Major Provisions of the Affordable Care Act

2010 | 2011 | 2012 | 2013 | 2014 | 2018

Coverage for young adults: Parents will be able to keep their children on their health policies until they turn 26.

Small-business tax credits: Small businesses (fewer than 25 employees and average wages under $50,000) that offer health care benefits and contribute at least 50 percent of the premium will be eligible for tax credits of up to 35 percent of their premium costs for two years. The credit rises to 50 percent of their premium costs in 2014.

Preexisting Condition Insurance Plan (PCIP): People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, Preexisting Condition Insurance Plan in their state. Premiums will be based on the health status of a standard population and cannot vary by more than a factor of four based on age. Annual out-of-pocket costs will be capped at $5,950 for individuals and $11,900 for families.

New insurance rules: Insurance companies will be banned from rescinding people's coverage when they get sick, and from imposing lifetime caps on coverage. Annual limits on benefits are phased out by 2014.

Protection for children: Insurers can no longer deny health coverage to children with preexisting conditions or exclude their conditions from coverage.

"Doughnut hole" rebates: Medicare will provide $250 rebates to beneficiaries who hit the Part D prescription drug coverage gap known as the "doughnut hole."

Preventive care: All new group and individual health plans will be required to provide free preventive care for recommended preventive services and immunizations. In 2011, Medicare also will provide free preventive care.

Payment reform: A Medicaid demonstration project will enable safety-net hospitals in up to five states to move from a fee-for-service payment model to a global fee model. Medicare will also take temporary steps to ensure that rural areas are protected from fluctuations in payment levels to physicians and hospitals.

Workforce improvements: Student loan programs for those training in primary care, nursing, and pediatrics will be expanded and a new National Health Care Workforce Commission will make recommendations for further action.

Quality improvement: An Interagency Working Group on Health Care Quality will issue a report to Congress with recommendations for improved collaboration between federal departments and agencies and the alignment of public and private initiatives.

Access to care: Funding will be increased by $11 billion over five years for community health centers and the National Health Services Corps to serve more low-income and uninsured people.

Annual review of premium increases: Health insurers will be required to submit justification for unreasonable premium increases to the federal and relevant state governments before they take effect, and to report the share of premiums spent on nonmedical costs.

Early retirees: A temporary reinsurance program will help offset the costs of expensive premiums for employers providing retiree health benefits.

Major Provisions of the Affordable Care Act

Limits on non-medical spending by health plans: Health plans in the large-group market that spend less than 85 percent of their premiums on medical care, and plans in the small-group and individual markets that spend less than 80 percent on medical care, will be required to offer rebates to enrollees.

"Doughnut hole" discounts: Medicare beneficiaries in the Part D prescription drug coverage "doughnut hole" will receive 50 percent discounts on all brand-name drugs. By 2020, the "doughnut hole" coverage gap will be closed.

Physician quality reporting: Medicare will launch a Physician Compare Web site where beneficiaries can compare measures of physician quality and patient experience. Medicare's Nursing Home Compare Web site will publish more data about nursing facilities, including summaries of substantiated complaints.

New payment and delivery approaches: A new Center for Medicare and Medicaid Innovation will test reforms that reward providers for quality of care rather than volume of services. Medicare will increase payment for primary care physicians by 10 percent for primary care services.

Long-term care insurance program: Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS). Participating employers will be required to automatically enroll employees 18 and over, but employees will have the option to opt out of the program.

Pharmaceutical manufacturer fee: Manufacturers and importers of branded drugs will have to pay an annual, nondeductible fee, based on market share.

OTC drug reimbursement restrictions: Over-the-counter drugs not prescribed by a doctor will no longer be reimbursable through flexible spending accounts or health reimbursement arrangements, or on a tax-free basis in health savings accounts.

Benefit disclosure: Employers will be required to disclose the value of benefits provided for each employee's health insurance coverage on the employee's W-2 forms.

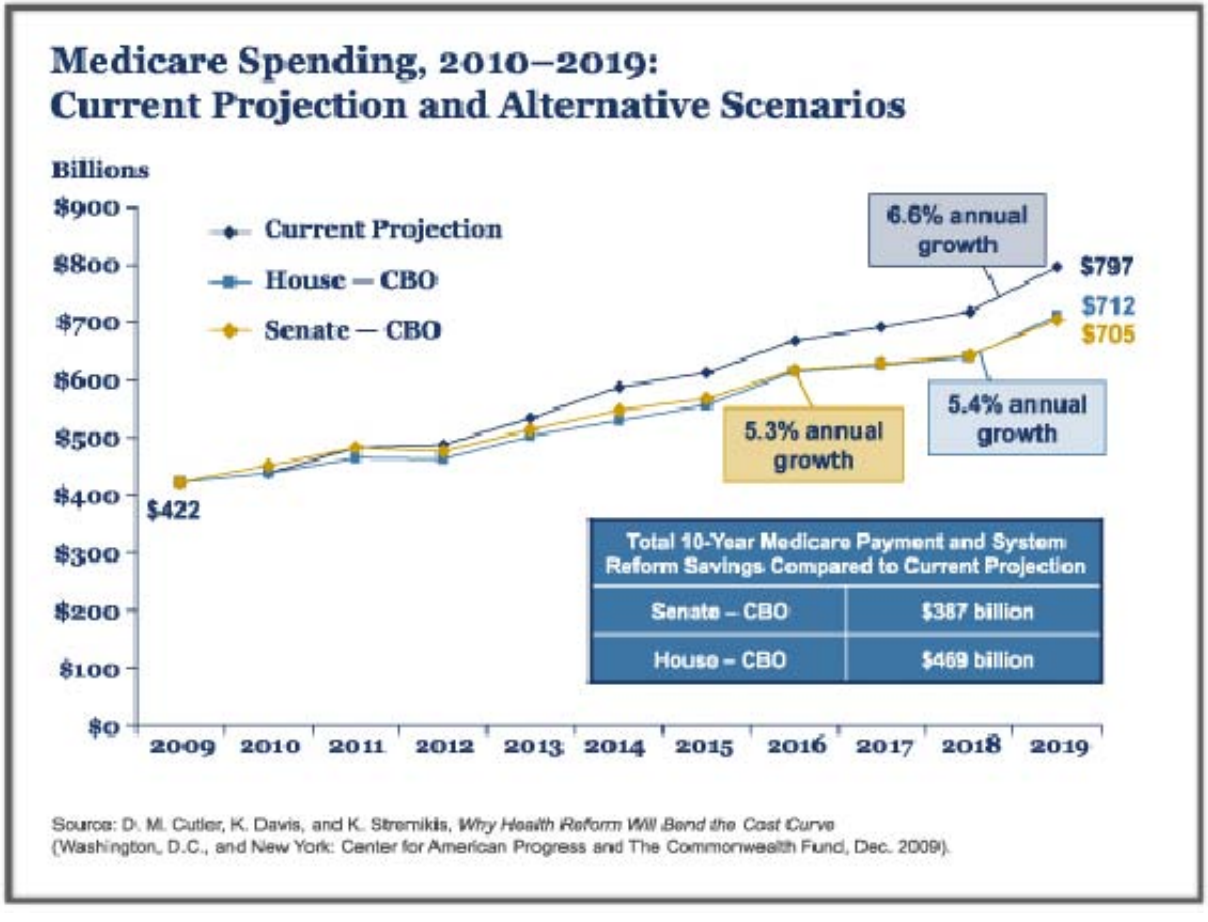
Major Provisions of the Affordable Care Act

