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HEALTH CARE REFORM

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HEALTH CARE REFORM

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I. INTRODUCTION AND OVERVIEW OF THE STATUTE

A. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, P.L. 111-148 ("PPACA", "HEALTH CARE REFORM" OR THE "ACT"): ESTABLISHMENT OF A NEW AMERICAN HEALTH CARE SYSTEM

1. The PPACA, signed into law on March 23, 2010, purports to overhaul the entire health care system within the United States, making it the most expansive health care reform statute in the history of the nation.

2. The PPACA was further supplemented and amended by the Health Care and Education Reconciliation Act, P.L 111-152 (March 30, 2010) ("HCERA").[1]

3. The responsibility for enforcement and the development of future guidance and standards rests primarily with the Department of Health and Human Services ("HHS" or the "Secretary").

4. Substantial authority also rests with the Internal Revenue Service ("IRS"), which is responsible for assessing taxes and penalties for non-compliance and which will implement new reporting and disclosure requirements.

5. The Act creates a health care system that is partially publicly financed but privately delivered.

   a. Health care coverage may be obtained through an employer-provided plan if it otherwise meets the universal coverage requirement.

   b. Lower-income individuals, as well as some middle-class individuals, will receive a tax credit (or a health coverage voucher) to allow them to pay for health insurance coverage purchased from one of the new "American Health Benefits

[1] For the purposes of this memo the terms "PPACA" or the "Act" are used, but where applicable, incorporate by reference the amendments made by the HCERA. Because the provisions of HCERA have been absorbed by and mirror the equivalent provisions of the PPACA, in most instances only the PPACA citations will be utilized. The term "Health Care Reform" used throughout shall also apply to HCERA.

Exchanges" to be set up by each state.

c. Private health insurance coverage will still be available to those who chose it – i.e. the PPACA does not mandate that individuals purchase their insurance through a state-run Health Benefits Exchange, or that Employers only offer insurance through the Exchange.

6. The Act expands and improves the Medicare program and proposes a system of universal health care coverage to "Qualified Individuals," including all legal U.S. residents and all residents living in U.S. territories.

7. "Qualified Individuals" is used to describe those persons eligible to enroll in a qualified health plan in the individual market. [PPACA §1312(e)(f)(1)(A)]. Incarcerated persons are not qualified individuals. [PPACA §1312(f)(1)(B)].

B. SHARED RESPONSIBILITY UNDER THE PPACA

1. Universal coverage is to be accomplished, in part, via the use of mandates placed upon individuals (to obtain coverage) and also upon employers (to offer coverage). These provisions of the PPACA are referred to as the "Shared Responsibility Requirements."

2. Individual Mandate – All individuals must maintain health insurance coverage that meets minimum criteria (described below) or must incur a penalty that will be calculated on a monthly basis based on a pre-established formula [PPACA §1501, 10106].

a. Individuals covered by a qualified health plan through an exchange will receive tax credits to help pay for insurance premiums.

b. Health plans that meet the minimum criteria above include Medicare Part A, Medicaid, CHIP, TRICARE, VA, eligible employer-sponsored coverage, individual health plans, grandfathered health plans, and such other coverage as designated by HHS.

3. Employer Mandate – Employers electing not to offer coverage that meets the minimum criteria will be subject to an additional tax that will help finance the health care coverage for their employees [PPACA §1513].

a. Applies to employers with at least 50 full-time employees.[2]

b. An exemption applies for small employers.[3]

c. When calculating the number of full-time employees, the employer must include "full-time equivalents." Full-time equivalents are determined by dividing the sum of hours worked by part-time employees over the course of a month by 120.

d. The penalty is generally the lesser of $3,000 for each full-time employee receiving assistance for credits to purchase coverage on the exchange or $2,000 for each full-time employee after subtracting the first 30.[4]

C. STATED PURPOSES OF THE HEALTH CARE REFORM

1. The primary goal of the legislation is to ensure that all Americans have access to the highest quality and most cost-effective health care services, regardless of their employment, income, or health care status.

a. It is anticipated that the PPACA will result in coverage to more than 94% of Americans.

b. Coverage will be extended to an additional 32 million Americans who currently do not have health care coverage.

2. The PPACA includes "dual use" programs intended to produce independently desirable results along with increased revenue through cost savings. For instance, the Act adopted improvements to crack down on waste and fraud in the Medicare and Medicaid system.

3. Coverage will be available via employer-provided health plans, private insurance programs, and state-run exchanges. The hope is that increased competition will lower health care costs.

D. QUALIFIED BENEFIT PLANS

1. For purposes of the Shared Responsibility Requirements, individuals must be enrolled in, or employers must provide coverage for,

[2] A full-time employee is defined as an employee who works an average of 30 or more hours a week.
[3] Small employers are defined as those with less than 50 employees. Small employers are eligible to receive tax credits to assist them in providing coverage to their employees.
[4] Additional rules apply to an employer that offers coverage considered insufficient [PPACA §1401].

"Qualified Benefit Plans" that meet minimum standards.

2. Only Qualified Plans will be available on the Exchange.

3. Qualified Plans are plans that include the essential benefits package required of plans sold in the Exchanges and must comply with limitations and on annual cost-sharing for plans sold on the Exchange [PPACA §§1302(a) and (c)].

4. Private health insurers my continue to offer coverage outside of the Exchange, so long as the above requirements are met [PPACA §1312(d)].

5. Self-insured employer group health plans and multi-employer welfare arrangements ("MEWAs") are generally not included in the term "health plan." [PPACA §1301(b)].

6. Grandfathered plans (see below) also qualify [PPACA §1251].

E. GRANDFATHERED PLANS

1. Grandfathered plans are exempt from the vast majority of new insurance reforms.

2. Grandfathered plans are defined as an existing group health plan or health insurance coverage in which a person was enrolled on the date of enactment.

3. Grandfathered status will apply to the plan indefinitely [PPACA §§1251(d), 1401].

4. A "group health plan" also includes a self-insured plan for purposes of the grandfathered plans rules.

5. Individuals who are enrolled in grandfathered health plans will be considered to have maintained "Minimum Essential Coverage" for themselves and any family members also enrolled in the Plan.

6. Grandfathered plans are entitled to maintain their provisions for the enrollment of new family members and new employees.

   a. Current enrollees may reenroll, even if the renewal is after the date of the enactment (March 23, 2010).

   b. Family members are allowed to enroll in the plan even after the date of enactment so long as permitted by the terms of

the plan on the date on enactment.

