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ANALYSIS OF THE HEALTH CARE REFORM LAW: PPACA AND THE RECONCILIATION ACT

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). On March 30, 2010, the Health Care and Education Reconciliation Act was enacted, the reconciliation law that made changes to the PPACA. After 18 months of legislative activity, preceded by decades of fits and starts, a major step forward was taken in reforming the country's health care system. Health care reform offers coverage for the majority of uninsured individuals in the United States and eventually will add up to 16 million individuals to the Medicaid program.

The National Health Law Program (NHeLP) analysis includes the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) as well as the amendments made to PPACA by the Health Care and Education Reconciliation Act (Recon. Act, P.L. 111-152). For those of you who are looking for an integrated version of the PPACA, including the Manager's Amendment and the Reconciliation Act, an unofficial version is available at http://s3.amazonaws.com/thf_media/2010/pdf/ppaca-consolidated.pdf.

NHeLP has undertaken a comprehensive analysis of these laws. Given NHeLP's focus on Medicaid and CHIP, civil rights, reproductive health and justice, and empowering low-income beneficiaries and their advocates, we have concentrated our analysis on areas of the law most related to those areas and populations.

The Table of Contents identifies the sections that have been analyzed. In addition to this broad analysis, NHeLP will release more in-depth analyses on specific topics. We anticipate that these focused stand-alone analyses will cover topics such as Medicaid, children's health, health care disparities, reproductive health and health care for immigrants.

The analysis primarily focuses on Titles I and II of the law. We have divided the document into three parts:

- Part I includes an analysis of PPACA Title I, covering the private insurance reforms and state-based exchanges;
- Part II includes an analysis of PPACA Title II, covering changes to the Medicaid program; and
- Part III analyzes selected provisions from Titles III, IV, VI, XIII and IX.

Notes

When reading this analysis, "Secretary" generally refers to the Secretary of the Department of Health and Human Services, unless specifically noted otherwise.

A few other notes and abbreviations are relevant to this analysis:

Abbreviations of Laws:

- SSA refers to the Social Security Act
- PHSA refers to the Public Health Service Act, 42 U.S.C. § 300gg et seq.
- DRA refers to the Deficit Reduction Act
- CHIPRA refers to the Children's Health Insurance Program Reauthorization Act
- IRC refers to the Internal Revenue Code of 1986

Abbreviation of Terms:

- FMAP refers to the Federal Medical Assistance Percentage
- FPL refers to the Federal Poverty Level
- LIS refers to the Low Income Subsidy for Medicare Part D

Abbreviation of Federal Agencies or other Organizations:

- DHS – Department of Homeland Security
- SSA – Social Security Administration
- Treasury – Department of the Treasury
- NAIC – National Association of Insurance Commissioners

We have generally included effective dates for each section. However, it is important to recognize that many provisions will not be implemented without appropriations. Thus, the appropriations process is critical to ensuring that many of the Act's important provisions can be implemented.

If you have any questions about the analysis or need further information, please call NHeLP at (202) 289-7661, or e-mail Mara Youdelman at Youdelman@healthlaw.org.

And finally, much thanks to the NHeLP staff – in particular Mara Youdelman – who worked tirelessly to complete this analysis:

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We hope you find this analysis useful.

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

Subtitle G—Miscellaneous Provisions

Amendments to the Public Health Service Act, PPACA § 1001, 10101, Recon. § 2301

Section 1001 of the PPACA[1] enacts a number of new sections in the Public Health Service Act (PHSA) (42 U.S.C. § 300gg) related to health insurance reforms.

No Lifetime or Annual Limits, PHSA § 2711

A group health plan and a health insurance issuer offering group or individual health insurance coverage are prohibited from establishing lifetime or annual limits for any participant or beneficiary on the monetary value of benefits. This restriction is limited, however, to "essential health benefits."[2] A plan/insurer may still impose annual and lifetime limits on non-essential health benefits. (*See* § 10101.)

However, there is an exception for group health plans or health insurance coverage that is not required to provide "essential health benefits" from imposing lifetime or annual limits if not permitted under other federal or state law. Other sections of the law exempt dental-only plans from providing essential health benefits (§ 1201, enacting PHSA § 2707). And ERISA-exempt group health plans and multiple employer welfare arrangements are exempt from the definition of "health plan," and only health plans must provide essential health benefits (§ 1301(b)(1)(B)). So while most individuals will not be subject to lifetime or annual limits, the exceptions do allow these limits to continue in certain circumstances.[3]

This provision is effective for plan years beginning on or after six months after the date of enactment (September 23, 2010). So if a plan's "year" runs January through December, the effective date will become January 1, 2011. But for plan years prior to January 1, 2014, a plan or issuer may impose a "restricted annual limit" (to be defined by the U.S. Department of Health and Human Services (HHS) on essential health benefits as long as access to needed services is made available with a minimal impact on premiums) (*see* § 10101). After 2014, the plans/issuers covered by this provision may not impose any annual limits on essential health benefits.

Prohibition on Rescissions, PHSA § 2712

A group health plan or health insurance issuer offering group or individual health coverage may not, after an individual is covered, rescind the policy.[4] There is an exception if an individual undertook fraud or made an intentional misrepresentation of a material fact (if

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[1] P.L. 111-148.

[2] Essential health benefits are defined in § 1302(b), *see infra.*

[3] The provision related to lifetime caps applies to all grandfathered health plans but the provision related to annual limits only apply to grandfathered group health plans (as defined in § 1251(e)) beginning with first plan year to which there provisions would otherwise apply. (*See* Recon. Act §§ 2301(a)(4)(A) & (4)(B)).

[4] The provision related to rescissions applies to grandfathered health plans (as defined in PPACA § 1251(e) beginning with first plan year to which there provisions would otherwise apply. (*See* Recon. Act. § 2301(a).)

prohibited by the terms of the plan or coverage). In this situation, a plan/issuer may cancel the plan/coverage only with prior notice and as permitted under PHSA §§ 2702(c) or 2742(b).

This provision is effective for plan years beginning on or after six months after the date of enactment (September 23, 2010). So if a plan's "year" runs January through December, the effective date will become January 1, 2011.

Coverage of Preventive Health Services, PHSA § 2713

A group health plan or health insurance issuer offering group or individual health coverage must provide, at a minimum, certain preventive health services with no cost-sharing. These preventive health services include:

- evidence-based items and services that the U.S. Preventive Services Task Force (USPSTF) rates as an "A" or a "B;"[5]
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (if recommended for the individual – for example, coverage would not be provided for an immunization for an adult if the immunization is only recommended for children);
- 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);
- with respect to women, any additional preventive care and screenings provided for in comprehensive guidelines supported by HRSA; and
- current recommendations of the USPSTF regarding breast cancer screening, mammography and prevention shall be considered the most current (other than those issued in or around November 2009).

Plans/insurers may cover additional preventive care or deny coverage for services not recommended by the USPSTF. The Secretary of HHS (Secretary) must establish the timeframe for when a plan must implement the recommendations, giving plans at least one year with regard to new recommendations for USPSTF items or services; immunizations; or HRSA evidence-based preventive care and screenings for infants, children, and adolescents.

This section also allows the Secretary to establish guidelines to allow plans/issuers to utilize "value-based insurance designs." The law does not give a definition so it will be left to the Secretary to define in regulations.

This provision is effective for plan years beginning on or after six months after the date of enactment (September 23, 2010). So if a plan's "year" runs January through December, the effective date will become January 1, 2011.

Extension of Dependent Coverage, PHSA § 2714

[5] For more information on the USPSTF recommendations, see http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations.

The law requires a group health plan or health insurance issuer offering group or individual health coverage that provides dependent coverage to extend that coverage until the dependent turns 26 years old.[6] The plan/issuer does not have to extend coverage to any child of a covered dependent.[7]

In early May, HHS, in conjunction with the Departments of Labor and Treasury and the Social Security Administration, issued interim final regulations implementing this provision.[8] As an example of issues addressed in the regulations, premiums and co-pays must be the same for these dependents as for younger dependents, and coverage must be the same.

This provision is effective for plan years beginning on or after six months after the date of enactment (September 23, 2010). So if a plan's "year" runs January through December, the effective date will become January 1, 2011. Secretary Sibelius has indicated HHS' interest in working with plans/issuers to expand the opportunity prior to the effective date.[9] And a number of plans have already indicated that they will allow dependents graduating college to remain covered instead of dis-enrolling and re-enrolling them after the effective date.

Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions, PHSA § 2715

The Secretary must develop standards (for group health plans and health insurance issuers offering group or individual health coverage) for a summary of benefits and coverage explanation that must be provided to applicants, enrollees, and policyholders or certificate holders.[10] The Secretary must consult with specific groups in developing the standards including the National Association of Insurance Commissioners (NAIC) and a working group composed of representatives of:

- health insurance-related consumer advocacy organizations;
- health insurance issuers;
- health care professionals;

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[6] The provision related to dependent coverage applies to grandfathered health plans (as defined in § 1251(e) beginning with the first plan year to which there provisions would otherwise apply, except grandfathered group health plans beginning before January 1, 2014 where the adult child is eligible to enroll in an eligible employer-sponsored health plan as defined in IRC § 5000A9f)(2). (*See* Recon. Act § 2301(a).)

[7] This section will not modify the definition of "dependent" as used in the Internal Revenue Code of 1986 (IRC) with respect to the tax treatment of the cost of coverage.

[8] *See* http://www.hhs.gov/ociio/regulations/index.html.

[9] See http://www.hhs.gov/news/press/2010pres/04/20100419a.html and http://www.hhs.gov/news/press/2010pres/04/20100420c.html. As of April 21, WellPoint, United Healthcare, Blue Cross Blue Shield plans, Kaiser Permanente, and Humana indicated that they will provide coverage for these dependents immediately.

[10] The provision related to a uniform explanation applies to grandfathered health plans (as defined in § 1251(e) beginning with the first plan year to which there provisions would otherwise apply, except grandfathered group health plans beginning before January 1, 2014. (*See* § 10103(d).)

- patient advocates (including those representing individuals with limited English proficiency); and
- other qualified individuals.

The provision outlines further requirements for the standards:

- a uniform format for the information of less than four pages and at least 12 point font size;
- language that is culturally and linguistically appropriate, and will be understood by the "average plan enrollee;"
- uniform definitions of standard insurance and medical terms[11] to allow consumer understanding and comparison between plans; a description of the coverage, including cost-sharing for each category of essential health benefits (*see* § 1302(b)(1)(A)-(J) described in subparagraphs (A) through (J) and other benefits defined by the Secretary;
- information on:
    - exceptions, reductions and limitations on coverage;
    - cost-sharing, including deductibles, co-insurance and co-payments;
    - provisions related to renewability and continuation of coverage; and
    - whether the plan/coverage provides "minimum essential coverage" (see IRC § 5000A(f)) and ensures that the plan or coverage share of the total allowed costs of benefits is not less than 60 percent of costs; and
- inclusion of:
    - a "coverage facts label" that includes examples illustrating common benefits scenarios (specified to include pregnancy and serious/chronic medical conditions);
    - a statement that the outline is a summary of the policy/certificate and that an individual should consult the coverage document to determine the governing contractual provisions;
    - contact information, including telephone number for the consumer to call with additional questions; and
    - a website to obtain additional information (the website must include a copy of the policy/certificate of coverage).

The Secretary must develop the standards by March 23, 2011, and is required to periodically review and update the standards, although there is no time interval specified.

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[11] The Secretary must develop standard definitions for certain insurance and medical terms. The insurance-related terms are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage. The medical terms are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent or exceptions of those medical benefits. § 2715(g).

By March 23, 2012, each health insurance issuer (including group health plans that are not self-insured) and sponsor or designated administrator of a self-insured group health plan (as those terms are defined in the Employment Retirement Income Security Act of 1974 [ERISA] § 3(16)) must provide the summary of benefits and coverage to:

- applicants (at the time of application);
- enrollees prior to enrollment/re-enrollment; and
- policy/certificate holders at the time of policy issuance or delivery of the certificate.

The summary may be provided in paper or electronically to comply with this section. Willful failure to provide the summary may result in a fine of up to $1,000, and may be assessed per enrollee so the failure to provide information to 10 enrollees constitutes 10 separate offenses and could result in a fine of $10,000. There is no maximum fine specified in the statute.

If a plan/issuer makes a "material modification" in any of the terms of the plan/coverage (as defined in ERISA § 102) that is not included in the summary, the plan/issuer must provide notification of the change to enrollees at least 60 days prior to the effective date of the change.

If state requirements for providing a summary of coverage require less information, the federal standards preempt the state requirements. While not specifically addressed, it is assumed that if a state requires more information than the federal standards, the additional state requirements will not be preempted.

Provision of Additional Information, PHSA § 2715A

A group health plan and a health insurance issuer offering group or individual health insurance coverage must comply with § 1311(e)(3) (regarding Transparency in Coverage).[12] Plans participating in the exchange must provide this information to the Secretary, state insurance commissioner and the exchange. Plans not participating in the exchange must still provide the information to the Secretary and state insurance commissioner.

Prohibition of Discrimination against Highly Compensated Individuals, PHSA § 2716

A group health plan (other than a self-insured plan) must comply with IRC § 105(h)(2), relating to prohibition on discrimination in favor of highly compensated individuals. A "highly compensated individual" is defined in IRC § 105(h)(5) and rules similar to the rules contained in paragraphs (3), (4) and (8) of IRC § 105(h) shall apply.

Ensuring the Quality of Care, PHSA § 2717

Not later than March 23, 2012, the Secretary must develop quality reporting requirements for group health plans and health insurance issuers offering group or individual health insurance coverage with respect to plan/coverage benefits and health care provider reimbursement

[12] *See infra,* § 1311(e)(3) is added by § 10104.

structures.[13] The Secretary must consult with experts in health care quality and stakeholders in developing the requirements, which must:

- improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model,[14] for treatment or services under the plan or coverage;
- implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
- implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and
- implement wellness and health promotion activities.[15]

Once adopted the plan/issuer must submit an annual report to the Secretary on whether the plan/coverage satisfies the elements described above. The Secretary may also provide exceptions for plans/issuers that substantially comply with the goals of quality reporting. Further, the plan/issuer must make the report available to its enrollees during each open enrollment period and HHS must make the reports available to the public on the internet. The Secretary may adopt penalties for plans/issuers who do not comply with the reporting requirements.

Bringing Down the Cost of Health Care Coverage, PHSA § 2718

A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan[16]) must submit to the Secretary, with respect to each plan

[13] By March 23, 2012, the Secretary must develop regulations that provide criteria for determining a reimbursement structure. Within 180 days of the promulgation of these regulations, the Government Accountability Office must conduct a study and submit a report to the Senate Health, Education & Pensions Committee and House Energy & Commerce Committee regarding the impact the activities under this section have had on the quality and cost of health care.

[14] The law includes the wrong citation for medical homes: rather than § 3602, we believe it should refer to § 3502. This would require a technical amendment to correct this reference.

[15] These include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants. The services may also include services such as smoking cessation; weight management; stress management; physical fitness; nutrition; heart disease prevention; healthy lifestyle support; and diabetes prevention. § 2717(b). Further, any wellness and prevention program may not require the disclosure or collection of information related to lawful gun ownership, presence, use or storage of guns and ammunition. Further, lawful ownership/possession/use/storage of guns and ammunition may not lead to an increase in premiums, denial of coverage, or reduction/denial of any discount/rebate/reward for participation in a prevention/wellness program. § 10101(e).

[16] *See* § 10101(d). Grandfathered health plans are discussed in § 1251, *see infra.*

year, a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. The report, which HHS will make publicly available on its website, must include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of re-insurance, that the coverage expends:

- on reimbursement for clinical services provided to enrollees under the coverage;
- 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 and licensing or regulatory fees.

Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) must, with respect to each plan year, provide an annual rebate to each enrollee, on a pro rata basis, if certain conditions are met. The rebate is provided if the ratio of the amount of premium revenue expended by the issuer on costs for clinical services and improving quality to the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and re-insurance under §§ 1341,[17] 1342,[18] and 1343[19]) for the plan year (except as provided in subparagraph (B)(ii)), is less than:

- in the large group market[20] – 85 percent,[21] or a higher percentage set by a state in regulation;[22] or
- in the small group[23]/individual market – 80 percent or such higher percentage set by a state in regulation[24] (except that the Secretary may adjust the state's percentage if the application of 80 percent may destabilize the individual market in such state).

So, unless a plan wants to provide a rebate, a large group plan must spend 85 percent of its revenue on clinical services or quality improvement or pay a rebate to enrollees. For the small

[17] This provision establishes a Transitional Reinsurance Program for Individual and Small Group Markets in each state**,** *see infra.*

[18] This provision establishes risk corridors for plans in individual and small group markets. (NOTE: This analysis does not include this provision.)

[19] This section addresses risk adjustment. (NOTE: This analysis does not include this provision.)

[20] A "large group market" is the market used by large employers to purchase group health insurance. A "large employer" is one that employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. *See* § 1304(b)(1).

[21] The Secretary may adjust this percentage (and the one in the next bullet) if appropriate on account of the volatility of the individual market due to the establishment of state exchanges.

[22] The law says that in setting this percentage, a state should seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the state, and value for consumers so that premiums are used for clinical services and quality improvements § 2718(b)(2).

[23] A "small group market" is the market used by small employers to purchase group health insurance. A "small employer" is one that average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. *See* § 1304(b)(2).

[24] § 2718(b)(2).

group/individual market, the amount is 80 percent. The amount of the rebate is either the amount by which the percentage exceeds the ratio percentage or the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees, and after accounting for payments or receipts for risk adjustment, risk corridors, and re-insurance under §§ 1341, 1342, and 1343). Beginning on January 1, 2014, the rebate shall be based on the averages of the premiums expended on the costs and total premium revenue for each of the previous three years for the plan.

The Secretary must promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties. Further, the NAIC (with certification from the Secretary) must establish uniform definitions of the activities reported above and standardized methodologies for calculating measures of these activities. This includes definitions of which activities, and in what regard such activities, constitute activities related to health care quality. Further, these methodologies must take into account the special circumstances of smaller plans, different types of plans and newer plans.

This provision also includes a requirement that hospitals establish, update, and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including charges for diagnosis-related groups established under Medicare.[25] In theory, this should allow patients better opportunities to compare charges for healthcare services. However, as many hospital services arise from emergencies, patients often do not have the time to compare charges before needing to select a hospital. Or many patients may have access to only certain hospitals because of geography or networks of preferred providers.

Appeals Process, PHSA § 2719

A group health plan and a health insurance issuer offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims.[26] At a minimum, the plan/issuer must:

- have in effect an internal claims appeal process;
- provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombuds established under § 2793[27] to assist such enrollees with the appeals processes; and
- allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

Internal Reviews. For group health plans and health insurance issuers offering group health coverage, an internal plan must initially incorporate the claims and appeals process, including

[25] *See* § 1886(d)(4) of the Social Security Act, 42 U.S.C. § 11395ww.
[26] *See* § 10101(g).
[27] *See infra,* in discussion of § 1002.

urgent claims, outlined in the relevant ERISA regulations.[28] These plans/issuers must update their processes in accordance with any standards established by the Secretary of Labor. For health insurance issuers offering individual health coverage and other issuers not subject to the above requirements, the issuer must provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and must update such process in accordance with any standards established by the Secretary for these issuers.

External Reviews. A group health plan and a health insurance issuer offering group or individual health insurance coverage must comply with the applicable state external review process for plans/issuers. At a minimum, this process must:

- include the consumer protections set forth in the Uniform External Review Model Act promulgated by the NAIC which is binding on these plans; or
- meet minimum standards established by the Secretary through guidance and that is similar to the process described above if:
    - the applicable state has not established an external review process that meets the requirements above; or
    - the plan is a self-insured plan that is not subject to state insurance regulation (including a state law that establishes an external review process described above).

The Secretary may deem the external review process of a group health plan or health insurance issuer, in operation as of the date of enactment of the PPACA, to be in compliance with the applicable process described above as determined appropriate by the Secretary.

Patient Protections, PHSA § 2719A

The law outlines a number of patient protections that apply to group health plans and health insurance issuers who offer group or individual benefits.[29] First, a participant, beneficiary, or enrollee who must designate or be assigned a primary care physician must be given the opportunity to designate any participating primary care provider who is available to accept the individual. If a person has children enrolled in coverage that requires, provides or assigns a primary care provider, the plan/issuer must permit designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if a provider participates in the network of the plan or issuer.

With regard to access to obstetrical and gynecological care, a plan/issuer that provides obstetrical or gynecological care and requires or assigns a primary care physician, must ensure enrollees have direct access to obstetrical or gynecological care. The plan/issuer may not require authorization or referral by the plan, issuer, or any person (including a primary care provider designated by or assigned to the enrollee) for any female participant, beneficiary, or enrollee

[28] *See* 29 CFR § 2560.503–1.
[29] *See* § 10101(h).

seeking coverage for obstetrical or gynecological care.[30] The obstetrical/gynecological health care professional must agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. If care and services related to obstetrical/gynecological items/services are provided or ordered by a participating health care professional who specializes in obstetrics or gynecology, the plan/issuer must treat the order as authorization by the enrollee's primary care provider. However, the obstetrical/gynecological provider may be required to notify an enrollee's primary health care professional or the plan/issuer of treatment decisions.

This provision states that emergency services[31] provided in a hospital's emergency department must be covered:

- without the need for any prior authorization determination;
- whether the health care provider furnishing the services is a participating provider with respect to these services;
- in a manner that, if these services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider with or without prior authorization, the provision of services cannot be more restrictive or limited or be subject to higher cost-sharing than if the services were provided in network;
- without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under § 2701 of this Act,[32] § 701 of the ERISA, or § 9801 of the IRC, and other than applicable cost-sharing).

Effective date: September 23, 2010 (six months after PPACA enactment).

Health Insurance Consumer Information, PPACA § 1002

This provision adds new section § 2793 to the PHSA. The provision establishes a new grant program to states or states' exchanges to establish, expand, or provide support for a state

[30] However, if a plan/issuer has imposed any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care, these still would apply.

[31] "Emergency services" means, with respect to an emergency medical condition, a medical screening examination (as required under EMTALA, the Emergency Medical Treatment and Active Labor Act, codified at 42 U.S.C. § 1867) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under EMTALA to stabilize the patient. In this context, "to stabilize" has the meaning given in EMTALA and "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that: places the health of the individual (or a pregnant woman's unborn child) in serious jeopardy, causes serious impairment to bodily function; or causes the serious dysfunction of any bodily organ or part.

[32] *See infra*, discussing fair health insurance premiums.

designated office of health insurance consumer assistance or ombuds. The designated office must, directly or in coordination with state health insurance regulators and consumer assistance organizations, receive and respond to inquiries and complaints concerning health insurance coverage with respect to federal and state health insurance requirements. The Secretary must establish criteria for carrying out the duties of these offices, which must include:

- assisting with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer;
- providing information about the external appeal process;
- collecting, tracking, and quantifying problems and inquiries encountered by consumers;
- educating consumers on their rights and responsibilities with respect to group health plans and health insurance coverage;
- assisting consumers with enrollment in a group health plan or health insurance coverage by providing information, referral, and assistance; and
- resolving problems with obtaining premium tax credits.

The offices must collect and report data on the types of problems consumers encounter and the inquiries made to the office (the detail of the data is not specified). The Secretary must use the data to identify areas where more enforcement action is necessary, and share the information with state insurance regulators and the Secretaries of Labor and Treasury for use in enforcement activities.

The funding for this program is initially $30 million which will remain available without fiscal year limitation (so that unspent funds may carryover to subsequent fiscal years). In subsequent years, the funding amount is not specified but referred to as "such sums as may be necessary.

Effective date: March 23, 2010 (although beginning with the next fiscal year) and grants may begin (if funding is available) in FY 2010 (which ends September 30, 2010).

Ensuring that Consumers Get Value for Their Dollars, PPACA §§ 1003, 10101

This provision adds a new section to the PHSA, § 2794. This provision requires the Secretary, in conjunction with states, to establish a process for an annual review for "unreasonable" increases in insurance premiums for health insurance coverage, beginning in 2010. As part of this review, health insurance issuers must submit to the Secretary and the relevant state a justification for any unreasonable premium increase prior to the implementation of the increase. The issuer must also prominently post this information on its website, and the Secretary must ensure public disclosure of information on these increases and justifications for all health insurance issuers. Beginning in 2014, the Secretary, in conjunction with states, must monitor premium increases both inside and outside of the exchange. For qualified health plans in the large group market that wish to participate in the exchange, the state must consider whether the plan has excess premium growth outside of the exchange as compared to the rate of growth inside the exchange.

The provision also establishes a new grant program for states to conduct the annual premium review, with grants available from 2010-2014. As a condition of receiving a grant, a state, through its Commissioner of Insurance, must:

- provide the Secretary with information about trends in premium increases in health insurance coverage in premium rating areas in the state; and
- make recommendations, as appropriate, to the state's exchange about whether particular health insurance issuers should be excluded from participation in the exchange based on a pattern or practice of excessive or unjustified premium increases.

The grants can assist states in reviewing, and, if appropriate under state law, approving premium increases for health insurance coverage as well as providing information and recommendations to the Secretary about trends and recommendations for exclusion of a plan from participation in the exchange. If the funds are not fully obligated by the end of FY 2014, the Secretary can provide grants to states for planning and implementing the insurance reforms and consumer protections under this section. The program is allocated $250 million which will be distributed to the states considering the number of plans of health insurance coverage offered in each state and the population of the state. No state qualifying for a grant under this section shall receive less than $1 million or more than $5 million for each grant year.

States may also use grant funds to establish centers at academic or other nonprofit institutions to collect medical reimbursement information from health insurance issuers, to analyze and organize such information, and to make this information available to issuers, health care providers, health researchers, health care policy makers, and the general public. These medical reimbursement data centers must:

- develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates;
- use the best available statistical methods and data processing technology to develop such fee schedules and other database tools;
- regularly update such fee schedules and other database tools to reflect changes in charges for medical services;
- make health care cost information readily available to the public through a website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and
- regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers.

These centers must also adopt by-laws that ensure that the center and its governing board are independent and free from all conflicts of interest. Further, the by-laws must ensure that the center is not controlled nor influenced by, and does not have any corporate relation to, any individual or entity that may make or receive payments for health care services based on the center's analysis of health care costs. Centers have no authority to compel health insurance issuers to provide data to it.

Effective date: March 23, 2010 (although beginning with the next fiscal year) and grants may begin (if funding is available) in FY 2010 (which ends September 30, 2010).

Immediate Access to Insurance for Uninsured Individuals with a Pre-existing Condition, PPACA § 1101

The Secretary of HHS must create a temporary high-risk insurance pool program to cover uninsured individuals with pre-existing conditions. § 1101(a). The insurance pool program will only exist until the state insurance exchanges begin (on January 1, 2014), although the Secretary may extend coverage past that date so that insured individuals do not experience lapses in coverage. When the state insurance exchanges begin, individuals in the high-risk insurance pools will be moved into insurance available through the exchanges. § 1101(a), (g)(3). The high-risk pools will be open to citizens, nationals, and others who are lawfully present in the U.S. and have a pre-existing condition. § 1101(d)(1), (d)(3). Eligibility determinations for the program will be appealable under provisions that the Secretary will develop. § 1101(f)(1).

The Secretary has the option to operate the pool program directly, or to contract with states and/or nonprofit organizations to operate a pool or multiple pools. § 1101(b). If a state already operates a high-risk pool and wishes to contract with HHS under this provision, the state must comply with a maintenance of effort requirement and fund its high-risk pool at the same level as it did in the year before it contracts with HHS. § 1101(b)(3). Except for state licensing and solvency laws, the federal law arising out of this section supersedes any state laws or regulations regarding high-risk pools developed in accordance with this section. § 1101(g)(5).

Congress appropriated $5 billion for the program to pay claims and administrative costs that are not covered by individuals' premiums. § 1101(g)(1). If these funds prove to be inadequate, then the Secretary must make adjustments in the program to avoid a deficit. § 1101(g)(2). Presumably, this means that the Secretary could impose rules limiting eligibility or coverage if the program demand appears that it will outstrip the allotted funding. The Secretary can also stop accepting applications if necessary to stay within the funding limitations. § 1101 (g)(4). A qualified pool must provide health insurance coverage "to all eligible individuals… [without imposing] any pre-existing condition exclusion with respect to such coverage. . ." § 1101(c)(2)(A). The plain language of this section would indicate that neither the Secretary nor a state could set an enrollment cap on a pool before taking applications as such a move might deny coverage to "all eligible individuals."

An eligible individual cannot have had creditable insurance coverage [33] during the six-month period prior to applying for the high-risk pool insurance. § 1101(d)(2).

The legislation includes provisions prohibiting health insurers or employment-based health plans from discouraging individuals from remaining enrolled in existing coverage to qualify for the high-risk pool. § 1101(e). Employers, health plans, and health insurers may be

[33] Creditable coverage is defined in 42 U.S.C. § 300gg(c). Creditable coverage includes a "state health benefits risk pool" and "Health insurance coverage," so most health insurance coverage within the previous six months would disqualify a person from the high-risk pool, and an individual could not move directly from the state pool to a federal or federally subsidized one. 42 U.S.C. § 300gg(c)(1)(B), (G).

sanctioned for offering financial incentives to an individual to dis-enroll. § 1101(e)(2)(A). Health insurers and health plans may also be sanctioned for discouraging continued enrollment in coverage by raising premiums, eliminating policies, or considering the health status of an insured individual. § 1101(e)(2)(B). States may also enforce or create mechanisms for enforcement of these prohibited acts. § 1101(e)(3). This section does not contain similar sanctions of public programs that might dis-enroll individuals in favor of the high-risk pool coverage, but the maintenance of effort requirements in § 2001 would appear to prohibit such state actions. The Secretary must develop procedures to guard against fraud, waste, and abuse. § 1101(f)(2).

Costs for coverage in the high-risk pool are apportioned between the various players. Insurers must cover at least 65 percent of the cost of the covered benefits. § 1101(c)(2)(B)(i). The insured individual's out-of-pocket limits (including deductibles, but excluding premiums) are capped at the same amounts as for high deductible health plans: $5,000 annually for individuals and $10,000 for a family. § 1101(c)(2)(B)(ii); 26 U.S.C. § 223(c)(2)(A). However, the Secretary may vary the out-of-pocket limits to ensure that the insurer is covering at least 65 percent of the cost of the covered benefits. The Act also limits how much variance is allowed for premiums. With some differences, new provisions in § 1201 of the Act apply to the premiums in the high-risk pool as well: variance by age for adults may only be up to 4 to 1; tobacco users can only be charge 1.5 times as much as a non-user; and premiums are established at a standard rate for a standard population. § 1101(c)(2)(C)(i)- (iii); § 1201 (amending § 2701 of the Public Health Service Act).

Effective date: According to HHS, the program is scheduled to begin July 1, 2010. It ends January 1, 2014, unless extended by the Secretary as described above.

Reinsurance for Early Retirees, PPACA § 1102

Within 90 days of March 23, 2010, the Secretary must establish a temporary re-insurance program to provide reimbursement to employment-based plans for some of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of these retirees). This funding is available through January 1, 2014.

