



# Health Reform Implementation Timeline

The implementation timeline is an interactive tool designed to explain how and when the provisions of the Affordable Care Act are implemented over the next several years.

You can show or hide all the changes occurring in a year by clicking on that year. Click on a provision to get more information. Customize the timeline by checking and unchecking specific topics.

## CUSTOMIZE BY TOPIC

Select All | Deselect All

- Provision in Effect or in Progress
- Provision Not in Effect

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- Affordability and Subsidies
- Employers

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- Financing and Taxes

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- Fraud and Abuse

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- Insurance

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- Long Term Care

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- Medicaid and CHIP

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- Medical Malpractice

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- Medicare

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- Prescription Drugs

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- Prevention

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- Quality

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- Workforce

## provision by year

### 2010 (26 in total, 26 in effect)

#### Review of Health Plan Premium Increases

Requires the federal government to create a process, in conjunction with states where insurers have to justify unreasonable premium increases. Provides guidance to states for reviewing premium increases.

**Implementation:** Plan year 2010

**Implementation update:** On August 16, 2010, HHS Secretary Kathleen Sebelius announced the award of \$46 million to 45 states and the District of Columbia to improve their processes for reviewing health plan premium increases. On December 21, HHS issued a proposed rule on premium rate reviews. HHS announced availability of another \$199 million in grants to states on February 24, 2011. A guidance sheet on rate reviews was issued on December 22, 2010. On May 19, 2011, a rule for the insurance rate review program was published in the Federal Register. On July 7, 2011, HHS released a list of states and territories with effective review programs in the private small group and individual markets, which it updates periodically; CMS will conduct the reviews in states without the authority or resources. On September 1, 2011, states and HHS will begin reviewing proposed premium increases for 2012.

#### Changes in Medicare Provider Rates

Reduces annual market basket updates for inpatient and outpatient hospital long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units and adjusts payments for productivity.

**Implementation:** Beginning fiscal year 2010; productivity adjustments added to market basket update in 2012

**Implementation update:** The Centers for Medicare and Medicaid Services issued several proposed and final rules reducing annual market basket updates for different provider types: inpatient hospital services (Final Rule August 16, 2010), outpatient hospital services (Final Rule for FY 2013 issued August 31, 2012), outpatient hospital services (Final Rule for FY 2013 issued August 31, 2012), outpatient hospital services (Final Rule for FY 2013 issued August 31, 2012), outpatient hospital services (Final Rule for FY 2013 issued August 31, 2012).

November 3, 2010), long-term care hospitals ([Final Rule](#) August 16, 2010; [Final Rule](#) for FY 2013 issued August 31, 2012), inpatient rehabilitation facilities and psychiatric hospitals and units ([Proposed Rule](#) January 27, 2011).

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#### Qualifying Therapeutic Discovery Project Credit

Provides tax credits or grants to employers with 250 or fewer employees for 50% of the investments costs in projects that have the potential to produce new therapies, reduce long-term cost growth, or advance the goal of curing cancer within 30 years. The grant or tax is available for investments made in 2009 or 2010.

**Implementation:** Program established within 60 days of enactment

**Implementation update:** On June 7, 2010, the IRS [announced](#) the availability of tax credits and grants through the program. On May 21, 2010, the IRS released the final rules for the program. Applications were due by July 21, 2010 and awards were announced on October 29, 2010. Nearly \$1 billion in tax [credits and grants](#) have been paid through the program as of July 2012.

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#### Medicaid and CHIP Payment Advisory Commission

Provides funding for and expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services in Medicaid.

**Implementation:** Funding appropriated for fiscal year 2010

**Implementation update:** On December 23, 2009, GAO announced the appointment of 17 members to MACPAC. MACPAC held its first public meeting on September 23 and 24, 2010. On March 15, 2011, MACPAC [released](#) its first [report](#), establishing the development of key baseline data and information on Medicaid and CHIP. The MACPAC website is available at <http://www.macpac.gov/>

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#### Comparative Effectiveness Research

Establishes a non-profit Patient-Centered Outcomes Research Institute to conduct research that compares the clinical effectiveness of medical treatments.

**Implementation:** Funding appropriated beginning fiscal year 2010.

**Implementation update:** On September 23, 2010, The General Accounting Office [announced](#) the appointment of 19 members to the Board of Governors for the Patient-Centered Outcomes Research Institute (PCORI). In addition, the Director of the Agency for Healthcare Research and Quality and the Director of the National Institutes of Health will serve on the 21-member Board. The PCORI website is available at <http://www.pcori.org/>. On May 22, 2012, PCORI released a series of [funding announcements](#).

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#### Prevention and Public Health Fund

Appropriates \$5 billion for fiscal years 2010 through 2014 and \$2 billion for each subsequent fiscal year to support prevention and public health programs.

**Implementation:** Funding appropriated beginning fiscal year 2010.

**Implementation update:** The Department of Health and Human Services has allocated \$500 million in funding from the Prevention and Public Health Fund for fiscal year 2010. Half of this funding is dedicated to [improving the supply of health care providers](#) and half will support public health and prevention priorities. On February 11, 2011, HHS [announces](#) \$750 million in funds from the Prevention and Public Health Fund.

Public Health Fund to help prevent tobacco use, obesity, heart disease, stroke, cancer; and to increase immunizations.

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#### Medicare Beneficiary Drug Rebate

Provides a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010. Further subsidies and discounts that ultimately close the coverage gap in 2011.

**Implementation:** January 1, 2010.

**Implementation update:** In May 2010, CMS issued a [consumer brochure](#) with information about the Medicare Part D coverage gap. In June 2010, the first checks were sent to Medicare beneficiaries who reached the Medicare Part D coverage gap, more commonly known as the “doughnut hole.” As of March 2011, 3.8 million beneficiaries had received a \$250 check to close the coverage gap, according to an [HHS report](#).

