Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Immediate Health Insurance Reforms						
Annual and Lifetime Limits	Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS. **Regulations:** HHS released an interim final rule on June 28. Plans may not establish lifetime limits. Individuals who lost coverage under a plan because they reached the lifetime maximum must be given notice that lifetime limits no longer apply and be given a special enrollment period for enrollment under the same terms and conditions as a similarly situated individual who did not lose coverage because they exhausted a lifetime limit. Annual limits on essential benefits are limited to: • $750,000 for plan years beginning 9/23/2010-9/23/2011 • $1.25 million for plan years beginning 9/23/2011-9/23/2012 • $2 million for plan years beginning 9/23/2012-12/31/2013 In determining whether an individual has reached the annual limit benefits, a plan may only take into account essential benefits. A plan may petition HHS for relaxation of the limits on annual limits if they would cause significant decrease in access to benefits or premium increases. Plans may still impose annual and lifetime limits on specific covered benefits that are not essential benefits, which have not yet been defined in regulation. In the interim, "the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term." These restrictions do not apply to health flexible spending arrangements		Lifetime limits: All plans Annual limits: All plans except grandfathered individual market plans	6 months after enactment	1001	PHSA 2711

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Rescissions	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Prior notification must be made to policyholders prior to cancellation. HHS released an interim final rule on June 28. Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These rules do not apply to prospective cancellations. A plan must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage.		All plans	6 months after enactment	1001	PHSA 2712
Coverage of preventive health services	Plans must provide coverage without cost-sharing for: • Services recommended by the US Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered. The Secretary will determine an interval of not less than 1 year after which new recommendations will be incorporated. **Regulations:** HHS released interim final rules on July 19. Plans that have a network of providers may impose cost sharing for preventive items and services delivered by out-of-network providers. Plans may use reasonable medical management techniques for coverage of preventive items and services to determine the frequency, timing, method, treatment or setting of services to the extent that they are not specified in the relevant recommendation or guideline. If a preventive service is billed separately from an office visit, the plan may impose cost sharing on the office visit. If it is not billed separately from the office visit, then the plan may not impose cost-sharing on the visit if the primary purpose of the visit is to receive the preventive item or service. A plan may impose cost-sharing for a treatment not described in the regulations,	Secretary of HHS	All non-grandfathered plans	6 months after enactment	1001	PHSA 2713

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	even if that treatment results from an item or service that is. This regulation expires on July 12, 2013, or such earlier date specified in final regulations.					
Extension of adult dependent coverage	Plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. The Secretary will define which adult children coverage must be extended. For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.	Secretary of HHS	All plans	6 months after enactment	1001 HR 4872 §2301	PHSA 2714
	Regulatory Guidance: HHS released an interim final rule on May 13, 2010. The rule clarifies that, with respect to children who have not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant (in the individual market, the primary subscriber). Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency on the participant or primary subscriber (or any other person), residency with the participant or primary subscriber (or any other person), student status, employment, eligibility for other coverage, or any combination of these. Surcharges for coverage of children under age 26 are not allowed except where the surcharges apply regardless of the age of the child (up to age 26), and that, for children under age 26, the plan cannot vary benefits based on the age of the child. The rule requires a plan or issuer to give a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment might otherwise occur. This enrollment period must be provided not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. In subsequent years, dependent coverage may be elected for an eligible child in connection with normal enrollment opportunities under the plan or coverage. Any child enrolling in group health plan coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under the regulations interpreting the HIPAA portability provisions.					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	Accordingly, the child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status and cannot be required to pay more.					
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions. **Regulations:** HHS released an interim final rule on June 21. Plans may not impose any exclusion of benefits (including a denial of coverage) limit coverage based upon a preexisting condition, for an individual under age 19.		All plans except grandfathered individual market plans	6 months after enactment for under 19.	1201 & 10103(e)	PHSA 2704
Uniform explanation of coverage documents and standardized definitions	The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. The summary must contain: • Uniform definitions of insurance and medical terms • A description of coverage and cost sharing for each category of essential benefits and other benefits • Exceptions, reductions and limitations in coverage • Renewability and continuation of coverage provisions • A "coverage facts label" that illustrates coverage under common benefits scenarios • A statement of whether it provides minimum essential coverage with an actuarial value of at least 60% that meets the requirements of the individual mandate • A statement that the outline is a summary and that the actual policy language should be consulted • A contact number for the consumer to call with additional questions and the web address of where the actual policy language can be found. The Secretary must consult with the NAIC, as well as a working group of insurers, providers, patient advocates, and those representing individuals with limited English proficiency.	**Secretary of HHS, in consultation with the NAIC and a working group of consumer advocacy organizations, insurers, health care professionals, patient advocates, and other qualified individuals.**	All plans	Standards developed within 12 months. Uniform documents implemented within 24 months	1001	PHSA 2715
Provision of additional information	All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied		All non-grandfathered plans	6 months after enactment	1001	PHSA 2715A

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	• Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage • Other information as determined appropriate by the Secretary					
Prohibition on discrimination based on salary	Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans. The Secretary of HHS will develop rules.		Fully insured non-grandfathered group health plans	6 months after enactment	1001	PHSA 2716
Ensuring quality of care	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors • Implement wellness and health promotion activities	Secretary of HHS, in consultation with experts in health care quality and stakeholders	All non-grandfathered plans	2 years after enactment	1001	PHSA 2717
Bringing down the cost of health care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. The report must include the percentage of total premium revenue, after accounting for risk adjustment, premium corridors, and payments of reinsurance that is expended on: • Reimbursement for clinical services • Activities that improve health care quality • All other non-claims expenses, including the nature of the costs, excluding Federal and State taxes and licensing or regulatory fees Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups. **Regulatory Guidance:** On November 22, HHS issued an interim final rule on November 22 and technical corrections on December 30. The regulations are based largely upon the NAIC's Patient Protection and Affordable Care Act Medical Loss Ratio Regulation.	**The NAIC shall establish, by December 31, 2010, uniform definitions of the categories of expenses and standardized methodologies for calculating measures of them.**	All fully insured plans, including grandfathered plans	01/01/11	1001	PHSA 2718

