Ropes and Gray LLP
Timeline of Health Reform Implementation
DRAFT- January 20, 2010

This timeline is based on the health reform bill passed by the Senate on December 24, 2009 (H.R. 3590). For certain provisions (indicated by *), we have assumed that the date of enactment will be March 1, 2010; there is, however, significant uncertainty as to the timing and prospects for passage as of this writing.

We have included implementation steps for which there are dates certain; however, many other administrative steps will need to be taken that were not given specific statutory deadlines and therefore are not included.

This document is under development. Please visit the Ropes & Gray Health Reform Resource Center at www.ropesgray.com for an updated version.

<table>
<tr><th colspan="2">Date</th><th>Reform Provision</th></tr>
<tr><th colspan="3">Insurance Reforms and Exchange</th></tr>
<tr><td rowspan="5">2010</td><td>2010</td><td>States must establish and implement for plan year 2010 a process for reviewing insurance premium increases, and insurers must justify unreasonable increases in premiums prior to implementation.</td></tr>
<tr><td>3/1/2010*</td><td>Insurers, including otherwise grandfathered plans, required to use uniform explanation of coverage documents, developed by the Secretary by this date.</td></tr>
<tr><td>6/1/2010*</td><td>High risk health insurance pool program established to provide health insurance coverage for eligible individuals (effective not later than 90 days after the enactment of the Act and ending on January 1, 2014).</td></tr>
<tr><td>9/1/2010*</td><td>Limited insurance reforms are imposed (6 months after the date of enactment).

Prohibits exclusion based on pre-existing conditions initially for children up to age 19 (applies to all adults as of 1/1/2014); Prohibits rescission of policies; Prohibits lifetime limits; Permits only annual limits as determined by the Secretary; Prohibits discrimination based on salary; Requires annual accounting of costs (for reimbursement of claims, improving health care quality, and other non-claims costs); Prohibits prior authorization for emergency care services or OB/GYN care; Insurers that require designation of a primary care provider must permit designation of any participating primary care provider; Plans with dependent coverage extended to 26th birthday; Insurers required to adopt specified internal claims and appeals procedures.

Note: These reforms do not apply to a plan in which an individual was enrolled on the date of enactment (with the exception of the annual accounting of costs).</td></tr>
<tr><td>9/1/2010*</td><td>States receive grants to establish medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.</td></tr>
<tr><td rowspan="3">2011</td><td>1/1/2011</td><td>Health insurers must begin providing a rebate to each enrollee if the amount the insurer spends on clinical services provided to enrollees and activities that improve health care quality does not exceed 85% of premium revenue for large groups (80% for small groups).</td></tr>
<tr><td>2/1/2011</td><td>Secretary of Labor is required to report information regarding self-insured group health plans (derived from Department of Labor Annual Return/Report of Employee Benefit Plan) and self-insured employers (derived from financial filings) to Congress.</td></tr>
<tr><td>2/1/2011</td><td>Secretary is required to study and report to Congress regarding the fully-insured and self-insured group health plan markets.</td></tr>
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Date		Reform Provision
2013	7/1/2013	Deadline for the Secretary to award loans and grants worth $6 billion to fund Consumer Operated and Oriented Plans, which will support the creation of non-profit, member-run health insurance companies to be offered through the Exchange.
	7/1/2013	Deadline for Secretary to issue regulations for the creation of health care choice compacts, which will allow multiple States to enter into an agreement under which one or more qualified health plans could be offered in the markets in all such States, but only be subject to the laws of the State in which the plan was written. The compacts will not take effect before 1/1/2016.
2014	1/1/2014	State-based exchanges become available; only individuals and small employers are initially eligible to participate.
	1/1/2014	Health plans seeking certification must submit to the Exchange, State, and Secretary, and make publicly available, certain information, including claims payment policies, and data on enrollment and denied claims.
	1/1/2014	Deadline for the Secretary to develop guidelines concerning improving health outcomes, preventing hospital readmissions, improving patient safety, implementing wellness and health promotion activities, and reducing health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
	1/1/2014	Qualified health plans are required to reimburse services provided at FQHCs at rates that are at least as high as rates under Medicaid.
	1/1/2014	Office of Personnel Management (OPM) must contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State.
	1/1/2014	Imposition of new tax penalty on individuals and employers with more than 50 employees who do not purchase or provide coverage.
	1/1/2014	Affordability premium credits and cost-sharing credits provided to non-Medicaid eligible individuals who are not enrolled in an affordable employer-sponsored plan with incomes between 133% and 400% FPL to purchase coverage through an Exchange.
	1/1/2014	Additional insurance reform policies take effect. Extends prohibition on pre-existing condition exclusions to all individuals under group health plans; Limits premium rating for individual and small group market (can only vary based on individual or family rating area, age (limited to 3:1 for adults), or tobacco use (limited to 1.5:1)); Implements guaranteed issue requirement; All private coverage must include the essential health benefits package; prohibits any waiting period that exceeds 90 days for group coverage; Prohibits denial of coverage for routine care provided to an individual enrolled in a clinical trial. *Note: These reforms do not apply to a plan in which an individual was enrolled on the date of enactment.*
	1/1/2014	100% federal financial assistance available for costs of newly eligible Medicaid expansion populations in all states.
2015	1/1/2015	Qualified health plans may contract with a hospital with greater than 50 beds only if the hospital utilizes a patient safety evaluation system, and with a health care provider only if the provider implements mechanisms required by regulation to improve health care quality.
	3/1/2015*	Deadline for GAO to submit to Congress a study on the affordability of health insurance coverage, including the effect of the tax credit, the availability of affordable health plans, and the ability of individuals to keep essential health benefits coverage.

