ROPES & GRAY LLP
Timeline of Health Reform Implementation
Updated June 21, 2010

This timeline provides a schedule for implementation of provisions of the Patient Protection and Affordable Care Act ("PPACA") (Pub.L. 111-148) as modified by the Health Care and Education Reconciliation Act ("HCERA") of 2010 (Pub.L. 111-152).

See Ropes & Gray's summary at http://www.ropesgray.com/files/upload/SummaryHealthReform.pdf for a more comprehensive review of health reform provisions.

(Note: Unless otherwise noted, Secretary refers to the Secretary of the Department of Health and Human

Date		Reform Provision
Insurance Reforms and Exchanges		
2010	CY 2010	For tax years beginning in 2010, 2011, 2012, and 2013, small employers with 25 or fewer "full-time equivalent" employees and average annual wages of no more than $50,000 may be eligible for a tax credit of 35% (25% for tax-exempt small employers) of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 50% of the total cost of coverage. Full credit available to employers with 10 or fewer employees and wages less than $25,000. (§§ 1421, 10105 PPACA)
	3/23/2010	States must establish and implement for plan year 2010 a process for reviewing insurance premium increases, and insurers must justify unreasonable increases in premiums prior to implementation. (§ 1003 PPACA)
	3/23/2010	States become eligible for $250 million in grants to monitor premium increases and establish medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services. (§ 1003 PPACA)
	6/23/2010	High risk health insurance pool program established to provide health insurance coverage for eligible uninsured individuals with a pre-existing condition as defined by the Secretary (effective not later than 90 days after the enactment of the Act and ending on January 1, 2014). (§ 1101 PPACA)
	6/23/2010	Temporary reinsurance program is established to pay for a portion of health benefits provided by employment-based plans to pre-Medicare eligible retirees and their eligible dependents. The program ends on January 1, 2014. $5 billion is appropriated for this program. (§§ 1102, 101012(a) PPACA)

Date		Reform Provision
Insurance Reforms and Exchanges (continued)		
2010	9/23/2010	Limited insurance reforms are imposed (unless otherwise indicated these reforms do not apply to "grandfathered" plans in which an individual or group was enrolled on the date of enactment): For individual and group plans, prohibits exclusion based on pre-existing conditions initially for children up to age 19 (applies to all adults as of 1/1/2014); Prohibits rescission of policies (applies to grandfathered plans); Prohibits lifetime limits (applies to grandfathered plans); Permits only annual limits as determined by the Secretary (applies to grandfathered group plans); Prohibits discrimination based on salary; Requires annual accounting of costs (for reimbursement of claims, improving health care quality, and other non-claims costs) (applies to grandfathered plans); Prohibits prior authorization for emergency care services or OB/GYN care; Insurers that require designation of a primary care provider must permit designation of any participating primary care provider; Plans with dependent coverage extended to 26th birthday (applies to grandfathered group plans before 2014, and all grandfathered plans beginning in 2014); Insurers required to adopt specified internal claims and appeals procedures; Plans must provide coverage for certain preventive services; Fully insured group health plans must comply with the non-discrimination rules under the tax codes. (§§ 1001, 1251, 10101 PPACA; § 2301(b) HCERA)
2011	1/1/2011	Health insurers (including grandfathered plans) must begin providing a rebate to each enrollee if the amount the insurer spends on clinical services provided to enrollees and activities that improve health care quality is less than 85% of premium revenue for large groups (80% for small groups). (§ 10101(f) PPACA)
	2/1/2011	Secretary is required to study and report to Congress regarding the fully-insured and self-insured group health plan markets. (§ 1254 PPACA)
	3/23/2011	Secretary of Labor is required to report information regarding self-insured group health plans (derived from Department of Labor Annual Return/Report of Employee Benefit Plan) and self-insured employers (derived from financial filings) to Congress. (§§ 1253, 10103(f)(2) PPACA)
	3/23/2011	Deadline for the Secretary to develop uniform explanation of coverage documents to be used by insurers, including otherwise grandfathered plans. (§§1001, 10101(b) PPACA)