The provision provides specific definitions of health benefits,[34] employment-based plans,[35] and early retirees.[36] Plans must:

[34] Medical, surgical, hospital, prescription drug, and such other benefits as determined by the Secretary, whether self-funded, or delivered through the purchase of insurance or otherwise.

[35] A group health benefits plan that provides health benefits to early retirees and is (I) maintained by one or more current or former employers (including without limitation any state or local government or political subdivision thereof), employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or (II) a multiemployer plan (as defined in § 3(37) of ERISA.

[36] Early retirees are defined as individuals who are age 55 and older but are not eligible for coverage under Medicare and who are not active employees of an employer maintaining, or currently contributing to, the employment based plan; or of any employer that has made substantial contributions to fund such plan.

- apply to the Secretary and implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions;
- provide documentation of the actual cost of medical claims involved; and
- be certified by the Secretary.

Plans may only submit claims for at least $15,000 but not more than $90,000, although these amounts will be adjusted annually based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000). In determining the amount of a claim, the plan must take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by the plan with respect to the health benefit. For purposes of determining the amount of any claim, the plan must include the costs paid by the early retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance. If the Secretary determines that a participating employment-based plan has submitted a valid claim, the Secretary must reimburse the plan for 80 percent of that portion of the costs attributable to the claim that exceed $15,000.

Plans may use the money paid to lower costs for the plan, including reducing premium costs for a group health benefit plan or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. The plan may not use the payments as general revenues. The Secretary must develop a mechanism to monitor the appropriate use of the payments by the plans. Payments received must be excluded in determining the gross income of a plan that is maintaining or currently contributing to a participating employment-based plan.

The Secretary is charged with establishing an appeals process to permit participating plans to appeal a determination of the Secretary with respect to submitted claims, and procedures to protect against fraud, waste, and abuse under the program. Further, the Secretary must conduct annual audits of claims data submitted by participating employment-based plans to ensure that such plans are in compliance with the requirements of this section.

The funding for this provision is initially $5 billion which may carryover from one fiscal year to the next. The Secretary can stop taking applications for participation based on the availability of funding.

On May 5, the Secretary released an interim final rule with comment period related to this provision. The regulation and a fact sheet are available at http://www.hhs.gov/ociio/regulations/index.html.

Effective date: March 23, 2010.

Immediate Information that Allows Consumers to Identify Affordable Coverage Options, PPACA §§ 1103, 10102

By July 1, 2010, the Secretary, in consultation with the states, must establish a mechanism, including a website, through which a resident or small business of a state may identify affordable health insurance coverage options in that state. The website, or "internet portal" as referred to by HHS, to the extent practicable, must provide ways to receive information on at least the following coverage options:

- health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of a single disease or condition, or an unreasonably limited set of diseases or conditions (as determined by the Secretary).
- coverage under Medicaid;
- coverage under the Children's Health Insurance Program;
- a state health benefits high-risk pool, to the extent that such high-risk pool is offered in such state;
- coverage under a high-risk pool under § 1101; and
- coverage within the small group market for small businesses and their employees, including re-insurance for early retirees under § 1102,[37] tax credits available under § 45R of the IRC (as added by § 1421[38]), and other information specifically for small businesses regarding affordable health care options.

Not later than May 21, 2010, the Secretary must develop and require utilization of a standardized format for this coverage information, which must be included on the website. The format must, at a minimum, require the inclusion of information on the percentage of total premium revenue expended on nonclinical costs (as reported under PHSA § 2718(a),[39] eligibility, availability, premium rates, and cost-sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in PHSA § 2715.[40] The Secretary may contract with qualified entities to carry out the activities of this section.

On May 10, the Secretary released an interim final rule with comment period related to this provision. The regulation and a fact sheet are available at http://www.hhs.gov/ociio/regulations/index.html.

Effective date: March 23, 2010.

Administrative Simplification, PPACA § 1104

This section amends HIPAA (the Health Insurance Portability and Accountability Act) by adding to HIPAA's purpose: 1) a clarification that the standards for electronic claims be uniform; and 2) the intent of reducing the clerical burden on patients, health care providers and health plans. The provision also adds electronic funds transfers to covered HIPAA transactions.

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[37] *See infra.*
[38] NOTE: This analysis does not address § 1421.
[39] *See infra.*
[40] *See infra.*

Further, for all HIPAA standards, HHS must adopt a single set of operating rules for each type of HIPAA transaction.[41] These standards and operating rules should have the goal of creating as much uniformity in the implementation of the electronic standards as possible. Further, they should be consensus-based, and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to HIPAA standards. In developing the operating rules, HHS must consider recommendations developed by a qualified nonprofit entity that:

- focuses its mission on administrative simplification;
- demonstrates a multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant federal agencies and other standard development organizations;
- has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices;
- builds on the existing HIPAA transaction standards; and
- allows for public review and updates.

The provision also sets up an advisory role for the National Committee on Vital and Health Statistics (NCVHS), which must:

- advise the Secretary as to whether a particular nonprofit entity meets the above requirements;
- review the operating rules developed and recommended by the nonprofit entity;
- determine whether such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;
- evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and
- submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

With this required input from NCVHS and the qualified non-profit entity, HHS must adopt new HIPAA standards by July 1, 2011, for implementation no later than January 1, 2013, and may allow for the use of a machine readable identification card. For any standard or operating rule recommended by NCVHS, HHS must issue an interim final rule with a 60-day comment period.

The definition of "operating rules" are "the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part." Because the current HIPAA standards did not reduce paperwork and simplification as much as desired, the new provision requires that in

[41] HIPAA transactions include: health claims or equivalent encounter information; health claims attachments; enrollment and dis-enrollment in a health plan; eligibility for a health plan; health care payment and remittance advice; health plan premium payments; first report of injury; health claim status; referral certification and authorization; and electronic funds transfers. *See* 42 U.S.C. § 1320d.

adopting standards and operating rules for HIPAA transactions, HHS should seek to reduce the clerical burden by reducing the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers. Further, the HIPAA standards and operating rules must:

- enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care, to the extent feasible and appropriate;
- be comprehensive, requiring minimal augmentation by paper or other communications;
- provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process, including adjudication and appeals; and
- describe all data elements, including reason and remark codes, in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement state or federal law, or to protect against fraud and abuse).

The provision sets up a number of deadlines for the establishment of operating rules:

- electronic funds transfer and health care payment and remittance advice transactions – final regulations by July 1, 2012, with an effective date no later than January 1, 2014; and
- health claims or equivalent encounter information, enrollment/dis-enrollment in a health plan, health plan premium payments, referral certification and authorization – final regulations by July 1, 2014, with an effective date no later than January 1, 2016.

After the standards and operating rules are finalized, health plans will have to submit certification of compliance pursuant to a form specified by HHS that includes adequate documentation of compliance. The health plan must demonstrate that it conducts the relevant electronic transactions in a manner that fully complies with the regulations of the Secretary and provides documentation showing that it has completed end-to-end testing for such transactions with its partners, such as hospitals and physicians. A plan must also ensure that any subcontracted services meet the applicable certification and compliance requirements and provide adequate documentation of this. HHS may designate independent, outside entities to conduct the certification for health plans. The deadlines for compliance are as follows:

- December 31, 2013 – eligibility for a health plan, health claim status, electronic funds transfers, health care payment and remittance advice;
- December 31, 2015 – compliance with any applicable standards and associated operating rules for health claims or equivalent encounter information, enrollment and dis-enrollment in a health plan, health plan premium payments, health claims attachments, and referral certification and authorization;

In addition, for any new or amended standard or operating rule for administrative or financial transactions covered by HIPAA, a health plan must file a statement with HHS certifying that the plan's data and information systems are in compliance. The health plan's compliance must occur by the effective date of the new/amended standard/operating rule. For both this

requirement and the general requirement above related to certification, the Secretary is to establish periodic audits to ensure compliance by health plans and their subcontractors.

By January 1, 2014, the Secretary must establish a review committee, which may be designated as NCVHS or another committee. The committee must:

- conduct hearings by April 1, 2014, and at least every two years subsequently, to evaluate and review the revised and adopted HIPAA standards and operating rules;
- provide recommendations for updating and improving the standards and operating rules after each set of hearings, beginning July 1, 2014;
- recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards; and
- ensure coordination, if appropriate, with standards for electronic health records issued by HHS under the Office of the National Coordinator for Health Information Technology.

The Secretary must adopt the committee's recommendations by issuing an interim final rule within 90 days of the committee's report with a 60-day public comment period. Any amendment made by this process would be effective 25 months after the comment period closes, giving plans ample time to adjust their systems and processes.

Beginning April 1, 2014, and then annually thereafter, the Secretary must assess a penalty fee against a health plan that fails to meet the certification and documentation of compliance requirements. The fee starts at $1[42] per covered life[43] until certification is complete. The penalty applies for each person covered by the plan for which the relevant data systems for major medical policies are not in compliance and is assessed each day the plan is noncompliant. HHS may also assign additional fees for misrepresentation if a plan knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance that is double the amount that would otherwise be imposed under this subsection. The provision also imposes annual limits on penalties – $20 per covered life or, if the plan knowingly provided inaccurate or incomplete information, $40 per covered life. HHS must establish a method of providing reasonable notice to plans and a dispute resolution procedure before a notice of penalties assessed is sent. The Secretary must also provide the Secretary of the Treasury with a report identifying those health plans that have been assessed any penalties by May 1, 2014, and annually thereafter. The Treasury will collect penalties and provide annual notice to plans not later than August 1 of each year (starting August 1, 2014) of the amount of penalties and due date for payment. Payment is due by November 1 of each year, and unpaid penalties may be charged interest and treated as a past-due, legally enforceable debt. The administrative costs of collecting assessed penalties shall be passed on to health plans on a pro-rata basis and added to the penalty fees being assessed.

[42] The penalty fee will be increased annually by the annual percentage increase in total national health care expenditures as determined by the Secretary.

[43] The number of covered lives under the health plan will be determined by the Secretary based on the most recent statements and filings that have been submitted by such plan to the Securities and Exchange Commission.

In addition to the regulations mentioned above, the provision specifies additional regulations the Secretary must adopt as follows:

- establishing unique health plan identifiers (based on input from NCVHS) – effective no later than October 1, 2012;
- electronic funds transfer – not later than January 1, 2012, with an effective date no later than January 1, 2014;
- health claims attachments – not later than January 1, 2014, with an effective date no later than January 1, 2016.

Finally, the provision amends Medicare payment requirements (42 U.S.C. § 1395y(a)) to only provide Medicare payments by electronic funds or electronic remittance not later than January 1, 2014.

Effective date: March 23, 2010.

General Reform, PPACA § 1201

The PPACA amends the Public Health Service Act (42 U.S.C. § 300gg et seq.) by inserting new sections on general reforms. These provisions become effective for plan years beginning on or after January 1, 2014, except for § 2704 which is effective for plan years beginning on or after September 23, 2010.

Fair Health Insurance Premiums, PHSA § 2701

Discriminatory insurance rates are restricted in this section. Insurance premium rates for individual and small group markets can only be varied by such factors as geography/rating area (subject to the Secretary's review), age (not to vary by a ratio of 3:1), tobacco use, and family structure. For the factor of age, the Secretary will consult with the National Association of Insurance Commissioners to determine permissible categories of age ranges (known as "bands").

The requirements of this section also apply in circumstances when states allow health insurance issuers to offer coverage for large group markets in the state exchange.

Guaranteed Availability of Coverage, PHSA § 2702

Health insurance issuers must accept every employer and individual in the state that applies for coverage for individual and group markets, subject to open or special enrollment periods. The Secretary will also promulgate regulations regarding enrollment periods.

Guaranteed Renewability of Coverage, PHSA § 2703

Health insurance issuers must guarantee that coverage is renewable. Previously, individuals who developed serious illnesses or those who used significant amounts of health resources were susceptible to cancelled or non-renewable health coverage because of their health status. Advocates should be aware of § 2703, particularly when representing this population.

Section 2703 becomes effective in 2010.

Prohibition of Pre-Existing Condition Exclusions or Other Discrimination Based on Health Status, PHSA § 2704

Previously, health insurance plans were permitted to exclude individuals from coverage due to their existing illnesses, those that were considered as being pre-existing, as well as due to other elements of health status at the time of application for insurance. Under § 2704, group health plans or issuers that offer group or individual health insurance coverage are prohibited from excluding individuals because of pre-existing conditions or discriminating against individuals who have a history of illness.

Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status , PHSA § 2705

Group health plans and insurers that offer group or individual coverage may not establish eligibility requirements based on the following factors:

- health status;
- medical condition (including both physical and mental illnesses);
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability (including conditions arising out of acts of domestic violence);
- disability; or
- any other health status-related factor determined appropriate by the Secretary.

Previously, for example, women have been denied health care coverage due to perceived pre-existing conditions such as being a domestic violence survivor, being pregnant or having had a cesarean section delivery. Other individuals were not able to obtain health care coverage because of chronic illnesses, such as cancer and HIV/AIDS. It is likely that some denials of coverage to individuals with these and other health-related factors may in actuality be a pretext for underlying and impermissible discrimination. This provision now prohibits this type of discrimination.

Second, § 2705 allows employers to reduce insurance premiums by up to 30 percent to encourage employees to participate in particular health and wellness programs for the purpose of health promotion and disease prevention. § 2705(j)(3)(A). In addition, the Secretaries of HHS and the Departments of Treasury and Labor are required to create a ten state demonstration program on health promotion by July 1, 2014 that will apply in individual markets in those states.

Third, this section requires the Secretaries of HHS, and the Departments of Labor and Treasury to submit a report to the appropriate Congressional committee that details:

- the effectiveness of wellness programs;
- the impact of these programs on access to care and affordability for participants and non-participants;
- the impact of incentives relating to premiums and cost-sharing on participants' behavior to improve their health; and
- the effectiveness of various types of rewards in changing health behavior.

This report shall be submitted no more than three years after the enactment date of PPACA. § 2705(m)(1).

Non-Discrimination in Health Care, PHSA § 2706

Group health plans and issuers who provide group or individual health insurance coverage are prohibited from discriminating against health providers who practice within the scope of that individual's license or certification under relevant state law. However, group health plans or issuers or the Secretary of HHS can determine different reimbursement rates based on quality performance measures.

Comprehensive Health Insurance Coverage, § 2707

Section 2707 requires health insurance issuers that provide coverage in the individual or small group market to ensure that the coverage includes a defined health benefit package, which is one that provides essential health benefits, limits cost-sharing, meets specific actuarial values, and is subject to specified levels of coverage, as defined under § 1302(a) of PPACA. Special rules apply for children-only plans and dental-only plans, which are also subject to § 1302.

Prohibition on Excessive Waiting Periods, PHSA § 2708

Under this section, group health plans and issuers offering group or individual health coverage are prohibited from requiring any waiting period more than 90 days, as defined by § 2704(b)(4) of PPACA.

Effective date: Plan years beginning on or after January 1, 2014 except for PHSA § 2704 which is effective September 23, 2010.

Preservation of Right To Maintain Existing Coverage, PPACA §§ 1251, 10103, Recon. § 2301

This provision permits individuals to keep their existing health insurance coverage in which they were enrolled as of the date of enactment of PPACA. Family members of individuals enrolled in health plans (as of the date of enactment of PPACA) will also be permitted to enroll in the individual's health plan, if the health plan allows the enrollment of family members. In addition, group health plans that were providing coverage as of the enactment of PPACA will

also be allowed to enroll new employees and their families in their plans. This section also defines grandfathered health plans as "any group health plan or health insurance coverage to which this section applies." § 1251. Although HHS is currently in the process of drafting guidance that further defines a "grandfathered plan," it is usually thought of as a plan in which an individual was enrolled and chooses to stay enrolled as of the enactment of the PPACA.

