

2010

March 23, 2010

- **Medicare Rebate.** Provides a \$250 rebate for individuals in Medicare that have reached the Part D coverage gap.
- **Medicare Extension for Health Hazards.** Expands Medicare to individuals exposed to environmental health hazards in an area subject to an emergency declaration and have developed chronic health conditions as of June 17, 2009.
- **Premium Increase Justification.** Requires health plans to justify premium increases when subject to established review process. States must then report trends in premium increase and recommend if health plans should be excluded from the Exchange due to unjustified increases.
- **Tax Credit.** Gives a tax credit of up to 35% of premiums to small employers (those with no more than 25 employees and less than \$50,000 average annual wages) providing health insurance to employees.
- **Expanding the Healthcare Workforce.** Improves low-interest student loan programs, scholarships, and loan repayment programs for health students and professionals in hopes to bolster the healthcare workforce capacity and meet patient needs.
- **Public Health Professionals.** Appropriates \$60 million in fiscal year 2010 for scholarships to mid-career public health professionals, with annual appropriations through 2015.
- **Disadvantaged Health Professionals.** Appropriates \$60 million annually for fiscal year 2010 through 2014 for educational assistance in health professions to individuals from disadvantaged backgrounds.
- **National Health Care Workforce Commission.** Establishes a national Commission to better align federal resources with health care needs.
- **Nurse Managed-Health Clinics.** Initiates annual grants for nurse-managed health clinics, appropriating \$50 million for fiscal year 2010 and increasing thereafter.
- **National Health Service Corps.** Increases annual funding for the National Health Service Corps, appropriating \$320 million for fiscal year 2010 and up to \$1.1 billion in 2015 and increasing 1% annually thereafter.
- **Ready Reserve Corps.** Appropriates \$17.5 million annually for fiscal years 2010-2014 for a Ready Reserve Corps to address national emergencies and public health disasters.
- **Provider Screenings.** Enhances health care provider screenings procedures to address waste and fraud in healthcare system.
- **Generic Versions of Biologics.** Authorizes the FDA to approve generic versions of biologics after 12 years of exclusivity.
- **New Therapy Investment.** Creates a \$1 billion credit to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic disease.

- **Mental and Behavioral Health Education and Training Grants.** Appropriates \$35 million annually for fiscal year 2010 through 2013 for mental and behavioral health education and training grants.
- **Fellowship Training Grants.** Appropriates \$39.5 million annually for fiscal year 2010 through 2013 towards fellowship training grants in public health.
- **Early Detection Grants.** Appropriates \$23 million for the fiscal year 2010 through 2014, and \$20 million for each five-year period thereafter for grants toward early detection of medical conditions related to environmental hazards.
- **Patient-Centered Outcomes Research Institute.** Terminates the Federal Coordinating Council for Comparative Effectiveness Research and establishes the independent non-profit Patient-Centered Outcomes Research Institute to identify national priorities in comparing the effectiveness of treatments and strategies.
- **Teaching Health Centers.** Appropriates \$25 million in fiscal year 2010 and \$50 million annually for two years towards Teaching Health Centers to operate primary care residency programs.
- **Centers of Excellence.** Appropriates \$50 million annually for fiscal year 2010 through 2015 to expand Centers of Excellence with a particular focus towards expanding regional locations, helping to promote specialized treatment.
- **Medical Homes.** Requires the Department of Health and Human Services (HHS) to create programs to facilitate development of medical homes and other collaborative management.
- **Cure Acceleration Network.** Appropriates \$500 million in fiscal year 2010 towards Cure Acceleration Networks (CAN), which are to promote technologies that support the development of high need cures, helping move new medical cures through the development pipeline faster.
- **Prevention Efforts.** Establishes a \$15 billion Prevention and Public Health Fund to provide to sustain the national investment in public health and prevention programs.
- **Preventive Improvements.** Creates a Preventive Services Task Force and Community Preventive Services Task Force to develop, update, and disseminate evidence-based recommendations.
- **Wellness Services.** Establishes a five-year grant program to support delivery of evidence-based and community-based prevention and wellness services.

