

## 2010 Timeline

<b>March 23, 2010</b>			<b>President Obama signed the Patient Protection and Affordable Care Act (PPACA), which reforms the nation's health care system, into law. The following timeline summarizes what the law's key provisions in the law do, and the effective date.</b>
<b>Provisions effective in 2010 unless otherwise noted</b>			
<b>Insurance Mandate</b>			
<b>March 23</b>	<b>Automatic enrollment</b>	Require employers with more than 200 employees to enroll their employees automatically in one or more of the health plans they offer. An employee may opt out.	
<b>Insurance Reforms</b>			
	<b>Grandfathered plans</b>	PPACA has many provisions that reform the health insurance market, which impact employers who offer group health plans. "Grandfathered" plans, those in existence on the date of the PPACA's enactment, are exempt from some but not all of the new health reforms. Grandfathered plans still can enroll new employees and family members. However, there is some confusion on what changes to the plan would cause a plan to lose this status.	
<b>Immediate</b>	<b>Rate review</b>	Establish a process for reviewing health care premium increases, which plans must justify. States also must report premium growth by plan. Plans with "excessive" increases may be barred from participating in the exchange in 2014.	
<b>June 23</b>	<b>Reinsurance for retiree health benefits</b>	Create a temporary reinsurance program for employers providing health coverage to retirees over age 55 who are not eligible for Medicare. The \$5 billion in funds for the program are available until 2014 or when funds are depleted.	
<b>July 1</b>	<b>Health insurance comparison website</b>	Direct the U.S. Department of Health and Human Services (HHS) to develop a website and other means to allow patients to obtain information regarding affordable health care options in their state, including availability of Medicaid, Children's Health Insurance Program (CHIP), and private insurance options	
<b>July 1</b>	<b>Coverage for uninsured with preexisting conditions</b>	Establish a new high-risk pool, called the Pre-Existing Condition Insurance Plan, to provide coverage for people who have been uninsured for at least six months because of a preexisting condition. States are encouraged to establish their own pool, but if they do not, the federal government will establish the pool for them. Texas chose not to establish a separate pool. For more information about the pool or to apply, visit <a href="http://www.pcip.gov">www.pcip.gov</a> .	

<b>Sept. 23</b>	<b>Dependent coverage</b>	Allow parents to keep their children up to age 26 on individual or group family policies (additional year for Texans). <i>Newly written policies and upon renewal of existing policies in the individual and group markets</i>
<b>Sept. 23</b>	<b>Children with preexisting conditions coverage</b>	Prohibit insurance companies from denying coverage to children under the age of 19 due to a preexisting condition. For adults, the provision becomes effective in 2014 for group health plans.
<b>Sept. 23</b>	<b>Eliminate lifetime limits on coverage</b>	Prohibit group and individual health plans, including grandfathered plans, from imposing lifetime maximum benefits in terms of dollar limitation on essential benefits, such as ambulatory, emergency, and hospital services. <i>Newly written policies and upon renewal of existing policies in the individual and group markets</i>
<b>Sept. 23</b>	<b>Waiting period for coverage</b>	Restrict waiting periods to 90 days or less. <i>Newly written policies and upon renewal of existing policies in the individual and group markets</i>
<b>Sept. 23</b>	<b>Regulates annual limits on insurance coverage</b>	Restrict group, new individual, and grandfathered plans on the annual dollar limits on the amount of coverage a patient may receive, as determined by HHS. Beginning in 2014, annual dollar limits are prohibited for all essential health benefits.
<b>Sept. 23</b>	<b>Emergency services</b>	Require group health plans and insurers to cover emergency services without prior authorization and in-network requirements.
<b>Sept. 23</b>	<b>Prohibition on rescissions</b>	Prohibit group or individual insurers from rescinding patients' benefits when they get sick, except in cases of fraud or if a person intentionally misrepresents a material fact. Also applies to grandfathered plans.
<b>Sept. 23</b>	<b>Preventive services</b>	Require new individual, group health plans and upon renewal of existing policies to cover preventive health services without charging a copay, deductible, or coinsurance, including immunizations, preventive care for women and children, and services rated "A" or "B" by the U.S. Preventive Services Task Force (USPSTF), recommended immunizations, preventive care for children and adolescents and additional preventative care and screenings for women.
<b>Sept. 23</b>	<b>Appeal process</b>	Provide patients a way to appeal health insurance coverage determinations and claims, and establish an external review process.
<b>Fall 2010</b>	<b>Consumer ombudsman</b>	Provide \$30 million in grant funding to states to encourage development of consumer ombudsman programs. The offices, once established, will provide consumers information about new coverage options and help with appeals when consumers are denied coverage under the new exchange(s) or subsidized insurance coverage, among other responsibilities.