Advocates should be mindful that previous abusive practices by health insurers have included rescinding existing health coverage for individuals with expensive or long-term health care treatment, or for circumstances such as complicated maternity care and cancer treatment. The PPACA now prohibits these practices.

Section 10103 of the Managers' Amendment adds a new PHSA § 2718 that provides requirements for medical loss ratios and uniform coverage documents to grandfathered and other group and individual health plans, including reporting to the Secretary on:

- total premium revenue;
- activities to improve health care quality;
- reimbursement for clinical services provided to enrollees; and
- non-claim costs certified by the Secretary and defined by the National Association of Insurance Commissioners.

These reports will be available to the public on the HHS website. The Manager's Amendment clarifies that the grandfathering of plans is effective as of the date of enactment of PPACA. The section also explains that the prohibition against pre-existing conditions exclusions for children's plans is effective six months after enactment of PPACA. § 10103.

Also, § 10103 adds a new PHSA § 2709 "Coverage for Individuals Participating in Approved Clinical Trials." This section prevents health insurers from denying or limiting coverage for the regular care that an individual would normally receive if they were not participating in a clinical trial. It also prohibits insurers from discriminating against an individual on the basis of their participation in the clinical trial. The section is applicable to all clinical trials that treat cancer and other life-threatening conditions. § 10103. Communities and low-income individuals who experience health disparities, such as cancer and other illnesses, may choose to participate in clinical trials to access ordinarily unavailable treatment. These new protections are important to ensure they maintain access to comprehensive care.

The Reconciliation Act § 2301 further amends the provisions of PPACA for grandfathered plans by providing requirements for excessive waiting periods, lifetime limits, rescissions, and extension of young adult coverage to grandfathered plans. These requirements were detailed in §§ 2708, 2711, 2712, 2714 of the PPACA, respectively. Moreover, § 2301 adds additional protections against exclusions of pre-existing coverage to group health plans and adult child coverage to group plans if the adult child cannot enroll in an employer-based health plan. Recon. § 2301.

Effective date: March 23, 2010.

Rating Reforms Must Apply Uniformly to All Health Insurance Issuers and Group Health Plans, PPACA § 1252

Under § 1252, states must apply uniform standards and requirements to all health plans in their insurance markets in their state.

Annual Report on Self-Insured Plans, PPACA § 1253 (added by § 10103)

By March 23, 2011, and annually thereafter, the Secretary of Labor must prepare an aggregate annual report including information on self-insured group health plans. The report must include information on plan type, number of participants, benefits offered, funding arrangements and benefit arrangements. The data will be obtained from the Annual Return/Report of Employee Benefit Plan report. The report must be submitted to the appropriate committees of Congress.

Study of Large Group Market, PPACA §§ 1254, 10103

Section 10103 of the Managers' Amendment adds § 1254 to PPACA. Under this section, the Secretary of HHS is required to perform a study of the fully insured and self-insured group health plan markets to compare the features of both, and determine the impact that new market initiatives are likely to negatively impact selection in the large group market. The report is due not later than one year after enactment.

Effective date: March 23, 2010.

Qualified Health Plan, PPACA §§ 1301, 10104

Among other provisions, § 1301 defines a "qualified health plan" as a health plan that:

- is certified by certain criteria in order to recognized by the exchanges;
- provides essential health benefit packages (as detailed in §1302(a) of the PPACA);
- is offered by licensed insurers that provide at least one qualified health plan at silver and gold levels;
- agrees to charge the same premium rate for the issuers' qualified health plans regardless of whether the plan is offered in the exchange, from the issuer, or through an agent; and
- complies with relevant regulations as designated by the Secretary, as well as the exchange. § 1301(a)(1).

Section 1301 refers back to the Public Health Service Act (§§ 2791(a); 2791(b)) to define the terms "group health plans," "health insurance coverage" and "health insurance issuer."

Section 10104 of the Managers' Amendment eliminates the community health insurance option from the new law (which was a public plan for individuals without access to employer-based health insurance or for those whose employer-based plans did not meet the minimum qualifications for qualifying coverage). Instead, the section adds multi-state plans and CO-OPS as qualified health plans, and permits qualified health plans to offer coverage through a qualified

primary care medical home plan, pursuant to the Secretary's requirements. In addition, § 10104 establishes that payments by qualified health plans to federally qualified health centers (FQHCs) to be at least as high as payments to FQHCs under Medicaid.

Effective date: March 23, 2010.

Essential Health Benefits Requirements, PPACA § 1302

This section defines the characteristics of an "essential benefit package" for health plans as:

- providing for essential health benefits as defined by the Secretary;
- limiting cost-sharing for such coverage; and
- providing either the bronze, silver, gold or platinum level of coverage (as detailed further in this section).

Further, the Secretary of HHS must define the essential health benefits, with the proviso that these benefits must include at least the following items and services:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

The Secretary of HHS must also ensure that the scope of these essential health benefits are equal in scope to the benefits provided under a typical employer health plan. To accomplish this, the Secretary will rely upon the findings of a Department of Labor survey of employer-based health plans to determine those benefits that are usually covered by employers and multi-employer plans.

When the Secretary has defined the essential health benefits, the Secretary must submit a report to the appropriate Congressional committees, along with a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) that the benefits conform to this section's provisions.

Advocates should be aware that the Secretary's definition of essential health benefits is subject to public notice and comment (although there is no requirement for a formal regulatory process), which provides an opportunity for input into ensuring that services that are particularly essential to the health of low-income communities and populations experiencing health disparities are included in the benefit package. For example, advocates should carefully

determine if preventive health screenings and relevant treatment for diabetes, hypertension, STIs, HIV/AIDS, and cancer are included, as well as contraceptive services and prenatal care (including high-risk care).

In addition, when defining essential health benefits, the Secretary must:

- ensure that the essential health benefits are not unduly weighted toward any category of services;
- ensure that individuals are not discriminated against because of their age, disability, or expected length of life, when coverage decisions and other related factors are determined;
- include the health needs of diverse populations, including women, children, people with disabilities, and others;
- ensure individuals still have access to essential health benefits, regardless of the individuals' age or anticipated life span, disability, quality of life or medical dependency;
- provide that qualified health plans include emergency department services (without prior authorization or limitations on coverage), regardless of whether the emergency services provider has a contractual relationship with the plan, and cost-sharing requirements are equivalent for out-of-network and in-network emergency services;
- provide that if a plan with stand-alone dental benefits is offered through the exchange, then other plans in the exchange without the same benefits will still be considered as a qualified health plans; and
- periodically review essential benefits and provide a publicly available report to Congress that includes: if enrollees are experiencing barriers to needed services; an assessment of whether services should be modified or updated; an assessment of expansion of benefits and reductions of existing benefits and its impact on costs; and gaps in access and services.

Health plans also have the option of providing benefits that are more expansive than those in the essential health benefits that are described in § 1302.

Requirements Relating to Cost-Sharing

Section 1302 defines cost-sharing as:

> deductibles, coinsurance, co-payments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense . . . with respect to essential health benefits covered under the plan.

The annual limit on cost-sharing (the sum of co-payments, the annual deductible and co-payments) under a health plan that provides essential health benefits in § 2014 cannot be more than the limits that apply to high-deductible plans based on the Internal Revenue Service Code § 223(c) (2)(A)(ii) (which are currently $5,950 for individual coverage and $11,900 for family coverage). Section 1302 also requires separate limits on annual deductibles for essential health benefit plans.

The PPACA imposes an annual limit on deductibles for employer-based plans in the small group market, which is $2,000 for single individuals and $4,000 for any other plan. Actuarial values of any health plan should not be impacted by these limitations.

Deductibles should not be applied to prevention benefits that are included in the Public Health Service Act, § 2713. § 1302(c)(2)(A).

Health Plan Coverage Levels

The Secretary may issue regulations that the essential health benefits provided in the following exchange plans are applicable to a "standard" population, not necessarily the population in any specific plan. Four categories of health plans will be offered in the exchange and a catastrophic plan will be available in the individual market:

- Bronze Plan - provides a minimum level of creditable coverage and provides essential health benefits (as previously defined); covers 60 percent of the actuarial equivalent of the benefit costs;
- Silver Plan – provides essential health benefits; covers 70 percent of the benefit costs;
- Gold Plan – provides essential health benefits; covers 80 percent of the benefit costs;
- Platinum Plan – provides essential health benefits; covers 90 percent of the benefit costs;
- Catastrophic Plan – provides catastrophic coverage only in the individual market for those up to age 30 who are not required to purchase coverage, or those individuals who can provide a certification (pursuant to IRC § 5000A(e)(1) or (5)) that they are without affordable coverage or are experiencing hardship; coverage levels are established by current health savings account amounts; coverage for three primary care visits and prevention benefits are not subject to deductible.

The Secretary may also issue regulations regarding employer contributions to health savings accounts to determine the level of employer's health plans' level of coverage, as well as guidelines that determine the minimal level of variation for actuarial variations. § 1302(d)(2)(B).

Child-Only Plans

If a qualified health plan in the exchange offers a Bronze, Silver, Gold, or Platinum level of coverage, then the issuer must offer the same qualified health plan in the exchange for enrollees who have not reached the age of 21 (at the beginning of the plan year).

Special Rules, PPACA, §§ 1303, 10104

Coverage of Abortion Services

The Hyde Amendment, a rider attached annually to a federal appropriations bill, has restricted federal funding for abortions except in limited circumstances (in cases of rape, incest, or threat to the life of the woman) for women enrolled in Medicaid. There are also other restrictions on abortion coverage for others whose health plans include federal funding, such as Peace Corps volunteers, federal government employees, and individuals who receive health care

through the Indian Health Service Act or the military. The PPACA extends certain funding restrictions to the private health insurance market.

Under the PPACA, more affluent women and those not dependent on federal resources for their health care will be facing barriers to coverage for abortion services as well as women dependent on federal subsidies for their health insurance. Specifically, § 1303 as amended by § 10104, affirms that states can enact laws to prohibit abortion coverage in qualified health plans in the exchanges. Moreover, qualified health plans in the exchanges can determine whether they will cover abortion services. .All individuals – not only women at risk for pregnancy, who are enrolled in plans that cover abortion and who are eligible for a federal subsidy – must pay their health care premiums in two separate checks or transactions. The insurer must hold these payments in separate and identified accounts, and pay for certain abortion services out of these accounts. State insurance commissioners must ensure that federal funds are segregated from funds designated for abortion coverage using general accounting principles and guidance from the Office of Management and Budget and the General Accounting Office.

While new restrictions on abortion coverage through the Exchanges have been enacted in health reform, Medicaid funding for abortions was not changed by health reform. The Hyde Amendment has been enacted in every Appropriationts Act since 1976, and currently limits Medicaid abortion coverage to cases of rape, incest, or threat to the life of the woman. This section recognizes that the Hyde Amendment has not been codified beyond the Appropriations riders and could change by the time this section becomes effective.

Conscience Clause Provisions and Existing Federal Laws

Section 1303 indicates that nothing in the section will have an impact on existing federal laws on abortion concerning conscience protections, willingness to provide abortion, and discrimination on the basis of the willingness or refusal to provide, pay for, or refer for these services. These federal conscience protections include the Church Amendment (42 U.S.C. 300a-7), which protects facilities that object to providing abortions or sterilizations, individuals who object to participating in a health care or research service, as well as protecting those who provide sterilizations or abortions. In addition, the Weldon Amendment (§ 508 (d)(1) of P.L. 111-8) prohibits discrimination against health care facilities and providers who are not willing to provide, pay for, provide coverage of, or refer for abortions.

Instead, advocates should be aware that § 1303 may present further questions as to how well providers who wish to provide the appropriate standard of reproductive health care by including abortion information, services, or referrals in the spectrum of health care services for women will actually be able to do so, particularly if confronted with institutional barriers. Section 1303 of PPACA indicates that federal and state laws regarding abortion are not pre-empted. Instead, the law presents further barriers for women to obtain legal abortions and is silent about how women should continue to exercise their rights to obtain this particular reproductive health service as indicated in *Roe v. Wade*.

Additionally, the section also maintains that its provisions should have no effect on the rights and obligations of employees and employers under Title VII of the Civil Rights Act of

1964 and the provision does not change Title VII in anyway. Under Title VII, an employer that wants to provide training, referrals or actual abortion services can ask about a potential employee's willingness to participate in such activities. Title VII requires that if an employee has an objection to performing any particular job functions, then the employer must offer an accommodation for the employee. Nonetheless, the employer does not have to offer an accommodation that would present an undue hardship to the business.

Executive Order 13535

On March 24, 2010, President Obama signed Executive Order 13535, "Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act." 75 Fed. Reg. 15599 (March 24, 2010). The executive order was part of an agreement to secure sufficient votes for passage of the PPACA in the Senate. Specifically, the executive order directed the Director of the Office of Management and Budget and the Secretary of HHS to develop by September 2010 a model set of segregation guidelines for state health insurance commissioners to use when determining if exchange plans are complying with the § 1303 (of PPACA) requirement to separate funds for enrollees who receive federal subsidy assistance. 75 Fed. Reg. 15599. Subsequently, the Secretary will issue regulations that will have the force of law to provide guidance to state health insurance commissioners on how to adhere to the model guidelines. 75 Fed Reg. 15600.

Moreover, the executive order noted that the PPACA created a new Community Health Center (CHC) Fund within HHS to assist in funding the community health center program. CHCs, pursuant to an existing federal regulation, have also prohibited from using federal funds for covering abortion services, except in limited circumstances. The executive order required the Secretary of HHS to ensure that program administrators and recipients of federal funds are aware of and comply with restrictions on abortion services for CHCs. 75 Fed. Reg. 15600.

Overall Impact of PPACA's Abortion Restrictions

The Hyde Amendment will impact more low-income women in 2014, due to the law's Medicaid expansions, which will be mandatory for states at that time. However, those women living in one of the few states that use state-only funds to provide abortion coverage under Medicaid will still have access to publicly funded abortion services. In addition, states have the option of passing laws to prohibit abortion coverage for private health plans in their exchanges, which will present new challenges for advocates to overcome. Accordingly, more affluent women will find themselves confronted with fewer health plans that may offer abortion coverage, and other women in the exchange will be faced with the barrier of paying for health care and abortion coverage with two separate payments.

Related Definitions, PPACA §§ 1304, 10104

Section 1304, as amended by § 10104, provides several definitions of certain terms and additional clarifications. Among these are:

- "small group market" – the market in which a plan is offered by small employer that employs 1 – 100 individuals. Before 2016, a state can limit the small group market to 50 people.
- "large group market" – the market in which a plan is offered by a large employer that employs more than 100 employees.
- exchanges are required to consult with "educated health care consumers," as defined by § 10104.

State advocates should examine if benefit packages of health plans in their respective exchanges vary due to whether the plans are offered in small or large group markets. Also, advocates should determine if health plans in their state exchanges are actually implementing activities to identify and reduce health disparities, and if not, this information should be conveyed to HHS.

Consumer Choices and Insurance Competition through Health Benefit Exchanges, PPACA §§ 1311-1313, 10104, 10203

Sections 1311 through 1313 address consumer choices and insurance competition through the state exchanges. We do not provide an in-depth analysis but a short overview of these sections below.

Section 1311

The first section, **§** 1311, provides grants to states to:

- set up American Health Benefit exchanges (exchanges) to facilitate the purchase of qualified health plans;
- provide for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP exchange'') that is designed to assist qualified employers in the state who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the state; and
- meet certain requirements as specified in the provision.