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#### Small Business Tax Credits

Provides tax credits to small employers with no more than 25 employees and an average annual wages of less than \$50,000 that provide health insurance for their employees. Phase I (2010-2013): tax credit up to 35% (25% for non-profits) of employer cost; Phase II (2014 and later): tax credit up to 50% (35% for non-profits) of employer cost if purchased through an insurance Exchange for two years.

**Implementation:** January 1, 2010

**Implementation update:** The Internal Revenue Service (IRS) sent postcard notices to small businesses alerting them to the availability of the new tax credit. The IRS also created a [fact sheet](#) for small businesses to determine whether they are eligible for the tax credit and a draft form for claiming the tax credit. On December 2, 2009, the IRS released [guidance](#) on the tax credits and the [form](#) that small businesses need to claim the credits.

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#### Medicaid Drug Rebate

Increases the Medicaid drug rebate percentage for brand name drugs to 23% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%) and to 13% of average manufacturer price for non-patented multiple source drugs. Extends the drug rebate to Medicaid managed care plans.

**Implementation:** January 1, 2010 for increase in Medicaid drug rebate percentage; March 23, 2010 for extension of drug rebate to Medicaid managed care plans.

**Implementation update:** The Centers for Medicare and Medicaid Services issued a State Medicaid Directors Letter on April 22, 2010 explaining the new rules. On April 11, 2010 and September 28, 2010, CMS issued [letters](#) to state Medicaid directors with additional [guidance](#) on the prescription drug rebates. On January 6, 2011, CMS issued another [letter](#) with further changes pursuant to the ACA.

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#### Coordinating Care for Dual Eligibles

Establishes the Federal Coordinated Health Care Office to improve care coordination for dual eligibles (people eligible for both Medicare and Medicaid).

**Implementation:** March 1, 2010

**Implementation update:** The Federal Coordinated Health Care Office was September 2010. On December 30, 2010, CMS issued a [notice](#) in the Federal Register announcing the establishment of the Federal Coordinated Health Care Office. On May 11, 2011, CMS issued a [fact sheet](#) detailing the states that have received contracts for up to \$1 million to "design new integrated care models for people enrolled in Medicare and Medicaid."

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#### Generic Biologic Drugs

Authorizes the Food and Drug Administration to approve generic versions of biologics and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

**Implementation:** March 23, 2010

**Implementation update:** On November 2-3, 2010, the Food and Drug Administration held a public hearing to obtain input on the issues and challenges related to implementing the Biologics Price Competition and Innovation Act of 2009, which was included in the health reform law. On October 5, 2010, HHS issued a [request for comment](#) notice in the Federal Register on the approval process for biosimilars.

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#### New Requirements on Non-profit Hospitals

Imposes additional requirements on non-profit hospitals to conduct community health needs assessments and develop a financial assistance policy and impose a tax of 1% per year for failure to meet these requirements.

**Implementation:** March 23, 2010

**Implementation update:** On May 27, 2010, the Internal Revenue Service issued a [notice requesting comment](#) on the new requirements for non-profit hospitals. On February 22, 2012, the IRS issued [proposed regulations](#) which provide information on the requirements for charitable hospitals relating to financial assistance and employment policies, billing, and collections.

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#### Medicaid Coverage for Childless Adults

Creates a state option to provide Medicaid coverage to childless adults with income up to 133% of the federal poverty level. (States will be required to provide this coverage in 2014.)

**Implementation:** April 1, 2010

**Implementation update:** On April 9, 2010, the Centers for Medicare and Medicaid Services issued a letter to State Health Officials and Medicaid Directors providing [guidance](#) on the new optional Medicaid coverage for childless adults with income up to 133% of the federal poverty level. Connecticut, the District of Columbia, and Minnesota have received approval to provide this optional coverage.

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#### Reinsurance Program for Retiree Coverage

Creates a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.

**Implementation:** 90 days following enactment until January 1, 2014

**Implementation update:** The Department of Health and Human Services began accepting applications for the [Early Retiree Reinsurance Program](#) on June 2, 2013, and approved more than 5,000 employer and union plans by the end of December 2013.

2010. HHS is continuing to accept until May 5, 2011. On December 14, 2010, HHS issued a [notice](#) stating that claims incurred after December 31, 2010 would be accepted. On April 19, 2013, CMS issued a [notice](#) that the program would be accepted starting Jan. 1, 2014.

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#### Pre-existing Condition Insurance Plan

Creates a temporary program to provide health coverage to individuals with existing medical conditions who have been uninsured for at least six months. The plan will be operated by the states or the federal government.

**Implementation:** Enrollment into the federal plan began July 1, 2010; implementation dates for the state-operated plans vary

**Implementation update:** The federal government is operating PCIP programs in 12 states and the District of Columbia, while the remaining states are running their own programs. On July 30, 2010, HHS released [interim rules](#) for the PCIP programs. On November 5, 2010, HHS announced [new plan options](#) for 2011 that include new premium rates for the federally administered programs. As of March 2011, 18,000 individuals had enrolled in a PCIP program.

**Learn more:** Learn more about protections for people with pre-existing conditions in our Health Reform [FAQ](#) page and view the [enrollment data](#) for PCIP plans in all states.

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#### New Prevention Council

Creates the National Prevention, Health Promotion and Public Health Council to develop a national prevention, health promotion and public health strategy.

**Implementation:** First report due July 1, 2010

**Implementation update:** On June 10, 2010, President Obama signed an Executive Order creating the National Prevention, Health Promotion, and Public Health Council (National Prevention Council). The Council is chaired by the Surgeon General. On July 1, 2010, the Council released its first [report](#). On September 15, 2010, the Council approved draft framework to guide development of the National Prevention Strategy. On June 16, 2011, the Council released the [National Prevention Strategy](#). The National Prevention Council also releases [Annual Status Reports](#).

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#### Consumer Website

Requires the Department of Health and Human Services to develop an internet website to help residents identify health coverage options.