7. Grandfathered plans must comply with the following reforms for plan years beginning on or after the dates of enactment (March 23, 2010).

   a. Development of uniform explanation and coverage documents; and

   b. Reporting of medical loss ratio and other financial information to the HHS.

8. Insurance reforms for which grandfathered health plans must comply for plan years beginning on or after September 23, 2010, include as follows:

   a. Prohibition on lifetime limits on essential health benefits.

   b. Prohibition on annual limits on essential health benefits. However, for plan years beginning before 2014, general health plans may impose a "restricted annual limit," to be defined by HHS in a way that ensures access to needed services while minimally impacting premiums.

   c. Prohibition on health plan rescissions.

   d. Requirement to extend dependent coverage to children until age 26. For plan years beginning before 2014, a child may enroll for dependent coverage on a grandfathered plan only if such individual is not eligible for an employment-based health plan.

9. Grandfathered group are also subject to a prohibition on exclusions for preexisting health conditions. This prohibition is effective for plan years beginning on or after January 1, 2014, except that for children under the age of 19, the provision becomes effective the first plan year beginning on or after September 23, 2010.

F. COLLECTIVE BARGAINING AGREEMENT APPLICABILITY

1. In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employer representatives and one or more employee representatives that was ratified before the date of enactment, the Act generally shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

2. Any amendment to a collective bargaining agreement relating to coverage which amends the coverage solely to conform to any requirement added by the Act will not be treated as a termination of the collective bargaining agreement [PPACA §1251(d)].

G. EXCISE TAXES ON HIGH COST BENEFIT PLANS

1. Such Plans will be levied an excise tax of 40% on the insurer or the plan administrator for any health plan coverage that is above the premium threshold.

2. Currently the threshold is set at $10,200 for single coverage plans and $27,500 for family coverage plans.

3. The excise tax applies to self-insured plans and plans sold in the group markets, but does not apply to plans sold in the individual markets.

4. Excise taxes do not apply to sale on dental and vision coverage.

5. Excise taxes apply to the amount of the premium that is in excess of the threshold only – i.e. not the entire cost of the premium.

II. STATUTORY ANATOMY OF THE PPACA

A. THE PPACA IS COMPRISED OF TEN TITLES

B. TITLE I – "QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS"

1. Addresses PPACA requirements that are immediately effective for 2010 or shortly thereafter.

2. "Immediate Improvements" include the following:

a. Elimination of lifetime and unreasonable annual limits on benefits (with annual limits prohibited entirely in 2014).

b. Prohibition of health insurance policy rescission.

c. Assistance for individuals denied coverage based on a pre-existing condition by providing immediate access to insurance coverage.

d. Outright prohibition on preexisting condition exclusions for children under the age of 19.

e. Immediate coverage of preventative services and immunizations.

f. Extension of dependant coverage up to age 26.

g. Development of Uniform Coverage Documents so that consumers may make educated comparisons when shopping for health insurance.

h. Institution of a cap on company non-medical, administrative expenditures.

3. Title I further establishes Shared Responsibility, systemic insurance market reforms to eliminate discriminatory practices by insurers, tax credits for individuals and small businesses aimed at decreasing the cost of health insurance, and American Health Benefit Exchanges.

C. TITLE II, "ROLE OF PUBLIC PROGRAMS"

1. Sets forth the rules governing the interaction of the Medicare programs, including the Support for the Children's Health Insurance Program ("SCHIP").

2. Title II contemplates that expansion of public programs will be financed with federal funds.

3. This Title significantly expands the scope of Medicaid.

a. States may expand Medicaid as early as April 1, 2010.

b. Beginning on January 1, 2014, Title II provides that all individuals who are not entitled to Medicare and who have family incomes up to 133% of the federal poverty level ("FPL") will become eligible for Medicaid.

D. TITLE III, "IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE"

1. Sets forth actions to be undertaken by both public and private programs to improve and streamline the health care system.

2. Included therein is the "National Strategy to Improve Health Care Quality."

3. Title III also establishes new reporting requirements, new incentives for health care personnel, and encourages the development of new

"patient care models."

E. TITLE IV, "PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH"

1. Focuses on the greater use of preventative medicine to reduce the incidents of disease in the population.

2. Title IV creates a new interagency prevention council to be supported by a newly created Prevention and Public Health Fund.

F. TITLE V, "HEALTH CARE WORKFORCE"

1. Encourages innovations in health care and workforce training, recruitment, and retention and establishes a new workforce commission.

2. Title V attempts to address shortages in primary care physicians and other areas of practice by making investments in the nation's health care workforce and providing new incentives to practice in underserved areas.

3. This Title invests in the National Health Service Corporation's Scholarship and Loan Repayment Programs to help expand the number of health care workers by providing cheaper alternatives for post-secondary education.

G. TITLE VI, "TRANSPARENCY PROGRAM INTEGRITY"

1. Seeks to provide consumers with information about physician ownership of hospitals and medical equipment companies, as well as nursing homes and other medical facilities.

2. The transparency espoused in Title VI is intended to make consumers aware of any other characteristics connected with either the ownership of those facilities or other pertinent public information.

3. Title VI also seeks to crack down on fraud, waste, and abuse in Medicare, Medicaid, SCHIP, and private insurance, with the purpose of decreasing the cost of health care.

4. This Title establishes a private non-profit entity that will identify priorities in patient-centered outcome research and will provide doctors with information on how to best treat patients and avoid wasteful overspending.

H. TITLE VII, "IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES"

1. Aims at establishing regulatory process for FDA approval of biosimilar versions of previously-licensed biological products.

2. Title VII is also intended to expedite the FDA's review of certain drug classes for greater efficiency and cost savings and to free up the review system for new drugs.

3. This Title also expands the scope of the existing 340B[5] drug discount program to allow more Americans to have access to medications at lower costs.

I. TITLE VIII, "CLASS ACT"

1. Establishes Community Living Assistance Services And Support ("CLASS").

2. CLASS attempts to make long-term support and services more affordable for Americans by providing a lifetime cash benefit to help people with severe disabilities remain in their own homes and communities.

   a. CLASS is a voluntary, self-funded insurance program provided through the workplace.

   b. Participation by workers is entirely voluntary, and for those who wish to participate, premiums will be paid through payroll deductions.