The Secretary may award the grants to the states beginning no later than March 23, 2011, and ending by January 1, 2015, and provide technical assistance to states to facilitate the participation of small businesses in the SHOP exchange. A state may combine the exchange and SHOP exchange through one entity, which can be a governmental agency or non-profit entity established by the state, but must be set up by January 1, 2014. The funding is to establish the exchange, but not for ongoing administrative costs, and beginning on January 1, 2015, the exchange must be self-sustaining. It can establish an assessment on user fees or assessments or generate funding in other ways. An exchange may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

The Secretary has the following responsibilities:

- to establish criteria for the certification of "qualified health plans" (by laying out a minimum list of nine criteria that plans must meet);
- to develop a rating system to rate the plans offered through the exchange on the basis of the relative quality and price;
- to develop an enrollee satisfaction survey,
- to maintain and to update its internet portal to provide information about the exchange; and
- to require the exchanges to provide for certain open enrollment periods.

This section also sets out specific rules and functions of the exchange, and includes strategies through a payment structure that provides increased reimbursement or other incentives to reward quality through market-based incentives for:

- improved health outcomes;
- the implementation of activities to prevent hospital readmissions;
- the implementation of activities to improve patient safety and reduce medical errors;
- the implementation of wellness and health promotion activities; and
- the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach and cultural competency trainings.

The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines for the strategies identified above. And plans must periodically report their activities to implement these strategies to the exchange. It seems the intent is for the public reporting to incentivize plans to possibly offer higher reimbursement or other incentives to participating providers. There is no funding attached or explicit requirement to undertake these strategies, only to report what has been done.

States will be responsible for certifying a health plan as a "qualified health plan" if the health plan meets the requirements for certification as promulgated by the Secretary, and the exchange determines that making the plan available through the exchange is in the interests of qualified individuals and qualified employers in the state or states in which such exchange operates (except that the exchange may not exclude a health plan on the basis that such plan is a fee-for-service plan, through the imposition of premium price controls, or on the basis that the plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly). Health plans seeking certification must submit a justification for any premium increase prior to implementation of the increase. The plans must prominently post such information on their websites. The exchange may take this information, and the information and the recommendations provided to the exchange by the state under PHSA § 2794(b)(1),[44] into consideration when determining whether to make the health plans available through the exchange. The exchange shall take into account any excess of premium growth outside the exchange as compared to the rate of such growth inside the exchange, including information reported by the states. Further, requirements for mental health parity apply to

[44] *See infra.*

qualified health plans to the same extent as it applies to health insurance issuers and group health plans.

Further, the exchange requires health plans seeking certification as qualified health plans to submit to the exchange, the Secretary, the state insurance commissioner, and make available to the public, accurate and timely disclosure of:

- claims payment policies and practices; periodic financial disclosures;
- data on enrollment and dis-enrollment;
- data on the number of claims that are denied;
- data on rating practices;
- information on cost-sharing and payments with respect to any out-of-network coverage;
- information on enrollee and participant rights under this Title; and
- any information as determined appropriate by the Secretary.

Most importantly, the information must be provided in "plain language" defined to mean "language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing. The Secretary and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing. Further, plans must permit individuals to learn the amount of cost-sharing (including deductibles, co-payments, and co-insurance) under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through a website and such other means for individuals without access to the Internet. Finally, the Secretary of Labor must update and harmonize its 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 for transparency established by the HHS Secretary.

This provision also addresses the establishment of navigators. The purpose of the navigators is to provide fair, accurate and impartial information, and the list of duties are provided in this section. The Secretary must establish standards for navigators, who may not be a health insurance issuer, or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan.

Section 1312

Section 1312 addresses consumer choice. A qualified individual[45] may enroll in any qualified health plan available to such individual and pay any applicable premium. A qualified

[45] A "qualified individual," with respect to the exchange, is an individual who is seeking to enroll in a qualified health plan in the individual market offered through the exchange and resides in the state that established the exchange (except with respect to territorial agreements.

employer[46] may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under § 1302(d) to be made available to employees through an exchange. An employee of a qualified employer can enroll in any plan that meets the level of coverage provided by the employer.

Health insurance issuers must consider all enrollees in all of its health plans in the individual market (other than grandfathered plans) as one single risk pool and all enrollees in the small group market as a separate single risk pool. A state may require an issuer to merge its individual and small group market risk pools if appropriate.

Any state requirements for health insurance policies or plans offered outside of an exchange would still apply. Participation in an exchange is voluntary, and nothing in this title of the law can compel an individual to enroll in a qualified health plan or participate in the exchange. Further, individuals may enroll in any qualified health plan except for catastrophic health plans, which have separate eligibility requirements.[47] The exchange cannot impose any penalty or other fee for an individual who cancels enrollment in a plan because the individual wants to transfer coverage for a plan providing minimum essential coverage outside the exchange. The Secretary must establish procedures for states to allow agents of brokers to enroll individuals in any qualified health plan and to assist individuals in applying for premium tax credits and cost-sharing reductions for plans.

After the effective date of this subtitle, members of Congress and their staff (full and part-time staff both in and out of Washington D.C.) may only be offered health plans that are created under PPACA or offered through an exchange.

This provision does impose a limitation on access to the exchange to qualified individuals. A qualified individual does not include:

- incarcerated individuals (except for incarcerated individuals pending disposition of charges); and
- someone who is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

Section 1313

Section 1313 addresses financial integrity, and requires an exchange to keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary a report concerning its accountings. The HHS Secretary, coordinating with the Office of the

[46] A "qualified employer" is a small employer who elects to make all its full-time employees eligible for one or more qualified health plans offered in the small group market through an exchange that offers qualified health plans. If a state allows issuers to offer qualified health plans in the large group market through an exchange, qualified employer also includes a large employer who elects to make all its full-time employees eligible for one or more qualified health plans offered in the large group market through an exchange that offers qualified health plans.

[47] *See infra* **§** 1302(e)(2).

Inspector general, may investigate an exchange, examine the properties and records of an exchange, and require periodic reports in relation to activities undertaken by an exchange. An exchange shall fully cooperate in any investigation conducted under this paragraph. The Secretary must also conduct annual audits of the exchanges. There are specific requirements to identify patterns of abuse, impose protections against fraud and abuse, and levy damages. Any federal payments made to an exchange are also subject to the False Claims Act. The Comptroller General of the Government Accountability Office is charged with conducting an ongoing study of exchange activities and enrollee in the plans, starting no later than five years after the exchanges become operational.

State Flexibility to Establish Basic Health Programs for Individuals Not Eligible for Medicaid, PPACA §§ 1331, 10104

Overview

States may establish basic health programs to offer coverage to people who are not eligible for Medicaid and have household incomes of 134 to 200 percent of FPL. States choosing to exercise this option may offer one or more standard health plans instead of offering coverage through the exchange. Such plans must provide at least the essential health benefits provided in qualified health plans offered through the exchange. § 1331(a)(1), (e).

Certification – Premiums and Cost-sharing

For a state to offer a Basic Health Program, the Secretary must certify that the monthly premium required is no more than that of the corresponding "silver plan"[48] (as defined by IRC § 36B(b)(3)(B) (established at PPACA § 1401)) that the individual would have been required to pay if enrolled in a qualified health plan offered under the exchange. This premium amount is determined after reduction for any premium tax credits and reduction for cost-sharing for which the individual is also eligible.

Any required cost-sharing may not exceed the amount required in a "platinum plan"[49] for individuals under 150 percent of FPL or the "gold plan"[50] for all others. § 1331(a)(2). Cost-sharing includes deductibles, co-insurance, co-payments, or similar charges but does not include premiums, balance billing for non-network providers, or spending for non-covered services. *See supra* § 1302(c)(3). The Secretary must also certify that the plans provide at least the essential health benefits offered in § 1302(b). § 1331(a)(2)(B).[51]

[48] While the PPACA does not designate limits on premiums for the tiered plans (platinum, gold, silver, bronze), a silver plan will cover 70 percent of health care costs and the individual will be responsible for the remaining 30 percent.

[49] Platinum plans will cover 90 percent of health care costs and individuals will be responsible for the remaining 10 percent.

[50] Gold plans cover 80 percent of health care costs and individuals will be responsible for the remaining 20 percent.

[51] These essential benefits are: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health services; prescription drugs; rehabilitation and habilitation services; laboratory services; preventive

Standard health plans

A "standard health plan" is what the plans offered through Basic Health are called. A standard health plan must provide at least for the essential health benefits provided through qualified health plans offered through the exchange and have a medical loss ratio of at least 85 percent. § 1331(b). The term "medical loss ratio" is not defined, but generally, it is the amount that a health plan collects in premiums that is expended on medical services, as opposed to profits, administration, marketing or other costs. The state must establish a competitive process for entering into contracts to offer these plans that includes negotiating benefit packages, premiums and cost-sharing. As part of its competitive process, states must consider a number of items including:

- innovation features such as care coordination, incentives for use of preventive services, and the establishment of relationships that maximize patient involvement in decision making;
- allowances for different health care needs and access to providers;
- contracting with managed care systems or systems that offer as many features of managed care as possible, and establishing specific performance measures focusing on quality of care and improved outcomes, requiring reporting to states with respect to these measures; and
- making information available in a useful form. § 1331(c)(1), (2); *see also* § 1302(b), *supra.*

Participating states must, to the greatest extent possible, make multiple standard health plans available to ensure choice. States may negotiate regional compacts with other states to include coverage of eligible individuals in all participating states. § 1331(c)(3). States must also seek to coordinate administration of this program with other state programs including Medicaid, the Children's Health Insurance Program, and any other state-administered health programs to maximize efficiency and improve continuity of care. § 1331(c)(4).

Transfer of Funds to States

If the Secretary determines that a state meets the requirements set forth above, HHS will transfer certain funds to that state for each year in which standard health plans are operating. States must establish a trust for the funds, and use them only to provide additional benefits or reduce the amount of premiums and cost-sharing for beneficiaries enrolled in the standard health plans. Trust fund expenditures, however, will not be counted as non-federal fund expenditures for the purpose of determining whether a state has met federal match requirement for any federally funded program (e.g. Medicaid or CHIP). § 1331(d)(1), (2).

The state will receive funds equal to 95 percent of the premium tax credits and cost-sharing reductions that would have been provided if the individuals enrolled in the Standard

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and wellness services and chronic disease management; and pediatric services, including oral and vision care. § 1331(b)(2), *see also* § 1302(b), *supra.*

Health Plans were enrolled in qualified health plans offered through the exchange. The Secretary must determine the amount to transfer on a per enrollee basis, taking into account all relevant factors necessary to determine the value of such premium tax credits and cost-sharing reductions that would have been provided, including the age and income of the enrollee, whether the enrollment is for self or family, variance in health care spending based on geographic differences in average spending for health care, and the health status of the individual. It should be based on the experience of other states, with a particular focus on enrollees with income below 200 percent of FPL. The Chief Actuary of CMS, in consultation with the Treasury Secretary, will certify whether the methodology used meets the necessary requirements, based on data from the state in question and comparable states. The restrictions on coverage of abortion services apply to Standard Health Plans to the same extent they apply to qualified health plans offered through the exchange. § 1331(d) as amended by § 10104(a), *see also* 1302, *supra*, describing abortion restrictions.

Eligible Individuals

To be eligible to enroll in standard health plans, individuals must be:

- state residents who are not eligible for Medicaid coverage that includes the minimum benefits provided qualified health plans offered through the exchange;
- under age 65;
- with a household income is greater than 133 percent but not greater than 200 percent of FPL or is an alien lawfully present with an income no greater than 133 percent of FPL but who is not eligible for Medicaid because of the individual's alien status; and
- is not eligible for "minimum essential coverage" as defined by IRC § 5000A(f) or is eligible for an employer-sponsored plan that is not "affordable coverage" as determined by IRC § 5000A(e)(2).

In addition, eligible individuals may be treated as qualified individuals eligible to participate in plans offered through the exchange. § 1331(e), as amended by § 10101(o). For a discussion of "minimum essential coverage" and "affordable coverage," *see* § 1501(b), *infra*.

Other Provisions

Each year, the Secretary must conduct a review of the program to ensure compliance with all requirements, including those related to eligibility verification, the use of federal funds, and quality and performance standards. § 1331(f). States may also allow HMOs, licensed health insurance insurers, or a network of health care providers to offer services under this program. § 1331(g).

Effective date: March 23, 2010.

Waiver for State Innovation, PPACA § 1332

Beginning January 1, 2017, states may apply for waivers from certain requirements related to health insurance coverage, including coverage offered through the exchange. Applications must include:

- a comprehensive description of the state legislation and program to implement the waiver;
- a 10-year budget plan that is budget neutral for the federal government; and
- an assurance that the state has enacted the implementing legislation.

These waivers may last up to five years.

The provisions that may be waived are those set forth in PPACA Parts I & II of Subtitle D and § 1402 and IRC §§ 36B, 4980H, and 5000A. § 1332(a). These provisions are discussed in greater detail elsewhere in this analysis. In brief, they govern the following:

- qualified health plans offered through the exchange (Part I of Subtitle D (§§ 1301-1304) ;
- consumer choice of health benefit plans offered through the exchange (Part II of Subtitle D (§§ 1311-1313));
- cost-sharing reduction requirements for individuals enrolling in qualified health plans offered through the exchange (§ 1402);
- the premium assistance tax credit (IRC § 36B (added by PPACA § 1401));
- responsibilities of employers regarding health coverage (IRC § 4980H (added by PPACA § 1513)); and
- the requirement to maintain minimal essential coverage (IRC § 5000A (added by PPACA § 1501(b)).

The HHS Secretary must carry out the responsibilities related to waivers of Parts I and II of Subtitle D, and section 1402 of the PPACA, while the Secretary of the Treasury is responsible for waivers of IRC § 36B, 4980H, and 5000A. § 1332(a)(6).

Waiver applications must be considered in accordance with regulations, which both Secretaries must promulgate within 180 days of the enactment of PPACA (September 2010). The regulations must provide a process for:

- providing public notice and comment, including public hearings, that ensure a meaningful level of public input;
- submitting a waiver that ensures disclosure of legal provisions that a state seeks to waive and specific plans to ensure compliance with all waiver program requirements;
- notice and comment after the application is received by the Secretary that ensures a meaningful level of public input, but that does not add to or duplicate existing requirements under the Administrative Procedures Act or that are unreasonable or unnecessarily burdensome to the states;
- the state's submission of reports to the Secretary concerning the implementation period; and
- periodic evaluation by the Secretary.

The Secretaries of HHS and Treasury must also report annually to Congress about actions taken with respect to the waivers under their jurisdiction. § 1332(a).

Waiver requirements

In order for a waiver request to be granted, the Secretary must determine that the state waiver plan will:

- provide coverage at least as comprehensive as that provided by qualified health plans offered through an exchange, as certified by CMS's Office of the Actuary;
- provide coverage and cost-sharing protection at least as affordable as other types of coverage provided by the PPACA; and
- not increase the federal deficit. § 1332(b).

States must enact a law that provides for state actions under the waiver, including implementation of a state plan. If a state chooses to terminate the waiver, it may repeal the law. *Id.*

If, as a result of the waiver, individuals and small employers would not qualify for premium tax credits, cost-sharing reductions, or small business credits for which they would otherwise be eligible, the Treasury Secretary shall provide for an alternative means for them to be paid to the state for the purpose of implementing the waiver plan. The alternative amount must be determined annually by the Secretary, taking into consideration the experiences of states participating in an exchange. § 1332(a)(3), *see also* §§ 1401-02 (describing premium tax credits and cost-sharing).

The HHS Secretary will determine the scope of any waiver and may not waive any federal law or requirement not in his or her authority. § 1332(c). Determinations on applications must be made no later than 180 days after receipt. If the waiver application is not granted, the Secretary must inform the appropriate Congressional committees of the denial and the reasons therefore. § 1332(d). No waivers may extend for longer than five years unless the state requests continuation. Unless the Secretary denies the application or requests more information in writing, the request will be deemed granted within 90 days. § 1332(e).