**Implementation:** July 1, 2010

**Implementation update:** On July 1, 2010, HHS launched a new consumer-focused health care website, [healthcare.gov](#), and on September 8, 2010, HHS launched a [Spanish-language version](#) of the site. On October 1, 2010, HHS added new information on private insurance coverage and premiums to the site.

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#### Tax on Indoor Tanning Services

Imposes a tax of 10% on the amount paid for indoor tanning services.

**Implementation:** July 1, 2010

**Implementation update:** On June 15, 2010, the Internal Revenue Service issued [regulations](#) implementing the new tax on indoor tanning services effective January 1, 2010. The first payments were due November 1, 2010.

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#### Expansion of Drug Discount Program

Expands eligibility for the 340(B) drug discount program to sole-community hospitals, critical access hospitals, certain children's hospitals, and other entities.

**Implementation:** Applications accepted beginning August 2, 2010

**Implementation update:** On June 28, 2010, the Health Resources and Services Administration began enrolling newly eligible organizations into the 340(B) drug discount program.

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#### Adult Dependent Coverage to Age 26

Extends dependent coverage for adult children up to age 26 for all individual and group policies.

**Implementation:** Plan or policy years beginning on or after September 23, 2010

**Implementation update:** On May 13, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations allowing adult children to remain on their parents' health plan until age 26. This new provision takes effect for new and existing plans when they renew on or after September 23, 2010.

**Learn more:** How does the provision that allows young adults to remain on parent's insurance work? Learn more on our Health Reform [FAQ](#).

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#### Consumer Protections in Insurance

Prohibits individual and group health plans from placing lifetime limits on the value of coverage, rescinding coverage except in cases of fraud, and from cancelling children coverage based on pre-existing medical conditions or from including pre-existing condition exclusions for children. Restricts annual limits on the dollar amount of coverage (and eliminates annual limits in 2014)

**Implementation:** Plan or policy years beginning on or after September 23, 2010 (annual limits eliminated in 2014)

**Implementation update:** On June 28, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued [regulations](#) implementing several consumer protection provisions in the health reform law. Certain of the provisions take effect for new plans and existing plans when they renew on or after September 23, 2010. Other provisions only apply to new plans established on or after September 23, 2010.

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#### Insurance Plan Appeals Process

Requires new health plans to implement an effective process for allowing consumers to appeal health plan decisions and requires new plans to establish an external review process.

**Implementation:** Plan or policy years beginning on or after September 23, 2010

**Implementation update:** On July 23, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations requiring standardized external processes for consumers to appeal health plan decisions. These rules apply to new plans established on or after September 23, 2010. On November 17,

HHS issued a request for information notice on the external review of health insurance claims. On August 4, 2011, HHS released a list of states with approved external review processes.

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#### Coverage of Preventive Benefits

Requires new health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, including recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

**Implementation:** Plan or policy years beginning on or after September 23, 2010

**Implementation update:** On July 19, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations on the new preventive benefit coverage requirements. These rules apply to new plans established on or after September 23, 2010. On August 1, 2010, the U.S. Preventive Services Task Force released its recommendations. On July 19, 2011, the Institute of Medicine released a report that recommended several women's preventive services that should be included in health plans with no cost-sharing. On August 1, 2011, HHS issued final regulations on preventive services, including requirements that insurers cover birth control with no cost-sharing. On August 3, 2011, HHS issued an amendment to the final regulations. On February 15, 2012, HHS issued [final rules](#) "authorizing exemption of group health plans and group health insurance coverage sponsored by certain religious employers from having to cover certain preventive health services. Also on February 15, 2012, HHS issued an [issue brief](#) estimating that 54 million Americans had received preventive benefits without cost-sharing. On August 1, 2012, HHS began requiring most new and renewing health plans to provide women preventive health services, including contraception, with no cost-sharing. HHS also issued a [brief](#) estimating that 47 million women will receive coverage for these services without cost sharing."

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#### Health Centers and the National Health Service Corps

Permanently authorizes the federally qualified health centers and NHSC program and increases funding for FQHCs and for the NHSC for fiscal years 2010-2012.

**Implementation:** Funding appropriated beginning fiscal year 2010

**Implementation update:** On October 8, 2010, HHS announced grant awards of \$100 million to 143 community health centers for infrastructure improvements and on October 26, 2010, HHS announced the availability of an additional \$335 million for existing community health centers to expand medical services.

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#### Health Care Workforce Commission

Establishes the National Health Care Workforce Commission to coordinate workforce activities and make recommendations on workforce goals and policies, and establishes the National Center for Health Workforce Analysis to undertake regional workforce data collection and analysis.

**Implementation:** Initial appointments to the National Health Care Workforce Commission September 30, 2010

**Implementation update:** On September 30, 2010, the Government Accountability Office announced the appointment of 15 members of the National Health Care Workforce Commission.

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**Medicaid Community-Based Services**

Provides states with new options for offering home and community-based care through a Medicaid state plan amendment to certain individuals and permit them to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

**Implementation:** October 1, 2010

**Implementation update:** On August 6, 2010, the Centers for Medicare and Medicaid Services issued a [letter](#) to State Medicaid Directors providing guidance on the flexibility to provide home and community-based services through Medicaid.

**2011** (20 in total, 18 in effect)**Minimum Medical Loss Ratio for Insurers**

Requires health plans to report the proportion of premium dollars spent on medical services, quality, and other costs and provide rebates to consumers if the share of the premium spent on clinical services and quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

**Implementation:** Requirement to provide rebates begins for coverage purchased in 2011, with the rebates issued to enrollees the year following (e.g., 2011 rebates provided in 2012).