J. TITLE IX, "REVENUE PROVISIONS"

1. Sets forth the means by which the Act is intended to generate revenue to support many of the included new programs.

2. Title IX attempts to tighten current health tax incentives, collect industry fees, institute modest excise taxes, and slightly increase the Medicare hospital insurance ("HI") tax for individuals who earn over certain stated amounts.

[5] The 340B Drug Program resulted from enactment of Public Law 102-585, Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The program limits the costs of covered outpatient drugs to certain federal grantees and federally qualified health centers.

3. This Title also imposes a fee on insurance companies selling high-cost health insurance program (so-called "Cadillac plans").

4. The Title attempts to change health care tax incentives by increasing penalties on non-qualified distributions from HSAs, capping FSA contributions, and standardizing the definition of qualified medical expenses.

5. Title IX also requires that employer-sponsored health coverage be reported on Form W-2 and assesses certain fees and excise taxes on items such as indoor tanning services.

K. TITLE X, "STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS"

1. Includes the original amendments to the PPACA that were made by HCERA.

2. Title X sets forth immediate actions to preserve and expand coverage as well as the specific provisions for improving coverage, such as removal of lifetime and annual limits, prohibitions on rescissions, and coverage of preventive health services.

3. This Title also includes provisions relating to support for pregnant and parenting teens and women, programs for Indian health care improvement, and Medicare coverage for individuals exposed to environmental health hazards.

III. IMMEDIATE CHANGES TO THE HEALTH CARE SYSTEM FOR 2010

A. IMMEDIATE ACCESS TO INSURANCE FOR UNINSUREDS WITH PREEXISTING CONDITIONS

1. The Act provides $5 billion in federal support for a new program to provide affordable coverage to uninsureds with preexisting conditions.

2. The PPACA establishes a "high-risk pool" to cover these individuals, and an appeals process for those denied coverage under the program.

3. The PPACA establishes premium rate limits for individuals who become insured under the new insurance coverage.

4. Section §1101(e) prohibits "dumping" by insurance issuers or employment-based health plans.

a. Dumping occurs when a health plan or insurance issuer discourages individuals from remaining enrolled in the plans.

b. Any plan or issuer found to be in violation of this section is required to reimburse the program for any expenses that HHS determines were incurred by the high-risk pool in association with the "dumping" of any such individuals.

5. The program will be in effect until the establishment of the Exchanges in 2014.

6. The Program is effective 90 days after enactment of the Act.

B. EARLY RETIREES REINSURANCE PROGRAM ("ERRP")

1. The Act provides $5 billion to reimburse certain group health plans that provide insurance coverage to early retirees.

2. The ERRP is explained in greater detail below.

C. CONSUMER INFORMATION FOR IDENTIFYING COVERAGE OPTIONS

1. HHS is directed to establish a mechanism, not later than July 1, 2010, in consultation with the States, through which a resident of any state can identify affordable health care options within that state.

2. A website will be created for the purposes of accomplishing health care option comparisons of pricing and benefit coverage.

3. HHS is allowed to contract with qualified entities for accomplishing its requirements.

D. ADMINISTRATIVE SIMPLIFICATION

1. The Act accelerates the HHS's adoption of uniform standards and operating rules for the electronic transactions between providers and health plans governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2. The Administrative Simplification Rules further requires the adoption of a unique plan identifier and transactions standards for EFT [PPACA §1104].

3. Health Plans are required to certify compliance with HIPAA or will be subject to penalties imposed by the Internal Revenue Service.

4. HHS will review benefit eligibility verification and prior authorizations when conducted as electronic transactions between providers and group health plans.

5. HHS is required to adopt uniform standards and operating rules for Electronic Funds Transfer payments ("EFT") Payments.

IV. SMALL BUSINESS TAX CREDITS

A. SMALL BUSINESS TAX CREDITS ARE REQUIRED BY THE PPACA SO THAT THEY CAN COMPETE WITH LARGER EMPLOYERS FOR TALENTED WORKFORCE BY CONTINUING TO PROVIDE HEALTH CARE COVERAGE TO THEIR EMPLOYEES

1. A small employer is defined as one with fewer than 25 full-time employees.

2. The average annual wages of such employees must be less than $50,000.

3. The employer must purchase health insurance coverage for its employees to be considered a "small employer" for purposes of the Act only.

4. Sliding Scale Approach used to calculate tax credits.

a. For tax years 2010-2013 the Act provides a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost.

b. A full credit will be available to employers with 10 or fewer employees whose average annual wages are not more than $25,000.

c. The credit continues to phase out as the size of the employer and the average wages of its work force increases.

d. Tax-exempt small businesses meeting the above requirements are eligible for tax credits above the 25% of the employer's contribution toward the employee's health insurance premium.

e. For tax years 2014 and later, eligible small business that purchase coverage through one of the new Exchanges will receive a tax credit of up to 50% of their contribution toward the employee's insurance premium if the employer

contributes at least 50% of the total premium.

f. Full credit will be available to employers with 10 or fewer employees and whose average annual wages are less than $25,000.

5. After the Exchanges go into effect, beginning in 2014, small businesses may only receive the credit if they purchase health insurance coverage through one of the Exchanges. [PPACA §1421]

6. Additional protections and incentives will be available to small businesses.

7. Web portals required for the Exchanges will provide standardized easy-to-understand information to small businesses to allow them to shop for coverage.

a. The web portal will provide information about available health coverage options including information regarding reinsurance for early retirees.

b. The portal will serve as informational source for small business tax credits and other information specifically for small businesses with respect to affordable care options.

8. The Governmental Accountability Office ("GAO") is directed to review the impact of the new health care exchanges on access to portable health care for small businesses.

V. A SUMMARY OF SOME GENERAL REFORM REQUIREMENTS

A. ANNUAL LIFETIME DOLLAR LIMITS ON ESSENTIAL BENEFITS

1. A health plan may not establish unreasonable annual dollar limits or lifetime limits on essential benefits beginning in 2010.

2. Amounts are calculated on the dollar value of benefits for any participant or beneficiary.

3. Until plan years beginning on or after January 1, 2014, restricted annual limits on essential benefits, as determined by HHS, are permitted. (New PHSA §2711) [PPACA §§1001, 10101].