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	▪ "**Plan Year**" is defined as the calendar year, which means the Medical Loss ratio will be calculated based on premiums received (minus taxes and fees) and claims and quality improvement activities expenses beginning January 1 and ending December 31. The MLR report will be completed and any required rebates will be paid in the following year. ▪ "**Small Group"** is defined as coverage issued to employers with 1-100 employees, unless, until 2016, state law specifies that the upper limit is 50. ▪ "**Federal and State taxes and licensing and regulatory fees"** are defined as adopted by the NAIC in the Supplemental Blank. Taxes include all taxes except federal income taxes on investment income. ▪ "**Expenses to improve health care quality**" are defined as adopted by the NAIC in the Supplemental Blank. In essence, such activities include those that: 1) improve health outcomes, including increasing the likelihood of desired outcomes compared to baseline and reducing health disparities among specified populations; 2) prevent hospital readmissions; 3) improve safety and reduce medical errors, lower infection and mortality rates; 4) increase wellness and promote health activities; or 5) enhance the use of health care data to improve quality, transparency, and outcomes. The interim final rule outlines some specific items that are included and not included in these activities. ▪ Experience is aggregated by state, by market (individual, small group, large group), and by licensed entity. In the case of an employer with employees in more than one state, the experience of the employer would be aggregated in the state where the contract was issued. ▪ Issuers who have blocks of business less than a given size can make a credibility adjustment to their MLR calculation. o Blocks with less than 1,000 life years are considered non-credible and will not be required to pay rebates in most cases. o Blocks greater than 1,000 but less than 75,000 life years may add a credibility adjustment to the calculated MLR. o The credibility adjustment is the product of a base factor that varies by life years and a plan cost-sharing factor that varies by deductible. o Blocks greater than 75,000 life years are considered fully credible and can't use a credibility adjustment. The factors for the credibility adjustment are as follows					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section

Table 1
Base Credibiilty Additive Adjustment Factors

Life Years	Additive Adjustment
<1,000	No Credibility
1,000	8.3%
2,500	5.2%
5,000	3.7%
10,000	2.6%
25,000	1.6%
50,000	1.2%
75,000	0.0%

Table 2
Plan Cost-Sharing Adjustment Factors by Deductible Range

<$2,500	1.00
$2,500	1.164
$5,000	1.402
>=$10,000	1.736

- **Payment of Rebates**. Rebates must be paid to the individual or entity that paid the premium no later than August 1 of the year following the end of the MLR reporting year. Issuers may provide rebates in the form of a premium credit or lump-sum reimbursement. If the total rebate for a group or individual policy is less than $5, insurers may instead aggregate them and increase the rebates due policyholders whose rebates are above the $5 threshold. In the group market, insurers may enter into arrangements to provide all rebates due a to a group to the policyholder for pro-rated distribution to enrollees.
- **Application to Expatriate and Limited Benefit Plans**. Expatriate plans, issued to U.S. nationals employed abroad are exempted from the MLR requirement due to their higher intrinsic administrative costs and the fact that these plans compete against plans issued by foreign insurers not subject to U.S. law, but must aggregate and report data to HHS. Plans that have received waivers from the restrictions on annual limits will be exempted from the MLR requirement for a period of one year while HHS determines what the future treatment of these plans will be. They will, however, be required to submit MLR data to HHS on a quarterly basis.
- **Adjustments**. Insurance Commissioners may request an adjustment of the minimum MLR for the individual market in their states. The interim final rule specifies the procedure for requesting an adjustment and for