**Implementation update:** On November 22, 2010, the Department of Health and Human Services issued an [interim final rule](#) on medical loss ratio (MLR) calculation that will apply to plans in the small and large group markets and individual insured companies. Several states have gotten temporary waivers from CBO and are exempt from the MLR requirements for a specific period of time. On December 1, 2011, HHS published a final rule in the Federal Register on [medical loss ratio requirements](#) and an [interim final rule](#) on medical loss ratio requirements for federal government plans. On May 16, 2012, HHS published a [final rule](#) in the Federal Register that "establishes a simple, straightforward [notice](#) requirement for health insurers that meet or exceed the MLR standards established by the Affordable Care Act."

**Closing the Medicare Drug Coverage Gap**

Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap. In 2013, begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand-name discount).

**Implementation:** January 1, 2011 (drug discount) and January 1, 2013 (federal subsidies)

**Implementation Update:** On December 17, 2010, CMS sent a [letter](#) to pharmaceutical companies providing operational guidance for pharmaceutical manufacturers participating in the Medicare Coverage Gap Discount Program. According to the guidance, the Discount Program became effective January 1, 2011. On June 28, 2011, CMS announced that nearly 500,000 people had received

discount on their brand-name prescription drugs, with an average savings of 10 percent per beneficiary. As of August 4, 2011, 900,000 Medicare beneficiaries who hit the prescription drug doughnut hole received a 50 percent discount on their prescription drugs. On August 2, 2012, CMS issued final drug manufacturer agreements coverage gap discount program.

On April 15, 2011, HHS issued a final rule specifying the details of the federal program.

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#### Medicare Payments for Primary Care

Provides a 10% Medicare bonus payment for primary care services; also, provides a 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas.

**Implementation:** January 1, 2011 through December 31, 2015

**Implementation update:** On November 29, 2010, CMS published a final rule that implements the 10 percent incentive payment for primary care services.

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#### Medicare Prevention Benefits

Eliminates cost-sharing for Medicare-covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and the Medicare deductible for colorectal cancer screening tests; authorizes Medicare coverage for a personalized prevention plan, including a comprehensive health assessment.

**Implementation:** January 1, 2011

**Implementation update:** On November 29, 2010, CMS published a final rule to augment the benefits for the "Initial Preventive Physical Examination," an annual visit for the purposes of developing a prevention plan for the patient. On December 1, 2010, CMS released a Medicare Consumer Guide to Preventive Services, including services that will no longer require cost-sharing (co-pays) in 2011 as a result of the health reform law. As of October 6, 2011, CMS reported that 20.5 million people participated in the free Annual Wellness Visit or received other preventive services with no cost-sharing.

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#### Center for Medicare and Medicaid Innovation

Creates the Center for Medicare and Medicaid Innovation to test new payment and service delivery system models that reduce costs while maintaining or improving quality of care.

**Implementation:** Center established by January 1, 2011

**Implementation update:** On November 17, 2010, CMS issued a notice announcing the establishment of the Center for Medicare and Medicaid Innovation in its organization. On January 26, 2012, CMMI released a report outlining the initiatives introduced by the center.

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#### Medicare Premiums for Higher-Income Beneficiaries

Freezes the income threshold for income-related Medicare Part B premiums through 2019 at 2010 levels resulting in more people paying income-related premiums, and reduces the Medicare Part D premium subsidy for those with income above \$85,000/individual and \$170,000/couple.

**Implementation:** January 1, 2011

**Implementation update:** On November 4, 2010, CMS issued a [fact sheet](#) v Medicare premium information for 2011 reflecting higher premiums for Medi beneficiaries whose incomes exceed a set threshold. In January 2011, the S Security Administration released a consumer publication reflecting the chan

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#### Medicare Advantage Payment Changes

Restructures payments to private Medicare Advantage plans by phasing-in | set at increasingly smaller percentages of Medicare fee-for-service rates; fr 2011 payments at 2010 levels; and prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered ben is required under the traditional fee-for-service program.

**Implementation:** January 1, 2011

**Implementation update:** The Centers for Medicare and Medicaid Services letter to Medicare Advantage plans on April 5, 2010 announcing the freeze i payment rates at 2010 levels. On November 22, 2010, CMS issued a [propo](#) updating the Medicare Advantage program. On April 15, 2011, CMS issued [rule](#) updating the Medicare Advantage program.

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#### Medicaid Health Homes

Creates a new Medicaid state option to permit certain Medicaid enrollees to designate a provider as a health home and provides states taking up the op 90% federal matching payments for two years for health home-related servi

**Implementation:** January 1, 2011

**Implementation update:** On November 11, 2010, CMS issued [guidance](#) to Medicaid Directors regarding health homes for Medicaid enrollees. As of Ma CMS has [approved](#) health home state plan amendments for eight states, an others have taken steps toward developing health homes.

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#### Chronic Disease Prevention in Medicaid

Provides 3-year grants to states to develop programs to provide Medicaid ei with incentives to participate in comprehensive health lifestyle programs and certain health behavior targets.

**Implementation:** January 1, 2011

**Implementation update:** On February 24, 2011, the Centers for Medicare & Medicaid Services announced the availability of \$100 million in grants for sta offer incentives to Medicaid beneficiaries who participate in prevention progr demonstrate improvements in health risk and outcomes. On September 13, CMS awarded grants to ten states to create statewide programs to prevent disease in both rural and urban areas.

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#### National Quality Strategy

Requires the Secretary of the federal Department of Health and Human Ser develop and update annually a national quality improvement strategy that in priorities to improve the delivery of health care services, patient health outcc population health.

**Implementation:** Initial strategy due to Congress by January 1, 2011

**Implementation update:** On September 11, 2010, HHS issued a request for comment notice on the National Health Care Quality Strategy and Plan. On 21, 2011, HHS released a report to Congress outlining the priorities set by the National Quality Strategy.

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#### Changes to Tax-Free Savings Accounts

Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a Health Reimbursement Account or health Flexible Spending Account and from being reimbursed on a tax-free basis through a Health Savings Account or Archer Medical Savings Account. Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the amount used.

