Patient Protection and Affordable Care Act of 2009:
Health Insurance Exchanges

Provision	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
SUBTITLE D—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS PART I—Establishment of Qualified Health Plans						

Qualified Health Plans Defined	A "qualified health plan" is a health plan that
	• Is certified by each Exchange through which it is offered
	• Provides the essential benefits package
	• Is offered by an issuer that is
	  • Licensed and in good standing in each state in which it is offered
	  • Agrees to offer at least one silver plan and one gold plan
	  • Agrees to charge the same premium whether the plan is sold through the Exchange or outside the Exchange
	  • Complies with other requirements of the Secretary and the Exchange
	A reference to a qualified health plan is also a reference to a Co-Op plan and a Multi-State plan.
	
	A qualified health plan may offer coverage through a primary care medical home plan
	
	A qualified health plan may vary premiums by rating area.
			Qualified Health Plans	01/01/14	1301	

Essential Health Benefits Requirements	The essential health benefits package must cover the following general categories of services: • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care	Secretary of HHS		01/01/2014	1302	

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	The scope of benefits is to be determined by the Secretary of HHS and equal to the scope of benefits under a typical employer-based plan. Nothing shall prevent a qualified health plan from providing benefits in excess of the essential benefits package. The cost-sharing under a health plan may not exceed the cost-sharing for high-deductible health plans in 2014 (currently $5,950 individual/$11,900 family). In following years, the limitation on cost-sharing is indexed to the rate or average premium growth. Deductibles for plans in the small group market are limited to $2,000 individual/$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement. The levels of coverage are defined as follows: • **Bronze level**-Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. • **Silver level**-Must provide coverage that provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan. • **Gold level**-Must provide coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan. • **Platinum level**-Must provide coverage that provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan. Individuals under 30 years of age or those exempt from the individual mandate because no affordable plan is available to them or because of a hardship may purchase a catastrophic plan providing the essential benefits package with a deductible equal to the total limitation on cost-sharing above and first-dollar coverage of at least three primary care visits. Plans offered through the Exchange must also be available as a plan available only to individuals under the age of 21.					
Special Rules	State opt-out of abortion coverage: A state may prohibit qualified health plans offered through the exchange from covering abortions. Special rules relating to coverage of abortion services:		Qualified health benefits plans	01/01/14	1303	

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	This title shall not be construed to require a plan to cover abortion services as part of the essential benefits package. If a plan covers elective abortion services, it may not use any funds attributable to subsidies provided through the Exchange to pay for them and must collect a separate payment from enrollees for the actuarial value of those services. State insurance commissioners shall insure that health plans comply with the the requirement that plans segregate funds for abortion services.					
Related Definitions	Small group market is defined to include employers with 1-100 employees. Until January 1, 2016, states may elect to define it as employers with 1-50 employees.			01/01/14 State option to define market as 1-50 ends 01/01/16	1304	
PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT PLANS						
Affordable choices of health benefits plans	Grants will be made available to states in amounts to be specified by the Secretary of HHS for planning and activities related to establishing an Exchange. Grants may be renewed if the State is making progress in establishing an Exchange and the market reforms. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees or other means. The Secretary is also directed to provide technical assistance to states on facilitating participation of small employers in SHOP exchanges. Each state shall establish, as a governmental agency or nonprofit entity, an American Health Benefit Exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (referred to as a "SHOP Exchange") to assist qualified employers in facilitating the enrollment of employees in small group qualified health benefits plans states. States may choose to establish a single Exchange that performs both functions. States may jointly form regional Exchanges or may form multiple subsidiary exchanges if each one serves a distinct geographic area. Exchanges may contract with entities with demonstrated experience in the individual and small group markets and in benefits coverage if the entity is not an insurer or controlled by an insurer, or with the state Medicaid agency. Exchanges must consult with relevant stakeholders, including consumers, those with experience facilitating coverage in qualified health plans, representatives of small businesses, state Medicaid offices, and advocates for enrolling hard-to reach populations. Exchange must publish online an accounting of its administrative costs, including of funds lost to waste, fraud, and abuse.	Secretary of HHS		Beginning not later than 1 year after the date of enactment, lasting until 01/01/15 01/01/14	1311	

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	Exchanges may not sell plans that are not qualified health benefits plans, except for stand-alone dental plans if they offer pediatric dental benefits meeting the requirements of the act.
	
	Exchanges must provide for an initial open enrollment period, annual open enrollment periods after the initial period, and special enrollment periods under circumstances similar to those for Medicare PDPs, and special enrollment period for Native Americans.
	
	Exchanges may sell qualified health plans that provide only the essential benefits package, except that states may require additional benefits if it defrays enrollees for the additional cost of these benefits.
	