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	consideration of requests by HHS.					
Appeals process	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.	Secretaries of Labor and HHS	All non-grandfathered plans	6 months after enactment	1001	PHSA 2719
	Regulatory Guidance: HHS released an interim final rule on July 23. The regulations expand the definition of "adverse benefit determination" to include rescissions of coverage whether or not there is an adverse effect upon any particular benefit. *Internal Appeals* Plans must comply with the DOL Claims regulations, as published in the Federal Register on Nov. 21, 2000, as currently modified. These modifications require plans to: • Treat a rescission of coverage as an adverse benefit • Notify a claimant of a benefit determination involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim, unless the claimant fails to provide sufficient information • Allow a claimant to review the claim file and present evidence and testimony • Provide a claimant, free of charge, with any new or additional evidence or rationales in connection with the claim as soon as possible • Ensure that all claims and appeals are adjudicated in a way designed to ensure the independence and impartiality of the persons involved • Ensure that any notice of adverse benefit includes information sufficient to identify the claim involved, • Ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision. • Provide a description of available internal appeals and external review processes, including information on how to initiate an appeal. • Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with the internal clams and appeals and external review processes. All internal appeals processes are deemed to have been exhausted if a plan fails to strictly adhere to all requirements and the claimant may file an external review. Individual market plans must only provide for one level of internal review and must retain records for six years. *External Appeals* If a state external review process provides, at a minimum, consumer protections in the NAIC Uniform Health Carrier External Review Model Act (#76), then carriers must meet that standard. Carriers in states whose processes do not meet that standard and plans not subject to state regulation must comply with a new Federal external review process that is similar to the NAIC model.					
Patient Protections	A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.		All non-grandfathered plans	6 months after enactment	1001	PHSA 2719A
	Regulations: HHS released an interim final rule on June 28. Any cost-sharing requirement for emergency services provided out-of-network cannot exceed cost-sharing requirements for in-network emergency services. Enrollees may, however, be required to pay, in addition to the in-network cost-sharing, any excess provider charges beyond the greater of: the following: • The median amount negotiated with in network providers for the					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	emergency service negotiated; • The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed; • The amount that would be paid by Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed. Any cost-sharing other than a copayment or coinsurance, such as a deductible, may be applied if that requirement applies to out-of-network benefits. A plan that requires the designation of a primary care provider must provide a notice to each participant of the terms of the plan regarding this designation, and any rights under this section. This notice must be provided with the summary plan description or other description of benefits, or in the case of an individual policy, when the issuer provides a primary subscriber with a policy, certificate, or contract. The regulation provides model language.					
Health insurance consumer assistance offices and ombudsmen	The Secretary of HHS shall provide $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to: • Assist with the filing of complaints and appeals • Collect, track, and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies As a condition of receiving a grant, a state must collect and report data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.			Date of enactment	1002	PHSA 2793
	Grant Requirements: HHS released a grant announcement on July 22. Applications must be submitted by September 10. Grant awards will be made around October 8. HHS will award grants based upon a state's population to state agencies, including insurance departments, independent offices of health insurance consumer assistance, attorneys general, and independent state consumer assistance agencies, or to nonprofit organizations contracting with the state. Agencies receiving grants must be able to advocate freely and vigorously on behalf of consumers and be capable of reporting objective data to the Secretary on the responsiveness of agencies that oversee private health insurance and					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	group plans and public coverage. Grant funds must be used to support the following activities: • Assist with the filing of complaints and appeals; • Collect, track and quantify problems and inquiries encountered by consumers; • Educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; • Assist consumers with enrollment in group health plans or health insurance coverage by providing information, referral, and assistance; and • Resolve problems obtaining premium subsidies/ Entities receiving grants must provide quarterly data to HHS on: • Caseload • Caller demographics • Types of coverage involved • Problem types • Data on referrals and responsiveness • Case resolution • Data on recovered benefits • Data on provider and industry behavior					
Ensuring that consumers get value for their dollars	The Secretary, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online. The Secretary shall award $250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services.	The Secretary in conjunction with the states.	All non-grandfathered fully-insured plans	2010 plan year	1003	PHSA 2794
	Regulatory Guidance: HHS released a notice of proposed rulemaking on December 21, 2010. The proposed rule would apply only to non-grandfathered individual and small group health insurance coverage. For the purposes of this rule, the rule defers to state definitions of the small group market. If a state has no definition, small group is defined as 1-50 employees. It does not include groups of more than 50 employees at this time. HHS is still reviewing whether or how this section will					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	apply to the large group market. **Rates subject to review.** A rate increase in excess of 10% for increases filed on or after July 1, 2011, or effective on or after that date if the state does not require filing. In calendar year 2012 and following, a rate increase in excess of 10% or a state-specific threshold if one is established by the Secretary. The rate increase exceeds a threshold if, in combination with other increases from the past 12 months, the weighted average increase for all enrollees exceeds the threshold. **Review of rates.** HHS will review all increases subject to review, unless it determines that the state has an effective rate review program and it provides HHS with a final determination of whether the increase is unreasonable. In determining whether a state has an effective rate review program in the individual or small group market, HHS will use the following criteria: 1. The state receives sufficient data and documentation from insurers in connection with increases 2. The state conducts an effective and timely review of the data and documentation 3. The state examines the reasonableness of the insurers' assumptions and the validity of historical data and the accuracy of the insurers' past projections. 4. The examination includes an analysis of the impact of changes in medical trend, utilization, cost-sharing, and benefits by major service categories, as well as the impact of changes in enrollee risk profile, over- or under-estimate of medical trend for prior periods, changes in reserve needs, changes in administrative costs that improve health care quality, changes in applicable taxes, licensing or regulatory fees, the medical loss ratio, and the insurer's risk-based capital status. 5. The state determines whether a rate is reasonable based upon a standard that is set forth in statute or regulation. **Definition of unreasonable.** An increase is unreasonable if it is: 1. Excessive—Premiums are unreasonably high in relation to the benefits provided. In determining this, HHS will consider: a. Whether the rate results in an MLR below the federal standard in the appropriate market b. Whether the assumptions behind the rate increase are not supported by substantial evidence or the choice of assumptions is unreasonable. 2. Unjustified—The data and documentation provided to HHS is incomplete, inadequate, or otherwise does not provide a basis for reasonableness. 3. Unfairly discriminatory—The increase results in premium variation between insureds in similar risk categories that are impermissible under state law or do not correspond to differences in expected costs if no					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	applicable state law exists. 4. A state finds it to be otherwise unreasonable. **Submission of disclosure.** An insurer must submit to HHS and the state (if it accepts them) a preliminary justification for each product affected by a rate increase that is subject to review. This must be submitted within the timeframe specified in the state's rate review process, or prior to implementation if the state has no requirement. The preliminary justification must consist of a summary, a written justification, and, if the review is conducted by HHS, rate filing documentation. If the claims experience of multiple products has been aggregated to calculate rate increases and those increases are uniform across all products, the insurer may submit a single, combined preliminary justification. The rate increase summary must contain historical and projected claims experience, trend projections for cost and utilization, claims assumptions related to benefit changes, allocation of the increase to claims and non-claims costs, PMPM allocation of current and projected premium, current and projected loss ratio, 3-year premium history for the product, and employee and executive compensation from the insurer's financial statement. The written justification must contain an explanation of the rating methodology, an explanation of the most significant factors causing the increase, and a brief description of the overall experience of the policy. The rate filing documentation must contain a description of the policy, the scope and reason for the increase, the average annual premium before and after the increase, past experience and other data used, a description of how the increase was determined, including a description and the source of any assumptions, the cumulative, projected future, and projected lifetime loss ratios, and the applicable federal medical loss ratio standard and justification for any failure to meet that standard. HHS will place the disclosures on its website along with its final determination and a brief explanation of its analysis. If a state reviews the increase, HHS will adopt the state's determination and will post the state's final determination on its website. If an insurer elects not to implement an unreasonable increase or to implement a lower increase, it must notify the state and HHS of that fact. If the issuer implements an unreasonable increase, it must submit a final justification to HHS and prominently post the information on the company web site for at least 3 years.					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Temporary high risk pool program	The Secretary shall establish a temporary high risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least 6 months. The program may be carried out directly or through contracts with states or nonprofit entities. States must agree not to reduce the annual amount expended for current high risk pools before enactment. Provides $5 billion to fund pools through 2013 Pools funded through these grants must: • Have no preexisting condition exclusions • Cover at least 65% of total allowed costs • Have an out-of-pocket limit no greater than the limit for high deductible health plans • Utilize adjusted community rating with maximum variation for age of 4:1 • Have premiums established at a standard rate for a standard population The Secretary shall establish criteria to prevent insurers and employers from encouraging enrollees to drop prior coverage based upon health status.	Secretary of HHS		90 days after enactment	1101	
	Regulatory Guidance: HHS distributed a Solicitation for State Proposals to Operate Qualified High Risk Pools on May 10. Individuals may satisfy the preexisting condition criterion for eligibility by providing evidence of a denial of coverage, that coverage is available only with an exclusionary rider, or the presence of certain medical conditions specified by the state and approved by HHS. Funds will be allocated on a non-competitive basis according to population, number of uninsured individuals, and geographic cost variations. HHS will establish accounts for states to draw down funds for benefit claims. Administrative expenses will be limited to 10% of the total state allocation.					
Temporary reinsurance program for early retirees.	The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80% of costs incurred by early retirees over the age of 55 but not eligible for Medicare between $15,000 and $90,000 annually. Payments under the program must be used to lower costs of the plan. Provides $5 billion to fund the program.	Secretary of HHS		90 days after enactment	1102	
	Regulatory Guidance: HHS released an interim final rule on May 5, 2010. The rules interpret the provision to require reimbursements to be made to the plan sponsor, rather than to the insurer providing coverage if the group health plan is fully-insured.					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Web portal to identify affordable coverage options	The Secretary shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage. It will allow them to receive information on: • Health insurance coverage • Medicaid • CHIP • Medicare • A high risk pool • Small group coverage, including reinsurance for early retirees, tax credits, and other information The Secretary shall develop a standard format to be used in presenting information relating to coverage options, which shall include: • The percentage of total premiums spend on nonclinical costs • Availability • Premium rates • Cost sharing	Secretary of HHS, in consultation with the states Secretary of HHS		07/01/10 60 days after enactment	1103	
	Regulatory Guidance: HHS released an interim final rule on May 5, 2010 and has held a series of conference calls and webinars with states. The first phase of the portal will launch by July 1, and will provide summary level information on coverage options by state and ZIP code. In October the second phase will launch providing more detailed pricing and benefit information with a plan-compare functionality. States have been asked to provide the names and contact information for each carrier in the state, and the number of plans each sells in the individual, small-group and large-group markets. This information will be used to verify information submitted by the individual insurers.					
Administrative simplification requirements	Requires the Secretary to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions.			Rules adopted by July 1, 2011 to become effective by January 1, 2013.	1104	SSA 1171
2014 Market Reforms						
SUBTITLE C—Quality Health Insurance Coverage for All Americans						

