THE COMMONWEALTH FUND

Timeline for Health Care Reform Implementation

Health Insurance Provisions

August 10, 2010

Health care reform legislation—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act ("the Affordable Care Act" or "the ACA")—includes numerous provisions to expand access to health insurance, improve the quality and comprehensiveness of coverage, and make coverage more affordable for all Americans. This timeline outlines when the various health insurance provisions will go into effect; click on the dates to see the provisions that will be implemented during that year.

2010 2011 2013 2014 2016 2018

2010

- **Young Adults on Parents' Health Plans.** Young adults may stay on or come on to their parents' health plans up to age 26, effective for plan years beginning on or after September 23, 2010 (six months after enactment). The provision requires all insurance plans that offer dependent coverage to offer the same level of coverage at the same price to their enrollees' adult children. Health plans or employers cannot charge a higher premium or offer fewer benefits to adult children than they do for young children and the employer premium contribution is tax-exempt no matter the child's age and dependent status. The law applies to all adult children regardless of living situation, degree of financial independence, or marital or student status. The provision applies to all employer plans including self-insured plans and all individual market plans. It also applies to both grandfathered (those in existence on March 23, 2010) and non-grandfathered plans (new plans). There is one restriction: prior to 2014, young adults may be covered by their parents' grandfathered employer group health plans only if they are not offered a plan through their employer. Health plans and employers that offer dependent coverage are required on or after September 23, 2010, to hold an enrollment period for young adults to come on to their parents' plans, but they can use their normal annual enrollment period and satisfy the requirement.

- **Prohibition on Preexisting Condition Exclusions for Children.** Beginning on September 23, 2010, families with children who have chronic health problems or other preexisting medical conditions can no longer be turned down for coverage

by an insurance company or have their child's condition excluded from their health benefits. The provision applies to all employer group and individual market plans. It also applies to grandfathered group insurance plans, but it does not apply to grandfathered plans purchased on the individual market.

- **Prohibition Against Rescissions.** Starting on September 23, 2010, all health insurance plans are prohibited from rescinding coverage once an enrollee is covered under a plan, except in the case of an individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact. The ban applies to all employer plans, including self-insured plans, and all plans sold on the individual insurance market. It also applies to both new plans and grandfathered plans. In the case of rescissions that are permissible under the new rules, health plans must provide at least 30 days' notice to enrollees before a plan can be cancelled.

- **Prohibitions Against Lifetime Benefit Limits.** Starting on September 23, 2010, the ACA prohibits all health plans from imposing lifetime limits on what their plans will pay in benefits. The ban applies to all employer plans, including self-insured plans, and all plans sold on the individual insurance market. It also applies to both new plans and grandfathered plans. For people who exceeded their lifetime limits before September 23, 2010, the plans must provide notice that the lifetime limit no longer applies and provide an enrollment period for those who since disenrolled from the health plan.

- **Prohibitions Against Annual Benefit Limits.** The ACA will prohibit all health plans except grandfathered plans sold on the individual market from imposing annual limits in 2014, but places restrictions on annual limits that increase gradually between 2010 and 2013 according to the following schedule:

    - Between September 23, 2010, and September 23, 2011, health plans cannot impose annual limits on health benefits of less than $750,000;
    - Between September 23, 2011, and September 23, 2012, health plans cannot impose annual limits of less than $1.25 million; and
    - Between September 23, 2012, and January 1, 2014, health plans cannot impose annual limits of less than $2 million.

  The restrictions on annual limits apply to "essential health benefits" as they are broadly defined in the ACA and not benefits that fall outside that definition. While the secretary of Health and Human Services (HHS) is required to determine the benefit package through future regulations, health plans must make good-faith efforts to comply with the annual limit restrictions on essential benefits as they are now defined in the ACA.

- **Small Business Tax Credits.** Starting on September 23, 2010, small businesses will be eligible for new tax credits to offset their premium costs. Tax credits will be available for up to a two-year period for companies with fewer than 25 employees and with average wages under $50,000. The full credit will be available to companies with 10 or fewer employees and average wages of $25,000, phasing out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit will cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit will cover 50 percent of that contribution. Tax-exempt organizations will be eligible to receive the tax credits, though the credits are

somewhat lower: 25 percent of the employer's contribution to premiums in 2010–13 and 35 percent beginning in 2014.

- **Preexisting Condition Insurance Plan (PCIP).** People who have been uninsured for at least six months and who have a preexisting condition will be eligible to purchase a PCIP in their state, with enrollment beginning in July and August 2010. Twenty-nine states and the District of Columbia chose to run their own PCIPs and the federal government will operate PCIPs in the 21 states that opted not to run their own plans. Premiums for all PCIPs will be set for a standard population in the individual insurance market in the state and can vary by tobacco use and rating area, and not by more than a factor of four based on age (i.e., 4:1 age bands). The PCIPs will be required to cover, on average, no less than 65 percent of medical costs (actuarial value) and to limit out-of-pocket spending to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies. They also cannot impose preexisting condition exclusions. The secretary of HHS will receive $5 billion to carry out the program, and the program terminates on January 1, 2014, when the health insurance exchanges become available.

