

American Affordable Health Choice Act/ Patient Protection and Affordable Care Act

Funding Required: \$829 - \$900 Billion

Municipal Update

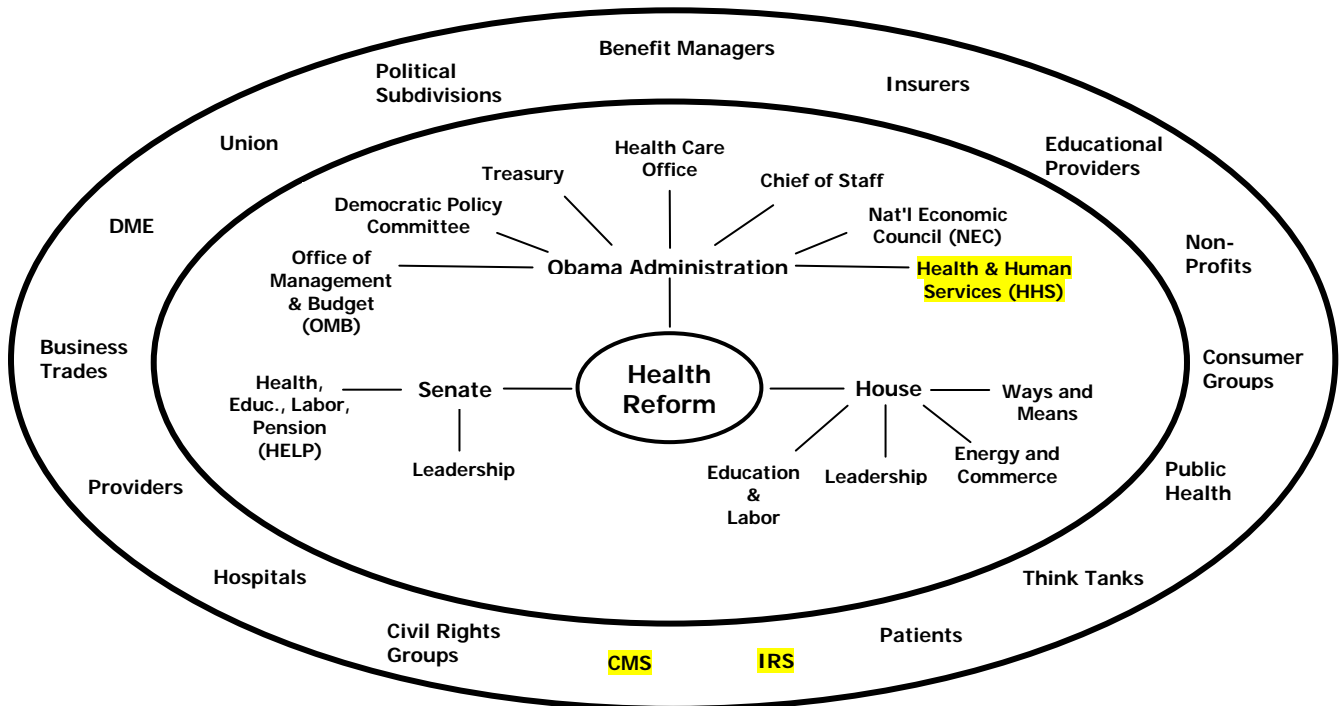
<ul style="list-style-type: none"> Municipalities are the fourth largest employer
<ul style="list-style-type: none"> 86% of all cities and towns provide health insurance for their employees, and most provide coverage for employee's families.
<ul style="list-style-type: none"> Cities and towns spend \$87 billion per year for healthcare for their employees and their families.
<ul style="list-style-type: none"> Approximately 17% of the employer's budget are health benefits for employees, retirees and families.
<ul style="list-style-type: none"> Local governments will need to review their health plans to determine if they comply with the new law and may have to modify their plans to meet new requirements.
<ul style="list-style-type: none"> Local governments will be able to continue to self-insure and to participate in state-wide risk pools for provision of benefits.
<ul style="list-style-type: none"> Local governments that self-insure must, after two years, demonstrate to the Secretary of Health and Human Services that their plans are sufficiently funded or capitalized to cover all likely medical claims.
<ul style="list-style-type: none"> The health care benefits of local governments, like all employers, must meet coverage minimums

Concerns

<ul style="list-style-type: none"> More than 1/2 of US hospitals are technically insolvent or at risk of insolvency.
<ul style="list-style-type: none"> The U.S. could face a shortage of Primary Care Physicians by 2025.
<ul style="list-style-type: none"> Solvency of self-funded plans is questioned due to poor reserve levels
<ul style="list-style-type: none"> Five out of Seven largest health insurers have slashed their full year earnings expectations, leading to massive stock sell-offs by investors.