**Implementation:** January 1, 2011

**Implementation update:** On September 3, 2010, the IRS issued [guidance](#) and [changes](#) on health flexible spending accounts including Health Reimbursement Accounts and health Flexible Spending Accounts noting that over-the-counter medicines prescribed by a doctor could be reimbursed by these tax-savings accounts.

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#### Grants to Establish Wellness Programs

Provides grants for up to five years to small employers that establish wellness programs.

**Implementation:** Funds have yet to be awarded due to budget debates related to the Prevention and Public Health Fund

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#### Teaching Health Centers

Establishes Teaching Health Centers and provides payments for primary care residency programs in community-based ambulatory patient care centers.

**Implementation:** Funding appropriated for five years beginning in fiscal year 2011.

**Implementation update:** On November 29, 2010, HRSA issued [guidelines](#) for community-based ambulatory patient care settings that operate a primary care residency program to apply for grants to establish teaching health centers. On January 25, 2011, HHS [announced](#) the designation of 11 new Teaching Health Centers.

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#### Medical Malpractice Grants

Authorizes \$50 million for five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

**Implementation:** Authorizes funding beginning fiscal year 2011.

**Implementation Update:** The Agency for Healthcare Research and Quality awarded seven [demonstration grants](#) for a total amount of \$19.7 million in June 2010 and funded thirteen [planning grants](#) for a total amount of \$3.5 million

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#### Funding for Health Insurance Exchanges

Provides grants to states to begin planning for the establishment of American Health Benefit Exchanges and Small Business Health Options Program Exchanges to facilitate the purchase of insurance by individuals and small employers.

**Implementation:** Grants awarded starting March 23, 2011; applications will accepted through October 15, 2014

**Implementation update:** On September 30, 2010, HHS awarded states \$4 billion to help plan the health insurance Exchanges. On February 17, 2011, HHS awarded “early innovator” grants to seven states. As of April 2013, HHS has awarded \$3.6 billion to states to fund implementation of the exchanges.

**Learn more:** Which states have received [grants](#) to establish their health insurance exchanges? Browse exchange data and more in our [State Health Facts](#) section.

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#### Nutritional Labeling

Requires disclosure of the nutritional content of standard menu items at chain restaurants and food sold from vending machines.

**Implementation:** Delayed

**Implementation update:** On January 21, 2011, the Food and Drug Administration [withdrew](#) the draft guidance it had previously issued and announced it will initiate a notice and comment rulemaking process. On April 6, 2011, the FDA published proposed rules in the Federal Register on nutritional labeling for vending machines and [chain restaurants](#). Establishments whose primary purpose is not selling food, such as movie theaters and bowling alleys, were exempted from the regulation.

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#### Medicaid Payments for Hospital-Acquired Infections

Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections.

**Implementation:** July 1, 2011

**Implementation update:** On June 6, 2011, the Centers for Medicare and Medicaid Services issued a [final rule](#) that prohibits federal Medicaid payments to states for health care-acquired infections.

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#### Graduate Medical Education

Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots and promotes training in outpatient settings.

**Implementation:** July 1, 2011

**Implementation update:** On November 29, 2010, the Department of Health and Human Services issued a [final rule](#) establishing a methodology for determining payments to hospitals for the direct costs of approved graduate medical education programs. The final rule also clarifies whether hospitals can be paid for situations in which one hospital incurs the costs of training medical residents at nonproviding settings. On March 14, 2011, CMS issued an [interim final rule](#) making revisions to the methodology, including reductions and increases to caps on payments to hospitals for residents.

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#### Medicare Independent Payment Advisory Board

Establishes an Independent Advisory Board, comprised of 15 members, to review legislative proposals containing recommendations to reduce the per capita Medicare spending if spending exceeds targeted growth rates.

**Implementation:** Funding available October 1, 2011; first recommendations due January 15, 2014

**Medicaid Long-Term Care Services**

Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to community-based attendant support services to certain people with disabilities.

**Implementation:** October 1, 2011

**Implementation update:** On February 22, 2011, the Centers for Medicare & Medicaid Services issued a [proposed rule](#) to allow states to provide home and community-based attendant services and supports through the Community First Choice Medicaid State plan option. On May 7, 2011, CMS issued a [final rule](#) effective October 1, 2011, CMS had [approved](#) Balancing Incentives Program applications from nine states.

**2012** (11 in total, 10 in effect)**Accountable Care Organizations in Medicare**

Allows providers organized as accountable care organizations (ACOs) that meet quality thresholds to share in the cost savings they achieve for the Medicare program.

**Implementation:** January 1, 2012

**Implementation update:** On April 7, 2011, the Department of Health and Human Services published a proposed rule in the Federal Register defining Accountable Care Organizations and set out requirements for governance, legal structure, transparency efforts and the incorporation of evidence-based medicine and quality improvement efforts. HHS also released facts sheets for providers and consumers, as well as sheets on legal issues and quality scoring in ACOs. The Federal Trade Commission and Department of Justice issued a joint policy statement on antitrust issues related to ACOs. On May 20, 2011, CMS issued a request for applications for the [Pioneer ACO Program](#), which is targeted at organizations that can demonstrate the improvements in quality and cost-savings of a mature ACO.

On December 19, 2011, CMS announced 32 health care organizations that participate in the new Pioneer Accountable Care Organization project.

On January 10, 2013, HHS [announced](#) that 106 new ACOs had been formed under the Medicare Shared Savings Program, bringing to 250 the total number of ACOs established since enactment of the ACA.

**Uniform Coverage Summaries for Consumers**

This provision of the Affordable Care Act (ACA) that requires private individual and group health plans to provide a uniform summary of benefits and coverage to all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and understand their coverage when they enroll.

**Implementation:** The provision applies to all individual and group health plans regardless of whether they are grandfathered or not, and takes effect by September 23, 2012.

**Implementation Update:** On August 19, 2011, the Department of Health and Human Services, the Department of Labor and the Department of the Treasury issued [proposed regulations](#) on the Summary of Benefits and Coverage disclosure required of health insurers. On February 9, 2012, HHS issued [final regulations](#), a template, and a glossary.