- **California Exchange.** Receive federal support for an existing, or newly established, consumer assistance office to operate the insurance Exchange, pending federal guidance
- **Insurance Premiums.** California will review health plan premium rates according to federal guidance

April 1, 2010

- **Medicaid Expansion.** Provides a state option that covers childless adults through a Medicaid state plan amendment (SPA).
- **FMAP.** Extends Medicaid federal match (FMAP) to cover MIAs up to 133% FPL.

- **Medi-Cal Expansion.** Makes necessary changes to state law for expanding coverage to newly eligibles, amending the Medi-Cal State Plan, and modifying the application and enrollment systems. The state is also required to define “benchmark benefits,” including “wraparound” benefits for children.
- **Federal Medical Assistance Percentage.** FMAP available to states for all individuals below 133% FPL (\$14,404 for an individual).
- **Dual-Eligibles.** California may pursue Home and Community-Based Service option for those eligible for both Medicare and Medi-Cal (aka Dual-Eligibles or Medi-Medis).

April 30, 2010

- **High-Risk Pool.** Deadline for the state to inform HHS of its intention to apply for a contract to operate California’s high-risk pool.

May 2010

- **Extending Dependent Coverage.** Selected health plans in California extend dependent coverage early to graduating college students.

June 1, 2010

- **Retiree Insurance.** Establishes a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare (*applications available June 1, 2010*).

June 23, 2010

- **Funding for Pre-Existing Conditions.** \$5 billion is available for uninsured individuals with pre-existing conditions to obtain insurance coverage in high-risk pools through 2014.
- **Temporary Re-insurance Program.** Creates a temporary re-insurance program for employers that provide benefits to retirees age 55 to 64 to help offset the costs of expensive health claims.

- **California Exchange.** Comptroller General must appoint CO-OP Advisory Board for insurance Exchange.

June 30, 2010

- **California High-Risk Pool.** Governor Schwarzenegger signs high-risk pool legislation into law.
- **Internet Portal.** HHS Internet portal for consumers to access information on coverage options goes live.

July 1, 2010

- **Web Improvement.** The Secretary of HHS must create an Internet website where individuals can identify affordable health insurance options offered in their state
- **Payment Protection for Rural Providers.** Extends Medicare payment protection to small rural hospitals with outpatient services, lab services, and those facilities playing a critical role in their communities.
- **Tanning Service Tax.** Applies a 10% tax on the amount of indoor tanning services (effective for services on or after *July 1, 2010*).

August 31, 2010

- **High-Risk Pool Applications.** MRMIB begins accepting names and information for those who think they might apply for high-risk pool in California.
- **§1115 Waiver.** California's current §1115 waiver expires.

September 1, 2010

- **Waiver Proposal.** Final date for California to submit final waiver proposal to the Centers for Medicare and Medicaid Services (CMS) for approval.
- **MIA Matching Funds.** All California counties express their intentions with respect to receipt of federal matching funds to cover MIAs up to 200% under a renewed §1115 waiver (*September 2010*).

September 23, 2010

- **Dependent Coverage Insurance Reform.** Extends dependent coverage up until age 26 for all individual and group policies.
- **Insurance Limitations.** Prohibits individual and group health plans from rescinding coverage and from imposing a lifetime limit on the dollar value of coverage. This excludes cases of fraud and certain annual limits as determined by the Secretary.
- **Appeals Process.** Requires new group and individual health plans to develop and implement an internal and external appeals process for coverage determination and claims.
- **Preventive Care.** Provides preventive care services, as rated by the U.S. Preventive Services Task Force, at no cost sharing for infants, children, adolescents, and women.
- **Pre-existing Conditions.** Bars employer and new individual health plans from imposing pre-existing condition exclusion on children's coverage (*applies to adults as of January 1, 2014*).
- **Medical Loss Ratio Reporting.** Requires health plans to report medical loss ratios (MLRs) in individual and small group markets.

