

HEALTH INSURANCE EXCHANGE AND INSURANCE OVERSIGHT (SECTION-BY-SECTION ANALYSIS)

(Information compiled from the Democratic Policy Committee (DPC) Report on The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. Available online at <http://dpc.senate.gov/healthreformbill/healthbill96.pdf>.)

Insurance reform

Sec. 1001. Amendments to the Public Health Service Act.

Sec. 2711. No lifetime or annual limits. As amended by **Section 10101**, prohibits plans from establishing lifetime limits, and annual limits beginning in 2014, on the dollar value of benefits. Prior to 2014, plans may only establish restricted annual limits as defined by the Secretary of Health and Human Services (HHS), ensuring access to needed services with minimal impact on premiums.

Sec. 2712. Prohibition on rescissions. Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation.

Sec. 2713. Coverage of preventive health services. Requires all new plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the CDC, certain child preventive services recommended by the Health Resources and Services Administration (HRSA), and women's preventive care and screening recommended by HRSA, without any cost-sharing.

Sec. 2714. Extension of dependent coverage. Requires all plans offering dependent coverage to allow individuals until age 26 to remain on their parents' health insurance.

Section 2301 of the *Reconciliation Act* eliminates the requirement that adult children be unmarried.

Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions. Requires the Secretary to develop standards for use by health insurers in compiling and providing an accurate summary of benefits and explanation of coverage for applicants, policyholders or certificate holders, and enrollees. The standards must be in a uniform format, using language that is easily understood by the average enrollee, and must include uniform definitions of standard insurance and medical terms. The explanation must also describe any cost-sharing, exceptions, reductions, and limitations on coverage, and examples to illustrate common benefits scenarios.

Sec. 2715A. Provision of additional information. As added by **Section 10101**, requires all plans to disclose the information required in section 1311(e), such as claims payment policies and rating practices. Plans that are not offered through the Exchange must submit this information to the Secretary of HHS and the State insurance commissioner and make such information available to the public.

Sec. 2716. Prohibition of discrimination in favor of highly compensated individuals. Employers that provide health coverage will be prohibited from limiting eligibility for coverage to highly compensated individuals.

Sec. 2718. Bringing down the cost of health care coverage. As amended by **Section 10101**, requires plans offering coverage in the group and individual markets (including grandfathered plans but excluding self-insured plans) to report to the Secretary the amount of premium revenues spent on clinical services, activities to improve quality, and all other non-claims costs as defined by the National Association of Insurance Commissioners and certified

by the Secretary of HHS. Beginning in 2011, large group plans that spend less than 85 percent of premium revenue and small group and individual market plans that spend less than 80 percent of premium revenue on clinical services and quality must provide a rebate to enrollees. In addition, each hospital operating within the United States shall publish a list of standard charges for items and services provided by the hospital.

Sec. 2719. Appeals process. As amended by **Section 10101**, requires new plans to implement an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process or the plan is self-insured, the plan shall implement an external review process that meets minimum standards established by the Secretary. The Secretary may deem the external review process of a plan in operation as of enactment to be in compliance with this section.

Sec. 1002. Health insurance consumer information. The Secretary shall award grants to States to enable them (or the Exchange) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. These independent offices will assist consumers with filing complaints and appeals, educate consumers on their rights and responsibilities, and collect, track, and quantify consumer problems and inquiries. Provides \$30 million in funding and is effective upon the date of enactment of the bill.

Sec. 1003. Ensuring that consumers get value for their dollars. For plan years beginning in 2010, the Secretary and States will establish a process for the annual review of increases in premiums for health insurance coverage. Requires States to make recommendations to their Exchanges about whether health insurance issuers should be excluded from participation in the Exchanges based on unjustified premium increases. Provides \$250 million in funding to States from 2010 until 2014 to assist States in reviewing and, if appropriate under State law, approving premium increases for health insurance coverage and in providing information and recommendations to the Secretary. As added by **Section 10101**, allows for the establishment of medical reimbursement data centers to develop fee schedules and other database tools that reflect market rates for medical services.

Sec. 1101. Immediate access to insurance for people with a preexisting condition. Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Provides up to \$5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.

Sec. 1103. Immediate information that allows consumers to identify affordable coverage options. Establishes an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. This information will include eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care, rather than administrative expenses, by the issuer. **Section 10102** clarifies that the internet portal shall be available to small businesses and shall contain information on coverage options available to small businesses.

