Health Reform Implementation Timeline

The implementation timeline is an interactive tool designed to explain how and when the provisions of the Affordable Care Act will be implemented over the next several years.

You can show or hide all the changes occurring in a year by clicking on that year. Click on a provision to get more information. Customize the timeline by checking and unchecking specific topics.

provision by year

2010 (26 in total, 26 in effect)

Review of Health Plan Premium Increases
Requires the federal government to create a process, in conjunction with states, where insurers have to justify unreasonable premium increases. Provides guidance to states for reviewing premium increases.

Implementation: Plan year 2010

Implementation update: On August 16, 2010, HHS Secretary Kathleen Sebelius announced the award of $46 million to 45 states and the District of Columbia to improve their processes for reviewing health plan premium increases. On December 22, 2010, HHS issued a proposed rule on premium rate reviews. HHS announced availability of another $199 million in grants to states on February 24, 2011. The final rule for the insurance rate review program was published in the Federal Register on July 7, 2011, HHS released a list of states and territories with effective review programs in the private small group and individual markets, which it updates periodically; CMS will conduct the reviews in states without the authority or resources. On September 1, 2011, states and HHS will begin reviewing premium increases for 2012.

Changes in Medicare Provider Rates
Reduces annual market basket updates for inpatient and outpatient hospital, long-term care hospital, inpatient rehabilitation facilities, and psychiatric hospital and units and adjusts payments for productivity.

Implementation: Beginning fiscal year 2010; productivity adjustments added to market basket update in 2012

Implementation update: The Centers for Medicare and Medicaid Services issued several proposed and final rules reducing annual market basket updates for different provider types: inpatient hospital services (Final Rule August 16, 2010), outpatient hospital services (Final Rule August 16, 2010), long-term care hospital services (Final Rule August 16, 2010), inpatient rehabilitation facilities (Final Rule October 26, 2010), and skilled nursing facilities (Final Rule October 26, 2010).

**Qualifying Therapeutic Discovery Project Credit**

Provides tax credits or grants to employers with 250 or fewer employees for 50% of the investments costs in projects that have the potential to produce novel therapies, reduce long-term cost growth, or advance the goal of curing cancer in 30 years. The grant or tax is available for investments made in 2009 or 2010.

**Implementation**: Program established within 60 days of enactment

**Implementation update**: On June 7, 2010, the IRS announced the availability of credits and grants through the program. On May 21, 2010, the IRS released the program. Applications were due by July 21, 2010 and awards were announced on October 29, 2010. Nearly $1 billion in tax credits and grants have been issued through the program as of July 2012.

**Medicaid and CHIP Payment Advisory Commission**

Provides funding for and expands the role of the Medicaid and CHIP Payment Access Commission to include assessments of adult services in Medicaid.

**Implementation**: Funding appropriated for fiscal year 2010


**Comparative Effectiveness Research**

Establishes a non-profit Patient-Centered Outcomes Research Institute to conduct research that compares the clinical effectiveness of medical treatments.

**Implementation**: Funding appropriated beginning fiscal year 2010.

**Implementation update**: On September 23, 2010, The General Accounting Office announced the appointment of 19 members to the Board of Governors for the Patient-Centered Outcomes Research Institute (PCORI). In addition, the Director for Healthcare Research and Quality and the Director of the National Institutes of Health will serve on the 21-member Board. The PCORI website is available at http://www.pcori.org. On May 22, 2012, PCORI released a series of funding announcements.

**Prevention and Public Health Fund**

Appropriates $5 billion for fiscal years 2010 through 2014 and $2 billion for subsequent fiscal years to support prevention and public health programs.

**Implementation**: Funding appropriated beginning fiscal year 2010.

**Implementation update**: The Department of Health and Human Services has allocated $500 million in funding from the Prevention and Public Health Fund for fiscal year 2010. Half of this funding is dedicated to improving the supply of care providers and half will support public health and prevention priorities. On February 11, 2011, HHS announced $750 million in funds from the Prevention and Public Health Fund.
Public Health Fund to help prevent tobacco use, obesity, heart disease, strc cancer; and to increase immunizations.

Medicare Beneficiary Drug Rebate

Provides a $250 rebate to Medicare beneficiaries who reach the Part D cov1 in 2010. Further subsidies and discounts that ultimately close the coverage in 2011.


Implementation update: In May 2010, CMS issued a consumer brochure v information about the Medicare Part D coverage gap. In June 2010, the first checks were sent to Medicare beneficiaries who reached the Medicare Part coverage gap, more commonly known as the "doughnut hole." As of March 3.8 million beneficiaries had received a $250 check to close the coverage gap, according to an HHS report.

Small Business Tax Credits

Provides tax credits to small employers with no more than 25 employees an average annual wages of less than $50,000 that provide health insurance for employees. Phase I (2010-2013): tax credit up to 35% (25% for non-profits) employer cost; Phase II (2014 and later): tax credit up to 50% (35% for non-employer cost if purchased through an insurance Exchange for two years.

Implementation: January 1, 2010

Implementation update: The Internal Revenue Service (IRS) sent postcards to businesses alerting them to the availability of the new tax credit. The IRS also created a fact sheet for small businesses to determine whether they are eligible for the tax credit and a draft form for claiming the tax credit. On December 2, 2010, IRS released guidance on the tax credits and the form that small businesses can use to claim the credits.