Hospital readmissions: Medicare will reduce payments to hospitals for potentially preventative readmissions for select conditions. Hospital readmission rates for these conditions will be published on the Hospital Compare Web site.

Accountable care: Medicare will launch a program that encourages providers to organize into accountable care organizations, which will share in savings generated by meeting quality targets and reducing costs.

Hospital value-based purchasing program: Medicare will reward hospitals that provide higher quality or better patient outcomes.

Understanding health disparities: Any federally conducted or supported health program, activity, or survey must collect and report data on race, ethnicity, sex, primary language, and disability status. The HHS Secretary will analyze the data for trends in health disparities at the state and federal levels and publish the data and findings online.



Major Provisions of the Affordable Care Act

Administrative simplification: Health insurers must follow administrative simplification standards for electronic exchange of health information to reduce paperwork and administrative costs.

Payment reform: A Medicare pilot program will evaluate how payment for post-acute services can be bundled with payment for an episode of care such as surgery. States will pay Medicaid providers rates that are at least equal to Medicare payment rates for primary care delivered through December 31, 2014.

Flexible spending limits: Contributions to flexible spending accounts (FSAs) will be limited to $2,500 a year, indexed to the Consumer Price Index (CPI).

Medicare taxes: In addition to the 1.45 percent employee portion of the Medicare Hospital Insurance tax currently imposed on wages, a 0.9 percent Medicare tax will be imposed on every taxpayer who receives wages or self-employment income in excess of $200,000 ($250,000 adjusted gross income in the case of a joint return). Also, a new 3.8 percent tax will apply to “unearned” income for certain high-income taxpayers.

Preventive services in Medicaid: The current state Medicaid option to provide diagnostic, screening, preventive, and rehabilitation services will be expanded to include more services. If a state Medicaid plan chooses to offer these preventive benefits and prohibits cost-sharing, the state will receive an increased federal medical assistance percentage (FMAP) contribution of 1 percentage point for these services.

Major Provisions of the Affordable Care Act

Essential benefits package: The Department of Health and Human Services will establish an essential standard benefits package for policies sold in the exchanges and individual and small-group markets with a choice among tiers of plans (bronze, silver, gold, and platinum) that have different levels of cost-sharing.

Independent payment advisory board. A new independent payment advisory board within the executive branch will work to identify areas of waste and federal budget savings in Medicare. The board's recommendations must not ration care, raise taxes, or change Medicare benefits, eligibility, or cost-sharing.

Insurance industry fee: Insurers will pay an annual fee, based on market share, to help pay for reform.

New rules for insurers: Insurers will be banned from restricting coverage or basing premiums on health status or gender.

Premium subsidies: Premium and cost-sharing assistance on a sliding scale will make coverage affordable for families with annual incomes between $30,000 and $88,000 that buy plans through the exchanges.

Shared responsibility for coverage: Individuals will be required to carry health insurance or pay a penalty, with some exceptions, and employers with 50 or more workers will be required to offer health benefits or be subject to a fine of $2,000 per employee (not counting the first 30 employees) if any worker receives federal premium subsidies for plans purchased through the insurance exchanges.

Insurance exchanges: New state-based marketplaces will offer small businesses and people without employer coverage a choice of affordable health plans that meet new essential benefit standards.

Medicaid expansion: Medicaid eligibility will be expanded to all legal residents with incomes up to 133 percent of the federal poverty level. Currently, states have different—and in many cases very low—eligibility thresholds, and most states do not cover adults without children.

Medicare managed care plans: Four- and five-star Medicare private plans will receive 5 percent bonuses as a reward for providing better clinical quality and patient experiences.

Major Provisions of the Affordable Care Act

High-cost insurance plans: A 40 percent excise tax will be levied at the insurer level on policies with premiums over $10,200 for individuals or $27,500 for family coverage. The premium thresholds are higher for retirees and workers in higher risk industries and are adjusted for the age and gender of workforces.