



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

## **Timeline for Major Provisions in Health Care Reform Patient Protection and Affordable Care Act (Public Law 111-148) 2010-2014**

### **2009**

#### **Hospitals and Health Systems**

- Hospitals may count time spent on certain non patient care (e.g., didactic) training activities toward direct Graduate Medical Education (GME) payments and indirect GME payments (7/1/09)
- First year of Medicaid Global Payments demonstration available in up to five states from FY 2010–2012 under which a large, safety net hospital system could alter its provider payment system from FFS to a capitated, global payment structure (10/1/09).
- Medicare market basket reduced 0.25 percent in each of FY 2010 and 2011 for inpatient and outpatient hospitals, long-term care hospitals (LTCH), IRFs, and psychiatric hospitals (10/1/2009)

### **2010**

#### **Hospitals and Health Systems**

- Extends Section 508 hospital reclassification until September 30, 2010.
- Expands 340B drug discounts to outpatient drugs for children's hospitals, cancer hospitals, critical access hospitals, sole community hospitals, and rural referral centers.
- Requires not-for-profit hospitals to conduct periodic community needs assessments.
- Extends rural outpatient hold harmless payments.
- Reduces Medicare inpatient, outpatient, inpatient rehabilitation facility, and psychiatric hospital payments by 0.25 percent, and long-term care hospital payments by 0.5 percent.
- Reduces home health agency Medicare market basket adjustment by 1 percent in each of FY 2011–2013.
- Expands the Recovery Audit Contractor (RAC) program to include audits of Medicare and Medicare Parts C and D with a deadline of 1/1/2011.
- Eliminates the exception for physician-owned hospitals under Stark Law and grandfathers in providers with Medicare agreements in place before December 31, 2010.





- Establishes grants for clinics and hospitals to promote positive health behaviors in underserved areas.
- Makes qualified teaching health centers eligible for direct GME and Indirect Medical Education (IME) payments for operating primary care residency programs (\$230 million total appropriated for fiscal years 2011 through 2015).
- American Recovery and Reinvestment Act (ARRA) Medicaid and Medicare HIT incentive payments begin for hospitals (early Medicaid payments may be available prior to this date).
- Provides a total of \$400 million in Medicare supplemental payments for FY 2011 and 2012 under the inpatient prospective payment system for hospitals located in counties in the bottom quartile of counties, as ranked by risk-adjusted spending per Medicare enrollee.
- Imposes additional requirements on non-profit hospitals. Imposes a tax of \$50,000 per year for failure to meet these requirements.
- In accordance with guidelines established by DHHS hospitals shall make public a list of hospital charges, including DRGs as established under Medicare.

### Health Coverage

- Prohibits all new health plans from denying children coverage based on pre-existing conditions.
- Establishes high risk health insurance pool program to provide health insurance coverage for eligible uninsured individuals with a pre-existing condition as defined by the Secretary (effective not later than 90 days after the enactment of the Act and ending on January 1, 2014).
- Eliminates co-payments for preventive services and exempts preventive services from Medicare deductibles.
- Requires new health plans to cover preventive services.
- Bans rescission practices and lifetime limits.
- Extends coverage to those up to age 26 through parents' insurance.
- Establishes health plan for companies with early retirees.
- Provides a one-time rebate of \$250 to Medicare Part D beneficiaries who reach the donut hole.
- Allows states to expand coverage to all non-elderly individuals up to 133 percent of the federal poverty level.
- Expands Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency



declaration made as of June 17, 2009, and have developed certain health conditions as a result.

