

Section 1 – name and table of contents

Division A

Section 100 – definitions and statement of purpose

Title 1: IMMEDIATE REFORMS (2010-2012)

§101 temporary national high-risk program

- For medically uninsurable
- Premiums 125% of standard rate
 - Adjusted by geography
 - Adjusted by age
 - 2/1 cap on premium variation by age
- \$1500 annual deductible
- No annual or lifetime caps
- Maximum cost sharing -- \$5000
- States must maintain their existing levels of financial effort
- \$5 billion appropriation
- COMMENTS: *could be very useful in CA, where state contributes only \$40 million to MRMIB and only 8,000 enroll out of potential 200,000 uninsured medically uninsurable*

§102 medical loss ratio (MLR)

- 85% medical loss ratio across an insurers book of business in the small group and large group markets
- Same MLR in the individual market
- Insurer who falls below these ratios must rebate the excess premium to subscribers
- Comments: *would apply to some commercial plans in California, resulting in rate reductions to subscribers*

§103 stopping rescission abuse

- Plans can only rescind coverage for individuals and employers if
 - Clear and convincing evidence of fraud
 - Independent external 3rd party review
- Comments: *stronger than CA law*

§104 sunshine on price gouging

- Annual review of premium increases; insurer must submit justification

§105 option for parents to extend dependent coverage to young adult children

- Up to age 27
- Carrier can increase premiums for added insured
- Applies to individual and employment based coverage (including ERISA plans)

§106 pre-existing condition exclusions in group health plans

- Look back period reduced from 6 months to 1 month
- Exclusion period reduced from 12 to 3 months

§107 prohibits acts of domestic violence from being treated as a pre-existing condition

- In group and individual markets

§108 ends denials and delays of necessary treatment for children with deformities

- In group and individual markets

§109 eliminates lifetime limits

- In group markets bans lifetime aggregate limits on covered benefits
- In individual market bans annual and lifetime limits on covered benefits

§110 post-retirement reductions in health benefits coverage

- Retirees cannot be singled out for reductions in employment-based health benefits, reductions must apply to active workers and vested retirees in equal measure
- Hardship exemption for financially distressed employers

§111 reinsurance program for early retirees

- Federal government will help with the costs of coverage for early retirees (55-64), not otherwise on Medicare, upon application by the employer
- Pays for 80% of the cost of claims between \$15,000 and \$90,000 per early retiree
- Savings may only be used to reduce the premium costs of coverage and reducing costs of beneficiary out of pocket payments
- Appropriation of \$10 billion
- COMMENTS: *might help stem employers' dropping of retiree health benefits; could be very beneficial for public employees like police and firefighters with early retirements*

§112 wellness program grants for small employers

- Must be evidence based, best practice programs
 - Health awareness, health education, health screenings, behavioral change, employee engagement
- Not more than \$150 per participating employee or more than \$50,000 for a three year grant, may pay up to 50% of the costs of the program.

§113 COBRA continuation

- Allows those on COBRA to extend the time limits of their coverage until the Exchange begins 1/1/13

§114 Grants for state Health Access Programs for the Uninsured

- Could include coverage for childless adults, exchanges, shared responsibility (employers, government and the individual), reinsurance, automated enrollment, market transparency), purchasing collaboratives (direct purchase of services)
- 20% state, local or private match
 - No supplanting
- Comments: *could be incredibly important in allowing CA to jumpstart the reform process and get a very favorable and flexible match on covering the MIAs*

§115 administrative simplification

- Standardize electronic administration among plans, payors and providers

- Billing, eligibility verification, real time, harmonize all data elements, electronic fund transfers, timely and transparent claims processes, coordination of benefits, unique plan identifiers
- Single binding companion guide and operating rules

Title II Protections and Standards for Qualified Health Benefits Plans

§201 Reforms in health insurance markets

- Applies to ERISA plans, group and individual coverage

§ 202 Grandfathered coverage – i.e. right to keep your current coverage

- Assures right to keep existing individual coverage
 - Insurer cannot change the benefits or cost sharing
 - Insurer cannot increase rates differentially for some subscribers
- Employment based and group coverage have a five year transition period to upgrade (if needed) to the essential benefits package and during the transition is “acceptable coverage”
- Individual coverage (other than grandfathered coverage) for the essential benefits package must be purchased through the Exchange

