Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)

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September 21, 2010

Congressional Research Service
7-....
www.crs.gov
R40942

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. This report summarizes the key provisions in PPACA (hereafter referring to PPACA as amended by P.L. 111-152) that affect private health insurance. PPACA imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health coverage; and provides financial assistance to certain individuals and, in some cases, small employers.

In general, PPACA requires individuals, beginning in 2014, to maintain health insurance, with some exceptions. Individuals will be required to maintain minimum essential coverage, which includes eligible employer coverage, individual coverage, grandfathered plans, and federal programs such as Medicare and Medicaid, among others. Employers are not explicitly required to provide health benefits, although certain employers with more than 50 employees may be required to pay a penalty if either (1) they do not provide insurance, under certain circumstances, or (2) the insurance they provide does not meet specified requirements. Several insurance market reforms will be implemented, including some prior to full implementation in 2014, such as prohibition against lifetime benefit limits and coverage for preexisting health conditions for children.

In addition to establishing new federal private health insurance standards, PPACA will enable and support states' creation by 2014 of "American Health Benefit Exchanges." An exchange cannot be an insurer, but will provide eligible individuals and small businesses with access to insurers' plans in a comparable way. The exchange will consist of a selection of private plans as well as "multi-state qualified health plans," administered by the Office of Personnel Management. Individuals will only be eligible to enroll in an exchange plan if they are not enrolled in Medicare, Medicaid, or acceptable employer coverage as a full-time employee. Based on income, certain individuals may qualify for a tax credit toward their premium costs and a subsidy for their cost-sharing; the credits and subsidies will be available only through an exchange. States will have the flexibility to establish basic health plans for low-income individuals not eligible for Medicaid.

Individual and small group coverage will be allowed to be offered through nonprofit, member-run health insurance companies. Such nonprofit insurers will be eligible for grants and loans distributed through the new Consumer Operated and Oriented Plan (CO-OP) program.

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The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. This report summarizes the key provisions in PPACA (hereafter referring to PPACA as amended by P.L. 111-152) that affect private health insurance.

With respect to the private health insurance market, mostly by full implementation in 2014, PPACA focuses on restructuring the market (particularly the small-group and nongroup markets), setting minimum standards for health coverage, and providing financial assistance to certain individuals and, in some cases, small employers. Overall, the law includes the following provisions:

- Beginning in 2014, individuals will be required to maintain health insurance, and certain employers with more than 50 full-time equivalent employees (FTEs) will be required to pay a penalty, with some exceptions.
- Several market reforms will be made, such as prohibition against lifetime benefit limits and coverage for preexisting health conditions.
- By 2014, either a state will establish separate exchanges to offer individual and small-group coverage, or the Secretary of Health and Human Services (hereafter referred to as the "Secretary" or "HHS Secretary" unless noted otherwise) will contract with a nongovernment entity to establish and operate exchanges in states that do not establish them. Exchanges will not be insurers but will provide eligible individuals and small businesses with access to private plans in a comparable way. The exchange will consist of a selection of private plans as well as "multi-state qualified health plans," administered by the Office of Personnel Management (OPM).
- Beginning in 2014, certain individuals with incomes below 400% of the federal poverty level may qualify for credits toward their premium costs and for subsidies towards their cost-sharing. This financial assistance will be available only through exchanges.
- States will be provided the flexibility to establish basic plans for low-income individuals not eligible for Medicaid.
- Existing plans offered by employers as well as plans offered in the nongroup market will be grandfathered.
- New plans may also be sold in both the individual and group market outside of an exchange.
- Individual and small group coverage will be allowed to be offered through nonprofit, member-run health insurance companies.

Congressional Budget Office and Joint Committee on Taxation Analysis

On March 20, 2010, the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) provided their final estimate of the direct spending and revenue effects of PPACA (as amended by P.L. 111-152).[1] CBO projects that PPACA will reduce federal deficits by $143 billion over the 10-year period of 2010-2019 and, by 2019, will insure 94% of the non-elderly, legally present U.S. population. According to the CBO, the gross 10-year cost of the exchange subsidies ($464 billion), increased federal Medicaid and CHIP outlays ($434 billion), and tax credits for small employers ($40 billion) will total $938 billion. These costs will be partially offset by $150 billion over the 10-year budget window, from four sources: net revenues from the excise tax on high-premium insurance plans ($32 billion); penalty payments by uninsured individuals ($17 billion); penalty payments by employers whose workers received subsidies via the exchanges ($52 billion); and other budgetary effects, mostly on tax revenues, associated with the expansion of federally subsidized insurance ($48 billion). Taking into account these offsets, the net cost of the coverage provisions, according to the CBO analysis, would be $788 billion over 10 years. According to CBO, these costs are more than offset by other PPACA changes affecting direct spending and revenues. For additional information on these revenue provisions, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*.

Overview of Report

This report summarizes key provisions affecting private health insurance in PPACA.[2] Most of the provisions will be effective beginning in 2014. Provisions effective prior to 2014 are described in the next section and are listed in **Appendix A** on immediate reforms.

The private health insurance provisions in this report are presented under the following topics:

- Individual mandate and employer requirements: the mandate for individuals to maintain health insurance and any requirements for employers.
- Private health insurance market reforms.
- Exchange, through which the following two items can only be offered:
  - Multi-state qualified health plans.
  - Premium subsidies.
- Immediate Individual and Group Market Reforms and Consumer Operated and Oriented Plan—Health Care Cooperatives.

[1] The March 20, 2010, estimate is available at http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf.

[2] This report does not discuss quality, wellness, administrative simplification, and other titles of PPACA, which are addressed in other CRS reports.

Immediate Individual and Group Market Reforms

PPACA requires implementation of a number of reforms in both the individual and group markets prior to the full implementation date for many other insurance reforms (January 1, 2014).[3] These reforms include the following, in the order in which they would become effective (see **Appendix A** for additional details and **Appendix B** for a chronology of implementation deadlines):

- authorizing the Secretary to award grants to states to provide information and assistance to health insurance consumers;
- establishing a process for the annual review of unreasonable premium increases;
- providing coverage assistance for those who are uninsured because of a preexisting condition;
- creating a temporary re-insurance program to support coverage for early retirees;
- establishing an Internet portal to assist consumers in identifying coverage options;
- prohibiting lifetime limits and restricted annual limits on essential benefits;[4]
- prohibiting rescissions of health insurance policies;
- requiring coverage of preventive services and immunizations;
- extending dependent coverage up to age 26;
- prohibiting discrimination based on salary with respect to eligibility for benefits;
- capping insurance company non-medical, administrative expenditures;
- ensuring that consumers have access to an effective appeals process;
- providing coverage for preexisting health conditions for enrollees under age 19;
- ensuring patient protections regarding the choice of a primary care provider, access to emergency services and obstetrical and gynecological care, and access to medical reimbursement data;
- requiring the Secretary to develop uniform summary of benefits documents so consumers can make easier comparisons when shopping for health insurance;
- facilitating administrative simplification to lower health system costs; and
- tasking the Secretary with developing requirements for quality of care.

In addition to the immediate reforms in PPACA, there are other private insurance reforms that were not identified as immediate but nonetheless become effective prior to 2014; those reforms include the following, in the order in which they would become effective (see **Appendix A** for additional details concerning implementation deadlines):

[3] The use of the term "immediate" to describe the first set of insurance reforms complies with statutory language; the heading for Subtitle A of P.L. 111-148 is "Immediate Improvements in Health Care Coverage for All Americans." However, most of these "immediate" reforms actually become effective after the date of enactment.

[4] Per §10101, the Secretary must define the scope of restricted annual limits.

- grandfathering of existing group and individual health plans;
- availability of small business tax credits;
- awarding of grants to employers to establish workplace wellness programs;
- availability of medical malpractice demonstration grants;
- determination made by the Secretary whether states have met requirements to establish their own exchange; and
- awarding of loans and grants to applicants to the consumer operated and oriented plan (CO-OP) program.

Health Insurance Terms Defined Under PPACA

PPACA will establish new health insurance plans and define existing health insurance terms. New health plans include the following:

- A "qualified health plan" (QHP) will be a health plan that is certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package (defined below; see "Essential Health Benefits Package"). A QHP issuer must be licensed and in good standing with each state in which it offers coverage; must offer at least one QHP each providing silver and gold levels of coverage (levels described below; see "Levels of Coverage"); must charge the same premium for a plan regardless if it is offered in or out of the exchange (including through an insurance agent); and must comply with regulations applicable to exchanges. QHPs will include qualified health plans offered through the CO-OP program (described below; see "Consumer Operated and Oriented Plan (CO-OP)").
- A "standard health plan" will be a plan established and maintained by the state under which eligible individuals are residents of the state who are not eligible to enroll in Medicaid; whose household income exceeds 133% but does not exceed 200% of the poverty line for the size of the family involved; who are not eligible for minimum essential coverage (as defined in section 5000A(f) of 23 the Internal Revenue Code of 1986); or are eligible for an employer-sponsored plan; and have not attained the age of 65 as of the beginning of the plan year. Such a plan will provide coverage equal to at least the essential health benefits (described below), and have a medical loss ratio[5] of at least 85%.

PPACA defines several terms applicable to private health insurance including the following:

- "Health plan" refers to health insurance coverage offered to individuals and groups, not including self-insured plans and multiple employer welfare arrangements (MEWAs)[6] not subject to state law.

[5] A medical loss ratio refers to the percentage of premiums collected by an insurer that is used to pay medical claims.

[6] The Employee Retirement Income Security Act defines a multiple employer welfare arrangement as an employee welfare benefit plan or other arrangement that is established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. MEWAs may not include plans covering (continued...)

- "Group health plan" refers to a plan that provides medical care to employees or their dependents, including self-insured plans. MEWAs could be considered group health plans for the purpose of private health insurance requirements under PPACA.
- "Grandfathered plan" refers to a health plan or health insurance coverage in which an individual is enrolled in on the date of enactment (March 23, 2010). Grandfathered plans (1) include plans that are renewed after this date; (2) allow for enrollment of family members, if such enrollment is permitted under the terms of the plan in effect on the date of enactment; and (3) allow for enrollment of new employees (and their families).[7]
- "Minimum essential coverage" (i.e., coverage required to fulfill the individual mandate) is defined as coverage under Medicare part A, Medicaid, the Children's Health Insurance Program (CHIP), Tricare,[8] the TRICARE for Life program, the veteran's health care program, the Peace Corps program, a government plan (local, state, federal) including the Federal Employees Health Benefits Program (FEHBP) and any plan established by an Indian tribal government, any plan offered in the individual, small group or large group market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary in coordination with the Treasury Secretary.
- "Essential health benefits package" refers to health insurance coverage that will provide "essential health benefits," will not exceed out-of-pocket and deductible limits specified in the law, and will not impose a deductible on preventive services.
- "Essential health benefits" refers to categories of benefits specified in the law (described below) which will be provided in an "essential health benefits package."

Individual Mandate and Employer Requirements

Individual Mandate

Beginning in 2014, PPACA includes a mandate for most individuals to have health insurance,[9] or potentially pay a penalty for noncompliance.[10] Individuals will be required to maintain minimum

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collective bargaining agreements, rural electric cooperative and rural telephone cooperative associations. Conceptually, MEWAs are designed to give small employers the ability to purchase low cost health coverage on terms similar to those available to large employers. For additional information about MEWAs, see U.S. Department of Labor, Employee Benefits Security Administration, Fact Sheet: MEWA Enforcement, April 2009, available at http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement.html.

[7] For additional descriptions of grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*.

[8] Tricare was added in H.R. 4887, as passed by both the House (March 20, 2010) and the Senate (April 12, 2010).

[9] §1501(b) as amended by §10106 (b) of P.L. 111-148 and by §1002 of P.L. 111-152.

[10] §1501 of P.L. 111-148 includes congressional findings that address the constitutionality of an individual mandate to (continued...)

essential coverage for themselves and their dependents. Those who do not meet the mandate will be required to pay a penalty for each month of noncompliance. The penalty will be calculated as the greater of either (1) a percentage of the amount by which household income exceeds the personal exemption for the applicable tax year[11] ("applicable income") or (2) a flat dollar amount assessed on each taxpayer and any dependents (e.g., family), with the total penalty for a family capped at 300% of the flat dollar amount. The percentage penalty amount based on applicable income will be 1.0% in 2014, 2.0% in 2015, and 2.5% thereafter. The annual flat dollar amount will be phased in—$95 in 2014, $325 in 2015, and $695 in 2016 and beyond (adjusted for inflation), assessed for each taxpayer and any dependents, up to the family cap. The flat dollar amount will be reduced by one-half for dependents under the age of 18. Finally, the penalty for noncompliance cannot exceed the national average premium for bronze-level qualified health plans offered through exchanges (for the relevant family size).

Some individuals will be provided with subsidies beginning in 2014 to help pay for their premiums and cost-sharing. (A complete description of who is eligible and the amount of subsidies is found in the section on Individual Eligibility for Premium Credits and Cost-sharing Subsidies). Others will be exempt from the individual mandate, including those with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals. No penalty will be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes individuals whose household income is less than the personal exemption amount for the applicable tax year, or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a QHP. Additionally, individuals whose required contribution[12] for a calendar year exceeds 8% of household income[13] will be exempt from the penalty. After 2014, the 8% will be adjusted to reflect the excess rate of premium growth and the rate of income growth for the period. Certain individuals who would otherwise be subject to the mandate, but are residing outside of the United States, as well as bona fide residents of any possession of the United States will be considered to have minimum essential coverage and therefore not subject to the penalty.

