

About the Law

Provisions of the Affordable Care Act, By Year

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2010

NEW CONSUMER PROTECTIONS

- **Putting Information for Consumers Online.** The law provides for [an easy-to-use website](#) where consumers can compare health insurance coverage options and pick the coverage that works for them. *Effective July 1, 2010.*
- **Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions.** The new law includes new rules to [prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.](#) *Effective for health plan years beginning on or after September 23, 2010 for new plans and existing group plans.*
- **Prohibiting Insurance Companies from Rescinding Coverage.** In the past, insurance companies could search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when he or she got sick. [The new law makes this illegal.](#) After media reports cited incidents of breast cancer patients losing coverage, insurance companies agreed to end this practice immediately. *Effective for health plan years beginning on or after September 23, 2010.*
- **Eliminating Lifetime Limits on Insurance Coverage.** Under the new law, insurance companies will be [prohibited from imposing lifetime dollar limits](#) on essential benefits, like hospital stays. *Effective for health plan years beginning on or after September 23, 2010.*
- **Regulating Annual Limits on Insurance Coverage.** Under the new law, [insurance companies' use of annual dollar limits](#) on the amount of insurance coverage a patient may receive will be restricted for new plans in the individual market and all group plans. In 2014, the use of annual dollar limits on essential benefits like hospital stays will be banned for new plans in the individual market and all group plans. *Effective for health plan years beginning on or after September 23, 2010.*
- **Appealing Insurance Company Decisions.** The law provides consumers with a way to [appeal coverage determinations or claims](#) to their insurance company, and establishes an external review process. *Effective for new plans beginning on or after September 23, 2010.*
- **Establishing Consumer Assistance Programs in the States.** Under the new law, states that apply receive [federal grants to help set up or expand independent offices to help consumers navigate the private health insurance system.](#) These programs help consumers file complaints and appeals; enroll in health coverage; and get educated about their rights and responsibilities in group health plans or individual health insurance policies. The programs will also collect data on the types of problems consumers have, and file reports with the U.S. Department of Health and Human Services to identify trouble spots that need further oversight. [Read a list of those who have received CAP grants.](#) *Grants Awarded October 2010.*

IMPROVING QUALITY AND LOWERING COSTS

- **Providing Small Business Health Insurance Tax Credits.** Up to 4 million small businesses are eligible for tax credits to help them provide insurance benefits to their workers. The first phase of this provision provides a credit worth up to 35 percent of the employer's contribution to the employees' health insurance. Small non-profit organizations may receive up to a 25 percent credit. *Effective now.*
- **Offering Relief for 4 Million Seniors Who Hit the Medicare Prescription Drug "Donut Hole."** An estimated four million seniors will reach the gap in Medicare prescription drug coverage known as the "donut hole" this year. Each such senior will receive a \$250 rebate. *First checks mailed in June, 2010, and will continue monthly throughout 2010 as seniors hit the coverage gap.*
- **Providing Free Preventive Care.** All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. Effective for health plan years beginning on or after September 23, 2010. Learn more about preventive care benefits
- **Preventing Disease and Illness.** A new \$15 billion Prevention and Public Health Fund will invest in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity. *Funding begins in 2010.*
- **Cracking Down on Health Care Fraud.** Current efforts to fight fraud have returned more than \$2.5 billion to the Medicare Trust Fund in fiscal year 2009 alone. The new law invests new resources and requires new screening procedures for health care providers to boost these efforts and reduce fraud and waste in Medicare, Medicaid, and CHIP. *Many provisions effective now.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing Access to Insurance for Uninsured Americans with Pre-Existing Conditions.** A new Pre-Existing Condition Insurance Plan will provide new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. States have the option of running this new program in their state. If a state chooses not to do so, a plan will be established by the Department of Health and Human Services in that state. *National program effective July 1, 2010.*
- **Extending Coverage for Young Adults.** Under the new law, young adults will be allowed to stay on their parents' plan until they turn 26 years old (in the case of existing group health plans, this right does not apply if the young adult is offered insurance at work). *While the provision takes effect in September, many insurance companies have already implemented this new practice. Check with your insurance company or employer to see if you qualify. Effective for health plan years beginning on or after September 23.*
- **Expanding Coverage for Early Retirees.** Too often, Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of high rates in the individual market. To preserve employer coverage for early retirees until more affordable coverage is available through the new Exchanges by 2014, the new law creates a \$5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents. *Applications for employers to participate in the program available June 1, 2010. For more information on the Early Retiree Reinsurance Program, visit www.ERRP.gov.*
- **Rebuilding the Primary Care Workforce.** To strengthen the availability of primary care, there are new incentives in the law to expand the number of primary care doctors, nurses and physician assistants. These include funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas. Doctors and nurses receiving payments made under any State loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on

