HHS announced 30 states will participate in the program; May 25, HHS issued an RFP for a federal high-risk pool third party administrator (Solicitation Number: 10-233-SOL-00200); July 30, OCIO published an interim final rule to implement the temporary program. The regulation became effective July 30. • April 27, HHS asked insurers to implement the ban on rescissions before September 23; June 22, Depts. of HHS, Treasury, and Labor issued an interim final rule for group health plans and insurance coverage relating to status as grandfathered plans (rule was effective August 27); September 3, HHS issued guidance on the process to receive a waiver on annual limits requirement; early October, HHS posted a list of entities granted a waiver; November 17, the Departments of HHS, Treasury, and Labor published an amendment to the current interim final rule to allow certain changes in policies, certificates, or contracts of insurance without loss of grandfathered status under the ACA (effective November 15, 2010); February 11, 2011, HHS published a proposed rule clarifying which

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2010	<p data-bbox="327 175 594 207"><u>COVERAGE cont'd</u></p> <ul data-bbox="373 345 1161 1360" style="list-style-type: none"> <li data-bbox="373 345 1161 443">• All new group health plans and individual market plans must provide first-dollar coverage for preventive services (by September 23, 2010). <li data-bbox="373 548 1161 613">• Extends dependent coverage to age 26 (by September 23, 2010). <li data-bbox="373 922 1161 987">• Regulates plans' use of annual limits to be defined by the secretary (by September 23, 2010). <li data-bbox="373 1060 1161 1190">• Secretary to work with states to establish an annual review of unreasonable rate increases, monitor premium increases, and award grants to states to carry out review process. <li data-bbox="373 1295 1161 1360">• Creates temporary reinsurance program for early retiree health benefits (55-64) (by December 23, 2010). 	<p data-bbox="1287 175 1843 272">consumer protection provisions of health insurance market reforms apply to student plans.</p> <ul data-bbox="1245 345 1885 1458" style="list-style-type: none"> <li data-bbox="1245 345 1885 508">• On July 14, Depts. of Treasury, Labor, and HHS issued interim final rule. The comment period ended on September 17 and the rule became effective for plan years beginning on or after September 23, 2010. <li data-bbox="1245 548 1885 881">• April 19, HHS announced working with insurers to expand coverage before September 23; April 27, IRS issued guidance on the tax treatment of health coverage for dependents up to age 27; May 13, HHS, Treasury, and Labor Depts. issued interim final rule detailing how group and individual insurers offering dependent coverage must implement regulation (comments were due August 11). <li data-bbox="1245 922 1885 1019">• On June 28, Depts. of Treasury, Labor, and HHS published an interim final rule. The rule became effective August 27. <li data-bbox="1245 1060 1885 1255">• April 30, HHS requested comments for regulatory guidance; June 7, HHS announced availability of \$51 million in grants; December 23, HHS published a proposed rule on the disclosure and review of unreasonable health insurance premium increases. <li data-bbox="1245 1295 1885 1458">• On Aug. 30, HHS launched the Early Retiree Reinsurance Program secure website: http://errp.gov; HHS said as of September 17 over 2,000 applications have been approved for the program; March 2, 2011, HHS

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2010	<p data-bbox="327 175 594 207"><u>COVERAGE cont'd</u></p> <ul data-bbox="375 380 1140 1114" style="list-style-type: none"> <li data-bbox="375 380 1140 509">• Requires new group health plans and new plans in the individual market to implement appeals process for coverage determinations and claims (by September 23, 2010). <li data-bbox="375 1052 1140 1114">• Begin first phase of small business tax credit (January 1, 2010). 	<p data-bbox="1289 175 1839 337">published a report on implementation of ERRP. The report listed plan sponsors by state and said that \$535 million in reimbursements had been paid through December 31, 2010.</p> <ul data-bbox="1245 380 1890 1279" style="list-style-type: none"> <li data-bbox="1245 380 1890 977">• May 5, HHS published an interim final rule effective June 1; \$5 billion available for program. On November 17, the Depts. of HHS and Labor published a notice requesting information to gain market analysis information in advance of future requests for proposals related to health plan external review processes; July 23, Depts. of Treasury, Labor, and HHS published an interim final rule with comments due by September 21. The rule became effective on September 21 and generally applies to plan years beginning on or after September 23, 2010. On August 26, IRS posted guidance detailing interim procedures for the federal external review process and model notices both for internal claims and appeals and for external review processes. <li data-bbox="1245 1052 1890 1279">• May 3, IRS issued guidance to help determine the amount of a new tax credit for small employers who make contributions toward their employees' health premiums; May 17, IRS issued guidance to small businesses that are eligible to claim the credit; December 2, IRS released final guidance for 2010.