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2016	1/1/2016	Multistate plans may be offered in the Exchange through health care choice compacts.
	10/1/2016	States begin picking up a share of the costs of Medicaid expansions. "Expansion" states receive federal assistance equal to their FMAP percentage plus 30.3 percentage points in FY2017, 31.3 in FY2018 for costs of the newly eligible. States that are not "expansion states" receive an FMAP increase of 34.3 percentage points in FY2017, 33.3 in FY2018.
2017	1/1/2017	States may permit businesses with more than 100 employees to purchase coverage in the Health Insurance Exchanges.
2018	10/1/2018	Federal assistance for costs of newly eligible Medicaid populations now 32.3 percentage point increase in FMAP for all states, regardless of whether they are an expansion state or not.

Public Program Expansion		
2014	1/1/2014	Medicaid expanded up to 133% of federal poverty level.
	1/1/2014	States may create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133% and 200% FPL (and lawfully present aliens whose income is not greater than 133% FPL and who is not eligible for Medicaid by virtue of alien status). Such individuals must be ineligible to receive affordable employer-sponsored insurance under which the employee contribution is equal to or less than 9.8% of income. Participating states receive 95% of the premium tax credits and cost-sharing subsidies that would have been provided to individuals who would have enrolled in the Exchange.
2015	10/1/2015	CHIP federal matching rate increased through FY 2019.

