	Patient Protection and Affordable Care Act merged with the Health Care and Education Reconciliation Act	Timeline
Overall Approach	*Phased in over the next 8 years. The bill includes an individual requirement to have health insurance, new state-based exchange to purchase coverage and for small employers to purchase coverage. Cost sharing for low-income individuals and tax credits for small employers. Employer mandates to provide coverage. New regulation on health plans and expansion of Medicaid.*	Many insurance reforms take effect right way Individual requirements, exchanges, subsidies and banning of pre existing conditions in 2014.
EMPLOYER REQUIREMENTS		
Requirements to Offer Coverage	*Employers with 50 or fewer employees are exempt from any of the requirements below.* Employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit are assessed a fee of $2,000 per employee (the first 30 employees are dropped from the payment calculation) Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% of the Federal Poverty Level (FBL), ($43,000 for an individual or $88,000 for a family of four), whose share of the premium exceeds 8% but is less than 9.5% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees who receive premium credits in the Exchange.	Effective: January 1, 2014
Waiting Period	*Employers cannot impose waiting periods of more than 90 days for employees to enroll in group health plans.*	Effective: January 1, 2014
Other	Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	Effective: January 1, 2014
PREMIUM & COST-SHARING SUBSIDIES TO INDIVIDUALS		
Eligibility	*Employees within 400% of FPL and receiving benefits from employer are eligible if the actuarial value of the plan is not at least 60% of the full actuarial value of the benefits of the plan or if the employee share of the premium exceeds 9.5% of income.* Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% of the benefits of the plan or if the employee share of the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.	Effective: January 1, 2014
PREMIUM SUBSIDIES TO EMPLOYERS		
Small Business Tax Credits	*Small businesses with 25 or fewer employees and average annual wages of less than $50,000 that purchase health insurance could be eligible for a tax credit. Employer must contribute 50% of coverage costs in order to obtain a maximum 50% credit for coverage costs for 2 years.* Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit. • Phase I: The credit phases-out as firm size and average wage increases. For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. • Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases.	Tax years 2010 – 2013 tax credit of 35% Tax years 2014 and later tax credit of 50% (for two years only)

	Patient Protection and Affordable Care Act merged with the Health Care and Education Reconciliation Act	Timeline
Reinsurance Program	Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program.	(Effective 90 days following enactment through January 1, 2014)
TAX CHANGES TO RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM		
Tax changes to health insurance	*Includes a tax penalty for individuals without coverage, limits contributions to FSAs and restricts purchases for over-the-counter products.* Impose a tax on individuals without qualifying coverage of the greater of $650 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014 • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2013) • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011) • Limit 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. (Effective January 1, 2011) • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. (Effective January 1, 2013) • Increase the Medicare Part A (hospital insurance) tax rate on unearned income on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly; funds deposited into the Medicare Part A Trust Fund. (Effective January 1, 2013)	FSA and HAS restrictions effective January 1, 2013 Itemized deduction and hospital insurance tax changes effective January 1, 2103
Tax changes related to health insurance – "Cadillac" Tax	*40% excises tax on "Cadillac" plans that have an aggregate value that exceeds $11,820 for individual coverage and $30,950 for family coverage for individuals in the construction industry.* Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $11,850 for individual coverage and $30,950 for family coverage (indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point). The same threshold amounts will for retired individuals age 55 and older who are not eligible for Medicare. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. (Effective January 1, 2013) Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments (Effective January 1, 2011)	Effective January 1, 2018
HEALTH INSURANCE EXCHANGES		
Creation and structure of health insurance exchanges	*Creates state-based exchange for individuals as well as ones for small businesses.* Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)	Must be established by January 1, 2014

	Patient Protection and Affordable Care Act merged with the Health Care and Education Reconciliation Act	Timeline
Benefit Tiers	*Four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets:* Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets: • Bronze plan represents minimum creditable coverage and provides the essential health benefits, covers 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010); • Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; • Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; • Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; • Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. Reduce the out-of-pocket limits for those with incomes up to 400% 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). These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.	Effective January 1, 2014
Insurance market and rating rules	Qualified plans must require guaranteed issue, renewal, allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchange. Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)	Some changes immediately and others in 2014.
BENEFIT DESIGN		
Essential benefits package	*Minimum plans would have to cover at least 60 percent of the actuarial value of covered benefits. Advisory Council will determine benefits package.* Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/ individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014) Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)	Effective January 1, 2014
CHANGES TO PRIVATE INSURANCE		
Temporary high-risk pool	*Temporary pool for high-risk individuals until exchanges are established.* Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)	Effective within 90 days of enactment until January 1, 2014
Medical loss ratio and premium rate reviews	Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)	Begins in 2010.

	Patient Protection and Affordable Care Act merged with the Health Care and Education Reconciliation Act	Timeline
Dependent coverage	*Young adults can remain on parents coverage.* Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)	Effective six months following enactment
Prevention/Wellness		
Coverage of preventive services	*Health plans must provide minimum services.* Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)	Effective six months following enactment
Construction – Physician Owned Hospitals		
Construction	*Restricts the construction and expansion of existing physician-owned hospitals.* Physician hospitals who have Medicare Certification in place by December 31, 2010 and who meet specific requirements within 18 months of the enactment of the legislation, will be grandfathered. Hospitals that do not meet these requirements, cannot add beds, ORs or procedure rooms (no physician owned hospital currently meets each of the requirements). For physician hospitals currently under construction, it is unclear whether they will be allowed to have new beds, new ORs and new procedure rooms certified upon completion.	Must meet certification by December 31, 2010
Workers Comp		
Workers Comp	*Will facilitate information sharing (benefits and payments) between insurance companies and workers compensation plan. Medicare uses this type of information sharing in an effort to shift claims from Medicare to worker's comp plans. It could facilitate claim shifting from private insurance to workers comp plans*	
FINANCING		
Financing	The Congressional Budget Office estimates the cost of the coverage components of the reconciliation bill in combination with the Patient Protection and Affordable Care Act to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. And Medicare tax increase from 1.45% to 2.35 for high-income taxpayers.	

Sources of Information:

From the Kaiser Family Foundation, the Patient Protection and Affordable Care Act (H.R. 3590), the Health Care and Education Reconciliation Act and supporting documents.