- **State Option to Expand Medicaid Eligibility.** Beginning on April 1, 2010, states have the option to cover parents and childless adults up to 133 percent of poverty and receive current federal matching contributions. States also may choose to phase in eligibility for this group based on income. By January 1, 2014, state Medicaid programs must cover this population in its entirety with a higher federal contribution, but states will have the option to provide new coverage for individuals who have income that exceeds 133 percent of the federal poverty level.

- **Limits on Share of Private Premiums Insurers Spend on Nonmedical Costs.** New limits will be set for the percent of premiums that insurers can spend on nonmedical costs. Beginning in 2010, health plans are required to report the proportion of premiums spent on items other than medical care. The secretary of HHS is to make these reports available on the HHS Web site. Generally medical care includes clinical services, activities to improve quality of care, and all other non-administrative costs. The secretary will issue regulations that explicitly define medical care, especially in the area of quality improvement activities, in addition to standardized methodologies for calculating measures. Beginning on January 1, 2011, health plans in the large-group market that spend less than 85 percent of their premiums on medical care and health plans in the small-group and individual markets that spend less than 80 percent on medical care will be required to offer rebates to enrollees. Percentages may be higher through state regulation. The secretary may also adjust the standard for the individual and small-group markets. The rebates will be equal to the excess of the minimum standard requirement over the actual ratio spent on medical care multiplied by the total amount of premium revenue.

- **Annual Review of Premium Increases.** Beginning with insurance plan years starting in 2010, the HHS secretary and states will establish a process for annual review of unreasonable premium increases. Health insurers will be required to submit to the secretary and the relevant state a justification for an unreasonable increase prior to implementation of the increase. The information will be required to be posted on insurers' Web sites. The bill appropriates $250 million to the secretary for grants ($1m to $5m) to states over the five-year period 2010–2014 to review and approve carrier premium increases and to provide required information and recommendations to the secretary of HHS.

- **Rebates for Medicare Part D Enrollees in the "Doughnut Hole."** In 2010, Medicare beneficiaries who reach the coverage gap, or doughnut hole, in prescription drug coverage ($2,830) will automatically receive $250 rebates.[1] The coverage gap is phased out completely by 2020.

- **Required Coverage of Recommended Preventive Care and Immunizations Without Cost-Sharing in Private Plans and Medicare.** Beginning on September 23, 2010, all non-grandfathered group and individual market health plans will be required to cover: recommended preventive services (without cost-sharing, for services provided in-network) which receive an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF); immunizations for children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); preventive care screenings for infants, children, and adolescents recommended by the Health Resources and Services Administration; and preventive care and screenings for women with guidelines to be released by HHS by August 2011. Health plans must cover preventive services in the first plan year beginning one year after recommendations have been issued. Coinsurance is also eliminated in Medicare for preventive services rated "A" or "B" by the USPSTF, and beneficiaries will receive an annual wellness visit with no copayment beginning in 2011.

- **Employer Early Retiree Health Benefits Reinsurance.** Starting in June 2010 and continuing through January 1, 2014, reinsurance will be available to employers providing health benefits to early retirees. This temporary reinsurance program will reimburse participating employment-based plans for part of the cost of providing health benefits to early retirees and eligible spouses, surviving spouses, and dependents (age 55 or older but not eligible for Medicare). Participating employment-based plans would receive reimbursement for 80 percent of the cost of benefits provided to an early retiree (including cost-sharing paid by the enrollee) in excess of $15,000 and below $90,000. The ACA appropriates $5 billion for the program.

2011

- **Discounts to Medicare Part D Enrollees in the Doughnut Hole.** Beginning on January 1, 2011, a new Medicare coverage gap discount program will provide a 50 percent discount on brand-name drugs to Medicare Part D enrollees who spend enough on prescription drugs to enter the doughnut hole. Under the program, manufacturers will provide discounts to eligible beneficiaries at the point-of-sale in the pharmacy or by mail order. Additional discounts on brand-name and generic drugs are phased in to completely close the doughnut hole for all Part D enrollees by 2020.

- **Long-Term Care Insurance (CLASS).** Starting January 1, 2011, employers and self-employed individuals may elect to participate in a national, voluntary insurance program for the purchase of community living assistance services and supports (CLASS program). Participating employers will be required to automatically enroll employees 18 and over, but employees would have the option to opt out of the program. Premiums would be paid through payroll deductions. The secretary of HHS is required to establish an enrollment mechanism

[1] Under the "standard" Part D benefit, the coverage gap starts when the retail cost of a beneficiary's medications reaches $2,830 and continues until the beneficiary has spent $4,550 in out-of-pocket costs (which would be reached when the covered cost of medications reaches $6,440). Most plans have some variant of the "standard" benefit, with many offering lower or no deductibles and alternative cost-sharing, and some offering coverage of at least some, usually generic, drugs when the coverage gap has been reached.

for self-employed people, those with more than one employer, and those working in companies that do not participate in the program. Each year, the secretary establishes premiums based on a 75-year actuarial estimate of the cost of the program. Premiums for enrollees will vary based on age of enrollment, but premiums would not change over the period of enrollment for an individual, unless it was determined that premiums will be insufficient to cover the future benefits of the program. People who have incomes below the poverty level or who are students ages 18–21 years will pay no more than $5 in premiums, which increases with inflation over time. The program will provide eligible enrollees who have paid premiums for at least 60 months a cash benefit of at least $50 a day on average to purchase nonmedical services and supports necessary to maintain community residence. To receive benefits, an enrollee must have a functional limitation that is expected to last for at least 90 days.