The process for obtaining these waivers allows for significant transparency. The requirement that states enact a law authorizing the waiver will help ensure that advocates are aware of the provisions of the waiver. Similarly, notice and an opportunity for public input both during the application stage and after the application is submitted should provide advocates with a meaningful opportunity for participation.

Because the notice and comment processes, as well as other aspects of the waiver process will be fleshed out in regulations, advocates should watch closely for an announcement of proposed rules in the Federal Register and take advantage of the opportunity to comment.

Transitional Reinsurance Program for Individual Market in Each State, PPACA §§ 1341, 10104

When the federal high-risk pool described in § 1101 terminates January 1, 2014, high-risk individuals in that pool will be transitioned to health coverage through the state insurance exchanges. The influx of high-risk individuals into the individual market could have a potentially destabilizing effect on premiums and create risks of adverse selection. § 1341(c)(1)(A). When insurance issuers provide policies to individuals or groups who pose a substantial risk of high medical costs, the issuers often purchase "re-insurance" to cover the projected additional costs of coverage over those costs generally estimated for an average risk population. Without the re-insurance's protection against the potentially higher costs, insurance companies may seek ways to avoid insuring high-risk individuals or may raise premiums to all insureds to provide a financial cushion. To minimize the potential negative effects on these insurance markets, the PPACA requires that states require health insurers and third-party administrators acting on behalf of group health plans to make payments to a state-designated and/or state-created re-insurance entity, which will then distribute the funds to cover additional health care costs of high-risk individuals. § 1341(a)(1), (b)(1)(A).

Each state or a group of states must have an "applicable re-insurance entity" – or more than one entity – which is a nonprofit, tax-exempt organization, which would receive premiums from insurers and administrators of group health plans to provide re-insurance for high-risk individuals covered in the individual market. § 1341(b)(1); (c). The re-insurance requirement will be in effect for the first three years of the exchanges. § 1341(b)(1)(A); (b)(3)(A); (c)(1)(A).

High-risk individuals will be identified either by:

- diagnostic and procedure codes that indicate a pre-existing, high-risk condition or illness on a list that the Secretary develops of 50-100 such high-risk conditions; or
- a comparable method recommended by the American Academy of Actuaries. § 1341 (b)(2)(A).

These provisions are likely to result in the termination of existing state high-risk pools. States must eliminate or modify their high-risk pools as necessary to carry out the re-insurance program. However, states may coordinate their high-risk pools with the re-insurance program to the extent that they are not inconsistent with the requirements of the re-insurance program. § 1341(d).

The re-insurance program takes effect January 1, 2014, although, as this section sets forth, the state and federal governments will need to take many steps, including identifying an applicable re-insurance entity, long before that date. § 1341(a).

Premium Tax Credits for the Health Insurance Exchange, PPACA §§ 1401, 10105, Recon. Act §§ 1001, 1004

This provision adds new section 36B of the Internal Revenue Code of 1986 (IRC) to create a new premium assistance tax credit for each eligible taxpayer for each taxable year. This tax credit is the mechanism by which individuals and families enrolled in private health

insurance in the newly created exchanges will be able to obtain financial assistance for payment of the monthly premium.

The amount of the premium assistance tax credit is calculated for an eligible individual's household for the whole year, combining each coverage month that the household members are eligible. The tax credit amount is determined according to income level between 0 to 400 percent[52] FPL. The tax credit pays for a significant portion of the monthly premium, and the eligible individual is responsible for contributing the remainder of the premium, based on a percentage of his/her income. The household's contribution is determined on a sliding scale from 2 percent of household income for persons under 133 percent FPL[53] to 9.5 percent of household income for persons between 300[54] and 400 percent FPL. The final and initial premium percentages (see below) create an upper and lower bound of a sliding scale for premiums. For example, for individuals with income between 133 and 150 percent, an individual at the lower end of this range will have a premium closer to the "initial" premium percentage while someone at the higher income (closer to 150 percent) will have a premium percentage closer to the "final" premium percentage. PPACA § 1401, Recon. Act. § 1001.

Household FPL Percentage	Initial Premium Percentage	Final Premium Percentage
Up to 133	2.0	2.0
133 up to 150	3.0	4.0
150 up to 200	4.0	6.3
200 up to 250	6.3	8.05
250 up to 300	8.05	9.5
300 up to 400	9.5	9.5

For example, an individual with two children who has an annual household income of $24,400 (which is just over 133 percent FPL for a family size of three) is purchasing a policy of a total annual cost of $11,500. She will receive a premium assistance tax credit of $10,768, and she will be responsible for paying $732 for the year (3 percent of her income). The individual contribution would be calculated $24,400 x.03 = $732. The credit amount would be calculated by $11,500 – 732 = $10,768.

After 2014, an individual's contribution to the monthly premium, as reflected in the percentages of income in the chart above, must be adjusted when premium rates grow more than income in a preceding calendar year. In 2019, this adjustment is linked to the Consumer Price Index (CPI), if the amount of premium tax credits and cost-sharing reductions exceed .504 percent of the gross domestic product for the preceding calendar year.

[52] 400 percent FPL is $73,240 of annual income for a family size of three using 2009 Federal Poverty Level (FPL) levels (which were in effect at the time of publication). All dollar amounts are based on annual 2009 FPL for a family size of three.
[53] 133 percent FPL is $24,352 for a family size of three.
[54] 300 percent FPL is $54,930 for a family size of three.

The amount of the premium assistance credit is calculated based on the lesser of: a premium for a plan in which the individual is already enrolled, or the adjusted monthly premium of the second lowest silver plan in the individual market in the area the individual lives, modified by an individual's household income. The monthly premium of a second lowest cost silver plan is used to determine the tax credit and the individual contribution calculations. The silver plan is defined at §§ 1302(d), 1401(a). IRC § 36B(b)(2), PPACA § 1401(a).

Plans with Different Benefits than Exchange Essential Benefits, IRC § 36B(b)(3)

If an individual is enrolled in a qualified health plan that offers benefits in addition to those required as essential benefits under § 1302(b)(5) (either voluntarily or because of a state law requirement), the premium assistance credit may not be based on the portion of the plan's premium that would be allocated to those additional benefits.

In contrast, if an individual is enrolled in two plans, one to provide the essential benefits of qualified health benefit plan in the exchange (§ 1302) and a separate plan to provide pediatric oral health benefits through a stand-alone dental plan, the premium credit may be calculated to include payment for the portion of pediatric oral health benefit in the stand-alone dental plan. However, cost-sharing reductions are not extended to individuals who have stand-alone dental coverage plans.[55]

Eligibility for the Credit and Other Qualifying Rules, Establishing New § 36B(c) of the Internal Revenue Code of 1986, PPACA §§ 1401(a), 10105, Recon. Act § 1001(a)(2)

A taxpayer eligible to receive the premium assistance tax credit is defined as:

- one who has household income that is equal to or above 100 percent FPL and below 400 percent FPL for a family size involved; or
- a lawfully present immigrant who has household income under 100 percent FPL for the family size involved and is ineligible for Medicaid based on immigration status.

Married couples must file a joint return to be eligible for a tax credit in the same calendar year for which they are applying for the credit. The statute uses the definition of "married" at IRC§ 7703. An individual cannot get a premium tax credit for a dependent if a deduction is being taken for that dependent by another taxpayer for the same calendar year. For example, if parents are divorced, a father who does not live with his child cannot get a tax credit that includes a deduction for his child if the mother who lives with the child is already taking deduction for the same child. Dependent is defined as a qualifying child or relative. *See* 26 U.S.C. § 152 for more detail.

An eligible taxpayer can receive a premium assistance tax credit for a coverage month in which he is enrolled, covered by a qualified health plan in an exchange established under § 1311, and paying the monthly premium for such coverage. However, a taxpayer cannot receive a

[55] For more details, *see* § 1402.

premium assistance tax credit for any month in which the taxpayer is eligible for "minimum essential coverage,"[56] which includes:

- government programs including: Medicare Part A, Medicaid, Children's Health Insurance Program, TRICARE for Life Program, Veteran's health care program and health care for peace corps volunteers;
- most employer-sponsored health insurance plans;
- "grandfathered" plans (as defined in § 1251); or
- other coverage the Secretary of the Treasury, in coordination with the HHS Secretary, can recognize, such as a state high-risk pool. IRC § 36B(c)(2)(B), PPACA § 1401(a).

Employer-sponsored health insurance plans are *not* considered minimum essential coverage if: 1) the employee contribution exceeds more than 9.5 percent of the taxpayer's household income, or 2) the plan pays less than 60 percent of the value of the plan. Also, if the taxpayer, spouse, and/or dependent are covered by an employer-sponsored plan or a grandfathered plan, he/she is not eligible for the premium assistance tax credit. An individual who has coverage that does *not* meet the standards of minimum essential coverage may eligible for a premium assistance tax credit for a qualified plan in the exchange, subject to other eligibility criteria. IRC § 36B(c)(2)(C), PPACA § 1401(a).

Treatment of Family Size and Income, IRC § 36B(d), PPACA §§ 1401(a), 10105, Recon. Act § 1004

Family size is determined by the number of individuals for whom a taxpayer can claim a deduction for a taxable year under IRC § 151.

Household income is determined by using "Modified Adjusted Gross Income" (MAGI) of the taxpayer's household income. Adjusted gross income is defined as gross income minus a number of deductions.[57]

MAGI is defined differently in various programs. In the PPACA and Recon. Act, MAGI is defined as adjusted gross income increased by:

- foreign income earned outside the United States excluded from gross income by IRC § 911;

[56] Minimum Essential Coverage is defined at § 5000A(f) of the Internal Revenue Code of 1986, PPACA§ 1501(b). *See* § 1501 for more detail.

[57] Deductions that are allowed under adjusted gross income include: trade and business deductions of the taxpayer, losses from the sale or exchange of property, alimony, retirement savings, moving expenses, interest on educational loans, higher education expenses, and health savings accounts. For a full list of adjusted gross income deductions, *see* 26 U.S.C. § 62. In addition to income that can be deducted, some income is excludable from gross income. For example, some Social Security income is excluded depending on the total amount of income and filing status of the taxpayer. *See* IRS Publication 54, Tax Guide for U.S. Citizens and Resident Aliens Abroad (2009); IRS Publication 17, Your Federal Income Tax for Individuals (Nov. 2009).

- housing costs when individuals live outside the United States also excluded from gross income by IRC § 911; and/or
- any amount of interest received or accrued by a tax payer during the taxable year that is tax exempt. PPACA § 1401(a), Recon. Act, § 1004.

In addition, the total MAGI of all individuals who were considered in the household for family size and were required to be tax-filers for the tax year in question are also included in household income.

The term "poverty line" has the same meaning as 42 U.S.C. 1397jj(c)(5). The poverty line for calculation of income for premium assistance tax credits must be the most recently published poverty line as of the first day of the regular enrollment period for coverage during the calendar year. *See* § 1311 for more information about enrollment periods.

Rules for Families with Household Members who are Not Lawfully Present, IRC § 36B(e), PPACA § 1401(a)

If the household has one or more members who are not lawfully present, the family size excludes those members. When determining household income, the income of everyone in the household is considered. The PPACA establishes a formula to calculate household income to determine tax credit eligibility. This formula ensures that lawfully present individuals will still receive a sufficient tax credit to purchase insurance for those who are eligible. The Secretary must use this formula or a comparable method that leads to the same result. Further, the Secretary must issue regulations setting out the methodology of income calculations and family size that place the "least burden" on persons applying for the credit who are lawfully present.

A lawfully present person is one who is reasonably expected to be lawfully present for the entire period of enrollment for which the credit is being sought, citizens and nationals of the United States.

Reconciliation of Credit and Advance Credit, IRC § 36B(f), PPACA § 1401(a), Recon. Act 1004(c)

There is a "reconciliation" process between the tax credit amount for which a taxpayer is determined eligible and the advance payment tax credit established in § 1412. So if an individual receives a higher tax credit than the individual is later determined eligible for, the individual may face an increase in taxes for the taxable year. For individuals with income below 400 percent FPL, the individual may not be charged more than $400.00 (or $250 for unmarried individuals). The Secretary must issue regulations to carry out the provision of § 1401 including the coordination of the tax credit with the advance credit payment under § 1412.

Each exchange is required to provide certain information to the Secretary and the taxpayer for each health plan participating in the exchange including:

- the level of coverage and total cost without premium or cost-sharing reductions;
- names and identifiable information for each beneficiary; and

- information that has been provided to the exchange to determine eligibility for an amount of a tax credit or advance payment.

The purpose of this provision is to limit the excess advance premium credit payment that may subject an individual to a tax increase.

Effective Date: Amendments to the Internal Revenue Code become effective in tax years after December 31, 2013.

Study on Affordable Coverage, PPACA § 1401(c)

Within the first five years after enactment of the PPACA, the Comptroller General must conduct a study of health insurance affordability and submit it to Congress with recommendations. The study must include:

- the impact of the premium assistance tax credit and the tax credit for small business employers on the expansion of health insurance coverage of individuals;
- the availability of affordable health insurance and an analysis of whether the income levels and subsidy amounts used to set the premium assistance tax credit is appropriate; and
- the ability of individuals to maintain essential benefits.

Effective date: March 23, 2010. However, the additions and amendments to the Internal Revenue Code made by this section apply to taxable years after December 31, 2013.

Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans in the Exchange, PPACA § 1402, Recon. Act § 1001

This section requires that qualified health plans in the exchange reduce cost-sharing for two groups of individuals:

- eligible individuals with household income between 100 and 400 percent FPL; and
- lawfully present immigrants with household income under 100 percent FPL ineligible for Medicaid.

The cost-sharing reductions decrease the deducible and co-pays of an individual for health care services covered by a qualified exchange plan (see § 1302, *infra*). Cost-sharing is defined as deductibles, co-insurance, co-payments, or similar charges and does not include premiums, balance billing for non-network providers, or spending for non-covered services.[58] The insurer will ultimately be reimbursed by HHS for these reductions. § 1402(a).

Further, an individual must be enrolled in a "silver" plan in the individual (not group) market, as defined in § 1302(d). While enrollment in the silver plan designates that the plan pays 70 percent of the share of the cost of the actuarial value of the benefits in the plan, an individual

[58] PPACA § 1302(c)(3).

who is eligible for a cost-sharing reduction will obtain additional financial assistance. But if an individual chooses to enroll in bronze, gold or platinum plan[59] the individual will not be eligible for a cost-sharing reduction. § 1402(b).

The HHS Secretary is required to notify the issuer of the qualified health plan of the individuals who are eligible for cost-sharing reductions, as HHS will already have information about each enrollee eligible for the premium assistance tax credits. The issuer of the qualified health plans is responsible for implementing the cost-sharing reduction methodology outlined below.

The cost-sharing reductions are conducted in two parts. *First*, the out-of-pocket limits provided under § 1302(c)(1)(B) are reduced for individuals between 100 and 400 percent FPL.

For an eligible individual with household income between:

- 100-200 percent FPL, the out-of-pocket limit is reduced by two-thirds;
- 201-300 percent FPL, the out-of-pocket limit is reduced by half; and
- 301-400 percent, the out-of-pocket limit is reduced by one-third.
  § 1402(c)(1)(A).

Second, the qualified health plans must provide further reduction in cost-sharing for persons with certain household income. The qualified health benefit plan must provide benefits and share the cost of the actuarial value of the benefits of the plan. By doing so, this provision sets cost-sharing limits for families enrolled in qualified health plans. For individuals whose household income is between:

- 100-150 percent FPL, the plan's share of the total cost of benefits is 94 percent;
- 151-200 percent FPL, the plan's share of the total cost of benefits is 87 percent;
- 201-250 percent FPL, the plan's share of the total cost of benefits is 73 percent;
- 251-400 percent FPL, the plan's share of the total cost of benefits is 70 percent.
  PPACA § 1402(c)(2), Recon. Act § 1001(b).