Taxpayers who are required to pay a penalty but fail to do so will receive a notice from Internal Revenue Service (IRS) that they owe the penalty. If they still do not pay the penalty, the IRS can attempt to collect the funds by reducing the amount of their tax refund in the future. However, individuals who fail to pay the penalty will not be subject to any criminal prosecution or penalty for such failure. The Secretary can not file notice of lien or levy on any property for a taxpayer who does not pay the penalty.

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obtain health insurance. For more information on this issue, see CRS report, CRS Report R40725, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, by Jennifer Staman and Cynthia Brougher.

[11] For example, for tax year 2010, the personal exemption amount is $3,650.

[12] Required contribution is defined as (1) in the case of an individual eligible to purchase minimum essential coverage through an employer (other than through the exchange), the portion of the annual premium that is paid by the individual for self-only coverage, or (2) or for individuals not included above, the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the State in which the individual resides, reduced by the amount of the premium credit for the taxable year.

[13] Household income is defined as the modified gross income of the taxpayer, plus the aggregate modified gross income of all other individuals for whom the taxpayer is allowed a deduction for personal exemptions for the taxable year.

Members of Congress and their staff can enroll only in health plans created under this Act or offered through an exchange. This provision applies only to those congressional staff who are full- and part-time employees employed by the official office of a Member of Congress.[14]

Employer Requirements

PPACA does not mandate an employer to provide employees with coverage; however, beginning in 2014, it does impose requirements on certain employers.[15] An employer with at least 50 full-time equivalents[16] (FTEs) that *does not provide* coverage may be subject to a penalty if at least one of its full-time employees receives a premium credit. An employer with at least 50 FTEs that *provides* access to coverage but fails to meet certain requirements may also be subject to a penalty. The number of FTEs excludes those full-time seasonal employees who work for less than 120 days during the year. The penalty for an applicable employer who provides coverage is similar to the penalty assessed against an employer who does not provide coverage. An employer may be subject to a penalty only in relation to its full-time workers, defined as those working an average of at least 30 hours per week. An employer is not subject to a penalty in relation to its part-time workers (those working less than an average of 30 hours per week). For additional information besides that provided below, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*.

Requirements and Penalties for an Employer Offering Health Insurance

For an employer that chooses to offer health insurance, the following rules would apply:

- Current employment-based plans will be considered grandfathered plans.
- A small employer may offer full-time employees and their dependents coverage in an exchange plan.
- A large employer may offer full-time employees the opportunity to enroll in a group health plan.
- An employer will not be treated as meeting the employer requirements if at least one full-time employee receives premium credits in an exchange plan because the employee's required contribution for self-only coverage exceeds 9.5% of the employee's household income or if the plan offered by the employer pays for less than 60% of covered health care expenses.[17]
- An employer must file a return providing the name of each individual for whom they provide the opportunity to enroll in minimum essential coverage, the length of any waiting period, the number of months that coverage was available, the

[14] For additional information, see CRS Congressional Distribution (CD) memorandum "Analysis of §1312(d)(3)(D) of P.L. 111-148, The Patient Protection and Affordable Care Act, and its Potential Impact on Members of Congress and Congressional Staff," by (name redacted), (name redacted) and Ida Brudnick, April 2, 2010, available upon request from the memorandum's authors.

[15] §1513(a) as amended by §10106 (e-g) of P.L. 111-148 and by §1003 of P.L. 111-152.

[16] The calculation of FTEs for any month includes (1) the number of full-time employees (defined as those working an average at least 30 hours per week), and (2) the aggregate number of hours of service of employees who are not full-time, divided by 120.

[17] §1401 of P.L. 111-148 as amended by §1001(a)(2)(A) of P.L. 111-152.

monthly premium for the lowest cost option, the plan's share of covered health care expenses paid for, the number for full-time employees, the number of months employees were covered (if any), and any other information required by the Secretary.[18] The employer must provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.[19]

- An employer will not pay a penalty for any part-time workers (those working less than 30 hours), even if that employee receives a premium credit.

In 2014, the *monthly* penalty assessed to the employer for each full-time employee *who receives a premium credit* will be one-twelfth of $3,000 for any applicable month. However, the total penalty for an employer will be limited to the *total* number of the firm's full-time employees minus 30, multiplied by one-twelfth of $2,000 for any applicable month. After 2014, the penalty amounts will be indexed by a premium adjustment percentage for the calendar year.

Finally those firms with more than 200 full-time employees that offer coverage will automatically enroll new full-time employees in a plan (and continue enrollment of current employees).[20] Automatic enrollment programs will be required to include adequate notice and the opportunity for an employee to opt out.

Requirements and Penalties for an Employer Not Offering Health Insurance

A firm with at least 50 FTEs that chooses not to offer health insurance to its full-time employees (and their dependents) will be subject to a penalty if any of its full-time employees receive premium credits in an exchange plan. In 2014, the penalty assessed to the employer will be equal to the number of full-time employees minus 30 multiplied by one-twelfth of $2,000, for any applicable month. After 2014, the penalty payment amount would be indexed by a premium adjustment percentage for the calendar year.

Employers that do not offer coverage must also file a return stating that they do not offer coverage, the number of full-time employees, and other information required by the Secretary. They must provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange.[21]

Free Choice Vouchers

An employer offering minimum essential coverage who pays any portion of the costs of such plan will provide free choice vouchers to each qualified employee.[22] A qualified employee is defined as an employee whose required contribution to the employer plan, for self-only coverage, is greater than 8% and less than 9.8% of the employee's household income for the taxable year, whose household income is not greater than 400% of the FPL for the relevant family size, and

[18] §1514 of P.L. 111-148.

[19] §1512 of P.L. 111-148.

[20] §1511 of P.L. 111-148.

[21] For additional information, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*.

[22] §10108 of P.L. 111-148.

who does not participate in the plan offered by the employer. Beginning after 2014, the 8% and 9.8% would be indexed by the rate of premium growth.

The amount of a voucher will be equal to the monthly portion of the cost of the employer plan that would have been paid by the employer if the employee were covered under the plan for which the employer pays the largest portion of plan costs, for either self or, if elected by the employee, family coverage.

An exchange will credit the amount of a voucher to the monthly premium of a qualified health plan in which the qualified employee is enrolled, and the employer will pay the exchange the credited amount. If the amount of the voucher exceeds the premium, the excess will be paid to the employee. An individual receiving a free choice voucher will not be eligible for the exchange premium credits or cost-sharing subsidies described later in this report.[23]

No penalty will be imposed on an employer with respect to any employee who is provided with a voucher.

Small Business Tax Credit

Certain small businesses are currently eligible for a tax credit[24] toward a share of their cost of health insurance coverage. In each of the four years 2010 through 2013, the full (or maximum) credit will cover up to 35% of a qualified for-profit employer's contributions[25] to health insurance, and 25% of nonprofit employers' contributions to premiums. Beginning in 2014, for for-profit employers, the maximum credit is 50% of the employer's contribution[26] toward premiums and 35% of employer contributions for nonprofit organizations. The small business tax credit that is available beginning in 2014 is only available to an employer for two consecutive tax years. The full credit is available to those employers with 10 or fewer full-time equivalent employees with average taxable wages are $25,000 or less. The credit is phased out as the number

[23] Individuals with free choice vouchers are explicitly (§10108(h)(1)) ineligible for premium credits and cost-sharing subsidies available to certain low- and middle-income individuals enrolled in exchange plans discussed later in this report. Individuals who are eligible for employer-sponsored coverage may only obtain premium credits (beginning in 2014) for exchange plans *if* the employee's required contribution for self-only coverage exceeds 9.5% of the employee's household income *or* if the plan offered by the employer pays for less than 60% of covered health care expenses. Thus, for example, it may be the case that an individual in 2014 eligible for employer-sponsored coverage in which he or she pays 9.0% of income toward premiums will initially seem eligible for premium credits if the plan pays for less than 60% of covered health care expenses. However, the employer is then required to provide a free choice voucher, which would make the individual ineligible for the premium credits and cost-sharing subsidies.

[24] §1421 as amended by §10105 (e) of P.L. 111-148.

[25] For 2010-2013, the "employer contribution" for the year will be calculated as the lesser of (1) the employer's actual premium contribution, or (2) the contribution the employer would have made if each of those same employees had enrolled in a plan with a premium equal to the average premium (determined by the Secretary of Health and Human Services (HHS)) for the small group market in the state, or area in the state, in which the employer offers health insurance. Any premium paid pursuant to a salary reduction arrangement under a section 125 cafeteria plan is not treated as paid by the employer.

[26] Beginning in 2014, the employer contribution will be calculated as the lesser of (1) the employer premium contribution toward qualified health plans (QHPs) offered by the employer through an exchange, or (2) the contribution the employer would have made if each of those same employees had enrolled in a QHP with a premium equal to the average (determined by the HHS Secretary) for the small group market in the rating area in which the employee enrolls for coverage.

of FTEs increases from 10 to 25 and as average employee compensation increases from $25,000 to $50,000.[27]

For nonprofit (tax-exempt) organizations, the credit will be in the form of a reduction in income and Medicare tax the employer is required to withhold from employees' wages and the employer share of Medicare tax on employees' wages (with the credit thus limited by these amounts). For all other qualifying employers, it will be in the form of a general business credit. This type of credit is not refundable, but is limited by the for-profit employer's actual tax liability. In other words, if a for-profit company had a year in which it ended up paying no taxes (i.e., it had no taxable income, after accounting for all its other deductions and credits), then the small business tax credit could not be used for that year; there would be no income tax for this credit to reduce. However, as a general business credit, an unused credit amount can generally be carried back for one year[28] and carried forward up to 20 years. For more information, see CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (PPACA)*.

Private Health Insurance Market Reforms

Besides the immediate reforms previously mentioned, PPACA also will establish new federal standards applicable to private health insurance coverage primarily after full implementation in 2014.[29] These standards will affect private health insurance in the individual, small group, and large group markets, depending on the standard. These standards will impose new requirements on states related to the allocation of insurance risk, modify the current state-based regulatory system applicable to private plans, and require coverage for specified categories of benefits. Before 2016, states will have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. A "large employer" will be an employer that had an average of at least 101 employees the preceding calendar year and at least one employee on the first day of the plan year.[30] States will be required to uniformly apply any standard or requirement it adopts under the private health insurance provisions of PPACA.

PPACA will establish "qualified health plans" (QHPs), a type of new health plan subject to a specified list of requirements related to marketing, choice of providers, plan networks, essential benefits, and other features. A QHP issuer will be licensed and in good standing with each state in which it will offer coverage; will offer at least one QHP each providing silver and gold levels of coverage (described below); will charge the same premium for a plan regardless if it was offered in or out of the exchange (including through an insurance agent); and will comply with regulations applicable to exchanges.[31]

[27] Beginning in 2014, these dollar amounts would be increased by the Consumer Price Index (CPI).

[28] For 2010 only, the credit cannot be carried back one year, because it is first available for tax years after December 31, 2009. Beginning in 2011 and thereafter, it can be carried back one year, as part of the general business credit.

[29] Most of the private health insurance provisions amend Title XXVII of the Public Health Service Act (PHSA, 42 U.S.C. 300gg et seq.). Title XXVII includes requirements on health insurance coverage for both the group and nongroup markets, enforcement applicable to such requirements, relevant definitions, and other provisions.

[30] §1304(b).

[31] §1301.

Existing plans may continue to offer coverage as grandfathered plans in the individual and group markets. Enrollment in such plans will be limited to those who were currently enrolled, their families, or new employees and their families in the case of grandfathered employer-sponsored coverage. Enrollees could continue and renew enrollment in a grandfathered plan indefinitely. Grandfathered plans will still be subject to a number of insurance reforms.[32] Existing group plans subject to one or more collective bargaining agreements will be grandfathered until the date on which the agreement terminates, at which time the immediate reforms and private market reforms will apply.[33]

Individual and Group Health Insurance Reforms

The law will apply new federal health insurance standards to group health plans as well as health insurance coverage offered in the individual, small group, and large group markets (depending on the standard), effective for plan years beginning on or after January 1, 2014. Among the insurance reforms are provisions that will subject new plans to the following requirements:

- Prohibit *group health plans (new and grandfathered)* and issuers in the *individual* and *group* markets from excluding coverage for preexisting health conditions.[34] (A "preexisting health condition" is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Excluding coverage for preexisting conditions refers to the case in which an applicant for coverage is offered a health insurance policy but that policy does not provide benefits for certain medical conditions.)
- Prohibit *group health plans* and issuers in the *individual* and *group* markets from basing eligibility for coverage on health status-related factors.[35] (Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the Secretary). It will allow for the offering of premium discounts or rewards based on enrollee participation in wellness programs (described in "Other Provisions" section).
- Impose nondiscrimination requirements on *group health plans* and issuers in the *individual* and *group* markets with respect to participating health care providers and individuals enrolled in such coverage.[36]
- Prohibit *group health plans*, issuers in the *group* market, and *grandfathered health plans* from imposing a waiting period greater than 90 days.[37] (A "waiting

[32] For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA).*

[33] §1001 and §1251 as amended by §10103(d)-(e) of P.L. 111-148, and further amended by §2301 of P.L. 111-152.