	An exchange must, at a minimum:
	• Certify qualified health benefits plans consistent with guidelines developed by the Secretary of HHS if making them available through the Exchange is in the interests of individuals and employers in the state.
	  • An Exchange may not exclude a health plan:
	    • Because it is a fee-for-service plan,
	    • Through the imposition of premium price controls
	    • On the basis that the plan provides necessary treatments in circumstances that the Exchange deems inappropriate or too costly
	  • In order to be certified, plans must:
	    • Meet marketing requirements
	    • Meet network adequacy requirements under PHSA §2702(c)
	    • Include in networks essential community providers that serve low-income, underserved communities
	    • Be accredited by an entity recognized by the Secretary for accreditation of health plans
	    • Implement market-based strategies for quality improvement
	    • Utilize a uniform enrollment form that takes into account criteria that the NAIC develops and submits to the Secretary
	    • Utilize the standard format established for presenting health benefits plan options; and
		NAIC				

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	• Provide information to the Exchange and enrollees on quality measures for health plan performance
	• Submit justifications of any premium increase prior to implementation and post it on its website. Such justifications shall be taken into account when certifying plans.
	• Submit to the Exchange, the Secretary of HHS, and the state Insurance Commissioner and publicly disclose the following information:
	    • 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 of cost-sharing and payments with respect to any out-of-network coverage
	    • Information on enrollee rights
	    • Other information specified by the Secretary
	• Allow individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website.
	• Contract with hospitals with more than 50 beds only if they utilize a patient safety evaluation system and provide education and counseling upon discharge, comprehensive discharge planning, and post-discharge reinforcement by a health care professional
	• Contract with a health care provider only if they implement quality improvement mechanisms required by the Secretary of HHS
	• Operate a toll-free consumer assistance hotline
	• Maintain a website to provide standardized comparative information on qualified health benefits plans					

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	• Assign a rating based upon relative quality and price to each qualified health benefits plan. • Use a standardized format for presenting coverage options under the Exchange, including use of the uniform outline of coverage • Inform individuals of eligibility requirements for the state's Medicaid program, CHIP program and any applicable state or local public program and screen and enroll eligible individuals in these programs • Certify exemptions from the individual mandate • Transfer information to the Secretary of Treasury on exemptions form the individual mandate, as well as on employees receiving subsidies through the exchange because the employer failed to provide sufficient affordable coverage. • Provide information to employers on employees who cease coverage in a qualified health benefits plan • Establish a navigator program to provide to entities with relationships to employers and employees, consumers, or self-employed individuals. Grants must be made out of operational funds, and may not use federal funds for establishment of Exchanges. Navigators will: • Conduct public education activities • Distribute information concerning enrollment in plans and subsidy availability • Facilitate enrollment in plans • Provide referrals to health insurance consumer assistance offices or ombudsmen to enrollees with grievances, complaints or questions: Eligible entities include • Trade, industry, and professional associations • Commercial fishing industry organizations • Community and consumer-focused nonprofit entities • Chambers of commerce • Unions • Resource partners of the Small Business Administration • Licensed insurance producers, • Other entities that are not insurers and do not receive any direct or indirect compensation from insurers in connection with plan enrollments or disenrollments.	Secretary of HHS				

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	The Secretary, in collaboration with states, will develop standards to ensure that information provided by navigators is fair, accurate, and impartial.	Secretary of HHS, in collaboration with states				
Consumer choice	Individuals enrolling in the Exchange may choose any plan for which they are eligible. Employers may specify a level of coverage for which to provide support, and employees may choose any plan that offers coverage at that level. Individuals may pay premiums directly to the insurer.			01/01/2014	1312	
	Insurers must consider all enrollees in all non-grandfathered plans in the individual and small group markets, respectively, to be members of the same risk pools. States may require the individual and small group markets to be merged, but may not require that grandfathered plans be pooled together with non-grandfathered plans.					
	Nothing in this title prohibits an insurer from offering insurance outside of the Exchange or eligible individuals and employers from purchasing coverage outside the Exchange. No individual or employer shall be compelled to purchase coverage through the Exchange. Members of Congress and their personal staff will no longer be eligible for the FEHBP, and must purchase coverage through the Exchange in order to receive coverage through the federal government.					
	The Secretary of HHS shall establish procedures for a state to allow producers to enroll individuals and employers in qualified health plans and to assist individuals in applying for subsidies.	Secretary of HHS				
	Only citizens and lawful residents may purchase coverage through the Exchange. Incarcerated individuals may not enroll through the Exchange.					
	Employers of 1-100 employees may offer 1 or more small group plans to employees through the Exchange. Beginning in 2017, states may allow insurers to offer large group plans through the Exchange.			01/01/2014. States may expand to larger employers beginning 01/01/2017.		
Financial Integrity	Exchanges must keep an accurate accounting of all activities, receipts and expenditures and annually report to the Secretary of HHS, who shall conduct annual audits and may investigate the affairs of an Exchange. An Exchange or State that has engaged in serious misconduct may be subject to a 1% reduction of all grants and payments administered by the Secretary of HHS until corrective actions are taken.			01/01/2014	1313	