Enforce insurance oversight laws

Part I – Health Insurance Market Reforms

Sec. 1201. Amendment to the Public Health Service Act.

Sec. 2701. Fair health insurance premiums. Establishes that premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1), and tobacco use (limited to a ratio of 1.5 to 1).

Section 10103 clarifies that this provision applies to insured plans in the large group market, not self-insured plans.

Sec. 2702. Guaranteed availability of coverage. Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.

Sec. 2703. Guaranteed renewability of coverage. Requires guaranteed renewability of coverage regardless of health status, utilization of health services or any other related factor.

Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status. No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past.

Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status. No group health plan or insurer offering group or individual coverage may set eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 percent for employee participation in certain health promotion and disease prevention programs. Authorizes a 10-State demonstration to apply such a program in the individual market.

Sec. 2706. Non-discrimination in health care. Prohibits discrimination against health care providers acting within the scope of their professional license and applicable State laws.

Sec. 2707. Comprehensive health insurance coverage. Requires health insurance issuers in the small group and individual markets to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all health plans to comply with limitations on allowable cost-sharing.

Sec. 2708. Prohibition on excessive waiting periods. Prohibits any waiting periods for group coverage that exceeds 90 days. **Section 10103** clarifies that waiting periods do not apply to the individual market.

Sec. 1251. Preservation of right to maintain existing coverage. Allows any individual enrolled in any form of health insurance to maintain their coverage as it existed on the date of enactment.

Section 10103 applies the requirements for medical loss ratios and uniform coverage documents to grandfathered plans. **Section 2301 of the *Reconciliation Act*** applies the requirements for excessive waiting periods, lifetime limits, rescissions, and extension of young adult coverage to grandfathered plans. Also, applies requirements relating to pre-existing coverage exclusions to group health plans, applies requirements regarding adult child coverage to group health plans only if the adult child is not eligible to enroll in an employer-sponsored plan.

Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans. Standards and requirements adopted by States must be applied uniformly to all plans in each relevant insurance market in a State.

Qualified health plans

Sec. 1301. Qualified health plan defined. Requires qualified health plans to be certified by Exchanges, provide the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels. **Section 10104** strikes the community health insurance option from this section, adds multi-state plans, and allows qualified health plans to provide coverage through a qualified direct primary care medical home plan that meets requirements established by the Secretary of HHS.

Sec. 1304. Related definitions. Defines the small group market as the market in which a plan is offered by a small employer that employs 1-100 employees. Defines the large group market as the market in which a plan is offered by a large employer that employs more than 100 employees. Before 2016, a State may limit the small group market to 50 employees. As amended by Section 10104, defines an “educated health care consumer,” and requires Exchanges to consult with enrollees who are educated health care consumers.

Consumer Choices and Insurance Competition through Health Benefit Exchanges

Sec. 1311. Affordable choices of health benefit plans. Requires the Secretary to award grants, available until 2015, to States for planning and establishment of American Health Benefit Exchanges. By 2014, requires States to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a SHOP Exchange for small businesses. Requires the Secretary to:

- Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
- Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an Exchange’s Internet portal.
- Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Allows States to require benefits in addition to essential health benefits, but States must defray the cost of such additional benefits. Section 10104 clarifies that States must make payments to cover the cost of additional benefits directly to individuals or plans, and not to Exchanges. Requires Exchanges to certify qualified health plans, operate a toll-free hotline and Internet website, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility for Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual responsibility requirement. Beginning in 2015, requires Exchanges to be self-sustaining and allows them to charge assessments or user fees. Allows Exchanges to certify qualified health plans if they meet certification criteria and offering them is in the interests of individuals and employers, and, as amended by **Section 10104**, requires Exchanges to consider the reasonableness of premium rate increases when determining whether to certify and offer plans. Allows regional or interstate Exchanges if the States agree to, and the Secretary approves, such Exchanges. Requires Exchanges to award grants to Navigators, which may include resource partners of the Small Business Administration, to educate the public about qualified health plans, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions.

As added by **Section 10104**, requires plans seeking certification by Exchanges to publicly disclose, in plain language, information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service. Requires the Secretary of Labor to update disclosure rules for group health plans to conform to these standards. Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings.