Date		Reform Provision
Insurance Reforms and Exchanges (continued)		
2012	3/23/2012	Insurers, including otherwise grandfathered plans, required to use uniform explanation of coverage documents developed by the Secretary by this date. (§ 1001 PPACA)
2013	1/1/2013	For taxable years beginning after December 31, 2012, annual salary contributions to health FSAs will be limited to $2,500 a year and will be indexed by the Consumer Price Index for taxable years beginning after December 31, 2013. (§§ 9005, 10902(a) PPACA; § 1403(b) HCERA)
	7/1/2013	Deadline for the Secretary to award loans and grants to fund Consumer Operated and Oriented Plans, which will support the creation of non-profit, member-run health insurance companies to be offered through the Exchange. ($6 billion is appropriated for the loans and grants.) (§ 1332 PPACA)
	7/1/2013	Deadline for Secretary to issue regulations for the creation of health care choice compacts, which will allow multiple States to enter into an agreement under which one or more qualified health plans could be offered in the markets in all such States, but only be subject to the laws of the State in which the plan was written. The compacts will not take effect before 1/1/2016. (§§ 1333, 10104(p) PPACA)
2014	1/1/2014	State-based exchanges become available; only individuals and small employers are initially eligible to participate. (§1311 PPACA)
	1/1/2014	Health plans seeking certification must submit to the Exchange, State, and Secretary, and make publicly available, certain information, including claims payment policies, and data on enrollment and denied claims. (§ 10104(f)(2) PPACA)
	1/1/2014	Deadline for the Secretary to develop guidelines for Exchange plans concerning improving health outcomes, preventing hospital readmissions, improving patient safety, implementing wellness and health promotion activities, and reducing health care disparities, including through the use of language services, community outreach, and cultural competency trainings. (§ 1001 PPACA)
	1/1/2014	Qualified health plans are required to reimburse services provided at FQHCs at rates that are at least as high as rates under Medicaid. (§§ 1334, 10104(b)(2) PPACA)

Date		Reform Provision
Insurance Reforms and Exchanges (continued)		
2014	1/1/2014	Office of Personnel Management must contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. (§§ 1334, 10104(q) PPACA)
	1/1/2014	Imposition of new tax penalty on individuals who do not purchase coverage, and tax penalty on employers with over 50 employees that have at least one employee receiving a subsidy to purchase through the Exchange. (Individual Penalties §§ 1501, 10106(a) PPACA) . Employer Penalties: §§ 1513 PPACA; 1003(b)(1) HCERA)
	1/1/2014	Affordability premium credits and cost-sharing credits provided to non-Medicaid eligible individuals who are not enrolled in an affordable employer-sponsored plan with incomes between 133% and 400% FPL to purchase coverage through an Exchange. (Premium Credits: §§ 1401, 10105(b) PPACA; § 1001 HCERA. Cost-sharing Credits: § 1402 PPACA, § 1001 HCERA)
	1/1/2014	Certain employers must begin reporting information to the IRS regarding employee coverage. (§§ 1514, 10108(j) PPACA)
	1/1/2014	Small business tax credit increased to 50% for for-profit small business (35% to tax-exempt small businesses) of the employer's contributions for qualified health plans offered by the employer through an Exchange, or contributions that the employer would have made if its employees had enrolled in an Exchange plan. The credit, which is available for two consecutive years, fully phases out for firms with average wages equal to or greater than $50,000. (§§ 1421, 10105 PPACA)
	1/1/2014	Additional insurance reform policies take effect (unless otherwise indicated these reforms do not apply to "grandfathered" plans in which an individual or group was enrolled on the date of enactment): Extends prohibition on pre-existing condition exclusions to all individuals under group health plans (applies to grandfathered group plans); Limits premium rating for individual and small group market (can only vary based on individual or family rating area, age (limited to 3:1 for adults), or tobacco use (limited to 1.5:1), but may be reduced by up to 30% based on participation in a wellness program); Implements guaranteed issue requirement; All private coverage must include the essential health benefits package; Prohibits any waiting period that exceeds 90 days for group coverage (applies to grandfathered group plans); Prohibits denial of coverage for routine care provided to an individual enrolled in a clinical trial. (§§ 1201, 1251, 10103 PPACA; § 2301 HCERA)

Date		Reform Provision
Insurance Reforms and Exchanges (continued)		
2014	1/1/2014	Health Plans may not place annual limits on essential health benefits. (§ 10101(a) PPACA)
2015	3/23/2015	Deadline for GAO to submit to Congress a study on the affordability of health insurance coverage, including the effect of the tax credit, the availability of affordable health plans, and the ability of individuals to keep essential health benefits coverage. (§ 1401(c) PPACA)
2016	1/1/2016	Plans may be offered in the Exchange through health care choice compacts. (§ 1333 PPACA)
2017	1/1/2017	States may permit businesses with more than 100 employees to purchase coverage in the Health Insurance Exchanges. (§ 1312(f) PPACA)
Public Coverage Programs		
2010	1/1/2010	Medicare Part D beneficiaries who reach the donut hole offered a one-time rebate of $250. (§ 1101 HCERA)
	3/23/2010	States may not restrict eligibility standards, methodologies or procedures for adults in Medicaid as compared to those in effect on the date of enactment until their state exchange becomes fully operational (although see potential exemption beginning January 2011). States may not restrict eligibility for children in Medicaid or CHIP through Sep. 30, 2019 (until FY 2020). (§ 2001 PPACA)
	4/1/2010	States may opt to expand coverage to all non-elderly individuals up to 133% federal poverty level. (§ 2001 PPACA)
	8/23/2010	Deadline for HHS to issue regulations to increase the transparency of the Medicaid waiver development and approval process. (§ 10201 PPACA)
2011	1/1/2011	States can receive an exemption from the Medicaid maintenance of effort related to eligibility for non-pregnant, non-disabled adults above 133% FPL between January 2011 and 2014 if they certify that they are experiencing a current or projected budget deficit. (§ 2001 PPACA)
	1/1/2011	Cost-sharing for Medicare-covered preventive services is eliminated; Medicare beneficiaries are eligible to receive an annual visit for personalized prevention plan services. (§ 4101 PPACA; § 10406 PPACA)