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PART I—HEALTH INSURANCE MARKET REFORMS **Subpart I—General Reform**						
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All plans except grandfathered individual market plans	6 months after enactment for individuals 19 and under. Plan years beginning 01/01/14 for all others.	1201	PHSA 2704
Fair health insurance premiums	Premiums may only vary by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family Each state shall establish one or more rating areas for the purposes of geographic rating. The Secretary shall review them and determine their adequacy. If they are not adequate, or if a state fails to establish them, the Secretary may establish rating areas for the state.	*Geographic rating areas*: States, with Secretarial review *Age bands*: Secretary, in consultation with the NAIC	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	Plan years beginning 01/01/14		PHSA 2701
Guaranteed availability of coverage	Insures must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods.	Secretary of HHS	Non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2702
Guaranteed renewability of coverage	Insurers must renew or coverage or continue it in force at the option of the plan sponsor or the individual.		All non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2703
Prohibiting discrimination against individual participants and beneficiaries based on health status	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status • Medical condition • Claims experience • Receipt of health care • Medical history	Secretary of HHS	All non-grandfathered plans	Plan years beginning 01/01/14		PHSA 2705

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	• Generic information • Evidence of insurability (including conditions arising out of domestic violence) • Disability • Any other health-status related factor deemed appropriate by the Secretary Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health status-related factor must limit such rewards to 30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. Wellness programs must be reasonably designed to promote health or prevent disease and must give eligible individuals the opportunity to qualify for the reward at least once per year, and rewards must be made available to all similarly situated individuals. Existing wellness programs established before March 23, 2010, may continue to be carried out. Creates a Wellness Program Demonstration Program in 10 states to allow states to design wellness programs for individual market enrollees.	Secretary of HHS, in consultation with Secretaries of Treasury and Labor	Non-grandfathered individual market plans	07/01/2014		
Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon: • Whether they receive subsidies • Whether they provide information to state or federal investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act	Secretary of HHS	All non-grandfathered plans	Plan years beginning 01/01/14		PHSA 2706
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.		All non-grandfathered plans	Plan years beginning 01/01/14		PHSA 2707
Prohibition on Excessive Waiting	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.		All group plans	Plan years beginning		PHSA 2708

