Timeline for Health Reform Implementation: Overview

Reform will unfold incrementally. Although some major elements of reform begin in 2010, others will be implemented over the course of several years.
In 2014, the most substantial changes—including shared responsibility for coverage, expansion of Medicaid, insurance exchanges, and creation of an essential benefits package—will take effect.

2010

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

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

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.

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

Small-business tax credits: Small businesses (25 or fewer employees and average wages under $50,000) that offer health care benefits will be eligible for tax credits of up to 35 percent of their premium costs for two years.

High-risk pool: People with preexisting conditions who have been uninsured for at least six months will have access to affordable insurance through a temporary, subsidized high-risk pool. Premiums will be based on the average health status of a standard population. Annual out-of-pocket costs will be capped at $5,950 for individuals and $11,900 for families.

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

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

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.

New insurance rules: Insurance companies will be banned from rescinding people's coverage when they get sick, and from imposing lifetime caps on coverage. Restrictions will be placed on annual limits.

2011

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.

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.

CLASS Act: A national, voluntary insurance program for purchasing community living assistance services and support (CLASS) will be established. All working adults will be automatically enrolled—unless they opt out—through payroll deductions that, after five years, will qualify them for monthly payments toward services to help them stay at home should they become disabled.

Pharmaceutical manufacturer fee: An annual, nondeductible fee will be imposed on pharmaceuticals and importers' branded drugs, 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.

Physician quality reporting: Medicare will launch a Physician Compare Web site where beneficiaries can compare measures of physician quality and patient experience.

"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.

Premium share spending: 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.

2012

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

2013

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

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

2014

Shared responsibility for coverage: Individuals will be required to carry health insurance, 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 governmental assistance with premiums through the insurance exchanges.

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. Annual, in addition to lifetime, limits on benefits are banned.

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.

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.

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.

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.

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.

2018

High-cost insurance plans: Insurers will face a 40 percent excise tax on policies with premiums over $10,200 for individuals or $27,500 for family coverage.