Delivery System Reform		
2009	7/1/09	Hospitals may count time spent on certain non patient care (e.g. didactic) training activities toward direct GME payments and indirect GME payments (IME applied for unsettled cost reports on or after October 1, 2001).
2010	1/1/2010	340B discounts extended to inpatient drugs.
	1/1/2010	Children's hospitals, critical access hospitals, and rural referral centers are newly eligible for 340B Drug Discount Program. (Note that Children's Hospitals technically can already access discounts under 2009 administrative guidance.)
	7/1/2010	Hospitals have new flexibility in counting time spent by residents in patient care activities in non-hospital settings toward Medicare direct GME and IME payments.
	10/1/2010	Qualified teaching health centers are eligible for direct GME and IME payments for operating primary care residency programs ($230 million total appropriated for fiscal years 2011 through 2015).
	10/1/2010	ARRA Medicaid and Medicare HIT incentive payments begin for hospitals (early Medicaid payments may be available prior to this date).
2011	1/1/2011	First of five years of 10% Medicare bonus for select E&M codes furnished by physicians and other primary care providers and major surgical procedures furnished by general surgeons in a health professional shortage area.
	1/1/2011	CMS Innovation Center must be operational and begin selecting and funding innovative payment and service delivery models ($5 million will be appropriated to set up the Center in FY 2010; $10 billion total will be appropriated for FYs 2011 through 2019).
	1/1/2011	Deadline for HHS plan to develop value-based purchasing programs for ambulatory surgery centers.
	1/1/2011	ARRA Medicaid and Medicare HIT incentive payments begin for eligible professionals.
	7/1/2011	Deadline for HHS to adopt regulations to prohibit federal Medicaid payment for services related to health-care acquired conditions.

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Date		Reform Provision
2011 (cont)	7/1/2011	Deadline for HHS to redistribute 65% of unused residency slots to increase primary care and general surgery residencies.
	10/1/2011	Deadline for HHS to issue a plan to develop value-based purchasing programs for skilled nursing facilities and home health agencies.
	10/1/2011	HHS begins to design, implement, monitor, and evaluate a Medicare graduate nurse education demonstration program for advance practice nurses ($50 million appropriated for each of FYs 2012 through 2015).
2012	1/1/2012	Qualifying groups of providers, including physicians and hospitals, may be recognized as Medicare ACOs and share in Medicare cost savings above a certain threshold.
	1/1/2012	First year of Medicaid pediatric Accountable Care Organization (ACO) demonstration project.
	1/1/2012	Secretary publishes rules to govern the value-based payment modifier to the physician fee schedule (to be implemented Jan. 1, 2015 for some physicians identified by the Secretary, and Jan. 1, 2017 for all physicians).
	10/1/2012	Hospital payments reduced under Medicare for hospital discharges to account for "excess readmissions" for a limited number of conditions.
2013	1/1/2013	Deadline for Secretary to establish Medicare pilot program to evaluate alternative payment methodologies, including bundled payments.
2014	7/1/2014	Deadline for the Medicare Advisory Board to submit its first annual public report, which includes information on system-wide health care costs, patient access to care, utilization, and quality-of-care.
	10/1/2014	Risk-adjusted Medicare Hospital-Acquired Conditions rates are implemented (hospitals in top quartile of HAC rates would receive 99% of their otherwise applicable Medicare payments).
	10/1/2014	ARRA Medicare eHR penalties take effect for hospitals.
2015	1/1/2015	Value-based payment modifier to the physician fee schedule implemented for an initial subset of physicians identified by the Secretary.
	7/1/2015	ARRA Medicare eHR penalties take effect for physicians.
2016	1/1/2016	Medicare primary care bonus payments end.
	1/1/2016	Medicaid bundled payment demonstration program ends.
	12/31/2016	Deadline for Secretary to submit a report to Congress on the results of the Medicaid bundled payment demonstration program.
2017	1/1/2017	Value-based payment modifier to the physician fee schedule implemented for all physicians.
	10/17/2017	Deadline for the Secretary to submit a report to Congress on the Medicare graduate nurse education demonstration program, including an evaluation on the growth in numbers of advanced-practice nurses and specialties, and the costs to the Medicare program.

Provider Payment Changes		
2009	10/1/2009	Medicare market basket is reduced 0.25% for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals (first year of ongoing cuts).
2010	10/1/2010	Home health agency Medicare market basket adjustment reduced by 1% (first year of ongoing cuts).
	10/1/2010	2nd year Medicare market basket reduced by 0.25% for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals.