Date		Reform Provision
Public Coverage Programs (continued)		
2011	1/1/2011	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 93% (from 100% in 2010). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2011	The Secretary will begin operation of a Medicare Coverage Gap Discount Program, under which brand-name manufacturers agree to provide a 50% discount on the negotiated price of a drug under the Medicare Part D program. (§ 3301 PPACA; § 1101 HCERA)
2012	1/1/2012	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 86% (from 93% in 2011). (§ 3301 PPACA; § 1101 HCERA)
2013	1/1/2013	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 79% (from 86% in 2012). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2013	Medicare Part D "donut hole" coinsurance for most brand-name drugs becomes 47.5%, including 50% rebate from Medicare Coverage Gap Discount Program, for 2013-2014. (§ 3301 PPACA; § 1101 HCERA)
	1/1/2013	States that provide Medicaid coverage for all preventive services recommended by the U.S. Preventive Services Task Force and eliminate cost-sharing for such services are eligible for a one percentage point increase in their FMAP. (§ 4106 PPACA)
2014	1/1/2014	States must expand Medicaid eligibility up to 133% of federal poverty level. Maintenance of effort related to eligibility for adults under Medicaid ends. (§ 2001 PPACA)
	1/1/2014	100% federal financial assistance available for costs of newly eligible Medicaid expansion populations in all states. (§ 2001 PPACA; § 1201 HCERA)
	1/1/2014	States may create a federally-funded, non-Medicaid state plan for non-elderly individuals with incomes between 133% and 200% FPL (and lawfully present aliens whose incomes are not greater than 133% FPL and who are not eligible for Medicaid by virtue of alien status). Such individuals must be ineligible to receive affordable employer-sponsored insurance under which the employee contribution is equal to or less than 9.5% of income. Participating states receive 95% of the premium tax credits and cost-sharing subsidies that would have been provided to individuals who would have enrolled in the Exchange. (§ 1331 PPACA)
	1/1/2014	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 72% (from 79% in 2013). (§ 3301 PPACA; § 1101 HCERA)

Date		Reform Provision
Public Coverage Programs (continued)		
2015	1/1/2015	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 65% (from 72% in 2014). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2015	Medicare Part D "donut hole" coinsurance for most brand-name drugs reduced to 45% (down from 47.5% in 2013-2014), including 50% rebate from Medicare Coverage Gap Discount Program, for 2015-2016. (§ 3301 PPACA; § 1101 HCERA)
	10/1/2015	CHIP federal matching rate increased by 23% through FY 2019. (§ 2101 PPACA)
2016	1/1/2016	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 58% (from 65% in 2015). (§ 3301 PPACA; § 1101 HCERA)
	10/1/2016	States begin picking up a share of the costs of Medicaid expansions. "Expansion" states receive federal assistance equal to their FMAP percentage plus 30.3 percentage points in 2017, 31.3 in 2018 for costs of the newly eligible. States that are not "expansion states" receive an FMAP increase of 34.3 percentage points in 2017, 33.3 in 2018. All states receive an FMAP increase of 32.3 percentage points in 2019. (§ 2001 PPACA; § 1201 HCERA)
2017	1/1/2017	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 51% (from 58% in 2016). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2017	Medicare Part D "donut hole" coinsurance for most brand-name drugs reduced to 40% (down from 45% in 2015-2016), including 50% rebate from Medicare Coverage Gap Discount Program. (§ 3301 PPACA; § 1101 HCERA)
2018	1/1/2018	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 44% (from 51% in 2017). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2018	Medicare Part D "donut hole" coinsurance for most brand-name drugs reduced to 35% (down from 40% in 2017), including 50% rebate from Medicare Coverage Gap Discount Program. (§ 3301 PPACA; § 1101 HCERA)
2019	1/1/2019	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 37% (from 44% in 2018). (§ 3301 PPACA; § 1101 HCERA)
	1/1/2019	Medicare Part D "donut hole" coinsurance for most brand-name drugs reduced to 30% (down from 35% in 2018), including 50% rebate from Medicare Coverage Gap Discount Program. (§ 3301 PPACA; § 1101 HCERA)