Objective: Universal Access to Healthcare Benefits

<ul style="list-style-type: none"> 2025 Shortage of physicians/widening the door to healthcare may impact access due to healthcare delivery system constraints
<ul style="list-style-type: none"> Reward medical students who choose a career as a primary care physician and choose to work in an underserved area
<ul style="list-style-type: none"> Primary care payment equity
<ul style="list-style-type: none"> College loan repayment program
<ul style="list-style-type: none"> Financial support for medical school with community center workforce offset
<ul style="list-style-type: none"> Increased access to Nurse Assistants and Physician Assistants
<ul style="list-style-type: none"> Most cost effective setting



Administrative Technology Cost Management

HEALTH INFORMATION TECHNOLOGY (HIT)/CLINICAL HEALTH ACT (HITECH)

▪ Automated ID Cards	\$ 18 billion	▪ Incentives for Highest Quality Providers	\$ 37 billion
▪ Eliminate Paper EOB's	\$ 14 billion	▪ Cancer Support Programs	\$ 5 billion
▪ Eliminate Paper Checks	\$109 billion	▪ Transplant Solution Programs	\$ 7 billion
▪ Expand On-Line Enrollment	\$ 31 billion	▪ Penalty for Readmissions	\$166 billion
▪ Integrate electronic medical records	\$ 13 billion	▪ Improved Case Management	\$ 55 billion
▪ Create a national payment clearing house	\$ 41 billion	▪ Advanced Illness Programs	\$ 18 billion
▪ Adopt quality database standards	\$ 1 billion	▪ Disease Management	\$ 25 billion
		▪ Gaps in Care Management	\$ 1.4 billion
		▪ Evidence Based Management	\$102 billion
		▪ Medical Home Care	\$ 20 billion
		▪ MD Comprehensive Compensation Program	\$ 24 billion
		▪ Radiology Management	\$ 13 billion

March 29, 2010 Business Insurance: Administrative Cost Management by Years

Funding Required: \$829 - \$900 Billion

Enactment Date: March 23/30, 2010

BENEFITS

Provision: Plan Benefits	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.		All 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 Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered. The Secretary will determine an interval of not less than 1 year after which new recommendations will be incorporated.	Secretary of HHS	All plans	6 months after enactment	1001	PHSA 2713
Extension of adult dependent coverage	<ul style="list-style-type: none"> ▪ 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. Pre-tax Review ▪ The Secretary will define which adult children coverage must be extended. ▪ For plan years beginning before 2014, group health plans will be required to cover adult 	Secretary of HHS	All plans	6 months after enactment	1001 HR 4872 §2301	PHSA 2714

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	children only if the adult child is not eligible for employer-sponsored coverage.					
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.		All plans	6 months after enactment for under 19.	1201 & 10103(e)	PHSA 2704
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 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 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.</p> <p>The Secretary of HHS will develop rules.</p>		Fully insured group health plans	6 months after enactment	1001	PHSA 2716
Ensuring quality of care	<p>Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan:</p> <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 	Secretary of HHS, in consultation with experts in health care quality and stakeholders	All plans	2 years after enactment	1001	PHSA 2717

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	activities					
Bringing down the cost of health care	<p>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:</p> <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 <p>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. (Section 2718 of the Public Health Service Act requires report of MLR within 6 months)</p> <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	<p>Internal claims appeal process:</p> <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. <p>External review:</p> <ul style="list-style-type: none"> ▪ 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. 	Secretaries of Labor and HHS	All plans	6 months after enactment	1001	PHSA 2719
Patient Protections	<ul style="list-style-type: none"> ▪ 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. ▪ 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. ▪ 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. 		All plans	6 months after enactment	1001	PHSA 2719A

