Health Care Reform Legislation Summary

Insurance

Patient Protection and Affordable Care Act, Pub. L. No. 111-148 ("PPACA")
Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 ("Recon")

PROVISION	DESCRIPTION	EFFECTIVE DATE(S)	CBO 10-YEAR SCORE[1]
Insurance Market Provisions			
Annual and Lifetime Limits PPACA § 10101(a); Recon § 2301 (creates new PHSA § 2711)	Prohibits a group health plan, a health insurance issuer offering group or individual health insurance and health plans where an individual was already enrolled on the date of enactment ("grandfathered plans") from placing annual or lifetime limits on the dollar value of benefits for any beneficiary.	Lifetime limits prohibited for all plans six months after enactment (i.e., September 23, 2010)	

[1] In general, the Congressional Budget Office (CBO) scores for the insurance provisions are included in the total estimate for expanding health insurance coverage. CBO estimates that, by 2019, the legislation would reduce the number of uninsured by 32 million, providing coverage for approximately 94 percent of legal nonelderly residents. 24 million of these individuals are expected to obtain insurance coverage through the Exchanges and an additional 16 million would obtain insurance through the expansion of Medicaid and CHIP.

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		Annual limits restricted for all plans from six months after enactment (i.e., September 23, 2010) to January 1, 2014, and prohibited for all plans after January 1, 2104	
Prohibition on Rescissions PPACA § 1001(5); Recon § 2301 (creates new PHSA § 2712)	Prohibits a group health plan, a health insurance issuer offering group or individual health insurance and grandfathered plans from rescinding coverage except in cases of fraud.	Six months after enactment (i.e., September 23, 2010)	
Coverage of Preventive Health Services PPACA § 1001(5) (creates new PHSA § 2713)	A group health plan and a health insurance issuer offering group or individual health insurance, but not a grandfathered plan, must offer coverage for certain preventive services approved by the U.S. Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices and screening and preventive services for infants, children and adolescents. Prohibits imposing any cost-sharing for the above services.	Six months after enactment (i.e., September 23, 2010)	
Dependent Coverage PPACA § 1001(5); Recon § 2301 (creates new PHSA § 2714)	Requires a group health plan, a health insurance issuer offering group or individual health insurance and grandfathered plans to provide coverage for a beneficiary's dependent child who is under 26 and unable to obtain coverage from an employer.	Six months after enactment (i.e., September 23, 2010)	

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Prohibition on Discrimination Based on Salary PPACA § 10101(d) (creates new PHSA § 2716)	Prohibits a plan sponsor of a group health plan (other than a self-insured plan) from establishing rules that discriminate in favor of high-wage employees.	Six months after enactment (i.e., September 23, 2010)	
Pre-existing Conditions PPACA § 1201; Recon § 2301 (creates new PHSA § 2704-05)	Prohibits a group health plan, a health insurance issuer offering group or individual health insurance and grandfathered health care plans from denying coverage or establishing eligibility rules based on health status or medical conditions. Employer wellness/disease prevention programs do not generally violate this provision. Establishes a wellness program demonstration project in 10 states for individual health plans. Permits discounts and rebates for adherence to health promotion and disease prevention programs.	January 1, 2014; six months after enactment for enrollees under age 19 (i.e., September 23, 2010) *(There is disagreement on whether the prohibition on denying coverage to children with pre-existing conditions comes into effect six months after enactment or on January 1, 2014. The Secretary of HHS has assured Congress that regulations will establish that the prohibition comes into effect on the earlier date)*	
Prohibition on Discriminatory Premium Rates PPACA § 1201 (creates new PHSA § 2701)	A health insurance issuer for coverage offered in the individual and small group market may only base premium rates on whether coverage is for an individual or family, on the geographic area based on rating areas, on age and on tobacco use.	January 1, 2014	