### Insurance Reforms and Exchanges

- For tax years beginning in 2010, 2011, 2012, and 2013, small employers with 25 or fewer “full-time equivalent” employees and average annual wages of no more than \$50,000 may be eligible for a tax credit of 35 percent (25 percent for tax-exempt small employers) of the employer’s contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50 percent of the total cost of coverage. Full credit available to employers with ten or fewer employees and wages less than \$25,000.
- Temporary reinsurance program is established to pay for a portion of health benefits provided by employment-based plans to pre-Medicare eligible retirees and their eligible dependents. The program ends on January 1, 2014. A total of \$5 billion is appropriated for this program.
- Other limited insurance reforms are imposed: 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); and 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. Insurers are required to adopt specified internal claims and appeals procedures. Fully insured group health plans must comply with the non-discrimination rules under the tax codes.
- Health plans must report the proportion of premium dollars spent on clinical services, quality, and other costs.

### State Requirements/Opportunities

- 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.
- States become eligible for \$250 million in grants to monitor premium increases and establish medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.
- Creates a state option to cover childless adults through a Medicaid State Plan Amendment.



- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women.
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met.

### Other

- Expands health professional loan repayment programs.
- Establishes Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.
- Establishes a National Health Care Workforce Commission to provide recommendations to Congress on aligning health care workforce resources.
- Establishes a Patient-Centered Outcomes Research Institute to conduct comparative effectiveness research.
- Increases Medicaid rebates to 23.1 percent of average manufacturer price on brand name drugs, and 13 percent on other drugs.
- Imposes a 10 percent service tax on indoor tanning.
- Allows employers with 100 employees or fewer who work 25 hours or more per week to compete for grant funding to implement wellness programs (funding is available through FY 2015).
- Increases the Medicaid drug rebate percentage for brand name drugs to 23.1 percent (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1 percent); increases the Medicaid rebate for non-innovator, multiple source drugs to 13 percent of the average manufacturer price; and extends the drug rebate to Medicaid managed care plans.
- Provides funding for and expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Creates a new office within the Centers for Medicare & Medicaid Services, the Federal Coordinated Health Care Office, to improve care coordination for dual eligibles.
- Requires the Secretary of Health and Human Services (HHS) to issue regulations to establish a process for public notice and comment for Section 1115 waivers in Medicaid and CHIP.



2011

### Hospitals and Health Systems

- Adjusts Medicare payments according to study on outpatient prospective payment system (exempting cancer hospital costs).
- Requires HHS Secretary to submit recommendations for reforming Medicare area wage index.
- Begins implementation of RUGs-IV payment changes for skilled nursing facilities.
- Prevents Medicaid payments to be used for hospital-acquired conditions.
- Extends reasonable cost payment for clinical diagnostic lab services for rural hospitals with fewer than 50 beds to July 1, 2011.
- Reduces Medicare inpatient, outpatient, skilled nursing facility, inpatient rehabilitation facility, psychiatric hospital, dialysis and long-term care hospital payments by a “productivity adjustment” of 0.1 percent.
- Redistributes unused residency slots, 75 percent of which must be used for general surgery or primary care.
- Requires HHS secretary to give additional Medicare funds to hospitals in the lowest cost counties in the country.
- Requires that the CMS Innovation Center is operational and begins 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, and \$10 billion appropriated for each ten-year period beginning with 2020).
- Establishes deadline for HHS plan to develop value-based purchasing programs for ambulatory surgery centers.
- Sets deadline for the General Accounting Office (GAO) report on 340B program given reform and the use of discounts to fulfill program objectives.
- Sets deadline for HHS to issue a plan to develop value-based purchasing programs for skilled nursing facilities and home health agencies.
- Requires HHS to begin to design, implement, monitor, and evaluate a Medicare graduate nurse education demonstration program for advance practice nurses, including up to five hospitals (\$50 million appropriated for each of FYs 2012 through 2015).
- Requires that tax-exempt hospitals comply with new requirements related to charges to uninsured and conducting community health needs assessments (applies in taxable years after enactment).



- Establishes new requirements for hospitals to qualify for Stark Rural Provider and Whole-Hospital Exceptions (effectively freezes applicability to hospitals with physician investment/ownership as of February 1, 2010, and establishes certain other requirements)
- Establishes a new trauma center program to strengthen emergency department and trauma center capacity.