[34] §1201 (new PHSA §2704) as amended by §10103(e) of P.L. 111-148, and further amended by §2301 of P.L. 111-152.

[35] §1201 (new PHSA §2705).

[36] §1201 (new PHSA §2706).

[37] §1201 (new PHSA §2708), as amended by §10103(b) of P.L. 111-148 and by §2301(a) of P.L. 111-152.

period" refers to the time period that must pass before an individual is eligible to use health benefits.)

- Require *individual* and *group* health insurance issuers to offer coverage on a guaranteed issue and guaranteed renewal basis.[38] ("Guaranteed issue" in health insurance is the requirement that an issuer accept every applicant for health coverage. "Guaranteed renewal" in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor [e.g., employer] or individual coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered is affordable.)
- Require issuers in the *individual* and *small group* markets to determine premiums for such coverage using adjusted community rating rules.[39] ("Adjusted, or modified, community rating" prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under the law, premiums will vary based only on the following risk factors: self-only or family enrollment; rating area,[40] as specified by the state; age (by no more than a 3:1 ratio across age rating bands established by the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC)), and tobacco use (by no more than 1.5:1 ratio).
- Require *QHPs* and issuers in the *individual* and *small group* markets to offer coverage that includes the "essential health benefits package" (see description below).[41]
- Prohibit *health plans* that provide the essential health benefits package from imposing annual cost-sharing requirements that exceed the out-of-pocket limits applicable to high deductible health plans (HDHPs) as defined under the health savings account (HSA) section of the IRC[42] beginning in 2014. Limits would be annually adjusted thereafter by rate of growth in health care premiums.[43]

Reforms Related to Allocation of Insurance Risk

PPACA includes provisions that will take into account the variation of insurance risk among plan enrollees and across health plans. Such provisions will

- Require any issuer in the *individual* or *small group* market to consider all enrollees in all plans offered by the issuer in the applicable market as members of a single risk pool, including enrollees not enrolled in such plans offered through the exchange.[44] ("Pooling" refers to the insurance industry practice of pooling the

[38] §1201 (new PHSA §§2702, 2703).

[39] §1201 (new PHSA §2701).

[40] As an example, some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.

[41] §§1201 (new PHSA §2707), 1302.

[42] For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.

[43] §1302(c).

[44] §1312(c).

insurance risk of individuals or groups in order to determine premiums.) States may also merge their individual and small group markets.

- Require each state to establish a reinsurance program for the *individual* market by no later than January 1, 2014, and lasting through 2016.[45] ("Reinsurance" typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums it collects will not be sufficient to cover its expenses and generate profit. For a health insurer, unusually high health care claims could lead to significant financial loss. Reinsurance shifts the risk of covering such high expenses from the primary insurer to a reinsurer.) The law will require all health insurance issuers and third-party administrators (TPAs) of group health plans to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity. The total contribution amounts will equal $12 billion in plan year 2014, $8 billion in 2015, and $5 billion in 2016. States could collect additional amounts from issuers. States will modify or terminate any existing high-risk pools to be consistent with the reinsurance provisions.
- Require the Secretary to establish and administer temporary risk corridors from 2014 through 2016, under which payments to QHPs in the *individual* and *small group* markets will be made according to applicable risk corridor rules, based on the program for regional participating provider organizations under Part D of the Medicare program.[46] ("Risk corridors" refer to a mechanism which adjusts payments to plans according to a formula based on each plan's actual, allowed expenses in relation to a target amount. If a plan's expenses exceed a certain percentage above the target, the plan's payment is increased. Likewise, if a plan's expenses exceed a certain percentage below the target, the plan's payment is decreased.)
- Require each state to adopt a risk-adjustment model, established by the Secretary, to apply risk adjustment to *health plans* and issuers in the *individual* and *small group* markets.[47] ("Risk adjustment" refers to a mechanism that adjusts payments to health plans to take into account the risk that each plan is bearing based on its enrollee population.) Plans with enrollment of less than average risk will pay an assessment to the state. States will provide payments to plans with higher than average risk.

Essential Health Benefits Package

The Secretary will specify the "essential health benefits" included in the "essential health benefits package" that QHPs will be required to cover (effective beginning in 2014). Essential health benefits[48] will include at least the following general categories:

- ambulatory patient services;

[45] §1341, as amended by §10104(r) of P.L. 111-148.

[46] §1342.

[47] §1343.

[48] §1302(b).

- 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 and chronic disease management; and
- pediatric services, including oral and vision care.

Coverage provided for the essential health benefits package will provide bronze, silver, gold, or platinum level of coverage (described below).[49] A health plan providing the essential health benefits package will be prohibited from imposing an annual cost-sharing limit that exceeds the thresholds applicable to HSA-qualified HDHPs.[50] Small group health plans providing the essential health benefits package will be prohibited from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014 (annually adjusted thereafter).[51] Such limits will be applied in a manner that will not affect the actuarial value of any health plan,[52] including a bronze level plan (described below). Consistent with the immediate reforms described above, plans providing the essential health benefits package will be prohibited from applying a deductible to preventive health services.[53]

PPACA will require the Secretary to define and periodically update coverage that provides essential health benefits. The Secretary will ensure that the scope of essential health benefits is equal to the scope of benefits under a typical employer-provided health plan (as certified by the Chief Actuary of the Centers for Medicare and Medicaid Services).[54] A health plan will be allowed to provide benefits in excess of the essential health benefits defined by the Secretary.[55] However, if a state requires such additional benefits in QHPs, the state must reimburse individuals for the additional costs of those benefits.[56]

[49] §1302(d).

[50] §1302(c).

[51] Ibid.

[52] "Actuarial value" is a summary measure of a health plan's benefit generosity. It is expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. For a background discussion about actuarial value, see CRS Report R40491, *Setting and Valuing Health Insurance Benefits*, by (name redacted).

[53] §1302(c).

[54] §1302(b).

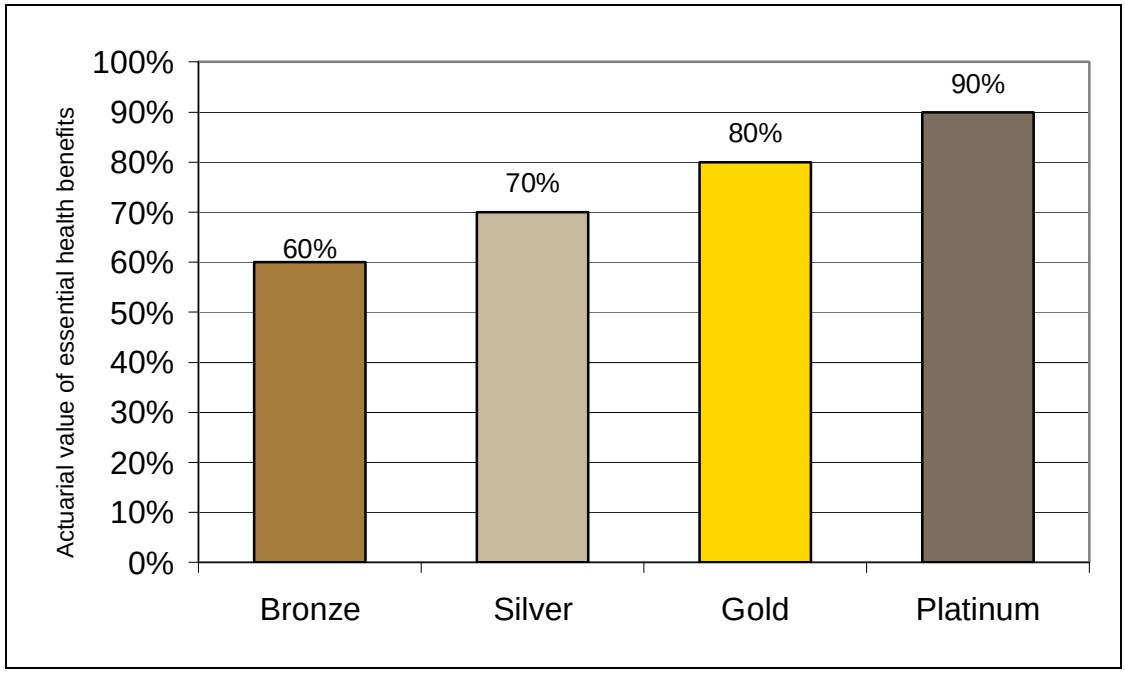
[55] §1302(b)(5).

[56] §1311(d)(3)(B), as amended by §10104(e).

Levels of Coverage

Beginning in 2014, PPACA will generally require QHPs to provide coverage at one of the following levels: bronze, silver, gold, or platinum. This requirement will apply regardless of whether or not the QHP is offered through an exchange (and premiums must be the same for QHPs inside and outside of the exchange). Excluding dental-only plans, health insurance issuers must offer a silver plan and a gold plan in the exchange. Each coverage level will be based on a specified share of the full actuarial value of the essential health benefits (see **Figure 1**). A health insurance issuer that offers coverage in any of these four levels will be required to offer the same level of coverage in a plan specifically designed for individuals under age 21.[57]

Figure 1. Actuarial Values for Levels of Coverage Provided by Qualified Health Plans



Source: CRS analysis of the Patient Protection and Affordable Care Act.

Another plan option permitted under PPACA in 2014 is a catastrophic plan. A catastrophic plan will provide coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for HSA-qualified HDHPs. Such deductibles will not apply to at least three primary care visits. A catastrophic plan will be permitted only in the individual market (1) for young adults (those under age 30 before the plan year begins), and (2) for those persons exempt from the individual mandate because no affordable coverage is available or they have a hardship exemption.[58]

[57] §1302(d).

[58] §1302(e).

Consumer Operated and Oriented Plan (CO-OP)

The creation of new health insurance cooperatives will be encouraged primarily through the distribution of $6 billion in funding under the Consumer Operated and Oriented Plan (CO-OP) program.[59] The Secretary will use the funds to foster the creation of new nonprofit member-run health insurance issuers that offer QHPs in the individual and small group markets.[60] Federal funds will be distributed as loans for start-up costs and grants for meeting solvency requirements. The funds must ultimately be repaid.[61]

PPACA will require the Secretary to make grant and loan awards no later than July 1, 2013, after taking into account the recommendations of the advisory board.[62] The Secretary will make grant and loan awards giving priority to applicants that offer QHPs on a statewide basis, that use an integrated care model, and have significant private support. The Secretary will ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state and the District of Columbia. If no health insurance issuer applies within a state, the Secretary will use funds for the program to award grants to encourage the establishment of qualified issuers within the state or the expansion of an issuer from another state to the state with no applicants. Grantees will enter into agreements with the Secretary to follow the provisions of PPACA, and any regulations promulgated by the Secretary. The agreement will include prohibitions for the use of loan or grant funds "for carrying on propaganda, or otherwise attempting, to influence legislation; or for marketing."[63]

The law will define a qualified nonprofit health insurance issuer as an organization meeting the following requirements:

- It must be organized as a nonprofit, member corporation under state law.
- It must not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization.
- Substantially all of its activities must consist of the issuance of QHPs in the individual and small group markets in each state in which it is licensed to issue such plans.
- It must not be sponsored by a state, county, or local government, or any government instrumentality.

[59] §1322, as amended by §10104(l).

[60] The definition in §1301 requires that a health insurance issuer offer at least one QHP at the silver and gold levels in an exchange, but not all its offerings will be required to participate in the exchange.

[61] Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary will promulgate regulations with respect to the repayment of loans and grants in a manner that is consistent with state solvency regulations and other similar state laws that may apply. In promulgating such regulations, the Secretary will provide that such loans will be repaid within 5 years and such grants will be repaid within 15 years, taking into consideration any appropriate state reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a state to provide for such repayment prior to awarding such loans and grants (§10104(l)).

[62] The advisory board will consist of 15 members appointed by the Comptroller General by June 23, 2010, and will be subject to ethics and conflict of interest standards protecting against insurance industry involvement and interference. Board members will receive no compensation, but will be reimbursed for their travel expenses. The board will terminate when it completes its duties, or on December 31, 2015, whichever comes first.

[63] §1322(b)(2)(C)(ii).

- Its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.
- Governance of the organization must be subject to a majority vote of its members.
- It must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members in accordance with regulations to be promulgated by the Secretary of HHS.
- Any profits made will be required to be used to lower premiums, improve benefits, or other programs intended to improve the quality of health care delivered to members.
- It must meet all the requirements that other issuers of QHPs in any state where the issuer offers a QHPs, including solvency and licensure requirements, rules on payment to providers, network adequacy standards, rate and form filing rules, applicable state premium assessments, and any other applicable state law.
- It must coordinate with state insurance reforms by not offering a health plan in the state until that state has in effect the market reforms required under the law.

PPACA will permit qualified nonprofit health insurance issuers participating in the CO–OP program to enter into collective purchasing arrangements, called a purchasing council, for services and items that increase administrative and other cost efficiencies. The purchasing council will focus on areas such as claims administration, general administrative services, health information technology, and actuarial services. The council will be explicitly prohibited from setting payment rates for health care facilities and providers. There will not be any representatives of federal, state, or local government or any employee or affiliate of an existing private insurer on the council. The Secretary of HHS will be prohibited from participation in any negotiations between qualified health insurance issuers or a private purchasing council and any health care facilities, providers or drug manufacturer. The Secretary will also be prohibited from establishing or maintaining a price structure or interfering in any way with the competitive nature of providing health benefits through the program.