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Periods				01/01/14		
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.		All non-grandfathered plans	Plan years beginning 01/01/14		PHSA 2709
PART II—OTHER PROVISIONS						
Preservation of right to maintain existing coverage	Subtitles A and C of this bill shall not apply to coverage in which an individual was enrolled as of the date of enactment.. The following provisions will apply to grandfathered plans: • PHSA §2708-Excessive waiting periods • PHSA §2711-Lifetime limits only • PHSA §2712-Rescissions • PHSA §2714-Extension of dependent coverage • PHSA §2715-Uniform summary of benefits and coverage and standardized definitions • PHSA §2718-Medical loss ratios Provisions of PHSA §2711 relating to annual limits and of PHSA §2704 relating to preexisting condition exclusions apply to grandfathered group health plans for plan years beginning when they would first otherwise apply. Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage. Coverage maintained pursuant to a collective bargaining agreement ratified before the date of enactment is not subject to Subtitles A and C until the expiration of that agreement. A Change made to coverage to conform to these subtitles is not considered termination of an agreement.		All coverage in place on the date of enactment.	Date of enactment (March 23, 2010)	1251	
	Regulations: HHS published an interim final rule on June 17. Grandfathered plans must provide notice to enrollees in any plan materials describing benefits that they believe themselves to be grandfathered. Model language is provided. Grandfathered plans must maintain records documenting the terms of the plan in connection with coverage in effect as of March 23, 2010. If the principal purpose of a merger, acquisition or similar business restructuring					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	is to cover new individuals under grandfathered plans, those plans will cease to be grandfathered. Group coverage maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, will continue to be grandfathered until the last of the collective bargaining agreements in effect on March 23, 2010 terminates. The following actions will cause a plan to lose its grandfathered status" • The elimination of all or substantially all benefits to diagnose or treat a particular condition; • Any increase in percentage cost-sharing requirements (such as coinsurance); • An increase in fixed-amount cost sharing other than a copayment (such as a deductible) of more than medical inflation plus 15%; • An increase in a copayment of more than medical inflation plus 15% or $5 increased by medical inflation, whichever is greater; • A decrease in the proportion of premiums paid by the employer of more than 5%; • Addition of an annual limit on benefits if the plan had neither an annual or lifetime limit in place on March 23, 2010; • Addition of an annual limit that is lower than the lifetime limit the plan had in place on March 23, 2010; or • Decrease of an annual limit that was in place on March 23, 2010. Changes made prior to March 23 but effective after March 23; changes made after March 23 pursuant to a contract entered into or an insurance department filing prior to March 23; and changes effective after March 23 pursuant to written amendments to a plan adopted prior to March 23 will be considered in place as of March 23. Changes made after March 23 and adopted prior to the date that this regulation was issued (June 14) will not cause a plan to lose grandfathered status if the changes are modified or revoked effective the first day of the plan year beginning September 23, 2010. **Updated Regulations:** HHS published an update to its grandfathering regulations on November 17. The update allows fully-insured group health plans to retain their grandfathered status if they replace existing coverage with a new policy, so long as the terms of the new policy do not violate any of the tests would cause an existing plan to lose					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	grandfathered status.					
Rating reforms must apply uniformly to all health insurance issuers and group health plans	Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.			Plan years beginning 01/01/14	1252	
Study of Large Group Market	The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure. The Secretary shall also collect information on: • The extent to which self-insured plans can offer less expensive coverage and whether lower costs are due to more efficient plan administration and lower overhead or the denial of claims and more limited benefit packages; • Claim denial rates and benefit fluctuations and the impact of limited recourse options for consumers; and • Potential conflict of interest as it relates to the health care needs of self-insured enrollees and the employer's financial contribution or profit margin.	Secretary of HHS Secretary of HHS, in conjunction with the Secretary of Labor		No later than 1 year after enactment	1254	
Effective Dates	All provisions of this subtitle become effective for plan years beginning January 1, 2014, except that the grandfathering of existing plans becomes effective on the date of enactment, and the prohibition on preexisting condition exclusions becomes effective with respect to enrollees under age 19 for plan years beginning 6 months after enactment.				1255	
Health Insurance Exchanges						
SUBTITLE D—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS PART I—Establishment of Qualified Health Plans						
Qualified Health Plans Defined	A "qualified health plan" is a health plan that • Is certified by each Exchange through which it is offered • Provides the essential benefits package • Is offered by an issuer that is • Licensed and in good standing in each state in which it is		Qualified Health Plans	01/01/14	1301	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	offered • Agrees to offer at least one silver plan and one gold plan • Agrees to charge the same premium whether the plan is sold through the Exchange or outside the Exchange • Complies with other requirements of the Secretary and the Exchange A reference to a qualified health plan is also a reference to a Co-Op plan and a Multi-State plan. A qualified health plan may offer coverage through a primary care medical home plan A qualified health plan may vary premiums by rating area.					
Essential Health Benefits Requirements	The essential health benefits package must cover the following general categories of services: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care The scope of benefits is to be determined by the Secretary of HHS and equal to the scope of benefits under a typical employer-based plan. Nothing shall prevent a qualified health plan from providing benefits in excess of the essential benefits package. The cost-sharing under a health plan may not exceed the cost-sharing for high-deductible health plans in 2014 (currently $5,950 individual/$11,900 family). In following years, the limitation on cost-sharing is indexed to the rate or average premium growth. Deductibles for plans in the small group market are limited to $2,000 individual/$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.	Secretary of HHS		01/01/2014	1302	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	The levels of coverage are defined as follows: • **Bronze level**-Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. • **Silver level**-Must provide coverage that provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan. • **Gold level**-Must provide coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan. • **Platinum level**-Must provide coverage that provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan. Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them or because of a hardship may purchase a catastrophic plan providing the essential benefits package with a deductible equal to the total limitation on cost-sharing above and first-dollar coverage of at least three primary care visits. Plans offered through the Exchange must also be available as a plan available only to individuals under the age of 21.					
Special Rules	State opt-out of abortion coverage: A state may prohibit qualified health plans offered through the exchange from covering abortions. Special rules relating to coverage of abortion services: This title shall not be construed to require a plan to cover abortion services as part of the essential benefits package. If a plan covers elective abortion services, it may not use any funds attributable to subsidies provided through the Exchange to pay for them and must collect a separate payment from enrollees for the actuarial value of those services. State insurance commissioners shall insure that health plans comply with the requirement that plans segregate funds for abortion services.		Qualified health benefits plans	01/01/14	1303	
Related Definitions	Small group market is defined to include employers with 1-100 employees. Until January 1, 2016, states may elect to define it as employers with 1-50 employees.			01/01/14 State option to define market as 1-50 ends 01/01/16	1304	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT PLANS						
Affordable choices of health benefits plans	Grants will be made available to states in amounts to be specified by the Secretary of HHS for planning and activities related to establishing an Exchange. Grants may be renewed if the State is making progress in establishing an Exchange and the market reforms. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees or other means. The Secretary is also directed to provide technical assistance to states on facilitating participation of small employers in SHOP exchanges.	Secretary of HHS		Beginning not later than 1 year after the date of enactment, lasting until 01/01/15	1311	
	Grant Announcement: HHS released a grant announcement on July 29. Applications are due by September 1, 2010. Awards will be made by September 30, 2010. Each state and the District of Columbia will be eligible for $1 million in this round of funding.. States receiving the grant will be required to provide quarterly reports, as well as a final project report that would include: • A draft implementation plan that includes goals, objectives, responsible parties, costs, timeframes and milestones; • A needs assessment that includes baselines of staff, funding, and information technology needs; • A list of resources and capabilities, an organizational chart that includes key personnel, and biographical sketches of such personnel; and • An evaluation plan to include a detailed description of data collection activities and analyses, from which the State will base its design for covering its uninsured. In the grant project narrative, states should describe activities that will be funded in the following areas: • Background research • Stakeholder involvement • Program integration • Resources and capabilities • Governance • Finance • Technical infrastructure • Business operations • Regulatory or policy actions.			01/01/14		

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	Grant funds may not be used to: • Provide direct services to individuals; • Meet matching requirements for other Federal programs; • Promote federal or state legislative and regulatory modifications; • Improve systems or processes solely related to Medicaid/SCHIP eligibility. Additional Exchange establishment grants are expected in early 2011.					
	Each state shall establish, as a governmental agency or nonprofit entity, an American Health Benefit Exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (referred to as a "SHOP Exchange") to assist qualified employers in facilitating the enrollment of employees in small group qualified health benefits plans states. States may choose to establish a single Exchange that performs both functions. States may jointly form regional Exchanges or may form multiple subsidiary exchanges if each one serves a distinct geographic area. Exchanges may contract with entities with demonstrated experience in the individual and small group markets and in benefits coverage if the entity is not an insurer or controlled by an insurer, or with the state Medicaid agency. Exchanges must consult with relevant stakeholders, including consumers, those with experience facilitating coverage in qualified health plans, representatives of small businesses, state Medicaid offices, and advocates for enrolling hard-to reach populations. Exchange must publish online an accounting of its administrative costs, including of funds lost to waste, fraud, and abuse. Exchanges may not sell plans that are not qualified health benefits plans, except for stand-alone dental plans if they offer pediatric dental benefits meeting the requirements of the act. Exchanges must provide for an initial open enrollment period, annual open enrollment periods after the initial period, and special enrollment periods under circumstances similar to those for Medicare PDPs, and special enrollment period for Native Americans. Exchanges may sell qualified health plans that provide only the essential benefits package, except that states may require additional benefits if it defrays enrollees for the additional cost of these benefits.					

