Patient Protection and Affordable Care Act of 2009:
Health Insurance Exchanges

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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 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.
			Qualified Health Plans	01/01/14	1301	

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	Secretary of HHS		01/01/2014	1302	

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	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. 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. • **Bronze 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:		Qualified health benefits plans	01/01/14	1303	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	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 the requirement that plans segregate funds for abortion services.					
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	
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. 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.	Secretary of HHS		Beginning not later than 1 year after the date of enactment, lasting until 01/01/15 01/01/14	1311	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section

	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.
	
	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
		NAIC				

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section

	• 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 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					

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	• 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. 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.	Secretary of HHS				

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	The Secretary, in collaboration with states, will develop standards to ensure that information provided by navigators is fair, accurate, and impartial.	Secretary of HHS, in collaboration with states				
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	
	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.	Secretary of HHS				
	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.			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.			01/01/2014	1313	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	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				
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 operation of nonprofit, member-run health insurance issuers	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 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. 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.	Secretary of HHS	C0-Op Plans	No later than 7/1/2013	1322	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory 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 • Licensure, and • Benefit plan material or information.			1/1/2014	1324	
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	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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	

Patient Protection and Affordable Care Act of 2009:
Immediate Health Insurance Market Reforms

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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.		All plans	6 months after enactment	1001	PHSA 2711
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.		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.	Secretary of HHS	All plans	6 months after enactment	1001	PHSA 2713
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
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All plans	6 months after enactment for under 19.	1201 & 10103(e)	PHSA 2704

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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 • 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		All plans	6 months after enactment	1001	PHSA 2715A
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 group health plans	6 months after enactment	1001	PHSA 2716

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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 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	**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
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 plans	6 months after enactment	1001	PHSA 2719

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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 plans	6 months after enactment	1001	PHSA 2719A
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
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.	Fully insured plans	2010 plan year	1003	PHSA 2794

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	
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	
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	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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

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

Patient Protection and Affordable Care Act of 2009:

Health Insurance Market Reforms

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
SUBTITLE C—Quality Health Insurance Coverage for All Americans **PART I—HEALTH INSURANCE MARKET REFORMS** **Subpart I—General Reform**						
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All 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	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status	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
based on health status	• Medical condition • Claims experience • Receipt of health care • Medical history • 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	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 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		All plans	Plan years beginning 01/01/14		PHSA 2707

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	Exchanges, they must also offer that coverage as a plan open only to children under age 21.					
Prohibition on Excessive Waiting Periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.		All group plans	Plan years beginning 01/01/14		PHSA 2708
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 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-Annual and lifetime limits • 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	
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	The Secretary of HHS shall conduct a study of self-insured and fully-	Secretary of HHS	No later than 1		1254	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Market	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, in conjunction with the Secretary of Labor	year after enactment			
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	
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	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
	• 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 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.	Office of Personnel Management		01/01/14	1334	

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	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.					
PART V—REINSURANCE AND RISK ADJUSTMENT						
Transitional reinsurance program for individual market in each state	State shall enact a model regulation established by the Secretary, in consultation 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	**Secretary of HHS, in consultation with the NAIC and with recommendations from the American Academy of Actuaries.**	All plans must pay assesments. Non-grandfathered individual plans may receive payments.	Plan years beginning in 2014 through 2016	1341	

<table>
<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>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.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Establishment of risk corridors for plans in individual and small group markets</td><td>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%.</td><td>Secretary of HHS</td><td>Individual and small group plans</td><td>Calendar years 2014-2016</td><td>1342</td><td></td></tr>
<tr><td>Risk adjustment</td><td>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 are have an actuarial risk that is below the average actuarial risk in that state.

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>Secretary of HHS, in consultation with the States</td><td>Non-grandfathered individual and small group plans</td><td>01/01/14</td><td>1343</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</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>
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Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	not eligible for subsidies. Individuals not lawfully present in the United States are not eligible for subsidies.					
Reduced cost-sharing for individuals enrolling in qualified health plans	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. 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.	Secretary of HHS, in consultation with Secretary of Treasury	Individuals between 100% and 400% FPL	01/01/14	1402	
PART II-Small Business Tax Credit						
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.	Secretary of Treasury		01/01/14	1501	IRC 5000A

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	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.					
PART II—Employer Responsibilities						
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,	Secretary of Treasury	Employers with more than 50 employees	01/01/2014	1513	IRC 4980H

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	and the first 30 employees are disregarded in calculating the penalty.					
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	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.				10108	

MAINE BUREAU OF INSURANCE
NEW FEDERAL HEALTH CARE LAW: SMALL BUSINESS TAX CREDIT
4/5/2010

This information will be updated when new information is available from U.S. Department of Health and Human Services and/or the Internal Revenue Service (Treasury)

WHEN DOES THE TAX CREDIT BEGIN?

The new federal health reform law[1] provides a Small Business Tax Credit to businesses for contributing toward their workers' health premiums, **beginning with the 2010 Tax Year.** The credit applies to all amounts paid or incurred in taxable years beginning after December 31, 2009.

WHO QUALIFIES?

Businesses with fewer than *25 full-time equivalent employees* (FTE) and average annual wages less than $50,000 per employee qualify. According to the IRS, "Because the eligibility formula is based in part on the number of FTEs, not the number of employees, many businesses will qualify even if they employ more than 25 individual workers."
http://www.irs.gov/newsroom/article/0,,id=220848,00.html?portlet=7

To receive the tax credit, an employer must have a group health plan and must pay at least 50% of the premium.

HOW MUCH IS THE TAX CREDIT?

The tax credit is a percentage of what the employer pays and is based on the average premium in the small group market in the State. The U.S. Department of Health and Human Services is required to determine the average premium for each state or region. *This fact sheet will be updated when such information is available from HHS.*

For Tax Years 2010 through 2013, the maximum credit in each year is 35% of the employer's contributions (25% for nonprofit employers).

Beginning Tax Year 2014, the maximum credit is 50% of the employer's contribution (35% for nonprofit employers). A business may receive two years of up to 50% tax credits. The two

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[1] The credit is provided under Section 45R of the Internal Revenue Code, which was enacted March 23, 2010 by Section 1421 of the Patient Protection and Affordable Care Act (PPACA).

years of 50% credit is in addition to any credit the employer might have received for tax years 2010 through 2013.

WHO IS ELIGIBLE FOR THE MAXIMUM TAX CREDIT?

The amount of the tax credit depends on the size and wages of the small business. A full 35% tax credit (50% in future years) is available for a business with 10 or fewer full time equivalent workers and average annual wages of $25,000 or less. The tax credit phases out completely at 25 workers (FTEs) or average wages of $50,000.

WHO IS NOT ELIGIBLE?

The tax credit is not available for coverage for working owners (sole proprietors, partners, 5% shareholders, 2% shareholders of S corporations) and their immediate families. Coverage for seasonal workers who work 120 or fewer days is not eligible for this tax credit.

HOW DO BUSINESSES CLAIM THE CREDIT?

The Small Business Health Insurance Tax Credit is part of the "general business credit," which reduces the income taxes a business owes. If the credit is more than taxes owed, the unused credit can be carried forward or back to other years that a business has a tax liability. Tax-exempt small businesses may apply the credit to their payroll taxes.

ADDITIONAL INFORMATION

Helpful information from the IRS:

http://www.irs.gov/newsroom/article/0,,id=220848,00.html?portlet=7