Sec. 1312. Consumer choice. Allows qualified individuals, defined as individuals who are not incarcerated and who are lawfully residing in a State, to enroll in qualified health plans through that State’s Exchange. Allows qualified employers to offer a choice of qualified health plans at one level

of coverage; small employers qualify to do so, and States may allow large employers to qualify beginning in 2017. Requires insurers to pool the risk of all enrollees in all plans (except grandfathered plans) in each market, regardless of whether plans are offered through Exchanges. Requires the offering of only qualified health plans through Exchanges to Members of Congress and their staff. As amended by **Section 10104**, requires the Secretary to establish procedures to allow agents or brokers to enroll individuals and employers in qualified health plans and assist them in applying for tax credits and cost-sharing reductions.

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements. Requires the Secretary, in consultation with NAIC, to set standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. Requires States to implement these standards by 2014. If the Secretary determines before 2013 that a State will not have an Exchange operational by 2014, or will not implement the standards, requires the Secretary to establish and operate an Exchange in the State and to implement the standards. Presumes that a State operating an Exchange before 2010 meets the standards, and establishes a process for the State to come into compliance with the standards.

Enroll CO-Ops and multi-state plans into the HIE

Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers. Requires the Secretary to award loans for start-up costs and grants to meet solvency requirements, until July 1, 2013, to member-run nonprofits that will offer qualified health plans. As amended by **Section 10104**, such loans must be repaid within 15 years. Establishes an Advisory Board with members appointed by the Comptroller General, to terminate by 2016. Prohibits health insurance issuers that existed on July 16, 2009 or governmental organizations from qualifying for the program. Allows participants to form a private purchasing council to enter into collective purchasing arrangements for items and services, but which may not set provider payment rates. Prohibits government representatives from serving on the board of directors of participants or the council. Appropriates \$6 billion for the CO-OP program, and exempts participants from taxation.

Waiver for state innovation in health benefit exchange

Sec. 1332. Waiver for State innovation. Beginning in 2017, allows States to apply for a waiver for up to 5 years of requirements relating to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. Requires States to enact a law and to comply with regulations that ensure transparency. Requires the Secretary to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Requires the Secretary to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.

Offering plans in more than one state

Sec. 1333. Provisions relating to offering of plans in more than one State. By July 1, 2013, requires the Secretary, in consultation with NAIC, to issue regulations for interstate health care choice compacts, which can be entered into beginning in 2016. Under such compacts, qualified health plans could be offered in all participating States, but insurers would still be subject to the consumer protection laws of the purchaser's State. Insurers would be required to be licensed in all participating States (or comply as if they were licensed), and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's State. Requires States to enact a law to enter into compacts and Secretarial approval, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit or weaken enforcement of State consumer protection laws.

Sec. 1334. Multi-State Plans. As added by **Section 10104**, requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State. Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for Federal Employees Health Benefits Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan; States may require multi-state plans to offer additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except States may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a separate risk pool and remain a separate program.

Participate in reinsurance, risk adjustment and risk corridors

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State. For 2014, 2015, and 2016, requires States to establish a nonprofit reinsurance entity that collects payments from insurers market and makes payments to insurers in the individual market that cover high-risk individuals. Requires the Secretary to establish Federal standards for the determination of high-risk individuals, a formula for payment amounts, and the contributions required of insurers, which must total \$25 billion over the three years.

Sec. 1343. Risk adjustment. Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-average risk. Risk adjustment applies to plans in the individual and small group markets, but not to grandfathered health plans.

Reporting to Secretary for refundable tax credits

Sec. 1401. Refundable tax credit providing premium assistance for coverage under a qualified health plan. Amends the Internal Revenue Code to provide tax credits to assist with the cost of health insurance premiums.

Sec. 36B. Refundable credit for coverage under a qualified health plan. As amended by **Section 1001 of the *Reconciliation Act***, the premium assistance credit amount is two percent for those up to 133 percent of poverty, and calculated on sliding scale starting at three percent of income for those at or above 133 percent of poverty and phasing out to 9.5 percent of income for those at 300-400 percent of poverty. The reference premium is the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. The premium assistance credits do not take into account benefits mandated by States. Employees offered coverage by an employer under which the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs or the premium exceeds 9.5 percent of the employee's income are eligible for the premium assistance credit. This section also provides for reconciliation of the premium assistance credit amount at the end of the taxable year and for a study on the affordability of health insurance coverage by the Comptroller General. The *Reconciliation Act* requires each Exchange to report to the Secretary and to the taxpayer information regarding health insurance coverage and any tax credits received.