Under the law, a CO–OP program grantee qualifies for exemption from federal income tax only with respect to periods for which the organization is in compliance with the requirements of the CO–OP program and with the terms of any CO–OP grant or loan agreement to which such organization is a party. CO–OP organizations will also be subject to organizational and operational requirements applicable to certain nonprofits under tax law, including the prohibitions on net earnings benefiting any private shareholder or individual, on substantial involvement in political activities, and on lobbying activities. CO–OP grantees will be required to file an application for exempt status with the Internal Revenue Service and will be subject to annual information reporting requirements. In addition, CO–OP grantees will be required to disclose on their annual information return the amount of reserves required by each state in which it operates ("solvency requirement") and the amount of reserves on hand.

Level Playing Field

Private health insurance issuers will not be subject to any federal or state law applicable to private health insurers unless QHPs in the CO-OP program and multi-state qualified health plans (MSQHPs; see "Multi-state Qualified Health Plans") are also subject to these laws.[64]

American Health Benefit Exchanges

Exchange Structure

In addition to establishing new federal private health insurance standards, PPACA enables and supports states' creation by 2014 of "American Health Benefit Exchanges," similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance. Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' QHPs[65] in a comparable way (in a similar way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). Exchanges will be state-established government or nonprofit entities that will have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.

Within one year of enactment, the Secretary will determine and make grant awards to states to create exchanges, with such sums appropriated as necessary. The grants can be renewed to states making progress in establishing an exchange, implementing the private health insurance market reforms, and meeting other benchmarks established by the Secretary. However, no grant may be awarded after January 1, 2015. Exchanges will have to be self-sustaining by then, using assessments on insurers or some other way to generate funds to support their operations.

PPACA requires the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC) and others, to set standards for exchanges, offering QHPs through exchanges, reinsurance, and risk adjustment as soon as possible after enactment. It will further require states to implement these standards, as well as the required private insurance market reforms, by 2014. If the Secretary determines before 2013 that a state will not have an exchange operational by 2014, or will not be able to implement the standards, the Secretary is required (directly or through an agreement with a non-profit entity) to establish and operate an exchange in the state and to implement the standards. A state operating an exchange with sizeable enrollment[66] before 2010 is presumed to meet the standards, unless the state is still out of compliance after completion of the process the Secretary is required to establish to assist such a state.[67]

[64] §1324, as amended by §10104(n).

[65] QHPs are described in an earlier section. An exchange could only make available (1) QHPs, and (2) standalone dental plans meeting certain requirements regarding pediatric dental benefits.

[66] §1321(e)(1) says, " … has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act…."

[67] §1321.

PPACA permits the creation of separate exchanges in each state for individuals versus small employers ("a Small Business Health Options Program … [or] 'SHOP exchange'"),[68] for which the Secretary will provide technical assistance to states. A state could merge them into a single exchange, "but only if the exchange has separate resources to assist individuals and employers."[69]

An exchange may operate in multiple states, if each state agrees to the operation of the exchange and if the Secretary approves. A state may have more than one exchange ("subsidiary exchanges") if each serves a geographically distinct area and the area served is adequately large.

New individual and small-group QHPs may be offered inside and outside of an exchange, but the premiums would have to be the same.[70] However, premium credits and cost-sharing subsidies will only be available through exchanges.

PPACA specifies that an exchange must do the following:

- implement procedures to certify, recertify and decertify QHPs;
- provide for the operation of a toll-free hotline;
- maintain a website through which individuals can view standardized comparative information on plans;
- assign a rating to each exchange plan based on criteria developed by the Secretary;
- use a standardized format for presenting exchange plan options;
- inform individuals of eligibility requirements for Medicaid, CHIP or any other state or local program and, if through the screening process the exchange determines they are eligible for one of those programs, enroll them;
- provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies;
- certify whether individuals are exempt from the individual mandate excise tax and transfer the list of such individuals to the Treasury Secretary;
- provide to employers the name of the employees who dropped the employer's coverage and received premium tax credits because the employer's plan was unaffordable or did not provide the required minimum actuarial value; and
- establish the Navigator program.[71]

[68] §1311(b)(1)(B).

[69] §1311(b)(2).

[70] §1301(a)(1)(C)(iii). See also 1312(d)(1), (2), and (3)(B).

[71] PPACA requires exchanges to establish a grant program for Navigators, which would receive funding from exchanges (not the federal government) to conduct public education activities regarding the availability of QHPs, distribute fair and impartial information on enrollment in plans and subsidies, facilitate enrollment in a qualified plan, provide referrals to individuals with grievances or questions, and provide information in a culturally and linguistically appropriate manner.

The Secretary will also establish procedures under which a state could permit insurance agents or brokers to enroll individuals in an exchange plan and to assist them in applying for premium credits and cost-sharing subsidies.

The Secretary, in coordination with the HHS Inspector General, will have authority to investigate exchanges. Exchanges will be subject to annual HHS audits. If the Secretary finds serious misconduct, payment otherwise due to the exchange may be rescinded, up to 1% of such payments, until corrective actions are taken that are deemed adequate by the Secretary. By January 1, 2019, GAO will conduct an ongoing study on exchange activities and the enrollees in exchange plans, reviewing the operation and administration of exchanges, any significant observations regarding the use and adoption of exchanges, recommendations for their improvement, and how many physicians are not accepting new patients enrolled in federal government health care programs and whether those programs' available provider networks are adequate.

Individual and Employer Eligibility for Exchange Plans

Beginning 2014, individuals may enroll in a plan through their state's exchange if they are (1) residing in a state that established an exchange, (2) not incarcerated, except individuals in custody pending the disposition of charges, and (3) lawful residents. Only lawful residents may obtain exchange coverage; unauthorized aliens will be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without any subsidy.[72]

Initially, only small employers could opt to offer coverage to their workers through an exchange. (They would have to make all of their full-time employees exchange eligible.) Before 2016, states will have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so). Participating employers may limit their workers' choice of exchange plans to a particular benefit level (tier); workers could then choose any available exchange plan at that level (e.g., silver).

Members of Congress and their staff can enroll only in health plans created under this Act or offered through an exchange. This provision only applies to those congressional staff who are full- and part-time employees employed by the official office of a Member of Congress.[73]

Premium Credits and Cost-Sharing Subsidies

Beginning 2014, some individuals will be eligible for premium tax credits toward their required purchase of health insurance, based on income. However, even when individuals have health insurance subsidized with premium credits, they may be unable to afford the cost-sharing

[72] §1312(f)(3). For more information about the treatment of noncitizens under the legislation, see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by (name redacted).

[73] For additional information, see CRS Congressional Distribution (CD) memorandum "Analysis of §1312(d)(3)(D) of P.L. 111-148, The Patient Protection and Affordable Care Act, and its Potential Impact on Members of Congress and Congressional Staff," by (name redacted), (name redacted) and Ida Brudnick, April 2, 2010, available upon request from the memorandum's authors.

(deductible and copayments) required to obtain health care. Thus, cost-sharing subsidies may also be available to those eligible for premium credits. Cost-sharing subsidies will only be available for silver plans sold through an exchange, including private plans.[74] The next section summarizes the premium credits, but for additional descriptions and analyses, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)*.

Premium Credits

Beginning January 1, 2014, qualifying individuals will receive advanceable, refundable tax credits toward the purchase of an exchange plan (although the advance payment will actually go directly to the insurer[75]). Individuals above 400% of the federal poverty level (FPL) will not be eligible for credits. Based on the premium of the second lowest cost silver plan available to the individual in an exchange, qualifying individuals between 300% and 400% FPL would have to pay no more than 9.5% of their incomes in premiums. For qualifying individuals with income above 133% to 300% FPL, the percent of income they will have to pay toward premiums will rise from 3% of income to 9.5% of income, as illustrated in **Figure 2** and in **Table 1** below.[76] Qualifying individuals at or below 133% FPL would pay no more than 2% of income toward premiums. Currently, for a family of three in the 48 contiguous states, 133% FPL is $24,352, and 400% FPL is $73,240.[77] The current dollar amount of income those maximum out-of-pocket premium payments represent are also shown in **Table 1**.

As mentioned above, the premium credit amount will be based on the second lowest cost silver plan available to the individual in an exchange. Individuals who enroll in more expensive plans will have to pay any additional amount. For example, although individuals eligible for premium credits may enroll in gold and platinum plans, they will have to pay the additional premiums out of pocket and will be ineligible for the cost-sharing subsidies; the cost-sharing subsidies will be available only to credit-eligible individuals enrolled in a silver plan.[78]

Although the Medicaid provisions of PPACA are generally beyond the scope of this report, eligibility for Medicaid as expanded under the law interacts with the provisions regarding premium credits and cost-sharing subsidies available for exchange coverage. From April 1, 2010, through 2013, states have the *option* to expand Medicaid to all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain noncitizenship status) who are otherwise ineligible for Medicaid up to 133% FPL. Beginning in 2014, states would be *required* to extend Medicaid to these individuals. Thus, in 2014, all non-elderly *citizens* and certain legal aliens up to 133% FPL will be eligible for Medicaid.[79] (If a person who applied for premium credits in an exchange was determined to be eligible for

[74] The premium credits and cost-sharing subsidies appear in §§1401-15, 10105 of PPACA, as amended by §§1001 and 1004 of P.L. 111-152.

[75] §1412(a)(3).

[76] In years after 2014, the percentages would be adjusted to reflect any percentage by which premium growth exceeded income growth.

[77] CRS computation based on "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf.

[78] §1402(b)(1).

[79] One might say that, notwithstanding what the new statute says, eligibility will in fact be required up to 138% FPL, because §1004(e) of P.L. 111-152 also requires income equivalent to 5% FPL be disregarded from household income.

Medicaid, the exchange would have that person enrolled in Medicaid.[80]) PPACA does not change noncitizens' eligibility for Medicaid.[81] Thus, for example, certain legal permanent residents (LPRs) who are below 133% FPL would be ineligible for Medicaid. However, when the credits become available in 2014, lawfully present taxpayers below 133% FPL who are not eligible for Medicaid may be eligible for premium credits.[82]

Table 1. Maximum Out-of-Pocket Premium Payments Under PPACA, If Currently Implemented

(for the 48 contiguous states and the District of Columbia)

Federal Poverty Line (FPL)	Maximum Premium as a % of Income (2014)	Maximum Annual Premium (current), by Family Size			
		1	2	3	4
100%	2.0%	$217	$291	$366	$441
133.00%	2.0%	$288	$388	$487	$587
133.01%	3.0%	$487	$656	$824	$992
150%	4.0%	$650	$874	$1,099	$1,323
200%	6.3%	$1,365	$1,836	$2,307	$2,778
250%	8.05%	$2,180	$2,932	$3,685	$4,438
300%	9.5%	$3,087	$4,152	$5,218	$6,284
350%	9.5%	$3,601	$4,845	$6,088	$7,332
400%	9.5%	$4,115	$5,537	$6,958	$8,379

Source: CRS computation based on "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf, and PPACA, for the second least expensive silver plan available to eligible individuals. If individuals choose more expensive plans, they would be responsible for additional premiums.

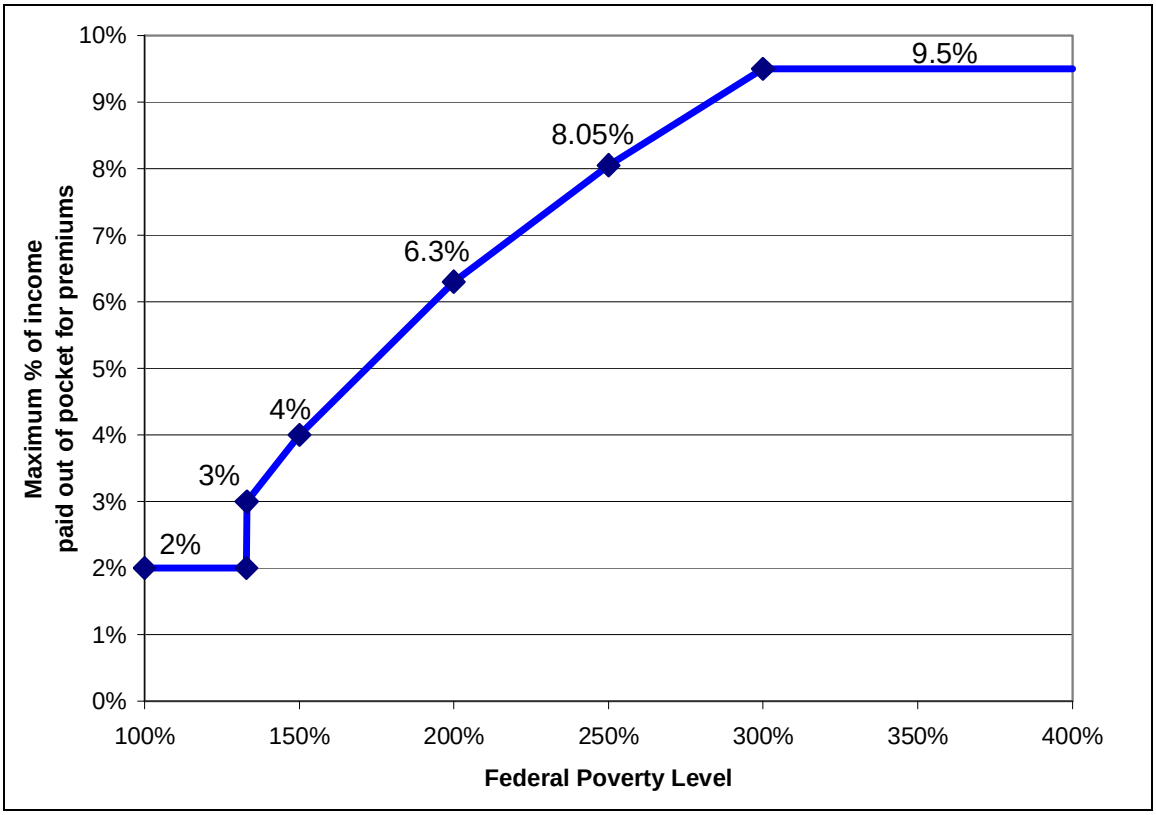
Besides the previously mentioned eligibility criteria, individuals will also generally be ineligible for credits if they are *eligible* for Medicare, Medicaid, CHIP, coverage related to military service, an employer-sponsored plan, a grandfathered plan, and other coverage recognized by the Secretary. An individual eligible for, but not enrolled in, an employer-sponsored plan could still be eligible for subsidies if the employee's contribution to premiums for self-only coverage exceeded 9.5% of household income or if the plan's payments cover less than 60% of total allowed costs, as long as the individual qualified for the credit on the basis of their income.