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2010	<p><u>COVERAGE cont'd</u></p> <ul style="list-style-type: none"> HHS to establish a website to allow residents to identify affordable insurance options in any state. Also to include information on reinsurance for early retirees, small business coverage options, and small business tax credits. Website must be up by July 1. Nonprofit BCBS organizations must have an MLR of 85% to take advantage of Section 833 tax benefits (beginning 2010 tax year). 	<ul style="list-style-type: none"> May 5, HHS published an interim final rule to establish website. Rule became effective May 10 and comments were accepted until June 4; website went live on July 1; November 15, OCIO held a live streamed press call to provide details on updates to the HealthCare.gov Insurance Finder. November 22, IRS published modification of Section 833.
2010	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> 10% tax on indoor tanning services (on or after July 1). 	<ul style="list-style-type: none"> June 15, Department of Treasury published final regulation implementing tax; first quarterly payment was due November 1.
2010	<p><u>DELIVERY SYSTEM</u></p> <ul style="list-style-type: none"> Creates interagency council that reports annually to the president to promote healthy policies, establish a prevention and public health investment fund, and establish an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. Establishes National Health Care Workforce Commission (by September 30). 	<ul style="list-style-type: none"> June 10, President Obama established the National Prevention, Health Promotion, and Public Health Council which issued its first report; July 1, HHS published a notice announcing the establishment of an Advisory Group on Prevention, Health Promotion, and Integrative and Public Health, composed of 25 nonfederal members. May 11, GAO posted a solicitation in the <i>Federal Register</i> announcing applications to be accepted for appointment to the National Health Care Workforce Commission. Letters of nomination and resumes were due to GAO by June 30; September 30, GAO announced appointments to the commission.

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2010	<p data-bbox="325 175 703 203"><u>DELIVERY SYSTEM cont'd</u></p> <ul data-bbox="384 212 1167 1360" style="list-style-type: none"> <li data-bbox="384 212 1167 407">• Directs HHS to develop methodology and criteria for designating medically underserved populations and health professional shortage areas by July 1, 2010, through a negotiated rulemaking committee. The committee shall be appointed no later than 30 days after publication of rule. <li data-bbox="384 548 1066 609">• Provides additional funding to Community Health Centers. <li data-bbox="384 857 1167 987">• Expands funding for scholarships and loan repayment for primary care practitioners in underserved areas participating in the National Health Service Corps (FY 2011). <li data-bbox="384 1031 1167 1193">• Excludes from gross income payments made under any state loan repayment or forgiveness program intended to increase availability of health services in underserved or health provider shortage areas (effective for tax years beginning in 2009). <li data-bbox="384 1268 1136 1360">• Expands low-interest student loan programs, scholarships, and loan repayments for health students and professionals. 	<ul data-bbox="1245 212 1892 1360" style="list-style-type: none"> <li data-bbox="1245 212 1892 511">• May 13, HRSA announced intent to use negotiated rulemaking process to establish methodology and criteria, asking for nominations and seeking comment on process (deadline June 10); September 22, the Negotiated Rulemaking Committee on Designation of MUPs and HPSAs first met and has continued to meet. The 8th meeting will be held May 18, 2011. <li data-bbox="1245 548 1892 813">• August 10, HHS announced \$250 million for “new access points” (through ARRA) grants to support more than 350 new health centers through HRSA applications due November 17; October 8, HHS announced \$727 million to 143 community health centers; October 26, HHS announced the availability of \$335 million to support existing CHCs. <li data-bbox="1245 857 1892 950">• HRSA accepted full-time loan repayment program applications until July 29. Applicants notified by October 15. <li data-bbox="1245 1024 1892 1187">• June 16, IRS announced healthcare professionals who received student loan relief under state programs that reward those who work in underserved communities may qualify for refunds on their 2009 income tax returns. <li data-bbox="1245 1263 1892 1356">• Application cycle for 2010 through HRSA closed in July for most programs. Applicants were notified in October.

