Patient Protection and Affordable Care Act of 2010

Timeline of Key Provisions

This is a timeline for the implementation of major provisions found in the health care reform legislation. Additional provisions just passed in the Senate, those found in the "Reconciliation Bill" that originated in the House of Representatives. As is the case with most laws the provisions will be subject to interpretation in the rulemaking process which will define implementation details. The full text of the legislation can be found on the Government Printing Office website.

2010

--Begins to close the Medicare prescription drug plan "donut hole" by providing a $250 rebate to beneficiaries whose benefits run out (the donut hole will be completely filled by 2020, with increases in the rebates going up in the interim).

--Allows young adults to stay on their parent's health insurance plans until the age of 26.

--Prevents insurance companies from revoking coverage when beneficiaries experience severe illness and prevents them from setting lifetime limits on benefits.

--Prevents insurers from denying coverage to children who have pre-existing conditions.

--Provides nearly immediate access to high-risk pools for people who have no insurance due to pre-existing condition exclusions.

--Eliminates cost-sharing for preventive services in Medicare and new private plans.

--Makes available small business tax credits for qualified small employers for 35 percent of their contributions to purchase health insurance for employees. When Health Insurance Exchanges begin operating, tax credits will go up to 50 percent of premiums.

--The Secretary of Health and Human Services will be required, by July 1, to establish a website through which residents of any state may find affordable health insurance coverage options. The website will also include information for small business tax credits and other information to assist them.

--Establishes a Geographic Practice Cost Index practice expense floor and changes the calculation to one that is more favorable to low-cost areas.

2011

--Provides an annual wellness visit and personalized prevention plan for Medicare beneficiaries, free of charge.

--Provides 10 percent higher payments in Medicare for primary care physicians and general surgeons.

--Establishes the Medicare and Medicaid Innovation Center to test new payment and service delivery models that could reduce health care expenditures and increase the quality of care.

--Creates long-term care insurance programs that will be administered through voluntary payroll deductions.

--Establishes the Community Care Transitions Program that will focus on care transitions for high-risk Medicare beneficiaries.

--Begins to transition Medicare Advantage payments by freezing them at 2010 levels.

--Establishes a Graduate Medical Education policy that will allow unused training slots to be re-distributed to primary care.

--Employers will be required to disclose the value of the health insurance benefit they provide to employees on their annual W-2 form.

--Begins assessing the annual fee on the pharmaceutical manufacturing industry allocated according to market share. The annual fee will not apply to pharmaceutical companies with sales of $5 million or less.

2012

--Establishes a Medicare shared savings program that promotes accountability for a defined patient population of at least 5,000 coordinating items and services under parts A and B in order to encourage integration. Entities that invest in infrastructure and redesigned care processes to achieve this integration and accountability will be known as Accountable Care Organizations (ACOs). (AMGA was instrumental in getting language into the Act that will reward and incentivize the creation of ACOs).

--Establishes a hospital value-based purchasing program to incentivize quality outcomes for acute care hospitals. The Secretary of Health and Human Services will be required to submit a plan to Congress, by 2012, on ways to establish home health care and nursing home value-based purchasing payment systems.

--Requires the Centers for Medicare and Medicaid Services to track hospital readmission rates for certain high-cost conditions in order to encourage reductions in avoidable hospital readmissions.

2013

--The Secretary of Health and Human Services must design a pilot program to test bundled payments for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services.

--Incentivizes State Medicaid programs to cover evidence-based preventive services at no cost to beneficiaries.

--Requires states to reimburse primary care physicians in the Medicaid program at Medicare rates.

--Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent. Individuals 65 years of age and older would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

--Increases the hospital insurance tax rate by 0.9 percent for individuals that earn more than $200,000 annually, and married couples earning over $250,000 that file jointly. Taxes for those earning these amounts will also be expanded to include a 3.8 percent tax on net investment income.

--Establishes a 2.3 percent excise tax on the first sale of a medical device. Excepted products are eye glasses, contact lenses, hearing aids, and any device that is typically purchased by people at retail stores for individual use.

2014

--Remaining insurance reforms will take place. Insurance companies will no longer be able to discriminate on the basis of pre-existing health conditions or charge higher rates due to health status or gender. Premiums can vary only on the basis of age, geography, family size, and tobacco use. Annual limits on benefits will be prohibited.

--Establishes health insurance exchanges in each state for the individual and small group markets, allowing people to comparison shop for standardized health insurance plans.

--Provides a choice of coverage through a multi-state plan, available nationwide. These plans will be offered by private insurance carriers and be supervised by the Office of Personnel Management.

--Makes premium tax credits available through the Exchange to assist people in getting health coverage. Credits will be available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for, or offered, other coverage.

--Individual mandates to obtain health insurance begin. Penalties for not obtaining coverage are phased in as follows: $95 for 2014, $325 for 2015, $695 for 2016 (or up to 2.5 percent of income, whichever is greater). If affordable health coverage is not available to an individual, they will not be assessed the penalties.

--Employer mandates to insure employees begins, requiring employers with 50 or more employees who do not offer coverage to pay $2,000 annually for each full-time employee in excess of the first 30, as long as one of the employees receives a tax credit. Waiting periods of over 90 days for newly insured individuals will be prohibited.

--Expansion of Medicaid for individuals at 133 percent of poverty for all non-elderly individuals (under age 65). States will receive 100 percent federal funding for the first three years, with slight decreases after that time.

--Expansion of value-based purchasing to certain providers including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospice providers by requiring the Secretary of Health and Human Services to implement quality measure reporting and pilot test value-based purchasing for each of these providers.

--Assesses an annual, non-deductible fee on the health insurance industry, according to market share. This assessment will not apply to insurance companies that net premiums of less than $25 million.

--Establishes an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector to explore ways to extend the solvency of Medicare by lowering costs, improving outcomes, promoting quality, efficiency, and evidence-based health care.

2018

--Imposes a 40 percent excise tax on so-called “Cadillac Plans” for insurance companies and plan administrators for any health insurance plan that is above the threshold of $10,200 for self-only coverage and $27,500 for family plans.