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#### Medicare Advantage Plan Payments

Reduces rebates paid to Medicare Advantage plans and provides bonus payments for high-quality plans.

**Implementation:** January 1, 2012.

**Implementation update:** On February 28, 2011, the Centers for Medicare and Medicaid Services issued a letter to Medicare Advantage plans announcing 2012 rates that included changes included in the health reform law. On November 22, 2010, CMS announced a [proposed rule](#) updating Medicare Advantage plan payments. On February 15, 2013, CMS issued an [advance notice](#) for 2014 outlining planned Medicare Advantage cuts. On February 15, 2013, CMS issued an [advance notice](#) for 2014 outlining planned Medicare Advantage cuts.

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#### Medicare Independence at Home Demonstration

Creates the Independence at Home demonstration program to provide high-quality Medicare beneficiaries with primary care services in their home.

**Implementation:** January 1, 2012

**Implementation update:** On December 21, 2011, the Center for Medicare and Medicaid Services published a [notice](#) in the Federal Register that creates the demonstration project using "physician and nurse practitioner directed home primary care teams."

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#### Medicare Provider Payment Changes

Adds a productivity adjustment to the market basket update for certain providers, resulting in lower rates than otherwise would have been paid.

**Implementation:** On May 5, 2011, CMS issued a proposed rule announcing changes to the prospective payment systems for inpatient hospitals and long-term care hospitals and the 2012 payment rates. On August 18, 2011, CMS issued a final rule on the payment changes and new payment rates.

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#### Fraud and Abuse Prevention

Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare.

**Implementation:** January 1, 2012.

**Implementation update:** On February 2, 2011, the Centers for Medicare and Medicaid Services issued a [final rule](#) implementing fraud and abuse prevention initiatives in Medicare, Medicaid, and CHIP. On March 23, 2011, CMS published a notice regarding the fee that new providers and providers updating their information would have to pay in order to fund fraud screening efforts.

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#### Annual Fees on the Pharmaceutical Industry

Imposes new annual fees on the pharmaceutical manufacturing sector.

**Implementation:** January 1, 2012.

**Implementation Update:**

On August 15, 2011, the Internal Revenue Service issued temporary regulations to provide guidance on the annual fee imposed on pharmaceutical companies. On November 29, 2012, the IRS issued [guidance](#) on the branded prescription drug fee for the 2013 fee year.

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#### Medicaid Payment Demonstration Projects

Creates new demonstration projects in Medicaid for up to eight states to pay for payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost savings.

**Implementation:** January 1, 2012 through December 31, 2016

**Implementation Update:** Funds for bundled payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost-savings have yet to be approved.

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#### Data Collection to Reduce Health Care Disparities

Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

**Implementation:** March 23, 2012

**Implementation update:** On June 30, 2011, HHS published a request for comment in the Federal Register on the proposed data collection standards for race, ethnicity, sex, primary language and disability status.

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#### Medicare Value-Based Purchasing

Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and requires plans to be developed and implement value-based purchasing programs for skilled nursing facilities, health care agencies, and ambulatory surgical centers.

**Implementation:** October 1, 2012.

**Implementation update:** On January 13, 2011, the Centers for Medicare and Medicaid Services issued a [proposed rule](#) that would implement a value-based purchasing program for hospitals in Medicare. On May 6, 2011, CMS published a [final rule](#) on the value-based purchasing program.

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#### Reduced Medicare Payments for Hospital Readmissions

Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.

**Implementation:** October 1, 2012

On August 18, 2011, CMS issued a [final rule](#) outlining the Hospital Readmission Reduction Program, which, under the Affordable Care Act, "payments to the hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions." The final rule includes "i) Those aspects of the Hospital

Readmissions Reduction Program that relate to the conditions and readmissions which the Hospital Readmissions Reduction Program will apply for the first year beginning October 1, 2012; (ii) the readmission measures and related methodology used for those measures, as well as the calculation of the readmission rates; and (iii) public reporting of the readmission data."

## 2013 (14 in total, 10 in effect)

### State Notification Regarding Exchanges

States indicate to the Secretary of HHS whether they will operate an American Benefit Exchange.

**Implementation:** January 1, 2013

**Implementation update:** On May 16, 2012, HHS issued a [Blueprint](#) that states submit to HHS by November 16, 2012 if they wish to operate a state-based or a Partnership exchange. On November 15, 2012, the Obama administration extended the deadline for submitting a state-based exchange blueprint to December 14, 2012 and set February 15, 2013 as the deadline for submitting a blueprint to participate in a partnership exchange. Seventeen states and DC notified HHS they planned to run a state-based exchange and another seven states indicated they will run a partnership exchange.

**Learn more:** Where are states in establishing and implementing their health insurance exchanges? Track state actions with our [Exchange Monitor](#).

### Medicare Bundled Payment Pilot Program

Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

**Implementation:** January 1, 2013

**Implementation Update:** On August 24, 2011, CMS issued a [notice](#) explaining the pilot program would work. On January 31, 2013, CMS issued a [press release](#) announcing that over 500 organizations were chosen to participate in the Bundled Payments for Care Improvement initiative.

### Medicaid Coverage of Preventive Services

Provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations.

**Implementation:** January 1, 2013

**Implementation Update:** On February 1, 2013, The Centers for Medicare & Medicaid Services issued a [letter](#) to state Medicaid directors providing guidance on how states can claim the one percentage point federal matching payment in

### Medicaid Payments for Primary Care

Increases Medicaid payments for primary care services provided by primary doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed 100% federal funding).

**Implementation:** January 1, 2013 through December 31, 2014

**Implementation Update:** On May 9, 2012, CMS issued a [proposed rule](#) for provision. According to a [CMS release](#), states are expected to receive more billion in new funds for their Medicaid primary care systems. On November 6, 2012, CMS published a [final rule](#) explaining the increase in Medicaid payment for care services by certain physicians in 2013 and 2014. CMS also released a [Q&A's](#) on the primary care payment increase.