those payments. *Effective 2010.*

- **Holding Insurance Companies Accountable for Unreasonable Rate Hikes.** The law allows states that have, or plan to implement, measures that require insurance companies to justify their premium increases will be eligible for \$250 million in new grants. Insurance companies with excessive or unjustified premium exchanges may not be able to participate in the new health insurance Exchanges in 2014. *Grants awarded beginning in 2010.*
- **Allowing States to Cover More People on Medicaid.** States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents. *Effective April 1, 2010.*
- **Increasing Payments for Rural Health Care Providers.** Today, 68 percent of medically underserved communities across the nation are in rural areas. These communities often have trouble attracting and retaining medical professionals. The law provides increased payment to rural health care providers to help them continue to serve their communities. *Effective 2010.*
- **Strengthening Community Health Centers.** The law includes new funding to support the construction of and expand services at community health centers, allowing these centers to serve some 20 million new patients across the country. *Effective 2010.*

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2011

IMPROVING QUALITY AND LOWERING COSTS

- **Offering Prescription Drug Discounts.** Seniors who reach the coverage gap will receive a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020. *Effective January 1, 2011.* [Download a brochure to learn more \(PDF, 3.6 MB\)](#)
- **Providing Free Preventive Care for Seniors.** The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans for seniors on Medicare. *Effective January 1, 2011.*
- **Improving Health Care Quality and Efficiency.** The law establishes a new Center for Medicare & Medicaid Innovation that will begin testing new ways of delivering care to patients. These methods are expected to improve the quality of care, and reduce the rate of growth in health care costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Additionally, by January 1, 2011, HHS will submit a national strategy for quality improvement in health care, including by these programs. *Effective no later than January 1, 2011.*
- **Improving Care for Seniors After They Leave the Hospital.** The Community Care Transitions Program will help high risk Medicare beneficiaries who are hospitalized avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities. *Effective January 1, 2011.*
- **Introducing New Innovations to Bring Down Costs.** The Independent Payment Advisory Board will begin operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund. The Board is expected to focus on ways to target waste in the system, and recommend ways to reduce costs, improve health outcomes for patients, and expand access to high-quality care. *Administrative funding becomes available October 1, 2011.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Services at Home and in the Community.** The new Community First Choice Option allows States to offer home and community based services to disabled individuals through Medicaid rather than institutional care in nursing homes. *Effective beginning October 1, 2011.*

HOLDING INSURANCE COMPANIES ACCOUNTABLE

- **Bringing Down Health Care Premiums.** To ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, because their administrative costs or profits are too high, they must provide rebates to consumers. *Effective January 1, 2011.*
- **Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage.** Today, Medicare pays Medicare Advantage insurance companies over \$1,000 more per person on average than is spent per person in Traditional Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77 percent of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The new law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care. *Effective January 1, 2011.* [Download a brochure to learn more \(PDF\)](#)