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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	<ul style="list-style-type: none"> ▪ 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. ▪ 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. 	The Secretary in conjunction with the states.	Fully insured plans	2010 plan year	1003	PHSA 2794
Temporary high risk pool program	<p>The Secretary shall establish a temporary high risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least 6 months.</p> <p>The program may be carried out directly or through contracts with states or nonprofit entities. States must agree not to reduce the annual amount expended for current high risk pools before enactment. Provides \$5 billion to fund pools through 2013</p> <p>Pools funded through these grants must:</p> <ul style="list-style-type: none"> ▪ Have no preexisting condition exclusions ▪ Cover at least 65% of total allowed costs ▪ Have an out-of-pocket limit no greater than the limit for high deductible health plans ▪ Utilize adjusted community rating with maximum variation for age of 4:1 ▪ Have premiums established at a standard rate for a standard population <p>The Secretary shall establish criteria to prevent insurers and employers from encouraging enrollees to drop prior coverage based upon health status.</p>	Secretary of HHS		90 days after enactment	1101	
Temporary reinsurance program for early retirees.	<p>The Secretary of HHS shall 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.</p> <p>Payments under the program must be used to lower costs of the plan. Provides \$5 billion to fund the program.</p>	Secretary of HHS		90 days after enactment	1102	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Web portal to identify affordable coverage options	<p>The Secretary shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage. It will allow them to receive information on:</p> <ul style="list-style-type: none"> ▪ Health insurance coverage ▪ Medicaid ▪ CHIP ▪ Medicare ▪ A high risk pool ▪ Small group coverage, including reinsurance for early retirees, tax credits, and other information <p>The Secretary shall develop a standard format to be used in presenting information relating to coverage options, which shall include:</p> <ul style="list-style-type: none"> ▪ The percentage of total premiums spend on nonclinical costs ▪ Availability ▪ Premium rates ▪ Cost sharing 	Secretary of HHS, in consultation with the states Secretary of HHS		07/01/10 60 days after enactment	1103	
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
SUBTITLE C—Quality Health Insurance Coverage for All Americans PART I—HEALTH MARKET REFORMS Subpart I—General Reform						
Fair health insurance premiums	<p>Premiums may only vary by:</p> <ul style="list-style-type: none"> ▪ Age (3:1 maximum) ▪ Tobacco (1.5:1 maximum) ▪ Geographic rating area ▪ Whether coverage is for an individual or a family <p>Each state shall establish one or more rating areas for the purposes of geographic rating. The Secretary shall review them and determine their adequacy. If they are not adequate, or if a state fails to establish them, the Secretary may establish rating areas for the state.</p>	<p><i>Geographic rating areas:</i> States, with Secretarial review</p> <p><i>Age bands:</i> Secretary, in consultation with the NAIC</p>	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange.	Plan years beginning 01/01/14		PHSA 2701
Guaranteed availability of coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods.	Secretary of HHS	Non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2702
Guaranteed renewability of coverage	Insurers must renew or coverage or continue it in force at the option of the plan sponsor or the individual.		All non-grandfathered fully-insured plans.	Plan years beginning 01/01/14		PHSA 2703
Prohibiting discrimination against individual participants and beneficiaries based on health status	<p>A plan may not establish rules for eligibility based on any of the following health status-related factors:</p> <ul style="list-style-type: none"> ▪ Health status ▪ Medical condition ▪ Claims experience ▪ Receipt of health care ▪ Medical history ▪ Generic information ▪ Evidence of insurability (including conditions arising out of domestic violence) ▪ Disability ▪ Any other health-status related factor deemed appropriate by the Secretary <p>Health promotion and disease prevention programs that base the conditions for obtaining</p>	Secretary of HHS Secretary of HHS, in consultation with Secretaries of Treasury and Labor	All non-grandfathered plans Individual market plans	Plan years beginning 01/01/14 07/01/14		PHSA 2705