Date		Reform Provision
Public Coverage Programs (continued)		
2020	1/1/2020	Medicare Part D "donut hole" coinsurance for generic drugs reduced to 25% in 2020 and each year thereafter (from 37% in 2019). (§ 1101 HCERA)
	1/1/2020	Medicare Part D "donut hole" coinsurance for most brand-name drugs reduced to 25% (down from 30% in 2019), including 50% rebate from Medicare Coverage Gap Discount Program, for 2020 and each year thereafter. (§ 3301 PPACA; § 1101 HCERA)
Delivery System Reform		
2009	7/1/09	Hospitals may count time spent on certain non patient care (e.g. didactic) training activities toward direct GME payments and indirect GME payments. (§ 5505 PPACA)
	10/1/09	First year of Medicaid Global Payments demonstration available in up to 5 states from FY 2010 to FY 2012 under which a large, safety net hospital system could alter its provider payment system from FFS to a capitated, global payment structure. (Such sums as may be necessary are authorized to be appropriated, but no funds are appropriated.) (§ 2705 PPACA)
2010	1/1/2010	Children's hospitals, critical access hospitals, and rural referral centers are newly eligible for 340B Drug Discount Program. (Note that Children's Hospitals technically can already access discounts under 2009 administrative guidance). (§ 7101 PPACA; § 2302 HCERA)
	7/1/2010	Hospitals have new flexibility in counting time spent by residents in patient care activities in non-hospital settings toward Medicare direct GME and IME payments. (§ 5508 PPACA)
	10/1/2010	Qualified teaching health centers are eligible for payments for the direct and indirect costs of operating residency programs ($230 million total appropriated for fiscal years 2011 through 2015). (§ 5508 PPACA)
	10/1/2010	ARRA Medicaid and Medicare HIT incentive payments begin for hospitals (early Medicaid payments may be available prior to this date). (§ 4102 ARRA)
2011	1/1/2011	CMS Innovation Center must be operational and begin selecting and funding innovative payment and service delivery models ($5 million will be appropriated to set up the Center in FY 2010; $10 billion total is appropriated for FYs 2011 through 2019, and $10 billion is appropriated for each 10 year period beginning with 2020). (§§ 3021, 10306 PPACA)

Date		Reform Provision
Delivery System Reform (continued)		
2011	1/1/2011	Deadline for HHS plan to develop value-based purchasing programs for ambulatory surgery centers. (§§ 3006, 10306 PPACA)
	1/1/2011	Deadline for Secretary to publish for public comment a recommended core set of health quality measures for adults eligible for Medicaid benefits. (§ 2701 PPACA)
	1/1/2011	ARRA Medicaid and Medicare HIT incentive payments begin for eligible professionals. (§ 4101 ARRA)
	7/1/2011	Deadline for HHS to adopt regulations to prohibit federal Medicaid payment for services related to health-care acquired conditions. (§ 2702 PPACA)
	7/1/2011	Deadline for HHS to redistribute 65% of unused Medicare graduate medical education residency slots based on statutory formula, with the goal of increasing primary care and general surgery residencies. (§ 5503 PPACA)
	8/23/2011	Deadline for GAO report on whether additional improvements to the 340B program are warranted. (§ 7103 PPACA)
	10/1/2011	Deadline for HHS to issue a plan to develop value-based purchasing programs for skilled nursing facilities and home health agencies (§§ 3006, 10301 PPACA)
	10/1/2011	HHS begins to design, implement, monitor, and evaluate a Medicare graduate nurse education demonstration program for advance practice nurses, including up to 5 hospitals ($50 million appropriated for each of FYs 2012 through 2015). (§ 5509 PPACA)
2012	1/1/2012	Qualifying groups of providers, including physicians and hospitals, may be recognized as Medicare ACOs and share in Medicare cost savings above a certain threshold. (§§ 3022, 10307 PPACA)
	1/1/2012	First year of Medicaid pediatric Accountable Care Organization (ACO) demonstration project. (Such sums as may be necessary are authorized to be appropriated, but no funds are appropriated.) (§ 2706 PPACA)
	1/1/2012	Deadline for Secretary to publish rules to govern the value-based payment modifier to the physician fee schedule (to be implemented Jan. 1, 2015 for some physicians identified by the Secretary, and Jan. 1, 2017 for all physicians). (§ 3007 PPACA)
	1/1/2012	Deadline for the Secretary to publish a final, initial core set of quality measures for adults in Medicaid. (§ 2701 PPACA)