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2010	<p data-bbox="327 175 638 204"><u>MEDICARE PAYMENT</u></p> <ul data-bbox="373 212 1167 1089" style="list-style-type: none"> <li data-bbox="373 212 1167 310">• Provides \$250 rebate for all Part D beneficiaries who hit the doughnut hole (gap in coverage) and gradually eliminates the doughnut hole by 2020. <li data-bbox="373 350 1167 412">• Extends payment protections for small rural hospitals and facilities that have a low volume of Medicare patients. <li data-bbox="373 518 1167 615">• Establishes 1.0 geographic physician practice expense floor for frontier states (population of less than 6 per mile in more than half the counties) (FY 2011). <li data-bbox="373 818 1167 915">• Extends the work geographic index floor and revises the practice expense geographic adjustment under the physician fee schedule. <li data-bbox="373 989 1167 1089">• Hospitals, inpatient psychiatric, and inpatient rehab facilities (IRFs) will receive a 0.25% reduction in their market basket (April 1; 2 years). 	<ul data-bbox="1241 212 1898 1154" style="list-style-type: none"> <li data-bbox="1241 212 1898 310">• April 28, HHS issued justification and approval for Medicare Part D coverage gap rebates; first checks were mailed June 10. <li data-bbox="1241 350 1898 477">• June 2, CMS published supplement to proposed FY 2011 IPPS (comments due by June 18); July 30, CMS published final FY 2011 IPPS; effective October 1. <li data-bbox="1241 518 1898 777">• June 25, CMS released proposed physician fee schedule providing a 1.0 GPCI floor; July 2, CMS issued the proposed rule for the Outpatient Prospective Payment System (OPPS); November 2, CMS released the final physician fee schedule for CY 2011 that includes the 1.0 GPCI floor; November 2, CMS released the final 2011 OPPS. <li data-bbox="1241 818 1898 945">• June 25, CMS released proposed physician fee schedule to extend the floor on geographic adjustments; November 2, CMS released the final physician fee schedule for CY 2011. <li data-bbox="1241 989 1898 1154">• May 21, CMS issued proposed rule on hospital payment provisions included in ACA; June 2, CMS published a supplement to the proposed rule; July 30, CMS published final FY 2011 IPPS; effective October 1.
2010	<p data-bbox="327 1161 638 1190"><u>MEDICAID PAYMENT</u></p> <ul data-bbox="373 1198 1125 1260" style="list-style-type: none"> <li data-bbox="373 1198 1125 1260">• States have option to expand Medicaid to parents and childless adults up to 133% FPL (effective April 1). 	<ul data-bbox="1241 1198 1898 1456" style="list-style-type: none"> <li data-bbox="1241 1198 1898 1456">• April 9, CMS sent letter to states with initial guidance on establishing the new eligibility group and informing them they have the option to provide coverage to those who qualify for the new group before 2014, and will receive increased FMAP for doing so. Early expansion states had to submit proposed plan amendments by June 30; June 18, CMS