Medicaid Drug Rebate

Increases the Medicaid drug rebate percentage for brand name drugs to 23 (except the rebate for clotting factors and drugs approved exclusively for use increases to 17.1%) and to 13% of average manufacturer price for non-multiple source drugs. Extends the drug rebate to Medicaid managed care.

Implementation: January 1, 2010 for increase in Medicaid drug rebate percent March 23, 2010 for extension of drug rebate to Medicaid managed care plans.

Implementation update: The Centers for Medicare and Medicaid Services State Medicaid Directors Letter on April 22, 2010 explaining the new rules. On November 11, 2010 and September 28, 2010, CMS issued letters to state Medicaid directors with additional guidance on the prescription drug rebates. On January 6, 2011, CMS issued another letter with further changes pursuant to the ACA.

Coordinating Care for Dual Eligibles

Establishes the Federal Coordinated Health Care Office to improve care coordination for dual eligibles (people eligible for both Medicare and Medicaid).

Implementation: March 1, 2010
Implementation update: The Federal Coordinated Health Care Office was established on September 2010. On December 30, 2010, CMS issued a notice in the Federal Register announcing the establishment of the Federal Coordinated Health Care Office. On May 11, 2011, CMS issued a fact sheet detailing the states that received contracts for up to $1 million to "design new integrated care model people enrolled in Medicare and Medicaid."

Generic Biologic Drugs

Authorizes the Food and Drug Administration to approve generic versions of drugs and grant biologics manufacturers 12 years of exclusive use before generic drugs can be developed.

Implementation: March 23, 2010

Implementation update: On November 2-3, 2010, the Food and Drug Administration held a public hearing to obtain input on the issues and challenges related to implementing the Biologics Price Competition and Innovation Act of 2009, which is included in the health reform law. On October 5, 2010, HHS issued a request for comment notice in the Federal Register on the approval process for biosimilars.

New Requirements on Non-profit Hospitals

Imposes additional requirements on non-profit hospitals to conduct community assessments and develop a financial assistance policy and impose a tax of $1 per year for failure to meet these requirements.

Implementation: March 23, 2010

Implementation update: On May 27, 2010, the Internal Revenue Service issued a notice requesting comment on the new requirements for non-profit hospitals. In 2012, the IRS issued proposed regulations which provide information or requirements for charitable hospitals relating to financial assistance and emergency medical policies, billing, and collections.

Medicaid Coverage for Childless Adults

Creates a state option to provide Medicaid coverage to childless adults with incomes up to 133% of the federal poverty level. (States will be required to provide this coverage in 2014.)

Implementation: April 1, 2010

Implementation update: On April 9, 2010, the Centers for Medicare and Medicaid Services issued a letter to State Health Officials and Medicaid Directors providing guidance on the new optional Medicaid coverage for childless adults with incomes up to 133% of the federal poverty level. Connecticut, the District of Columbia, and Minnesota have received approval to provide this optional coverage.

Reinsurance Program for Retiree Coverage

Creates a temporary reinsurance program for employers providing health insurance to retirees over age 55 who are not eligible for Medicare.

Implementation: 90 days following enactment until January 1, 2014

Implementation update: The Department of Health and Human Services began accepting applications for the Early Retiree Reinsurance Program on June 2, and approved more than 5,000 employer and union plans by the end of December 2012.
2010. HHS is continuing to accept until May 5, 2011. On December 14, 201 issued a notice stating that claims incurred after December 31, 2011 would be accepted. On April 19, 2013, CMS issued a notice that the program would be accepted.

Pre-existing Condition Insurance Plan
Creates a temporary program to provide health coverage to individuals with existing medical conditions who have been uninsured for at least six months. The plan will be operated by the states or the federal government.

**Implementation:** Enrollment into the federal plan began July 1, 2010; implementation dates for the state-operated plans vary.

**Implementation update:** The federal government is operating PCIP programs in the states and the District of Columbia, while the remaining states are running their own programs. On July 30, HHS released interim rules for the PCIP programs. On November 5, 2010, HHS announced new plan options for 2011 that include premiums for the federally administered programs. As of March 2011, 18,000 individuals had enrolled in a PCIP program.

**Learn more:** Learn more about protections for people with pre-existing conditions and our Health Reform FAQ page and view the enrollment data for PCIP plans in states.

New Prevention Council
Creates the National Prevention, Health Promotion and Public Health Council to develop a national prevention, health promotion and public health strategy.

**Implementation:** First report due July 1, 2010.


Consumer Website
Requires the Department of Health and Human Services to develop an interactive website to help residents identify health coverage options.

**Implementation:** July 1, 2010.

**Implementation update:** On July 1, 2010, HHS launched a new consumer-focused health care website, healthcare.gov, and on September 8, 2010, HHS launched the Spanish-language version of the site. On October 1, 2010, HHS added new information on private insurance coverage and premiums to the site.

Tax on Indoor Tanning Services
Imposes a tax of 10% on the amount paid for indoor tanning services.

**Implementation:** July 1, 2010.
Implementation update: On June 15, 2010, the Internal Revenue Service implemented regulations implementing the new tax on indoor tanning services effective June 1, 2010. The first payments were due November 1, 2010.

Expansion of Drug Discount Program
Expands eligibility for the 340(B) drug discount program to sole-community critical access hospitals, certain children’s hospitals, and other entities.