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	Health insurance issuers that offer coverage in the large group market through the American Health Benefit Exchange or the Small Business Health Options Program ("SHOP Exchange") will be subject to the same premium rating rules.		
Comprehensive Insurance Coverage PPACA § 1201 (creates new PHSA § 2707)	Requires a health insurance issuer that offers coverage in the individual or small group market to provide coverage for the essential health benefits package.	January 1, 2014	
Non-Discrimination Against Health Care Providers PPACA § 1201 (creates new PHSA § 2706)	Prohibits a group health plan and a health insurance issuer offering group or individual health insurance from discriminating against health care providers with respect to participation or coverage under the plan.	January 1, 2014	
Guaranteed Availability of Coverage PPACA § 1201 (creates new PHSA §§ 2702-03)	Health insurance issuers offering coverage in the individual or group market must accept every employer and individual that applies for coverage and must guarantee renewability of coverage.	January 1, 2014	
Prohibition on Excessive Waiting Periods PPACA § 1201 (creates new PHSA § 2708)	Prohibits group health plans, health insurance issuers offering group or individual insurance and grandfathered plans from applying waiting periods that exceed 90 days.	January 1, 2014	

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Coverage for Individuals Participating in Clinical Trials PPACA § 10103(c) (creates new PHSA § 2709)	Requires a group health plan and a health insurance issuer offering group or individual health insurance to provide coverage for routine patient costs for items and services furnished in connection with participation in approved clinical trials. Plans may not deny an enrollee access to an approved trial or discriminate against the enrollee for participating in such a trial. Approved clinical trials are limited to trials conducted in relation to cancer or another life-threatening disease that is federally funded, is conducted under an investigational new drug application or is a drug trial that is exempt from an investigational new drug application.	January 1, 2014	
Patient Protections PPACA § 10101(h) (creates new PHSA § 2719A)	Any group health plan or a health insurance issuer offering group or individual health insurance that allows for designation of a primary care provider is prohibited from placing restrictions on such designation. Plans that offer benefits for emergency services are prohibited from requiring prior authorization and must apply in-network cost-sharing requirements for emergency services to services rendered by participating or non-participating providers. Prohibits plans from requiring authorization or referrals for obstetrical and gynecological care if provided by a participating health care professional. Establishes data centers to develop fee schedules that reflect market rates for medical services.	Six months after enactment (i.e., September 23, 2010)	
Uniform Application of Reforms PPACA § 1252	States must apply rating reforms uniformly to all health insurance plans in each insurance market.	January 1, 2014	

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Mandates			
Individual Mandate PPACA §§ 1501-02; Recon § 1002	Requires individuals to obtain either "minimum essential coverage" by purchasing insurance or obtaining coverage from an employer or otherwise pay a yearly fine. To ensure individuals have coverage, insurers must report identifying information to the Secretary of HHS. Penalties increase over time, beginning with a flat fee of $95 or 1 percent of household income, whichever is greater, extending up to a flat fee of $695 or 2.5 percent of household income. Individuals with income below a certain threshold, financial hardships or religious objections, as well as individuals who have had a gap in coverage for less than three months, are exempt from paying the fine.	January 1, 2014	Saves $4 billion a year from 2017-2019
Employer Mandate PPACA §§ 1511-1515; Recon § 1003	Requires employers with more than 50 full-time employees to offer coverage, contribute to premiums or pay a fine if at least one full-time employee receives a premium tax credit through an Exchange. To ensure employers offer coverage, employers are required to report information to HHS. The fine imposes a $2,000 penalty per full-time employee, excluding the first 30 employees from the calculation. Large employers who offer coverage but still have at least one full-time employee receiving a tax credit will also need to pay a fine—the lesser of $3,000 for each employee receiving the credit or $2,000 for each full-time employee. Small employers are exempt from the penalties. Large employers that offer coverage must also automatically enroll employees into the lowest cost premium plan unless the employee explicitly opts out.	January 1, 2014	