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Date		Reform Provision
2011	10/1/2011	Medicare market basket reduced 0.1% (down from .25% in FYs 2009-2010) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments described below.
	10/1/2011	First year of annual productivity-based market basket adjustment for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services to account for economy-wide productivity gains.
	10/1/2011	Second year Home health agency Medicare market basket adjustment reduced by 1%.
2012	10/1/2012	1% of Inpatient Prospective Payment System payments to be withheld under the Medicare value-based purchasing program.
	10/1/2012	Medicare market basket reduced 0.1% (same amount as FY 2012) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments.
	10/1/2012	Secretary to implement a 0.5% market basket reduction for hospice providers in each FY from 2013 through 2019
	10/1/2012	Third year Home health agency Medicare market basket adjustment reduced by 1%.
2013	10/1/2013	Medicare market basket reduced 0.2% (up from 0.1% in FY 2013) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments (each year through FY 2019).
	10/1/2013	1.25% of Inpatient Prospective Payment System payments to be withheld under the Medicare value-based purchasing program.
	10/1/2013	Home health agency Medicare prospective payment rates to be rebased based on factors determined by the Secretary.
2014	1/15/2014	Independent Medicare Advisory Board may begin submitting reports to MedPAC, the President, and Congress, regarding strategies to reduce excess cost growth.
	10/1/2014	Medicare market basket reduced 0.2% (same amount as FY 2014) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments (each year through FY 2019).
	10/1/2014	Medicare disproportionate share hospital (DSH) cuts begin ($24 billion total over 10 years).
	10/1/2014	Medicaid DSH cuts estimated to begin in some states, based on trigger related to decrease in the percentage of uninsured ($19 billion total over 10 years).
	10/1/2014	Independent Medicare Advisory Board recommendations take effect beginning in FY 2015.
	10/1/2014	1.5% of Inpatient Prospective Payment System payments to be withheld under the Medicare value-based purchasing program.
	10/1/2014	Prospective Payment System established for Medicare-covered services furnished by FQHCs (the Secretary, at his or her discretion, may request information from FQHCs in advance of this date, in order to help design and implement the Prospective Payment System).
2015	1/15/2015	Deadline for the Medicare Advisory Board to submit its first biennial set of recommendations on how to slow national health care expenditures while maintaining or improving quality of care.
	10/1/2015	1.75% of Inpatient Prospective Payment System payments to be withheld under the Medicare value-based purchasing program.
	10/1/2015	Medicare market basket reduced 0.2% (same amount as FYs 2014-2015) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments.

Date		Reform Provision
2016	10/1/2016	2% of Inpatient Prospective Payment System payments to be withheld under the Medicare value-based purchasing program.
	10/1/2016	Medicare market basket reduced 0.2% (same amount as FYs 2014-2016) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments.
2017	10/1/2017	Medicare market basket reduced 0.2% (same amount as FYs 2014-2017) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments.
2018	10/1/2018	Medicare market basket reduced 0.2% (same amount as FYs 2014-2018) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals; these market basket adjustments are in addition to productivity-based adjustments.

Financing		
2010	1/1/2010	Medicaid rebates increase to 23.1% of average manufacturer price on brand-name drugs, and 13% on other drugs.
	1/1/2010	$2.3 billion annual excise tax imposed on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30 each year .
2011	1/1/2011	First year of new annual fee on health insurance plans ($2 billion for 2011; assessed based on insurer's net premiums).
	1/1/2011	First year of annual excise tax on medical device manufacturers and importers ($2 billion per year 2011 through 2017; $3 billion after 2017).
	1/1/2011	Penalty increases from 10% to 20% for nonqualified Health Savings Account payments.
2012	1/1/2012	Threshold for itemized deductions for medical expenses is increased from 7.5% to 10% of adjusted gross income (not effective until Jan. 1, 2017 for individuals over the age of 65).
	1/1/2012	Increase in the amount of the annual fee on health insurance plans to $4 billion (up from $2 billion in 2011; assessed based on insurer's net premiums).
	1/1/2012	Competitive benchmark amount is applied to Medicare Advantage plans, reducing total payments to the plans by $118 billion over ten years.
	10/1/2012	$2 per enrollee fee ($1 for fiscal year 2013) imposed on insurers, including self-insured employer plans, to finance Patient-Centered Outcomes Research Trust Fund.
2013	1/1/2013	40% excise tax imposed on the value of any employer-sponsored plan that exceeds $8,500 for individual and $23,000 for family coverage.
	1/1/2013	Additional 0.9% Medicare hospital insurance tax imposed on wages above $200,000 for individual filers and $250,000 for joint filers.
	1/1/2013	Increase in annual fee on health insurance plans to $7 billion (up from $4 billion in 2012; assessed based on insurer's net premiums).
2014	1/1/2014	Increase in annual fee on health insurance plans to $9 billion (up from $7 billion in 2013; assessed based on insurer's net premiums) ($9 billion assessment applies through 2016).
2017	1/1/2017	Increase in annual fee on health insurance plans to $10 billion (up from $9 billion in 2014-2016; assessed based on insurer's net premiums) ($10 billion assessment applies through 2019).
2018	1/1/2018	Annual excise tax on medical device manufacturers and importers increases from $2 billion to $3 billion.