Thus, an individual's responsibility for payment of co-pays, deductibles, etc. will range from six percent of the value of the plan to 30 percent of the value of the plan depending on an individual's household income level. For example, for a family with household income of 135 percent FPL, the plan will be responsible for 94 percent of the total benefit cost, and the family will be responsible for paying six percent of the total cost of the benefits in co-pays and deductibles. In contrast, for a family with household income of 300 percent FPL, the plan will be responsible for 70 percent of the total costs of the benefits in the plan, and the family will be responsible for paying 30 percent of the plan's benefits in co-pays and deductibles. The

[59] Bronze, silver, gold, and platinum plans reflect different levels of cost-sharing, not different benefit packages. They will likely have different premium levels as well. For example, in a bronze plan the plan is responsible for 60 percent of the share of cost of the value of the benefits of the plan and is the individual is responsible for the remaining 40 percent of the value of the benefits of the plan. A bronze plan may have a less expensive monthly premium than the higher tiered plans. If an individual chooses a bronze plan, he/she would not be eligible for a cost-sharing reduction.

percentages establishing the plan's share of total cost of benefits of a plan was amended and increased by the Reconciliation Act.

This is an area where more guidance is needed on how these two issues – out-of-pocket and cost-sharing limitations – are applied to individuals and families.

Effective date: March 30, 2010.[60]

Methodology of Payment for Reduction in Cost-Sharing, § 1402(c)(3)

The issuer of the qualified health plan must notify HHS of the cost-sharing reductions it makes. HHS must make periodic and timely payments to the issuer of the qualified health plan equal to the value of the cost-sharing reductions. These payments to the issuer of the qualified health plan may be made using a capitated payment system that uses appropriate risk adjustments.

Plans with Additional Benefits or Stand-Alone Dental Plans, § 1402(c)(4), (5)

There is no cost-sharing reduction for additional benefits beyond the essential benefits required of a qualified benefit plan.[61] While plans may provide additional benefits under § 1302(b)(5), or states may require additional benefits, the cost of these additional benefits do not entitle an individual to further cost-sharing reductions. Further, an individual who enrolls in two plans – one for essential benefits and a separate stand-alone dental plan to obtain pediatric dental benefits, does not receive a further cost-sharing reduction for the benefits in the stand-alone dental plan.

Special Rules for American Indians, § 1402(d)

Issuers of qualified health plans must eliminate all cost-sharing for enrolled Indians with household incomes less than 300 percent FPL. This includes services covered by the plan that are provided directly by the Indian Health Service, an Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract health services. The issuer may not reduce payment to providers as a result of the elimination of cost-sharing. The HHS Secretary must pay the issuer of the qualified health plan for this cost-sharing reduction. An individual is determined an "Indian" as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)).

Rules for Families with Household Members who are Not Lawfully Present, § 1402(e)

This section applies the identical methodology for family size and household income to determine cost-sharing reductions, as established for premium assistance tax credits in IRC § 36B(e), added by § 1401(a). Note that this section requires any methodology used to place the "least burden" on the eligible individuals. *See* § 1401 for more detail.

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[60] Because this section was amended by the Reconciliation Act, the effective date is that of the Reconciliation Act (March 30, 2010) and not of the PPACA (March 23, 2010).

[61] *See* PPACA § 1302(b), *infra.*

Definitions and Special Rules, § 1402(f)

Cost-sharing reductions can only be given to an individual for a coverage month in which the individual is receiving a premium assistance tax credit under IRC § 36B. *See* § 1401 for more details on premium assistance tax credits.

The cost-sharing eligibility determination will be made on the basis of data from the most recently available taxable year for which the advance determination is going to be made, per § 1412. *See* § 1412 for more detail on advance determinations.

Section 1402 became effective March 23, 2010, except for the cost-sharing percentages as noted above.

Eligibility Determination for Participating in the Exchange, Tax Credits, and Reduced Cost-Sharing, PPACA § 1411

The HHS Secretary must establish a program to determine eligibility for coverage in the exchange and eligibility for tax credits and cost-sharing reductions. The program must determine whether:

- an individual is a citizen or a lawfully present immigrant;
- an individual meets the income and coverage requirements for a tax credit and cost-sharing reduction;
- an employer's coverage is treated as "unaffordable;" and
- to grant an exemption from the personal responsibility requirement or the penalty when an individual does not obtain insurance. § 1411(a).

An applicant for enrollment in a qualified health plan in the exchange in the individual market must provide the following five pieces of information for each person to be covered by a plan ("enrollee"):[62]

- name, address, and date of birth;

- an attestation of citizenship or legal immigrant status:[63]
    - an enrollee who attests that he/she is a citizen must also provide a Social Security Number;

[62] The statute uses two terms – applicant and enrollee – to mean a person who is applying for coverage in a qualified health plan. The intent of using the word enrollee seems to specify the person who will be covered by a qualified exchange plan, not merely the person completing the application. Certain documents must be submitted and verified on behalf of each enrollee. The statute also uses the term applicant for persons who are applying for coverage for others and for themselves. This analysis tracks the language in the statute closely.

[63] Under this provision, the law precludes any individual who is not lawfully present from purchasing insurance in the exchange, even if the individual is able to pay for the coverage and is not seeking any subsidy or cost-sharing assistance.

- an enrollee who attests to legal immigration status must provide a Social Security number, "if applicable," and documentation of the enrollee's immigration status to be determined by the Secretary of HHS, in consultation with the Secretary of Homeland Security. § 1411(b)(2).

- information regarding income and family size for eligibility for premium assistance tax credits or reduced cost-sharing. An applicant must provide: 1) tax payer identity information; 2) filing status; 3) number of individuals allowed a deduction; 4) modified gross adjusted income for each person in the tax filing household; and 5) other information the Secretary may require to ascertain if the individual is eligible for the tax credit or cost-sharing reduction.[64] This information must be provided for the second calendar year preceding the calendar year in which the plan year begins. Enrollees must also submit changes in circumstances with respect to family size and significant reductions in income. § 1411(b)(3).[65]

- information regarding the benefit package, affordability, and other specifics of employer-sponsored coverage, if the enrollee has such coverage. If the enrollee is claiming that the coverage is unaffordable, he/she needs to submit the income and household information as required when an enrollee is applying for a tax credit or cost-sharing reduction. § 1411(b)(4).

- information for exemptions from the individual responsibility requirement and penalty for not having coverage. The HHS Secretary must develop the documentation requirements for enrollees who are applying for exemptions based on a hardship exemption, religion, or health care sharing ministry. When applying for an exemption based on lack of affordable coverage or when an enrollee's income is under 100 percent FPL, this provision also requires the enrollee to submit income and family size information detailed in subsections three and four *supra*. § 1411(b)(5).

Note that this provision refers to exemptions for persons whose household income is under 100 percent FPL. This exemption was amended by the Reconciliation Act and instead an exemption can be issued for persons under "the filing threshold." Thus this provision is inconsistent with the amendments of the Reconciliation Act and will need to be amended legislatively or interpreted accordingly.

Verification of Information Submitted by Enrollee, PPACA § 1411(c)

[64] This information is detailed at newly established IRC § 6103(l)(21), amended by PPACA § 1414(a).
[65] For example, if the enrollee is applying in 2010 for plan year beginning January 1, 2011, the enrollee would provide household income and family size information for the year ending December 31, 2009. Permission is also granted to the Secretary of the Treasury to disclose income and family size information to the Secretary of HHS, upon her request, to determine eligibility for the exchange, tax credits, and cost-sharing. There are confidentiality and privacy protections built into the exchange of data between agencies and the exchange. *See* PPACA § 1411(g), and Amendment to the Internal Revenue Code § 6103(l)(21), PPACA § 1414.

The exchange must submit an enrollee's information collected pursuant to § 1411(b), *supra*, to the HHS Secretary for verification purposes.

For verification of citizenship and immigration status, the HHS Secretary is required to verify the attestations made by enrollees by submitting the enrollee's information and attestation to the Social Security Administration (attesting to citizenship) or to the Department of Homeland Security (DHS) (attesting to legal immigration status). An enrollee's information is also submitted to DHS when an enrollee's U.S. citizen attestation is inconsistent with the records of the Social Security Administration (SSA). § 1411(c)(2).

To verify income and family size for eligibility determinations for a tax credit or cost-sharing reduction, the HHS Secretary must submit an enrollee's information to the Secretary of the Treasury. § 1411(c)(3).

The verification of an enrollee's information between federal agencies must be conducted through electronic, on-line systems, or another method determined by the HHS Secretary, in consultation with the Secretary of the Treasury and the Commissioner of Social Security. The HHS Secretary has discretion to determine an alternative verification methodology. Specifically, the Secretary of the Treasury may send income and family size information directly to the exchange. In addition, HHS may delegate some responsibilities of verification to the exchange. Any alternative methodology established must meet privacy and confidentiality protections provided in newly created IRC § 6103, added by § 1414 *infra*. §§ 1411(c)(1), 1411(c)(4), 1411(d).

Verification Actions, PPACA § 1411(e)

Once enrollee information has been verified, the enrollee has met the eligibility criteria for a premium assistance tax credit and a credit sharing reduction. The HHS Secretary must inform the Secretary of the Treasury of the enrollee's eligibility so that advance payment of the tax credit under § 1412(c) may be made. § 1411(e)(2). *See* § 1412 below for more detail on advance payment.

If an enrollee's information for an exemption from the individual responsibility requirement has been verified, the Secretary of HHS issues a certification of the exemption.

Verification of Citizenship and Lawful Presence, PPACA § 1411(e)(3)

To better understand the requirements established in the exchange to document and verify citizenship and lawful presence of enrollees, this analysis provides some background information. As discussed above, PPACA requires that each enrollee be a U.S. citizen or be lawfully present. Therefore, verification of citizenship or lawful presence is necessary for every enrollee.

Verification of citizenship for a federal health program has been most recently addressed through provisions in the Deficit Reduction Act of 2005 (DRA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). The DRA established a requirement

that applicants for and recipients of Medicaid who are U.S. citizens provide documentation verifying their citizenship for the first time.[66] To be eligible for full Medicaid benefits, an individual must be a citizen or national of the United States or a qualified legal immigrant. Before passage of the DRA, most states allowed U.S. citizens to attest to their citizenship under the penalty of perjury when applying for Medicaid benefits.[67] The DRA citizenship documentation provision and implementing regulations established an onerous process disproportionately impacting U.S. citizens who are low-income minorities, elderly and women.[68]

In 2009, the Children's Health Insurance Program Reauthorization Act, added § 1396a(ee) to the Medicaid Act, providing a state option for an electronic data verification process with the Social Security Administration to meet the citizenship verification requirements, *in lieu* of the more onerous provisions of the DRA.[69]

The PPACA bases its verification of citizenship process on the system established in CHIPRA. If the information an applicant submits is inconsistent with the records of the SSA or DHS with respect to citizenship or lawful presence, the applicant's eligibility will be determined based on the process for citizenship verification in the Medicaid program by §1396a(ee). § 1411(e)(3).

By utilizing the process set forth at § 1396a(ee), this provision applies some important protections to applicants proving their citizenship or lawful presence. First, it allows an electronic verification match between the state (or here the applicant's information provided to the exchange or HHS) and the Social Security Administration (SSA) to be sufficient to establish citizenship verification without requiring the applicant to assemble and proffer documents.

Second, § 1396a(ee) provides a process when there is inconsistency between the information an applicant provides and the records of the Social Security Administration. Section 1396a(ee) requires that the state must make a "reasonable effort" to resolve the inconsistency. If still unresolved, the individual must be given a notice explaining the inconsistency and a 90-day period from the date of the notice to resolve the issue. The individual may then present further information to resolve the inconsistency. 42 U.S.C. § 1396a(ee)(1)(B).

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[66] 42 U.S.C. § 1396b(x)(3) and 42 C.F.R. § 435.407. For more information on the DRA citizenship documentation requirement, *see* National Health Law Program publications: *Fact Sheet: Citizenship Documentation Requirements under the Deficit Reduction Act* (Sept. 2006), http://www.healthlaw.org/images/stories/issues/qanda.citizen.documentation.pdf, *Changes to the Citizenship Documentation Requirements under the Final Rule published 72 Fed. Reg. 38662-38697 (July 13, 2007)*, http://www.healthlaw.org/images/stories/issues/DRA.Changes.pdf.

[67] *See* 42 U.S.C. §§ 1320b-7(d), 1396a(b)(3).

[68] *See* Brennan Center for Justice, *Citizens Without Proof: A Survey of Americans' Possession of Documentary Proof of Citizenship and Photo Identification* (Nov. 2006), at 3, *available at* http://www.brennancenter.org/page/-/d/download_file_39242.pdf; Amicus Brief of NAACP Legal Defense Fund, *Crawford v. Marion County Election Board*, 128 S. Ct. 1610 (2008), *available at* http://www.naacpldf.org/content/pdf/crawford/LDF_Crawford_Amicus_Brief.pdf.

[69] *See* 42 U.S.C. § 1396a(ee)(1). CHIPRA also extended the citizenship verification requirement established by the DRA to CHIP applicants and recipients as well. 42 U.S.C. § 1397ee(c)(9)(A).

Finally, § 1396a(ee) requires the state to continue to provide Medicaid benefits while it is making a reasonable effort to resolve an issue, as well as during the additional 90-day period. If the individual was not able to present sufficient documentation, or the inconsistency could not be resolved, an individual may be dis-enrolled within 30 days, after the 90-day period ends. These same processes established by § 1396a(ee) have been applied to persons applying to a qualified health plan in the exchange. Although it would be preferable to have no citizenship documentation requirements, by applying § 1396a(ee), Congress has adopted a verification process that provides protections for applicants and enrollees during the verification of eligibility process for qualified health plans in an exchange.

While NHeLP is opposed to citizenship documentation generally, if it is going to exist, then it should be undertaken in the least cumbersome manner possible. This provision is less burdensome than the citizenship verification process established by the DRA.

Verification of Other Information (Not Citizenship or Lawful Presence), PPACA § 1411(e)(4)

The exchange must make a reasonable effort to identify and address any inconsistency that may arise between the applicant's submitted information and the SSA, DHS, or HHS's records for all required information (other than citizenship or lawful presence addressed above). If an inconsistency is not resolved, an individual has a right to a notice of the inconsistency and a 90-day period from the date of the notice to address and resolve the issue. This provision mirrors § 1396a(ee), *supra*. The HHS Secretary may extend this 90-day period for enrollments during 2014. § 1411(e)(4)(A).

To resolve an inconsistency regarding an issue other than citizenship or lawful presence, an exchange may make a decision based on the information contained in the application any time during the 90-day period. For eligibility for a tax credit or cost-sharing reduction, if an inconsistency cannot be resolved by the end of the 90-day period, an exchange may make a decision based on information held by the relevant federal agencies (DHS, SSA, and Treasury) and must notify the applicant of that decision. When an applicant is found eligible for the exchange because his/her employer-based coverage is not affordable or not providing essential benefits, the exchange must notify the employer, as that employer may be liable for a penalty under IRC § 4980H, established by PPACA § 1513. No exemption may be granted by the exchange if an inconsistency regarding an applicant's request for an exemption from the individual responsibility to purchase coverage or from a penalty is not resolved within the 90-day period. The exchange must notify each person who has an inconsistency in his/her application and inform that person of the appeals process. § 1411(e)(4)(B).

Appeals and Redeterminations, PPACA § 1411(f), Confidentiality of Applicant Information, PPACA § 1411(g)

The HHS Secretary in consultation with DHS, SSA and Treasury must establish procedures to hear and make decisions regarding appeals and re-determinations for any inconsistency and/or verification issue raised under § 1411(e). Employers also have appeal rights when they are issued penalties for failing to provide affordable coverage or coverage that includes minimum essential benefits. Further, employees have rights to confidentiality of their

income and IRS information when employers are issued a penalty and appealing the penalty decision. § 1411(f).