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Right to Maintain Existing Coverage PPACA § 1251; Recon § 2301	Clarifies that individuals are not required to terminate existing coverage.	Date of enactment (i.e., March 23, 2010)	
State-Based Health Insurance Exchanges and Coverage Programs			
State Insurance Exchanges PPACA §§ 1301-1313	Each state is required to establish an American Health Benefit Exchange and Small Business Health Options Program ("SHOP Exchange") to facilitate insurance purchasing by individuals and small employers. If a state fails to establish an Exchange by the January 1, 2014 deadline, the Secretary must establish and operate the Exchange within the state. Initially, only individuals and small employers are eligible to participate in the Exchange. After 2017, states may permit employers in the large group market to participate. All plans offered through the Exchange must be "qualified health plans" that include the following essential benefits— ▪ ambulatory patient services ▪ emergency services ▪ hospitalization ▪ maternity and newborn care ▪ mental health and substance use 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.	Established no later than January 1, 2014	Start-up costs $2 billion, other spending costs $5 billion

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	States may mandate that plans offer additional required benefits and can elect to prohibit coverage of abortion services. Exchanges may offer four benefit categories of plans (bronze, silver, gold, platinum) and a separate catastrophic plan. Secretary of HHS must provide grants to help establish the Exchanges; however, Exchanges must be self-sustaining by January 1, 2015. The Exchanges are administered by governmental agencies or nonprofit organizations. An Exchange must have an initial open enrollment period and later annual and special open enrollment periods, with special monthly enrollment for Native Americans. Exchanges must, at a minimum, perform the following functions: (a) implement certification procedures for qualified health plans; (b) provide a toll-free telephone hotline for assistance requests; (c) maintain a Web site where enrollees and potential enrollees can obtain standardized comparative information on qualified health plans; (d) assign a rating to each qualified health plan; (e) use standardized formats for presenting health benefits plan options; (f) inform individuals of eligibility requirements for various programs (e.g., Children's Health Insurance Program (CHIP), Medicaid); (g) establish a cost and cost-sharing calculator for individuals; (h) develop a certification process for individuals not required to purchase insurance; (i) provide employers with the names of employees who cease coverage with a qualified health plan; and (j) establish a navigator program. Requires Exchanges to award grants to eligible entities to establish Navigator Programs to educate public about availability of health coverage through Exchanges and facilitate enrollment.		

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	Exchanges must keep a record of all activities, receipts and expenditures; the Secretary and the Inspector General of HHS are permitted to audit and investigate Exchanges. Clarifies that Act does not prohibit insurers from offering coverage outside the Exchange and excludes individuals who are incarcerated or are unlawfully residing in the United States from participating in an Exchange.		
High-Risk Insurance Pool PPACA § 1101	Establishes a temporary high-risk insurance pool for individuals with pre-existing conditions who have been uninsured for the preceding six months. The pool cannot deny coverage on the basis of pre-existing conditions and places limits on out-of-pocket costs. The intent is to provide immediate relief to individuals who have no insurance and then phase out these insurance pools once the Exchanges are established.	90 days after enactment, (i.e., June 21, 2010) ending January 1, 2014:	
Reinsurance Program PPACA § 1102(a)	Creates a temporary reinsurance program to reimburse participating employment-based plans for a portion of the cost of providing coverage for retired individuals over the age of 55 who are not eligible for Medicare.	90 days after enactment (i.e., June 21, 2010), ending January 1, 2014	Costs $5.0 billion
Consumer Protections PPACA §§ 1002, 10102(b)	Provides $30 million in grants in the first fiscal year to states and Exchanges to help establish insurance assistance offices and programs to assist with filing complaints and appeals and educate consumers about their rights regarding insurance coverage.	Funds appropriated for FFY 2010	
CO-OP Program PPACA § 1322	Creates Consumer Operated and Oriented Plan ("CO-OP Program") to foster (through loans and grants) the creation of nonprofit, member-run health insurance.	July 1, 2013	