Implementation: Applications accepted beginning August 2, 2010

Implementation update: On June 28, 2010, the Health Resources and Services Administration began enrolling newly eligible organizations into the 340(B) discount program.

Adult Dependent Coverage to Age 26
Extends dependent coverage for adult children up to age 26 for all individual group policies.

Implementation: Plan or policy years beginning on or after September 23, 2010.

Implementation update: On May 13, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations allowing adult children to remain on their parents’ health plan until age 26. This new provision takes effect for new and existing plans when they renew on or after September 23, 2010.

Learn more: How does the provision that allows young adults to remain on parent’s insurance work? Learn more on our Health Reform FAQ.

Consumer Protections in Insurance
Prohibits individual and group health plans from placing lifetime limits on the value of coverage, rescinding coverage except in cases of fraud, and from excluding children coverage based on pre-existing medical conditions or from including existing condition exclusions for children. Restricts annual limits on the dollar coverage (and eliminates annual limits in 2014).

Implementation: Plan or policy years beginning on or after September 23, 2010 (annual limits eliminated in 2014)

Implementation update: On June 28, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations implementing several consumer protection provisions in the health reform law. Certain of the provisions take effect for new plans and existing plans when they renew on or after September 23, 2010. Other provisions only apply to new plans established on or after September 23, 2010.

Insurance Plan Appeals Process
Requires new health plans to implement an effective process for allowing consumers to appeal health plan decisions and requires new plans to establish an external review process.

Implementation: Plan or policy years beginning on or after September 23, 2010.

Implementation update: On July 23, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations requiring standardized internal processes for consumers to appeal health plan decisions. These rules apply to new plans established on or after September 23, 2010. On November 17
HHS issued a request for information notice on the external review of health insurance claims. On August 4, 2011, HHS released a list of states with app external review processes.

Coverage of Preventive Benefits
Requires new health plans to provide at a minimum coverage without cost-sharing 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.

Implementation: Plan or policy years beginning on or after September 23, 2010

Implementation update: On July 19, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) issued regulations on the new preventive benefits coverage requirements. These rules apply to new plans established on or after September 23, 2010. On August 1, 2010, the U.S. Preventative Services Task Force released its recommendations. On July 19, 2011, the Institute of Medicine released its report that recommended several women's preventive services that should be included in health plans with no cost-sharing. On August 1, 2011, HHS issued final regulations on preventive services, including requirements that insurers provide birth control with no cost-sharing. On August 3, 2011, HHS issued an amendment to the final regulations. On February 15, 2012, HHS issued final rules "authorizing exemption of group health plans and group health insurance coverage sponsored by certain religious employers from having to cover certain preventive health services, including contraceptive services, with no cost-sharing."

Also on February 15, 2012, HHS issued an issue brief estimating that 54 million Americans had received preventive benefits without cost-sharing. On August 3, 2011, HHS began requiring most new and renewing health plans to provide women preventive health services, including contraception, with no cost-sharing. HHS announced in a brief estimating that 47 million women will receive coverage for these services without cost sharing.

Health Centers and the National Health Service Corps
Permanently authorizes the federally qualified health centers and NHSC programs and increases funding for FQHCs and for the NHSC for fiscal years 2010-2012.

Implementation: Funding appropriated beginning fiscal year 2010

Implementation update: On October 8, 2010, HHS announced grant awards totaling $143 million to 143 community health centers for infrastructure improvements and on October 26, 2010, HHS announced the availability of an additional $335 million to existing community health centers to expand medical services.

Health Care Workforce Commission
Establishes the National Health Care Workforce Commission to coordinate workforce activities and make recommendations on workforce goals and policies. It also establishes the National Center for Health Workforce Analysis to undertake regional workforce data collection and analysis.

Implementation: Initial appointments to the National Health Care Workforce Commission on September 30, 2010

Implementation update: On September 30, 2010, the Government Accountability Office announced the appointment of 15 members of the National Health Care Workforce Commission.
Medicaid Community-Based Services

Provides states with new options for offering home and community-based services through a Medicaid state plan amendment to certain individuals and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.

Implementation: October 1, 2010

Implementation update: On August 6, 2010, the Centers for Medicare and Medicaid Services issued a letter to State Medicaid Directors providing guidance on flexibility to provide home and community-based services through Medicaid.

2011 (20 in total, 18 in effect)

Minimum Medical Loss Ratio for Insurers

Requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers if the percentage of the premium spent on clinical services and quality is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.

Implementation: Requirement to provide rebates begins for coverage purchased in 2011, with the rebates issued to enrollees the year following (e.g., 2011 rebate to be provided in 2012).

Implementation update: On November 22, 2010, the Department of Health and Human Services issued an interim final rule on medical loss ratio (MLR) requirements that will apply to plans in the small and large group markets and individual insurance companies. Several states have gotten temporary waivers from the Department of Health and Human Services and are exempt from the MLR requirements for a specific period of time. On December 16, 2011, HHS published a final rule in the Federal Register on medical loss ratio (MLR) requirements and an interim final rule on medical loss ratio requirements for federal government plans. On May 16, 2012, HHS published a final rule in the Federal Register that “establishes a simple, straightforward notice requirements for health insurers that meet or exceed the MLR standards established by the Affordable Care Act.”