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2012

IMPROVING QUALITY AND LOWERING COSTS

- **Linking Payment to Quality Outcomes.** The law establishes a hospital Value-Based Purchasing program (VBP) in Traditional Medicare. This program offers financial incentives to hospitals to improve the quality of care. Hospital performance is required to be publicly reported, beginning with measures relating to heart attacks, heart failure, pneumonia, surgical care, health-care associated infections, and patients' perception of care. *Effective for payments for discharges occurring on or after October 1, 2012.*
- **Encouraging Integrated Health Systems.** The new law provides incentives for physicians to join together to form "Accountable Care Organizations." These groups allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness and reduce unnecessary hospital admissions. If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. *Effective January 1, 2012.*
- **Reducing Paperwork and Administrative Costs.** Health care remains one of the few industries that relies on paper records. The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information. Using electronic health records will reduce paperwork and administrative burdens, cut costs, reduce medical errors and most importantly, improve the quality of care. *First regulation effective October 1, 2012.*
- **Understanding and Fighting Health Disparities.** To help understand and reduce persistent health disparities, the law requires any ongoing or new Federal health program to collect and report racial, ethnic and language data. The Secretary of Health and Human Services will use this data to help

identify and reduce disparities. *Effective March 2012.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Providing New, Voluntary Options for Long-Term Care Insurance.** The law creates a voluntary long-term care insurance program – called CLASS -- to provide cash benefits to adults who become disabled. The Secretary shall designate a benefit plan no later than *October 1, 2012.*

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2013

IMPROVING QUALITY AND LOWERING COSTS

- **Improving Preventive Health Coverage.** *To expand the number of Americans receiving preventive care, the law provides new funding to state Medicaid programs that choose to cover preventive services for patients at little or no cost. Effective January 1, 2013.*
- **Expanding Authority to Bundle Payments.** The law establishes a national pilot program to encourage hospitals, doctors, and other providers to work together to improve the coordination and quality of patient care. Under payment “bundling,” hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundles of items or services are billed separately to Medicare. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a “bundled” payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program. *Effective no later than January 1, 2013.*

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Medicaid Payments for Primary Care Doctors.** As Medicaid programs and providers prepare to cover more patients in 2014, the Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase is fully funded by the federal government. *Effective January 1, 2013.*
- **Providing Additional Funding for the Children’s Health Insurance Program.** Under the new law, states will receive two more years of funding to continue coverage for children not eligible for Medicaid. *Effective October 1, 2013. [Learn more](#)*

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2014

NEW CONSUMER PROTECTIONS

- **Prohibiting Discrimination Due to Pre-Existing Conditions or Gender.** The law implements strong reforms that prohibit insurance companies from refusing to sell coverage or renew policies because of an individual’s pre-existing conditions. Also, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status. *Effective January 1, 2014.*
- **Eliminating Annual Limits on Insurance Coverage.** The law prohibits new plans and existing group plans from imposing annual dollar limits on the amount of coverage an individual may

receive. *Effective January 1, 2014.*

- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Insurers will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases. *Effective January 1, 2014.*

IMPROVING QUALITY AND LOWERING COSTS

- **Making Care More Affordable.** Tax credits to make it easier for the middle class to afford insurance will become available for people with income between 100 percent and 400 percent of the poverty line who are not eligible for other affordable coverage. (In 2010, 400 percent of the poverty line comes out to about \$43,000 for an individual or \$88,000 for a family of four.) The tax credit is advanceable, so it can lower your premium payments each month, rather than making you wait for tax time. It's also refundable, so even moderate-income families can receive the full benefit of the credit. These individuals may also qualify for reduced cost-sharing (copayments, co-insurance, and deductibles). *Effective January 1, 2014.*
- **Establishing Health Insurance Exchanges.** Starting in 2014 if your employer doesn't offer insurance, you will be able to buy insurance directly in an Exchange -- a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges, and you will be able buy your insurance through Exchanges too. *Effective January 1, 2014.*
- **Increasing the Small Business Tax Credit.** The law implements the second phase of the small business tax credit for qualified small businesses and small non-profit organizations. In this phase, the credit is up to 50 percent of the employer's contribution to provide health insurance for employees. There is also up to a 35 percent credit for small non-profit organizations. *Effective January 1, 2014. [Learn more.](#)*