Sec. 1001 of Reconciliation. Tax Credits. Improves the financing for premiums and cost sharing for individuals with incomes up to 400% of the federal poverty level. Subsection (a) improves tax credits to make premiums more affordable as a percent of income; and subsection (b) improves support for cost sharing, focusing on those with incomes below 250 percent of the federal poverty level. Starting in 2019, constrains the growth in tax credits if premiums are growing faster than the consumer price index, unless spending is more than 10 percent below current CBO projections.

Determining exchange eligibility

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions. The Secretary shall establish a program for determining whether an individual applying for coverage in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, is a citizen or national of the United States or an alien lawfully present in the United States and meets the income and coverage requirements; whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable; and whether to grant a certification attesting that, for purposes of the individual responsibility requirement, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

Enrollment into HBE, Medicaid or CHIP

Sec. 1413. Streamlining of procedures for enrollment through an Exchange and State Medicaid, CHIP, and health subsidy programs. Requires the Secretary to establish a system for the residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children's health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs. Allows for limited disclosure of tax return information to carry out eligibility requirements for certain programs listed in the Act.

Sec. 2201. Enrollment Simplification and coordination with State Health Insurance Exchanges. Allows individuals to apply for and enroll in Medicaid, CHIP or the Exchange through a State-run website. Requires State Medicaid and CHIP programs and the Exchange to coordinate enrollment procedures to provide seamless enrollment for all programs.

Premium tax credits and cost-sharing reductions

Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions. Allows for the advanced payment of premium assistance tax credits and cost-sharing reductions for eligible individuals. Prohibits any Federal payments to individuals who are not lawfully present in the United States.

Sec. 1421. Credit for employee health insurance expenses of small businesses. Amends the *Internal Revenue Code* to provide tax credits to small employers. **Sec. 45R. Employee health insurance expenses of small employers.** As amended by Section 10105, provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. In 2010 through 2013, eligible employers can receive a small business tax credit for up to 35 percent of their contribution toward the employee's health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution. In 2014 and beyond, eligible employers who purchase 13 coverage through the State Exchange can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

Individual requirements for minimum coverage and reporting

Sec. 1501. Requirement to maintain minimum essential coverage. Contains findings of Congress related to the individual responsibility requirement, which are amended by Section 10106.

Sec. 5000A. Requirement to maintain minimum essential coverage. Requires individuals to maintain minimum essential coverage beginning in 2014. As amended by **Section 1002 of the Reconciliation Act**, failure to maintain coverage will result in a penalty of the greater of \$95 or one percent of income in 2014, \$325 or two percent of income in 2015 and \$695 or 2.5 percent of income in 2016, up to a cap of the national average bronze plan premium. Families will pay half the amount for children up to a cap of \$2,250 for the entire family. After 2016, dollar amounts will increase by the annual cost of living adjustment. Exceptions to the individual responsibility requirement to maintain minimum essential coverage are made for religious objectors, individuals not lawfully present, and incarcerated individuals. Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income below the filing threshold, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.

Sec. 1002 of Reconciliation. Individual responsibility. Modifies the assessment that individuals who choose to remain uninsured pay in three ways: (a) exempts the income below the filing threshold, (b) lowers the flat payment from \$495 to \$325 in 2015 and from \$750 to \$695 in 2016 and (c) raises the percent of income that is an alternative payment amount from 0.5 to 1.0 percent in 2014, 1.0 to 2.0 percent in 2015, and 2.0 to 2.5 percent for 2016 and subsequent years to make the assessment more progressive.

Sec. 1502. Reporting of health insurance coverage. Amends the *Internal Revenue Code* to require the reporting of health insurance coverage.

Sec. 6055. Reporting of health insurance coverage. Requires every person that provides coverage to report certain information about the coverage to the IRS.

Employer responsibility to provide and report coverage

Sec. 1511. Automatic enrollment for employees of large employers. Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

Sec. 1512. Employer requirement to inform employees of coverage options. Requires that an employer provide notice to their employees informing them of the existence of an Exchange. Also, if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium assistance tax credit and

cost sharing reduction. Finally, if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health 14 benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

Sec. 1513. Shared responsibility for employers. Requires an employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit to make a payment of \$750 per full-time employee. Section 10106 clarifies that the calculation of full-time workers is made on a monthly basis, and that an “applicable large employer” with respect to “construction industry employers” as employers with at least five full-time employees and with an annual payroll in excess of \$250,000. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$400 for any full-time employee in a 30-60 day waiting period and \$600 for any full-time employee in a waiting period longer than 60 days. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees’ wages are reduced by reason of the application of the assessable payments.

