

TIMELINE FOR IMPLEMENTATION OF THE AFFORDABLE CARE ACT

2010:

NEW CONSUMER PROTECTIONS

- **Eliminated pre-existing coverage exclusions for children:** under age 19.
- **Prohibited insurers from dropping coverage:** for instance, it is now illegal for health insurers to search for an error on a customer's application or other technical mistake and use this error to stop covering people when they get sick; some insurers targeted cancer patients.
- **Eliminated lifetime dollar limits on insurance coverage.**
- **Regulated annual dollar limits on insurance coverage:** until 2014, when the use of annual limits on essential benefits will be banned.
- **Provided consumer protection in health insurance plans:** with an independent appeals process if insurers deny coverage.
- **Created transparent consumer website:** where consumers can compare health insurance options.

IMPROVING QUALITY AND LOWERING COSTS

- **Provided health insurance tax credits to small businesses:** up to 35 percent of the employer's contribution for employees' insurance; non-profit organizations pay up to 25 percent.
- **Helped subsidize Medicare prescription drug donut hole:** \$250 rebate for individuals who hit the gap in Medicare prescription drug coverage.
- **Covered preventive health-care benefits:** health insurance plans must cover certain preventive services such as mammograms and colonoscopies without cost-sharing charges (deductibles, co-payment, or coinsurance).
- **Reduced health-care fraud:** requiring new screening procedures for health-care providers to reduce fraud and waste.
- **Coordinated care for dual eligibles** (people eligible for both Medicare and Medicaid): established federal Coordinated Health Care Office to improve care coordination.
- **Established Patient-Centered Outcomes Research Institute:** to conduct outcomes research that compares the clinical effectiveness and appropriateness of different medical treatments.
- **Therapeutic discovery grants and tax credits:** to small medical product businesses for up to 50 percent of the investments costs in projects with the potential to produce new therapies, reduce long-term cost growth, or advance the goal of curing cancer.

INCREASING ACCESS TO AFFORDABLE CARE

- **Provided access to insurance for uninsured Americans with pre-existing conditions:** a transitional high-risk pool provides coverage to the uninsured with pre-existing conditions; states have the option of running their own temporary high risk pool or if a state chooses not to do so, a pool will be established by the federal government.
- **Extended health insurance coverage for young adults through their parents:** young adults allowed to stay on their parents' health insurance plan until age 26 unless they are offered insurance at work.
Problem Addressed: 1 in 3 young adults are uninsured (Kaiser, 2011).
- **Strengthened the primary care workforce:** incentives expanded the number of primary care physicians, nurses, and physician assistants; included funding for scholarships, loan repayments, and tax relief for working in medically underserved communities.
- **Reviewed health insurance plan premium increases:** States that require health insurers to justify their premium increases were eligible for federal grants (\$150 million); insurers with excessive or unjustified premium increases will not be able to participate in the new health insurance exchanges.
- **Changed Medicaid provider rates:** States received increased federal matching funds for Medicaid, making it easier for states to cover more of their residents.
- **Provided payments for rural health-care providers:** 68 percent of the nation's medically underserved communities are in rural areas (Kaiser, 2011) and these communities often have trouble attracting and retaining health-care professionals.
- **Changed Medicare provider rates:** reduced annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units and adjusts payments for productivity.
- **Expanded drug discount program for safety-net providers:** reduced drug costs 20 to 50 percent.
- **Authorized generic biologic drugs:** and granted biologics manufacturers 12 years of exclusive use before generics can be developed.
- **Established National Health Care Workforce Commission:** to coordinate federal workforce activities.
- **Strengthened community health centers:** for primary health-care programs to more than 4000 sites in low-income communities in inner cities and isolated rural areas.
- **Authorized permanent funding of the National Health Services Corps:** who have provided primary health-care in underserved communities since 1972; in exchange, the health-care professionals are given either loan repayments or scholarships throughout their medical education.
- **Expanded Medicaid & CHIP Payment Advisory Commission:** role to include assessments of adult health-care services.
- **Expanded Medicaid home and community-based services:** allows States to offer home and community-based services through Medicaid rather than institutional care in nursing homes.
- **Provided Medicaid coverage for childless adults:** up to 133% of the federal poverty level (\$14,500).
- **Increased Medicaid drug rebate:** percentage for brand-name drugs to 23.1 percent and to 13 percent of

average manufacturer price for non-innovator, multiple source drugs.