Date		Reform Provision
Delivery System Reform (continued)		
2012	1/1/2012	Improvements in the Medicare Physician Feedback Program take effect. Deadlines for the Secretary to develop an "episode grouper" that "combines separate but clinically related items and services into an episode of care for an individual, as appropriate" and to begin providing reports to physicians that compare patterns of resource use of the individual physician to such patterns of other physicians. (§ 3003 PPACA)
	1/1/2012	First year of Medicaid bundled payment demonstration, under which hospitals would receive a single payment for acute and post-acute care provided in hospital and non-hospital settings. (§ 2704 PPACA)
	10/1/2012	Hospital payments reduced under Medicare for hospital discharges to account for "excess readmissions" for a limited number of conditions. (§§ 3025, 10309 PPACA)
	10/1/2012	1% of Inpatient Prospective Payment System payments to be withheld to fund the Medicare value-based purchasing program for hospitals. (§ 3001 PPACA)
2013	1/1/2013	Deadline for Secretary to establish Medicare pilot program to evaluate alternative payment methodologies, including bundled payments. (§§ 3023, 10308 PPACA)
	1/1/2013	Deadline for Secretary to develop a standardized format for reporting information based on the new quality measures for adults in Medicaid and to create procedures to encourage states to use them to voluntarily report information on the quality of health care provided. (§ 2701 PPACA)
	10/1/2013	1.25% of Inpatient Prospective Payment System payments to be withheld to fund the Medicare value-based purchasing program for hospitals. (§ 3001 PPACA)
2014	1/1/2014	Deadline for Secretary to send a report to Congress on the new quality measures for adults in Medicaid. (§ 2701 PPACA)
	10/1/2014	Deadline for implementing risk-adjusted Medicare Hospital-Acquired Conditions (hospitals in top quartile of HAC rates would receive 99% of their otherwise applicable Medicare payments). (§ 3008 PPACA)
	10/1/2014	ARRA Medicare eHR penalties take effect for hospitals. (§ 4102 ARRA)
	10/1/2014	1.5% of Inpatient Prospective Payment System payments to be withheld to fund the Medicare value-based purchasing program for hospitals. (§ 3001 PPACA)

Date		Reform Provision
Delivery System Reform (continued)		
2015	1/1/2015	Value-based payment modifier to the physician fee schedule implemented for an initial subset of physicians identified by the Secretary. (§ 3007 PPACA)
	7/1/2015	ARRA Medicare eHR penalties take effect for physicians. (§ 4101 ARRA)
	10/1/2015	1.75% of Inpatient Prospective Payment System payments to be withheld to fund the Medicare value-based purchasing program for hospitals. (§ 3001 PPACA)
2016	10/1/2016	2% of Inpatient Prospective Payment System payments to be withheld to fund the Medicare value-based purchasing program for hospitals in FY 2017 and each year thereafter. (§ 3001 PPACA)
2017	1/1/2017	Value-based payment modifier to the physician fee schedule implemented for all physicians. (§ 3007 PPACA)
	1/1/2017	Deadline for Secretary to submit a report to Congress on the results of the Medicaid bundled payment demonstration program. (§ 2704 PPACA)
	10/17/2017	Deadline for the Secretary to submit a report to Congress on the Medicare graduate nurse education demonstration program, including an evaluation on the growth in numbers of advanced-practice nurses and specialties, and the costs to the Medicare program. (§ 5509 PPACA)
Provider and Plan Payment Changes		
2009	10/1/2009	Medicare market basket reduced 0.25% in each of FY 2010 and 2011 for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals. (§§ 3401, 10319 PPACA; § 1105 HCERA)
2010	10/1/2010	Home health agency Medicare market basket adjustment reduced by 1% in each of FY 2011-2013. (§§ 3401, 10319 PPACA; § 1105 HCERA)
	10/1/2010	$400 million total provided in Medicare supplemental payments for FY 2011 and 2012 under the inpatient prospective payment system for hospitals located in counties in the bottom quartile of counties, as ranked by risk adjusted spending per Medicare enrollee. (§ 1109 HCERA)

Date		Reform Provision
Provider and Plan Payment Changes (continued)		
2011	1/1/2011	First of five years of 10% Medicare bonus for select E&M codes furnished by physicians and other primary care providers and major surgical procedures furnished by general surgeons in a health professional shortage area. (§ 5501 HCERA)
	1/1/2011	Medicare Advantage payments frozen. (§ 1102 HCERA)
	10/1/2011	Medicare market basket reduced 0.1% (from .25% in FYs 2009-2010) in each of FY 2012 and 2013 for inpatient and outpatient hospitals, long-term care hospitals, IRFs, and psychiatric hospitals. (§§ 3401, 10319 PPACA; § 1105 HCERA)
	10/1/2011	First year of annual productivity-based market basket adjustment for inpatient and outpatient hospital services, SNFs, LTCHs, IRFs, home health, psychiatric hospitals, hospice, ASCs, and other services to account for economy-wide productivity gains. (§§ 3401, 10319 PPACA; § 1105 HCERA)
2012	1/1/2012	Beginning of phase-in of new Medicare Advantage payments, tied to state spending levels. Phase-in will take 3 years in most states, but some states will have 4 or 6 years, depending on difference between current payments and benchmark. (§ 1102 HCERA)
	1/1/2012	Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better will receive bonus payment of 1.5%; some plans in qualifying areas may receive double bonuses. (§ 1102 HCERA)
	10/1/2012	Secretary to implement a 0.5% market basket reduction for hospice providers in each FY from 2013-2019. (§§ 3401, 10319 PPACA; § 1105 HCERA)
	10/1/2012	Fee-for-service and managed care payments for Medicaid increased to at least 100% of Medicare Part B rates for primary care services from physicians in family medicine, general internal medicine, and internal medicine. The federal government will pay 100% of the costs of the amount of the increased payments during these two years. (§ 1202 HCERA)
2013	1/1/2013	Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better will receive bonus payment of 3%, up from 1.5% in 2012 (new plans receive 2.5%); some plans in qualifying areas may receive double bonuses. (§ 1102 HCERA)
	10/1/2013	Medicare market basket reduced 0.3% (compared with 0.1% for FY2013) for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals. (§§ 3401, 10319 PPACA; § 1105 HCERA)