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	An exchange must, at a minimum:
	• Certify qualified health benefits plans consistent with guidelines developed by the Secretary of HHS if making them available through the Exchange is in the interests of individuals and employers in the state.
	  • An Exchange may not exclude a health plan:
	  • Because it is a fee-for-service plan,
	  • Through the imposition of premium price controls
	  • On the basis that the plan provides necessary treatments in circumstances that the Exchange deems inappropriate or too costly
	  • In order to be certified, plans must:
	  • Meet marketing requirements
	  • Meet network adequacy requirements under PHSA §2702(c)
	  • Include in networks essential community providers that serve low-income, underserved communities
	  • Be accredited by an entity recognized by the Secretary for accreditation of health plans
	  • Implement market-based strategies for quality improvement
	  • Utilize a uniform enrollment form that takes into account criteria that the NAIC develops and submits to the Secretary
	  • Utilize the standard format established for presenting health benefits plan options; and
	  • Provide information to the Exchange and enrollees on quality measures for health plan performance
	  • Submit justifications of any premium increase prior to implementation and post it on its website. Such justifications shall be taken into account when certifying plans.
	  • Submit to the Exchange, the Secretary of HHS, and the state Insurance Commissioner and publicly disclose the following information:
	  • Claims payment policies and practices
	  • Periodic financial disclosures
	  • Data on enrollment
	  • Data on disenrollment
	  • Data on the number of claims that are					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	denied • Data on rating practices • Information of cost-sharing and payments with respect to any out-of-network coverage • Information on enrollee rights • Other information specified by the Secretary • Allow individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website. • Contract with hospitals with more than 50 beds only if they utilize a patient safety evaluation system and provide education and counseling upon discharge, comprehensive discharge planning, and post-discharge reinforcement by a health care professional • Contract with a health care provider only if they implement quality improvement mechanisms required by the Secretary of HHS • Operate a toll-free consumer assistance hotline • Maintain a website to provide standardized comparative information on qualified health benefits plans • Assign a rating based upon relative quality and price to each qualified health benefits plan. • Use a standardized format for presenting coverage options under the Exchange, including use of the uniform outline of coverage • Inform individuals of eligibility requirements for the state's Medicaid program, CHIP program and any applicable state or local public program and screen and enroll eligible individuals in these programs • Certify exemptions from the individual mandate • Transfer information to the Secretary of Treasury on exemptions form the individual mandate, as well as on employees receiving subsidies through the exchange because the employer failed to provide sufficient affordable coverage. • Provide information to employers on employees who cease coverage in a qualified health benefits plan • Establish a navigator program to provide to entities with relationships to employers and employees, consumers, or self-employed individuals. Grants must be made out of operational funds, and may not use federal funds for establishment of Exchanges.					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	Navigators will: • Conduct public education activities • Distribute information concerning enrollment in plans and subsidy availability • Facilitate enrollment in plans • Provide referrals to health insurance consumer assistance offices or ombudsmen to enrollees with grievances, complaints or questions: Eligible entities include • Trade, industry, and professional associations • Commercial fishing industry organizations • Community and consumer-focused nonprofit entities • Chambers of commerce • Unions • Resource partners of the Small Business Administration • Licensed insurance producers, • Other entities that are not insurers and do not receive any direct or indirect compensation from insurers in connection with plan enrollments or disenrollments. The Secretary, in collaboration with states, will develop standards to ensure that information provided by navigators is fair, accurate, and impartial.					
Consumer choice	Individuals enrolling in the Exchange may choose any plan for which they are eligible. Employers may specify a level of coverage for which to provide support, and employees may choose any plan that offers coverage at that level. Individuals may pay premiums directly to the insurer. Insurers must consider all enrollees in all non-grandfathered plans in the individual and small group markets, respectively, to be members of the same risk pools. States may require the individual and small group markets to be merged, but may not require that grandfathered plans be pooled together with non-grandfathered plans. Nothing in this title prohibits an insurer from offering insurance outside of the Exchange or eligible individuals and employers from purchasing coverage outside the Exchange. No individual or employer shall be compelled to purchase coverage through the Exchange. Members of Congress and their personal staff will no longer be eligible for the FEHBP, and must purchase coverage through the Exchange in order to receive coverage through the federal government.			01/01/2014	1312	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	The Secretary of HHS shall establish procedures for a state to allow producers to enroll individuals and employers in qualified health plans and to assist individuals in applying for subsidies. Only citizens and lawful residents may purchase coverage through the Exchange. Incarcerated individuals may not enroll through the Exchange. Employers of 1-100 employees may offer 1 or more small group plans to employees through the Exchange. Beginning in 2017, states may allow insurers to offer large group plans through the Exchange.	Secretary of HHS		01/01/2014. States may expand to larger employers beginning 01/01/2017.		
Financial Integrity	Exchanges must keep an accurate accounting of all activities, receipts and expenditures and annually report to the Secretary of HHS, who shall conduct annual audits and may investigate the affairs of an Exchange. An Exchange or State that has engaged in serious misconduct may be subject to a 1% reduction of all grants and payments administered by the Secretary of HHS until corrective actions are taken. The Secretary of HHS shall provide for the efficient and non-discriminatory administration of the Exchanges and shall implement measures to reduce fraud and abuse. The False Claims Act shall apply to any payments that include federal funds.	Secretary of HHS		01/01/2014	1313	
PART III—State Flexibility Relating to Exchanges						
State flexibility in operation and enforcement of Exchanges and related requirements	The Secretary of HHS shall issue regulations setting standards for the requirements for Exchanges, the offering of qualified health plans sold through Exchanges, reinsurance and risk adjustment mechanisms and other requirements the Secretary deems appropriate. A state that elects to operate an exchange must adopt the federal standards or a state law implementing them by January 1, 2014. If the Secretary determines by January 1, 2013 that the state is not electing to operate an Exchange or that it will not have the Exchange operational by January 1, 2014 or has not taken necessary actions to implement the market reforms, the Secretary shall operate an Exchange, either directly or through agreement with a non-profit entity.	**Secretary of HHS, in consultation with the NAIC, its members, insurers, consumer organizations and other interested parties.**			1321	
Federal program to assist establishment and	The Secretary of HHS shall provide Co-Op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. In making the loans and grants, the Secretary must give priority to plan that offer qualified	Secretary of HHS	Co-Op Plans	No later than 7/1/2013	1322	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
operation of nonprofit, member-run health insurance issuers	health plans on a statewide basis, use integrated care models, and have significant private support and ensure that there is sufficient funding to establish at least 1 Co-Op plan in each state. Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. *[NOTE: H.R. 1473, enacted on April 15, 2011 reduced funding for Co-Op loans and grants to $3.8 billion.]* Any entity receiving a loan or grant must be organized under state law as a nonprofit, member corporation and may not have been a health insurance issuer prior to 7/16/2009 and may not be sponsored by a state or local government. Governance of the organization must be subject to a majority vote of its members and must avoid insurance industry involvement and interference. Any profits made by the organization must be used to lower premiums, improve benefits, or improve the quality of care. The organization must meet all requirements that are required of other qualified health plans, including solvency and licensure rules, rules on payments to providers, network adequacy rules, rate and form filing rules, and any applicable premium assessments. Co-Op plans may not offer coverage in a state until the state has adopted the market reforms in Subtitles A and C of this legislation. Co-Op plans will be considered tax-exempt as long as they abide by restrictions of this section. Co-Op plans may form a private purchasing council through which to enter into collective purchasing arrangements for items and services that increase administrative efficiency, including claims administration, administrative services, health IT, and actuarial services, within the confines of federal antitrust law.					
Level Playing Field	Health insurance plans shall not be subject to any of the following state or federal laws unless Co-Op plans and multistate health plans are also subject to them: • Guaranteed renewal • Rating • Preexisting conditions • Non-discrimination • Quality improvement and reporting • Fraud and abuse • Solvency and financial requirements • Market conduct • Prompt payment • Appeals and grievances • Privacy and confidentiality			1/1/2014	1324	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	• Licensure, and • Benefit plan material or information.					
SUBTITLE D—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS PART IV-STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS						
State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid	The Secretary of HHS shall establish a basic health program under which a state may contract with standard health plans providing at least essential benefits to individuals between 133% and 200% FPL and legal immigrants above 133% FPL who are not eligible for Medicaid. The federal government will provide states creating basic health programs the subsidy funds that eligible individuals would have otherwise received. Individuals eligible to participate in these plans would not be eligible to purchase coverage through the Exchange, and premiums may not exceed what the individual would have paid in the Exchange. Cost-sharing may not exceed that of a platinum plan in the Exchange for individuals below 150% FPL or that of a gold plan for all others. Plans must have an MLR of at least 85%. States may enter into compacts to allow residents of all compacting states to enroll in all standard plans.	Secretary of HHS			1331	
Waiver for State Innovation	A state may apply for waivers of the following requirements: • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate The Secretary of HHS may not waive any law that is not within the jurisdiction of HHS (such as ERISA). The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver. State waiver plans must provide coverage that is at least as comprehensive as coverage offered through Exchanges, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are good for 5 years and may be renewed unless the Secretary disapproves a request for renewal within 90 day of receipt. The Secretary must coordinate and consolidate this waiver application process	Secretary of HHS, within 180 days of enactment..		Plan years beginning January 1, 2017	1332	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	and the waiver processes for Medicare, Medicaid, CHIP, and any other federal health care law.					
Provisions relating to offering of plans in more than one state	Two or more states may enter into a "health care choice compact" under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Issuers would continue to be subject to the following laws of the purchaser's home state: • Market conduct; • Unfair trade practices; • Network adequacy; • Consumer protection standards, including rating rules; • Laws addressing performance of the contract. Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws.	**Secretary of HHS, in consultation with the NAIC**, no later than July 1, 2013		01/01/16	1333	
Multi-State Plans	The Director of OPM shall contract with insurers to offer at least 2 multi-state qualified health benefits plans through the Exchange in each state to provide individual and small group coverage. At least one plan in each state must be provided by a nonprofit entity. The Director may set standards for multistate plans regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrolless. Participating insurers must be licensed in each state where it sells coverage and are subject to all requirements of State law that are not inconsistent with requirements of this section. Plans must offer a uniform benefit package in each state which consists of the essential benefits package and any additional benefits required by a state, as long as the state reimburses enrollees for the cost of these additional benefits. States with rating rules that restrict variation due to age to less than 3:1 may require multi-state plans to adhere to these requirements. Insurers must sell multi-state plans in 60% of states in the first year they offer them, 70% of states in the second year, 85% of states in the third year, and all states in the fourth year. Requirements for FEHBP plan that do not conflict with this title will apply to multi-state plans. Multi-state plans will be considered a separate risk pool from FEHBP plans.	Office of Personnel Management		01/01/14	1334	
PART V—REINSURANCE AND RISK ADJUSTMENT						
Transitional	State shall enact a model regulation established by the Secretary, in consultation	**Secretary of HHS,**	All plans must	Plan years	1341	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
reinsurance program for individual market in each state	with the NAIC that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016. Insurers and TPAs, on behalf of self-insured plans, must make payments to the reinsurance entity and non-grandfathered individual market insurers that cover high risk individuals will receive payments from the entity if they cover high risk enrollees in the individual market. High-risk individuals will be identified on the basis of a list of medical conditions or another comparable objective method of identification recommended by the American Academy of Actuaries. Payments will be based upon a schedule of payments for each condition or another method recommended by the American Academy of Actuaries. Assessments will be based on the percentage of revenue of each insurer and the total costs of providing benefits to enrollees in self-insured plans or a specified amount per enrollee. The total amount of contributions will be based on the best estimates of the NAIC and not including additional assessments to cover administrative costs, equal $12 billion for plan years beginning in 2014, $8 billion in 2015, and $5 billion in 2016. States may collect additional amounts from issuers on a voluntary basis. Of these amounts, $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 shall be deposited in the US Treasury and will not be available for this program. Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation. States may have more than one reinsurance entity and two or more states may enter into agreements to create entities to administer reinsurance in all such states.	**in consultation with the NAIC and with recommendations from the American Academy of Actuaries.**	pay assessments. Non-grandfathered individual plans may receive payments.	beginning in 2014 through 2016		
Establishment of risk corridors for plans in individual and small group markets	The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	Secretary of HHS	Qualified health plans	Calendar years 2014-2016	1342	
Risk adjustment	Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees have an actuarial risk that is greater than the average actuarial risk in that state.	Secretary of HHS, in consultation with the States	Non-grandfathered individual and small group	01/01/14	1343	