4. Any plan that does not provide essential benefits is not prohibited from placing annual or lifetime limits on specific benefits.

5. Only to be done on a "per beneficiary" basis.

a. Only to the extent that such benefits may be limited pursuant to State or Federal law [PPACA §2711].

B. GUARANTEED RENEWAL OF COVERAGE

1. Renewal requirements:

a. Health insurance issuers in the individual and group health insurance market in a state must accept and renew coverage for every employer and individual.

b. Effective for plan years beginning on or after January 1, 2014.

2. Applies to all non-grandfathered, fully insured plans [PPACA §2703].

C. NO RESCISSION OF COVERAGE – PPACA §2712

1. Group health plans may not rescind coverage with respect to an enrollee once the enrollee is covered under that plan or coverage.

2. However, group health plans are not prohibited from rescinding coverage if the enrollee became covered under the plan via an act or practice constituting fraud, or if the enrollee makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

3. Even if an individual will have his or her coverage rescinded due to fraud or intentional misrepresentation, the plan is nevertheless required to provide prior notice.

4. The issuer is not required to accept applicants outside of open or special enrollment periods.

5. The prohibition against rescission of coverage is effective for plan years beginning on or after September 23, 2010.

D. COVERAGE OF PREVENTATIVE HEALTH SERVICES- PPACA §2713

1. A group health plan and a health insurance issuer offering group or individual coverage must, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for preventative services and immunizations.

2. Preventative services include evidence-informed preventative care and screenings provided to infants, children, and adolescents.

3. Effective for plan years beginning on or after September 23, 2010.

E. UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS STANDARDIZED INFORMATION DISCLOSURE (WITH NOTICE OF MODIFICATIONS 60 DAYS IN ADVANCE)

1. Group health plans (including self-insured health plans) and health insurance issuers offering group or individual health insurance coverage shall use HHS standards for the provision of summary of benefits and coverage explanations.

2. The explanation, which must be presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font, must:

a. Be presented in a manner determined to be understandable by the average health plan enrollee;

b. Include uniform definitions of standard insurance terms as well as a description of the coverage;

c. Include the exceptions, reductions, and limitations on coverage, cost-sharing provisions, renewability and continuation of coverage provisions, and examples of common benefit scenarios;

d. Include a statement as to whether the plan meets 60% of actuarial value;

e. Include a statement that the outline is a summary; and

f. Include a contact number for the consumer and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

3. These requirements apply to grandfathered plans as well.

4. Delivery of the explanation:

a. Electronic delivery is acceptable.

b. 60 days' advance notice of modification in a plan is required.

F. PROHIBITION OF DISCRIMINATION BASED ON SALARY

1. Insured group health plans are prohibited from discriminating in favor of highly compensated individuals. (New PHSA §2716) [PPACA §1001]

2. In effect, the prohibition on discrimination in favor of highly compensated employees in self-insured group plans has been extended to fully-insured group plans.

3. Plan sponsors of group health plans are prohibited from establishing rules relating to the health insurance coverage eligibility of any full-time employee based on the total hourly or annual salary of the employee.

4. Plan sponsors are also prohibited from establishing any other eligibility rules which would have the overall effect of discriminating in favor higher wage employees.

5. Plan sponsors are allowed to establish contribution requirements necessary for enrollment in the plan even if they discriminate to the extent that employees with lower hourly wages pay a lower percentage of contributions toward their health care than employees with higher salaries, who will proportionately pay a higher percentage of contributions.

G. NO WAITING PERIODS LONGER THAN 90 DAYS

1. A group health plan shall not apply any waiting period that exceeds 90 days.

2. This become effective for plan years beginning on or after on January 1, 2013.

VI. ESSENTIAL HEALTH BENEFITS [§1302(B)]

A. ESSENTIAL HEALTH BENEFITS MUST BE AVAILABLE TO ALL INDIVIDUALS COVERED BY THE PPACA

1. Plans will not be qualified if they do not offer essential benefits.

2. Essential health benefits will be determined by the Secretary of the Health and Human Services.

3. Essential Benefits are the minimum level of benefits that must be provided by all health care plans.

B. ESSENTIAL HEALTH BENEFITS FORM THE BASIS FOR THE COVERAGE AMERICANS WILL RECEIVE FROM THEIR PLANS

1. HHS shall issue regulations from time to time as to what benefits fall within the category of essential benefits.

2. The Act provides that the following items and services constitute essential health benefits: (1) ambulatory patient services; (2) emergency room services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance disorder services; (6) prescription drugs; (7) rehabilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services including oral and vision care.

3. In determining what constitutes essential health benefits the Secretary is instructed to conduct a survey of employer-sponsored coverage to determine the typical benefits covered by employers including multiemployer plans and to provide a report on such to the Secretary of Health and Human Services.

4. The Act delineates rules for determining whether a benefit is "essential."

5. HHS must ensure that prescribed "essential benefits" reflect an appropriate balance among different health categories.

6. Benefits may not be unduly weighted within any one category.

7. Essential benefits may not discriminate against individuals because of their age, disability, or expected length of life, and shall take into account the health care needs of diverse segments of the population.

8. Considerations for determining what constitutes essential benefits are set forth in PPACA §1302(b).

VII. PREVENTATIVE HEALTH SERVICES AND WELLNESS PROGRAMS

A. U.S. PREVENTATIVE SERVICES TASK FORCE ("USPSTF")

1. Established by the PPACA to monitor the administration of wellness programs.

2. The USPSTF will make recommendations on what types of preventative and wellness services should be made available to individuals, with the goal of what services are crucial in preventing disease in the first place.

3. Current recommendations from the U.S. Preventative Services Task Force for breast cancer screenings will not be considered.

B. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL ("NPHPPHC")

1. The NPHPPHC will coordinate federal prevention, wellness, and public health activities, and is given the responsibility of developing a national strategy to improve the nation's health.

2. The Act creates a Prevention and Public Health Fund to expand and sustain funding for the prevention of disease and for public health programs.

3. Similarly, the Act creates related task forces that will develop, update, and disseminate evidence-based recommendations on the use of clinical and community prevention services.

C. PREVENTION AND PUBLIC HEALTH FUND

1. The Fund is set up for the prevention, wellness, and public health activities including prevention research and health screenings.

2. It will also fund the "Education and Outreach Campaign" for preventative benefits as well as immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015.