### Health Coverage

- Requires all health plans to report annually on the share of premiums spent on medical care, and issues rebates to beneficiaries for excessive medical loss ratios.
- Expands Medicaid eligibility to all people under 133 percent of the poverty level; this provision is voluntary until 2014.
- Establishes voluntary payroll deduction for long-term care insurance program.
- Eliminates cost-sharing for Medicare-covered preventive services; Medicare beneficiaries are eligible to receive an annual visit for personalized prevention plan services.
- Reduces Medicare Part D “donut hole” coinsurance for generic drugs to 93 percent (from 100 percent in 2010). The Secretary will begin operation of a Medicare Coverage Gap Discount Program, under which brand name manufacturers agree to provide a 50 percent discount on the negotiated price of a drug under the Medicare Part D program.

### Insurance Reforms and Exchanges

- Requires the Secretary to study and report to Congress regarding the fully-insured and self-insured group health plan markets.
- Requires the Secretary of Labor 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.
- Sets deadline for the Secretary to develop uniform explanation of coverage documents to be used by insurers, including otherwise grandfathered plans.
- Requires health plans to report on rebates to consumers.

### State Requirements/Opportunities

- Allows states to receive an exemption from the Medicaid maintenance of effort



related to eligibility for non-pregnant, non-disabled adults above 133 percent Federal Poverty Level (FPL) between January 2011 and 2014 if they certify that they are experiencing a current or projected budget deficit.

- Creates a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90 percent FMAP for two years for health home-related services including care management, care coordination, and health promotion.
- Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.

### Other

- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.
- Provides scholarship and loan repayment funds for primary care practitioners in National Health Services Corps areas (\$1.5 billion from 2011 to 2015).
- Establishes the community care transitions program for high-risk Medicare beneficiaries.
- Establishes deadline for Secretary to publish for public comment a recommended core set of health quality measures for adults eligible for Medicaid benefits.
- Begins ARRA Medicaid and Medicare HIT incentive payments for eligible professionals.
- Initiates first of five years of 10 percent 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.
- Restructures payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service rates.
- Imposes a \$2.5 billion excise tax on branded pharmaceutical manufacturers and importers. Imposes a tax on sales made in the preceding calendar year. Payment date no later than 9/30/2011.
- Increases penalty from 10 percent to 20 percent for nonqualified Health Savings Account payments.
- Requires Secretary to designate a plan to create a long-term care insurance program, (i.e., a voluntary program for purchasing community living assistance



services or the CLASS program) to be financed by voluntary payroll deductions that would cover the full cost of the program.

- Establishes an Innovative Center within CMS to test and evaluate various payment structures and methodologies.
- Makes new Community Health Center (CHC) Fund appropriations available. Appropriates \$9.5 billion from 2011 to 2015 for unspecified Community Health Center program activities, and \$1.5 billion from 2011 to 2015 for construction and renovation of CHCs.
- Provides Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

## 2012

### Hospitals and Health Systems

- Extends Medicare dependent hospital classification through September 30, 2012.
- Extends FLEX programs through 2012.
- Reduces Medicare inpatient, outpatient, skilled nursing facility, inpatient rehabilitation facility, psychiatric hospital, dialysis and long-term care hospital payments by a “productivity adjustment” of 0.1 percent.
- Reduces payments for hospitals with “higher-than-expected” readmission rates for specific conditions; maximum reduction is 1 percent.
- Establishes a Medicare value-based purchasing program that adjusts 1 percent of payment according to data collection and reporting on five medical conditions.
- Begins voluntary accountable organization payment program.
- Requires HHS secretary to give additional Medicare funds to hospitals in the lowest cost counties in the country.
- Implements the 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.

### Health Coverage

- Reduces Medicare Part D “donut hole” coinsurance for generic drugs to 86 percent (from 93 percent in 2011).



