Implementation Timeline[1] Under H.R. 3590 The Patient Protection and Affordable Care Act

March 23, 2010

Following is a timeline description of some of the major provisions of the health system reform legislation that the President signed into law March 23, 2010. Because of the complexity of the legislation, only brief summaries are included of the provisions that most directly relate to American Medical Association (AMA) policy. Future documents will be produced that provide more details on aspects of the legislation.

2010

- Extension of medical liability protections under the Federal Tort Claims Act to officers, governing board members, employees and contractors of free clinics.
- Fully funded practice expense Geographic Practice Cost Index (GPCI) floor increase: 2010 and 2011.
- Work GPCI floor extension: Effective for 2010.
- Administrative Simplification: The operating rules development process begins. Health Plans must adopt and implement a set of operating rules for certain electronic transactions within specified time periods on future dates.
- Small business tax credits for employee insurance plans phase-in begin.
- Temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
- Temporary national high-risk pool to provide immediate access to health coverage for individuals with pre-existing medical conditions.
- Dependent coverage for children up to age 26 in all individual and group policies.
- Prohibit rescissions of coverage in all plans, except in cases of fraud.
- Prohibit lifetime limits on coverage and restrict annual limits in all individual and group health plans.
- Prohibit pre-existing condition exclusions for children in all plans.
- Require new group and individual health plans to cover certain preventive services and immunizations without cost-sharing.

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1 This document highlights the implementation timeline for provisions in the H.R. 3590 relating to elements included in American Medical Association Resolution 203 (I-09). A more comprehensive summary document will be forthcoming.

- Require health plans to report medical loss ratios.
- Establish process for states to review and report increases in health plan premiums, and for plans to justify their increases.
- Establish the Patient-Centered Outcomes Research Institute to contract with appropriate federal agencies or the private sector to conduct comparative effectiveness research (CER).

2011

- Primary care/general surgery Medicare bonus (10 percent over 5 years): Effective January 1, 2011 through December 31, 2015. Primary care bonus applies to primary care physicians (family medicine, internal medicine, geriatric medicine or pediatric medicine) and practitioners (NP, CNS, or PA) for whom primary care services (HCPCS codes 99201-99215; 99304-99340; and 99341-99350) account for at least 60 percent of Medicare allowed charges over a designated time period.
- Funding for state demonstration programs to evaluate alternative liability reform models authorized for five fiscal years.
- Physician Quality Reporting Initiative (PQRI) bonuses: Effective for 2011 through 2014, with 1 percent bonus in 2011 and 0.5 percent bonus in subsequent years.
- Plans required to provide rebates if medical loss ratios exceed required minimums.
- Secretary of Health and Human Services (HHS) to oversee convening of stakeholders to receive input on an ICD-9-CM to ICD-10 crosswalk by January 1, 2011.
- Coverage for Medicare wellness and preventive care services, incentives for Medicare preventive services established through elimination of coinsurance.
- Coverage for preventive services and eliminate cost-sharing for such services in Medicaid, and require coverage of tobacco cessation services for pregnant women.
- Restrictions on physician ownership of specialty hospitals: New requirements for meeting exception for physician ownership of hospital effective 18 months after enactment. To qualify for exception the physician ownership or investment and provider agreement must be in place by August 1, 2010 (or December 31, 2010 if the Reconciliation Bill is enacted).

2012

- Practice expense GPCI floor subject to budget neutrality adjustments.
- Medicare claims data release: Effective January 1, 2012.
- Secretary of HHS to solicit input and consider additional electronic transaction standards and operating rules by January 1, 2012.
- Adoption of unique health plan identifier system must occur no later than October 1, 2012 (through rule making).

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- Government Accountability Office (GAO) must issue a report on whether new federal polices, standards and guidelines would create causes of action against health care providers.

2013

- Public reporting of physician performance information to begin January 1, 2013.
- Administrative Simplification: Starting December 31, 2013, health plans would be required to file a certification statement with the Secretary of HHS that their data and information systems comply with the most current published standards.
- Administrative Simplification: Operating rules for eligibility and health plan claims status transactions take effect by January 1, 2013.

2014

- Requirement for most individuals to have acceptable coverage or pay a tax penalty; tax credits and cost-sharing subsidies available.
- Health insurance exchanges established in each state for individuals and small businesses; provide choice of coverage through a multi-state plan.
- Require all qualified health benefits plans to offer at least the essential health benefits package (except grandfathered plans).
- No annual limits on dollar value of coverage.
- Penalties on employers of more than 50 who do not offer coverage and have at least one full-time employee who receives tax credit.
- Require guarantee issue and renewability, limited rate variation, risk adjustment in individual and small group markets, no pre-existing condition exclusions for adults.
- Ensure coverage for individuals participating in clinical trials.
- Limit any waiting periods for coverage to 90 days.
- Expand Medicaid to all individuals under 65 with incomes up to 133 percent of federal poverty level; enhanced payments for primary care physicians in 2013 and 2014 (assuming passage of the Reconciliation Bill).
- Allow states to create a Basic Health Plan.
- Enhanced employer-provided employee wellness programs.
- Administrative Simplification: Operating rules for electronic funds transfers (EFT) and health care payment and remittance advice to take effect by January 1, 2014 (Health care providers, including physicians, must also comply with EFT standard for Medicare payments by January 1, 2014).

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2015

- Independent Payment Advisory Board (IPAB): First implementation year of IPAB Medicare cost reduction recommendations.
- PQRI penalties: Effective beginning 2015 (1.5 percent); (2016 and subsequent years, 2 percent).
- Cantwell cost/quality value index: Effective January 1, 2015 (based on 2014 performance).

2016

- Multi-state compacts to allow insurers to sell policies across state lines (regulations by July 1, 2013).
- Administrative Simplification: Operating rules for health claims or equivalent encounter information, enrollment/disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions to take effect by January 1, 2016.
- Administrative Simplification: Adoption of health claims attachments standard and operating rules to take effect by January 1, 2016.