D. COMMUNITY-BASED PROGRAMS

1. Grants will support the delivery of evidence-based and community based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates, and addressing health disparities, especially in rural and frontier areas.

E. WELLNESS PROGRAMS

1. Grants will be provided to small employers that establish wellness programs for up to five years beginning in the fiscal year 2011.

2. Technical assistance and other resources will be provided to evaluate employer-based wellness programs.

3. Employers will be entitled to offer employees rewards in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided, of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

4. The employers must offer an alternative standard for individuals for whom it may be unreasonably difficult or inadvisable to meet the above standard.

5. The reward limit may be increased to 50% of the cost of coverage if so deemed appropriate.

   a. Ten state pilot programs will be established by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and demonstrations will be expanded in 2017 if the proceeding plan is effective.

   b. The wellness program portion of the Act will require a report on the effectiveness and impact of wellness programs on the whole.

VIII. EXTENSION OF INSURANCE COVERAGE TO DEPENDENT CHILDREN UP TO AGE 26

A. TAX-FREE COVERAGE FOR CHILDREN THROUGH END OF YEAR CHILD TURNS 26

1. A group health plan or health insurance issuer offering group or individual health insurance coverage of group or individual insurance that provides dependent coverage must allow an adult dependent to continue coverage until the child turns 26, regardless of student or marital status. (New PHSA §2714) [PPACA §1001]

2. For plan years beginning before January 1, 2014, group health plans are not required to extend adult dependent coverage if the child is eligible to enroll in another eligible employer-sponsored health plan. [HCERA §2301(a)]

3. The dependent need not be unmarried to receive the coverage.

4. HHS shall issue regulations regarding the scope of dependents that will fall under the age 26 requirement.

5. This provision does not require a health plan or insurer to cover children of children receiving dependent coverage.

6. Coverage for adult children is nontaxable until the end of the year in which the adult child turns age 26. [HCERA §1004(d)]

IX. OTHER DISCRIMINATION PROVISIONS MANDATED/CLARIFIED BY PPACA

A. MENTAL HEALTH AND SUBSTANCE ABUSE

1. Parity in mental health and substance use disorder benefits will apply to qualified benefit plans, requiring that such benefits are not afforded less coverage than "non" mental health and substance abuse benefits.

2. A plan may not, under the act, discriminate against coverage for benefits for mental health and substance use disorder. (PHSA §2726) [PPACA§1311(j)]

B. GENERAL DISCRIMINATION REQUIREMENTS

1. A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

2. Health status

3. Medical condition (including both physical and mental illnesses)

4. Claims experience

5. Receipt of health care

6. Medical history

7. Genetic information

8. Evidence of insurability (including conditions arising out of acts of domestic violence)

9. Disability

10. Any other health status-related factor determined appropriate by the Secretary.

11. Wellness programs may condition a premium discount or rebate on an individual satisfying a standard that is related to a health status factor if the plan meets certain requirements.

12. Codifies current HIPAA wellness rules, but increases the wellness incentive limit from 20% to 30%.

13. The Departments of Labor, HHS, and the Treasury may promulgate regulations to effectuate this provision and have the discretion to increase the limit to 50%.

    a. This provision becomes effective in 2014 (New PHSA §2805) [PPACA §1201].

C. TITLE VII DISCRIMINATION PROTECTION

1. Individuals are protected against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination in Employment Act, and the Rehabilitation Act from exclusion or participation in, or denial of benefits under, any health program or activity. [PPACA § 1557]

X. IMPROVING QUALITY AND DECREASING COST OF HEALTH INSURANCE

A. IMPROVING QUALITY OF COVERAGE

1. Health insurance administration will be simplified by adopting a single set of operating rules for eligibility verification and claims status, electronic funds transfers and health care payment and remittance, health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization.

2. Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life.

3. The Act also imposes a number of loss containment programs on the Medicaid system which will effectually restructure payments to the Medicare Advantage Plan.

4. The Food and Drug Administration will be authorized to approve generic versions of biologic drugs and grant biologics and manufacturers 12 years of exclusive use before generics can be

developed.

B. WASTE, FRAUD, AND ABUSE IN PUBLIC PROGRAMS WILL BE REDUCED, THUS REDUCING COSTS

1. PPACA mandates provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of Durable Medical Equipment ("DME") suppliers.

2. Enrollment moratoria will be used in areas identified as being at elevated risk of fraud in all public programs.

3. Medicare and Medicaid program providers and suppliers are required to establish compliance programs of their own.

4. A database will be developed to capture and share data across federal and state programs.

5. New requirements will increase penalties for submitting false claims, strengthen standards for community mental health centers, and increase funding for anti-fraud activities.

C. COST CONTAINMENT PROGRAMS

1. Comparative effectiveness research will be supported by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatment.

   a. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels.

   b. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage.

2. Awards will be provided for five-year demonstration grants to states who will develop, implement, and evaluate alternatives to current tort litigation.

3. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders to address tort litigation.

a. Also provided to states who have developed proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance.

4. The Act has also issued numerous rules aimed at improving the quality of the Medicare system, much of which will focus on intense study and research into the effectiveness – overall – of the Medicare system.

XI. APPEALS UNDER THE PPACA

A. APPEAL AND GRIEVANCE PROCEDURES

1. A group health plan and a health insurance issuer offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations.

2. Participants must have the ability to receive continued coverage during the review process. (New PHSA §2719) [PPACA §§1001, 10101]

B. INTERNAL CLAIMS AND APPEALS

1. A group health plan and a health insurance issuer that offers group or individual insurance coverage must have an effective internal appeals process, including notice to enrollees of available appeals processes, along with an opportunity to review their file and present evidence. (New PHSA §2719) [PPACA §§1001, 10101]

2. The above is effective for plan years beginning on or after September 23, 2010.

C. EXTERNAL REVIEW

1. Group health plans must further establish external appeals process that meets the NAIC Uniform Review Model Act or the standards established by HHS. (New PHSA §2719) [PPACA §§1001, 10101]

XII. PREEXISTING CONDITION RULES UNDER THE PPACA

A. NO GROUP HEALTH PLAN OR ISSUER OFFERING GROUP OR INDIVIDUAL COVERAGE MAY DENY COVERAGE TO ANY INDIVIDUAL BASED ON ANY PREEXISTING CONDITION

1. Almost all health plans have traditionally denied coverage for a set amount of time to new enrollees who have suffered from a previous

illness under a "preexisting conditions" provision.