Sec. 1514. Reporting of employer health insurance coverage. Requires large employers to report to the Secretary whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer’s share of the total allowed costs of benefits provided under the plan. The employer must also report the number and names of full-time employees receiving coverage.

Sec. 10108. Free choice vouchers. Requires employers that offer coverage and make a contribution to provide free choice vouchers to qualified employees for the purchase of qualified health plans through Exchanges. The free choice voucher must be equal to the contribution that 62 the employer would have made to its own plan. Employees qualify if their required contribution under the employer’s plan would be between 8 and 9.8 percent of their income. Excludes free choice vouchers from taxation and voucher recipients are not eligible for tax credits.

Sec. 1003 of Reconciliation. Employer responsibility. Improves the transition to the employer responsibility policy for qualifying employers by subtracting the first 30 full time employees from the payment calculation (e.g., a firm with 51 workers full-time that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable payment amount per employee). Applies the same size threshold for all employers. The provision also changes the applicable payment amount for firms that do not offer coverage to \$2,000 per full-time employee. Employers who offer coverage but whose employees receive tax credits will also see the aggregate cap on payments increased to \$2,000. Also, eliminates the assessment for workers in a waiting period, while applying the same size threshold for all firms subject to the employer responsibility requirement.

Offering of exchange-participating qualified health plans through cafeteria plans

Sec. 1515. Offering of exchange-participating qualified health plans through cafeteria plans.

Amends the Internal Revenue Code related to cafeteria plans.

Sec. 125(f)(3). Certain exchange-participating health plans not qualified. Plans provided through the exchange will not be an eligible benefit under an employer-sponsored cafeteria plan, except in the case of qualified employers (i.e., small employers, and, after 2017, large employers in electing states) offering a choice of plans to their employees through the exchange.

Health Information Technology

Sec. 1561. Health information technology enrollment standards and protocols. Requires the development of standards and protocols to promote the interoperability of systems for enrollment of individuals in Federal and State health and human services programs. These standards shall allow for electronic data matching, and electronic documentation. The Secretary may require State or other entities to incorporate such standards as a condition of receiving Federal health information technology funds.

Income definitions

Sec. 1004 of Reconciliation. Income definitions. Modifies the definition of income that is used for purposes of tax credit and subsidy eligibility and the individual responsibility requirement. The modifications conform the income definition to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds. The provision also extends the exclusion from gross income for employer provided health coverage for adult children up to the end of the calendar year in which the child turns age 26.

Insurance reforms

Sec. 2301 of Reconciliation. Insurance Reforms. Extends the prohibition of lifetime limits, prohibition on rescissions, and a requirement to provide coverage for adult children up to age 26 to all existing health insurance plans starting six months after enactment. Extends the limitation on excessive waiting periods to all existing group plans, effective in 2014. For group health plans, prohibits pre-existing condition exclusions in 2014, restricts annual limits beginning six months after enactment, and prohibits them starting in 2014. For coverage of adult children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage.

High-Risk Insurance Pool

Sec. 1101. Immediate access to insurance for people with a preexisting condition. Enacts a temporary insurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition. Ensures premium rate limits for the newly insured population. Provides up to \$5 billion for this program, which terminates when the American Health Benefit Exchanges are operational in 2014. Also establishes a transition to the Exchanges for eligible individuals.

This group may also want to review the provision which allows the state to create a basic health plan for people under 200% FPL.

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid. Allows States to contract, through a competitive process that includes negotiation of premiums, cost-sharing, and benefits, with standard health plans for individuals who are not eligible for Medicaid or other affordable coverage and have income below 200 percent of the Federal Poverty Level (FPL). Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits.

Requires the Secretary to transfer to participating States 95 percent of the tax credits and cost-sharing reductions that would have been provided to individuals enrolled in standard health plans if they were enrolled in qualified health plans. **Section 10104** clarifies that legal immigrants whose income is less than 133 percent of the Federal Poverty Level (FPL), and who are not eligible for Medicaid by virtue of the five year waiting period, are eligible for the basic health program.