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	<p>a premium discount or any other reward upon a health status-related factor must limit such rewards to 30% of the cost of coverage. The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate.</p> <p>Wellness programs must be reasonably designed to promote health or prevent disease and must give eligible individuals the opportunity to qualify for the reward at least once per year, and rewards must be made available to all similarly situated individuals. Existing wellness programs established before March 23, 2010, may continue to be carried out.</p> <p>Creates a Wellness Program Demonstration Program in 10 states to allow states to design wellness programs for individual market enrollees.</p>					
Non-discrimination in health care	<p>Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks.</p> <p>Plans may not discriminate against individuals or employers based upon:</p> <ul style="list-style-type: none"> ▪ Whether they receive subsidies ▪ Whether they provide information to state or federal investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act 	Secretary of HHS	All plans	Plan years beginning 01/01/14		PHSA 2706
Comprehensive health insurance coverage	<p>All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).)</p> <p>If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.</p>		All plans	Plan years beginning 01/01/14		PHSA 2707
Prohibition on Excessive Waiting Periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.		All group plans	Plan years beginning 01/01/14		PHSA 2708
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.		All plans	Plan years beginning 01/01/14		PHSA 2709
PART II—OTHER PROVISIONS						
Preservation of right to maintain existing coverage	<p>Subtitles A and C of this bill shall not apply to coverage in which an individual was enrolled as of the date of enactment. The following provisions will apply to grandfathered plans:</p> <ul style="list-style-type: none"> ▪ PHSA §2708-Excessive waiting periods ▪ PHSA §2711-Annual and lifetime limits ▪ PHSA §2712-Rescissions ▪ PHSA §2714-Extension of dependent coverage ▪ PHSA §2715-Uniform summary of benefits and coverage and standardized definitions ▪ PHSA §2718-Medical loss ratios <p>Provisions of PHSA §2711 relating to annual limits and of PHSA §2704 relating to preexisting condition exclusions apply to grandfathered group health plans for plan years beginning when they would first otherwise apply.</p>		All coverage in place on the date of enactment.	Date of enactment (March 23, 2010)	1251	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
	<p>Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage. Coverage maintained pursuant to a collective bargaining agreement ratified before the date of enactment is not subject to Subtitles A and C until the expiration of that agreement.</p> <p>A Change made to coverage to conform to these subtitles is not considered termination of an agreement.</p>					
Rating reforms must apply uniformly to all health insurance issuers and group health plans	<p>Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.</p>			Plan years beginning 01/01/14	1252	
Study of Large Group Market	<p>The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure.</p> <p>The Secretary shall also collect information on:</p> <ul style="list-style-type: none"> ▪ The extent to which self-insured plans can offer less expensive coverage and whether lower costs are due to more efficient plan administration and lower overhead or the denial of claims and more limited benefit packages; ▪ Claim denial rates and benefit fluctuations and the impact of limited recourse options for consumers; and ▪ Potential conflict of interest as it relates to the health care needs of self-insured enrollees and the employer's financial contribution or profit margin. 	Secretary of HHS Secretary of HHS, in conjunction with the Secretary of Labor	No later than 1 year after enactment		1254	
Effective Dates	<p>All provisions of this subtitle become effective for plan years beginning January 1, 2014, except that the grandfathering of existing plans becomes effective on the date of enactment, and the prohibition on preexisting condition exclusions becomes effective with respect to enrollees under age 19 for plan years beginning 6 months after enactment.</p>				1255	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
SUBTITLE D—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS PART IV-STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS						
State Flexibility to Establish Basic Health Programs for Low-Income Individuals Not Eligible for Medicaid	<ul style="list-style-type: none"> ▪ The Secretary of HHS shall establish a basic health program under which a state may contract with standard health plans providing at least essential benefits to individuals between 133% and 200% FPL and legal immigrants above 133% FPL who are not eligible for Medicaid. The federal government will provide states creating basic health programs the subsidy funds that eligible individuals would have otherwise received. ▪ Individuals eligible to participate in these plans would not be eligible to purchase coverage through the Exchange, and premiums may not exceed what the individual would have paid in the Exchange. Cost-sharing may not exceed that of a platinum plan in the Exchange for individuals below 150% FPL or that of a gold plan for all others. Plans must have an MLR of at least 85%. ▪ States may enter into compacts to allow residents of all compacting states to enroll in all standard plans. 	Secretary of HHS			1331	