2. A temporary high-risk health insurance pool shall be established to provide coverage for eligible individuals who had been denied health care coverage on the basis of a preexisting condition.

3. The pool will exist until 2014 (when Exchanges are operational).

4. Health insurance coverage in the pool shall cover not less than 65 percent of the total allowed costs of benefits. Out of pocket limits shall not be greater than the limit in IRC §223(c)(2), but may be modified.

5. Individuals who are currently covered must be uninsured or not have creditable coverage for six months before joining the high-risk pool.

6. If the Secretary finds the insurer or employer plan has encouraged individual to disenroll in that plan prior to enrolling in high risk pool, the issuer or plan must reimburse high risk pool for medical expenses incurred by individual. An example would be offering a financial incentive to disenroll. [PPACA §1101]

7. Section 1101 of the PPACA requires the secretary to establish further regulations for the purpose eliminating preexisting condition clauses within healthcare contracts.

B. PPACA SETS FORTH ELIGIBLE INDIVIDUALS WHO WILL BENEFIT FROM THE NEW PROHIBITION ON PREEXISTING CONDITIONS

1. The individual must be a citizen or national of the United States or is otherwise lawfully present.

2. The person must not have been covered under creditable coverage as defined in Section 2701(c)(1) of the Public Health Service Act during the six-month period prior to the date on which the individual is applying for coverage through the high-risk pool.

3. The individual must have a preexisting condition as determined in a manner consistent with the guidelines issued by the Secretary.

C. NO DISCRIMINATION BASED ON PREEXISTING CONDITIONS

1. Entities discouraging individuals with preexisting conditions from enrolling in the high-risk pool, or discriminating against them in any other manner, are subject to sanctions.

2. In determining whether discrimination has occurred, or whether an entity has "discouraged participation" in the high-risk pool, the Secretary will follow a pre-set list of criteria established by HHS.

XIII. EARLY RETIREE REINSURANCE PROGRAM ("ERRP")

A. PURPOSE OF THE ERRP

1. To encourage employers to continue to provide health coverage to early retirees.

2. The ERRP does not require that employers or plan sponsors to create health coverage plans for early retirees, but instead is meant to provide a subsidy for those who do have such a program.

B. ERRP RULES

1. The Secretary of HHS was directed to 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.

2. Payments under the program must be used to lower costs of the plan.

3. Congress has set aside $5 billion to fund the program, and when those monies have been depleted the ERRP will end.

C. HEALTH AND HUMAN SERVICES REGULATIONS WERE PUBLISHED ON MAY 5, 2010

1. The regulations address health plans eligible to participate in the program, procedures for plan sponsors applying for benefits, and standards calculating the cost threshold and cost limit.

2. The ERRP begins June 1, 2010, and will terminate the earlier of January 1, 2014, or the date the $5 billion earmarked for the program is exhausted.

D. "EMPLOYMENT BASED PLANS" ARE ELIGIBLE FOR THE SUBSIDY UNDER THE ERRP

1. Employment based plans are defined as group health plans that provide benefits to early retirees (except for any federal governmental plans). 45 C.F.R. §149.2.

2. Health plans eligible for the subsidy will be reimbursed only if they maintain coverage for retirees who are:

   a. age 55 and over,

   b. not yet eligible for Medicare, and not an active employee of an employer maintaining or contributing to the plan (or of an employer that has made substantial contributions to the plan).

3. Enrolled spouses, surviving spouses, and dependents of retirees are also considered to be early retirees for purposes of the program.

4. A person may be presumed active by HHS if under the Medicare Secondary Payor ("MSP") rules the person is considered to be receiving health coverage by reason of current employment status. 45 C.F.R. §149.2.

E. IN ORDER TO PARTICIPATE IN THE PROGRAM EMPLOYMENT BASED PLANS MUST BE CERTIFIED BY HHS

1. To be certified, plans must include programs and procedures that have generated or have the potential to generate cost savings with respect to participants with chronic and high-cost conditions. 45 C.F.R. §149.35(a)(2).

2. A chronic and high-cost condition under the regulations means a condition for which $15,000 or more in health benefit claims are likely to be incurred during a plan year by any one participant.

3. In selecting programs and policies to lower costs, plan sponsors are required to take a "reasonable" approach to determine how they may improve the quality of care while at the same time lowering the costs of care.

4. The plan sponsor must submit an application to HHS to become certified. As part of its application, the plan sponsor must:

5. Make available all required information, data, documents, and records.

6. Have a written agreement with its insurer or the plan to disclose information to HHS necessary for operation of the program.

a. Ensure policies and procedures are in place to protect against fraud, waste and abuse. 45 C.F.R. §149.35(b)(1), (2) and (3).

F. APPLICATIONS FOR QUALIFICATION UNDER THE ERRP MUST SPECIFY CERTAIN PLAN INFORMATION AS WELL AS INDICATE HOW THE SUBSIDIES WILL BE USED

1. Applications are processed in the order they are received.

2. A plan sponsor is not required to submit a separate application for each plan year.

3. The HHS has stated that it will publish application forms sometime in June of 2010.

4. The regulations set forth specific items required to be included in the application, including a "plan sponsor agreement":

a. The plan sponsor agreement must include an assurance that the plan sponsor has a written agreement with its health insurance issuer or employment based plan as applicable and sets forth how disclosure of information will be made to the Secretary of HHS.

b. The agreement must also include an acknowledgement that the information in the application is being provided for purposes of obtaining federal funds and that all subcontractors acknowledge that information provided in connection with the subcontract is used for purposes of obtaining federal funds. 45 C.F.R. §149.40(4)(ii). The agreement must also provide that the plan sponsor attests that policies and procedures have been fully implemented to reduce fraud, waste, and abuse.

c. The plan is not required to submit its written policies and procedures, but they must be made available to the Secretary at any time if so requested. 45 C.F.R. §149.40(4)(iii).

G. CLAIMS FOR REIMBURSEMENT MAY BE SUBMITTED BY CERTIFIED PLAN SPONSORS

1. Claims for an early retiree for a plan year cannot be submitted until the total paid costs for health benefits for that retiree incurred for that specific plan year exceeds the threshold (currently $15,000).