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2010	<p data-bbox="327 175 722 207"><u>MEDICAID PAYMENT cont'd</u></p> <ul data-bbox="373 448 1125 646" style="list-style-type: none"> <li data-bbox="373 448 1125 513">• States must cover tobacco cessation programs for pregnant women (FY 2011). <li data-bbox="373 578 1125 646">• Rebate increase to 23.1% for name brand drugs using AMP (January 1, 2010). 	<p data-bbox="1289 175 1871 407">announced CT as the first state permanently to add low-income adults to its Medicaid program, effective June 21, 2010; February 25, 2011, CMS issued a State Medicaid Director letter and FAQ to address the Medicaid and CHIP ACA mandated “maintenance of effort” requirements.</p> <ul data-bbox="1241 448 1871 646" style="list-style-type: none"> <li data-bbox="1241 448 1871 545">• February 9, 2011, HHS announced award of \$60 million in grants from Public Health Fund to implement anti-tobacco media campaigns. <li data-bbox="1241 578 1871 646">• April 22, CMS issued guidance to state Medicaid directors.
2010	<p data-bbox="327 654 621 686"><u>OTHER PROVISIONS</u></p> <ul data-bbox="373 686 1125 1425" style="list-style-type: none"> <li data-bbox="373 686 1125 751">• Establishes the Patient Centered Outcomes Research Institute (PCORI) upon date of enactment. <li data-bbox="373 1190 1125 1287">• \$1 billion 2-year temporary refundable tax credits to encourage investment in new biotechnology (tax years 2009 and 2010). <li data-bbox="373 1352 1125 1425">• Increases adoption tax credit and adoption assistance exclusion by \$1,000 and makes refundable. 	<ul data-bbox="1241 686 1871 1425" style="list-style-type: none"> <li data-bbox="1241 686 1871 1117">• May 7, GAO published a notice seeking nominations for the Patient Centered Outcomes Research Institute governing board. Nominations and resumes were due by June 30; September 23, GAO announced appointments to PCORI Board of Governors; November 12, GAO announced an additional appointment; November 22, first meeting of PCORI Board of Governors held; January 19, 2011 board meeting held in CA; March 7, 2011, board meeting held in MO; May 16, board meeting held in NY; next scheduled board meeting July 19 in Washington, DC. <li data-bbox="1241 1190 1871 1320">• May 21, IRS issued notice establishing the program and announcing the procedure to apply for credits and cash grants; November 3, grant awards announced. <li data-bbox="1241 1352 1871 1425">• September 29, IRS issued guidance on expanded adoption credit.

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2010	<p><u>OTHER PROVISIONS cont'd</u></p> <ul style="list-style-type: none"> FDA authorized to approve biosimilars (follow-on biologics). 	<ul style="list-style-type: none"> July 23, FDA approved an application for generic Levonox (enoxaparin); December 9, FDA and CMS held a joint summit to discuss the future of bio/pharmaceutical regulation; December 8, FDA published a notice requesting stakeholders notify FDA if they intend to participate in consultation meeting on the development of a user fee program for biosimilars; December 9, CMS and FDA held a joint summit to discuss the future of bio/pharmaceutical regulation.
2011	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> All health plans must annually report medical loss ratios (MLR) (beginning January 1). Creates long-term care insurance programs financed by voluntary payroll deductions (Community Living Assistance Services and Supports Act, CLASS Act) (January 1). 	<ul style="list-style-type: none"> November 22, HHS issued interim final regulations (effective January 1, 2011); April 12, HHS, Treasury, and Labor Depts. requested public comments on MLR; April 12, HHS requested NAIC to assist in defining MLR and requested NAIC finish by June 1, 2010; August 17, NAIC executive committee overwhelmingly approved the final MLR blanks proposal; October 21, NAIC approved its final model MLR regulation and forwarded it to HHS. June 15, HHS established the Personal Care Attendants Workforce Advisory Panel; January 10, 2011, HHS established the CLASS office within the Administration on Aging to implement the CLASS program; March 17, 2011, Administration on Aging released FAQs on CLASS program.

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2011	<p><u>COVERAGE cont'd</u></p> <ul style="list-style-type: none"> Employers to disclose the value of benefits provided for each employee's coverage on annual W-2 (tax year 2011). Creates Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees (tax year 2011). Rules adopted for providing a single set of operating rules for eligibility verification and claims status (July 1). 	<ul style="list-style-type: none"> October 12, IRS issued guidance saying it would make the reporting requirement optional in 2011; March 29, 2011, IRS published guidance that reporting is voluntary in 2011 and for small employers in 2012.
2011	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> Conforms definition of qualified medical expenses for HSA, FSA, and HRA to that used for itemized deductions (tax year 2011). Increases tax to 20% for HSA withdrawals prior to age 65 not used for qualified medical expenses. Increases tax to 20% for MSA withdrawals not used for qualified medical expenses (tax year 2011). Pharma nondeductible fee of \$2.5 billion (tax year 2011). 	<ul style="list-style-type: none"> September 3, IRS issued guidance reflecting statutory changes for tax-favored arrangements to pay for over-the-counter medicines and drugs in 2011. IRS Publication 969 outlines changes for 2011. November 29, IRS issued guidance on the annual fee for drug manufacturers (Notice 2010-71). Preliminary 2011 fee calculations are to be based on information submitted by manufacturers on Form 8947 to be submitted to the IRS by January 20, 2011; February 7, 2011, IRS issued notice (2011-9) revising and superseding some initial guidance (2010-71) on orphan drugs and Medicare and Medicaid drug rebates and extended the deadline for comments to June 15, 2011.