- **Enrollment Standards.** HHS Secretary to develop secure standards and protocols for enrollment in federal and state health and human services programs.

- ****Adoption Credit.** Allows adopting families to receive an extra \$1,000 credit, which will be tax deductible (*effective until December 2011*).
- ****New Therapy Investment.** Creates a \$1 billion capped investment to encourage new therapies that prevent, diagnose, and treat acute and chronic disease (*Available for qualifying investments made in 2009 and 2010*).
- ****Blue Cross Blue Shield.** Requires that the non-profit organizations of Blue Cross Blue Shield keep their medical loss ratio at 85% to be eligible for tax credits.

2011

January 1, 2011

- **CLASS Program.** Creates a national insurance program to purchase community living assistance services and supports.
- **Medicare Prevention.** Eliminates all cost sharing for preventive services, as recommended by the U.S. Preventive Task Force, covered by Medicare and waives the deductible for colorectal cancer screening test.
- **Wellness for Medicare.** Provides personalized prevention plans and access to comprehensive health risk assessments to Medicare patients while also providing incentives for Medicare and Medicaid patients to complete behavior modification programs.
- **Medicare Bonus.** Provides a 10% Medicare bonus for health professionals, specifically primary care physicians and general surgeons, practicing in shortage areas (*effective through 2015*).
- **Medicare Payments.** Sets Medicare Advantage Plan payments to different percentages of Medicare fee-for-service rates.
- **Innovation in Medicare.** Establishes an Innovation Center within the Centers for Medicare and Medicaid Services.
- **Medical Home for Chronic Conditions.** Establish a new Medicaid state plan option to allow enrollees, with at least two chronic conditions to specify a provider as a health home, providing a 90% FMAP for two years for related services.
- **Wellness Programs.** Provide \$200 million in grants for up to five years to small employers to create wellness programs.
- **National Health.** Develops a National Prevention, Health Promotions and Public Health Council who will be required to develop a national strategy to improve the nation's health.
- **Workforce.** Addresses health care workforce shortage through a variety of loans, grants, and scholarships towards training programs.
- **Care Coordination.** Creates the Community-based Collaborative Care Network Program to support coordination and integration of health care services for low-income uninsured and underinsured populations.
- **Improving Access.** Provides \$1 billion funding for community health centers and \$1.5 billion for the National Health Services Corps over five year, creating new programs to support school-based health centers and nursed-managed health clinics.

- **Plans Report Amount Spent on Care.** Health Insurance and grandfather plans must report annual share of premiums dollars spent on medical care, and those totaling less than 80-85% of benefits must provide consumer rebate.
- **Pharmaceutical Fee.** Imposes an annual fee on the pharmaceutical manufacturer industry, excluding companies with sales of brand drugs totaling \$5 million or less.
- **Pharmaceutical Discount.** Pharmaceutical manufacturers must provide a 50% discount on brand name drugs filled in the Medicare part D coverage gap while phasing in federal subsidies for generic filled prescriptions.
- **Tax on Pharmaceutical Manufacturers.** Imposes \$2.5 billion fee on pharmaceutical manufacturers according to market share.
- **Health Savings Account.** Increases the tax on health savings account (HSA) withdrawals for non-qualified health expenditures from 10% to 20%.
- **Caloric Reporting for Restaurants and Vending Machines.** Requires chain restaurants and vending machines to display calorie information for each menu item.
- **Tobacco Programs.** Requires health plans to cover tobacco cessation programs for pregnant women.
- **Community Health Centers.** Increases funding for community health centers, \$1 billion in 2011 increasing to \$3.6 billion in 2015, with additional \$1.5 billion annually for infrastructure renovation.
- **Primary Care Training.** Allows unused residency training slots to be redistributed to increase primary care training in underserved areas.
- **State Tort Projects.** Appropriates \$50 million for state tort reform demonstration projects.
- **Reporting Value of Health Benefits on Tax Forms.** Requires employers to report the value of health benefits on each employee's FY 2011 W-2 tax form.
- **Simple Cafeteria Plan.** Establishes a Simple Cafeteria Plan to provide small business with a tax-free mechanism to provide benefits to their employees.
- **Geriatric Career Incentives.** Initiates \$10 million in annual funding towards geriatric career incentive rewards (*extends through 2013*).
- **NQIS Due.** Due date for an HHS National Quality Improvement Strategy.