### Insurance Reforms and Exchanges

- Requires insurers, including otherwise grandfathered plans, to use uniform explanation of coverage documents developed by the Secretary by this date.

### Other

- Increases funds for nursing and allied health professionals' loan repayment programs.
- Recognizes qualifying groups of providers, including physicians and hospitals, as Medicare ACOs who can share in Medicare cost savings above a certain threshold.
- Implements first year of Medicaid pediatric Accountable Care Organization (ACO) demonstration project. (Sums as necessary are appropriated.)
- Sets deadline for Secretary to publish rules to govern the value-based payment modifier to the physician fee schedule (to be implemented January 1, 2015, for some physicians identified by the Secretary, and January 1, 2017, for all physicians).
- Sets deadline for the Secretary to publish a final, initial core set of quality measures for adults in Medicaid.
- Implements improvements in the Medicare Physician Feedback Program. Sets deadlines for the Secretary to develop an "episode grouper" that "combines separate but clinically related items and services into an episode of care for an individual, as appropriate" and to begin providing reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians.
- Begins phase-in of new Medicare Advantage payments, tied to state spending levels. Phase-in will take three years in most states, but some states will have four or six years, depending on difference between current payments and benchmarks.
- Enables Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better to receive bonus payment of 1.5 percent; some plans in qualifying areas may receive double bonuses.
- Secretary to implement a 0.5 percent market basket reduction for hospice providers in each FY from 2013-2019.
- Increase fee-for-service and managed care payments for Medicaid to at least 100 percent of Medicare Part B rates for primary care services from physicians in family medicine, general internal medicine, and internal medicine. The federal



- government will pay 100 percent of the costs of the amount of the increased payments during these two years.
- Increases threshold for itemized deductions for medical expenses from 7.5 percent to 10 percent of adjusted gross income (not effective until January 1, 2017, for individuals over the age of 65).
  - Imposes a \$3 billion excise tax annually through 2016 (up \$500 million from 2011) on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30/2012.
  - Imposes a \$2 per enrollee fee (\$1 for fiscal year 2013) on insurers, including self-insured employer plans, to finance Patient-Centered Outcomes Research Trust Fund.
  - Requires CDC to conduct, at regular intervals, a national worksite health policies and programs survey to assess employer-based health policies and programs.
  - Creates the Medicare Independence at Home demonstration program.
  - Reduces rebates for Medicare Advantage plans.
  - Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

## 2013

### Hospitals and Health Systems

- Establishes quality and efficiency measures for prospective payment system-exempt cancer hospitals to report.
- Establishes a pay-for-reporting program for freestanding and unit-based inpatient psychiatric hospitals, inpatient rehabilitation facilities, long-term care hospitals, and hospices.
- Reduces Medicare inpatient, outpatient, skilled nursing facility, inpatient rehabilitation facility, psychiatric hospital, dialysis, and long-term care hospital payments by a “productivity adjustment” of 0.3 percent.
- Simplifies administrative burdens by standardizing electronic exchange of health information.
- Begins voluntary bundled payment pilot program for ten medical conditions.
- Expands Medicare value-based program to include more conditions and efficiency measures.



- Sets deadline for Secretary to establish Medicare pilot program to evaluate alternative payment methodologies, including bundled payments across the continuum for an episode of care.
- Rebases home health agency Medicare prospective payment rates according to factors determined by the Secretary.
- Implements Medicare disproportionate share hospital (DSH) cuts 10/1/2013 (\$22 billion total over ten years).
- Applies Medicaid DSH cuts of \$500 million to states based on methodology determined by the Secretary (effective 10/1/2013).

### Health Coverage

- Begins nonprofit consumer-operated and oriented plans (CO-OPs).
- Reduces Medicare Part D “donut hole” coinsurance for generic drugs to 79 percent (from 86 percent in 2012).
- Implements Medicare Part D “donut hole” coinsurance for most brand name drugs at 47.5 percent, including 50 percent rebate from Medicare Coverage Gap Discount Program, for 2013-2014.