Date		Reform Provision
Provider and Plan Payment Changes (continued)		
2013	10/1/2013	Home health agency Medicare prospective payment rates to be rebased according to factors determined by the Secretary. (§§ 3131, 10315 PPACA)
	10/1/2013	Medicare disproportionate share hospital (DSH) cuts begin ($22 billion total over 10 years). (§§ 3133, 10316 PPACA; § 1104 HCERA)
	10/1/2013	Medicaid DSH cuts of $500 million applied to states based on methodology determined by the Secretary. (§§ 2551, 10201 PPACA; § 1203 HCERA)
2014	1/1/2014	Medicare Advantage rebate system phased in based on plan quality. Plans with 4.5 stars may offer rebates of 70% of the difference between the benchmark and their bid; those with 3.5-4.5 stars may offer 60% rebates, and those with less than 3.5 stars may offer 50% rebates. (§ 1102 HCERA)
	1/1/2014	Medicare Advantage plans with quality rankings of 4 stars (out of 5) or better will receive bonus payment of 5%, up from 3% in 2013 (new plans receive 3.5%); some plans in qualifying areas may receive double bonuses. (§ 1102 HCERA)
	1/1/2014	Medicare Advantage plans must achieve a medical loss ratio of at least 85%, or face penalties. (§ 1103 HCERA)
	1/15/2014	Independent Payment Advisory Board may begin developing and submitting proposals to MedPAC, the President, and Congress, regarding strategies to reduce excess cost growth. Such proposals may not include recommendations that would reduce payment rates for hospitals and other providers subject to productivity adjustments. (§§ 3403, 10320 PPACA)
	8/15/2014	Independent Payment Advisory Board recommendations for certain providers, including Medicare Advantage and Part D Plans, are automatically enacted if Congress fails to pass an alternative package that cuts costs by the same amount. Payment changes will be implemented either at the start of FY 2015 (Oct. 1, 2014) or calendar year 2015, depending on provider type. (§§ 3403, 10320 PPACA)
	10/1/2014	Prospective Payment System established for Medicare-covered services furnished by FQHCs. (§ 10501(i) PPACA)
	10/1/2014	Medicare market basket reduced 0.2% (compared with 0.3% for FY 2014) in each of FY 2015 and 2016 for inpatient and outpatient hospitals, LTCHs, IRFs, and psychiatric hospitals. (§§ 3401, 10319 PPACA; § 1105 HCERA)

Date		Reform Provision
Provider and Plan Payment Changes (continued)		
2014	10/1/2014	Medicaid DSH cuts of $600 million applied to states in each of FY 2015 and 2016, based on methodology determined by the Secretary. (§§ 2551, 10201 PPACA; § 1203 HCERA)
2015	1/1/2015	Qualified health plans may contract with a hospital with greater than 50 beds only if the hospital utilizes a patient safety evaluation system, and with a health care provider only if the provider implements mechanisms required by regulation to improve health care quality. (§ 1311 PPACA)
	1/15/2015	Deadline for the Independent Payment Medicare Advisory Board to submit its first biennial set of recommendations on how to slow non-federal national health care expenditures while maintaining or improving quality of care. (§§ 3403, 10320 PPACA)
2016	10/1/2016	Medicare market basket reduced 0.75% (compared with 0.2% in FYs 2015 and 2016) in each of FY 2017 through 2019 for inpatient and outpatient hospitals, long-term care hospitals (LTCHs), IRFs, and psychiatric hospitals. (§§ 3401, 10319 PPACA; § 1105 HCERA)
	10/1/2016	Medicaid DSH cuts of $1.8 billion applied to states based on methodology determined by the Secretary. (§ 2551, 10201 PPACA; § 1203 HCERA)
2017	10/1/2017	Medicaid DSH cuts of $5 billion applied to states based on methodology determined by the Secretary. (§ 2551, 10201 PPACA; § 1203 HCERA)
2018	10/1/2018	Medicaid DSH cuts of $5.6 billion applied to states based on methodology determined by the Secretary. (§ 2551, 10201 PPACA; § 1203 HCERA)
2019	10/1/2019	Medicaid DSH cuts of $4 billion applied to states based on methodology determined by the Secretary. (§ 2551, 10201 PPACA; § 1203 HCERA)
2020	1/1/2020	Independent Payment Advisory Board proposals may include binding recommendations to reduce payment rates for hospitals and other providers previously subject to productivity adjustments (and excluded from prior IPAB proposals) for services provided after 1/1/2020. (§§ 3403, 10320 PPACA)