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	The Secretary of HHS shall provide for the efficient and non-discriminatory administration of the Exchanges and shall implement measures to reduce fraud and abuse. The False Claims Act shall apply to any payments that include federal funds.	Secretary of HHS				
PART III—State Flexibility Relating to Exchanges						
State flexibility in operation and enforcement of Exchanges and related requirements	The Secretary of HHS shall issue regulations setting standards for the requirements for Exchanges, the offering of qualified health plans sold through Exchanges, reinsurance and risk adjustment mechanisms and other requirements the Secretary deems appropriate. A state that elects to operate an exchange must adopt the federal standards or a state law implementing them by January 1, 2014. If the Secretary determines by January 1, 2013 that the state is not electing to operate an Exchange or that it will not have the Exchange operational by January 1, 2014 or has not taken necessary actions to implement the market reforms, the Secretary shall operate an Exchange, either directly or through agreement with a non-profit entity.	**Secretary of HHS, in consultation with the NAIC, its members, insurers, consumer organizations and other interested parties.**			1321	
Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers	The Secretary of HHS shall provide Co-Op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. In making the loans and grants, the Secretary must give priority to plan that offer qualified health plans on a statewide basis, use integrated care models, and have significant private support and ensure that there is sufficient funding to establish at least 1 Co-Op plan in each state. Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. Any entity receiving a loan or grant must be organized under state law as a nonprofit, member corporation and may not have been a health insurance issuer prior to 7/16/2009 and may not be sponsored by a state or local government. Governance of the organization must be subject to a majority vote of its members and must avoid insurance industry involvement and interference. Any profits made by the organization must be used to lower premiums, improve benefits, or improve the quality of care. The organization must meet all requirements that are required of other qualified health plans, including solvency and licensure rules, rules on payments to providers, network adequacy rules, rate and form filing rules, and any applicable premium assessments. Co-Op plans may not offer coverage in a state until the state has adopted the market reforms in Subtitles A and C of this legislation. Co-Op plans will be considered tax-exempt as long as they abide by restrictions of this section.	Secretary of HHS	Co-Op Plans	No later than 7/1/2013	1322	

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	Co-Op plans may form a private purchasing council through which to enter into collective purchasing arrangements for items and services that increase administrative efficiency, including claims administration, administrative services, health IT, and actuarial services, within the confines of federal antitrust law.					
Level Playing Field	Health insurance plans shall not be subject to any of the following state or federal laws unless Co-Op plans and multistate health plans are also subject to them: • Guaranteed renewal • Rating • Preexisting conditions • Non-discrimination • Quality improvement and reporting • Fraud and abuse • Solvency and financial requirements • Market conduct • Prompt payment • Appeals and grievances • Privacy and confidentiality • Licensure, and • Benefit plan material or information.			1/1/2014	1324	
Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost sharing, and individuals responsibility exemptions	The Secretary of HHS shall develop a program for the determination of eligibility for Exchange participation, subsides, and exemptions. Exchanges must collect specified relevant information for determining eligibility from the individual mandate and submit it to the Secretary of HHS for verification by relevant federal agencies and report the results back to the Exchange.	Secretary of HHS			1411	
Advance determinations and payment of premium tax credits and cost-sharing reductions	The Secretary of HHS, in consultation with the Secretary of Treasury must establish a program for the advance determination of income eligibility for individuals applying for subsidies through the Exchange. The Secretary of HHS will notify the Exchange and the Secretary of Treasury, and the Secretary of Treasury will make the necessary payments to the insurer, who must reduce the individual's premiums and cost-sharing. States may provide subsidies in addition to the federal subsidies.	Secretary of HHS, in consultation with the Secretary of Treasury			1412	

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Streamlining of procedures for enrollment through an Exchange and state Medicaid, CHIP, and health subsidy programs	The Secretary shall establish a system for individuals to apply for enrollment in Medicaid, SCHIP through an Exchange. The Secretary must provide a single streamlined form that may be used in applying for all applicable state health subsidy programs. This form can be filed online, by mail, or by telephone. States may develop and use their own alternative streamlined forms consistent with standards developed by the Secretary of HHS.	Secretary of HHS			1413	