[80] §1311(d)(4) and §1413(a).

[81] As under current law, certain legal aliens would be eligible for full Medicaid benefits (e.g., refugees and some legal permanent residents [LPRs] who have been here at least five years) while others would not (e.g., certain LPRs who have been here less than five years).

[82] For more information about the treatment of noncitizens and the verification of individuals' eligibility for premium credits under the various bills, see CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by (name redacted).

Figure 2. Maximum Out-of-Pocket Premiums for Eligible Individuals in 2014 Under PPACA, by Federal Poverty Level (FPL)



Cost-Sharing Subsidies

Those who qualify for premium credits and are enrolled in an exchange plan at the silver tier beginning in 2014 will also be eligible for assistance in paying any required cost-sharing for their health services. As previously mentioned, exchange plans will be required to limit out-of-pocket costs based on high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.[83] As shown in **Table 2**, the cost-sharing subsidies will further reduce those out-of-pocket maximums by two-thirds for qualifying individuals between 100% and 200% FPL, by one-half for qualifying individuals between 201% and 300% FPL, and by one-third for qualifying individuals between 301% and 400% FPL. Additional cost-sharing subsidies (i.e., reductions in copayments, deductibles, etc.), if necessary, will be provided to ensure that the plan covers the percentages of allowed health care expenses shown in **Table 2**. The Secretary will make periodic payments to insurers (potentially using capitated, risk-adjusted payments) for the cost-sharing subsidies of their qualified enrollees.

[83] Internal Revenue Service (IRS) Rev. Proc. 2009-29, Section 2, available at http://www.irs.gov/pub/irs-drop/rp-09-29.pdf.

Table 2. Cost-Sharing Subsidies in PPACA (2014): Out-of-Pocket Maximums and Average Percentage of Allowed Expenses Paid by Plan, by Income Tier

Federal poverty level (FPL)	Out-of-pocket limit relative to maximum permissible for HSA-qualified high deductible health plans	Percent of allowed health care expenses covered by plan
Up to 150%	Reduced by two-thirds	94%
151% - 200%	Reduced by two-thirds	87%
201% - 250%	Reduced by one-half	73%
251% - 300%	Reduced by one-half	70%
301% - 400%	Reduced by one-third	70%

Source: PPACA (P.L. 111-148, as amended by P.L. 111-152).

Notes: In 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage. Thus, a two-thirds reduction in 2010 (although these provisions are not effective until 2014) would be an out-of-pocket maximum of $2,000 for single coverage and $4,000 for family coverage; a one-half reduction would be $3,000 and $6,000, respectively; and a one-third reduction would be $4,000 and $8,000, respectively.

Multi-state Qualified Health Plans

The Director of the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans (MSQHPs) ultimately through every exchange in all the states, to provide individual and small group coverage. Any individual eligible to purchase insurance through the exchange may enroll in a MSQHP. Enrollment is voluntary, and individuals may be eligible for premium credits and cost-sharing assistance.[84]

A health insurance issuer offering a MSQHP must do the following: meet the requirements in every state's exchange; be licensed in each state and subject to all requirements of state law not inconsistent with MSQHPs; comply with the minimum standards prescribed for carriers offering health benefits plans under the Federal Employees Health Benefits Program (FEHBP); meet other requirements as determined appropriate by the OPM Director, in consultation with the Secretary; offer a uniform benefits package in each state consisting of the essential benefits; meet all requirements of a qualified health plan, "including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange";[85] meet the rating requirements of PPACA (except for certain state rating requirements); and also offer the plan in all geographic regions, and in all states that adopted adjusted community rating before the date of enactment of PPACA.

Each contract for an MSQHP will be for at least one year and can be automatically renewed if neither party provides notice to terminate. At least one contract will be with a nonprofit entity. The OPM Director will enter into a contract with a health insurance issuer if the issuer offers the plan in at least 60% of states in the first year, at least 70% in the second year, at least 85% in the third year, and in all states thereafter.

[84] §10104 (q) of P.L. 111-148.

[85] §1334(c)(1)(B) per §10104(q) of P.L. 111-148.

The OPM Director will implement MSQHPs with similar contracting provisions affecting carriers under FEHBP—through negotiating with each MSQHP on (1) medical loss ratio, (2) profit margin, (3) premiums to be charged, and (4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. The OPM Director can prohibit the offering of any MSQHP that does not meet these criteria.

The requirements of the FEHBP program will apply only to MSQHPs to the extent that they are not in conflict with the requirements of PPACA. The OPM Director cannot reduce financial or personnel resources to the functions of OPM related to the administration of FEHBP. The Director can (1) establish separate units or offices within OPM to ensure that the administration of MSQHPs do not interfere with the administration of FEHBP, and (2) appoint additional personnel to carry out MSQHP activities. MSQHPs will be separate from FEHBP, with a separate risk pool, and FEHBP plans will not be required to offer a MSQHP.

Additional State Options

State Flexibility to Establish a Basic Health Program

PPACA will establish a program to support coverage of low-income individuals not eligible for Medicaid modeled after the Washington State Basic Health (BH) Plan program administered and financed by the Washington State Health Care Authority (HCA). [86] The BH Plan started as a pilot program established by the Washington State "Health Care Access Act of 1987."[87] PPACA will create a similar state option for individuals who are not eligible for Medicaid, have not reached the age of 65, and whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved.[88] Generally eligible individuals would be those under 200% of poverty who would otherwise be eligible for premium credits in an exchange. However, under PPACA, an individual eligible for a state's basic health program would not be eligible for exchange coverage.[89]

The law will require the Secretary to establish a program where a state or a regional compact of states could establish one or more standard health plans. The Secretary will transfer to the state for each fiscal year for which one or more standard health plans are operating within the state the amount equal to 95% of the premium tax credits under section 36B of the IRC of 1986, and the cost-sharing reductions under section 1402, that will have been provided for the fiscal year to eligible individuals enrolled in standard health plans if such eligible individuals were allowed to enroll in QHPs through an exchange. A standard heath plan will be defined as a health benefits plan that the state contracts with that

- will not be open for enrollment to a broad group of individuals, but only to individuals eligible for the program;[90]

[86] §1331 as amended by §10104(o).

[87] "Basic Health Plan 2008 Annual Report," http://www.basichealth.hca.wa.gov/documents/2008AnnualReport.pdf.

[88] This includes lawfully present individuals who may not be citizens, per §10104(o).

[89] §1331(e)(2).

[90] In other words, the plan will be program specific and not open to the broader market. Eligibility requirements include being a resident of the state that is not eligible to enroll in Medicaid; whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved; who is not eligible for minimum essential (continued...)

- provides at least the essential health benefits defined in the law; and
- in the case of a plan that provides health insurance coverage offered by a health insurance issuer, has a medical loss ratio of at least 85%.

PPACA will provide that a state basic health program establish a competitive process for entering into contracts with standard health plans including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. The competitive process will consider the following:

- innovative features including, but not limited to care coordination and care management (emphasizing chronic conditions);
- incentives for use of preventive services, and establishment of patient/doctor relationships that maximize patient involvement in health care decision-making;
- contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market; and
- specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Under the law, states will be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. States will also be allowed to negotiate a regional compact with other states to include coverage of eligible individuals in all such states. State administrators will be encouraged to find ways to integrate their negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs.

Waiver for State Innovation

Beginning in 2017, the law will permit states to apply for a waiver for up to five years of requirements relating to QHPs, exchanges, premium tax credits, cost-sharing subsidies, the individual mandate, and certain employer requirements. The state applying for the waiver will be required to enact a law, provide a 10-year budget plan ensuring budget neutrality for the federal government, and to comply with regulations that ensure transparency. The Secretary will be required to provide to a state the aggregate amount of premium credits and cost-sharing subsidies that would have been paid to residents of the state in the absence of a waiver. The Secretary will only be permitted to grant a request for a waiver if the Secretary determined that the state plan will do the following:

- provide coverage that is at least as comprehensive as the coverage offered through exchanges as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the state and from comparable states about their experience with programs created under PPACA;

(...continued)

coverage (as defined in section 5000A(f) of 23 the Internal Revenue Code of 1986); or is eligible for an employer-sponsored plan; and has not attained the age of 65 as of the beginning of the plan year.

- provide coverage and cost-sharing protections against excessive out-of-pocket spending;
- provide coverage to at least a comparable number of its residents as will be provided without the waiver; and
- not increase the federal deficit.

Offering Plans in More Than One State

Under PPACA, not later than July 1, 2013, the Secretary, in consultation with NAIC, will promulgate regulations for interstate health care choice compacts, which can be entered into beginning in 2016. Under such compacts, QHPs will be offered in all participating states, but insurers will still be subject to the consumer protection laws of the purchaser's state. Insurers will be required to be licensed in all participating states and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's state. The law also will require that states enact a law to enter into compacts and to obtain approval of the Secretary, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as would otherwise be provided. Moreover, the law will require that the compact will not increase the federal deficit or weaken enforcement of state consumer protection laws.

This provision will also allow insurers in the individual and small group markets to offer a QHP nationwide, which will be subject not only to the state benefit mandate laws of the state in which the plans are issued, but would require such plans to provide the essential benefits package. States will be permitted to enact a law to opt out of allowing the offering of nationwide plans. Insurers will be required to file plan forms for review with each state.

Other Provisions

Abortion

In addressing the coverage of abortion services by qualified health plans offered through an exchange, PPACA refers to the so-called "Hyde Amendment" to distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, and abortions for which such funds may not be used. Under the Hyde Amendment, funds appropriated for HHS may be used to pay for an abortion if a pregnancy is the result of an act of rape or incest, or if a woman's life would be endangered if an abortion were not performed. Such funds may not be used, however, for elective abortions. Under PPACA, individuals who receive premium credits or cost-sharing reductions (available beginning in 2014) will be permitted to purchase an exchange plan that includes coverage for elective abortions. However, to ensure that funds attributable to a premium subsidy are not used to pay for elective abortion services, PPACA prescribes payment and accounting requirements for plan enrollees and issuers, as described in greater detail below.[91]

[91] §1303, as amended by §10104(c).

Additionally, after the enactment of PPACA, on March 24, 2010, President Obama issued an executive order that reaffirmed the abortion funding restrictions included in PPACA.[92] The order was reportedly the result of negotiations with some House members who expressed concerns over the abortion provisions of PPACA.

Under PPACA, the issuer of a qualified health plan will determine whether to provide coverage for either elective abortions or abortions for which federal funds appropriated for HHS are permitted. A plan issuer would also appear able to not cover either type of abortion. In addition, PPACA will permit a state to prohibit abortion coverage in exchange plans by enacting a law to with such a prohibition.

The issuer of a qualified health plan that provides coverage for elective abortions will be required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of health services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage for elective abortions. The plan issuer must deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services. State health insurance commissioners must ensure compliance with the segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, Office of Management and Budget circulars on funds management, and Government Accountability Office guidance on accounting.

To determine the actuarial value of the coverage for elective abortions, the plan issuer will estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including such coverage. The estimate may take into account the impact on overall costs of including coverage for elective abortions, but may not take into account any cost reduction estimated to result from such services, such as prenatal care, delivery, or postnatal care. The per month cost will have to be estimated as if coverage were included for the entire population covered, but may not be less than $1 per enrollee, per month.

Under PPACA, a qualified health plan that provides coverage for elective abortions will also be required to provide notice of such coverage to enrollees as part of a summary of benefits and coverage explanation at the time of enrollment. The notice, any plan advertising used by the issuer, any information provided by the exchange, and any other information specified by the Secretary will provide information only with respect to the total amount of the combined payments for elective abortion services and other services covered by the plan.

PPACA also provides for conscience protection and the preservation of certain state and federal abortion-related laws. The measure prohibits exchange plans from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. State laws concerning the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements will not be preempted. Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, are not affected by PPACA.

[92] Exec. Order No. 13,535, 75 *Federal Register* 15,599, March 24, 2010.