Date		Reform Provision
Financing		
2010	1/1/2010	Medicaid rebates increase to 23.1% of average manufacturer price on brand-name drugs, and 13% on other drugs, and rebates extended to drugs provided through Medicaid managed care plans. (§ 2501 PPACA; § 1206(a) HCERA)
	3/23/2010	Codify Economic Substance Doctrine, a tax law doctrine that requires transactions to have an economic purpose other than reduction of tax liability. Revenue collected from this will go to health care reform. Applicable for transactions entered into after 3/23/2010. (§ 1409 PPACA)
	7/1/2010	10% service tax imposed on indoor tanning. (§ 10907 PPACA)
2011	1/1/2011	$2.5 billion excise tax imposed on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30. (§ 9008 PPACA; § 1404(a) HCERA)
	1/1/2011	Penalty increases from 10% to 20% for nonqualified Health Savings Account payments. (§ 9004 PPACA)
2012	1/1/2012	Threshold for itemized deductions for medical expenses is increased from 7.5% to 10% of adjusted gross income (not effective until Jan. 1, 2017 for individuals over the age of 65). (§ 9013 PPACA)
	1/1/2012	$3 billion excise tax imposed annually through 2016 (up $500 million from 2011) on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30. (§ 9008 PPACA; § 1404(a) HCERA)
	10/1/2012	$2 per enrollee fee ($1 for fiscal year 2013) imposed on insurers, including self-insured employer plans, to finance Patient-Centered Outcomes Research Trust Fund. (§ 6301(d) PPACA)
2013	1/1/2013	First year of annual excise tax on medical device manufacturers and importers (2.3% on sales of all taxable medical devices, excluding eyeglasses, contact lenses, and hearing aids; estimated to raise $27 billion). (§ 1405 HCERA)
	1/1/2013	Additional 0.9% Medicare hospital insurance tax imposed on wages above $200,000 for individual filers, $125,000 for married filing separate filers, and $250,000 for joint filers. (§§ 9015, 10906(a) PPACA; § 1402(b) HCERA)

Date		Reform Provision
Financing (continued)		
2013	1/1/2013	Annual salary contributions limited to health flexible spending arrangements to $2,500 a year and indexes the limit by CPI-U beginning in 2014. (§§ 9005, 10902(a) PPACA; § 1403(b) HCERA)
	1/1/2013	For taxable years after December 31, 2012, deduction eliminated for expenses allocable to Medicare Part D subsidy received by employers. (§ 9012(b) PPACA; § 1407 HCERA)
2014	1/1/2014	First year of annual fee on health insurance plans ($8 billion; assessed based on insurer's net premiums, and only 50% of tax-exempt insurers premiums are included in calculation of the fee). (§§ 9001, 10905 PPACA; § 1406(a) HCERA)
	1/1/2014	For corporation with assets of not less than $1 billion (determined as of the end of the preceding taxable year), any required installment of corporate estimated tax due in July, August, or September of 2014 increased to 116%. (§ 1410 of HCERA)
	1/1/2014	Imposition of new tax penalty on individuals who do not purchase coverage, and tax penalty on employers with over 50 employees that have at least one employee receiving a subsidy to purchase through the Exchange. (Individual Penalties §§ 1501, 10106(a) PPACA) . Employer Penalties: §§ 1513 PPACA; 1003(b)(1) HCERA)
2015	1/1/2015	The threshold for exemption from the shared responsibility payment will change from 8% of modified adjusted gross household income to the "percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period." (§ 1501(b) PPACA)
2017	1/1/2017	Increase in annual fee on health insurance plans to $13.9 billion (up from $11.3 billion in 2016; assessed based on insurer's net premiums and only 50% of tax-exempt insurers premiums are included in calculation of the fee). (§§ 9001, 10905 PPACA; § 1406(a) HCERA)
	1/1/2017	$3.5 billion excise tax imposed (up $500 million from 2016) on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30. (§ 9008 PPACA; § 1404(a) HCERA)