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2011	<p><u>DELIVERY SYSTEM</u></p> <ul style="list-style-type: none"> • HHS to submit national quality strategy (by January 1). • Expands primary care and nurse training programs (July). 	<ul style="list-style-type: none"> • September 10, HHS posted initial National Health Care Quality Strategy and Plan, sought public input in the development of a National Health Care Quality Strategy and Plan; March 21, 2011, HHS released the National Strategy for Quality Improvement in Health Care (National Quality Strategy). • A number of HRSA-administered grant opportunities funded by the Prevention and Public Health Fund were announced in 2010; November 15, HRSA Committee on Training in Primary Care Medicine and Dentistry met, will meet again June 13-14, 2011; April 11-12, 2011, National Advisory Council on Nurse Education and Practice met.
2011	<p><u>MEDICARE PAYMENT</u></p> <ul style="list-style-type: none"> • Provides 50% discount to beneficiaries on brand name drugs and biologics in the doughnut hole and begins phasing in additional discounts on all drugs to fill the doughnut hole by 2020 (beginning January 1). • Provides beneficiaries a free, initial wellness visit and subsequent annual personalized prevention plan (January 1). 	<ul style="list-style-type: none"> • April 30, CMS issued preliminary guidance on the monthly prospective payment to Part D plans for the manufacturers' discounts; May 21, CMS issued notice detailing the draft model agreement drug manufacturers will sign to participate in the discount program; August 13, CMS finalized the model manufacturer agreement and model third party administrator agreement for the discount program. The deadline for manufacturers to return signed agreements and an associated labeler code spreadsheet was September 1, 2010. • June 25, CMS released proposed physician fee schedule that waives co-pays for annual wellness visit under Medicare (comments due by August 24); November 2, CMS released final physician fee schedule.

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2011	<p data-bbox="327 175 730 204"><u>MEDICARE PAYMENT cont'd</u></p> <ul data-bbox="373 212 1163 1190" style="list-style-type: none"> <li data-bbox="373 212 1024 277">• Eliminates cost sharing for preventive services (January 1). <li data-bbox="373 415 1104 513">• 10% bonus payment for five years for primary care physicians and general surgeons operating in health professional shortage areas (January 1). <li data-bbox="373 586 1142 651">• Establishes Center for Medicare & Medicaid Innovation (CMMI) (January 1). <li data-bbox="373 854 1136 919">• Administrative funding for the Independent Payment Advisory Board (IPAB) becomes available (October 1). <li data-bbox="373 959 1163 1024">• Establishes the Community Care Transitions Program for high-risk beneficiaries (January 1). <li data-bbox="373 1130 1129 1195">• Freezes Medicare Advantage payment benchmarks at 2010 levels (January 1). 	<ul data-bbox="1241 212 1892 1325" style="list-style-type: none"> <li data-bbox="1241 212 1892 375">• June 25, CMS released proposed physician fee schedule that waives co-pays for all preventive services under Medicare; November 2, CMS released final physician fee schedule. <li data-bbox="1241 415 1860 545">• June 25, CMS released proposed physician fee schedule that includes a 10% bonus for primary care providers; November 2, CMS released final physician fee schedule. <li data-bbox="1241 586 1892 813">• On November 16, CMS formally established the Center for Medicare and Medicaid Innovation (CMMI); March 21, 2011, CMMI re-launched its website, which includes functionality for the public to submit ideas regarding innovative payment and delivery models. <li data-bbox="1241 959 1892 1089">• October 7, CMS posted a mailbox for receiving comments on program; December 3, CMS held meeting to provide guidance to providers and answer questions. <li data-bbox="1241 1130 1860 1325">• November 5, CMS announced Medicare premiums, deductibles, and coinsurance amounts for 2011; April 5, 2011, CMS released the final 2011 call letter for MA and Part D plans, along with capitation rates for MA plans for 2011.