Closing the Medicare Drug Coverage Gap

Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begins phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap. In 2013, begins phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (reducing coinsurance from 100% in 2010 to 25% in 2020, in addition to the 50% manufacturer brand-name discount).

Implementation: January 1, 2011 (drug discount) and January 1, 2013 (federal subsidies)

Implementation Update: On December 17, 2010, CMS sent a letter to pharmaceutical companies providing operational guidance for pharmaceutical manufacturers participating in the Medicare Coverage Gap Discount Program. According to the guidance, the Discount Program became effective January 1, 2011. On June 28, 2011, CMS announced that nearly 500,000 people had received the 50% discount.
discount on their brand-name prescription drugs, with an average savings of beneficiary. As of August 4, 2011, 500,000 Medicare beneficiaries who hit the prescription drug doughnut hole received a 50 percent discount on their pre:

On April 15, 2011, HHS issued a final rule specifying the details of the federal program.

Medicare Payments for Primary Care

Provides a 10% Medicare bonus payment for primary care services; also, a 10% Medicare bonus payment to general surgeons practicing in health professional shortage areas.

Implementation: January 1, 2011 through December 31, 2015

Implementation update: On November 29, 2010, CMS published a final rule implementing the 10 percent incentive payment for primary care services.

Medicare Prevention Benefits

Eliminates cost-sharing for Medicare-covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force or the Medicare deductible for colorectal cancer screening tests; authorizes Medicare coverage for a personalized prevention plan, including a comprehensive health assessment.

Implementation: January 1, 2011

Implementation update: On November 29, 2010, CMS published a final rule augmenting the benefits for the "Initial Preventive Physical Examination," an essential part of developing a prevention plan for the patient. On December 1, CMS released a Medicare Consumer Guide to Preventative Services, including services that will no longer require cost-sharing (co-pays) in 2011 as a result of health reform law. As of October 6, 2011, CMS reported that 20.5 million people participated in the free Annual Wellness Visit or received other preventive services with no cost-sharing.

Center for Medicare and Medicaid Innovation

Creates the Center for Medicare and Medicaid Innovation to test new payment and delivery system models that reduce costs while maintaining or improving quality of care.

Implementation: Center established by January 1, 2011

Implementation update: On November 17, 2010, CMS issued a notice annulling the establishment of the Center for Medicare and Medicaid Innovation in its organization. On January 26, 2012, CMMI released a report outlining the initial ideas introduced by the center.

Medicare Premiums for Higher-Income Beneficiaries

Freezes the income threshold for income-related Medicare Part B premiums through 2019 at 2010 levels resulting in more people paying income-related premiums, and reduces the Medicare Part D premium subsidy for those with income above $85,000/individual and $170,000/couple.

Implementation: January 1, 2011
Restructures payments to private Medicare Advantage plans by phasing-in a set at increasingly smaller percentages of Medicare fee-for-service rates; for 2011 payments at 2010 levels; and prohibits Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits required under the traditional fee-for-service program.

Implementation: January 1, 2011

Implementation update: On November 11, 2010, CMS issued guidance to Medicaid Directors regarding health homes for Medicaid enrollees. As of March 2011, CMS has approved health home state plan amendments for eight states, and others have taken steps toward developing health homes.

Chronic Disease Prevention in Medicaid
Provides 3-year grants to states to develop programs to provide Medicaid enrollees with incentives to participate in comprehensive health lifestyle programs and certain health behavior targets.

Implementation: January 1, 2011

Implementation update: On February 24, 2011, the Centers for Medicare & Medicaid Services announced the availability of $100 million in grants for states to offer incentives to Medicaid beneficiaries who participate in prevention programs to demonstrate improvements in health risk and outcomes. On September 13, CMS awarded grants to ten states to create statewide programs to prevent disease in both rural and urban areas.

National Quality Strategy
Requires the Secretary of the federal Department of Health and Human Services to develop and update annually a national quality improvement strategy that in priorities to improve the delivery of health care services, patient health outcomes, and population health.

Implementation: Initial strategy due to Congress by January 1, 2011

http://kff.org/interactive/implementatio

Changes to Tax-Free Savings Accounts
Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a Health Reimbursement Account or health Flexible Spending Account and from being reimbursed on a tax-free basis through a Health Savings Account or Archer Medical Savings Account. Increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the amount used.

Implementation: January 1, 2011

Implementation update: On September 3, 2010, the IRS issued guidance on changes on health flexible spending accounts including Health Reimbursement Accounts and health Flexible Spending Accounts noting that over-the-counter medicines prescribed by a doctor could be reimbursed by these tax-savings accounts.

Grants to Establish Wellness Programs
Provides grants for up to five years to small employers that establish wellness programs.

Implementation: Funds have yet to be awarded due to budget debates related to Prevention and Public Health Fund.

Teaching Health Centers
Establishes Teaching Health Centers and provides payments for primary care residency programs in community-based ambulatory patient care centers.

Implementation: Funding appropriated for five years beginning in fiscal year 2010.


Medical Malpractice Grants
Authorizes $50 million for five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Implementation: Authorizes funding beginning fiscal year 2011.

Implementation Update: The Agency for Healthcare Research and Quality seven demonstration grants for a total amount of $19.7 million in June 2010 funded thirteen planning grants for a total amount of $3.5 million.

