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

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
SUBTITLE C—Quality Health Insurance Coverage for All Americans **PART I—HEALTH INSURANCE MARKET REFORMS** **Subpart I—General Reform**						
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All plans	6 months after enactment for individuals 19 and under. Plan years beginning 01/01/14 for all others.	1201	PHSA 2704
Fair health insurance premiums	Premiums may only vary by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family Each state shall establish one or more rating areas for the purposes of geographic rating. The Secretary shall review them and determine their adequacy. If they are not adequate, or if a state fails to establish them, the Secretary may establish rating areas for the state.	*Geographic rating areas*: States, with Secretarial review *Age bands*: Secretary, in consultation with the NAIC	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	Plan years beginning 01/01/14		PHSA 2701
Guaranteed availability of coverage	Insures must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods.	Secretary of HHS	Non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2702
Guaranteed renewability of coverage	Insurers must renew or coverage or continue it in force at the option of the plan sponsor or the individual.		All non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2703
Prohibiting discrimination against individual participants and beneficiaries based on health status	A plan may not establish rules for eligibility based on any of the following health status-related factors: • Health status • Medical condition	Secretary of HHS	All non-grandfathered plans	Plan years beginning 01/01/14		PHSA 2705

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	• Claims experience • Receipt of health care • Medical history • Generic information • Evidence of insurability (including conditions arising out of domestic violence) • Disability • Any other health-status related factor deemed appropriate by the Secretary Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health status-related factor must limit such rewards to 30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. Wellness programs must be reasonably designed to promote health or prevent disease and must give eligible individuals the opportunity to qualify for the reward at least once per year, and rewards must be made available to all similarly situated individuals. Existing wellness programs established before March 23, 2010, may continue to be carried out. Creates a Wellness Program Demonstration Program in 10 states to allow states to design wellness programs for individual market enrollees.	Secretary of HHS, in consultation with Secretaries of Treasury and Labor	Individual market plans	07/01/2014		
Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon: • Whether they receive subsidies • Whether they provide information to state or federal investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act	Secretary of HHS	All plans	Plan years beginning 01/01/14		PHSA 2706
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.		All plans	Plan years beginning 01/01/14		PHSA 2707

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Prohibition on Excessive Waiting Periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.		All group plans	Plan years beginning 01/01/14		PHSA 2708
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.		All plans	Plan years beginning 01/01/14		PHSA 2709
PART II—OTHER PROVISIONS						
Preservation of right to maintain existing coverage	Subtitles A and C of this bill shall not apply to coverage in which an individual was enrolled as of the date of enactment.. The following provisions will apply to grandfathered plans: • PHSA §2708-Excessive waiting periods • PHSA §2711-Annual and lifetime limits • PHSA §2712-Rescissions • PHSA §2714-Extension of dependent coverage • PHSA §2715-Uniform summary of benefits and coverage and standardized definitions • PHSA §2718-Medical loss ratios Provisions of PHSA §2711 relating to annual limits and of PHSA §2704 relating to preexisting condition exclusions apply to grandfathered group health plans for plan years beginning when they would first otherwise apply. Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage. Coverage maintained pursuant to a collective bargaining agreement ratified before the date of enactment is not subject to Subtitles A and C until the expiration of that agreement. A Change made to coverage to conform to these subtitles is not considered termination of an agreement.		All coverage in place on the date of enactment.	Date of enactment (March 23, 2010)	1251	
Rating reforms must apply uniformly to all health insurance issuers and group health plans	Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.			Plan years beginning 01/01/14	1252	
Study of Large Group Market	The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure.	Secretary of HHS	No later than 1 year after enactment		1254	

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	The Secretary shall also collect information on: • The extent to which self-insured plans can offer less expensive coverage and whether lower costs are due to more efficient plan administration and lower overhead or the denial of claims and more limited benefit packages; • Claim denial rates and benefit fluctuations and the impact of limited recourse options for consumers; and • Potential conflict of interest as it relates to the health care needs of self-insured enrollees and the employer's financial contribution or profit margin.	Secretary of HHS, in conjunction with the Secretary of Labor				
Effective Dates	All provisions of this subtitle become effective for plan years beginning January 1, 2014, except that the grandfathering of existing plans becomes effective on the date of enactment, and the prohibition on preexisting condition exclusions becomes effective with respect to enrollees under age 19 for plan years beginning 6 months after enactment.				1255	
SUBTITLE D—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS PART IV-STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS						
State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid	The Secretary of HHS shall establish a basic health program under which a state may contract with standard health plans providing at least essential benefits to individuals between 133% and 200% FPL and legal immigrants above 133% FPL who are not eligible for Medicaid. The federal government will provide states creating basic health programs the subsidy funds that eligible individuals would have otherwise received. Individuals eligible to participate in these plans would not be eligible to purchase coverage through the Exchange, and premiums may not exceed what the individual would have paid in the Exchange. Cost-sharing may not exceed that of a platinum plan in the Exchange for individuals below 150% FPL or that of a gold plan for all others. Plans must have an MLR of at least 85%. States may enter into compacts to allow residents of all compacting states to enroll in all standard plans.	Secretary of HHS			1331	
Waiver for State Innovation	A state may apply for waivers of the following requirements: • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate	Secretary of HHS, within 180 days of enactment..		Plan years beginning January 1, 2017	1332	