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Date		Reform Provision
Compliance and Transparency		
2009	10/1/2009	New 340B program integrity requirements for manufacturers and covered entities take effect and HRSA enforcement funding available .
2010	3/1/2010*	Anti-kickback statute intent standard amended such that a person may violate the anti-kickback statute without actual knowledge of or specific intent to violate the statute.
	9/1/2010*	Secretary establishes a Medicare self-referral disclosure protocol (no later than six months after enactment).
2011	1/1/2011	Deadline for Recovery Audit Contractor program expansion to Medicare Parts C & D and Medicaid.
	9/1/2011*	Report on Medicare self-referral disclosure protocol due to Congress (18 months after enactment)
2013	3/31/2013	Drug and device manufacturers must report all payments or other transfers of value greater than $10 to physicians and teaching hospitals (and every 90 days thereafter).
	3/31/2013	Drug and device manufacturers and group purchasing organizations must report physician ownership and investment data (and every 90 days thereafter).
2014	1/1/2014	The False Claims Act applies to payments made by, through, or in connection with the Exchange if payments include any federal funds.
TBD by Secretary		Providers and suppliers are required to establish and maintain compliance programs that satisfy requirements to be established by the Secretary as a condition of enrollment in Medicare, Medicaid, and CHIP.

Other		
2010	1/1/2010	Tax-exempt hospitals must comply with new requirements related to charges to uninsured and conducting community health needs assessments (applies in taxable years after enactment).
	1/1/2010	Part D donut hole reduced by $500 and 50% discount imposed on brand-name drugs in the donut hole.
2011	1/1/2011	Cost-sharing for Medicare-covered preventive services is eliminated; Medicare beneficiaries are eligible to receive an annual visit for personalized prevention plan services.
	10/1/2011	Employers with 100 employees or less are eligible to compete for grant funding to implement wellness programs (funding is available through FY 2015).
2012	3/1/2012*	CDC is required to conduct, at regular intervals, a national worksite health policies and programs survey to assess employer-based health policies and programs.
	10/1/2012	First year of Medicaid bundled payment demonstration, under which hospitals would receive a single payment for acute and post-acute care provided in hospital and non-hospital settings.
	10/1/2012	User fee program established for submission of applications to the FDA for approval of follow-on biologics.
	10/1/2012	Secretary must designate a plan to create a long-term care insurance program (the CLASS program) to be financed by voluntary payroll deductions that would cover the full cost of the program.
2013	1/1/2013	States that provide Medicaid coverage for all preventive services recommended by the U.S. Preventive Services Task Force and eliminate cost-sharing for such services are eligible for a one percentage point increase in their FMAP.
2014	7/1/2014	Employers may provide premium discounts, rebates or other rewards to employees who participate in wellness programs.
	7/1/2014	Ten-state demonstration project under which participating states may permit individual health plans to offer premium discounts, rebates or other rewards to enrollees participating in wellness programs commences.