- **Value of Employer Benefits Reported on W-2 Forms.** Employers are required to disclose the cost of employer-sponsored health benefits provided to employees on each employee's W-2 forms beginning with W-2 forms for the 2011 tax year.

- **Increased Tax on Nonmedical Distributions from Health Savings Accounts (HSAs).** The current tax on spending distributions from HSAs or Archer Medical Savings Accounts (MSAs) that are not used for qualified medical expenses is increased from 10 percent to 20 percent for HSAs and from 15 percent to 20 percent for Archer MSAs of the disbursed amount, for tax years starting after December 31, 2010.

- **Over-the-Counter Drug Costs Reimbursement Restrictions in HRA, FSA, HSA plans.** Over-the-counter drugs not prescribed by a doctor cannot be reimbursed through a health reimbursement arrangement (HRA) or health flexible spending account (FSA). Such drugs cannot be reimbursed on a tax-free basis through an HSA or Archer MSA.

2012

- **Quality Reporting by Health Plans.** The law includes a set of quality improvement reporting requirements for both employer group health plans, including self-insured plans, and individual market plans. Within two years of enactment, the HHS secretary must develop guidelines for use by health insurers to report information on initiatives and programs that: 1) improve outcomes through case management, care coordination, chronic disease management, and medication and care compliance initiatives; 2) prevent hospital readmissions through comprehensive discharge planning with patient-centered education, counseling, and post-discharge follow-up; 3) reduce medical errors and improve patient safety; 4) implement wellness and health promotion activities (which may include smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention); and 5) support activities to reduce health and health care disparities. Group health plans and health insurance issuers offering group or individual coverage must submit annual reports in accordance with these guidelines and reports will be made available to the secretary and enrollees.

2013

- **Insurer Administrative Simplification Requirements.** Requires the HHS secretary to adopt standards and operating rules for administrative transactions between insurers and providers. The standards and operating rules will focus on enabling determination of an individual's eligibility and financial responsibility for services prior to or at the point of care; reducing paper communications; and supporting a transparent claims management process. By December 31, 2013, health plans must certify that their information systems are in compliance with applicable standards for eligibility determinations, health claim status, health care payment, and electronic fund transfers.

- **Limits on Contributions to FSAs.** The amount of contributions to FSAs in cafeteria plans is limited to $2,500 a year, indexed to the consumer price index for subsequent years.

- **Health Care Choice Compacts.** The HHS secretary, in consultation with the National Association of Insurance Commissioners, is required to issue regulations by July 31, 2013 to support the creation of health care choice compacts. These compacts will allow two or more states to enter into an agreement to facilitate the purchase of qualified health plans across state lines, beginning in 2016.

2014

- **New Insurance Rating Rules.** Premiums charged by a health insurance issuer for new health insurance coverage (non-grandfathered plans) offered in the exchanges and the individual or small-group market may vary only by certain factors: 1) whether an individual or family is covered; 2) the geographic or "rating area" in which the coverage is offered, as established by each state or HHS; 3) age, although age rating cannot vary by more than 3 to 1 for adults—meaning the highest premium rate for adults can be no more than three times the lowest premium rate; and 4) tobacco use, where the highest premium rate may be no more than 1.5 times the premium rate for a nonsmoker. Also, if a state allows insurers in the large-group market in a state to offer coverage in the insurance exchange, these premium limitation requirements will apply (except to self-insured group health plans). Effective for plan years beginning on or after January 1, 2014.

- **Prohibition of Preexisting Condition Exclusions.** Health plans may not impose any preexisting condition exclusions. The restriction applies to both employer plans, including self-insured plans, and plans sold in the individual and small-group markets and the exchanges. It applies to grandfathered group plans but not grandfathered plans sold on the individual market. Effective for plan years beginning on or after January 1, 2014.

- **Prohibition of Discrimination Based on Health Status.** Health plans cannot impose eligibility rules for individuals and dependents enrolling in health plans based on health status, medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or other factors determined by the HHS secretary. The restriction applies to both employer plans, including self-insured plans, and plans sold in the individual market and the exchanges. It does not apply to grandfathered plans. Allows employers to adopt wellness programs linking premium discounts, rebates, or rewards to enrollees meeting a health status standard if certain conditions are met. Effective for plan years beginning on or after January 1, 2014.

- **Guaranteed Availability and Renewability of Coverage.** Insurance carriers selling health plans in the individual and group markets and exchanges must accept every employer and individual in the state who applies for coverage and must renew the coverage at the option of the employer or individual. Does not apply to grandfathered plans. Under regulations to be issued by the HHS secretary, health plans may use open enrollment periods and must designate special enrollment periods for people with qualifying events. Effective for plan years beginning on or after January 1, 2014.

- **Limits on Waiting Periods.** Prohibits all group health plans from imposing waiting periods for coverage to go into effect of more than 90 days. Effective for plan years beginning on or after January 1, 2014.