Funding for Health Insurance Exchanges
Provides grants to states to begin planning for the establishment of America Benefit Exchanges and Small Business Health Options Program Exchanges to facilitate the purchase of insurance by individuals and small employers.
Implementation: Grants awarded starting March 23, 2011; applications will accepted through October 15, 2014

Implementation update: On September 30, 2010, HHS awarded states $4 to help plan the health insurance Exchanges. On February 17, 2011, HHS a "early innovator" grants to seven states. As of April 2013, HHS has awarded $3.6 billion to states to fund implementation of the exchanges.

Learn more: Which states have received grants to establish their health insurance exchanges? Browse exchange data and more in our State Health Facts section.

Nutritional Labeling
Requires disclosure of the nutritional content of standard menu items at chain restaurants and food sold from vending machines.

Implementation: Delayed

Implementation update: On January 21, 2011, the Food and Drug Administration withdrew the draft guidance it had previously issued and announced it will undertake a notice and comment rulemaking process. On April 6, 2011, the FDA published proposed rules in the Federal Register on nutritional labeling for vending machine and chain restaurants. Establishments whose primary purpose is not selling such as movie theaters and bowling alleys, were exempted from the regul

Medicaid Payments for Hospital- Acquired Infections
Prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections.

Implementation: July 1, 2011

Implementation update: On June 6, 2011, the Centers for Medicare and Medicaid Services issued a final rule that prohibits federal Medicaid payments to states for hospital-acquired infections.

Graduate Medical Education

Increases the number of Graduate Medical Education (GME) training positions, redistributing currently unused slots and promotes training in outpatient settings.

Implementation: July 1, 2011

Implementation update: On November 29, 2010, the Department of Health and Human Services issued a final rule establishing a methodology for determining payments to hospitals for the direct costs of approved graduate medical education programs. The final rule also clarifies whether hospitals can be paid for situations in which one hospital incurs the costs of training medical residents at nonproviding settings. On March 14, 2011, CMS issued an interim final rule making revisions and increases to caps on payments to hospitals for residents.

Medicare Independent Payment Advisory Board

Establishes an Independent Advisory Board, comprised of 15 members, to provide legislative proposals containing recommendations to reduce the per capita growth in Medicare spending if spending exceeds targeted growth rates.

Implementation: Funding available October 1, 2011; first recommendations January 15, 2014

http://kff.org/interactive/implementation-timeline/
Medicaid Long-Term Care Services

Creates the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services and establishes the Community First Choice Option in Medicaid to community-based attendant support services to certain people with disabilities.

**Implementation:** October 1, 2011

**Implementation update:** On February 22, 2011, the Centers for Medicare & Medicaid Services issued a proposed rule to allow states to provide home and community-based attendant services and supports through the Community First Choice Medicaid State plan option. On May 7, 2011, CMS issued a final rule. October 1, 2011, CMS had approved Balancing Incentives Program applications from nine states.

### 2012 (11 in total, 10 in effect)

#### Accountable Care Organizations in Medicare

Allows providers organized as accountable care organizations (ACOs) that meet quality thresholds to share in the cost savings they achieve for the Medicare program.

**Implementation:** January 1, 2012

**Implementation update:** On April 7, 2011, the Department of Health and Human Services published a proposed rule in the Federal Register defining Accountable Care Organizations and set out requirements for governance, legal structures, transparency efforts, and the incorporation of evidence-based medicine and efforts. HHS also released facts sheets for providers and consumers, as well as sheets on legal issues and quality scoring in ACOs. The Federal Trade Commission and Department of Justice issued a joint policy statement on antitrust issues to ACOs. On May 20, 2011, CMS issued a request for applications for the Pioneer ACO Program, which is targeted at organizations that can demonstrate the improvements in quality and cost-savings of a mature ACO.

On December 19, 2011, CMS announced 32 health care organizations that participate in the new Pioneer Accountable Care Organization project.

On January 10, 2013, HHS announced that 106 new ACOs had been formed for the Medicare Shared Savings Program, bringing to 250 the total number of ACOs established since enactment of the ACA.

#### Uniform Coverage Summaries for Consumers

This provision of the Affordable Care Act (ACA) that requires private individual and group health plans to provide a uniform summary of benefits and coverage for all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and understand their coverage when they enroll.

**Implementation:** The provision applies to all individual and group health plans regardless of whether they are grandfathered or not, and takes effect by July 23, 2012.
Implementation Update: On August 19, 2011, the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury issued proposed regulations on the Summary of Benefits and Coverage disclosure required of health insurers. On February 9, 2012, HHS issued final regulations, a template, and a glossary.

Medicare Advantage Plan Payments
Reduces rebates paid to Medicare Advantage plans and provides bonus payments to high-quality plans.


Medicare Independence at Home Demonstration
Creates the Independence at Home demonstration program to provide high-quality primary care services in their homes.

Implementation: January 1, 2012

Implementation update: On December 21, 2011, the Center for Medicare and Medicaid Services published a notice in the Federal Register that creates the demonstration project using "physician and nurse practitioner directed home primary care teams."

Medicare Provider Payment Changes
Adds a productivity adjustment to the market basket update for certain provider services resulting in lower rates than otherwise would have been paid.

Implementation: On May 5, 2011, CMS issued a proposed rule announcing changes to the prospective payment systems for inpatient hospitals and long-term care hospitals and the 2012 payment rates. On August 18, 2011, CMS issued a final rule on the payment changes and new payment rates.