Waiver for State Innovation	<p>A state may apply for waivers of the following requirements:</p> <ul style="list-style-type: none"> ▪ Requirements for Qualified Health Benefits Plans ▪ Requirements for Health Insurance Exchanges ▪ Requirements for reduced cost-sharing in qualified health benefits plans ▪ Requirements for premium subsidies ▪ Requirements for the employer mandate ▪ Requirements for the individuals mandate <p>The Secretary of HHS may not waive any law that is not within the jurisdiction of HHS (such as ERISA).</p> <p>The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver.</p> <p>State waiver plans must provide coverage that is at least as comprehensive as coverage offered through Exchanges, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are good for 5 years and may be renewed unless the Secretary disapproves a request for renewal within 90 day of receipt.</p> <p>The Secretary must coordinate and consolidate this waiver application process and the waiver processes for Medicare, Medicaid, CHIP, and any other federal health care law.</p>	Secretary of HHS, within 180 days of enactment.		Plan years beginning January 1, 2017	1332	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
Provisions relating to offering of plans in more than one state	<p>Two or more states may enter into a “health care choice compact” under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Issuers would continue to be subject to the following laws of the purchaser's home state:</p> <ul style="list-style-type: none"> ▪ Market conduct; ▪ Unfair trade practices; ▪ Network adequacy; ▪ Consumer protection standards, including rating rules; ▪ Laws addressing performance of the contract. <p>Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws.</p>	Secretary of HHS, in consultation with the NAIC, no later than July 1, 2013		01/01/16	1333	
Multi-State Plans	<ul style="list-style-type: none"> ▪ The Director of OPM shall contract with insurers to offer at least 2 multi-state qualified health benefits plans through the Exchange in each state to provide individual and small group coverage. At least one plan in each state must be provided by a nonprofit entity. The Director may set standards for multistate plans regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrollees. ▪ Participating insurers must be licensed in each state where it sells coverage and are subject to all requirements of State law that are not inconsistent with requirements of this section. Plans must offer a uniform benefit package in each state which consists of the essential benefits package and any additional benefits required by a state, as long as the state reimburses enrollees for the cost of these additional benefits. States with rating rules that restrict variation due to age to less than 3:1 may require multi-state plans to adhere to these requirements. ▪ Insurers must sell multi-state plans in 60% of states in the first year they offer them, 70% of states in the second year, 85% of states in the third year, and all states in the fourth year. ▪ Requirements for FEHBP plan that do not conflict with this title will apply to multi-state plans. Multi-state plans will be considered a separate risk pool from FEHBP plans. 	Office of Personnel Management		01/01/14	1334	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PART V—REINSURANCE AND RISK ADJUSTMENT						
Transitional reinsurance program for individual market in each state	<ul style="list-style-type: none"> ▪ State shall enact a model regulation established by the Secretary, in consultation with the NAIC, that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016. Insurers and TPAs, on behalf of self-insured plans, must make payments to the reinsurance entity and non-grandfathered individual market insurers that cover high risk individuals will receive payments from the entity if they cover high risk enrollees in the individual market. ▪ High-risk individuals will be identified on the basis of a list of medical conditions or another comparable objective method of identification recommended by the American Academy of Actuaries. Payments will be based upon a schedule of payments for each condition or another method recommended by the American Academy of Actuaries. ▪ Assessments will be based on the percentage of revenue of each insurer and the total costs of providing benefits to enrollees in self-insured plans or a specified amount per enrollee. The total amount of contributions will be based on the best estimates of the NAIC and not including additional assessments to cover administrative costs, equal \$12 billion for plan years beginning in 2014, \$8 billion in 2015, and \$5 billion in 2016. States may collect additional amounts from issuers on a voluntary basis. Of these amounts, \$2 billion in 2014, \$2 billion in 2015 and \$1 billion in 2016 shall be deposited in the US Treasury and will not be available for this program. ▪ Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation. States may have more than one reinsurance entity and two or more states may enter into agreements to create entities to administer reinsurance in all such states. 	Secretary of HHS, in consultation with the NAIC and with recommendations from the American Academy of Actuaries.	All plans must pay assessments. Non-grandfathered individual plans may receive payments.	Plan years beginning in 2014 through 2016	1341	
Establishment of risk corridors for plans in individual and small group markets	The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs. Plans will receive payments if their ratio of non-administrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	Secretary of HHS	Individual and small group plans	Calendar years 2014-2016	1342	
Risk adjustment	<ul style="list-style-type: none"> ▪ Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state. ▪ The Secretary of HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans. 	Secretary of HHS, in consultation with the States	Non-grandfathered individual and small group plans	01/01/14	1343	