- **Risk-Pooling.** Requires insurance carriers selling plans in the exchanges and individual market to pool the risk of all enrollees, including those who do not enroll through an exchange, into a single risk pool. Grandfathered plans are excluded. Similarly, health insurance issuers in the small-group market are required to pool the risk of all enrollees, including those who do not enroll through an exchange, into a single risk pool. Grandfathered plans are excluded. If a state combines the individual and small-group markets, insurers will pool the risks of both individual and small-group enrollees inside and outside the exchanges.

- **Reinsurance and Risk Adjustment.** To reduce the incentive for insurers in the individual and small-group markets to cherry-pick good health risks and to increase the incentive for them to attract and care for chronically ill enrollees, the legislation creates a mechanism to equalize risks across patients, thereby compensating insurance carriers for high-cost patients. The legislation includes two temporary reinsurance mechanisms and one permanent risk-adjustment program: a state transitional reinsurance pool, a temporary federal risk corridor program, and a permanent state risk-adjustment program.

    - **Transitional reinsurance.** The legislation requires all states to establish or contract with a nonprofit reinsurance entity for 2014, 2015, and 2016 that will collect payments from all insurers in the individual and group markets and third-party administrators of self-insured group plans, and will make payments to insurers in the individual market and those selling plans through the exchanges that cover high-risk individuals. The secretary of HHS will be required to establish federal standards for the determination of high-risk individuals, a formula for payment amounts, and contributions required of insurers. Contributions from insurers must amount to $25 billion over the three years. This temporary reinsurance program is designed to counter adverse selection problems in the early years of the exchange. Amounts remaining unexpended as of December 31, 2016, may be used to make payments under any state's individual market reinsurance program during the two-year period beginning January 1, 2017.

    - **Risk corridors.** The legislation requires the HHS secretary to establish and administer a risk-corridor program for qualified health plans offered in the individual and small-group markets in 2014, 2015, and 2016. The program would be modeled after those applied to regional participating provider organizations in Medicare Part D. If "allowable costs" (total amount of costs that the plan incurred in providing covered benefits, reduced by administrative expenses) are between 97 percent and 103 percent of the "target amount" (the total annual premium, including subsidies, minus administrative expenses), plans would receive no payment. If allowable costs were higher than 103 percent of the target amount for the plan and year, the secretary would make a payment to the plan. Alternatively, if allowable costs were lower than 97 percent of the target amount, the plan would make a payment to the secretary. Effective for calendar years 2014, 2015, and 2016.

- **Risk adjustment.** Under this permanent program, the legislation requires states to assess a charge on health plans and health insurance issuers if the actuarial risk of enrollees in that plan is less than the average actuarial risk of all enrollees in the state excluding self-insured plans (i.e., enrollees in the plan had lower health risks compared with all plans [excluding self-insured plans] in the state). In addition, states will make a payment to those health plans with higher actuarial risks (also excluding self-insured plans). The risk adjustment will apply to plans in individual and small-group markets but not grandfathered plans. The HHS secretary will develop the criteria and methods to be used in implementing risk adjustment in consultation with the states.

- **State Insurance Exchanges.** Each state is required to establish an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange by 2014 for individuals and small employers with 50 to 100 employees, at state discretion; after 2017, states have the option of opening the small business exchange to employers with more than 100 employees. States can opt to provide a single exchange for individuals and small employers. Groups of states can form regional exchanges or states can form more than one in-state exchange, but the exchanges must serve a geographically distinct area. While the individual and small-group markets will not be replaced by the exchanges, the same market rules will apply inside and outside the exchanges. Premium subsidies can be used only for plans purchased through the exchanges. The HHS secretary will award grants, available beginning in March 2011 until January 1, 2015, to states for planning and establishing the exchanges. After January 1, 2015, each state exchange must be self-sufficient; however, the exchange may charge assessments or user fees. If the secretary determines in 2013 that a state will not have an exchange operational by 2014, the secretary is required to establish and operate an exchange in the state. In 2017, states will have the opportunity to opt out of the federal requirements to establish insurance exchanges through a five-year waiver, if they are able to demonstrate that they can offer all residents coverage at least as comprehensive and affordable as that required by the bill. The exchanges will be administered by a governmental agency or a nonprofit.

  - **Federal responsibilities for exchanges.** The HHS secretary's responsibilities with respect to the exchanges include: establishing certification criteria for "qualified health plans" that will be sold through the exchanges; defining the essential benefits package and requiring qualified health plans to provide the essential benefits package; requiring insurance carriers issuing plans to offer at least one qualified health plan at the silver and gold levels; requiring qualified health plans to meet marketing requirements established by the secretary and not employ marketing practices or benefit designs that discourage the enrollment of people with health problems; ensuring a sufficient choice of providers; ensuring that essential community providers who serve predominantly low-income and medically underserved individuals are included in the networks; ensuring that qualified health plans are accredited on clinical quality measures, patient experience ratings, and other measures including consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and network adequacy; implementing a quality improvement strategy; developing a uniform enrollment form for individuals and employers and presenting plan information in a standard format; and providing information on quality measures on health plan performance. In addition, the secretary will develop a rating system that will rate qualified health plans within each benefit level on the basis of relative quality and price that will be provided on the Internet portal for individuals and employers and establish a model template for an exchange's Internet portal. The portal would be used to direct individuals and employers to qualified health plans, to help them determine whether they are eligible for premium and cost-sharing

credits and present standardized information about health plans to facilitate ease of choice. The secretary also will determine an initial and open enrollment period as well as special enrollment periods for people under varying circumstances. The secretary is also required to establish procedures under which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies**.** Such procedures may include the establishment of rate schedules for broker commissions paid by health plans offered through the exchange.