- **Medical Home for Chronically Ill Medi-Medis.** California may pursue health homes for chronically ill dual-eligibles.

March 21, 2011

- **Exchange Planning Grants.** HHS must make available Exchange planning grants for states.

March 23, 2011

- **Private Health Plans.** HHS must develop a standardized format for benefits summary and coverage information for private health plans.

July 1, 2011

- **No Payment for Hospital Acquired Conditions.** Prohibits federal Medicaid payments for services related to hospital-acquired conditions.
- ****Medicare Cost-Sharing.** Prohibit higher cost sharing of Medicare Advantage Plans for some of the Medicare covered benefits than traditionally required in the fee-for-service program.
- ****Medicare Income Freeze.** Freeze threshold for income-related Medicare part B premiums at 2010 levels through 2019, and reduce subsidy for specified individuals (those with incomes above \$85,000/individual and \$170,000/couple).

October 1, 2011

- **Extending Medicaid Option.** State may pursue Medicaid Community First Choice Option.

2012

January 1, 2012

- **Safety Net Hospitals.** Provides pilot authority for an all-encompassing flat rate (or global capitated rate) payment to safety net hospitals (*effective fiscal years 2010-2012*).
- **At-Home Medicare.** Establishes the Medicare Independence at Home demonstration program for chronically ill Medicare patients. Programs are aimed towards improving health outcomes while reducing expenditures by creating payment incentives and new delivery systems composed of primary care teams, directed by physicians and nurse practitioners.
- **Integrated Care.** Enhanced payment for primary care services to act as an incentive to form Accountable Care Organizations (ACOs) that will assist in improving efficiencies and quality.
- **Hospitalization Bundle Payments.** Establishes demonstration projects that use bundle payments for care involving hospitalizations (*effective through December 31, 2016*).

March 23, 2012

- **Quality Reporting.** Requires HHS to set regulations on the requirements for health-plan quality reporting.
- **Standardized Benefit Summaries.** Requires health plans to provide standardized benefit summaries and coverage information for consumers.
- **Data Collection.** Requires improved data collection and reporting on race, ethnicity, sex, primary language, and disability status for underserved, rural, and frontier populations (*March 2012*).

October 1, 2012

- **Quality Improvement.** Create a hospital value-based purchasing program to help improve quality outcomes in acute care hospitals. The Secretary must submit a plan to

Congress outlining how to transition home health and nursing home providers into a value-based purchasing payment system.

- ****Mental Health Hospitals.** Provide Medicaid payments to mental health hospitals for the adult patients that require emergency stabilization of a condition (*effective through December 31, 2015*).

December 31, 2012

- **Elimination of Part D Subsidy.** Eliminates deduction for the subsidy for employers who have maintained prescription drug plans for eligible Medicare Part D retirees.
- ****Hospital Readmissions.** Requires CMS to track hospital readmission rates for high-volume and high-cost conditions while providing a new financial incentive for hospitals to make necessary changes to avoid preventable readmissions.
- ****Medicare Cost-Sharing.** Makes Part D cost-sharing for full-benefit dual eligible individuals, specifically those receiving home and community based care services, equal to that of individuals receiving institutional care.