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<tr><th>Provision</th><th>Notes</th><th>Standards Development</th><th>Applicability</th><th>Effective Date</th><th>PPACA Section</th><th>Statutory Section</th></tr>
<tr><td></td><td>The Secretary of HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.</td><td></td><td>plans</td><td></td><td></td><td></td></tr>
<tr><td colspan="7">SUBTITLE E—AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS
PART I- Premium Tax Credits and Cost-Sharing Reductions
Subpart A—Premium Tax Credits and Cost-Sharing Reductions</td></tr>
<tr><td>Refundable tax credit providing premium assistance for coverage under a qualified health plan</td><td>A tax credit is created for qualified taxpayers between 100% and 400% FPL that covers the difference between a percentage of household income and the second-lowest cost silver level plan available through the Exchange in the individual's rating area. The percentage of income varies on a sliding scale within the following ranges:<table><tr><td>Income</td><td>Premium Cap</td></tr><tr><td><133% FPL</td><td>2%</td></tr><tr><td>133-150% FPL</td><td>3-4%</td></tr><tr><td>150-200% FPL</td><td>4-6.3%</td></tr><tr><td>200-250% FPL</td><td>6.3-8.05%</td></tr><tr><td>250-300% FPL</td><td>8.05%-9.5%</td></tr><tr><td>300-400% FPL</td><td>9.5%</td></tr></table>The above percentages will be adjusted to reflect the growth of premiums. Credits will be advanced to insurer through which the individual purchased coverage.