- **State responsibilities for exchanges.** State exchanges will be required to certify qualified health plans, operate a toll-free hotline and Web site, rate qualified health plans, present plan options in a standard format, inform individuals of the eligibility requirements for Medicaid and the Children's Health Insurance Program, provide an electronic calculator to calculate plan costs, grant certifications of exemption from the individual responsibility requirement, and transfer to the Department of Treasury information necessary to enforce the employer responsibility penalties. Exchanges will be required to be self-sustaining by 2015 and will be allowed to charge assessments or user fees to participating health insurance issuers or otherwise generate funding to support their operations. The exchanges also will award grants to "navigators" who will educate the public about qualified health plans, distribute information on enrollment and subsidies, facilitate enrollment, and provide referrals on grievances. Navigators may include trade and professional organizations, farming and commercial fishing organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, or licensed insurance agents or brokers.

- **Qualified Employers Purchasing Through the Exchange.** Employers that are qualified to offer coverage to their employees through the exchange may provide premium support for a level of coverage (bronze, silver, gold, or platinum) and employees may choose a plan within the designated level.

- **Qualified Health Plans.** Qualified health plans are those that are certified by the exchanges, provide the essential benefits package, are offered by a duly licensed health insurance issuer, comply with market regulations, and offer at least one qualified plan at the silver and gold levels. Qualified health plans can be sold outside the exchange but the insurance issuer must charge the same premium for qualified plans sold within or outside the exchanges.

- **Choice of Qualified Plans.** In addition to qualified health plans offered by private insurance carriers, new nonprofit Consumer Operated and Oriented Program (CO-OP) plans that meet qualified health plan requirements may be offered through the exchanges. In addition, the federal Office of Personnel Management (OPM) will contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit.

- **Multistate Plans.** The legislation requires the director of the federal Office of Personnel Management (OPM) to contract with health insurers to offer at least two multistate qualified health plans (at least one nonprofit) through the exchanges in each state for individuals and small employers. OPM would negotiate contracts similar to the way in which it currently negotiates contracts for the Federal Employees Health Benefits Program (FEHBP). OPM can prohibit multistate plans that do not meet standards for medical loss ratios, profit margins, and premiums. Multistate plans will be required to cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multistate plans to offer additional benefits, but they must pay for the additional cost. Multistate plans must comply with 3:1 age rating, except where states require

more protective age rating. Multistate plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the health reform law. FEHBP will maintain a separate risk pool and remain a separate program.

- **Health Care Cooperatives.** The legislation establishes the Consumer Operated and Oriented Plan (CO-OP) program to award grants and loans to support the development of nonprofit health insurance organizations that will offer qualified health plans. Health care cooperatives are nonprofit, consumer-governed organizations that provide insurance and deliver health services. Any health insurance issuer that existed prior to July 16, 2009, may not qualify for the CO-OP program. Priority will be given to plans that operate on a statewide basis, utilize integrated care models, and have significant private support. The secretary of HHS will ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state. The law appropriates $6 billion for the CO-OP program and the secretary will begin awarding grants and loans on July 1, 2013.

- **Medical Home Plans.** A qualified health plan may be offered by a qualified direct primary care medical home plan that meets criteria established by the secretary of HHS and other requirements of qualified health plans.

- **Premium Review.** Continuing the annual review of unreasonable premium increases that began in 2010, the legislation requires the secretary of HHS, in conjunction with the states, to monitor premium increases inside and outside the exchanges beginning in 2014 and require carriers to submit a justification for any "unreasonable" increase prior to implementation. In addition, states, as a condition of receiving a grant (see Annual Review of Premium Increases [2010]), are required to provide the secretary with information on trends in premium increases in the state and make recommendations to the state insurance exchanges on whether particular insurance carriers should be excluded from participation based on a pattern or practice of excessive or unjustified premium increases. In considering whether to open the exchanges to large employers (more than 100 workers) in 2017, states must consider trends in premium growth outside and inside the exchanges.

- **Rewarding Quality Through Market-Based Incentives.** Qualified health plans are required to report to the exchange activities related to the implementation of new provider payment structures that provide increased reimbursement or other incentives aimed at improving quality and health outcomes. The secretary of HHS is to develop guidelines for activities aimed at improving health outcomes, preventing hospital readmissions, improving patient safety, wellness programs, and reducing health disparities (see Quality Reporting by Health Plans [2014]). Beginning January 1, 2015, qualified health plans will be allowed to enter into contracts with hospitals with greater than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for hospital discharge.