2013

January 1, 2013

- **Medicaid Primary Care Payment Increase.** Requires that Medicaid payment rates to primary care physicians be no less than 100% of Medicare payment rates in 2013 and 2014. There is 100% federal funding to states for the incremental cost.
- **Care Collaboration.** Creates a national pilot program for payment bundling to encourage increased collaboration and care coordination between doctors, hospitals, and post-acute care providers to enhance Medicare savings.
- **Medical Device Tax.** Creates a 2.3% excise tax on the sale of medical devices by manufacturers or importers, excluding devices purchased by the public at retail price for individual use, such as with eye glasses, contact lenses, hearing aids, etc (*on sales made on or after January 1, 2013*).
- **Tax for Higher Paid Workers.** Imposes an increased hospital insurance tax rate by 0.9% on individuals earning over \$200,000 and \$250,000 for married individuals filing together. This also extends the taxable base to include net investment income for individuals earning over \$200,000 and \$250,000 for joint returns (*tax years beginning 2013 or later*).
- **Federal Subsidies for Prescriptions in Part D Donut Hole.** Requires the phasing-in of federal subsidies for brand-name prescription drugs within the Medicare Part D coverage gap (*Tax years beginning 2013 or later*).
- **Limitation on Executive Compensation Deduction.** Limits the deduction of executive compensation to \$500,000 per taxable year if at least 25% of the provider's premium income is from health plans meeting the minimum coverage requirements (*effective 2013 but applies to services performed after 2009*).

- **Special Needs.** Dual-eligible Special Needs Plans must contract with the state.

July 1, 2013

- **Insurance Exchange.** Requires HHS to begin awarding loans and grants for health insurance co-operatives. Co-Ops are non-profit, non-government, consumer-driven health plans that are owned and controlled by individuals and small businesses (who purchase the insurance), serving as an alternative to private insurance.

December 31, 2013

- **Temporary High-Risk Pool.** The temporary high-risk pool ends.
- ****Administration Standards.** Requires health plans to establish uniform standards and business rules as it relates to electronically exchanging health information.
- ****Health Flexible Savings Account.** Limits contributions to health FSAs to \$2,500 per year (*indexed by CPI for subsequent years*).

2014

January 1, 2014

- **Health Insurance Regulation.** Prohibits the discriminatory practices of insurance companies involving the sale and renewal of health plans based on health status, the exclusion of coverage for treatments based on pre-existing conditions, and increased rates due to health status, gender, etc. Premiums will only vary based on age (at no more than a 3.1 ratio), geography, family size, and tobacco use.
- **Medicaid Expansion.** Increases the eligibility for Medicaid to 133% the FPL for non-elderly individuals while also providing full federal funding to states to cover the expanded population.
- **Health Insurance Exchanges Launch.** Health Insurance Exchanges in every State to be opened to individuals and small businesses, allowing individuals to comparison shop when seeking affordable health coverage. Subsidies available in the form of refundable tax credits only through the Exchange.
- **Individual Mandate.** Requires an individual to have health insurance coverage or pay a set penalty of \$95 in 2014, \$325 in 2015, \$695 or 2.5% of income in 2016. The family penalty will be capped at \$2,250 and will pay half the amount for children. Individuals will not be penalized if affordable coverage is not available.
- **Employer Play-or-Pay.** Employers that have *at least one* employee purchasing insurance through the exchange and receiving a premium tax credit will be subject to a penalty. For employers *not* offering coverage, there will be a \$2,000 annual penalty for each full-time employee, receiving a premium credit, over the first 30 employees. For employers *offering* insufficient coverage, (defined as that which exceeds 9.5% of an employees income or coverage that pays for less than 60% of expenses) there will be a \$3000 annual penalty for each full-time employee, receiving a premium credit, over the first 30 employees.

