

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

| Provision | Notes | Standards Development | Applicability | Effective Date | PPACA Section | Statutory Section |
|---|--|-----------------------|---|--|-----------------|-------------------|
| Annual and Lifetime Limits | Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS. | | Lifetime limits: All plans Annual limits: All plans except grandfathered individual market plans | 6 months after enactment | 1001 | PHSA 2711 |
| Rescissions | Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Prior notification must be made to policyholders prior to cancellation. | | All plans | 6 months after enactment | 1001 | PHSA 2712 |
| Coverage of preventive health services | Plans must provide coverage without cost-sharing for: <ul style="list-style-type: none"> • Services recommended by the US Preventive Services Task Force • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration <p>Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.</p> <p>The Secretary will determine an interval of not less than 1 year after which new recommendations will be incorporated.</p> | Secretary of HHS | All non-grandfathered plans | 6 months after enactment | 1001 | PHSA 2713 |
| Extension of adult dependent coverage | Plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. The Secretary will define which adult children coverage must be extended. | Secretary of HHS | All plans | 6 months after enactment | 1001 | PHSA 2714 |
| | For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage. | | | | HR 4872 §2301 | |
| Preexisting condition exclusions | A plan may not impose any preexisting condition exclusions. | | All plans except grandfathered individual market plans | 6 months after enactment for under 19. | 1201 & 10103(e) | PHSA 2704 |

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| Uniform explanation of coverage documents and standardized definitions | <p>The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees. The summary must contain:</p> <ul style="list-style-type: none"> • Uniform definitions of insurance and medical terms • A description of coverage and cost sharing for each category of essential benefits and other benefits • Exceptions, reductions and limitations in coverage • Renewability and continuation of coverage provisions • A “coverage facts label” that illustrates coverage under common benefits scenarios • A statement of whether it provides minimum essential coverage with an actuarial value of at least 60% that meets the requirements of the individual mandate • A statement that the outline is a summary and that the actual policy language should be consulted • A contact number for the consumer to call with additional questions and the web address of where the actual policy language can be found. <p>The Secretary must consult with the NAIC, as well as a working group of insurers, providers, patient advocates, and those representing individuals with limited English proficiency.</p> | Secretary of HHS, in consultation with the NAIC and a working group of consumer advocacy organizations, insurers, health care professionals, patient advocates, and other qualified individuals. | All non-grandfathered plans | Standards developed within 12 months. Uniform documents implemented within 24 months | 1001 | PHSA 2715 |
| Provision of additional information | <p>All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language:</p> <ul style="list-style-type: none"> • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage • Other information as determined appropriate by the Secretary | | All non-grandfathered plans | 6 months after enactment | 1001 | PHSA 2715A |
| Prohibition on discrimination based on salary | <p>Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully-insured group plans. The Secretary of HHS will develop rules.</p> | | Fully insured non-grandfathered group health plans | 6 months after enactment | 1001 | PHSA 2716 |

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| Ensuring quality of care | Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: <ul style="list-style-type: none"> • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors • Implement wellness and health promotion activities | Secretary of HHS, in consultation with experts in health care quality and stakeholders | All non-grandfathered plans | 2 years after enactment | 1001 | PHSA 2717 |
| Bringing down the cost of health care | Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. The report must include the percentage of total premium revenue, after accounting for risk adjustment, premium corridors, and payments of reinsurance that is expended on: <ul style="list-style-type: none"> • Reimbursement for clinical services • Activities that improve health care quality • All other non-claims expenses, including the nature of the costs, excluding Federal and State taxes and licensing or regulatory fees Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. <p>All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups</p> | The NAIC shall establish, by December 31, 2010, uniform definitions of the categories of expenses and standardized methodologies for calculating measures of them. | All fully insured plans, including grandfathered plans | 01/01/11 | 1001 | PHSA 2718 |
| Appeals process | Internal claims appeal process: <ul style="list-style-type: none"> • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: <p>All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.</p> | Secretaries of Labor and HHS | All non-grandfathered plans | 6 months after enactment | 1001 | PHSA 2719 |

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| Patient Protections | <p>A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians.</p> <p>If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.</p> <p>A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.</p> | | All non-grandfathered plans | 6 months after enactment | 1001 | PHSA 2719A |
| Health insurance consumer assistance offices and ombudsmen | <p>The Secretary of HHS shall provide \$30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to:</p> <ul style="list-style-type: none"> • Assist with the filing of complaints and appeals • Collect, track, and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies <p>As a condition of receiving a grant, a state must collect and report data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.</p> | | | Date of enactment | 1002 | PHSA 2793 |
| Ensuring that consumers get value for their dollars | <p>The Secretary, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online.</p> <p>The Secretary shall award \$250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services.</p> | The Secretary in conjunction with the states. | All non-grandfathered fully-insured plans | 2010 plan year | 1003 | PHSA 2794 |

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

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