



Health Reform Implementation Timeline

HR 3590: The Patient Protection and Affordable Care Act

Below is a brief summary that outlines the implementation timeline and effective dates of the major provisions in the health care reform legislation of interest to physicians.

2010

COVERAGE

- Immediate temporary high-risk pool with subsidized premiums for uninsured with pre-existing conditions who have been denied health care coverage.
- Temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
- Allows parents to continue coverage for children up to age 26.
- Establishes catastrophic-only coverage for those up to 30 years of age.
- Tax credits for small business employee insurance coverage starts to phase-in.
- Requires group and individual health plans to cover certain preventive services without cost-sharing.

INSURANCE INDUSTRY REFORMS

- Health plans required to report medical loss ratios. In 2011, plans that do not dedicate 85% of revenue to direct patient care must provide a rebate to enrollees.
- Health plans must have adequate provider networks.
- No insurance denial for pre-existing conditions for children.
- Prohibits plans from rescinding coverage when a patient gets sick.
- Prohibits life-time or annual limits on benefits.
- Health plans must implement operating rules for certain electronic transactions within specified time periods.

ACCESS TO CARE AND PHYSICIAN PAYMENT

- Medicare 5% payment increase for mental health psychotherapy services.

- Practice expense change increases physician payments in rural states 2010-2012. Mandates a national study on physician practice expenses. California physicians held harmless from this provision 2010-2012.
- Starts to increase utilization rate assumption for advanced imaging equipment from 50%-65% and up to 75% in 2014 which reduces the reimbursement rates for advanced imaging services.

MEDICARE PRESCRIPTION DRUG PROGRAM:

- Closes the donut hole for seniors.

COMPARATIVE EFFECTIVENESS RESEARCH (CER)

- Establishes independent, non-profit CER institute to support clinical research on comparative effectiveness. Board of Governors with four physician representatives. Prohibits use of research for coverage, payment or policy recommendations.

2011

REVENUE

- Some revenue provisions, including the fees on health plans, pharmaceutical and device manufacturers and the Medicare tax start to phase in 2011-2014.
- Medicare payment cuts to health plans, pharma, medical device manufacturers, hospitals, home health and nursing homes begin.

MEDICARE

- **Primary Care Bonus:** 10% bonus payments for internists, geriatricians, family physicians and pediatricians for 5 years (2011-2015) for whom primary care services (HCPCS codes 99201-99215; 99304-99340; and 99341-99350) account for at least 60% of Medicare allowed charges over a designated period of time. The bonus would be paid on a monthly or quarterly basis for each service that qualifies for payment.
- **Rural General Surgeons Bonus:** 10% bonus payment for general surgeons practicing in health professional shortage areas for 5 years (2011-2015).
- **Medicare Advantage Health Plans:** Starts to phase-in fiscal neutrality for Medicare Fee-for-Service and Medicare Advantage (MA). Sets MA payment based on average of bids from MA plans in each market area. Establishes a quality bonus for care coordination, care management and quality. \$130+ billion cut.
- **Medical Homes:** Establishes a demonstration program for primary care medical homes for patients with multiple chronic conditions. Physicians eligible for shared savings bonus payment. Nurse Practitioners and Physician Assistants may lead medical homes but only if state scope of practice laws allow it. CA law prohibits.
- **Future Ban on Physician-Owned Hospitals.** New exceptions for existing physician-owned hospitals effective 18 months after enactment. To qualify for an exception, the physician-ownership agreement must be in place by December 31, 2010

- **Physician Utilization:** 5% penalty for physician utilization outliers eliminated. Continues the current program to provide confidential feedback to physicians comparing their utilization and resources use to their peers.
- **Quality Reporting:** Continues the current Medicare PQRI quality reporting program. Provides 0.5%-1% bonuses for physicians 2011-2013. Participation mandatory in 2014 with penalties for nonparticipation.
- **ICD-9 to ICD-10 crosswalk.** Secretary required to hold stakeholder meetings.
- Coverage for wellness and preventive services and eliminates some coinsurance.
- **Fraud and Abuse:** Multiple initiatives to curb fraud and abuse start to phase-in.
- **Graduate Medical Education** changes starts to phase in:
 - Redistributes current unused residency slots for primary care and general surgery.
 - Allows for training in outpatient settings.
 - Allows teaching health centers to expand primary care residency programs.
- **Health Care Workforce Augmentation** starts to phase-in: Authorizes the National Health Care Workforce Commission to examine barriers to primary care careers, authorizes state grants, increased funding for NHSC scholarship and loan repayment program; easing of access to loans for primary care providers, funding for health professions and diversity programs; other support for pediatrics, mental health and public health.