<b>Medicare</b>		
<b>Immediate</b>	<b>Medicare Part D “donut hole” rebate</b>	Provide a \$250 rebate to Medicare patients who reach the Part D coverage gap, known as the donut hole, in 2010. New law also gradually eliminates the donut hole by 2020.
<b>Immediate</b>	<b>Physician Compare website</b>	Require HHS to develop a Physician Compare website that will contain information on physicians enrolled in Medicare. The website must be online by January 2011.
<b>Jan 1, 2010-2011</b>	<b>Medicare fee schedule adjustments</b>	<a href="http://www.texmed.org/uploadedFiles/Governmental_Affairs/U.S._Congress/HealthReformSchoolMedicare.pdf">www.texmed.org/uploadedFiles/Governmental_Affairs/U.S._Congress/HealthReformSchoolMedicare.pdf</a>
<b>Medicaid starts Jan. 1; Medicare starts March 10</b>	<b>Federal Coordinated Health Care Office</b>	Creates a new office within the Center for Medicare & Medicaid Services (CMS) — the Federal Coordinated Health Care Office, to improve care coordination for patients who are dually eligible for Medicare and Medicaid.
<b>December 2010</b>	<b>Ban on physician-owned hospitals</b>	Prevents physician-owned hospitals that do not have a provider agreement before Dec. 31, 2010, from participating in Medicare. Ambulatory surgical centers that have converted to a hospital after March 23, 2010, also are not eligible for an exception that will allow payment in Medicare. Physician-owned hospitals exempt from the ban include those that have a provider agreement in effect on Dec. 31, 2010. These hospitals cannot have increased the number of licensed operating rooms, procedure rooms, or beds after March 23, 2010. Also, they must meet requirements that prevent conflicts of interest, prevent increased physician investment, and ensure emergency medical treatment and transfer. These hospitals may expand the number of operating rooms, procedure rooms, or beds only by applying to the government for an exception.
<b>Medicaid/CHIP</b>		
<b>Immediate</b>	<b>Medicaid/CHIP eligibility</b>	Prohibit states from establishing more restrictive eligibility requirements or procedures for Medicaid adults through Jan. 1, 2014 (or when the exchange becomes operational) and for children’s Medicaid and CHIP until October 2019. This would mean, for example, Texas cannot reduce enrollment in CHIP by reducing current eligibility levels. States with budget deficits can seek an exemption for this requirement for adult enrollees with incomes above 133 percent of poverty, except pregnant women or patients with disabilities, meaning this provision will have no impact on Texas because parents are covered well below this threshold.
<b>Immediate</b>	<b>Family planning</b>	Eliminate state waivers to establish a Medicaid family planning program. States now may implement the family planning as an optional Medicaid benefit. Texas currently operates the program under the name Women’s Health Program (WHP). In Texas, WHP provides family planning services, excluding abortion, to women ages 18-45 who are not pregnant. Services include Pap smears, breast exams, and contraceptives.
<b>Immediate</b>	<b>Medicaid and CHIP Payment Access Commission</b>	Provide funding for the Medicaid and CHIP Payment Access Commission (MACPAC) and expand its role to include Medicaid-enrolled adults, including dual-eligibles. Congress established MACPAC in 2009 as part of the CHIP reauthorization act but did not fund it at that time. MACPAC is modeled on the Medicare Payment Advisory Commission. The new entity, which already has been appointed, will evaluate Medicaid and CHIP payment and regulatory policies that undermine Medicaid and CHIP patients’ ability to obtain timely health care services.

<b>Jan. 1</b>	<b>Medicaid drug rebate</b>	Increase 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); increase the Medicaid rebate for noninnovator, multiple source drugs to 13 percent of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
<b>October 2010</b>	<b>Medicaid coverage for comprehensive tobacco cessation programs for pregnant women</b>	Requires Medicaid coverage of comprehensive tobacco cessation services for pregnant women. Texas currently covers most tobacco cessation prescription drugs but not counseling.
<b>Prevention and Wellness</b>		
<b>Immediate</b>	<b>Prevention/wellness grants</b>	Establish the Prevention and Public Health Fund to support expansion of current public health evidence-based, community prevention and wellness programs; outreach campaigns; and immunization programs (\$500 million is to be allocated in 2010).
<b>Sept. 1</b>	<b>Mental health</b>	Allows the HHS secretary to give states grants to educate the public about postpartum depression as well as establish and operate cost-effective services for women who have or are at risk of developing postpartum depression.
<b>Sept. 1</b>	<b>Family planning</b>	Provides \$75 million per year through FY 2014 to states for programs to promote "personal responsibility," including the education of adolescents on abstinence and contraception for the prevention of teenage pregnancy and sexually transmitted infections; also restores funding for abstinence education.
<b>Quality and Reporting (effects on physicians)</b>		
<b>Immediate</b>	<b>Fraud and abuse: Expansion of national database on physician adverse actions</b>	Add more burdensome regulatory efforts on top of the already existing scheme of fraud and abuse laws. For instance, the federal government is expanding its national database of physician "adverse actions." The National Practitioner Data Bank and the Health Care Integrity Data Bank are being merged and the types of activities that must be reported are expanded. Under the new law, "any adverse action" taken against a physician by a state or fraud enforcement agency must be reported and listed. This is an expansion of the current standard. Health plans and hospitals already are required to report adverse actions of certain types. Physicians should take time to review their operations and compliance programs to ensure they are in compliance with the new laws.
<b>Immediate</b>	<b>Compliance program</b>	Require certain Medicare providers and suppliers to implement compliance programs. HHS to develop core elements to include in compliance program.
<b>Immediate</b>	<b>Enhanced penalties</b>	Increase penalties and extend the use of civil monetary penalties; CMS has more flexibility to impose intermediate sanctions.
<b>Immediate</b>	<b>Health care fraud and abuse control (Medicare)</b>	Increase funding for the Health Care Fraud and Abuse Control Fund by \$250 million over next 10 years.
<b>Immediate</b>	<b>Extends gainsharing demonstration</b>	Extends the gainsharing demonstration authorized by the Deficit Reduction Act of 2005 to evaluate arrangements between hospitals and physicians designed to improve quality and efficiency for patients.