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
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EMPLOYER

SUBTITLE E—AFFORDABLE COVERAGE CHOICES FOR ALL AMERICANS

PART I - Premium Tax Credits and Cost-Sharing Reductions

Subpart A—Premium Tax Credits and Cost-Sharing Reductions

Refundable tax credit providing premium assistance for coverage under a qualified health plan	<p>A tax credit is created for qualified taxpayers between 100% and 400% FPL that covers the difference between a percentage of household income and the second-lowest cost silver level plan available through the Exchange in the individual's rating area. The percentage of income varies on a sliding scale within the following ranges:</p> <table border="1" data-bbox="305 541 698 798"> <thead> <tr> <th>Income</th> <th>Premium Cap</th> </tr> </thead> <tbody> <tr> <td><133% FPL</td> <td>2%</td> </tr> <tr> <td>133-150% FPL</td> <td>3-4%</td> </tr> <tr> <td>150-200% FPL</td> <td>4-6.3%</td> </tr> <tr> <td>200-250% FPL</td> <td>6.3-8.05%</td> </tr> <tr> <td>250-300% FPL</td> <td>8.05%-9.5%</td> </tr> <tr> <td>300-400% FPL</td> <td>9.5%</td> </tr> </tbody> </table> <p>The above percentages will be adjusted to reflect the growth of premiums. Credits will be advanced to insurer through which the individual purchased coverage.</p> <p>Individuals eligible for employer-sponsored coverage for which the employee's contribution does not exceed 9.5% of household income are not eligible for subsidies. Individuals not lawfully present in the United States are not eligible for subsidies.</p>	Income	Premium Cap	<133% FPL	2%	133-150% FPL	3-4%	150-200% FPL	4-6.3%	200-250% FPL	6.3-8.05%	250-300% FPL	8.05%-9.5%	300-400% FPL	9.5%	Secretary of Treasury	Individuals between 100% and 400% FPL	01/01/14	1401	IRC 36B
Income	Premium Cap																			
<133% FPL	2%																			
133-150% FPL	3-4%																			
150-200% FPL	4-6.3%																			
200-250% FPL	6.3-8.05%																			
250-300% FPL	8.05%-9.5%																			
300-400% FPL	9.5%																			
Reduced cost-sharing for individuals enrolling in qualified health plans	<ul style="list-style-type: none"> ▪ Cost sharing for individuals enrolling in the silver level of coverage through an exchange who are between 100%-400% FPL. ▪ Cost-sharing reduced so that the plan covers 94% of the benefit costs of the plan for individuals between 100%-150% FPL, 87% of benefit costs for individuals between 150%-200% FPL, 73% for individuals between 200%-250% FPL, and 70% for individuals between 250%-400%FPL. Native Americans below 300% FPL will have no cost-sharing under a plan. ▪ The Secretary will make periodic payments to insurers for the value of these cost-sharing reductions. Reductions to cost-sharing will not apply to additional benefits provided under a plan or to mandated benefits beyond the essential benefits package. 	Secretary of HHS, in consultation with Secretary of Treasury	Individuals between 100% and 400% FPL	01/01/14	1402															

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PART II—Small Business Tax Credit						
Credit for employee health insurance expenses for small businesses	<ul style="list-style-type: none"> ▪ Small employers 25 or fewer employees will receive tax credit as follows: ▪ Tax years 2010-2013—Employers that contribute at least 50% of premium, or 50% of the average small group premium in the state, will receive a credit against general business tax for 35% (or 25% in the case of a tax-exempt small employer) of the total non-elective contribution the for the plan. ▪ Tax years 2014 and later—Employers that contribute at least 50% of premium towards coverage in the exchange will receive a credit of 50% (or 35% in the case of a tax-exempt small employer). Employers may receive the credit for two years. ▪ The credit is phased out for employers with 10-25 employees and employers whose average wages are from \$25,000-\$50,000, indexed to the annual cost-of-living adjustment. 	Secretary of Treasury	Small businesses with 25 or fewer employees	01/01/14	1421	IRC 45R
SUBTITLE F—SHARED RESPONSIBILITY FOR HEALTH CARE PART I—Individual Responsibility						
Requirement to maintain minimum essential coverage	<p>If a taxpayer fails to maintain minimum essential coverage, they will be required to pay an annual tax penalty of the greater of \$95for each household member, up to three, or 1% of household income in 2014, \$325 or 2% of household income in 2015 and \$695 or 2.5% of income in following years. The penalty is prorated for each month in which a taxpayer fails to maintain minimal essential coverage. Taxpayers are exempted from the penalty if:</p> <ul style="list-style-type: none"> ▪ The individual has a religious objection to purchasing health insurance. ▪ The cost of the taxpayer's premium contribution for employer-sponsored coverage or for the lowest-cost bronze level coverage available in the Exchange exceeds 8% of household income. The 8% threshold is indexed to the amount by which average premium growth exceeds wage growth. ▪ The taxpayer's household income is below the federal income tax filing threshold ▪ The taxpayer is a member of a recognized Indian tribe ▪ The break in coverage is less than three months ▪ The Secretary of HHS determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage ▪ The individual is enrolled in a health care sharing ministry ▪ The individual resides outside the United States <p>Any criminal penalty against a taxpayer for failure to pay the penalty is waived, and the Secretary of Treasury may not file liens or levies to collect the penalty.</p>	Secretary of Treasury		01/01/14	1501	IRC 5000A