§211 no pre-existing condition exclusions

§212 all plans are guaranteed issuance and renewal and no rescissions

- Can be cancelled for non-payment of premiums, must have a grace period

§213 insurance rating rules

- Can vary based on age, but not more than 2/1
- Can vary based on geography (as determined by states)
- Can vary based on family size (as determined by states)
- Study report and recommendations to Congress to avoid adding incentives for employers to self insure

§214 parity in mental health and substance abuse benefits in all plans in all markets

§215 provider networks

- Must be adequate to assure access to covered services
- Cost sharing differentials must be transparent to consumers/subscribers
- Must be available on line so potential and actual subscribers can learn in which plans individual medical providers participate

§216 parental option to cover young adult children in parent’s plan up to age 27

- Plan can charge an increased premium for adding an adult child in this option

§217 must give 90 days notice before changing cost sharing during the plan’s year

§221 coverage of essential benefits

- Plans outside the Exchange must offer essential benefits and may offer such other benefits as they choose
- Plans inside the Exchange must offer essential benefits and may offer additional benefits as a “premium plus plan”
 - Can offer extra benefits outside the Exchange as a separate policy
- Can subcontract for mental, dental, vision, etc. with stand alone plans

§222 essential benefits

- Hospitalization, outpatient hospital and emergency services, professional services, prescriptions, mental health and substance abuse, preventive services (graded A or B for effectiveness), maternity care, well baby and well

child care (includes dental, vision and hearing for children under 21), rehab and habilitative services, durable medical equipment, prosthetics and supplies

- No cost sharing on well baby and well child care and preventive services, (graded A or B)
- No lifetime or annual benefit maximums
- \$5000 for an individual (\$10,000 for a family) out of pocket annual max
- Basic plan = 70% of actuarial value of essential benefits
- Abortion services (Medicaid required, Medicaid prohibited)
 - Plans are not required nor prohibited from covering abortion services
 - Plans cannot be required to cover abortion services for which Medicaid funding is already barred
 - The public option plan must cover Medicaid required abortion services and is neither barred or required to cover other abortion services
 - The Exchange and its contracting plans cannot use federal funds to pay for abortion services for which Medicaid funding is prohibited

§223 Health Benefits Advisory Committee

- Recommends covered treatments, services and cost sharing within the essential, enhanced and premium plans
- Recommends updates periodically to Secretary
- Basic plan = 70% of actuarial value of essential benefits
- Enhanced plan = 85% of the actuarial value of the essential benefits
- Premium plan = 95% of actuarial value of essential benefits

§224 adoption of Committee recommendations

- Secretary who must approve or reject the whole package of recommendations within 45 days and the reasons therefore
- If rejected, Committee can modify and resubmit
- Secretary must make initial recommendations within 18 months of passage of the Act

§231 Uniform marketing standards for all plans

§232 Plan must have grievance and appeals process

- Internal review
- Impartial, external, de novo 3rd party review

§233 Information transparency and plan disclosure

- Specified information must be disclosed to Commissioner and the public
- Plain language must be used in such disclosure: concise, well organized and readily understandable by the public
- Cost sharing must be transparent and readily available for each item of service
- Contracting must be transparent to the contracting provider
- Pharmacy Benefit Manager (PBM) practices must be disclosed to the Commissioner and the contracting health plan
 - Commissioner annually prepares a report on overall PBM practices and effectiveness in controlling drug prices and spending

§234 Application to plans not within the Exchange to the extent specified by the Commissioner

§235 Plans must pay claims in the timely fashion required for Medicare Advantage plans

§236 Standardized rules for coordination and subrogation of benefits

§237 Plans must comply with administrative simplification

§238 preserves state non-discrimination rules

§239 study sales and marketing practices of pharmaceutical manufacturers with physicians

§240 dissemination of end of life planning information

- Information shall not promote suicides or euthanasia
- No preemption of state laws
- No requirement for any individual to complete advanced directives, etc.

§241 Health Choices Administration is an independent agency, headed by a Commissioner

§242 Duties

- Set standards for health plans
- Run the Exchange
- Distribute individual affordability credits
- Establish and enforce accountability for all plans in and outside the Exchange to comply with federal rules
- Collect data to promote quality and value, etc.