Fraud and Abuse Prevention
Establishes procedures for screening, oversight, and reporting for providers and suppliers that participate in Medicare, Medicaid, and CHIP; requires additional entities to register under Medicare.


Implementation update: On February 2, 2011, the Centers for Medicare and Medicaid Services issued a final rule implementing fraud and abuse prevention initiatives in Medicare, Medicaid, and CHIP. On March 23, 2011, CMS published a notice regarding the fee that new providers and providers updating their info would have to pay in order to fund fraud screening efforts.

Annual Fees on the Pharmaceutical Industry

http://kff.org/interactive/implementation-timeline/
Imposes new annual fees on the pharmaceutical manufacturing sector.

**Implementation:** January 1, 2012.

**Implementation Update:**

On August 15, 2011, the Internal Revenue Service issued temporary regulations to provide guidance on the annual fee imposed on pharmaceutical companies. November 29, 2012, the IRS issued guidance on the branded prescription drug fee for the 2013 fee year.

**Medicaid Payment Demonstration Projects**

Creates new demonstration projects in Medicaid for up to eight states to pay for payments for episodes of care that include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in savings.

**Implementation:** January 1, 2012 through December 31, 2016

**Implementation Update:** Funds for bundled payments for episodes of care include hospitalizations and to allow pediatric medical providers organized as accountable care organizations to share in cost-savings have yet to be appropriated.

**Data Collection to Reduce Health Care Disparities**

Requires enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

**Implementation:** March 23, 2012

**Implementation update:** On June 30, 2011, HHS published a request for comment in the Federal Register on the proposed data collection standards for race, ethnicity, sex, primary language and disability status.

**Medicare Value-Based Purchasing**

Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and requires plans to develop value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

**Implementation:** October 1, 2012.

**Implementation update:** On January 13, 2011, the Centers for Medicare and Medicaid Services issued a proposed rule that would implement a value-based purchasing program for hospitals in Medicare. On May 6, 2011, CMS published a final rule on the value-based purchasing program.

**Reduced Medicare Payments for Hospital Readmissions**

Reduces Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions.

**Implementation:** October 1, 2012

On August 18, 2011, CMS issued a final rule outlining the Hospital Readmissions Reduction Program, which, under the Affordable Care Act, "payments to the hospitals under section 1886(d) of the Act will be reduced to account for certain excess readmissions." The final rule includes "(j) Those aspects of the Hospital Readmissions Reduction Program..."
Readmissions Reduction Program that relate to the conditions and readmissions which the Hospital Readmissions Reduction Program will apply for the first year beginning October 1, 2012; (ii) the readmission measures and related methodology used for those measures, as well as the calculation of the readmission rates; and (iii) public reporting of the readmission data.

### 2013 (14 in total, 10 in effect)

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<td>States indicate to the Secretary of HHS whether they will operate an American Benefit Exchange.</td>
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<tr>
<td><strong>Implementation:</strong> January 1, 2013</td>
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<tr>
<td><strong>Implementation Update:</strong> On May 16, 2012, HHS issued a Blueprint that states submit to HHS by November 16, 2012 if they wish to operate a state-based or a Partnership exchange. On November 15, 2012, the Obama administration extended the deadline for submitting a state-based exchange blueprint to December 14, 2012 and set February 15, 2013 as the deadline for submitting a blueprint to participate in a partnership exchange. Seventeen states and DC notified HHS they planned to run a state-based exchange and another seven states indicated they will run a partnership exchange.</td>
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<tr>
<td><strong>Learn more:</strong> Where are states in establishing and implementing their health insurance exchanges? Track state actions with our Exchange Monitor.</td>
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<tr>
<th>Medicare Bundled Payment Pilot Program</th>
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<tr>
<td>Establishes a national Medicare pilot program to develop and evaluate making bundled payments for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.</td>
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<tr>
<td><strong>Implementation:</strong> January 1, 2013</td>
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<tr>
<td><strong>Implementation Update:</strong> On August 24, 2011, CMS issued a notice explaining the pilot program would work. On January 31, 2013, CMS issued a press release announcing that over 500 organizations were chosen to participate in the Bundled Payments for Care Improvement initiative.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Medicaid Coverage of Preventive Services</th>
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<tbody>
<tr>
<td>Provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations.</td>
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<tr>
<td><strong>Implementation:</strong> January 1, 2013</td>
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<tr>
<td><strong>Implementation Update:</strong> On February 1, 2013, The Centers for Medicare and Medicaid Services issued a letter to state Medicaid directors providing guidance on how states can claim the one percentage point federal matching payment in</td>
</tr>
</tbody>
</table>
Increases Medicaid payments for primary care services provided by primary doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed 100% federal funding).

**Implementation**: January 1, 2013 through December 31, 2014

**Implementation Update**: On May 9, 2012, CMS issued a proposed rule for provision. According to a CMS release, states are expected to receive more billion in new funds for their Medicaid primary care systems. On November 1 CMS published a final rule explaining the increase in Medicaid payment for care services by certain physicians in 2013 and 2014. CMS also released a Q&A's on the primary care payment increase.

**Itemized Deductions for Medical Expenses**

Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income. Waives the increase for individuals age 65 and older for tax years 2013 through

**Implementation**: January 1, 2013

**Implementation Update**: On February 4, 2013, the IRS published its 2012 explaining the itemized deduction for medical and dental expenses.