- **Annual Limits.** Eliminates annual limits on the amount of coverage an individual can receive through employer and new individual health plans.
- **Clinical Trials.** Prevents health plans from dropping or denying routine care coverage if an individual decides to participate in a clinical trial that treat cancer or other life-threatening diseases.
- **Health Care Tax Credits.** Provides premium tax credits through the Exchange to individuals with incomes between 133-400% FPL who are not eligible for (or offered) acceptable coverage.
- **Small-Employer Tax Credit.** Continues the second phase of the tax credit for small employers who qualify.
- **Free-Choice Vouchers.** Provides free-choice vouchers for workers who do not qualify for tax credits but are contributing a high portion of their individual income to employer health plans. These vouchers allow an individual to utilize an Exchange health plan with their employer contribution.

- **Transition into Medi-Cal.** State is responsible for transitioning children ages 6-18 with family incomes between 100-133% FPL from the Healthy Families Program to Medi-Cal coverage.
- **Medically Indigent Adults.** Federal government will pay 100% of the cost of covering Medically Indigent Adults (MIAs) for three years; phase down starts with 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter (*effective through 2016*).
- **Modifications to Eligibility and Enrollment.** Changes in eligibility and enrollment rules must be applied, modifying adjusted gross income (AGI) formula for Medi-Cal and Health Families.
- **Simplification of Programs.** State must implement procedures to simplify the enrollment process of Medi-Cal and Healthy Families with one electronic application form .
- **End of MOEs for Adults.** Maintenance of Effort (MOE) requirements for adults covered by Medi-Cal expires. States may begin modifying Medi-Cal eligibility levels, standards, and income requirements.
- **Federal Risk Corridors.** Payment adjustments begin for health plans in Federal Risk Corridor.
- **Permanent Risk Adjustment Program.** State must establish a permanent risk adjustment program.
- **Transitional Temporary Reinsurance Program.** State must adopt model regulations and establish transitional temporary reinsurance program.

- ****Plan Fee.** Imposes an annual, non-deductible fee on health insurance plans whose net premiums written are more than \$25 million.
- ****Multi-State Option.** Creates a multi-state option that will be available through nationwide health plans supervised by the Office of Personal Management, giving individuals more choice of coverage.

2015

January 1, 2015

- **Quality-Over-Quantity Payment for Physicians.** Creates a physician value-based payment program to promote increased quality of care for Medicare recipients.
- **Continuing Innovation and Lower Health Costs. Establishes** an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector. Proposals are focused towards extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care.
- **Reducing Medicare Reimbursement Rates for Conditions Acquired in Hospitals.** Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1% (*effective fiscal year 2015*).

April 1, 2015

- **Transitioning Children.** Permits States to transition children who are eligible for Healthy Families to Medi-Cal or other coverage comparable to Medi-Cal in the Exchange. However, HHS must first certify that Exchange coverage is adequate.

September 30, 2015

- **CHIP Funding Ends.** The block grant that funds the Children's Health Insurance Program (CHIP) expires.

October 1, 2015

- **Children in the Exchange.** Permits States to start enrolling children who are eligible for Healthy Families into the Exchange.
- **Federal Matching for Healthy Families.** Allows the state to receive 88% matching rate for the Healthy Families Program.

2016

January 1, 2016

- **Option to Create Care Choice Compacts.** Permits states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact (*may not take effect before January 1, 2016*).

2017

January 1, 2017

- **Risk Corridor Payments Expire.** Ends the Federal risk corridor payments.

2018

January 1, 2018

- **“Cadillac Tax” Begins.** Imposes tax on the cost of coverage in excess of \$27,500 (family coverage) and \$10,200 (single coverage). It will be increased to \$30,950 (family) and \$11,850 (single) for retirees and employees in high-risk professions. Inflation is taken into account and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

2019

January 2019

- **Maintenance of Effort.** MOE requirements for children in Medicaid end. State may begin modifying Medi-Cal eligibility levels, standards, and income levels for children.

Note: ** indicates non-specified date for implementation, but is effective within listed year.

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