Prohibition Against Discrimination on Assisted Suicide

PPACA prohibits the federal government, and any state or local government or health care provider that receives federal financial assistance under PPACA or any health plan created under PPACA, from subjecting an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. Nothing in the above can be construed to apply or to affect any limitation relating to (1) the withholding or withdrawing of medical treatment or medical care, (2) the withholding or withdrawing of nutrition or hydration, (3) abortion, or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as it is not also furnished for the purpose of causing, or assisting in causing, death. The HHS Office for Civil Rights is designated to receive complaints of discrimination based on this issue.[93]

Medical Malpractice

PPACA expresses the sense of the Senate that (1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; (2) states are encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and (3) Congress should consider establishing a state demonstration program to evaluate alternatives to the existing civil litigation system with respect to medical malpractice claims.[94]

PPACA appropriates $50 million for a five-year period, beginning in FY2011, for the HHS Secretary to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation.[95] These grants will exist for no more than five years. Under the provision, a state desiring a grant is required to develop an alternative that (1) allows for the resolution of disputes caused by health care providers or organizations, and (2) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data. Each state will have to identify the sources from and methods by which compensation will be paid, and demonstrate that its proposed alternative to tort litigation meets certain goals and criteria. The Secretary will provide to the states that are applying for the grants technical assistance, including guidance on common definitions, non-economic damages, avoidable injuries, and disclosure to patients of health care errors and adverse events.

The Secretary will consult with a review panel composed of relevant experts appointed by the Comptroller General when reviewing states' applications. Furthermore, each state that receives a grant is required to submit a report to the Secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance. Similarly, the Secretary must submit a report to Congress that examines any differences that may result in the area of quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance. Additionally, the Secretary, in consultation with the review panel, must conduct an overall evaluation of the

[93] §1553.

[94] §6801.

[95] §10607.

effectiveness of grants awarded and to submit the findings of the evaluation to Congress. The Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) must each conduct an independent review on the impact of state alternatives implemented on their programs and beneficiaries.

The law will not limit any prior, current, or future efforts of any state to establish any alternative to tort litigation.

Multiple Employer Welfare Arrangements

PPACA contains certain provisions intended to combat fraud and abuse relating to multiple employer welfare arrangements (MEWAs). For example, PPACA prohibits persons (in connection with MEWAs) from knowingly making false statements or representations in connection with the marketing or sale of the plan that concerns, among other things, the financial solvency and the benefits provided by the MEWA. Pursuant to regulations to be promulgated by the Secretary of Labor, MEWAs will be required to register with the Secretary before operating in a state. In addition, the Labor Secretary is authorized to adopt regulatory standards or to issue orders that a person engaged in the business of providing insurance through a MEWA is subject to the laws of the state in which such person operates. PPACA also allows the Labor Secretary to issue cease and desist orders against certain MEWAs if it appears to the Secretary that the alleged conduct of the MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.[96]

Wellness Programs Offered by Employers/Private Insurers

While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits group health plans and group health insurance issuers from imposing higher premiums or contributions among "similarly situated" participants based on certain health-related factors, it does allow the provision of premium discounts, rebates, or reduced cost-sharing for enrollee participation in wellness programs. Among other provisions related to wellness programs, PPACA codifies an amended version of the HIPAA wellness program regulations.[97] Consistent with current regulation, the law indicates that wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward (or do not offer a reward) would not violate HIPAA, so long as participation in the programs is made available to all similarly situated individuals. However, if any of the conditions for obtaining a reward under a wellness program are based on an individual meeting a certain standard relating to a health factor, the program must meet additional requirements. Among these requirements, the reward must be capped at 30% of the cost of the employee-only coverage under the plan, but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate. Further, this type of wellness program must be reasonably designed to promote health or prevent disease. A program complies with this requirement if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome; is not a subterfuge for discriminating based on a health status factor; and is not highly suspect in the method chosen to

[96] §§6601, 6604-6606.

[97] §1201, which creates §2705 of the PHSA.

promote health or prevent disease. PPACA also requires the Secretary of HHS, in consultation with the Secretaries of the Treasury and Labor, to establish a 10-state pilot program no later than July 1, 2014, in which participating states must apply the wellness program provisions to health insurers in the individual market.

Report on Self-Insured Plans and Study of Large Group Market

PPACA requires that not later than one year after enactment, and annually thereafter, the Secretary of Labor prepare an annual report, using data collected from the Form 5500 on self-insured group health plans, including plan type, number of participants, benefits offered, funding arrangements, benefit arrangements, assets, liabilities, contributions, investments, and expenses.[98] The law also requires that the Secretary of HHS, not later than one year after enactment, conduct a study of the fully insured and self-insured group health plan markets, to compare the characteristics of employers, health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent—and to determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to become self-insured.[99]

[98] For more details on the Form 5500 see Department of the Treasury, Department of Labor, and Pension Benefit Guaranty Corporation, "2010 Instructions for Form 5500 Annual Return/Report of Employee Benefit Plan," available at http://www.dol.gov/ebsa/pdf/2010-5500inst.pdf.

[99] "Fully insured" refers to the insurance market not subject to the ERISA federal preemption of state regulation. A fully insured welfare benefit plan has its benefits provided exclusively through insurance contracts or policies, the premiums of which must be paid directly to the insurance carrier by the employer or employee organization from its general assets or partly from its general assets and partly from contributions by its employees or members. The insurance contracts or policies must be issued by an insurance company or similar organization, such as Blue Cross and Blue Shield or Wellpoint, that is qualified to do business in any state.

Appendix A. Immediate Individual and Group Market Reforms Under Title I

This appendix provides more details on the immediate private health insurance reform provisions in Title I, Subtitles A and B of PPACA.[100] The PPACA term "immediate" refers to the legal effective date of the provision. The actual implementation date, however, may not be immediate due to the number of steps required to make the provision operational. For example, the administrative simplification provision is effective on enactment, but this sets in motion a series of implementation steps culminating in health plans certifying their use of the newly developed standards by December 31, 2015.[101] **Appendix B** provides detail on the required implementation steps for all of the Title I private health insurance reforms.

High-Risk Pools for Individuals with a Preexisting Condition

Not later than 90 days after enactment, the Secretary must establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals during the period beginning on the date the program is established and ending on January 1, 2014.[102] The high-risk pool is required to not impose any preexisting condition exclusions, and the out-of-pocket limit will not be greater than the maximum amount for HSA-qualified HDHPs,[103] except that the Secretary is permitted to modify the limit if necessary to ensure the pool meets the actuarial limit for the program. The premium rate charged for the high-risk pool coverage may vary on the basis of age by a factor of not greater than 4 to 1 and be established at a standard rate for a standard population. The Secretary is granted the authority to issue additional requirements determined to be appropriate for the calculation of premium rates. An individual will be eligible if he/she

- is a citizen or national of the United States or is lawfully present in the United States;
- has not been covered under creditable coverage during the six-month period prior to the date on which such individual is applying for coverage through the high-risk pool; and
- has a preexisting condition, as determined in a manner consistent with guidance to be issued by the Secretary.

Bringing Down the Cost of Health Care Coverage

Effective for plan years beginning on or after six months after enactment, issuers in the group and individual markets (including grandfathered health plans) are required to submit to the Secretary a report concerning the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums.[104] The report must also include the

[100] §1001 through §1105.

[101] §1104.

[102] §1101.

[103] For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is $5,950 for single coverage and $11,900 for family coverage.

[104] §1001, as amended by §10101: §2718 PHSA. Beginning on January 1, 2014, this calculation would be based on the (continued...)

percentage of total premium revenue, after accounting for risk adjustment, risk corridors, and payments for reinsurance, that the coverage expends

- on reimbursement for clinical services;
- for activities that improve health care quality; and
- on all other non-claims costs including an explanation of the nature of such costs and excluding federal and state taxes, licensing, or regulatory fees.

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including grandfathered health plans) will provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on clinical claims and health quality costs, after accounting for taxes, regulatory fees, risk adjustment, risk corridors, and reinsurance, is less than 85% in the large group market and 80% for the small group and individual markets. States are permitted to increase the percentages, but the Secretary may adjust the state percentage for the individual market if it is determined that the application of 80% would destabilize the market. The rebate amount will be equal to the product of the amount by which the percentage exceeds the ratio (both described above) and the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees) and after accounting for risk adjustment, risk corridors and reinsurance.

No Lifetime or Annual Limits

For plan years beginning on or after six months after enactment, group health plans, grandfathered plans, and health insurance issuers offering group or individual plans are prohibited from establishing lifetime limits on the dollar value of essential health benefits for any participant or beneficiary, or annual limits except those defined as "restricted" as determined by the Secretary.[105] The Secretary will ensure that there is access to needed services available with minimal impact on premiums. The provision for restricted annual limits sunsets with the plan year beginning January 1, 2014. In other words, from January 1, 2014, going forward annual limits will be prohibited in manner similar to lifetime limits. Health plans and health insurance issuers will be permitted to place annual or lifetime limits on specific covered benefits that are not essential health benefits, to the extent that such limits are otherwise permitted by federal and state law.

Prohibition on Rescissions

The practice of "rescission" refers to canceling medical coverage after a policyholder has become sick or injured. Effective for plan years beginning on or after six months after enactment, the law generally prohibits rescissions for a group health plan, a grandfathered plan, and a health insurance issuer offering group or individual health insurance coverage.[106] Rescissions will still be permitted in cases where the covered individual committed fraud or made an intentional

(...continued)

averages of the premiums expended on the costs for each of the previous three years for the plan. The Secretary would make these reports available to the public on the Internet site of the Department of Health and Human Services.

[105] §1001, as amended by §10101: §2711 PHSA.

[106] §1001: §2712 PHSA.

misrepresentation of material fact as prohibited by the terms of the plan or coverage. A cancellation of coverage in this case requires prior notice to the enrollee.

Sunshine on Health Insurance Premium Rates

The Secretary must, in conjunction with the states, establish a process for the annual review of unreasonable increases in premiums for health insurance coverage beginning in the 2010 plan year. Health insurance issuers will be required to submit to the Secretary, and the relevant state, a justification for an unreasonable premium increase prior to implementation of the premium.[107]

The Secretary must carry out a program of grants to states during the five-year period beginning with FY2010 for carrying out the premium review. There is appropriated to the Secretary $250 million available for these grants. As a condition of these grants, states are required to provide the Secretary with information about trends in premium increases and make recommendations about if a particular issuer should be excluded from participation in the exchange due to a pattern or practice of excessive or unjustified premium increases.

Coverage of Preventive Health Services

Effective for plan years beginning on or after six months after enactment, group health plans and health insurance issuers in the group and individual markets are required to provide coverage for preventive health services.[108] These preventive services include the following:

- evidence-based items or services that have in effect a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF);[109]
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);[110]

[107] §1003.

[108] §1001: §2713 PHSA.

[109] The USPSTF is currently sponsored by the Agency for Healthcare Research and Quality (AHRQ), as an independent panel of private-sector experts in prevention and primary care issues. For more background see http://www.ahrq.gov/clinic/uspstfab.htm. A rating of "A" means the service is recommended and there is high certainty that the net benefit is substantial. A rating of "B" means the service is recommended, and there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. See "U.S. Preventive Services Task Force Grade Definitions" available online at http://www.ahrq.gov/CLINIC/uspstf/gradespost.htm#brec.

[110] The ACIP consists of 15 experts in fields associated with immunization who have been selected by the Secretary of Health and Human Services to provide advice and guidance to the Secretary and the CDC on the control of vaccine-preventable diseases. The Committee develops recommendations for the routine administration of vaccines to children and adults in the civilian population; recommendations include age for vaccine administration number of doses and dosing interval, and precautions and contraindications. http://www.cdc.gov/vaccines/recs/acip/.

- with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[111] and
- with respect to women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA.

A plan or issuer is permitted to cover or deny additional services not recommended by the USPSTF. For the purposes of this provision the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention is considered the most current other than those issued in or around November 2009.

The law permits the Secretary to develop guidelines for group health plans and health insurance issuers in the group and individual markets to utilize value-based insurance designs. Value-based insurance designs, as defined in prior testimony before the Senate Committee on Budget, refers to coverage that encourages the use of services that have clinical benefits exceeding the costs, while discouraging the use of services when the expected clinical benefits do not justify the costs.[112]

Extension of Dependent Coverage

Effective for plan years beginning on or after six months after enactment, a group health plan, a grandfathered plan, and a health insurance issuer offering coverage in the group or individual markets that provided dependent coverage must extend that coverage to adult children until the individual is 26 years of age.[113] This will not apply to a child of the child receiving dependent coverage. For group plans that are grandfathered, the coverage is limited to those adult children that do not have an offer of coverage from an employer.[114]

Development and Utilization of Uniform Explanation of Coverage Documents

No later than 12 months after enactment, the Secretary will develop standards for group health plans, grandfathered plans, and health insurance offers in the group and individual markets with

[111] HRSA is the primary federal agency within the Department of Health and Human Services for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to uninsured people, people living with HIV/AIDS, and pregnant women, mothers and children. For more background see http://www.hrsa.gov/about/default.htm.

[112] Statement of Peter R. Orszag "Health Care and the Budget: Issues and Challenges for Reform" before the Committee on the Budget, United States Senate, June 21, 2007.