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	• Requirements for the individuals mandate The Secretary of HHS may not waive any law that is not within the jurisdiction of HHS (such as ERISA). The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver. State waiver plans must provide coverage that is at least as comprehensive as coverage offered through Exchanges, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are good for 5 years and may be renewed unless the Secretary disapproves a request for renewal within 90 day of receipt. The Secretary must coordinate and consolidate this waiver application process and the waiver processes for Medicare, Medicaid, CHIP, and any other federal health care law.					
Provisions relating to offering of plans in more than one state	Two or more states may enter into a "health care choice compact" under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Issuers would continue to be subject to the following laws of the purchaser's home state: • Market conduct; • Unfair trade practices; • Network adequacy; • Consumer protection standards, including rating rules; • Laws addressing performance of the contract. Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws.	**Secretary of HHS, in consultation with the NAIC**, no later than July 1, 2013		01/01/16	1333	
Multi-State Plans	The Director of OPM shall contract with insurers to offer at least 2 multi-state qualified health benefits plans through the Exchange in each state to provide individual and small group coverage. At least one plan in each state must be provided by a nonprofit entity. The Director may set standards for multistate plans regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrolless. Participating insurers must be licensed in each state where it sells coverage and are subject to all requirements of State law that are not inconsistent with requirements of this section. Plans must offer a uniform benefit package in each state which consists of the essential benefits package and any additional benefits required by a state, as long as the state reimburses enrollees for the cost of these additional benefits. States with rating rules	Office of Personnel Management		01/01/14	1334	

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	that restrict variation due to age to less than 3:1 may require multi-state plans to adhere to these requirements. Insurers must sell multi-state plans in 60% of states in the first year they offer them, 70% of states in the second year, 85% of states in the third year, and all states in the fourth year. Requirements for FEHBP plan that do not conflict with this title will apply to multi-state plans. Multi-state plans will be considered a separate risk pool from FEHBP plans.					
PART V—REINSURANCE AND RISK ADJUSTMENT						
Transitional reinsurance program for individual market in each state	State shall enact a model regulation established by the Secretary, in consultation with the NAIC, that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016. Insurers and TPAs, on behalf of self-insured plans, must make payments to the reinsurance entity and non-grandfathered individual market insurers that cover high risk individuals will receive payments from the entity if they cover high risk enrollees in the individual market. High-risk individuals will be identified on the basis of a list of medical conditions or another comparable objective method of identification recommended by the American Academy of Actuaries. Payments will be based upon a schedule of payments for each condition or another method recommended by the American Academy of Actuaries. Assessments will be based on the percentage of revenue of each insurer and the total costs of providing benefits to enrollees in self-insured plans or a specified amount per enrollee. The total amount of contributions will be based on the best estimates of the NAIC and not including additional assessments to cover administrative costs, equal $12 billion for plan years beginning in 2014, $8 billion in 2015, and $5 billion in 2016. States may collect additional amounts from issuers on a voluntary basis. Of these amounts, $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 shall be deposited in the US Treasury and will not be available for this program. Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation. States may have more than one reinsurance entity and two or more states may enter into agreements to create entities to administer reinsurance in all such states.	**Secretary of HHS, in consultation with the NAIC and with recommendations from the American Academy of Actuaries.**	All plans must pay assesments. Non-grandfathered individual plans may receive payments.	Plan years beginning in 2014 through 2016	1341	
Establishment of risk corridors for plans in individual and small group markets	The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less	Secretary of HHS	Individual and small group plans	Calendar years 2014-2016	1342	

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<tr><th>Provision</th><th>Notes</th><th>Standards Development</th><th>Applicability</th><th>Effective Date</th><th>PPACA Section</th><th>Statutory Section</th></tr>
<tr><td></td><td>administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Risk adjustment</td><td>Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state.

The Secretary of HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.</td><td>Secretary of HHS, in consultation with the States</td><td>Non-grandfathered individual and small group plans</td><td>01/01/14</td><td>1343</td><td></td></tr>
<tr><td colspan="7">SUBTITLE E—AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS
PART I- Premium Tax Credits and Cost-Sharing Reductions
Subpart A—Premium Tax Credits and Cost-Sharing Reductions</td></tr>
<tr><td>Refundable tax credit providing premium assistance for coverage under a qualified health plan</td><td>A tax credit is created for qualified taxpayers between 100% and 400% FPL that covers the difference between a percentage of household income and the second-lowest cost silver level plan available through the Exchange in the individual's rating area. The percentage of income varies on a sliding scale within the following ranges:
<table><tr><td>Income</td><td>Premium Cap</td></tr><tr><td><133% FPL</td><td>2%</td></tr><tr><td>133-150% FPL</td><td>3-4%</td></tr><tr><td>150-200% FPL</td><td>4-6.3%</td></tr><tr><td>200-250% FPL</td><td>6.3-8.05%</td></tr><tr><td>250-300% FPL</td><td>8.05%-9.5%</td></tr><tr><td>300-400% FPL</td><td>9.5%</td></tr></table>The above percentages will be adjusted to reflect the growth of premiums Credits will be advanced to insurer through which the individual purchased coverage.