2. All claims must include a list of all related retirees for whom claims are being submitted.

3. The plan sponsor must submit documentation showing the actual costs of the items and services for the claims being submitted as well as *prima facie* evidence that the early enrollee paid his or her portion of the plan (if applicable).

4. Fully insured plans may request that the health insurer submit the required information directly to HHS.

5. Any records submitted to the Secretary in connection with a claim for reimbursement must be maintained for a period of at least six years.

6. HHS has specified that it may be publishing further regulations on this requirement, but currently the responsibility for maintaining the above records lies with the plan sponsor, whether or not it is the health insurance issuer who submits the documents directly to the Secretary.

H. AMOUNT OF SUBSIDY

1. ERRP reimburses plan sponsors for each retiree enrolled in the certified plan for 80% of the cost for health benefits net of "negotiated price concessions" for claims incurred during the plan year.

   a. Negotiated price concessions reflect concessions that have already been subtracted from the amount the employment based plan or insurer paid in the amounts of post-point of sale negotiated price concessions received. 45 C.F.R. §149.110.

   b. HHS recognizes that most negotiated price concessions may not be received until after the payment has been made and in some cases even after the plan year in which the payment was made has ended.

   c. The ERRP program requires that the plan sponsors disclose any point-of-sale negotiated price concessions.

2. Reimbursement is made for amounts paid on behalf of each early retiree (and each enrolled spouse, surviving spouse, and dependents) to the extent that the claims for such retiree exceed $15,000, but only up to $90,000 of such costs. 45 C.F.R. §149.115(c).

a. These amounts are adjusted annually for each fiscal year.

b. Adjustment is based on the percentage increase and the medical care component of the consumer price index.

3. The maximum reimbursement for any one beneficiary is 80% of $75,000 or $60,000.

4. The plan sponsor cannot aggregate early retirees for purposes of reaching the threshold.

5. The $15,000 threshold includes the amounts paid by the retiree as part of a cost sharing program.

I. TRANSITION PROVISIONS APPLY FOR THE FIRST YEAR THAT ERRP IS EFFECTIVE

1. Claims cannot be reimbursed if they were incurred prior to the effective date of the ERRP.

2. The HHS determined that allowing any prior claims might unfairly benefit plans that had plan years beginning well in advance of the effective date of the ERRP (June 1, 2010) to the detriment of other plans.

3. Only claims incurred on and after June 1, 2010, will count toward the $15,000 cost threshold.

J. PLAN SPONSORS MAY ONLY USE THE SUBSIDY TO REDUCE THEIR OWN HEALTH CARE COSTS OR REDUCE COSTS OF THEIR PARTICIPANTS – OR A COMBINATION OF BOTH

1. The subsidy may not be used as general revenue.

K. APPEAL PROGRAM

1. Plan sponsors have 15 calendar days after receipt of an adverse reimbursement determination to submit an appeal.

2. All appeals must be in writing and sent to the HHS Secretary.

3. All decisions made upon this appeal are final and binding.

4. There is only one appeal level to determine if funds available for the program.

5. If the adverse determination was based on the unavailability of funds, i.e. the $5,000,000,000 set aside for the program, it is not appealable.

L. ALL PLAN SPONSORS WHO APPLY FOR SUBSIDIES WILL BE SUBJECT TO AUDITS TO ENSURE FISCAL INTEGRITY

M. THE SECRETARY MAY IN CERTAIN CIRCUMSTANCES REOPEN AND REVISE A REIMBURSEMENT DETERMINATION

1. The Secretary may reopen a determination either upon its own motion or that of a plan sponsor. 45 C.F.R. §149.610(a).

2. The Secretary is free to open a reimbursement determination in instances of fraud. 45 C.F.R. §149.610(a)(3).

3. Other time limits apply to any determination revisions for reasons other than fraud.

4. The Secretary may reopen and revise any reimbursement determination for any reason within one year of the determination. 45 C.F.R. §149.610(a)(1).

5. A determination may be reopened by the Secretary within four years if there is a showing of good cause. 45 C.F.R. §149.610(a)(2).

a. Good cause may be present if the Plan can show the following: (1) new and material evidence existing that was not readily available at the time the reimbursement determination was made by the Secretary, (2) a clerical error in the computation of the reimbursement determination, or (3) evidence that was relied upon in making the determination is shown to be clearly erroneous.

b. Good cause does not include a change of legal interpretation or administrative rulings upon which the determination for reimbursement was made.

XIV. THE HEALTH CARE EXCHANGES

A. CREATION AND STRUCTURE OF HEALTH INSURANCE EXCHANGES

1. PPACA §1311 mandates each state to create a state-based American Health Benefit Exchanges and Small Business Health Options Program ("SHOP") Exchanges.

a. SHOP exchanges are established specifically to allow small businesses to purchase coverage.

b. State may merge an exchange and a SHOP exchange.

2. Territories may also establish exchanges.

3. States may form regional exchanges or allow more than one Exchange to operate in a state as long as each exchange serves a distinct geographic area.

B. PURPOSE OF THE EXCHANGES

1. The exchanges will facilitate the purchase of qualified health plans by individuals, who will receive a federal grant to aid in the purchase of coverage.

2. Exchanges shall be administered by a governmental agency or non-profit organization.

3. Individuals and small business will be able to "shop around" for health insurance by reviewing and comparing health plans online.

4. The exchanges will have web portals that will facilitate online comparison, price review, and benefit review.

5. If a state fails to implement the necessary requirements for an exchange, HHS will step in to operate the exchange.

6. Individuals and small businesses with up to 100 employees can purchase qualified coverage.

C. ELIGIBILITY TO PURCHASE IN THE EXCHANGES

1. Individual Eligibility

2. Access to participate in an exchange is limited to U.S. citizens and legal immigrants who are not incarcerated.

3. The participant can also be a legal resident of the United States.

4. "Qualified Individuals" may enroll in any qualified health plan available for which the individual is eligible.

a. A qualified individual is a legal U.S. resident who lives in a state with an exchange.

b. The individual must seek to enroll in a qualified health plan in the individual market through the exchange.

5. HHS will establish procedures to determine eligibility to participate in the Exchange, and for the receipt of premium tax credits or reduced cost-sharing [PPACA §1411].

6. Employer Eligibility

7. Employers who may participate in the exchange are generally limited to 100 employees or less.

8. Employers participate in the exchange by electing to make all full-time employees eligible for plans through the exchange.