- **Established National Prevention, Health Promotion & Public Health Council:** to develop a national strategy.
- **Established Prevention & Public Health Fund:** to expand supply of primary care providers and support public health and prevention priorities (tobacco use, obesity, heart disease, stroke, and cancer; and to increase immunizations); \$5.0 billion (2010 through 2014) and \$2.0 billion thereafter.

HOLDING HEALTH INSURERS ACCOUNTABLE

- **Created temporary reinsurance program for retiree health insurance coverage:** for employers providing health insurance coverage to retirees over age 55 who were not eligible for Medicare (\$5 billion).

NEW HEALTH-CARE TAXES

- **Imposed new requirements on non-profit hospitals:** to conduct community needs assessments and offer financial assistance to the medically needy; tax of \$50,000 per year assessed for failure to meet these requirements.
- **Taxed indoor tanning services:** 10 percent tax.

2011:

IMPROVING QUALITY AND LOWERING COSTS

- **Prescription drug discounts:** people with Medicare insurance who fall in the coverage gap will receive a 50 percent discount when buying brand-name prescription drugs. Over the next ten years, additional savings will be offered until the coverage gap is completely closed in 2020.
- **Requires free preventive care under Medicare:** such as annual wellness visits and personalized prevention plans.
- **Establishes Center for Medicare & Medicaid Innovation:** to test new ways of delivering health-care to patients that improves the quality of care and reduces the rate of growth in costs for public insurance programs.
- **Improving care for seniors after they leave the hospital:** helps high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions to the hospital by coordinating care and connecting patients to services in their communities.
- **Establishes Independent Payment Advisory Board:** to target waste, reduce costs, improve health outcomes, and expand access to high-quality health-care.
- **National quality strategy report:** outlines six national priorities to improve the delivery of health care, patient health outcomes, and population health: patient safety; coordination of care; promotion of effective prevention and treatment practices (starting with cardiovascular disease); implementation of best practices; making quality care more affordable; ensuring patient-provider partnerships.
- **Prohibits Medicaid payments for hospital-acquired infections.**

- **Makes Medicare data available to the public for research.**

INCREASING ACCESS TO AFFORDABLE CARE

- **Increased access to services at home and in the community:** to the disabled through Medicaid rather than institutional care in nursing homes.
- **Established CLASS program:** a national, voluntary insurance program for purchasing community living assistance services and supports (premium-supported; not government-funded).
- **Strengthened community health centers.**
- **Chronic disease prevention in Medicaid:** provides 3-year grants to states to develop programs to provide the Medicaid insured with incentives to participate in comprehensive health lifestyle programs and meet certain health behavior targets (\$100 million).
- **Funded health insurance exchanges:** in seven states (\$49 million).
- **Increased graduate medical education:** training positions by redistributing unused slots and promotes training in outpatient settings.
- **Provides grants to establish wellness programs:** for small businesses.
- **Created Medicaid health homes:** permits the Medicaid insured with chronic conditions to designate a provider as a health home and provided states taking up the option with 90 percent federal matching payments for 2 years of integrated services.
- **Created Medicaid long-term care services:** to increase non-institutionally based long-term care services.
- **Authorized medical malpractice grants:** to states to develop, implement, and evaluate alternatives to current malpractice litigation (\$50 million).
- **Raised Medicare payments for primary care:** by 10 percent.
- **Eliminated cost-sharing for Medicare prevention services.**
- **Required nutritional labeling:** on standard menu items at chain restaurants and food sold from vending machines.
- **Established teaching health centers:** for primary care medical and dental residency programs in community-based ambulatory care centers.

HOLDING HEALTH INSURERS ACCOUNTABLE

- **Requires minimum medical loss ratios for health insurers:** to ensure premium dollars are spent on health-care, at least 80 to 85 percent of all premium dollars collected by health insurers must be spent on health-care services and quality improvement; insurers that spend too much on overhead must provide

rebates to consumers.

