

TIMELINE FOR REFORM

2011

PREMIUM SHARING: Large-group health plans that spend less than 85 percent of premium dollars on medical care, and small-group and individual plans that spend less than 80 percent, will offer rebates to enrollees.

BENEFIT DISCLOSURE: Employers will disclose the value of insurance benefits on W-2s.

NEW PAYMENT APPROACH: A new Center for Medicare and Medicaid Innovation will test reforms rewarding providers for quality rather than volume.

“DOUGHNUT HOLE”: Medicare beneficiaries in the prescription drug coverage “doughnut hole” will get 50 percent discounts on brand-name drugs.

PHYSICIAN QUALITY REPORTING: Medicare will launch a Physician Compare website.

OTC DRUG REIMBURSEMENT: Over-the-counter drugs not prescribed by a doctor will no longer be reimbursable through flexible spending arrangements or health savings accounts.

CLASS ACT: An insurance program for purchasing community living assistance services and support (CLASS) will be established. Working adults will be enrolled — unless they opt out — through payroll deductions that, after five years, will provide payments to help them stay at home if disabled.

2012

MEDICARE PURCHASING: Medicare will reward hospitals that provide higher quality or better patients outcomes.

2013

ADMINISTRATIVE SIMPLIFICATION: Health insurers will begin following simplified standards for electronic exchange of information.

FLEXIBLE SPENDING LIMITS: Contributions to flexible spending accounts will be limited to \$2,500 a year, indexed to the Consumer Price Index.

2014

COVERAGE MANDATE: Individuals will be required to carry health insurance, and employers with 50 or more workers will be required to offer health benefits or be fined \$2,000 per employee (not counting the first 30 employees) if a worker gets governmental help with premiums through the insurance exchanges.

NEW RULES FOR INSURERS: Insurers will be banned from restricting coverage or basing premiums on health status. They will be obliged to compete on value.

INSURANCE INDUSTRY FEE: Insurers will pay an annual fee, based on market share, to help pay for reform.

PREMIUM SUBSIDIES:

Premium and costs-sharing assistance on a sliding scale will be available for families with annual incomes from \$30,000 to \$88,000 that buy plans through health exchanges.

ESSENTIAL BENEFITS PACKAGE:

HHS will establish a standard essential benefits package for policies in individual and small-group markets with a choice among tiers (bronze, silver, gold and platinum) with different levels of cost-sharing.

MEDICAID EXPANSION:

Medicaid eligibility will be expanded to all legal residents with incomes up to 133 percent of federal poverty level.

INSURANCE EXCHANGES: New state marketplaces will offer small businesses and people without employer coverage a choice of policies meeting essential benefit standards.

MEDICARE MANAGED CARE PLANS: Four- and five-star Medicare private plans will get 5 percent bonuses for providing better clinical quality and patient experiences.

INDEPENDENT PAYMENT ADVISORY BOARD: A new independent payment advisory board in the executive branch will work to identify areas of waste and federal budget savings in Medicare. Its recommendations must not ration care, raise taxes or change Medicare benefits.

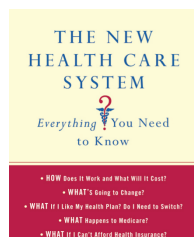
2018

HIGH-COST INSURANCE PLANS: Insurers will face a 40 percent excise tax on policies with premiums over \$10,200 for individuals or \$27,500 for family coverage.

Looking for more information on the health care legislation?

You can check out a new HHS Web site: www.healthcare.gov.

It also lists companies that offer insurance coverage, with prices available by Oct. 1.



Or take a look at a new book: **The New Health Care System: Everything You Need to Know**, by David Nather, a former reporter for the Congressional Quarterly and The Dallas Morning News.