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2011	<p><u>MEDICARE PAYMENT cont'd</u></p> <ul style="list-style-type: none"> • Modification of equipment utilization factor for advanced imaging services (January 10). • Unused GME slots to be redistributed to other sites for primary care (July 1). • Prohibits physician-owned hospitals without a Medicare agreement as of December 31, 2010, from participating in Medicare. 	<ul style="list-style-type: none"> • June 25, CMS released proposed physician fee schedule that sets the assumed utilization rate at 75% for the practice expense portion of diagnostic imaging (comments due by August 24). • July 2, CMS issued the proposed rule for the hospital Outpatient Prospective Payment System (OPPS); November 2, CMS issued final OPPS. • July 2, CMS issued the proposed rule for the OPPS. Incorporates provision that narrows access to the whole hospital and rural provider exceptions by prohibiting their use by new physician-owned hospitals and limiting the ability of existing physician-owned hospitals to expand their capacity or qualify for the rural exception; November 2, CMS issued final OPPS.
2011	<p><u>MEDICAID PAYMENT</u></p> <ul style="list-style-type: none"> • Start of Community First Choice Option for home and community-based services to disabled individuals (October 1). 	<ul style="list-style-type: none"> • August 6, CMS issued memo to state Medicaid directors providing guidance on removing barriers to offering home and community-based services through Medicaid state plans; October 7, CMS posted a mailbox for receiving comments regarding the Transitions of Care program at CareTransitions@cms.hhs.gov; Dec 3, CMS held a meeting to provide guidance to providers.
2012	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> • CLASS Act benefit plan has to be in place (no later than October 1). 	<ul style="list-style-type: none"> • January 28, 2011, HHS formally reorganized the Administration on Aging to establish the Office of Community Living Assistance Services and Supports to implement CLASS Act.

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2012	<u>COVERAGE cont'd</u> <ul style="list-style-type: none"> Administrative simplification regulations effective October 1. 	<ul style="list-style-type: none"> November 8, HHS published a notice notifying states of eligibility for funding to address eligibility determinations and other requirements.
2012	<u>FINANCING</u> <ul style="list-style-type: none"> Annual pharma fee of \$2.8 billion (2012-2013). 	
2012	<u>DELIVERY SYSTEM</u> <ul style="list-style-type: none"> Federal health programs to collect and report racial, ethnic, and language data (March 2012). 	
2012	<u>MEDICARE PAYMENT</u> <ul style="list-style-type: none"> Reforms physician payment to increase payment for primary care services. Implements accountable care organizations (ACOs) (January 1). Establishes value-based purchasing program for hospitals (FY 2013). 	<ul style="list-style-type: none"> June 24, CMS hosted an open-door forum on ACOs for public feedback on the program; October 5, CMS OIG held a workshop on ACOs and implications on antitrust, physician self-referral, antikickback, and CMP laws; November 15, CMS posted a request for information regarding ACOs; March 31, 2011, CMS issued proposed ACO regulation; May 17, 2011, CMS announced 3 additional ACO initiatives: Pioneer ACOs, Advanced Payment ACO Model, and Accelerated Development Learning Sessions. April 19, CMS issued the proposed hospital IPPS payment rule that recommends adding 10 new quality measures to the list of those on which hospitals must report; August 16, CMS issued final IPPS that requires 45 quality measures for reporting in FY 2011; January 13, 2011, CMS posted a proposed rule governing VBP program; February 10, 2011, CMS held a special open-door forum to discuss the proposed rule.