[113] §1001: §2714 PHSA. The FEHBP has a provision in current law for extending depended coverage. It is defined as for unmarried dependent child under 22 years of age at chapter 89 of title 5, United States Code. Some stakeholders have sought clarification on the applicability of this provision to the FEHBP. For example, see http://www.nteu.org/Documents/FEHBPLetter1-12-10.pdf. On April 23, 2010, the Office of Personnel Management stated that, "[u]nder the Affordable Care Act, adult children up to age 26 will be eligible for health insurance coverage. The effective date of this provision is the first day of the plan year that is six months following enactment of the law. For the Federal Employees Health Benefits (FEHB) Program, that means January 1, 2011." Available at http://www.opm.gov/insure/health/reform/index.asp.

[114] For more information, see CRS Report R41220, *Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted) and (name redac ted).

respect to providing their enrollees with a summary of benefits (SB) and coverage.[115] The Secretary will periodically review and update the standards developed. The Secretary will consult with the National Association of Insurance Commissioners (NAIC), and representatives of health-insurance related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals as deemed appropriate. These federal standards preempt any standards developed under state law. **Table A-1** summarizes the standards for the SB.

Not later than 24 months after the date of enactment, each plan will provide a SB to an applicant at the time of application, to an enrollee prior to the time of enrollment or re-enrollment, and to a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate. The SB can be in paper or electronic form. Enrollees will have to be given notice of any materials changes in benefits no later than 60 days prior to the date that the modifications would become effective. Any entity that willfully fails to provide the information required is subject to a fine of not more than $1,000 for each such failure, as defined to be each enrollee that did not receive the required information.

Table A-1. Summary of Benefits and Coverage Document Requirements

Issue area	Requirements
Prohibitions	• Cannot exceed 4 pages in length.
	• Cannot use smaller than 12-point font.
Required description	• Coverage including cost sharing for each of the essential health benefit categories.
	• Any exceptions, reductions, and limitations on coverage.
	• Renewability and continuation provisions.
	• Whether the plan covers minimum essential benefits.
	• Other benefits as identified by the Secretary.
	• Contact information including a phone number and Internet web address for consumer information.
Other requirements	• Must be presented in a culturally and linguistically appropriate manner utilizing language understandable by the average plan enrollee.
	• Must use uniform definitions of standard insurance and medical terms.
	• Must have a statement ensuring that not less than 60% of allowed costs are covered by the benefits.
	• Must have a statement that the document is a summary and should not be consulted to determine the governing contractual provisions.

Source: CRS analysis of PPACA.

[115] §1001: §2715 PHSA.

Prohibition of Discrimination Based on Salary

Effective for plan years beginning on or after six months after enactment, the sponsor of a group health plan (other than a self-insured plan) is prohibited from establishing rules relating to health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee.[116] In no way will eligibility rules be permitted to discriminate in favor of higher wage employees.

Ensuring the Quality of Care

Beginning upon enactment and concluding not later that two years after enactment, the Secretary must develop reporting requirements for use by group health plans or health insurance issuers in the group and individual markets including regulations governing acceptable provider reimbursement structures.[117] The Secretary must develop these requirements in consultation with experts in health care quality and other stakeholders. Once implemented, plans and health insurance issuers will annually submit to the Secretary and to enrollees a report on the use of the reimbursement structures and quality programs that do the following:

- improve health outcomes through use of quality reporting, case management, care coordination and chronic disease management;
- implement activities to prevent hospitalization readmissions;
- implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence based medicine, and health information technology; and
- implement wellness and health promotion activities.[118]

With respect to gun rights, a wellness or promotion activity cannot require disclosure or collection of any information relating to (1) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual, or (2) the lawful use, possession, or storage of a firearm or ammunition by an individual. A health plan issued in accordance with the law is prohibited from increasing premium rates, denying health insurance coverage, and reducing or withholding a discount, rebate, or reward offered for participation in a wellness program on the basis of or on reliance on the lawful ownership, possession, use or storage of a firearm or ammunition.

[116] §1001, as amended by §10101: §2716 PHSA.

[117] §1001: §2716 PHSA. No later than 180 days after promulgation of these regulations the Government Accountability Office (GAO) would also be required to conduct a study regarding the impact of these activities and report their findings to the Senate Committee on Health, Education, Labor, and Pensions, and the House Committee on Energy and Commerce.

[118] Wellness and prevention would be permitted to include health risk assessments and ongoing face-to-face, telephonic, or web-based interventions including smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention. For more background on wellness issues see CRS Report R40661, *Wellness Programs: Selected Legal Issues*, coordinated by (name redacted).

Appeals Process

Effective for plan years beginning on or after six months after enactment, the law requires that a group health plan and a health insurance issuer in the group or individual markets implement an effective appeals process for coverage determinations and claims.[119] The process at a minimum must

- have in effect an internal claims appeals process;
- provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable assistance; and
- allow an enrollee to review their file, present evidence and testimony and to receive continued coverage pending the outcome.

To comply with the requirements, group plans are expected to initially incorporate the claims and appeals procedures set forth at 29 CFR §2560.530-1 and will update their processes in accordance with any standards established by the Secretary of Labor.[120] To comply with the requirements, health insurance issuers offering individual health coverage will provide internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS.

A group health plan and health insurance issuer offering group or individual coverage must comply with the applicable state external review process that at a minimum includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the NAIC. The plan or issuer is required to implement an effective external review process that meets the minimum standards established by the Secretary if the applicable state has not established standards that meet the NAIC model requirements, or if the plan is self-insured and therefore is not subject to state insurance regulation.

Health Insurance Consumer Information

Effective on enactment, the Secretary will award grants to states to enable them, or the exchanges operating in the states, to establish, expand, or provide support for an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman.[121] There is $30 million appropriated for the first fiscal year of the program and authorization for such sums as necessary in subsequent fiscal years. To be eligible to receive a grant, a state will designate an independent Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman, that will directly or in coordination with state health insurance regulators and consumer assistance organizations, receive, and respond to inquires and complaints concern health insurance coverage. The Secretary will establish criteria for the grant, and the Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman will

- assist with the filing of complaints and appeals;

[119] §1001, as amended by §10101: §2719 PHSA.

[120] Section 503 of ERISA, codified at 29 CFR §2560.530-1, requires that employee benefit plans provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and to afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

[121] §1002: §2793 PHSA.

- collect, track, and quantify problems and inquires;
- assist consumers with enrollment in a group health plan or health insurance coverage; and
- resolve problems with obtaining premium tax credits.

Reinsurance For Early Retirees

The Secretary is required to create, within 90 days after enactment, a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older, and are not eligible for Medicare (and their dependents).[122] The law defines eligible employment-based plans as those plans provided to retirees and maintained by one or more employers (including any state or political subdivision), former employers or employee organizations or associations, or a voluntary employees' beneficiary association or a multiemployer plan. Health benefits are defined as medical, surgical, hospital, prescription drug, and other benefits as determined by the Secretary. A retiree is defined as an individual who is 55 years of age or older, is not eligible for Medicare, and is not an active employee.

Participating plans will submit claims for reimbursement to the Secretary that contain documentation of the actual costs of the items and services. In determining the amount of the claim the plan will take into account any negotiated price concessions obtained by the plan and any costs paid by the retiree or beneficiary in deductibles, copayments, and coinsurance will be included along with the amounts paid by the plan. The Secretary will determine if a claim is valid and in such cases will pay 80% of the portion of costs that exceeds $15,000, but is less than $90,000. These amounts will be adjusted annually by the medical care component of the Consumer Price Index (CPI) for all urban consumers rounded to the nearest multiple of $1,000. Amounts paid to plans will be required to be used to reduce premium costs, deductibles, copayments, coinsurance, or other out-of-pocket costs for plan participants and beneficiaries.

Immediate Information to Identify Affordable Coverage

The law requires the Secretary, in consultation with the states, to establish an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options not later than July 1, 2010.[123] The law also requires that, not later than 60 days after enactment, the Secretary must develop a standardized format to be used for the presentation of information used on the Internet portal. The information on the portal will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care compared to administrative costs.

Standards for Electronic Billing and Other Administrative Transactions

The law establishes a timeline, extending through mid-2014, for the development and adoption of a single set of operating rules for each of the administrative and financial electronic transactions

[122] §1102.

[123] §1103.

for which there is an existing HIPAA standard.[124] Those transactions, between health care providers and health plans, include patient eligibility inquiry/response, reimbursement claims, and payment and remittance advice. The standards and associated operating rules will permit the determination of a patient's eligibility and financial responsibility (i.e., cost-sharing requirements) for specific services prior to or at the point of care, among other capabilities. The law also mandates the adoption of an electronic funds transfer (EFT) standard for the payment of health claims.[125] By December 31, 2015, health plans will have to certify that their health information technology systems comply with the most current standards and operating rules. Health plans that fail to meet the certification requirements will be fined.

Patient Protections

Effective for plan years beginning on or after six months after enactment, if a group health plan or health insurance issuer in the group or individual markets requires or provides for designation by a participant, beneficiary or enrollee of a participating primary care provider, then the plan or issuer is required to permit the designation of any participating primary care provider who is available to accept the individual.[126] This same provision applies for pediatric care for any child who is a participant, beneficiary, or enrollee of a group health plan or health insurance issuer in the group or individual markets.

If the group health plan or health insurance issuer in the group or individual markets covers services in an emergency department of a hospital they are required to cover those services without the need for any prior authorization and without the imposition of coverage limitations irrespective of the provider's contractual status with the plan. If the emergency services are provided out-of-network, the cost-sharing requirement will be the same as the cost-sharing for an in-network provider. Patients will also have protected access to obstetrical and gynecological care.

Preexisting Condition Exclusion Prohibition for Children under 19 Years of Age

Group health plans, grandfathered health plans, and health insurance issuers offering group or individual health insurance coverage may not impose any preexisting condition exclusion enrollees who are under 19 years of age for plan years beginning on or after 6 months from enactment, September 23, 2010.[127]

Health Insurance Reform Implementation Fund

The law establishes a Health Insurance Reform Implementation Fund within HHS for federal administrative expenses for carrying out the legislation and appropriates $1 billion to the fund.[128]

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[124] §1104.

[125] This provision does not require plans to use EFT in order to pay providers' health care claims. However, if EFT is chosen, then the electronic transaction must comply with the EFT standard. Note, the EFT standard applies only to the electronic transfer of payments to health care providers' bank accounts; it does not include access to patients' accounts nor does it address patients' financial responsibility.

[126] §10101: §2719A PHSA.

[127] §1251, as amended by §10103 of P.L. 111-148 and further amended by §2301 of P.L. 111-152: §2704 PHSA.

[128] §1005 of P.L. 111-152.

Appendix B. Implementation Timeline for Private Health Insurance Reforms

Table B-1 lists the implementation deadlines for the private health insurance reforms established by PPACA (P.L. 111-148, as amended by P.L. 111-152). This list only includes implementation deadlines as required by law. Several implementation requirements do not have a specific date and are indicated as "not specified" in the table. This table does *not* present effective dates for authorities or rules that do not include implementation requirements. For example, there are no implementation requirements, such as promulgating regulations, for the prohibition on rescissions[129] that has an effective date of plan years beginning on or after six months after enactment.[130]

Table B-1. Chronology of Implementation Deadlines for Private Health Insurance Reforms

(in P.L. 111-148, as amended by P.L. 111-152)

Implementation deadline or effective date	Summary of Provision
March 23, 2010 (enactment date of P.L. 111-148)	The Secretary shall award grants to states (or the exchanges operating in such states) to establish, expand, or provide support for offices of health insurance consumer assistance; or health insurance ombudsman programs (§1002: §2793 PHSA).
March 23, 2010	The Secretary, in conjunction with states, shall establish a process for the annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health insurance coverage. (§1003: §2794 PHSA).
March 23, 2010	The Secretary of HHS shall establish the Consumer Operated and Oriented Plan (CO–OP) program to foster the creation of nonprofit health insurance cooperatives to offer qualified health plans in the reformed individual and small group markets (§1322).
March 23, 2010-FY2014	The Secretary shall carry out a program to award grants to states to assist in carrying out premium rate reviewing and, if appropriate under state law, approving premium increases for health insurance coverage; and in providing information and recommendations to the Secretary on premium rate reviews (§1003: §2794 PHSA).
March 30, 2010 (enactment date of P.L. 111-152)	The Health Insurance Reform Implementation Fund is established within HHS for federal administrative expenses for carrying out health reform. P.L. 111-152 appropriated $1 billion to the fund (§1005).
As soon as practicable after enactment	The Secretary of HHS shall issue regulations setting standards for meeting the requirements with respect to the establishment and operation of exchanges; the offering of qualified health plans through exchanges; the establishment of the reinsurance and risk adjustment programs under part V; and such other requirements as the Secretary determines appropriate (§1321).
May 23, 2010	The Secretary of HHS shall develop a standardized format to be used for the presentation of information relating to the coverage options for the internet portal (§1103, as amended by §10102).

[129] §1001 of PPACA.

[130] §1004 of PPACA.