§243 Consult and coordinate

- With states and NAIC
- With FTC and other federal agencies

§244 Ombudsman

§251 Relationship to other requirements

- Does not supersede other requirements in the Public Health Act, ERISA or state law except insofar as the Commissioner determines there is a conflict

§252 prohibits discrimination in health care based on personal characteristics extraneous to the provision of high quality health care

§253 Whistleblower protections

§254 does not supersede collective bargaining agreements

§255 severability

§256 does not supersede Hawaii Prepaid Health Act or its ERISA exemption

§257 allows actions by state Attorneys General as *parens patriae*

§258 abortion laws

- No preemption of state laws
- No effect on federal laws
- No effect on federal civil rights laws

§259 non-discrimination on the basis of entities or individuals' policies with respect to abortion

§260 authority of FTC to conduct studies and prepare reports

§261 does not establish any standard of care for malpractice

§262 applies federal anti-trust law to insurers

§263 study how to increase use of electronic health records by small health care providers

Title III Health Insurance Exchange

§301 Exchange established

- Negotiates rates with plans
- Outreach and enrollment
- Risk pooling mechanism

§302 eligible individuals and employers

- Individuals eligible to enroll if not enrolled in an employer plan as a full time employee or have Medicaid or Medicare coverage, includes dependents
- Eligible employers
 - Year 1: smallest employers (25 or less)
 - Year 2: smaller employers (50 or less)
 - Year 3: larger employers as defined by Commissioner, can be phased in
- Acceptable coverage:
 - Qualified coverage from employers or individually purchased
 - Grandfathered coverage
 - Medicaid, Medicare, Tri-Care, VA benefits
- Employee choice of plans
- Continuing eligibility options for individuals and employers
- Multi-employer plans can access depending on employer size
- Special situation authority
- Study of groups and individuals excluded who should be included

§303 benefit packages

- Contracting plans must offer basic plan
- Contracting plans may offer enhanced plan, premium plan and premium plus plan. The major differences are cost sharing. Individuals with the premium credits get financial help on both the premium and the cost sharing.
- Basic = 70% of the actuarial value of the essential benefits package
- Enhanced = 85% of the actuarial value of the essential benefits package
- Premium = 95% of the actuarial value of the essential benefits package
- Premium plus = 95% of the actuarial value of the essential benefits package, plus extra benefits, such as dental and vision
- Commissioner establishes a range of cost sharing; contracting plans may vary from recommendations by plus or minus 10%.
- State benefit mandates apply to the Exchange Plans if the state agrees to pay for the incremental cost of those mandates for those state residents receiving affordability premium credits in the plan.
- There must be at least one plan in each premium area that does not cover abortions and one that does so. And in the plans that do cover abortion services, the federal funds must be segregated to pay only for abortions that meet the federal Medicaid requirements.

§304 Contracting with the Exchange

- Commissioner sets the standards, solicits bid, negotiates prices, rejects excessive premiums or premium increases and enters into contracts. He enforces the contracts, including assuring network adequacy, and terminates contracts for good cause after notice and hearing.
- Plans must be licensed in the state(s) for which it gets a contract, must report data for risk pooling, implement the affordability credits for premiums and cost sharing, provide an adequate provider network and comply with special rules governing care to Indians.
- Plans must contract with FQHCs and safety net providers delineated in §1927(c)(1)(D)(i)(IV) of the Social Security Act, but only if the provider agrees to the generally applicable payment rate of the plan, and plan must provide culturally and linguistically appropriate services.

§305 Outreach and Enrollment of Eligible Individuals and Employers

- Outreach to vulnerable populations, enrollment by phone, mail, electronically and in person at convenient community locations
- Open annual enrollment in the fall and special enrollment in special circumstances as they occur.
- Individuals pay premiums directly to plans.
- Commissioner provides information on benefits, cost sharing, premiums, quality, provider networks and consumer satisfaction in a comparative manner in plain language.
- Auto enrollment of newborns in Medicaid for 60 days if the newborn has no other acceptable coverage.
- Helps enroll in Medicaid those who are Medicaid eligible.
- Nothing affects roles of agents and brokers, that is determined by state law.
- Outreach, information and enrollment for small employers
 - Through non-profit small employer benefit arrangements (coops) permissible as well.