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2012	<p><u>MEDICARE PAYMENT cont'd</u></p> <ul style="list-style-type: none"> • CMS to implement IOM recommendations on geographic disparities. • Develops a value-based Medicare payment modifier for physicians (must be applied to all physicians by 2017). • Secretary to submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing system. • CMS to track hospital readmission rates for certain high-cost conditions and implements payment penalty for hospitals with highest readmission rates (FY 2013). • Bonus payment to Medicare Advantage plans with 4- and 5-star quality ratings. • MA payments phased down over 3, 5, and 7 years between 95% and 115% of Medicare FFS. 	<ul style="list-style-type: none"> • September 16 and 17, IOM conducted meetings to discuss geographic adjustments; November 4 and 5, IOM held a meeting; November 9 and 10, IOM held a conference on geographic variation and the promotion of high-value care; January 17 and 18, 2011, IOM held second meeting; January 20, 2011, third meeting held; February 17, 2011, fourth meeting held; June 1, 2011, IOM released its report on geographic variation in healthcare spending. • May 26, CMS posted solicitation for grouper episode for Medicare; June 25, CMS issued proposed Medicare physician fee schedule for CY 2011 that discussed implementation of this provision; September 24, CMS held a listening session on transition to a value-based system; October 4, HHS convened a National Summit on Health Care Quality and Value where it was announced these efforts will likely be guided by the CMMI. • November 10, CMS announced 2011 Medicare Star Ratings demonstration. • April 5, 2011, CMS issued final 2012 policies for Medicare drug and health plans.

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2012	<p><u>MEDICARE PAYMENT cont'd</u></p> <ul style="list-style-type: none"> Hospitals, inpatient psychiatric, IRFs, and LTCHs will receive a 0.1% reduction in their market basket. Begin productivity adjustments for hospitals, inpatient psychiatric, IRFs, LTCHs, SNFs, and ESRD. 	<ul style="list-style-type: none"> April 19, 2011, CMS issued proposed 2012 payment update for LTCH and IRFs; April 28, 2011, CMS issued final 2012 payment update for inpatient psychiatric facilities.
2013	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> Health plans to adopt and implement uniform standards and business rules for the electronic exchange of health information. Creates Consumer Operated and Oriented Plans (Co-Ops); \$6 billion available by July 1. 2 years additional funding for CHIP for children not eligible for Medicaid. 	<ul style="list-style-type: none"> April 14, 2011, Section 1857 of the 6-month Continuing Resolution (P.L. 112-10) rescinded \$2.2 billion from the start-up fund.
2013	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> Imposes 2.3% excise tax on all medical device sales (tax year 2013). Increases the income threshold to 10% AGI for claiming itemized medical expense deductions (those over 65 maintain 7.5% AGI through 2016). Limits the amount of contributions to FSAs to \$2,500/year indexed by CPI for subsequent years (tax year 2013). Increases Medicare HI tax by 0.9% on wages over \$200K (\$250K joint filers). 	<ul style="list-style-type: none"> December 3, the IRS issued a request for public comment on the excise tax (Notice 2010-89). Comments were due by March 3, 2011.

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2013	<p><u>FINANCING cont'd</u></p> <ul style="list-style-type: none"> • Medicare HI tax of 3.8% on net investment income for those earning more than \$200K (\$250K joint filers). • Annual fee on health plans to fund the Patient Centered Outcomes Research trust fund. 	
2013	<p><u>MEDICARE PAYMENT</u></p> <ul style="list-style-type: none"> • Begins national pilot program on bundled payments. 	
2013	<p><u>MEDICAID PAYMENT</u></p> <ul style="list-style-type: none"> • Incentives to states for programs to cover evidence-based preventive services with no cost-sharing. • States to pay Medicaid primary care physicians the same rate as Medicare with federal funds for additional state costs. • Eliminates the deduction for the subsidy for employers maintaining drug plans for their Medicare Part D eligible retirees. 	
2013	<p><u>OTHER PROVISIONS</u></p> <ul style="list-style-type: none"> • Limits executive compensation deductibility to \$500,000 per taxable year for insurance providers if at least 25% of insurance provider's gross premium income from health business is derived from health insurance plans meeting minimum creditable coverage requirements. 	
2014	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> • Establishes health insurance exchanges in states. 	<ul style="list-style-type: none"> • August 3, OCIO published a notice soliciting comments regarding state exchanges to inform future rulemaking and grant solicitations. OCIO requested comments on a number of specific questions in the following areas: state exchange planning and establishment grants; implementation timeframes and considerations; exchange operations; qualified health plans; quality; an exchange for nonelecting states; enrollment and eligibility; outreach; rating areas; consumer experience; employer participation;