Date		Reform Provision
Financing (continued)		
2018	1/1/2018	40% excise tax on the value of any individual employer-sponsored plan that exceeds $10,200 multiplied by the health cost adjustment percentage. For family coverage, 40% excise tax on the value of any employer-sponsored coverage that exceeds $27,500 multiplied by the health cost adjustment percentage. (§§ 9001, 10901(b) PPACA; § 1401(a) HCERA)
	1/1/2018	Increase in annual fee on health insurance plans to $14.3 billion (up from $13.9 billion in 2016; assessed based on insurer's net premiums and only 50% of tax-exempt insurers premiums are included in calculation of the fee). (§§ 9001, 10905 PPACA; § 1406(a) HCERA)
	1/1/2018	$4.2 billion excise tax imposed (up $700 million from 2017) on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30. (§ 9008 PPACA; § 1404(a) HCERA)
2019	1/1/2019	Increase in annual fee on health insurance plans to $14.3 billion (the amount for 2018) plus the rate over the premium growth during the previous year. Increases in all years hereafter will be tied to premium growth rates. (§§ 9001, 10905 PPACA; § 1406(a) HCERA)
	1/1/2019	$2.8 billion annual excise tax imposed (down $1.4 billion from 2017) on branded pharmaceutical manufacturers and importers. Tax on sales made in the preceding calendar year. Payment date no later than 9/30. (§ 9008 PPACA; § 1404(a) HCERA)
Compliance and Transparency		
2010	3/23/2010	Anti-kickback statute intent standard amended such that a person may violate the anti-kickback statute without actual knowledge of or specific intent to violate the statute. (§ 6402 PPACA)
	9/23/2010	Secretary establishes a Medicare self-referral disclosure protocol (no later than six months after enactment). (§ 6409 PPACA)
	9/23/2010	Deadline for HRSA to issue regulations implementing new 340B program integrity requirements for manufacturers and covered entities. (§ 7102 PPACA)

Date		Reform Provision
Compliance and Transparency (continued)		
2011	1/1/2011	Tax-exempt hospitals must comply with new requirements related to charges to uninsured and conducting community health needs assessments (applies in taxable years after enactment). (§ 9007 PPACA)
	1/1/2011	Deadline for Recovery Audit Contractor program expansion to Medicare Parts C & D and Medicaid. (§ 6411 PPACA)
	9/23/2011	New requirements for hospitals to quality for Stark Rural Provider and Whole-Hospital Exceptions (effectively freezes applicability to hospitals with physician investment/ownership as of February 1, 2010, and establishes certain other requirements). (§ 6001 PPACA)
2012	3/23/2012	Report on Medicare self-referral disclosure protocol due to Congress (by 18 months after the self-referral disclosure protocol is established). (§ 6409 PPACA)
2013	3/31/2013	New Sunshine Provisions go into effect. Drug and device manufacturers must begin reporting payments to physicians and teaching hospitals, and both manufacturers and group purchasing organizations must begin reporting physician ownership and investment data to the Secretary on an annual basis. (§ 6002 PPACA)
2014	1/1/2014	The False Claims Act applies to payments made by, through, or in connection with the Exchange if payments include any federal funds. (§ 1313 PPACA)
Other		
2010	3/23/2010	Abbreviated regulatory pathway for FDA approval of biosimilar and interchangeable products is provided. (§ 7002 PPACA)
	10/1/2010	Employers with 100 employees or fewer who work 25 hours or more per week are eligible to compete for grant funding to implement wellness programs (funding is available through FY 2015). (§ 10408 PPACA)
	10/1/2010	New Community Health Center Fund appropriations become available. Appropriates $9.5 billion from 2011 to 2015 for unspecified Community Health Center program activities, $1.5 billion from 2011 to 2015 for construction and renovation of CHCs, and $1.5 billion from 2011 to 2015 for the National Health Service Corps. (§ 10503 PPACA; § 2303 HCERA)

Date		Reform Provision
Other (continued)		
2011	1/1/2011	Secretary must designate a plan to create a long-term care insurance program (the CLASS program) to be financed by voluntary payroll deductions that would cover the full cost of the program. (§ 8001 *et seq.* PPACA; § 10801 PPACA)
2012	3/23/2012	CDC is required to conduct, at regular intervals, a national worksite health policies and programs survey to assess employer-based health policies and programs. (§ 4303 PPACA)
	10/1/2012	User fee program established for submission of applications to the FDA for approval of follow-on biologics. (§ 7002 PPACA)
2014	1/1/2014	Employers may provide premium discounts, rebates or other rewards to employees who participate in wellness programs. (§ 1201 PPACA)
	7/1/2014	First year of ten-state demonstration project under which participating states may permit individual health plans to offer premium discounts, rebates or other rewards to enrollees participating in wellness programs commences. (No funding specifically authorized or appropriated, but funds potentially available under the Prevention and Public Health Fund for wellness activities under the Public Health Service Act.) (§ 1201 PPACA)