- **Changes Medicare Advantage program:** Medicare pays Medicare Advantage health insurers over \$1000 more per person on average than original Medicare. These additional payments are paid for in part by increased premiums paid by all Medicare beneficiaries, including 77 percent of seniors not enrolled in a Medicare Advantage plan. Medicare Advantage overpayments to health insurers were eliminated. Individuals in a Medicare Advantage plan still receive guaranteed Medicare benefits with bonus payments to plans that provide high quality care.
- **Provided funding for health insurance exchanges:** for States to begin planning for the establishment of exchanges which will facilitate the purchase of insurance by individuals and small businesses.

NEW HEALTH-CARE TAXES

- **Changed tax-free savings accounts.**
- **Raised Medicare premiums for higher-income beneficiaries.**

2012:

IMPROVING QUALITY AND LOWERING COSTS

- **Links Medicare payments to quality outcomes.** The law establishes a hospital Value-Based Purchasing program in traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures on treating heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care.
- **Encourages accountable care organizations in Medicare:** Provides incentives to integrate health systems so physicians join together to form accountable care organizations through which physicians can better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health-care system, they can keep some of the money that they have helped to save.
- **Reduces paperwork and administrative costs.** Health-care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care.
- **Combats persistent health disparities:** all Federal health programs must collect and report racial, ethnic, and language data.
- **Fraud and abuse prevention.**
- **Medicare value-based purchasing.**
- **Reduces Medicare payments for hospital readmissions:** to account for preventable readmissions.

INCREASING ACCESS TO AFFORDABLE CARE

- **Medicaid payment demonstration projects:**
- **Medicare Advantage plan payments:**
- **Medicare independence at home demonstration projects:**
- **Medicare provider payment changes:**
- **Establishes long-term care insurance:** creates a national, voluntary long-term care insurance program to provide cash benefits to adults who become disabled.

NEW HEALTH-CARE TAXES

- **Imposes annual fees on the pharmaceutical industry**

2013:

IMPROVING QUALITY AND LOWERING COSTS

- **Medicaid coverage of preventative services:** To expand the number of Americans receiving preventive care, new funding will be provided to state Medicaid programs that choose to cover preventive services for patients at little or no cost.
- **Pilot project for Medicare payment bundling:** A national pilot program will be established to encourage hospitals, physicians, and other providers to work together to improve the coordination and quality of patient care. Under payment bundling, hospitals, physicians, and providers will be paid a flat rate for an episode of care rather than the current fragmented system where each service or test is billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health-care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.
- **Financial disclosure:**
- **Closes the Medicare drug coverage gap:**

INCREASING ACCESS TO AFFORDABLE CARE

- **Medicaid Payments for Primary Care:** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government.
- **Extends CHIP:** to 2015 for children not eligible for Medicaid; increases outreach and enrollment grants to help reach more eligible children.

HOLDING HEALTH INSURERS ACCOUNTABLE

- **Fosters creation of co-op health insurance plans:** non-profit, member-run health insurance companies.

- **States provide notification to HHS regarding operation of health insurance exchanges:**

NEW HEALTH-CARE TAXES

- **Increases Medicare tax rate:** for Medicare Part A (hospital insurance) on wages by 0.9 percent (from 1.45 to 2.35 percent) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and imposes a 3.8% assessment on unearned income.
- **Taxes employers who fail to provide retiree health insurance coverage:** assesses a fee of \$2000 to \$3000 per full-time employee on employers that do not offer retirees' coverage.
- **Limits flexible spending accounts:** for medical expenses to \$2,500 per year, increased annually by the cost of living adjustment.
- **Limits itemized deductions for medical expenses:** increases the threshold for the itemized deduction for unreimbursed medical expenses by 2.5 percent (from 7.5 percent to 10 percent) of adjusted gross income; waives increase for individuals age 65 and older.
- **Taxes medical devices:** 2.3 percent.