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2014	<p data-bbox="327 175 594 204"><u>COVERAGE cont'd</u></p> <ul data-bbox="380 716 1167 1425" style="list-style-type: none"> <li data-bbox="380 716 1167 813">• Prohibits annual limits on group plans and prohibits plans from refusing coverage to individuals with preexisting conditions and requires modified community ratings. <li data-bbox="380 854 1167 914">• Provides choice of coverage through multistate plans available nationwide under the supervision of OPM. <li data-bbox="380 954 1167 984">• Individual mandate becomes effective. <li data-bbox="380 1024 1167 1084">• Premium tax credits and subsidies available through the exchange. <li data-bbox="380 1125 1167 1255">• Workers exempt from the individual mandate (affordability) but who do not qualify for tax credits allowed to use their employer contribution to join a plan through an exchange. <li data-bbox="380 1295 1167 1325">• Employer mandate becomes effective. <li data-bbox="380 1365 1167 1425">• Medicaid expansion to 133% FPL and broader populations (with 100% FMAP for first 3 years). 	<p data-bbox="1293 175 1892 708">risk adjustment, reinsurance, and risk corridors; and economic analysis, Paperwork Reduction Act, and Regulatory Flexibility Act considerations; comments were due by October 4, 2010; September 29, NAIC released a model regulation for health insurance exchanges. Comments on the model were due by October 4; October 29, HHS announced competitive “Early Innovator” grants to help states build the HIT infrastructure necessary to operate exchanges; January 20, 2011, HHS announced a second round of grant funding to states; May 23, 2011, HHS announced 3 health insurance exchange establishment awards (IN, RI, WA).</p>

Year	Provision	Status
2014	<p><u>COVERAGE cont'd</u></p> <ul style="list-style-type: none"> • Second phase of small business tax credit. • Plans participating in the exchange must cover essential health benefits. • Plans prohibited from dropping or limiting coverage for individuals participating in clinical trials. 	<ul style="list-style-type: none"> • January 1, 2011, the IOM Board on Health Care Services first met on how to define; March 2-3, 2011, IOM second meeting; March 21, 2011, third meeting; April 14, 2011, fourth meeting.
2014	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Pharma annual nondeductible fee of \$3 billion (3 years). • Annual nondeductible fee on health insurers of \$8 billion. 	
2014	<p><u>MEDICARE PAYMENT</u></p> <ul style="list-style-type: none"> • Secretary to implement quality measure reporting programs for ambulatory surgical centers, LTCHs, IRFs, inpatient psychiatric facilities, PPS-exempt cancer hospitals, and hospice providers. • First report to Congress from the Independent Payment Advisory Board (IPAB) (January 15). • Market basket minus 0.3% for hospitals, inpatient psychiatric, IRFs, and LTCHs. 	
2015	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Annual nondeductible fee on health insurers of \$11.3 billion (2015-2016). 	
2015	<p><u>MEDICARE PAYMENT</u></p> <ul style="list-style-type: none"> • Implementation of a value index for physicians. • Market basket minus 0.2% for hospitals, inpatient psychiatric, IRFs, and LTCHs. 	
2016	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> • States can form interstate insurance compacts with HHS approval. 	

Year	Provision	Status
2016	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Implementation of VBP pilot programs for IRFs, LTCHs, psychiatric hospitals, cancer hospitals, and hospice providers. • Secretary submits plan to Congress to expand the Medicare bundled payments pilot program. 	
2017	<p><u>COVERAGE</u></p> <ul style="list-style-type: none"> • States can allow large employers and multiemployer plans to purchase coverage in the exchange. 	
2017	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Pharma annual nondeductible fee of \$4 billion. • Annual nondeductible fee on health insurers of \$13.9 billion. 	
2017	<p><u>MEDICARE PAYMENT</u></p> <ul style="list-style-type: none"> • Market basket minus 0.75% for acute care hospitals, inpatient psychiatric hospitals, IRFs, and LTCHs (and subsequent years). • Physician pay-for-quality program begins for all physicians. 	
2018	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Pharma annual nondeductible fee of \$4.1 billion. • Annual nondeductible fee on health insurers of \$14.3 billion. • Begin excise tax on high-cost employer-sponsored health plans. 	
2019	<p><u>FINANCING</u></p> <ul style="list-style-type: none"> • Pharma annual nondeductible fee of \$2.8 billion (2019 and beyond). • Annual nondeductible fee on health insurers of \$14.3 billion (plus rate of premium growth). 	