9. States may pass their own legislation to allow businesses with more than 100 employees to purchase coverage in a SHOP exchange beginning in 2017.

10. Once an employer becomes eligible to participate in an exchange, it will remain eligible regardless of how many employees it has [PPACA §§1311, 1304(b), 1312(f)].

D. HEALTH PLANS ELIGIBILITY FOR THE EXCHANGE

1. Health Plans must be "Qualified Health Plans" to be offered through the exchange.

2. To qualify, a plan or provider must agree to offer at least one silver level and one gold level plan.

3. The plan or provider must agree to charge the same premium rate for each qualified plan of the provider without regard to whether or not the plan is offered on the exchange.

4. All plans must provide the "Essential Benefits," which include cost-sharing limits.

E. MULTI-STATE PLANS

1. The Office of Personnel Management ("OPM") is directed to contract with insurers to offer at least two multi-state plans in each exchange [PPACA §10104(q)].

2. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.

3. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan.

4. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules.

5. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

F. CONSUMER OPERATED AND ORIENTED PLAN (CO-OP)

1. HHS is directed to establish Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia.

2. Eligibility:

a. An organization must not be an existing health insurer or sponsored by a state or local government.

b. Substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed.

c. Governance of the organization must be subject to a majority vote of its members.

d. The organization must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. [PPACA §§1322, 10104]

G. BENEFIT TIERS

1. The PPACA mandates the creation of four benefit categories of plans plus a separate catastrophic plan to be offered through the exchange, as well as in the individual and small group markets:

2. A Bronze plan represents minimum creditable coverage and provides the essential health benefits, covers 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);

3. A Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;

4. A Gold plan provides the essential health benefits, covers 80% of the benefits costs of the plan, with the HSA out-of-pocket limits;

5. A Platinum plan provides the essential health benefits, covers 90% of the benefits costs of the plan, with the HSA out-of-pocket limits.

6. Catastrophic plans.

    a. These plans are available to those up to age 30.

    b. Individuals exempt from the mandate to purchase coverage (the "Individual Mandate") may purchase a catastrophic plan.

    c. Provides catastrophic coverage only with the coverage level set at the HSA current law levels.

    d. Prevention benefits and coverage for three primary care visits would be exempt from the deductible.

    e. This plan is only available in the individual market.

H. EXEMPTION FROM THE INDIVIDUAL MANDATE

1. The individual must have a certificate that such individual is exempt.

2. Reasons for exemption are the inability to purchase other coverage or that coverage presents a financial hardship. [PPACA §§1302(d) and (e)].

I. STATE BASIC HEALTH PLANS

1. HHS will establish a basic health care plan that states may offer to individuals who have incomes above the Medicaid eligibility mark but below 200% of the FPL.

2. Eligible persons and families will have access to coverage options through the Basic health plan rather than through an exchange.

3. States may enroll the following individuals.

    a. Under the age of 64.

b. Do not have access to affordable employer sponsored coverage meeting the minimum creditable coverage standards.

c. Residents of an area served by the Plan.

d. Have gross family income above 133% percent and below 200% of FPL. [PPACA §§1331, 10104]

J. ENSURING AFFORDABLE COVERAGE

1. Tax credits will be provided to limit the amount that an individual must spend on health care insurance premiums.

2. Eligible individuals with household incomes between 100% and 400% of the FPL enrolled in a "silver plan" offered by an exchange are eligible for a cost-sharing subsidy.

3. Generally, the amount of the subsidy is as follows:

a. 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);

b. 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);

c. 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

4. These out-of-pocket reductions are applied within the actual limits of the plan and will not increase the actuarial value of the plan.

K. ADDITIONAL QUALIFICATIONS FOR PLANS ON THE EXCHANGE

1. Qualified health plans participating in the Exchange must:

a. Meet certain marketing requirements;

b. Have adequate provider networks;

c. Contract with essential community providers;

d. Contract with navigators to conduct outreach and enrollment assistance;

e. Be accredited with respect to performance on quality measures;

f. Use the uniform enrollment form and standard formats to present plan information.

2. Qualified health plans are required to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

L. ADDITIONAL REQUIREMENTS OF THE EXCHANGES

1. Exchanges must maintain a call center for customer service and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits.

2. States must develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail, or by phone.

3. Exchanges must be able to contract with state Medicaid agencies to determine eligibility for tax credits in the exchanges.

4. Exchanges are required to submit financial reports to the Secretary and comply with oversight investigations, including a GAO study on the operation and administration of exchanges.

M. ABORTION COVERAGE

1. The PPACA will permit states to prohibit coverage for abortions.

2. Plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) must create allocation accounts.

3. The accounts will segregate premium payments for abortion services from premium payments for all other coverage.

4. The purpose of segregating the premium payments is to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage.

5. Plans providing abortion services must estimate the actuarial value of covering abortions.

6. Plans must take into account the cost of the abortion benefit to be valued at no less than $1 per enrollee per month.

7. Plans cannot take into account any savings that might be reaped as a result of the abortions. [PPACA §1303]

N. FREE CHOICE VOUCHERS

1. Vouchers must be provided to certain employees to allow them to purchase coverage in exchange.

2. Employers with more than 50 employees that offer health insurance coverage must provide a "free choice voucher" to those employees with an income less than 400% of the federal poverty level whose share of the premium exceeds 8% but is less than 9.8% of income.

3. The voucher amount must be equal to what the employer would have paid if the employee had chosen the employer's plan.

4. Employers will not be subject to fines for such an employee's participation in the exchange.

O. PLAN REPORTING TO HHS AND THE STATE INSURANCE AGENCY

1. All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language:

a. Claims payment policies and practices.

b. Periodic financial disclosures.

c. Data on enrollment.

d. Data on disenrollment.

e. Data on the number of claims that are denied.

f. Data on rating practices.

g. Information on cost-sharing and payments with respect to out-of-network coverage.

h. Other information as determined appropriate by the Secretary.

XV. MISCELLANEOUS MANDATES OF THE PPACA

A. FLEXIBLE SPENDING ARRANGEMENTS/HEALTH REIMBURSEMENT ARRANGEMENTS/HEALTH SAVINGS ACCOUNTS PROVISIONS

1. Over-the-counter medications will be reimbursable only with a physician's prescription, effective January 1, 2011.

2. FSA contributions are capped at $2,500 (indexed).