Individuals eligible for employer-sponsored coverage for which the employee's contribution does not exceed 9.5% of household income are not eligible for subsidies. Individuals not lawfully present in the United States are not eligible for subsidies.</td><td>Secretary of Treasury</td><td>Individuals between 100% and 400% FPL</td><td>01/01/14</td><td>14
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<tr><td>Reduced cost-sharing for individuals enrolling in qualified health plans</td><td>Cost sharing for individuals enrolling in the silver level of coverage through an exchange who are between 100%-400% FPL. Cost-sharing reduced so that the plan covers 94% of the benefit costs of the plan for individuals between 100%-150% FPL, 87% of benefit costs for individuals between 150%-200% FPL, 73% for individuals between 200%-250% FPL, and 70% for individuals between 250%-400%FPL. Native Americans</td><td>Secretary of HHS, in consultation with Secretary of Treasury</td><td>Individuals between 100% and 400% FPL</td><td>01/01/14</td><td>14
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	below 300% FPL will have no cost-sharing under a plan. The Secretary will make periodic payments to insurers for the value of these cost-sharing reductions. Reductions to cost-sharing will not apply to additional benefits provided under a plan or to mandated benefits beyond the essential benefits package.					
PART II-Small Business Tax Credit						
Credit for employee health insurance expenses for small businesses	Small employers with 25 or fewer employees will receive tax credit as follows: Tax years 2010-2013—Employers that contribute at least 50% of premium, or 50% of the average small group premium in the state, will receive a credit against general business tax for 35% (or 25% in the case of a tax-exempt small employer) of the total nonelective contribution the for the plan. Tax years 2014 and later—Employers that contribute at least 50% of premium towards coverage in the exchange will receive a credit of 50% (or 35% in the case of a tax-exempt small employer). Employers may only receive the credit for two years. The credit is phased out for employers with 10-25 employees and employers whose average wages are from $25,000-$50,000, indexed to the annual cost-of-living adjustment.	Secretary of Treasury	Small businesses with 25 or fewer employees	01/01/14	14	IR C 4 5 R
SUBTITLE F—SHARED RESPONSIBILITY FOR HEALTH CARE **PART I—Individual Responsibility**						
Requirement to maintain minimum essential coverage	If a taxpayer fails to maintain minimum essential coverage, they will be required to pay an annual tax penalty of the greater of $95for each household member, up to three, or 1% of household income in 2014, $325 or 2% of household income in 2015 and $695 or 2.5% of income in following years. The penalty is prorated for each month in which a taxpayer fails to maintain minimal essential coverage. Taxpayers are exempted from the penalty if: • The individual has a religious objection to purchasing health insurance. • The cost of the taxpayer's premium contribution for employer-sponsored coverage or for the lowest-cost bronze level coverage available in the Exchange exceeds 8% of household income. The 8% threshold is indexed to the amount by which average premium growth exceeds wage growth. • The taxpayer's household income is below the federal income tax filing threshold	Secretary of Treasury		01/01/14	15	IR C 5 0 0 0 A

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	• The taxpayer is a member of a recognized Indian tribe • The break in coverage is less than three months • The Secretary of HHS determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage • The individual is enrolled in a health care sharing ministry • The individual resides outside the United States Any criminal penalty against a taxpayer for failure to pay the penalty is waived, and the Secretary of Treasury may not file liens or levies to collect the penalty.					
PART II—Employer Responsibilities						
Automatic enrollment for employees of large employers	Employers with more than 200 employees offering a health benefits plan must automatically enroll all new employees one of the plans and automatically continue the enrollments of current employees, unless either opts out.		Employers with more than 200 full-time employees		15	FL S A 1 8 A
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits.		Employers subject to the Fair Labor Standards Act	03/01/2013	15	FL S A 1 8 B
Shared responsibility for employers regarding health coverage	If an employer fails to offer minimum essential coverage and one of its employees receives a subsidy through the Exchange, it will be subject to a penalty of $2000 per employee. Employers offering coverage whose employees receive a subsidy through the exchange will be subject to a penalty of $3,000 per employee receiving a subsidy. The penalty shall not exceed $2000 times the number of full-time employees. Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty.	Secretary of Treasury	Employers with more than 50 employees	01/01/2014	15	IR C 4 9 8 0 H
OTHER PROVISIONS						
GAO study regarding the rate of denial of	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance	Government Accountability		One year after	15	

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coverage and enrollment by health insurance and group health plans	plans by group health plans and health insurance issuers.	Office		enactment		
Free choice vouchers	Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400%FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange.				10	