- **Essential Health Benefits Package.** The legislation defines an essential health benefits package that all qualified health plans and plans sold in the individual and small-group markets must cover, at a minimum. The benefit requirements do not apply to grandfathered plans or self-insured plans. The package will be determined by the HHS secretary and must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; and preventive and wellness services, including chronic disease management. In addition, the plans must cover pediatric services, including vision and oral care. The scope of the benefits provided must be equivalent to the scope of

benefits provided under the "typical" employer-sponsored plan. Health plans may provide benefits in addition to those included in the essential health benefits package. In defining the essential health benefits, the HHS secretary will: 1) ensure that the benefits are appropriately balanced among the benefit categories; 2) not make coverage decisions or establish reimbursement rates, incentive programs, or benefits that discriminate on age, disability, or expected lifespan; 3) consider the health care needs of diverse segments of the population; 4) ensure that benefits are not denied based on age, disability, dependency, or expected length and quality of life; 5) ensure that plans provide emergency services without prior authorization and that out-of-network and in-network emergency services have the same cost-sharing; 6) provide that plans in an insurance exchange are not denied qualification solely because they do not cover pediatric dental care, if coverage is offered through another stand-alone dental plan in the exchange; 7) periodically review benefits and report to Congress whether enrollees have difficulty accessing needed services because of cost, whether the benefits need to be updated, how to modify benefits to address access gaps, and the potential of additional benefits to increase costs; and 8) update benefits to address gaps in access to coverage.

- **Benefit Levels.** Qualified health plans offered through the exchange and plans offered in the individual and small-group markets must provide coverage of the essential benefits at the bronze, silver, gold, and platinum levels. Qualified health plans are at least required to offer silver and gold plans in the exchange. The bronze package will represent minimum creditable coverage with an actuarial value of 60 percent (i.e., covering 60 percent of enrollees' medical costs) with out-of-pocket spending limited to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies. The silver benefit package will have an actuarial value of 70 percent and the same out-of-pocket limits; the gold package will have an actuarial value of 80 percent and the same out-of-pocket limits; and the platinum package will have an actuarial value of 90 percent and the same out-of-pocket limits. A catastrophic benefit package could be made available for adults younger than age 30. This may be similar to HSA-eligible, high-deductible plans, but include the essential benefits package, preventive services excluded from the deductible as under current HSA law, three primary care visits, and cost-sharing to HSA out-of-pocket limits. People who are unable to find a plan with a premium that is 8 percent or less of their income will be able to purchase the catastrophic plan as well, regardless of age. Deductibles of greater than $2,000 for individuals and $4,000 for families will be prohibited in the small-group market.

- **Premium Credits.** Refundable premium tax credits for qualified health plans purchased through the exchange will be available on a sliding scale for individuals and families earning between 133 percent ($29,327 for a family of four) and 400 percent ($88,200 for a family of four) of the federal poverty level (FPL). Those with incomes up to 133 percent of FPL will become eligible for Medicaid. The reference premium for determining premiums is the second-lowest cost silver plan available in the market area where the individual resides. Premium contributions are limited as a share of income to:

  Up to 133% FPL: 2.0%
  133%–150% FPL: 3.0–4.0%
  150%-200% FPL: 4.0–6.3%
  200%–250% FPL: 6.3%–8.05%
  250%–300% FPL: 8.05%–9.5%
  300%–400% FPL: 9.5%

The premium credits apply to tax years ending after December 31, 2013.

- **Growth in Premium Credits.** For tax years beginning after 2014, premium credits will be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. Starting in 2019, the law will make an additional adjustment to the premium credits based on the excess of premium growth over the consumer price index, unless the aggregate of the premium credits and the cost-sharing reductions are less than .504 percent of the gross domestic product in the preceding calendar year.

    - **Study on affordability.** Within five years of enactment of the legislation, the comptroller general will conduct a study and report to Congress on the affordability of health insurance, including: the effect of the premium subsidies on expanding and maintaining coverage; the availability of affordable health plans; whether the affordability standards for determining if employees with employer plans are eligible for subsidized coverage through the exchanges are appropriate, and whether they can be lowered without substantially increasing federal costs or reducing employer-provided coverage; and the ability of individuals to maintain essential health benefits coverage.

- **Cost-Sharing Assistance and Out-of-Pocket Limits.** The law limits the amount of out-of-pocket cost-sharing for families earning up to 400 percent of poverty for qualified health plans purchased through the exchange. Cost-sharing includes deductibles, coinsurance, and copayments. It does not include premiums, balance billing amounts for nonnetwork providers, or spending for noncovered services. Cost-sharing reductions will lower the annual out-of-pocket limit from the HSA limit of $5,950 for individuals and $11,900 for families for eligible individuals on a sliding scale by the following amounts:

    - two-thirds, or $1,983 for individuals and $3,967 for families, earning between 100 percent and 200 percent of poverty;
    - one-half, or $2,975 for individuals and $5,950 for families, earning between 200 percent and 300 percent of poverty; or
    - one-third, or $3,967 for individuals and $7,933 for families earning between 300 percent and 400 percent of poverty.

In addition, the plan's share of the total costs of benefits under the plan (actuarial value) is increased from the silver plan level of 70 percent to:

- 94 percent, if household income is between 100 percent and 200 percent of poverty;
- 87 percent, if household income is between 150 percent and 200 percent of poverty; or
- 73 percent, if household income is between 200 percent and 250 percent of poverty.

The secretary of HHS will adjust the out-of-pocket limits if necessary to ensure that the limits do not cause the actuarial values to increase beyond 70 percent for those with incomes between 250 percent and 400 percent of poverty. Cost-sharing is eliminated for preventive services for people at all income levels.