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#### Itemized Deductions for Medical Expenses

Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income. It waives the increase for individuals age 65 and older for tax years 2013 through 2015.

**Implementation:** January 1, 2013

**Implementation Update:** On February 4, 2013, the IRS published its [2012](#) explaining the itemized deduction for medical and dental expenses.

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#### Flexible Spending Account Limits

Limits the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year, increased annually by the cost of living adjustment.

**Implementation:** January 1, 2013

**Implementation update:** On June 25, 2012, the IRS issued [guidance](#) limiting contributions to health flexible spending arrangements at \$2,500 for plans beginning in 2013.

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#### Medicare Tax Increase

Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income for higher-income taxpayers.

**Implementation:** January 1, 2013

**Implementation Update:** on December 5, 2012, the IRS and Treasury Department issued proposed regulations on the additional [tax on wages](#) and the [net investment income tax](#).

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#### Employer Retiree Coverage Subsidy

Eliminates the tax-deduction for employers who receive Medicare Part D retiree subsidy payments.

**Implementation:** January 1, 2013

**Implementation update:** On February 8, 2013, the IRS published an [online](#) explaining how the retiree drug subsidy works.

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#### Tax on Medical Devices

Imposes an excise tax of 2.3% on the sale of any taxable medical device.

**Implementation:** January 1, 2013

**Implementation update:** On February 7, 2012, the IRS issued a [proposed rule](#) providing guidance on the tax that will be imposed on medical devices. On February 5, 2012, the IRS and the Treasury Department issued [final regulations](#) on the tax, as well as [interim guidance](#) on tax-related issues such as taxable medical device licensing, tax treatment, and donations.

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#### Financial Disclosure

Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

**Implementation Update:** Report to HHS due March 31, 2014. CMS issued a [proposed rule](#) on December 19, 2011 and a [final rule](#) on February 8, 2013. The [final rule](#) delays the start of the initial data collection period from January 1, 2013 to August 1, 2013 and the initial report to the Secretary of the Department of Health and Human Services to March 31, 2014 (from March 31, 2013).

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#### CO-OP Health Insurance Plans

Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies.

**Implementation:** CO-OPs established by July 1, 2013

**Implementation update:** On March 14, 2011, the Department of Health and Human Services (HHS) issued a [report](#) on the Consumer Operated and Oriented Plan (CO-OP) Program. The report included recommendations by the CO-OP Advisory Board on governance, finance, infrastructure, and compliance. On July 18, 2011, HHS published a proposed rule that would implement the CO-OP program. On December 13, 2011, HHS issued a [final rule](#). On February 21, 2012, HHS [announced](#) that "seven non-profits offering coverage in eight states have been awarded \$638,677,300." As of December 2012, nearly \$2 billion in loans had been awarded to CO-OPs in 23 states.

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#### Extension of CHIP

Extends authorization and funding for the Children's Health Insurance Program (CHIP) through 2015 (current authorization is through 2013).

**Implementation:** Fiscal year 2013. On February 17, 2011, CMS issued a [final rule](#) detailing CHIP funding allotments through 2015.

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#### Medicare Disproportionate Share Hospital Payments

Reduces Medicare Disproportionate Share Hospital (DSH) payments initially and subsequently increases payments based on the percent of the population that is uninsured and the amount of uncompensated care provided.

**Implementation:** October 1, 2013

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#### Medicaid Disproportionate Share Hospital Payments

Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary to develop a methodology for distributing the DSH re

**Implementation:** October 1, 2013

## 2014 (17 in total, 3 in effect)

### Medicare Independent Payment Advisory Board Report

Establishes an Independent Advisory Board, comprised of 15 members, to review legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate.

**Implementation:** First recommendations due January 15, 2014 (Funding available October 1, 2011)

### Expanded Medicaid Coverage

Expands Medicaid to all individuals not eligible for Medicare under age 65 (including pregnant women, parents, and adults without dependent children) with income at or below 133% FPL and provides enhanced federal matching payments for new eligible individuals.

**Implementation:** January 1, 2014 (states have the option to expand coverage for childless adults beginning April 1, 2010)

### Presumptive Eligibility for Medicaid

Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations.

**Implementation:** January 1, 2014.

### Individual Requirement to Have Insurance

Requires U.S. citizens and legal residents to have qualifying health coverage or pay a phased-in tax penalty for those without coverage, with certain exemptions.

**Implementation:** January 1, 2014.

**Implementation Update:** On January 30, 2013, the IRS issued proposed regulations on the individual shared responsibility provision. The IRS also prepared a set of [Q&As](#) on the so-called individual mandate. On January 30, 2013, HHS released a companion proposed [rule](#) on minimum essential coverage.

**Learn more:** How will the requirement that people be insured or pay a penalty under the health reform law? This simple [infographic](#) explains how “the individual mandate” works.

### Health Insurance Exchanges

Creates state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or a non-profit organization, through which individuals and small businesses with fewer than 100 employees can purchase qualified coverage. Exchanges will have a similar role for applying for health programs, including coverage through the Exchanges, Medicaid and CHIP programs.

**Implementation:** January 1, 2014

**Implementation update:** On July 11, 2011, HHS issued two proposed rules for health insurance exchanges. The [first rule](#) detailed the specifics of how state

set up their exchanges, while the [second rule](#) focused on the standards related to risk adjustment, risk corridors and reinsurance provisions. HHS released the final [rule](#) on risk adjustment, risk corridors and reinsurance on March 27, 2012, and the final [rule](#) on risk adjustment, risk corridors and reinsurance on March 23, 2012. HHS also issued a proposed [rule](#) on the exchange on March 11, 2013.

