Timeline for Implementation of Key Provisions of the Patient Protection and Affordable Care Act (PPACA) for 2013-2014

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The 2010 Patient Protection and Affordable Care Act ("PPACA") has already been protested, litigated, appealed and upheld – and many of PPACA's key provisions have not yet been implemented. The many planned changes to the country's health care system due to unfold under the Act were strategically spaced out, scheduling several key dates where various requirements will be imposed. The implementation of the PPACA is phased through January 2020.

The most talked-about date may be January 1, 2014, where all U.S. citizens and others "lawfully present" in the country must obtain health care coverage – whether through an employer, a government program or a health insurance exchange – or will be required to pay a penalty in the form of a tax. Several other changes are designed to enhance coverage options, including the availability of tax credits and subsidies, and penalties for employers who do not offer affordable coverage.

Some of the most anticipated changes to be implemented in 2013 and 2014 include:

- Increased funding for certain Medicaid adult preventative services and vaccines
- Payment bundling to hospitals, doctors and providers that aim to provide more efficient and higher quality health care
- Increased Medicaid payments for primary care physicians, which are designed to increase the pool of primary care physicians available to service Medicaid patients
- Termination of annual dollar limits on essential health benefits
- Penalties for large employers (50 employees or more) who do not offer affordable and/or adequate health care coverage.

The chart below summarizes the key provisions of the PPACA that are set to be implemented in 2013 and 2014. While the dates set out below are current as of the date of publication, readers should be advised that these dates may be extended or delayed.

Effective Date	Item	Notes
January 1, 2013	Improvement of preventative health coverage	New funding will be provided to state Medicaid programs that choose to cover preventative services for patients at little or no cost. Section 4106(b) of the PPACA establishes a funding increase for certain adult preventative services and vaccines. (Section 4106 of the PPACA).

January 1, 2013	Caps on healthcare flexible spending accounts (FSAs) and limited purpose flexible spending accounts (LPFSAs) take effect	The annual maximum contribution for FSAs and LPFSAs are capped at $2,500. Previously, the maximum contributions for FSAs and LPFSAs were set by individual employers. This limit only applies to contributions made through payroll deduction, NOT employer matching contributions.
January 1, 2013	Payment "bundling"	Hospitals, doctors and providers will be paid a flat rate for an episode of care rather than the current fragmented system where items are billed separately to Medicare. The goal of these "bundled" payments is to provide more efficient health care while maintaining and improving quality of care. (Sections 3023 and 1866(D) – National Pilot Program on Payment Bundling). On January 31, 2013, CMS announced the health care organizations selected to participate in the program.
January 1, 2013	Increasing Medicaid payments for primary care doctors	Requires states to pay Medicaid primary care providers at least as much as Medicare providers. The idea is to attract new physicians to Medicaid and provide greater support to physicians already participating in Medicaid. As a result, Medicaid fees paid to certain physicians for primary care services will increase by 73% on average in 2013. (Final Rule-77 Fed. Reg. 66670, 2012).
No later than July 1, 2013	Deadline for distributions of grant money for insurance CO-OPs	The federal government is required to distribute grant money to help establish Consumer Operated and Oriented Plans (CO-OPs). CO-OPs are designed to be non-profit health insurers run by their customers and are meant to offer consumer-friendly, affordable options to individuals and small businesses. Specifically, the Secretary of Health and Human Services must ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state.
August 1, 2013	Reporting Requirements under the "Sunshine" provisions of PPACA kick in	Drug and device manufacturers will be required to track and disclose any payments or other "transfers of value" to physicians and teaching hospitals. Categories of payments that must be reported include consulting fees, honoraria, gifts, food, entertainment, travel, and charitable contributions.
October 1, 2013	Additional funding for Children's Health Insurance Program (CHIP)	States will receive two more years of funding to continue coverage for children not eligible for Medicaid through September 30, 2015. (Sections 2101 and 10203(c)(d)).
January 1, 2014	Health insurance marketplace established	Individuals who work for employers who do not offer health care coverage