- **Increase in Small Businesses Tax Credit.** The sliding-scale tax credits created in 2010 to assist eligible small employers in providing health insurance are expanded. Beginning in 2014, the full tax credit is increased to 50 percent of the employer premium contribution from 35 percent for plans purchased through the insurance exchanges. Tax credits will be available for up to a two-year period for small businesses with fewer than

25 employees and with average wages under $50,000. The full credit will be available to businesses with 10 or fewer employees and average wages of $25,000, and will phase out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. The full tax credit is also increased for tax-exempt organizations from 25 percent of their premium contribution to 35 percent.

- **Medicaid Expansion.** Beginning on January 1, 2014, income eligibility for Medicaid is expanded to all individuals up to 133 percent of poverty, or $14,404 for an individual and $29,327 for a family of four. This new mandatory eligibility category for Medicaid is for individuals who earn less than 133 percent of poverty, are under the age of 65, are not enrolled or eligible for Medicare benefits, and are not qualified for another mandatory Medicaid category. Those newly eligible for Medicaid under the expansion would receive a "benchmark" benefit package that states can currently provide to some populations as an alternative to mandatory benefits under traditional Medicaid. Benchmark coverage must include the essential health benefits including prescription drugs and mental health services.

- **Medicaid Payments to States for Coverage Expansion.** Provides federal Medicaid matching payments for the costs of services for newly eligible individuals at the following rates in all states (except in "expansion states" that have already expanded Medicaid to both parents and nonpregnant childless adults to 100 percent of poverty before December 1, 2009): 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. Expansion states will receive additional federal financial assistance that will phase-in over 2014–2019 according to a formula such that, in 2019 and later, expansion states will receive the same level of federal matching for this population as other states.

- **Individual Requirement to Have Health Insurance.** Beginning in 2014, all individuals will be required to have minimum essential coverage, or face a penalty. Essential coverage can be achieved in a variety of ways including through an eligible employer-sponsored plan, Medicare, Medicaid, CHIP, TRICARE for Life (the veteran's health care program), a health plan offered in the individual market or exchanges, a grandfathered plan, or other coverage that the HHS secretary recognizes for this purpose. There are some exemptions from the penalty: individuals who cannot find a plan at a cost of less than 8 percent of their income, net of subsidies, and employer contributions; people who have incomes below the tax filing threshold ($9,350 for single coverage and $18,700 for a couple); those who have been without coverage for less than three months; incarcerated individuals; those not lawfully present in the country; and certain religious exemptions and individuals with certain other circumstances. People who are not exempt from the requirement and who cannot demonstrate on a tax form that they have minimum essential coverage will be required to pay a penalty equal to the greater of $95 or 1 percent of applicable income (income in excess of the tax filing threshold) in 2014, $325 or 2 percent of applicable income in 2015, and $695 or 2.5 percent of applicable income in 2016, up to a maximum of the three times that amount per family, or $2,085.[2]

[2] The tax filing threshold is the combination of the personal exemption amount plus the standard deduction amount. For 2010, the tax filing threshold is $9,350 for an individual, $18,700 for a married couple filing jointly, and $26,000 for a married couple with two children. See H. Chaikind and C. L. Peterson, *Individual Mandate and Related Information Requirements Under PPACA*, Congressional Research Service, July 20, 2010.

- **Employer Shared Responsibility.** The legislation does not include an employer mandate but imposes penalties on employers with 50 or more workers whose employees are eligible for premium subsidies through the exchanges. Among employers with 50 or more full-time equivalent workers who do not offer health insurance, the legislation will require a payment of $2,000 per full-time employee (those working more than 30 hours per week) if an employee becomes eligible for a premium subsidy through the exchanges. The first 30 full-time workers in a company are not considered in the penalty calculation. For firms that offer coverage and have 50 or more full-time equivalent workers: if a full-time worker is determined to be eligible for premium subsidies through the exchange either because his/her premium contribution exceeds 9.5 percent of income or his coverage does not meet the minimum essential benefits standard (plan covers at least 60 percent of an enrollee's costs), the company must pay the lesser of $3,000 for each full-time worker who receives such a premium subsidy through the exchange or $2,000 for each full-time worker.

- **Free Choice Vouchers.** Employers that offer minimum essential coverage and contribute to the cost of coverage are required to offer "free choice vouchers" to qualified employees with incomes below 400 percent of poverty to purchase health plans through the exchange. Employees qualify for the vouchers if their required contribution for self-only coverage under the employer's plan is between 8 percent and 9.8 percent of their income. [3] The value of the voucher must be equal to the contribution that the employer would have made to its own plan. When a voucher is presented to an exchange, the exchange will credit the amount of the voucher to the monthly premium of any qualified health plan in the exchange in which the qualified employee enrolls. If the amount of the voucher is greater than the premium, the excess amount is paid to the employee. Free choice vouchers are excluded from taxation and voucher recipients are not eligible for premium credits or cost-sharing subsidies. After 2014, the 8 percent and 9.8 percent thresholds would be indexed to the rate of premium growth.

- **Children's Health Insurance Program Reauthorization (CHIP).** The law extends the current reauthorization period of CHIP for two years, through September 30, 2015. States are required to maintain income eligibility levels for CHIP through September 30, 2019. From October 1, 2015, through September 30, 2019, states are provided a 23-percentage-point increase in federal medical assistance percentage rates, subject to a cap of 100 percent.