§306 Other functions such as risk pooling to adjust for adverse selection and distribution of the affordability credits

§307 Exchange Trust Fund

§308 Options for State-Based Exchanges (including multi-state compacts)

- Must do all the federal exchange functions except Commissioner may retain certain functions and authority
- Federal/state matching grant for the costs of operating the state Exchange

§309 Interstate Health Insurance Compacts

- States may form compacts to facilitate the sale of individual health insurance across state lines.
 - Each compacting state must retain and exercise its regulatory authority and subsidiary licensing of multi-state plans selling to its residents
 - Grants available to help states form contracts (up to \$1 million per state)

§310 Cooperatives

- \$5 billion to make grants and loans for start up non-profit, member governed cooperatives

- For coverage through the national or a state Exchange
- Profits must be used to lower premiums, improve benefits or increase quality
- Preference for statewide, integrated delivery networks with significant non-governmental financing

§311 no superseding of VA or Defense Department authorities

PUBLIC OPTION

§321 Public Option

- Only available through the Exchange
- Goal = low cost plan, but on a level playing field
- Offers basic, enhanced and premium plans, may offer premium plus plan

§322 Premiums

- Must fully finance the costs of benefits and administration
- Must have a reserve
- \$2 billion in start-up funding to create a claims reserve, to be repaid over 10 years; no taxpayer bailouts

§323 Rates

- To be negotiated with providers
 - Not less than Medicare nor more than the average commercial rates
 - Test innovative payment methods
 - Provider network is Medicare participating providers unless they opt out

§324 Modernized payment initiatives and delivery system reform

- Can test out medical home payments, care management, value based purchasing, bundling, partial capitation, direct contracting and performance based payments
- Improve health outcomes, address geographic variations, manage chronic illness, reduce health disparities, modify cost sharing to encourage use of high value services, promote delivery system reform, particularly in high cost geographic areas

§325 Provider participation

- Must be licensed or certified
- Preferred physicians: no balance billing
- Non-preferred physicians: balance billing limited to 15% of total payment
- Other providers: no balance billing

§326 Fraud and Abuse applies

§327 HIPAA applies

§328 Patient privacy and security applies

§329 Enrollment is voluntary in public option

§330 Members of Congress can enroll

§331 Memorandum of Understanding with VA for reimbursement

AFFORDABILITY CREDITS

§341 Credits are only available through the Exchange

- Premium subsidies (affordability credits) paid directly by Exchange to plans
- Cost sharing subsidies paid directly to plans
- Commissioner determines eligibility for credits

- Only US citizens and legal permanent residents are eligible
 - Must declare under penalty of perjury (verification process, using Homeland Security to check residency status)
- In years 1 and 2, individuals with affordability credits can only use them for basic plans
- In year 3, individuals can use the premium affordability credits for the enhanced or premium plans, but must pay the incremental difference of the more costly plans.

§ 342 affordable credit eligible individuals

- Members of the family are treated as a single unit, rather than separate applicants
- Must have income between 133% and 400% of FPL
 - Income is modified adjusted gross income (see line 37 on your federal tax return)
- Must not be enrolled in (or eligible for) Medicaid or any other acceptable coverage other than an “Exchange Plan”,
 - Must not be the employee of an Exchange participating employer
 - Must not be the full time employee of an employer who offers coverage to full time employees
 - Exception: if employee obligation exceeds 12% of adjust gross income

§343 affordability premium credits and

§344 cost sharing affordability credits

- Calculation of premium and cost sharing credits:
 - The premium credit pays for the difference between your share of the premium and the reference premium (the average of the three lowest cost plans in your area)
 - The cost sharing credits pay for the difference between your cost sharing and 70%. So that for example for families and individuals with income between 150 and 200% of FPL, the Exchange would pay the plan 23% of the plans actuarial value to make up for the reduced cost sharing for those in this income bracket.
- Calculating your share of premium and cost sharing

| | Initial premium percent | Final premium percent | Actuarial value percent | Out of pocket limit |
|------------------------|-------------------------|-----------------------|-------------------------|---------------------|
| Income 133-150% of FPL | 1.5% | 3.0% | 97% | \$500 |
| 150-200% of FPL | 3.0% | 5.5% | 93% | \$1000 |
| 200-250% | 5.5% | 8.0% | 85% | \$2000 |
| 250-300% | 8.0% | 10.0% | 78% | \$4000 |
| 300-350% | 10.0% | 11.0% | 72% | \$4500 |
| 350-400% | 11.0% | 12.0% | 70% | \$5000 |