		will be able to purchase it directly from the Health Insurance Marketplace. PPACA creates state-based American Health benefit Exchanges and Small Business Health Options (SHOP) Exchanges, which will be administered by a government agency or non-profit organization. SHOP exchanges are designed for small businesses with up to 100 employees.
January 1, 2014	Increased access to Medicaid	Americans under 65 who earn less than 133% of the poverty level (about $14,000 for an individual; $29,000 for family of 4) will be eligible to enroll in Medicaid. (Subtitle A – improved access to Medicaid. Section 2001, Medicaid coverage for the lowest income populations).
January 1, 2014	Termination of annual dollar limits on essential health benefits	For plan years beginning after 2012, group health plans may not establish any annual dollar limits on essential health benefits.
January 1, 2014	Presumptive eligibility determinations by hospitals	Hospitals and clinics that are participating Medicaid providers can determine, based on preliminary applicant information, whether a person is eligible for Medicaid for purposes of providing medical assistance during a presumptive eligibility period. (Section 2202, permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations).
January 1, 2014	Penalty for non-covered individuals	Starting in 2014, individuals who do not obtain health insurance either through their employer, a health insurance exchange or through another program (such as Medicare, Medicaid, etc.) will be required to pay a tax. The exact tax imposed will depend on a formula: o In 2014 it will be the greater of $95 per adult or 1% of taxable income. o In 2015 it will be the greater of $325 per adult or 2% of taxable income. o In 2016 it will be the greater of $695 per adult of 2.5% of taxable income. After 2016 the penalty will increase annually based on a cost-of-living adjustment. The penalty for a child (minor under 18) is half of that as for an adult.
January 1, 2014	Tax credits become available for low-	Individuals and families with incomes of up to 400% of the federal poverty

	income individuals	level that are not eligible for Medicaid, employer-sponsored insurance, or other acceptable coverage can obtain subsidies or credits that can be used to reduce premiums for health insurance obtained through the state insurance exchanges.
January 1, 2014	Increase in small business health insurance tax credit	The small business tax credit for qualified small businesses and small non-profit organizations is increased to up to 50% of the contribution to employees' health insurance premiums. (Section 1421 – Credit for employee health insurance expenses of small businesses). A 35% credit applies to small non-profit organizations.
January 1, 2014	Grants to states for Health Exchanges	Requires the Health and Human Services Secretary to provide grants to states to establish American Health Benefit Exchanges. (Section 1002 Health Insurance Consumer Information).
January 1, 2014	Premium assistant credits	Provide premium assistant credits for individuals and families that have income at or less than 400% of the federal poverty level and enrolled in health plans exchanges. (Section 1401 – refundable tax credit providing premium assistance for coverage under a qualified health plan).
January 1, 2014	Caps on out-of-pocket expenditure for health plans	Lower and middle income groups will pay less out-of-pocket costs than those with higher incomes. The new caps guarantee the consumer will not pay more than a fixed amount annually in out of pocket expenditures for these covered services. (Section 1402 reduced cost sharing for individuals enrolling in qualified health plans).
January 1, 2014	Insurers may not drop or limit coverage for participating in a clinical trial	Health care plans will be prohibited from dropping coverage because an individual chooses to participate in a clinical trial, and cannot deny coverage for routine care they would otherwise provide if an individual is enrolled in a clinical trial. This provision applies to non-grandfathered plans only.
January 1, 2014	Penalty for large employers	Large employers (defined as any employer with over 50 fulltime equivalent or "FTE" employees) must offer health insurance coverage for all of their fulltime employees, or offer affordable and adequate healthcare coverage. Coverage is considered not affordable if an employee is required to pay more than 9.5% of his/her "household income" for coverage. Coverage is insufficient if employee co-pays and deductibles result in the coverage providing less than 60% of the benefit costs. Employers who fail to do so

		will have to pay a penalty if one or more of their FTE employees obtains insurance through a healthcare exchange, **or** qualifies for a subsidy or credit. Importantly, any penalty paid under this provision is not deductible as a business expense. (Section 1513).
January 1, 2014	Guaranteed coverage	Requires that insurers on the individual market, small group market and the exchanges must provide and renew coverage to individuals regardless of health state. Premiums may vary based only on age, geographic area, family composition and tobacco use.