- **Basic Health Program.** The secretary of HHS is required to establish a Basic Health Program. The program gives states the option of pooling 95 percent of the federal premium and cost-sharing subsidies for people earning between 133 percent and 200 percent of poverty who would otherwise be eligible for subsidized coverage through an exchange. The state can use the pooled subsidies to establish a non-Medicaid, state-based "standard health plan" offered by private insurers under contract with the state. Standard health plans would be required to meet the essential benefits package requirements. States and the secretary must ensure that eligible individuals do not pay higher premiums than they would pay in the exchange, and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with incomes below 150 percent of poverty

[3] The reconciliation bill (H.R. 4872) signed on March 30, 2010, lowered the highest premium cap for people with incomes between 300 percent and 400 percent of poverty from 9.8 percent in the Senate bill (H.R. 3590, The Patient Protection and Affordable Care Act), signed on March 23, 2010, to 9.5 percent of income. Consistent with that change, the reconciliation bill lowered the threshold premium contribution at which employees with employer coverage become eligible for premium subsidies through the insurance exchange from 9.8 percent to 9.5 percent of income.

or the gold plan for all other enrollees.[4] The state will create a competitive process for entering into contracts with standard health plans, including negotiating premiums, cost-sharing, and benefit packages directly with private health plans. In negotiation with plans, states will consider additional factors such as incentives for care coordination and management, use of preventive care services, patient involvement in decision-making, managed care, and reporting on established performance measures in the areas of quality improvement and health outcomes. Individuals with incomes between 133 percent and 200 percent of poverty in states that create basic health programs would not be eligible for subsidies in the exchange. In addition, participating plans would be required to meet a minimum medical-loss ratio of 85 percent. State administrators would seek to provide a choice of more than one plan. States could band together to form regional compacts that would pool coverage of all eligible individuals in those states in contracts with standard health plans.

- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Prohibits group health plans, including self-insured plans, and individual market plans from dropping coverage because an individual chooses to participate in a clinical trial or from denying coverage for routine care that it would otherwise cover because an individual is enrolled in a clinical trial.

2016

- **Health Care Choice Compacts.** The secretary of HHS will develop regulations for health care choice compacts by 2013, which will be implemented beginning in 2016. Health care choice compacts will allow two or more states to enter into an agreement to allow for purchase of qualified health plans across state lines, beginning in 2016. The qualified health plan issuer would generally be subject only to the laws and regulations of the state in which the policy was written, except it must comply with market conduct, unfair trade practices, network adequacy, and consumer protection standards in the state in which the purchaser resides. It also must be licensed or meet certain other standards in all participating states. Plans must notify consumers that the policy may not be subject to all laws and regulations in the purchaser's state. Benefit packages will be required to be as comprehensive and protective from out-of-pocket costs as those offered through the insurance exchanges, and the compacts cannot increase the federal deficit or weaken enforcement of new market regulations. The secretary will approve compacts only if she determines that they will provide comprehensive and affordable coverage.

[4] The Senate bill (H.R. 3590, The Patient Protection and Affordable Care Act), signed into law on March 23, 2010, included this language and referred to cost-sharing subsidies for lower-income persons for plans offered through the exchange. Under the Senate bill, cost-sharing through the exchange would be capped at 90 percent for people with incomes between 100 percent and 150 percent of poverty, which is also the level of cost-sharing for the platinum plan, and 80 percent for people with incomes between 150 percent and 200 percent of poverty, which is also the level of the gold plan. The reconciliation bill (H.R. 4872) signed into law on March 30, 2010, increased cost-sharing subsidies for people in those income ranges from 90 percent to 94 percent and from 80 percent to 87 percent. Presumably the cost-sharing limits in the reconciliation bill will apply to the standard plans offered through state Basic Health Programs.

2018

- **Excise Tax on High-Cost Employer-Provided Health Plans Becomes Effective.** Insurers will face a 40 percent excise tax on health coverage to the extent that the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The provision establishes an annual threshold limitation and the excise tax is equal to 40 percent of the value of a plan that exceeds this threshold. In 2018 the annual threshold dollar limit is $10,200 for single coverage or $27,500 for family coverage. These thresholds are increased to $11,850 for individuals or $30,950 for families in the case of retirees over age 55, electrical or telecommunications repairpersons, law enforcement or fire protection workers, out-of-hospital emergency medical providers, individuals whose primary work is longshore work, and those engaged in the construction, mining, agriculture, forestry, and fishing industries. The provision includes an adjustment for firms with higher health care costs due to the age or gender of their workforces. The initial threshold amounts may be adjusted upward if health care costs increase more than expected prior to 2018. The thresholds are to be increased at the rate of the Consumer Price Index (CPI) but in 2019 the amount will increase with CPI plus one percentage point. The provision is applicable for tax years beginning after December 31, 2017.

Sources

S. Amendment 2786 and S. Amendment 3276 in the nature of a substitute to H.R. 3590, The Patient Protection and Affordable Care Act, introduced November 18, 2009, Manager's Amendment December 19, passed December 24, 2009, 111th Congress, 1st Session, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf.

H. R. 4872, The Health Care & Education Affordability Reconciliation Act of 2010, introduced March 18, 2010, 111th Congress, 2nd Session, available at http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf; Summary and other supporting documents available at http://www.rules.house.gov/111_hr4872_secbysec.html.

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