### Insurance Reforms and Exchanges

- For taxable years beginning after December 31, 2012, limits annual salary contributions to health FSAs to \$2,500 a year and requires that they be indexed by the Consumer Price Index for taxable years beginning after December 31, 2013.
- Sets deadline for the Secretary to award loans and grants 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. (\$6 billion is appropriated for the loans and grants.)
- Implements 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.
- Simplifies health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013).



### State Requirements/Opportunities

- 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.

### Other

- Establishes a 2.9 percent tax on medical devices estimated to raise \$27 billion.
- Sets deadline for Secretary to develop a standardized format for reporting information based on the new quality measures for adults in Medicaid, and to create procedures to encourage states to use them to voluntarily report information on the quality of health care provided.
- Enables Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better to receive a bonus payment of 3 percent, up from 1.5 percent in 2012 (new plans receive 2.5 percent); some plans in qualifying areas may receive double bonuses.
- Imposes an additional 0.9 percent Medicare hospital insurance tax on wages above \$200,000 for individual filers, \$125,000 for married filing separate filers, and \$250,000 for joint filers.
- Limits annual salary contributions to health flexible spending arrangements to \$2,500 a year and indexes the limit by CPI-U beginning in 2014.
- For taxable years after December 31, 2012, eliminates deduction for expenses allocable to Medicare Part D subsidy received by employers.
- Implements new Sunshine Provisions. Drug and device manufacturers must begin reporting payments to physicians and teaching hospitals, and both manufacturers and group purchasing organizations must begin reporting physician ownership and investment data to the Secretary on an annual basis.
- Increases Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100 percent federal funding.
- 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.



2014

### Hospitals and Health Systems

- Implements reductions in Medicare and Medicaid disproportionate share. Medicaid DSH cuts of \$600 million applied to states in each of FY 2015 and 2016, based on methodology determined by the Secretary.
- Reduces inpatient, outpatient, inpatient rehabilitation facility, long-term care hospital, and psychiatric hospital payments by 0.2 percent.
- Ends grants for clinics and hospitals to promote positive health behaviors in underserved areas.
- Expands readmission policy to include more conditions; maximum reduction in payments to hospitals with higher-than-expected readmission rate increases to 3 percent.
- Allows Medicare value-based program to adjust payments by 1.5 percent.
- Provides hospitals in the top 25<sup>th</sup> percentile of certain hospital-acquired condition rates with a 1 percent payment reduction (effective FY 2015).
- Implements ARRA Medicare EHR penalties for hospitals.

### Health Coverage

- Requires U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Implements health benefit exchanges.
- Bans coverage refusal based on pre-existing conditions for all people.
- Requires states to cover all former foster children up to age 26 through Medicaid.
- Provides tax credit up to 50 percent of premiums to small businesses.
- Provides 100 percent federal funding for costs associated for Medicaid “newly eligibles” through 2016.
- Reduces Medicare Part D “donut hole” coinsurance for generic drugs to 72 percent (from 79 percent in 2013).
- Reduces the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019).



## Insurance Reforms and Exchanges

- Initiates availability of state-based exchanges; only individuals and small employers are initially eligible to participate.
- Requires health plans seeking certification to submit to the Exchange, state, and Secretary, and to make publicly available, certain information, including claims payment policies, and data on enrollment and denied claims.
- Sets deadline for the Secretary to develop guidelines for Exchange plans 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.
- Requires qualified health plans to reimburse services provided at Federally Qualified Health Centers at rates that are at least as high as rates under Medicaid.
- Requires Office of Personnel Management to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each state.
- Imposes a new tax penalty on individuals who do not purchase coverage, and a tax penalty on employers with over 50 employees that have at least one employee receiving a subsidy to purchase through the Exchange.
- Provides affordability premium credits and cost-sharing credits to non-Medicaid eligible individuals who are not enrolled in an affordable employer-sponsored plan with incomes between 133 percent and 400 percent federal poverty level to purchase coverage through an Exchange.
- Requires certain employers to begin reporting information to the Internal Revenue Service regarding employee coverage.
- Increases small business tax credit to 50 percent for for-profit small business (35 percent to tax-exempt small businesses) of the employer's contributions for qualified health plans offered by the employer through an Exchange, or contributions that the employer would have made if their employees had enrolled in an Exchange plan. The credit, which is available for two consecutive years, fully phases out for firms with average wages equal to or greater than \$50,000.
- Implements additional insurance reform policies. 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, but may be reduced by up to 30 percent based on participation