<b>Immediate</b>	<b>Trauma center grant program</b>	Expands funding to strengthen the nation's trauma and emergency department capacity. The law allocates \$100 million in additional funding to distribute to states in FY 2010-15.
<b>Immediate</b>	<b>Demonstration project for nurse practitioners</b>	Authorize grant funding and training demonstration grant program for family nurse practitioners for careers as primary care providers in federally qualified health centers (FQHCs) and nurse-managed health clinics. These are defined in the new law as practices managed by advanced nurse practice nurses who provide primary care or wellness services to underserved or vulnerable populations and that are associated with a school, university, FQHC, or social services agency. Grants can't exceed \$600,000 per year.
<b>Sept. 1</b>	<b>Self-referral disclosure protocols</b>	Require HHS to develop and post on the CMS website self-referral disclosure protocols. The protocols must cover the procedures for self-disclosures, the effect of self-disclosure on corporate integrity agreements, and information regarding possible reductions in penalties for self-disclosure of Stark Law violations.
<b>Dec. 1</b>	<b>RAC contracts</b>	Expand the Recovery Audit Contractor (RAC) program to Medicaid and Medicare parts C and D. Texas will be required to contract with at least one RAC by the end of the year. The sole purpose of the RACs is to identify underpayments and overpayments and to recoup any overpayments
<b>By Jan. 1, 2011</b>	<b>Payment bundling pilot</b>	Direct HHS secretary to establish a pilot program for integrated care (involving payment bundling) for an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services. An episode of care includes three days before the admission to a hospital for an applicable condition, the length of stay in a hospital, and 30 days after the patient is discharged.
<b>By Jan. 1, 2011</b>	<b>Physician Compare website</b>	Establish Physician Compare Internet site in 2010, which will use Physician Quality Reporting Initiative measures, assessments of outcomes, episodes of care and risk-adjusted resource use, efficiency measures, patient satisfaction and family engagement measures, an assessment of the safety and effectiveness of care, and any other information the HHS secretary shall determine appropriate. The plan must permit a physician to "review" his or her results before they are made public. The program must ensure an accurate portrayal of a physician's performance and reflect the care "provided to all patients" through Medicare and "other payers."
<b>Tax Implications</b>		
<b>Immediate</b>	<b>Small-business tax credit</b>	<p>The new law provides a tax credit for small employers with fewer than 25 full-time equivalent employees and average annual compensation levels not exceeding \$50,000 if the employer provides health care benefits and pays at least half of the premium cost. Credit phases out with more employees and higher compensation.</p> <ul style="list-style-type: none"> <li>• The credit is in effect for tax years starting in 2009.</li> <li>• Physician practices that are most likely to be eligible for the credit are those in which physicians' salaries are not reported as wages, such as some partnerships and S corporations.</li> <li>• The largest tax credit of 35 percent is available to employers with 10 or fewer employees and average annual wages of \$26,000.</li> </ul>

<b>Workforce</b>		
<b>July 1</b>	<b>GME funding</b>	Allow residents to qualify for Medicare graduate medical education (GME) funding for some nonpatient care activities that are part of the required curriculum.
<b>Sept. 1</b>	<b>Expands grants for primary care training programs</b>	Expand existing grant opportunities for primary care training programs and authorize demonstration projects for training residents in new primary care competencies that focus on patient-centered medical homes or interdisciplinary graduate training in various public health fields.
<b>Sept. 1</b>	<b>Pediatric specialty loan repayment program</b>	Establish within the Department of Health and Human Services a pediatric-specialty loan repayment program. Eligible physicians include pediatric medical and surgical specialties or child and adolescent psychiatrists. Excludes from gross income payments made to physicians or other health care professionals participating in state loan repayment programs.
<b>Sept. 30</b>	<b>Health Workforce Commission</b>	Create a Health Workforce Commission to study and oversee federal workforce issues. It is expected the commission will learn quickly about the need for greater federal support to expand GME slots.
<b>By July 1, 2011</b>	<b>GME training slots</b>	Increase GME training positions, with priority for primary care and general surgery, by reallocating up to 65 percent of currently unused Medicare GME slots. Priority will go to states with the lowest resident physician-to-population ratios. This provision is expected to have minimal impact, less than 300 slots, for the entire United States.



Physicians Caring for Texans