§345 Income determinations

- Income is based on the most recent taxable year as verified by a cross check with the Treasury Department for the applicant’s tax return

- This can be adjusted for a significant change in the applicant's income due for example to being laid off

§346 Special rules for US territories (e.g. Puerto Rico, Guam and Virgin Islands)

§347 No federal payments for affordability credits for the undocumented

Title IV Shared Responsibility

§401 Individual responsibility to obtain acceptable coverage in §501

§411 Employers offer and contribute towards coverage or purchase coverage through the Exchange or pay a fee

§412 Employer pays at least 72.5% of the lowest cost plan for individual full time employees and 65% of the lowest cost plan for family coverage

- Employer reports offering, contributions and employees covered
- Employer offers and pays pro rata for hours, weeks or months worked
- Employees auto enrolled in lowest cost plan, but may opt out during a 30 day period

§413 Employer contributions in lieu of coverage

- 8% of average wages, but not more than the minimum contributions to coverage in §412
- Small employer rules:
 - 0% of first \$500,000 in salary
 - 2% of salary in excess of \$500,000 up to \$585,000
 - 4% of salary in excess of \$585,000 up to \$670,000
 - 6% of salary in excess of \$670,000 up to \$750,000

§414 Steering employees to decline offered coverage and instead enroll in the Exchange is prohibited and sanctioned

§415 Impact study and recommendations

§416 Study hardship exemptions for employers

§421 Application to ERISA plans

- Employer elects to offer and contribute or to pay the tax/fee
- Employer can make different election for full time and part-time employees and for different lines of business

§422 Penalties for non-compliance

§423 Application to other group plans

- Employer elects to offer and contribute or to pay the tax/fee
- Employer can make different election for full time and part-time employees

§424 Coordinated policies among Commissioner, Labor, Treasury and HHS

Title V Tax Code Amendments

§501 Individuals without acceptable coverage pay a 2.5% tax on adjusted gross income over and above the standard deduction(s)

- But not in excess of the average national premium for the individual or family
- Acceptable coverage includes group or individual basic coverage, group or individual grandfathered coverage, Medicare, Medicare, TriCare, VA, HIS or other coverage
- Acceptable coverage must be reported by the issuer identifying the insured and all other persons covered under the policy

§511 Employer election requirements

- Employer elects to offer coverage or pay tax
 - Can elect differently for full time and part-time employees

§512 Contribution requirements for non-offering employers

- 8% payroll tax with exemptions and phase up for small employers

§521 Credit for small employers

- 50% of employer contribution for premiums
 - Phased down from \$20,000 to \$40,000 in average wages
 - Phased down from 10 to 25 employees
 - Not allowed for employees whose earnings exceed \$80,000 annually
 - Credit only allowed for two years
 - No double benefit – i.e. tax credits offset tax deductions

§531 limits pharmaceutical distributions from HSAs (health savings accounts) to prescribed medications and insulin

§532 limits employee salary reductions for FSAs (flexible spending accounts) to \$2500 annually

§533 increases the penalties for non-qualified distributions from HSAs from 10% to 20%

§534 Denial of deductions for federal subsidies of prescription drug plans which have been excluded from gross income

§541 permits disclosure of tax return information needed to administer the Exchange subsidies

§542 coverage purchased through the Exchange cannot be paid for with cafeteria plans except where the employer is eligible to purchase in the Exchange

§543 subsidies for the retiree reinsurance plan are not included as gross income to the retirees

§544 CLASS program premiums treated the same as any other long-term care insurance

§545 medical care to Indians excluded from their gross income

§551 surcharge of 5.4% on adjusted gross incomes in excess of \$500,000 for an individual, \$1 million for joint returns

§552 2.5% excise tax on medical devices

§553 Expansion of corporate information reporting requirements

§554 Delay in application of worldwide application of interest

§561 prevents foreign multi-nationals in tax havens from avoiding tax on US earnings

§562 codification of economic substance doctrine

§563 more likely than not standard for large publicly traded avoidance of tax penalties

§564 provides tax exclusion for coverage of adult children under age 27 of insured individual