- in a wellness program); 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. Health plans may not place annual limits on essential health benefits.
- Requires that the False Claims Act applies to payments made by, through, or in connection with the Exchange if payments include any federal funds.
  - Implements first year of annual fee on health insurance plans (\$8 billion; assessed based on insurer's net premiums, and only 50 percent of tax-exempt insurers premiums are included in calculation of the fee).
  - Reduces the out-of-pocket limits for those with incomes up to 400 percent of federal poverty level (FPL) to the following levels:
    - 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family)
    - 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family)
    - 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family).
  - Continues administrative simplification: Simplifies health insurance administration by electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014).

### State Requirements/Opportunities

- Requires that states expand Medicaid eligibility up to 133 percent of federal poverty level. Maintenance of effort related to eligibility for adults under Medicaid ends.
- Makes available 100 percent federal financial assistance for costs of newly eligible Medicaid expansion populations in all states.
- Allows states to create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133 percent and 200 percent FPL (and lawfully present aliens whose income is not greater than 133 percent FPL and who are not eligible for Medicaid by virtue of alien status). Participating states receive 95 percent of the premium tax credits and cost-sharing subsidies that



would have been provided to individuals who would have enrolled in the Exchange.

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

### Other

- Requires all eligible professionals to participate in the physician quality reporting initiative and provides a 0.5 percent bonus to those reporting properly.
- Sets deadline for Secretary to send a report to Congress on the new quality measures for adults in Medicaid.
- Phases in Medicare Advantage rebate system based on plan quality. Plans with 4.5 stars may offer rebates of 70 percent of the difference between the benchmark and their bid; those with 3.5-4.5 stars may offer 60 percent rebates, and those with less than 3.5 stars may offer 50 percent rebates.
- Enables Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better to receive bonus payments of 5 percent, up from 3 percent in 2013 (new plans receive 3.5 percent); some plans in qualifying areas may receive double bonuses.
- Requires Medicare Advantage plans to achieve a medical loss ratio of at least 85 percent, or face penalties.
- Independent Payment Advisory Board begins developing and submitting proposals to MedPAC, the President, and Congress, regarding strategies to reduce excess cost growth. Such proposals may not include recommendations that would reduce payment rates for hospitals and other providers subject to productivity adjustments.
- Independent Payment Advisory Board recommendations for certain providers, including Medicare Advantage and Part D Plans, are automatically enacted if Congress fails to pass an alternative package that cuts costs by the same amount. Payment changes will be implemented either at the start of FY 2015 (Oct. 1, 2014) or calendar year 2015, depending on provider type.
- Establishes Prospective Payment System for Medicare-covered services furnished by Federally Qualified Health Centers.
- For corporation with assets of not less than \$1 billion (determined as of the end of the preceding taxable year), any required installment of corporate estimated tax due in July, August, or September of 2014 increases to 116 percent.



- Imposes new tax penalties on employers with 50 or more employees who do not provide insurance (and have at least one employee who qualifies for a premium tax credit) or who do not provide affordable insurance.
- Allows employers to provide premium discounts, rebates or other rewards to employees who participate in wellness programs.
- Implements first year of 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. (No funding specifically authorized or appropriated, but funds potentially available under the Prevention and Public Health Fund for wellness activities under the Public Health Service Act.)