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PART II—Employer Responsibilities						
Automatic enrollment for employees of large employers	Employers with more than 200 employees offering a health benefits plan must automatically enroll all new employees one of the plans and automatically continue the enrollments of current employees, unless either opts out.		Employers with more than 200 full-time employees		1511	FLSA 18A
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits.		Employers subject to the Fair Labor Standards Act	03/01/13	1512	FLSA 18B
Shared responsibility for employers regarding health coverage	If an employer fails to offer minimum essential coverage and one of its employees receives a subsidy through the Exchange, it will be subject to a penalty of \$2000 per employee. Employers offering coverage whose employees receive a subsidy through the exchange will be subject to a penalty of \$3,000 per employee receiving a subsidy. The penalty shall not exceed \$2000 times the number of full-time employees. Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty.	Secretary of Treasury	Employers with more than 50 employees	01/01/14	1513	IRC 4980H
OTHER PROVISIONS						
Free choice vouchers	Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400%FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange.				10108	
Non-Addressed	<ol style="list-style-type: none"> Over the counter drugs are not payable from healthcare FSA,HSA or HRA 2011 Medicaid Expansion for Texas is identified as a cost of \$24 billion over the next 10 years Flexible Spending Accounts \$2,500 per year 2013 Medicare Tax Base for incomes in excess of \$200,000/\$250,000 2013 Excise Tax 40% \$10,000 individuals, \$27,500 families, \$11,850 for retirees, and \$30,950 for employees in high-risk professions, such as police and fire Payment Adjustment Accuracy 9.30.12 \$1.00 PEPM for Quality Research Fund, second year \$2.00 PMPM sunset in 2019 Managed Care Fee Tax Exempt Insurance Providers, sidecar stipulates, and that 50% of net premiums which relate to their tax-exempt status be used to calculate the fee. Fee also applies to Medicare Advantage and Medicaid plans. Eligibility of Part-time (30 hours/wk) and full time employees 					

Provision: Plan Benefits	Notes	Standards Development	Applicability	Effective Date	PPACA Section	Statutory Section
PROVIDER						
OTHER PROVISIONS						
GAO study regarding the rate of denial of coverage and enrollment by health insurance and group health plans	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance plans by group health plans and health insurance issuers.	Government Accountability Office		One year after enactment	1562	

*** Oversight will be conducted by Consumer Information and Insurance**

Health Plan Transition to Healthcare Reform Compliance Timeline

Bill Signed: March 23, 2010

SideCar/Resolutions Signed: March 30, 2010

Year	Employer	Health Plan	Employee
Six Month Enactment		No Lifetime Maximum	
		No Calendar Year Maximums on <i>Essential</i> Benefits	
		Extension of coverage up to age twenty-six (26)	
		No pre-existing limitation on children under the age of nineteen (19)	
		Preventive/Wellness no cost share (Definition of wellness needs to be defined: diagnostic testing, preventive, smoking cessation and health education)	
		Standard Appeal Process	
		No prior-notification for OB-GYN and Emergent Care	
		Emergency Care visits (network and non-network) paid at same benefit percentage	
		Prohibits rescission except in case of fraud	
		Prohibition on rescissions	
		Prohibition of discrimination based on salary	
		Medical Loss Ratio limitations	
		Plans begin transparency protocol	
June 2010	Small Business Tax Credits <ul style="list-style-type: none"> ▪ Credit of up to 35% of the employer's contribution is provided if the employer contributes at least 50% of the total premium or 50% of a benchmark premium; ▪ The full credit will be available to employers with 10 or fewer employees and average annual wages less than \$25,000. ▪ Tax exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of their contribution toward employee health insurance programs 	<ul style="list-style-type: none"> ▪ Retiree age 55 ▪ Reinsurance Program 80% of claims per retiree between \$15,000-\$90,000 	\$250 rebate for beneficiaries who reach doughnut hole in 2010
		<i>Tax-Free</i> Coverage for children up to age twenty-six (26)	
		Premium Review Begins (excluding self-insured)	
		Requires health plans to report the proportion of premium/contribution dollars	

