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

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Annual and Lifetime Limits	Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS.		All plans	6 months after enactment	1001	PHSA 2711
Rescissions	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Prior notification must be made to policyholders prior to cancellation.		All plans	6 months after enactment	1001	PHSA 2712
Coverage of preventive health services	Plans must provide coverage without cost-sharing for: • Services recommended by the US Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered. The Secretary will determine an interval of not less than 1 year after which new recommendations will be incorporated.	Secretary of HHS	All plans	6 months after enactment	1001	PHSA 2713
Extension of adult dependent coverage	Plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. The Secretary will define which adult children coverage must be extended. For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.	Secretary of HHS	All plans	6 months after enactment	1001 HR 4872 §2301	PHSA 2714
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All plans	6 months after enactment for under 19.	1201 & 10103(e)	PHSA 2704

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Uniform explanation of coverage documents and standardized definitions	The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. The summary must contain: • Uniform definitions of insurance and medical terms • A description of coverage and cost sharing for each category of essential benefits and other benefits • Exceptions, reductions and limitations in coverage • Renewability and continuation of coverage provisions • A "coverage facts label" that illustrates coverage under common benefits scenarios • A statement of whether it provides minimum essential coverage with an actuarial value of at least 60% that meets the requirements of the individual mandate • A statement that the outline is a summary and that the actual policy language should be consulted • A contact number for the consumer to call with additional questions and the web address of where the actual policy language can be found. The Secretary must consult with the NAIC, as well as a working group of insurers, providers, patient advocates, and those representing individuals with limited English proficiency.	**Secretary of HHS, in consultation with the NAIC and a working group of consumer advocacy organizations, insurers, health care professionals, patient advocates, and other qualified individuals.**	All plans	Standards developed within 12 months. Uniform documents implemented within 24 months	1001	PHSA 2715
Provision of additional information	All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage • Other information as determined appropriate by the Secretary		All plans	6 months after enactment	1001	PHSA 2715A
Prohibition on discrimination based on salary	Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans. The Secretary of HHS will develop rules.		Fully insured group health plans	6 months after enactment	1001	PHSA 2716

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Ensuring quality of care	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors • Implement wellness and health promotion activities	Secretary of HHS, in consultation with experts in health care quality and stakeholders	All plans	2 years after enactment	1001	PHSA 2717
Bringing down the cost of health care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. The report must include the percentage of total premium revenue, after accounting for risk adjustment, premium corridors, and payments of reinsurance that is expended on: • Reimbursement for clinical services • Activities that improve health care quality • All other non-claims expenses, including the nature of the costs, excluding Federal and State taxes and licensing or regulatory fees Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups	**The NAIC shall establish, by December 31, 2010, uniform definitions of the categories of expenses and standardized methodologies for calculating measures of them.**	All fully insured plans, including grandfathered plans	01/01/11	1001	PHSA 2718
Appeals process	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.	Secretaries of Labor and HHS	All plans	6 months after enactment	1001	PHSA 2719

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Patient Protections	A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.		All plans	6 months after enactment	1001	PHSA 2719A
Health insurance consumer assistance offices and ombudsmen	The Secretary of HHS shall provide $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to: • Assist with the filing of complaints and appeals • Collect, track, and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies As a condition of receiving a grant, a state must collect and report data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.			Date of enactment	1002	PHSA 2793
Ensuring that consumers get value for their dollars	The Secretary, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online. The Secretary shall award $250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services.	The Secretary in conjunction with the states.	Fully insured plans	2010 plan year	1003	PHSA 2794

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Temporary high risk pool program	The Secretary shall establish a temporary high risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least 6 months. The program may be carried out directly or through contracts with states or nonprofit entities. States must agree not to reduce the annual amount expended for current high risk pools before enactment. Provides $5 billion to fund pools through 2013 Pools funded through these grants must: • Have no preexisting condition exclusions • Cover at least 65% of total allowed costs • Have an out-of-pocket limit no greater than the limit for high deductible health plans • Utilize adjusted community rating with maximum variation for age of 4:1 • Have premiums established at a standard rate for a standard population The Secretary shall establish criteria to prevent insurers and employers from encouraging enrollees to drop prior coverage based upon health status.	Secretary of HHS		90 days after enactment	1101	
Temporary reinsurance program for early retirees.	The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80% of costs incurred by early retirees over the age of 55 but not eligible for Medicare between $15,000 and $90,000 annually. Payments under the program must be used to lower costs of the plan. Provides $5 billion to fund the program.	Secretary of HHS		90 days after enactment	1102	
Web portal to identify affordable coverage options	The Secretary shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage. It will allow them to receive information on: • Health insurance coverage • Medicaid • CHIP • Medicare • A high risk pool • Small group coverage, including reinsurance for early retirees, tax credits, and other information The Secretary shall develop a standard format to be used in presenting information relating to coverage options, which shall include: • The percentage of total premiums spend on nonclinical costs • Availability • Premium rates • Cost sharing	Secretary of HHS, in consultation with the states Secretary of HHS		07/01/10 60 days after enactment	1103	

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Administrative simplification requirements	Requires the Secretary to develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions.			Rules adopted by July 1, 2011 to become effective by January 1, 2013.	1104	SSA 1171

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