MEDICAID

- Coverage for preventive services and eliminates cost-sharing.

2012

MEDICARE

- Practice Expense study finished and implemented on a budget neutral basis.

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

- CMS is required to establish a program to allow groups of physicians who report on quality and coordinate care to share in the savings (particularly from preventing unnecessary ER visits or hospitalizations) achieved in their region. ACOs can be small groups of loosely affiliated physicians or large organized groups. ACOs do not have to involve a hospital. Because ACOs will be groups of physicians who are clinically and financially integrated, it establishes a path to anti-trust relief in the private sector.

MEDICAL LIABILITY

- GAO report due on whether the new practice guidelines and payments policies in the health care reform bill would create causes of action against physicians.

2013

MEDICARE

- **Quality Reporting:** Requires public reporting of Medicare physician and private payer performance information related to quality (PQRI) and other factors such as care coordination, resource use and patient satisfaction. Data would meet certain safeguards (valid, risk-adjusted) and physicians would have prior opportunity to review the data. Requires appropriate attribution methodology, timely feedback and accurate systems that can provide reliable data. AMA and CMA worked to include multiple amendments to protect physician information and ensure that it is accurate based on the CCHRI experience in CA. Further protections need to be addressed in clean-up legislation.
- Administrative Simplification requires health plans to certify that their information systems comply with standards. New operating rules for eligibility and health plan claim status transactions take effect.

2014

COVERAGE

- **Individual Mandate** for uninsured to purchase health insurance begins. Penalties up to 10% of income for those who do not purchase insurance.
- Tax credits and cost-sharing subsidies begin to make insurance affordable.
- No Employer Mandate but substantial fees on large employers who do not provide coverage.

EXCHANGE

- State-based Health Insurance Exchanges established to provide the uninsured with a choice of private health plans, benefit packages and doctors. Health plans must offer at least the essential health benefits package.
- Uninsured Coverage through Health Insurance Exchange:
 - Covers 2.3 million Californians (incomes between 133% FPL-400% of FPL; \$28,665 and \$88,200 for a family of four) through private insurance with tax credits and subsidies.
 - Covers 1 million who have incomes above 400% of FPL through private insurance.
 - Tax credits for small employers to cover 637,700 California small business employees.
 - Tax credits to help low-income families afford premiums based on sliding fee scale linked to income.

MEDICAID

- Covers 1.7 million Californians (incomes up to 133% of FPL \$28,665) in Medi-Cal. 100% federal financing in 2014 phased down to 90% in 2020. Enhanced federal match in expansion states.
- Provides an increase in Medicaid reimbursement rates for primary care physicians (internists, family physicians and pediatricians) up to Medicare levels for E&M services and immunizations in 2013 and 2014.

INSURANCE INDUSTRY REFORMS

- Prohibition on insurers denying coverage to adults with pre-existing conditions.
- Modified community rating limits variation only on age, geographic area, tobacco use and family size.
- Requires premium risk adjustment in individual and small group markets.
- Requires insurers to limit waiting periods for coverage to 90 days.
- Administrative Simplification operating rules for electronic funds transfers (EFT) and health care payment and remittance advice takes effect. Physicians also required to comply with the EFT standards for Medicare payments.

2015

MEDICARE

- **Independent Medicare Payment Advisory Board (IPAB) takes effect.** Independent Board appointed by the President to reduce Medicare payments if Medicare spending exceeds general health care spending. The Board not elected or accountable to physicians and seniors. IPAB must take into consideration system-wide costs, patient access, utilization and quality of care by region, types of services and providers. Congress would only have 30 days to overturn recommendations with a supermajority 2/3 vote.

Hospitals not included in the IPAB considerations until 2019.

Changes to the IPAB were not eligible for the Budget Reconciliation bill. Many California House Democratic leaders who oppose the IPAB, have vowed to address it in subsequent legislation.

- **Value Index Modifier:** Modifies physician payment based on level of spending and quality reporting. Physicians who spend less than national average paid a higher rate. Physicians who spend more than the national average paid a lower rate. CMA amendments ensure that rate is adjusted for geographic practice expense and socioeconomic status of the patients. AMA and CMA also won amendments to protect the quality reporting information. Further clean-up legislation will be necessary.

2016

- Multi-state compacts to allow insurers to sell policies across state lines implemented. Implementation regulations due by 2013.
- Additional Administrative Simplification rules take effect. Operating rules for claims, enrollment/disenrollment and health claims attachment standards.

2018

- Implements Cadillac tax on health plans offering high-end benefits.

CBO Score

- CBO Projects deficit reduction over 20 years. \$138 billion in first 10 yrs; \$1 trillion in second decade. Slows rate of health care spending growth from 6%/yr to 5%/yr.