2014:

NEW CONSUMER PROTECTIONS

- **Bans discrimination due to pre-existing conditions, gender or age:** prohibits health insurers from refusing to sell coverage or renew policies because of pre-existing conditions; also limits the ability of health insurers to charge higher rates due to health status, gender, or age.
- **Allows presumptive eligibility for Medicaid:** by hospitals for all Medicaid-eligible populations.
- **Guarantees availability of health insurance:** requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the health insurance exchanges.
- **Eliminates annual dollar limits on health insurance coverage:** prohibits health insurers from imposing annual dollar limits on the amount of coverage an individual may receive.
- **Ensures health insurance coverage for individuals participating in clinical trials:** health insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial; applies to all clinical trials that treat cancer or other life-threatening diseases.

IMPROVING QUALITY AND LOWERING COSTS

- **Provides health-care tax credits.** The act includes tax credits to make it easier for the middle class to afford insurance will become available for people with incomes above 100 percent and below 400 percent of poverty (\$43,000 for an individual or \$88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage; these individuals may also qualify for reduced cost-sharing (copayments, coinsurance, and deductibles).

- **Provides affordable basic health insurance:** through state health insurance exchanges; private insurance; will increase competition and consumer choice, make the nation's health insurance marketplace more transparent, and help bring down costs.
- **Expands small business tax credit:** up to 50 percent of the employer's contribution to provide health insurance for employees; up to 35 percent credit for small non-profit organizations.
- **Medicare payments for hospital-acquired infections:**
- **Provides health insurance premium and cost-sharing subsidies:**

INCREASING ACCESS TO AFFORDABLE HEALTH-CARE

- **Expands Medicaid coverage:** to Americans earning less than 133 percent of poverty (approximately \$14,000 for an individual and \$29,000 for a family of four); states will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years.
- **Mandates individuals have health insurance:** individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans; if affordable coverage is not available, individuals will be eligible for an exemption.
- **Provides free choice vouchers:** to employees who cannot afford the health insurance coverage provided by their employers, may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in an exchange.
- **Medicare Independent Payment Advisory Board report:**
- **Reduces Medicare disproportionate share hospital payments:** to hospitals serving high levels of uninsured and publicly insured populations.
- **Reduces Medicaid disproportionate share hospital payments**

HOLDING HEALTH INSURERS ACCOUNTABLE

- **Mandates health insurance coverage of essential health-care:** creates an essential health benefits package that provides a comprehensive set of services, limiting annual cost-sharing to the Health Savings Account limits (\$5,950/individual and \$11,900/family in 2010). Creates four categories of plans to be offered through the Health insurance exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover.
- **Medicare Advantage plan loss ratios:**
- **Creates temporary reinsurance program for health plans:** Creates a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- **Permits wellness program rewards:** employers may offer employees rewards of 30 to 50 percent of the cost of health insurance coverage for participating in a wellness program and meeting certain health-related standards.

NEW HEALTH-CARE TAXES

- **Employer requirements:** Assesses a fee of \$2,000 per full-time employee, excluding the first 30 employees, on 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. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees.
- **Fees on health insurance sector:**

2015:

INCREASING ACCESS TO AFFORDABLE HEALTH-CARE

- **Increases federal match for CHIP:**

IMPROVING QUALITY AND LOWERING COSTS

- **Pays providers based on value not volume:** providers who provide higher value care will receive higher payments than those who provide lower quality care.

2016:

HOLDING HEALTH INSURERS ACCOUNTABLE

- **Permits states to form health-care choice compacts:** allows health insurers to sell policies in any state participating in the compact.

2017:

NEW HEALTH-CARE TAXES

- **Taxes high-cost health insurance:** imposes an excise tax on insurers of employer-sponsored health plans with aggregate expenses that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

See National Institute Health-Care Management & Law (for a more detailed timeline explaining each provision, as well as the problem being addressed by each reform): <http://www.nih-cml.org>

Sources: 45 C.F.R. §§ 144, 146-147 (2011); Kaiser Family Foundation. (2011). *Implementation timeline*. Menlo Park, CA; White House. (2011); White House. (2011). *Health reform in action: About the law. The Affordable Care Act*. Washington, DC; White House .