On May 16, 2012, HHS issued [guidance](#) for Federally-facilitated Exchanges which will be run by HHS in states that have not established an exchange or selected to run a Partnership exchange. Also on August 14, 2012, HHS issued [Blueprint](#) that states must submit to HHS by November 16, 2012 if they wish to operate a state-based exchange or a Partnership exchange. On November 16, 2012, HHS extended the deadline for submitting a blueprint for a state-based exchange to December 14, 2012. It also extended the deadline for submitting a state-facilitated partnership exchange blueprint to February 15, 2013. Enrollment in exchanges began on October 1, 2013. HHS issued [FAQs](#) on exchanges, market reform and Medicaid on December 10, 2012. The Department also released additional [FAQs](#) on the partnership exchanges on January 3, 2013.

**Learn more:** Where are states in establishing and implementing their health insurance exchanges? Track state actions with the [Exchange Monitor](#).

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#### Health Insurance Premium and Cost Sharing Subsidies

Provides refundable and advanceable tax credits and cost sharing subsidies for eligible individuals. Premium subsidies are available to families with income between 133-400% of the federal poverty level to purchase insurance through Exchanges, while cost sharing subsidies are available to those with income at or below 250% of the poverty level.

**Implementation:** January 1, 2014

**Implementation Update:** On May 23, 2012, the IRS released final [regulations](#) related to the health insurance premium tax credits. [Corrections](#) to these regulations were published on July 17, 2012. Additionally, on January 30, 2013, IRS released final [rule](#) on the premium tax credit test for affordability of employer-sponsored insurance.

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#### Guaranteed Availability of Insurance

Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio in the individual market and the small group market and the Exchanges), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio in the individual market and the small group market and the Exchanges).

**Implementation:** January 1, 2014

**Implementation Update:** On February 28, 2013, HHS issued a final [rule](#) implementing guaranteed availability of insurance.

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#### No Annual Limits on Coverage

Prohibits annual limits on the dollar value of coverage.

**Implementation:** January 1, 2014

**Implementation Update:** On June 28, 2010, HHS issued interim final [regulations](#) prohibiting lifetime and annual limits on coverage.

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#### Essential Health Benefits

Creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits (\$5,950/individual and \$11,900/family in 2010). Creates four categories of plans offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover.

**Implementation:** January 1, 2014

**Implementation Update:** On October 7, 2011, the Institute of Medicine released recommendations on the Essential Health Benefits package. On December 16, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) released a [bulletin](#) on the Essential Health Benefits rulemaking process. On February 25, 2012, CCIIO issued an [illustrative list](#) of the three largest small group plans in each state to "facilitate a better understanding of the intended approach to EHBs." On February 21, 2012, HHS issued FAQs on how HHS is intending to approach rulemaking defining Essential Health Benefits. On February 20, 2013, HHS issued a final rule outlining standards related to Essential Health Benefits.

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#### Multi-State Health Plans

Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortion beyond those permitted by federal law.

**Implementation:** January 1, 2014

**Implementation Update:** On March 1, 2013, the U.S. Office of Personnel Management released its final [rule](#) on the Multi-State Plan Program, establishing standards for the program and explaining OPM's approach to its implementation.

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#### Temporary Reinsurance Program for Health Plans

Creates a temporary reinsurance program to collect payments from health plans in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

**Implementation:** January 1, 2014 through December 31, 2016

**Implementation Update:** On March 23, 2012, HHS issued a [final rule](#) implementing standards for states related to reinsurance and risk adjustment and for health insurance providers related to implementing reinsurance, risk corridors, and risk adjustment.

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#### Basic Health Plan

Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive subsidies in the Exchange.

**Implementation:** January 1, 2014

**Implementation update:** On September 14, 2011, CMS issued a [request for information](#) regarding state flexibility to establish Basic Health Plan. On February 1, 2013, HHS delayed implementation of the Basic Health Program until 2015. The scope of coverage changes being implemented on January 1, 2014.

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#### Employer Requirements

Assesses a fee of \$2,000 per full-time employee, excluding the first 30 employees with more than 50 employees that do not offer coverage and have one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee who receives a premium tax credit, will pay the lesser of \$3,000 for each employee who does not receive a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees.

**Implementation:** January 1, 2014

**Implementation Update:** On December 28, 2012, the IRS issued proposed regulations on the Employer Shared Responsibility provisions of the Affordable Care Act.

**Learn more:** Larger employers will have to pay a penalty if they don't provide comprehensive, affordable coverage to their employees. Find out how employer responsibilities will work with this simple infographic.

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#### Medicare Advantage Plan Loss Ratios

Requires Medicare Advantage plans to have medical loss ratios no lower than 65%.

**Implementation:** January 1, 2014

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#### Wellness Programs in Insurance

Permits employers to offer employees rewards of up to 30%, potentially increasing to 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

**Implementation:** Changes to employer wellness plans effective January 1, 2014; state pilot programs established by July 1, 2014

**Implementation Update:** On November 20, 2012, HHS and the Department of the Treasury issued a proposed rule on wellness programs. The proposed regulations will "increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan and clarify what constitutes a reasonable design of health-contingent wellness programs and reasonable alternatives."

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#### Fees on Health Insurance Sector

Imposes new fees on the health insurance sector.

**Implementation:** January 1, 2014

**Implementation Update:** On March 1, 2013, the Treasury Department and the IRS issued proposed regulations on the annual fee on certain health insurance policies beginning in 2014.

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#### Medicare Payments for Hospital-Acquired Infections

Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%.

**Implementation:** Fiscal Year 2015

### **2015** (1 in total, 0 in effect)

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#### Increase Federal Match for CHIP

Provides for a 23 percentage point increase in the Children's Health Insurance Program (CHIP) match rate up to a cap of 100%.

**Implementation:** October 1, 2015

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### **2016** (1 in total, 0 in effect)

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#### Health Care Choice Compacts

Permits states to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.

**Implementation:** January 1, 2016

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### **2018** (1 in total, 0 in effect)

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#### Tax on High-Cost Insurance

Imposes an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

**Implementation:** January 1, 2018

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