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Basic Health Plan PPACA § 1331	Allows states to create Basic Health Plan for low-income individuals (those earning between 133 and 200 percent of the federal poverty level (FPL)) who were uninsured for the past six months; they would be eligible to participate in the Exchange and receive premium assistance.	January 1, 2014	
Waivers for State Innovation PPACA § 1332	Allows Secretary of HHS to grant waivers to states for requirements relating to Exchanges, reduced cost-sharing for individuals in qualified plans and tax credits.	January 1, 2017	
Health Care Choice Compacts PPACA § 1333	Permits states to form Health Care Choice Compacts and allow insurers to sell policies in any state participating in the compact.	Secretary of HHS must issue regulations by July 1, 2013 Compacts may not take effect before January 1, 2016	
Multi-State Plans Health Care Choice Compacts PPACA § 1334	Requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange (at least one plan must be offered by a nonprofit entity and at least one plan must not provide coverage for abortion services for which federal funding is prohibited).	January 1, 2014	
Risk Adjustment			
Transitional Reinsurance PPACA § 1341	Requires states to establish nonprofit reinsurance entity for 2014-2016 that will collect payments from all insurers in the individual and group markets and make payments to insurers in the individual market that cover high-risk individuals. Contributions from insurers must amount to $25 billion over the three years.	January 1, 2014	Savings of $106 billion bundled into score of reinsurance and risk adjustment
Risk Corridors PPACA § 1342	Requires Secretary of HHS to establish and administer a risk corridor program for qualified health plans offered in the individual and small-group markets in 2014-2016, under which plans would receive or make payments depending on the difference between their allowable costs	January 1, 2014	Savings of $106 billion bundled into score of reinsurance and risk adjustment

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	(i.e., total amount of costs plan incurred in providing covered benefits, reduced by administrative expenses) and "target amount" (the total annual premium, including subsidies, minus administrative expenses). If allowable costs are between 97 percent and 103 percent of the "target amount," plans will receive no payment. If allowable costs are higher than 103 percent of the target amount, the Secretary of HHS will make a payment to the plan. If allowable costs are lower than 97 percent of the target amount, the plan would make a payment to the Secretary of HHS.		
Risk Adjustment PPACA § 1343	States, together with the Secretary of HHS, must develop methods and criteria by which they will require payments from health plans offered in the individual and small-group markets in which enrollees had lower health risks, compared with all plans. States will pay health plans with higher risks. The risk adjustment will apply to plans in individual and small-group markets, but not grandfathered plans. Self-insured plans are excluded from this program.	Secretary of HHS will adopt criteria and methods for the risk adjustment "as soon as practicable after the date of enactment" (i.e., March 23, 2010)	Savings of $106 billion bundled into score of reinsurance and risk adjustment
Increased Affordability for Individuals			
Premium Tax Credits PPACA § 1401	Provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400 percent of FPL to purchase insurance through Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to percentages of income for specified income levels: ▪ Up to 133 percent of FPL: 2 percent of income ▪ 133-150 percent of FPL: 3-4 percent of income ▪ 150-200 percent of FPL: 4-6.3 percent of income ▪ 200-250 percent of FPL: 6.3-8.05 percent of income ▪ 250-300 percent of FPL: 8.05-9.5 percent of income	January 1, 2014	Costs $107 billion

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	▪ 300-400 percent of FPL: 9.5 percent of income Limits availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan shares less than 60 percent of the total allowed costs of benefits provided under the plan, or if the employee share of the premium exceeds 9.5 percent of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the United States will be eligible for premium credits.		
Cost-Sharing Reductions PPACA § 1402	Provides cost-sharing subsidies and annual cost-sharing limits to eligible individuals and families. Subsidies have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level— ▪ 100-150 percent of FPL: 94 percent ▪ 150-200 percent of FPL: 87 percent ▪ 200-250 percent of FPL: 73 percent ▪ 250-400 percent of FPL: 70 percent Out-of-pocket expenses will be capped based on income level, as follows— ▪ 100-200 percent of FPL: $1,983 for individuals and $3,967 for families (one-third of health savings account (HSA) limit) ▪ 200-300 percent of FPL: $2,975 for individuals and $5,950 for families (one-half of HSA limit) ▪ 300-400 percent of FPL: $3,967 for individuals and $7,933 for families (two-thirds of HSA limit)	January 1, 2014	Cost of $350 billion bundled into score of premiums and cost sharing