**Flexible Spending Account Limits**

Limits the amount of contributions to a flexible spending account for medical expenses to $2,500 per year, increased annually by the cost of living.

**Implementation**: January 1, 2013

**Implementation update**: On June 25, 2012, the IRS issued guidance limiting contributions to health flexible spending arrangements at $2,500 for plans beginning in 2013.

**Medicare Tax Increase**

Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (1.45% to 2.35%) 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 for higher-income taxpayers.

**Implementation**: January 1, 2013

**Implementation Update**: on December 5, 2012, the IRS and Treasury Dep issued proposed regulations on the additional tax on wages and the net investment income tax.

**Employer Retiree Coverage Subsidy**

Eliminates the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

**Implementation**: January 1, 2013

**Implementation update**: On February 8, 2013, the IRS published an online explaining how the retiree drug subsidy works.

**Tax on Medical Devices**
Imposes an excise tax of 2.3% on the sale of any taxable medical device.

**Implementation:** January 1, 2013

**Implementation update:** On February 7, 2012, the IRS issued a proposed rule providing guidance on the tax that will be imposed on medical devices. On May 5, 2012, the IRS and the Treasury Department issued final regulations on the tax as well as interim guidance on tax-related issues such as taxable medical device licensing, tax treatment, and donations.

**Financial Disclosure**

Requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

**Implementation Update:** Report to HHS due March 31, 2014. CMS issued a proposed rule on December 19, 2011 and a final rule on February 8, 2013. The rule delays the start of the initial data collection period from January 1, 2013 to August 1, 2013 and the initial report to the Secretary of the Department of Health and Human Services to March 31, 2014 (from March 31, 2013).

**CO-OP Health Insurance Plans**

Creates the Consumer Operated and Oriented Plan (CO-OP) to foster the creation of non-profit, member-run health insurance companies.

**Implementation:** CO-OPs established by July 1, 2013

**Implementation update:** On March 14, 2011, the Department of Health and Human Services (HHS) issued a report on the Consumer Operated and Oriented Plan (CO-OP) Program. The report included recommendations by the CO-OP Advisory Board on governance, finance, infrastructure, and compliance. On July 18, 2011, HHS published a proposed rule that would implement the CO-OP program. On December 13, 2011, HHS issued a final rule. On February 21, 2012, HHS announced that "seven non-profits offering coverage in eight states have been awarded a total of $638,677,300." As of December 2012, nearly $2 billion in loans had been awarded to CO-OPs in 23 states.

**Extension of CHIP**

Extends authorization and funding for the Children's Health Insurance Program (CHIP) through 2015 (current authorization is through 2013).

**Implementation:** Fiscal year 2013. On February 17, 2011, CMS issued a final rule detailing CHIP funding allotments through 2015.

**Medicare Disproportionate Share Hospital Payments**

Reduces Medicare Disproportionate Share Hospital (DSH) payments initially and subsequently increases payments based on the percent of the population uninsured and the amount of uncompensated care provided.

**Implementation:** October 1, 2013

**Medicaid Disproportionate Share Hospital Payments**

Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary to develop a methodology for distributing the DSH re
Implementation: October 1, 2013

2014 (17 in total, 3 in effect)

Medicare Independent Payment Advisory Board Report
Establishes an Independent Advisory Board, comprised of 15 members, to

I legislative proposals containing recommendations to reduce the per capita growth in Medicare spending if spending exceeds a target growth rate.

Implementation: First recommendations due January 15, 2014 (Funding as

I October 1, 2011)

Expanded Medicaid Coverage
Expands Medicaid to all individuals not eligible for Medicare under age 65 (e.g., pregnant women, parents, and adults without dependent children) with income at or below 133% FPL and provides enhanced federal matching payments for new eligibili

I Implementation: January 1, 2014 (states have the option to expand coverage

childless adults beginning April 1, 2010)

Presumptive Eligibility for Medicaid
Allows all hospitals participating in Medicaid to make presumptive eligibility determinations for all Medicaid-eligible populations.

Implementation: January 1, 2014.

Individual Requirement to Have Insurance
Requires U.S. citizens and legal residents to have qualifying health coverage, a phased-in tax penalty for those without coverage, with certain exemptions

Implementation: January 1, 2014.

Implementation Update: On January 30, 2013, the IRS issued proposed re

QAs on the so-called individual mandate. On January 30, 2013, HHS rele

Learn more: How will the requirement that people be insured or pay a pen under the health reform law? This simple infographic explains how “the indiv

Health Insurance Exchanges
Creates state-based American Health Benefit Exchanges and Small Busine

options Program (SHOP) Exchanges, administered by a governmental age

non-profit organization, through which individuals and small businesses with

100 employees can purchase qualified coverage. Exchanges will have a sin

for applying for health programs, including coverage through the Exchanges, Medicaid and CHIP programs.

Implementation: January 1, 2014

Implementation update: On July 11, 2011, HHS issued two proposed rules:

health insurance exchanges. The first rule detailed the specifics of how state
set up their exchanges, while the second rule focused on the standards relating to risk corridor and reinsurance provisions. HHS released the final rule on exchanges on March 27, 2012, and the final rule on risk adjustment, risk corridors and reinsurance on March 23, 2012. HHS also issued a proposed rule on the exchange on March 11, 2013.