An applicant for insurance coverage in the exchange, a tax credit, or cost-sharing reduction is only required to provide information that is "strictly necessary" to authenticate identity, determine eligibility, and determine the amount of the credit or cost-sharing reduction. In addition, all applicant information must be kept confidential by those persons who receive it for purposes of verification of eligibility determinations. The applicant's information must not be used or disclosed for any other purpose other than determining eligibility for health insurance in an exchange, premium assistance tax credits or cost-sharing, or related determinations for coverage for insurance in an exchange. § 1411(g). Any person who knowingly and willfully uses or discloses information in violation of § 1411(g) may be subject to a penalty of up to $25,000.

Penalties, PPACA § 1411(h)

Applicants can be subject to a civil penalty of up to $25,000 if the applicant does not provide correct information under § 1411(b) and when the provision of such information is due to negligence or disregard of HHS rules or regulations.[70] There is a good cause exception; no penalty will be imposed if there was a reasonable cause for the failure to provide correct information, and the applicant acted in good faith. Civil penalties can increase up to $250,000 for applicants who "knowingly and willfully" provide false or fraudulent information under § 1411(b).

HHS Study on Administration of Employer Responsibility, PPACA § 1411(i)

By January 1, 2013, HHS in consultation with Treasury is required to conduct a study of the procedures necessary to administer Title I of PPACA and IRC § 4980H, as added by PPACA § 1513. The study must address the procedures necessary to protect:

- employees' right to keep income and tax return information confidential from employers;
- employees' right to enroll in a qualified health plan if their employer does not provide affordable coverage; and
- an employer's right to due process when issued a penalty for alleged failure to provide affordable coverage or coverage that includes minimum essential benefits.

The study must be submitted to the relevant committees in Congress with any necessary legislative recommendations.

While the sections on eligibility for enrollment in a qualified health plan, tax credit and cost-sharing reduction, as well as necessary verification, do not specify that regulations must be issued by the Secretary, numerous provisions contained in these sections will require guidance from HHS in order to effectively implement them. In addition, two sections of the PPACA

[70] Negligence and disregard are defined at § 6662 of the Internal Revenue Code of 1986 (26 U.S.C. § 6662).

require coordination and simplification of enrollment processes for tax credits, cost-sharing reductions, Medicaid and CHIP.[71] Low-income beneficiary advocates may be able to provide important input and perspectives during the implementation process.

Effective date: March 23, 2010.

Advance Determination and Payment of Premium Tax Credit and Cost-Sharing Reductions, PPACA § 1412

The HHS Secretary must establish, in consultation with the Secretary of the Treasury, a program to establish determinations made under § 1411 for coverage in the exchange and eligibility for premium assistance tax credits and cost-sharing deductions in advance of the plan year. The HHS Secretary must notify the exchange and the Secretary of the Treasury of these advance eligibility determinations. The Secretary of the Treasury must then make advance payments of premium tax credits and reduced cost-sharing, as appropriate, to the issuer of the qualified health plan. The issuer of the health plan must make the appropriate reductions in premium and cost-sharing for each eligible enrollee, providing notice to the enrollee of the reductions in payment due to the advance payment on each billing statement. § 1412(a), (c).

These advance determinations must be made during an open enrollment period or other enrollment period determined by the HHS Secretary, and be based on the most recent taxable year's information that is available. There also must be special enrollment provisions for persons who have changes in circumstances, including loss of a job or a reduction of 20 percent or more of income. § 1412(b).

If the enrollee does not pay his/her share of the premiums, the issuer of the qualified health plan must notify the Secretary of HHS of the non-payment and allow a three-month grace period prior to termination from the plan. § 1412(c)(2).

Persons who are not lawfully present in the United States may not receive federal payments, tax credits, or cost-sharing reductions through a provision in this subtitle or amendments made by this subtitle. § 1412(d).

States have flexibility to provide additional premium or cost-sharing assistance to that provided for in this subtitle for or on behalf of persons who are eligible for insurance coverage by a qualified health plan in an exchange. § 1412(e).

Effective date: March 23, 2010.

Streamlining of Procedures for Enrollment through an Exchange and State Medicaid, CHIP and Health Subsidy Programs, PPACA § 1413

[71] *See* § 1413 requiring enrollment simplification and coordination efforts, and § 2201 requiring an internet-based system be developed to coordinate tax-credit/cost-sharing reductions, enrollment for Medicaid, and CHIP.

This provision requires that the HHS Secretary establish a system through which residents of each state may apply for "applicable state health subsidy programs." The term "applicable state health subsidy program" means:

- a program in which individuals can enroll in a qualified health plan offered through an exchange, which includes the premium tax credits and cost-sharing reductions;
- a state Medicaid program;
- a state CHIP program; and
- a state program offering basic health care coverage for low-income individuals not eligible for Medicaid. § 1413(e).

The Secretary of HHS will develop and provide to states a single, streamlined form to be used to apply for all applicable state health subsidy programs. Applicants may submit the form online, in person, by mail and by telephone. The form may be filed with an exchange or with state officials operating another health subsidy program, and should be structured in a user-friendly manner to maximize applicants' ability to complete it. States may use a supplemental or alternative form for individuals who apply for eligibility not determined on the basis of household income. Applicants who have submitted a form will receive notice of eligibility for applicable state health subsidy programs, and will not need to provide additional information or paperwork unless it is specifically mandated by law. § 1413(b). This provision is significant because it means that applicants will need to complete only a single form to apply for enrollment in Medicaid, CHIP, a state program or a qualified health plan through an exchange rather than completing a different form for each program.

The provision mandates that individuals applying through an exchange be screened and enrolled in Medicaid or CHIP programs if they qualify. This follows the screen and enroll requirements found in the Balanced Budget Act of 1997 and subsequent CHIP regulations, which have been critical to ensuring that children enroll in the program for which they are found eligible. Once the new enrollment processes are established, advocates are hopeful that children who are currently uninsured despite the fact that they qualify for Medicaid or CHIP will finally enroll in one of these two public benefit programs. § 1413(a).

States are required to develop a secure electronic interface for exchange of data to determine eligibility for all programs with a single application. The data matching arrangements must provide access to eligibility data for those who receive assistance from health subsidy programs and those who apply for such assistance. Each state health subsidy program must establish, verify, and update eligibility for participation in the program using data matching arrangements and must determine eligibility based upon reliable third party data. There is an exception to using the data matching arrangement – when costs of use outweigh expected gains in accuracy, efficiency and program participation. The Secretary will promulgate standards governing the timing, contents and procedures for data matching. § 1413(c).

According to this provision, nothing in the statute prohibits state Medicaid agencies from contracting with private entities to determine eligibility for all applicable state health subsidy programs. Note, however, that the provision keeps in place the Title XIX requirement that Medicaid eligibility must be determined by a public agency. § 1413(d). This means that the

state Medicaid agency or similar public agency will continue to be responsible for Medicaid determinations and will not simply be allowed to delegate this authority because of private contracting related to eligibility for enrollment in a qualified health plan through an exchange.

Overall, this provision will have a significant potential in enrolling millions of currently uninsured children in one of several health coverage programs. Through the established screen and enroll procedures, there will essentially be no wrong door for children seeking coverage.

While this option offers much promise for low-income individuals in navigating through what has traditionally been a complex application and enrollment process, advocates should think carefully about processes and forms as they are being created and critically assess whether they adequately meet the needs of low-income clients. Literacy level and language access will need to be addressed, as will the balance between eliciting sufficient information for appropriate enrollment into one of the state-offered programs and requesting too much information which creates barriers to eligibility and enrollment and inhibits proper and efficient administration.

Additionally, the section explicitly states that private contractual agreements involving eligibility determinations for state health subsidy programs are not prohibited. Given the checkered history of private contractors determining CHIP eligibility in a number of states, advocates should be concerned about the permissive nature of this provision. Among the many concerns are lack of transparency, accountability and accessibility of contractors' actions. In a number of states, including California, Indiana and Texas, when attorneys and advocates have asked about how eligibility decisions are made, what specific processes are used and what avenues of appeals are available to clients, contractors have claimed that their information and claim processes are proprietary and have refused to share them. Moreover, state CHIP agencies often have defended contractors against such inquiries.[72] These experiences suggest that in the future, low-income clients and their advocates will face similar problems.

Effective date: March 23, 2010.

Disclosures to Carry Out Eligibility Requirements For Certain Programs, PPACA § 1414

The Secretary of the Treasury, upon written request of the Secretary of HHS, is authorized to disclose taxpayer information to the Secretary of HHS, to its officers, employees and contractors. This information must pertain to income determinations regarding premium tax credits, cost-sharing reductions, eligibility in a state Medicaid program, CHIP program or basic health program. The return information is limited to:

- taxpayer identity information;
- filing status;
- number of individuals for whom a deduction is allowed;
- modified adjusted gross income; and

[72] For more information about advocates' experience with California's CHIP program, Healthy Families, *see* Kulkarni, M., Fendell, S., and Berry, E., Public Health and Private Profit: A Witch's Brew, *Clearinghouse Review* January-February 2002.

- taxable year.

The information may be disclosed by the Secretary of HHS to an exchange or its contractors. Use of disclosed information is restricted to establishing eligibility for participation in an exchange or in state programs. § 1414(a) (amending § 6103 of the Internal Revenue Code).

The Secretary of HHS and the exchanges are authorized to collect and use the names and Social Security numbers of individuals in order to administer the provisions of the PPACA. Since January 1, 2010, states have been allowed to work with the SSA to verify citizenship documentation of individuals applying for Medicaid and CHIP. § 1414(a), amending IRC § 6103.

Effective date: March 23, 2010.

Premium Tax Credit and Cost-Sharing Reduction Payments Disregarded for Federal and Federally Assisted Programs, PPACA § 1415

The provision provides that tax credits and refunds allowed by IRC § 36B will not be counted as income or resources for the month of receipt and the two months following for purposes of determining individual eligibility for benefits or assistance offered by federal programs or state or local programs financed by federal funds. Additionally, any allowed cost-sharing reduction payment, which is the amount of the premium subsidy, or advance payment of the credit under § 36B made under PPACA § 1402 or § 1412 will be treated as if it were made to the qualified health plans in which the individual is enrolled. The payment will not be treated as if it were made to the individual and, therefore, will not be considered taxable income. § 1415.

Effective date: March 23, 2010.

Requirement to Maintain Minimum Essential Coverage, PPACA §§ 1501, 10106, Recon. § 1002, 1004

Findings of Congress

Congress made several findings that included:

- the individual responsibility requirement to maintain health insurance coverage is commercial and economic in nature, which ultimately impacts interstate commerce (due to personal decisions that are made about how and when health care and insurance is purchased);
- health insurance and health care services play a significant role in the nation's economy, including the purchase and shipment of medical drugs and supplies and the purchase of health plans from national insurers (which again impacts interstate commerce);
- the individual responsibility requirement will increase demand for health care services, as well as the number of people in the United States who are insured;
- increasing the number of insured individuals will decrease the number of medical bankruptcies and improve families' financial security;

- the federal government plays a vital role in regulating health insurance (and interstate commerce), as demonstrated by the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act; and
- the Supreme Court determined that insurance is interstate commerce and subject to federal regulation in *U.S. v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944).

Maintenance of Minimum Essential Coverage, § 5000A

Beginning in 2014, individuals and their dependents are required to maintain minimum essential coverage. Failure to do so will result in a penalty of the greater of $95 or one percent of income in 2014, $325 or two percent of income in 2015, and $695 or 2.5 percent of income in 2016, up to a maximum level equal to the national average premium for qualified health plans which have a bronze level of coverage. Recon. § 1002. After 2016, penalty dollar amounts will increase based on the annual cost of living adjustment. §10106.

Families are required to pay a penalty of half of the amount for uninsured children, up to a maximum of $2,250 for the family. Recon. § 1002. Certain exemptions exist to the personal responsibility requirement of maintaining minimum essential coverage: e.g., for individuals not lawfully present in the U.S., religious objectors, and incarcerated populations. Similarly, individuals excluded from the penalty provision are:

- members of Native American tribes (because they obtain their health care primarily through the Indian Health Service);
- recipients of hardship waivers;
- taxpayers with incomes below the filing threshold; and
- individuals who were not covered for a period of less than three months during the year. Recon.§ 1002.

Advocates should be aware that outreach efforts should be made to encourage communities to obtain health insurance coverage to avoid penalties and maintain a quality level of health, in addition to advising individuals with limited incomes about the availability of subsidies to purchase coverage in the exchange.

Reporting of Health Insurance Coverage, PPACA § 1502

This provision indicates that the requirement of reporting health insurance amends the Internal Revenue Service Code.

Reporting of Health Insurance Coverage, § 6055

Every person who provides minimum essential coverage to an individual during a particular calendar year must also report certain information to the Internal Revenue Service, pursuant to a time and format that will determined by the Secretary. § 10106 .

Second, the Secretary of the Treasury, along with the I.R.S. and the Secretary of HHS, must send a notice to individuals who are not enrolled in a health plan with minimum level of coverage and have filed a tax return. The notice should include information on services available in each state exchange.

Advocates should review the Treasury Department's notices to ensure their timeliness, as well as whether they reflect the recipient's preferred language and level of health literacy. Recommendations, if any, to improve the sufficiency of the notices should be forwarded to HHS and to the Treasury Department.

Effective date: Calendar years after 2013.

Nondiscrimination, PPACA § 1557

This provision extends the application of existing federal civil rights laws prohibiting discrimination on the basis of race, color or national origin; sex; disability; or age to any health program or activity receiving Federal financial assistance; any program or activity administered by an Executive agency; or any entity established under Title 1 of the Affordable Care Act. The provision affords these protections by prohibiting covered entities from discriminating on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), and § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794). The provision prohibits any individual from being excluded from participation in, denied the benefits of, or subjected to discrimination under, any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). This provision extends the protections to "contracts of insurance," which generally have been exempted from civil rights protections.[73]

Further, the provision allows the use of the same enforcement mechanisms provided for and available under Title VI, Title IX, § 504, or the Age Discrimination Act. Victims of intentional discrimination will be able to bring cases in court, and the Department of Health and Human Services will have the enforcement authority to act on both individual complaints and initiate its own investigations of both intentional and disparate impact discrimination. Nothing in this section shall preempt a state law that provides greater protections to employees than those provided under this section.

The Secretary may promulgate regulations to implement this section. HHS has designated the Office for Civil Rights to draft the regulations, a process currently underway.

Health Information Technology Enrollment Standards and Protocols, PPACA § 1561

The Secretary, in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee will develop standards and protocols to promote

[73] *See e.g.*, 42 U.S.C. § 2000d-4.

the interoperability of secure electronic systems to enroll individuals in federal and state health programs, allowing for electronic data matching and electronic documentation. Electronic matching can include data such as vital records, tax records and enrollment systems. Among other features, standards and protocols for electronic enrollment must also create streamlined systems; give individuals the capability of applying, managing, and recertifying their eligibility on line (and at home); and provide notice of eligibility and recertification through other media, such as e-mail and cellular telephones. In addition, the Secretary has the option of requiring, as a condition of receiving federal funds for HIT systems, that states incorporate HIT standards and protocols into those systems. § 1561.

Accordingly, advocates should look for opportunities to serve on national, state, or local HIT advisory committees in order to provide information that may be pertinent to enrolling low-income populations, communities of color, individuals with disabilities, the elderly, and individual with limited English proficiency in federal and state programs with HIT systems. Advocates and other HIT stakeholders should also be committed to facilitating the use of HIT systems in these communities, once enrollment has taken place.