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Insurance Cost Controls PPACA § 10101(f) (creates new PHSA § 2718)	A health insurance issuer offering group or individual health insurance, including grandfathered plans, shall provide an annual rebate to enrollees if the ratio of premium revenue spent on reimbursement for clinical services and efforts to improve health care quality to total premium revenue is less than 85 percent for large group markets or 80 percent for small and individual markets.	Rebates must begin no later than January 1, 2011	
Tax Credits and Cost-Sharing Reduction Payments Disregarded for Federal Programs PPACA § 1415	Clarifies that any premium tax credit or cost-sharing reduction payment shall not be taken into account as income of an individual for purposes of determining eligibility for federal programs.	Effective upon enactment (i.e., March 23, 2010)	
Tax Credit for Small Businesses PPACA § 1421	Businesses with 25 or fewer employees and average annual wages of less than $50,000 can receive a tax credit for purchasing health insurance for employees. The amount of the tax credit phases out as firm size and average wage increases.	Credits apply to amounts paid or incurred in taxable years beginning after December 31, 2010	
Administrative Simplification and Reporting Requirements			
Streamlining Procedures for Enrollment in Health Programs PPACA § 1413	Requires states to use a single, streamlined form through which state residents may apply for enrollment in, receive a determination of eligibility for, and participate in state health subsidy programs.	Effective upon enactment (i.e., March 23, 2010)	
Reporting Requirements PPACA § 1001(5) (creates new PHSA § 2717)	Requires group health plans and health insurance issuers offering group or individual insurance coverage to annually submit reports to the Secretary of HHS and to enrollees describing how benefits and coverage improve health outcomes, prevent hospital readmissions, improve patient safety and implement wellness and prevention programs.	Reporting requirements must be developed no later than two years after enactment (i.e., March 23, 2012)	

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Appeals Process PPACA § 10101(g) (creates new PHSA § 2719)	Requires group health plans and health insurance issuers offering group or individual insurance coverage (but not grandfathered plans) to implement and provide notice of an internal appeals process for claims and coverage determinations. Insurers must also implement an effective external review process that meets certain minimum standards.	Six months after enactment (i.e., September 23, 2010)	
Review of Insurance Premiums PPACA § 10101(i)	States, in conjunction with the Secretary of HHS, will annually review unreasonable increases in premiums. Plans with excessive premiums may be excluded from participating in the Exchange.	Reviews begin with the 2010 plan year Plans may be excluded from the Exchange beginning January 1, 2104	
Administrative Simplification PPACA §§ 1104, 10109	Adopts a uniform set of operating rules and transaction standards for electronic transactions of health information. A set of operating rules will be developed for eligibility and claim status transactions and for claim payment/remittance advice transactions. Standards will be developed in consultation with a nonprofit entity and will allow public review and revision. Health plans must file statements with the Secretary of HHS certifying compliance with the operating rules and transaction standards; failure to meet the standards will result in penalties in the amount of $1 per covered life (increased on an annual basis).	Adoption of operating rules for eligibility transactions no later than July 1, 2011, ensuring implementation by January 1, 2013; adoption of operating rules for payment/remittance advice no later than July 1, 2012, ensuring implementation by January 1, 2014; penalties begin April 1, 2014	Effects on Medicaid save $7.3 billion Effects on Medicare save $4.3 billion
Report on Self-Insured Plans PPACA § 1253	Requires Secretary of Labor to issue annual reports on self-insured plans.	First report due one year after enactment (i.e., March 23, 2011)	

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Study on Large Group Market PPACA § 1254	Requires Secretary of HHS to conduct study of fully insured and self-insured health plan markets to determine the extent to which insurance reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure.	One year after enactment (i.e., March 23, 2011)	
Health Information Technology Enrollment Standards and Protocols PPACA § 1561	Directs the Secretary of HHS to establish standards and protocols to facilitate enrollment in federal and state health programs. Awards grants to states and local governments to develop technologies to implement the enrollment standards and protocols.	Standards and protocols developed no later than 180 days after enactment (i.e. September 19, 2010)	