On May 16, 2012, HHS issued guidance for Federally-facilitated Exchanges which will be run by HHS in states that have not established an exchange or selected to run a Partnership exchange. Also on August 14, 2012, HHS issued a proposed rule on the exchange on March 11, 2013. On May 16, 2012, HHS issued guidance for Federally-facilitated Exchanges which will be run by HHS in states that have not established an exchange or selected to run a Partnership exchange. Also on August 14, 2012, HHS issued a final rule on the exchange on March 11, 2013.

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Learn more: Where are states in establishing and implementing their health insurance exchanges? Track state actions with the Exchange Monitor.

Health Insurance Premium and Cost Sharing Subsidies
Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals. Premium subsidies are available to families with income between 133-400% of the federal poverty level to purchase insurance through Exchanges, while cost sharing subsidies are available to those with income between 250% of the poverty level.

Implementation: January 1, 2014

Implementation Update: On May 23, 2012, the IRS released final regulations related to the health insurance premium tax credits. Corrections to this regulation were published on July 17, 2012. Additionally, on January 30, 2013, IRS released a final rule on the premium tax credit test for affordability of employer-sponsored insurance.

Guaranteed Availability of Insurance
Requires guarantee issue and renewability of health insurance regardless of 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 for individual and the small group market and the Exchanges.

Implementation: January 1, 2014

Implementation Update: On February 28, 2013, HHS issued a final rule implementing guaranteed availability of insurance.

No Annual Limits on Coverage
Prohibits annual limits on the dollar value of coverage.

Implementation: January 1, 2014

Essential Health Benefits

Creates an essential health benefits package that provides a comprehensive services, limiting annual cost-sharing to the Health Savings Account limits ($5,950/individual and $11,900/family in 2010). Creates four categories of products offered through the Exchanges, and in the individual and small group markets varying based on the proportion of plan benefits they cover.

**Implementation:** January 1, 2014


Multi-State Health Plans

Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortion beyond those permitted by federal law.

**Implementation:** January 1, 2014

**Implementation Update:** On March 1, 2013, the U.S. Office of Personnel Management released its final rule on the Multi-State Plan Program, establishing standards for the program and explaining OPM’s approach to its implementation.

Temporary Reinsurance Program for Health Plans

Creates a temporary reinsurance program to collect payments from health plans in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.

**Implementation:** January 1, 2014 through December 31, 2016

**Implementation Update:** On March 23, 2012, HHS issued a final rule implementing reinsurance and risk adjustment and for health insurance providers related to implementing reinsurance, risk corridors, and adjustment.

Basic Health Plan

Permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive subsidies in the Exchange.

**Implementation:** January 1, 2014

**Implementation Update:** On September 14, 2011, CMS issued a request for information regarding state flexibility to establish Basic Health Plan. On February 19, 2013, HHS delayed implementation of the Basic Health Program until 2015 due to the scope of coverage changes being implemented on January 1, 2014.
Employer Requirements
Assesses a fee of $2,000 per full-time employee, excluding the first 30 employees with more than 50 employees that do not offer coverage and have 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 who receives a premium tax credit, will pay the lesser of $3,000 for each employee receiving premium credit or $2,000 for each full-time employee, excluding the first 30 employees.

Implementation: January 1, 2014

Implementation Update: On December 28, 2012, the IRS issued proposed regulations on the Employer Shared Responsibility provisions of the Affordable Care Act.

Learn more: Larger employers will have to pay a penalty if they don’t provide comprehensive, affordable coverage to their employees. Find out how employer responsibilities will work with this simple infographic.

Medicare Advantage Plan Loss Ratios
Requires Medicare Advantage plans to have medical loss ratios no lower than 70%.

Implementation: January 1, 2014

Wellness Programs in Insurance
Permits employers to offer employees rewards of up to 30%, potentially increasing 50%, of the cost of coverage for participating in a wellness program and meeting certain health-related standards; establishes 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Implementation: Changes to employer wellness plans effective January 1, 2014; state pilot programs established by July 1, 2014

Implementation Update: On November 20, 2012, HHS and the Department issued a proposed rule on wellness programs. The proposed regulations would increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan and clarify what constitutes reasonable design of health-contingent wellness programs and reasonable alternatives.

Fees on Health Insurance Sector
Imposes new fees on the health insurance sector.

Implementation: January 1, 2014

Implementation Update: On March 1, 2013, the Treasury Department and issued proposed regulations on the annual fee on certain health insurance plans beginning in 2014.

Medicare Payments for Hospital-Acquired Infections
Reduces Medicare payments to certain hospitals for hospital-acquired conditions.

http://kff.org/interactive/implementation-timeline/ 7/1/2013
**Implementation: Fiscal Year 2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Action</th>
<th>Description</th>
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| **2015** (1 in total, 0 in effect) | Increase Federal Match for CHIP | Provides for a 23 percentage point increase in the Children's Health Insurance Program (CHIP) match rate up to a cap of 100%.  
**Implementation:** October 1, 2015 |
| **2016** (1 in total, 0 in effect) | Health Care Choice Compacts | Permits states to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.  
**Implementation:** January 1, 2016 |
| **2018** (1 in total, 0 in effect) | Tax on High-Cost 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.  
**Implementation:** January 1, 2018 |