INCREASING ACCESS TO AFFORDABLE CARE

- **Increasing Access to Medicaid.** Americans who earn less than 133 percent of the poverty level (approximately \$14,000 for an individual and \$29,000 for a family of four) will be eligible to enroll in Medicaid. States will receive 100 percent federal funding for the first three years to support this expanded coverage, phasing to 90 percent federal funding in subsequent years. *Effective January 1, 2014.*
- **Promoting Individual Responsibility.** Under the new law, most individuals who can afford it will be required to obtain basic health insurance coverage or pay a fee to help offset the costs of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption. *Effective January 1, 2014.*
- **Ensuring Free Choice.** Workers meeting certain requirements who cannot afford the coverage provided by their employer may take whatever funds their employer might have contributed to their insurance and use these resources to help purchase a more affordable plan in the new health insurance Exchanges. *Effective January 1, 2014.*

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IMPROVING QUALITY AND LOWERING COSTS

- **Paying Physicians Based on Value Not Volume.** A new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value care will receive higher payments than those who provide lower quality care. *Effective January 1, 2015.*

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HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.



Small Business Health Care Tax Credit for Small Employers



The small business health care tax credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees.

Received a Postcard from the IRS?

Millions of small employers received postcards from the IRS beginning in April 2010 that alerted them to the new small business health care tax credit and encouraged them to check their eligibility. Even if you didn't receive a postcard, your business still may be eligible. Read [more](#) about this effort.

Eligibility Rules

- **Providing health care coverage.** A qualifying employer must cover at least 50 percent of the cost of health care coverage for some of its workers based on the single rate.
- **Firm size.** A qualifying employer must have less than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 half-time workers may be eligible).
- **Average annual wage.** A qualifying employer must pay average annual wages below \$50,000.
- **Both taxable (for profit) and tax-exempt firms qualify.**

Amount of Credit

- **Maximum Amount.** The credit is worth up to 35 percent of a small business' premium costs in 2010 (25% for tax-exempt employers). On Jan. 1, 2014, this rate increases to 50 percent (35 percent for tax-exempt employers).
- **Phase-out.** The credit phases out gradually for firms with average wages between \$25,000 and \$50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Three Simple Steps for Employers to Qualify

To determine if your small business or tax exempt organization qualifies for the small business health care tax credit, follow the three simple steps on our [fact sheet](#).

Examples

Scenarios illustrate [how the credit applies](#) to employers in different circumstances.

Claiming the Credit

Small employers, whether businesses or tax-exempt organizations, will use new [Form 6841](#), Credit for Small Employer Health Insurance Premiums, to calculate the small business health care tax credit.

Small businesses will include the amount of the credit as part of the general business credit on their income tax returns.

Tax-exempt organizations will include the amount of the credit on Line 44f of revised [Form 990-T](#), Exempt Organization Business Income Tax Return. Form 990-T has been revised for the 2011 filing season to enable eligible tax-exempt organizations — even those that owe no tax on unrelated business income — to claim the small business health care tax credit.

For more information, see our [news release](#).

Questions and Answers

Need more detailed information? We have [answers](#).

YouTube Primer on Health Care Credit

This new [video](#) explains the who, what, why and how of the small business health care tax credit.

For More Information

New [guidance](#) makes it easier for small businesses to determine whether they're eligible for the new health care tax credit under the Affordable Care Act and how large a credit they'll receive.

Related Items:

- [IR-2010-98](#), IRS Releases Form to Help Small Businesses Claim New Health Care Tax Credit
- [IRS Marketing Express Widgets](#)
- [Flyer on the Small Business Health Care Tax Credit for small employers](#)
- [Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance](#)
- [Affordable Care Act Tax Provisions](#)

Page Last Reviewed or Updated: March 08, 2011

3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:

1

Determine the total number of your employees (not counting owners or family members):

Full-time employees: _____
(enter the number of employees who work at least 40 hours per week)

+

Full-time equivalent of part-time employees: _____
(Calculate the number of full-time equivalents by dividing the total annual hours of part-time employees by 2080.)

= _____ total employees

If the total number of employees is fewer than 25 **GO TO STEP 2**

2

Calculate the average annual wages of employees (not counting owners or family members):

Take the total annual wages paid to employees: _____

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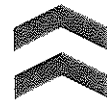
Divide it by the number of employees from STEP 1: _____
(total wages ÷ number of employees)

= _____ average wages

If the result is less than \$50,000, **AND**

3

You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then



you may be able to claim the **Small Business Health Care Tax Credit**.
Find out more information at IRS.gov