Implementation deadline or effective date	Summary of Provision
June 23, 2010	The Secretary of HHS shall establish a temporary high risk health insurance pool program (§1101).
June 23, 2010	The Secretary of HHS shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and to the eligible spouses, surviving spouses, and dependents of such retirees (§1102).
July 1, 2010	The Secretary of HHS, in consultation with the states, shall establish a mechanism, including an Internet website, through which a resident of any state may identify affordable health insurance coverage options in that state (§1103, as amended by §10102).
September 23, 2010	The Secretary of HHS shall promulgate regulations to define the dependents to whom coverage will be extended (§1001: §2714 PHSA).
September 23, 2010	The Secretary of HHS shall promulgate regulations relating to the state innovation waivers (§1332).
September 23, 2010	The Secretary of HHS, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs, as determined by the Secretary (§1561: §3021 PHSA)
December 31, 2010	Subject to the certification of the Secretary of HHS, the National Association of Insurance Commissioners shall establish uniform definitions for the clear accounting of costs under §2718 PHSA including standardized methodologies for calculating measures of such activities (§10101: §2718 PHSA).
March 23, 2011	The Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage (§1001: §2715 PHSA).
March 23, 2011-January 1, 2015	The Secretary of HHS shall award grants to the states to establish the American Health Benefit Exchanges (§1311).
March 23, 2011, and annually thereafter	The Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Return/Report of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans as well as data from the financial filings of self-insured employers. The Secretary shall submit such reports to the appropriate committees of Congress (§10103: §1253 PHSA)
March 23, 2011	The Secretary of HHS shall conduct a study of the fully insured and self-insured group health plan markets to compare the characteristics of employers health plan benefits, financial solvency, capital reserve levels, and the risks of becoming insolvent; and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure. The Secretary shall submit to the report to the appropriate committees of Congress (§10103: §1254 PHSA).
March 23, 2011	GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of applications to enroll in health insurance plans by group health plans and health insurance issuers (§10107: §1562).
July 1, 2011	The Secretary of HHS shall establish a set of operating rules for eligibility and health claim status transactions (§1104: §1171 SSA).

Implementation deadline or effective date	Summary of Provision
January 1, 2012, and not less than every 3 years thereafter	The Secretary of HHS shall solicit the input of the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee, and the Health Information Technology Standards Committee and other stakeholders on the development of standards for financial and administrative transactions (§10109: §1104).
March 23, 2012	A health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan will begin using the uniform summary of benefits and coverage explanation (§1001: §2715 PHSA).
March 23, 2012	The Secretary of HHS shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that promote quality of care and promulgate regulations with respect to reimbursement structures (§1001: §2717 PHSA).
July 1, 2012	The Secretary of HHS shall determine the definition of an initial open enrollment period, annual open enrollment periods, and special enrollment periods for the exchange (§1311).
September 23, 2012	GAO shall review the regulations regarding reimbursement structures for promoting quality of care and shall conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report regarding the impact the activities under these regulations (§1001: §2717 PHSA).
January 1, 2013	If the Secretary of HHS has determined that a state will not have any required exchange operational by January 1, 2014, or has not taken the actions the Secretary determines necessary to implement, then the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate an exchange within the state (§1321).
January 1, 2013	The Secretary of HHS shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of the employer responsibility provisions the rights of employees confidentiality and the rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers are preserved (§1411).
January 1, 2013	The Secretary of HHS shall conduct a study to examine the feasibility and implication of adjusting the application of the federal poverty level for premium tax credits and cost sharing reduction for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States (§10105: §1416).
March 1, 2013	The Secretary of Labor shall promulgate regulations instructing applicable employers to provide to each employee at the time of hiring written notice informing the employee of the existence of an exchange; eligibility for the premium tax credit and cost sharing reduction; and if the employee purchases a qualified health plan through the exchange, that the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer (§1512: §18B Fair Labor Standards Act of 1938).
March 23, 2013	The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning the impact and effectiveness of wellness programs (§1201: §2705 PHSA).

Implementation deadline or effective date	Summary of Provision
July 1, 2013	The Secretary of HHS, prior to awarding loans and grants under the CO–OP program, shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with state solvency regulations and other similar state laws that may apply (§10104: §1322 PHSA).
July 1, 2013	The Secretary of HHS shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more states may enter into an agreement (§1333).
July 1, 2013	The Secretary of HHS shall award the loans and grants under the CO-OP program (§1322).
December 31, 2013	A health plan shall file a statement with the Secretary HHS, in such form as the Secretary may require, certifying that the data and information systems are in compliance with any applicable standards for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice (§1104: §1171 SSA).
December 31, 2013	The Secretary of the Treasury will develop a method for large employers to report required information on health insurance coverage (§1514: §6055, chapter 61 IRC).
Calendar years beginning after 2013	The Secretary of the Treasury shall develop a method through which every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return reporting health insurance coverage (§1502: §6055 IRC).
Not later than June 30 of each year in the calendar years beginning after 2013	The Secretary of the Treasury, in consultation with the Secretary of HHS, shall send a notification to each individual who files an individual income tax return and who is not enrolled in minimum essential coverage (§1502: §6055 IRC).
January 1, 2014	Each state shall establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and is designed to assist small employers in facilitating the enrollment of their employees in qualified health plans (§1311).
January 1, 2014-ongoing	The Secretary shall continue to operate, maintain, and update the Internet portal developed under §1103 and to assist states in developing and maintaining their own such portal (§1311).
January 1, 2014	The Secretary of HHS, in conjunction with the states, shall monitor premium increases of health insurance coverage offered through an exchange and outside of an exchange (§1003: §2794 PHSA).
January 1, 2014	The Secretary of HHS will establish a review committee that will ensure coordination of the administrative simplification standards with the standards that support the certified electronic health record technology approved by the Office of the National Coordinator for Health Information Technology (§1104: §1171 SSA).
January 1, 2014	Each state that elects to operate an exchange shall have adopted and have in effect the established federal standards or a state law or regulation that the Secretary of HHS determines implements the standards within the state (§1321).
January 1, 2014	The Secretary of HHS shall establish a basic health program which a state may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits to eligible low-income individuals not eligible for Medicaid in lieu of offering such individuals coverage through an exchange (§1331).
January 1, 2014-2017	Each state shall have a transitional reinsurance program for individual and small group markets in each state (§1341).

Implementation deadline or effective date	Summary of Provision
January 1, 2014-December 31, 2016	The Secretary of HHS shall establish and administer a program of risk corridors similar to Medicare Part D for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums (§1342).
January 1, 2014	The Secretary of HHS shall establish procedures for determining eligibility for the exchange, premium tax credits, reduced cost-sharing, and individual responsibility exemptions (§1411).
January 1, 2014	The Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary hears and makes decisions with respect to appeals of any eligibility determination (§1411).
January 1, 2014	The Secretary of HHS shall establish a separate appeals process for employers who are notified that they may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 (§1411).
April 1, 2014, and annually thereafter	The Secretary of HHS will assess a penalty fee against a health plan that has failed to meet certain administrative simplification requirements (§1104: §1171 SSA).
July 1, 2014	The Secretary of HHS, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-state wellness demonstration project (§1201: §2705 PHSA).
July 1, 2014	The Secretary of HHS shall adopt operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions (§1104: §1171 SSA).
December 31, 2014	GAO shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States and report to the appropriate committees of the Congress (§1322).
January 1, 2015	A qualified health plan may contract with a hospital with greater than 50 beds only if such hospital utilizes a patient safety evaluation system as described in part C of title IX of the PHSA; and implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge (§1311).
March 23, 2015	GAO shall conduct a study on the affordability of health insurance coverage, including the impact of the premium tax credit for exchange plans, and the ability of individuals to maintain essential health benefits coverage (§1401).
December 31, 2015	A health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization (§1104: §1171 SSA).
January 1, 2016	The Health Care Choice Compacts may start (§1333).
January 1, 2017	Issuers of health insurance coverage in the large group market in the state are permitted to offer qualified health plans in such market through an exchange (§1312).
January 1, 2017	A state may apply to the Secretary of HHS for a state innovation waiver for the requirements of the exchange (§1332).
January 1, 2019	GAO shall conduct an ongoing study of exchange activities and the enrollees in qualified health plans offered through exchanges (§1313).

Implementation deadline or effective date	Summary of Provision
Not specified	The Secretary shall promulgate regulations with respect to enrollment periods for the guaranteed availability of coverage. (§1201: §2702 PHSA).
Not specified	The HHS Secretary shall define the essential health benefits. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary. The Secretary of HHS shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meets the limitations required by law (§1302).
Not specified	Under regulations issued by the Secretary of HHS, the level of coverage of a plan shall be determined on the basis that the essential health benefits described shall be provided to a standard population and without regard to the population the plan may actually provide benefits to (§1302).
Not specified	The Secretary of HHS shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates (§1302).
Not specified	For plan years starting on or after 6 months after enactment a health insurance issuer offering group or individual health insurance coverage shall provide a clear accounting of costs to the HHS Secretary. The Secretary shall make the reports received available to the public on the Internet website of the Department of Health and Human Services (§1001, as amended by §10101: §2718 PHSA).
Not specified	The Secretary of HHS shall review the premium rating areas created by the states. The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes (§1201: §2701 PHSA).
Not specified	The Secretary of HHS shall, by regulation, establish criteria for the certification of health plans as qualified health plans (§1311, as amended by §10104).
Not specified	The Secretary of HHS shall develop a rating system for qualified health plans offered through an exchange in each benefits level on the basis of the relative quality and price and shall include an enrollee satisfaction survey system (§1311).
Not specified	The Secretary of HHS, in consultation with experts in health care quality and stakeholders, shall develop guidelines for plans in the exchange concerning payment structures for that provides increased reimbursement or other incentives for improving health outcomes (§1311).
Not specified	The Secretary of HHS shall establish standards for exchange navigators that will conduct public education activities, distribute fair and impartial information, and facilitate enrollment in qualified health plans. The exchanges shall award grants to entities that qualify as navigators (§1311).
Not specified	Exchanges shall annually submit to the Secretary a report of their finances. Exchanges shall be subject to annual audits by the Secretary of HHS (§1313).
Not specified	The Secretary of HHS shall annually report to Congress concerning actions taken by the Secretary with respect to state innovation waivers (§1332).
Not specified	The Secretary of HHS shall in consultation with states, establish criteria and methods to be used in carrying out the risk adjustment activities and may utilize criteria and methods similar to the criteria and methods utilized under Medicare parts C or D (§1343).

Implementation deadline or effective date	Summary of Provision
Not specified	The Secretary of HHS, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of the premium assistance credit and shall prescribe such regulations as may be necessary to carry out the other provisions of this section (§1401: §36B IRC).
Not specified	The Secretary of HHS, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of cost-sharing reductions (§1402).
Not specified	The Secretary of HHS, in consultation with the Secretary of the Treasury, shall establish a program under which, upon request of an exchange, advance determinations are made of the income eligibility for the premium tax credits and cost-sharing subsidies (§1412).
Not specified	The Secretary of HHS shall establish a system under which if an individual applying to an exchange is found to be eligible for Medicaid or CHIP, the individual will be enrolled under such plan or program (§1413).
Not specified	The Secretary of HHS shall develop and provide to each state a single, streamlined form that may be used to apply for all applicable state health subsidy programs within the state (e.g., Medicaid, CHIP, premium credits in the state's exchange); may be filed online, in person, by mail, or by telephone; and may be filed with an exchange or with state officials operating one of the other applicable state health subsidy programs (§1413).
Not specified	Each state shall develop for all applicable health subsidy programs a secure, electronic interface allowing an exchange of data for the determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the method established for data verification. Each applicable state health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in applicable health subsidy programs (§1413).
Not specified	The Secretary of HHS shall promulgate standards governing the timing, contents, and procedures for data matching for determining eligibility for participation in applicable state health subsidy programs (§1413).
Not specified	The Secretary of Labor shall promulgate regulations regarding automatic enrollment of new full-time employees and to continue the enrollment of current employees in a health benefits plan offered through an applicable employer (§1511: §18A Fair Labor Standards Act of 1938).
Not specified	The Secretary of the Treasury, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee with respect to the application of the shared employer responsibility (§1513: §4980H, Chapter 43 IRC).
Not specified	The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable employer payments under section 4980H of the IRC on the basis of the National Compensation Survey published by the Bureau of Labor Statistics. The Secretary shall report the results of the study to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate (§1513).
Not specified	The Secretary of HHS shall award grants to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed for enrollment purposes under §3021 PHSA (§1561: §3021 PHSA).
Not specified	The Secretary of HHS shall promulgate regulations for enforcing the premium rebate provisions of §2718 PHSA and may provide for appropriate penalties (§10101: §2718 PHSA).

Implementation deadline or effective date	Summary of Provision
Not specified	The Secretary of Labor shall update and harmonize the rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established by the Secretary of HHS for transparency of qualified health plans in an exchange (§10104: §1311 PHSA).
Not specified	The Director of the Office of Personnel Management shall establish an advisory board to provide recommendations regarding multi-state qualified health plans (§10104: §1334 PHSA).

Source: CRS analysis of P.L. 111-148, as amended by P.L. 111-152.

Notes: PHSA means Public Health Service Act. IRC means Internal Revenue Code. SSA means Social Security Act. HIT means Health Information Technology. HHS means Health and Human Services.

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Acknowledgments

The authors wish to thank (name redacted), former CRS Specialist in Health Care Financing, who co-authored the original report. (name redacted) (7-....) contributed the section on abortion. Kirsten Colello (7-....) contributed the section on assisted suicide. Vivian Chu (7-....) contributed the section on medical malpractice. Jennifer Staman (7-....) contributed the sections on MEWAs and wellness programs. In addition, (name redacted) (7-....) made contributions to this report in reference to unauthorized aliens.