Individuals eligible for employer-sponsored coverage for which the employee's contribution does not exceed 9.5% of household income are not eligible for subsidies. Individuals not lawfully present in the United States are not eligible for subsidies.</td><td>Secretary of Treasury</td><td>Individuals between 100% and 400% FPL</td><td>01/01/14</td><td>1401</td><td>IRC 36B</td></tr>
<tr><td>Reduced cost-sharing for individuals enrolling in qualified health plans</td><td>Cost sharing for individuals enrolling in the silver level of coverage through an exchange who are between 100%-400% FPL. Cost-sharing reduced so that the plan covers 94% of the benefit costs of the plan for individuals between 100%-150% FPL, 87% of benefit costs for individuals between 150%-200% FPL, 73% for individuals between 200%-250% FPL, and 70% for individuals between 250%-400%FPL. Native Americans below 300% FPL will have no cost-sharing under a plan.</td><td>Secretary of HHS, in consultation with Secretary of Treasury</td><td>Individuals between 100% and 400% FPL</td><td>01/01/14</td><td>1402</td><td></td></tr>
</table>

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	The Secretary will make periodic payments to insurers for the value of these cost-sharing reductions. Reductions to cost-sharing will not apply to additional benefits provided under a plan or to mandated benefits beyond the essential benefits package.					
Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost sharing, and individuals responsibility exemptions	The Secretary of HHS shall develop a program for the determination of eligibility for Exchange participation, subsides, and exemptions. Exchanges must collect specified relevant information for determining eligibility from the individual mandate and submit it to the Secretary of HHS for verification by relevant federal agencies and report the results back to the Exchange.	Secretary of HHS			1411	
Advance determinations and payment of premium tax credits and cost-sharing reductions	The Secretary of HHS, in consultation with the Secretary of Treasury must establish a program for the advance determination of income eligibility for individuals applying for subsidies through the Exchange. The Secretary of HHS will notify the Exchange and the Secretary of Treasury, and the Secretary of Treasury will make the necessary payments to the insurer, who must reduce the individual's premiums and cost-sharing. States may provide subsidies in addition to the federal subsidies.	Secretary of HHS, in consultation with the Secretary of Treasury			1412	
Streamlining of procedures for enrollment through an Exchange and state Medicaid, CHIP, and health subsidy programs	The Secretary shall establish a system for individuals to apply for enrollment in Medicaid, SCHIP through an Exchange. The Secretary must provide a single streamlined form that may be used in applying for all applicable state health subsidy programs. This form can be filed online, by mail, or by telephone. States may develop and use their own alternative streamlined forms consistent with standards developed by the Secretary of HHS.	Secretary of HHS			1413	
PART II-Small Business Tax Credit						

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Credit for employee health insurance expenses for small businesses	Small employers with 25 or fewer employees will receive tax credit as follows: Tax years 2010-2013—Employers that contribute at least 50% of premium, or 50% of the average small group premium in the state, will receive a credit against general business tax for 35% (or 25% in the case of a tax-exempt small employer) of the total nonelective contribution the for the plan. Tax years 2014 and later—Employers that contribute at least 50% of premium towards coverage in the exchange will receive a credit of 50% (or 35% in the case of a tax-exempt small employer). Employers may only receive the credit for two years. The credit is phased out for employers with 10-25 employees and employers whose average wages are from $25,000-$50,000, indexed to the annual cost-of-living adjustment.	Secretary of Treasury	Small businesses with 25 or fewer employees	01/01/14	1421	IRC 45R
SUBTITLE F—SHARED RESPONSIBILITY FOR HEALTH CARE **PART I—Individual Responsibility**						
Requirement to maintain minimum essential coverage	If a taxpayer fails to maintain minimum essential coverage, they will be required to pay an annual tax penalty of the greater of $95for each household member, up to three, or 1% of household income in 2014, $325 or 2% of household income in 2015 and $695 or 2.5% of income in following years. The penalty is prorated for each month in which a taxpayer fails to maintain minimal essential coverage. Taxpayers are exempted from the penalty if: • The individual has a religious objection to purchasing health insurance. • The cost of the taxpayer's premium contribution for employer-sponsored coverage or for the lowest-cost bronze level coverage available in the Exchange exceeds 8% of household income. The 8% threshold is indexed to the amount by which average premium growth exceeds wage growth. • The taxpayer's household income is below the federal income tax filing threshold • The taxpayer is a member of a recognized Indian tribe • The break in coverage is less than three months • The Secretary of HHS determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage • The individual is enrolled in a health care sharing ministry • The individual resides outside the United States Any criminal penalty against a taxpayer for failure to pay the penalty is waived, and the Secretary of Treasury may not file liens or levies to collect the penalty.	Secretary of Treasury		01/01/14	1501	IRC 5000A
PART II—Employer Responsibilities						

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Automatic enrollment for employees of large employers	Employers with more than 200 employees offering a health benefits plan must automatically enroll all new employees one of the plans and automatically continue the enrollments of current employees, unless either opts out.		Employers with more than 200 full-time employees		1511	FLSA 18A
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits.		Employers subject to the Fair Labor Standards Act	03/01/2013	1512	FLSA 18B
Shared responsibility for employers regarding health coverage	If an employer fails to offer minimum essential coverage and one of its employees receives a subsidy through the Exchange, it will be subject to a penalty of $2000 per employee. Employers offering coverage whose employees receive a subsidy through the exchange will be subject to a penalty of $3,000 per employee receiving a subsidy. The penalty shall not exceed $2000 times the number of full-time employees. Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty.	Secretary of Treasury	Employers with more than 50 employees	01/01/2014	1513	IRC 4980H
OTHER PROVISIONS						
GAO study regarding the rate of denial of coverage and enrollment by health insurance and group health plans	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance plans by group health plans and health insurance issuers.	Government Accountability Office		One year after enactment	1562	
[Free choice vouchers]	NOTE: This provision was repealed by H.R. 1473, enacted on April 15, 2011. [Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400%FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange.]		[Non-grandfathered fully insured group plans.]		[10108]	

PHSA-Public Health Service Act
SSA-Social Security Act of 1935