Year	Employer	Health Plan	Employee
		on clinical services, quality and other costs	
2011		<ul style="list-style-type: none"> Higher penalty for Health Savings Accounts 10% to 20% cash out penalty 	Part D discounts on brand-name and generic drugs in doughnut hole for retirees in Prescription Drug Plan
		<ul style="list-style-type: none"> Eligible Pre-tax over the counter purchases will require physician prescription - Jan 2011 	Medicare Advantage reimbursements for 2011 are frozen at 2010 levels — Medicare Advantage reimbursements will decrease over several years
12 months after enactment		Standard Format Guidelines (must comply 24 months of enactment)	
		Over the Counter Medications paid under Section 125 must have prescription	
2012	Employer W-2 reporting on 2011 benefit coverage	<ul style="list-style-type: none"> \$1.00 PPM for comparative effectiveness research 2012-2019 - \$2.00 indexed Sunset in 2019 	
		Plans to begin reporting on quality and health outcomes	
		Requires health plans to provide rebates to consumers for the amount of the premium/contribution that is less than 85% for plans in large group market and 80% in individual/small group market (50% for tax exempt; 100% for others)	
2013		Section 125 contributions capped at \$2,500	Medicare wage tax increase for high income individuals: <ul style="list-style-type: none"> single - \$200,000 couples - \$250,000
		Employer notice to employees about Health Insurance Exchange	Retiree Part D Drug Subsidy (RDS) is taxable starting in 2013 (most government entities are not taxable)
2014	Employers to report to IRS on plan features (and provide statements to employees by January 31, 2015)	Prohibited waiting periods in excess of 90 days	Medicaid Expansion
	<ul style="list-style-type: none"> Employer <i>Free Rider</i> Penalty - applies to employers with 50 or more employees, including public sector employers; must aggregate hours of part-time employees to create total number of employees with subtraction of first 30 workers when paying assessment If employer does not offer coverage (and one employee receives a tax credit in the Exchange) Penalty is \$2,000 times the total # of full-time employees (2080 hours) If employer does offer coverage but coverage is unaffordable or value less than 60% of plan costs (and one employee receives a tax credit in the Exchange) Penalty is \$3,000 times # of full-time employees getting tax credit in Exchange 	40% Excise Tax on high-cost plans	Exchange Subsidies to individuals up to 400% of Federal Poverty Level
	<ul style="list-style-type: none"> <i>Free-choice Vouchers</i> - vouchers offered if employees with incomes less than 400% of the Federal Poverty Level if contributions for employer plan or 8-9.8% of employees household income and employee does not enroll in employer plan 	Implementation of Insurance Exchange (all exchanges have to comply with mental health parity)	<ul style="list-style-type: none"> Requires individual to purchase health coverage beginning in 2014, phasing in penalties 2014 penalty is the lower of \$95 per individual per year or 1% of total

Year	Employer	Health Plan	Employee
	<ul style="list-style-type: none"> Vouchers are equal to amount employer would have provided toward employee's coverage Employers pay vouchers to exchange; if coverage through Exchange is less than voucher amount, Exchange pays different to employee 		<p>incomes</p> <ul style="list-style-type: none"> 2015 penalty is the lower of \$395 per individual per year or 2.0% of total income 2016 penalty is the lower of \$695 per individual, up to maximum of three times that for families, per year or 2.5% of household income Exemptions exist for financial hardship if lowest plan offered exceeds 8.0% of individual income
	Large employers must begin automatic enrollment	Minimum essential coverage of employee reporting: <ul style="list-style-type: none"> ✓ Platinum ✓ Gold ✓ Silver ✓ Bronze ✓ Young invincible <age 30 	
	Employer mandate penalties begin	Prohibition on exclusions based on preexisting conditions for all enrollees	
	<ul style="list-style-type: none"> Eligible small businesses purchasing coverage through the state Exchange tax credit of up to 50% of the employers contribution is provided, if the employers contributes at least 50% of the total premium/contribution amount Credits will be available for two years, full credit will be available to employers with 10 or fewer employees and average annual wages less than \$25,000 Tax exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of their contribution toward employee health insurance premiums/contributions 	Guaranteed availability and renewability	
		Prohibition based on health status	
		Coverage for clinical trials eligible services	
		For years 2014, 2015 and 2016, states will be required to establish a temporary reinsurance program to help stabilize premiums for coverage in the individual and small group market with specific risk corridors. Plan payment programs for reinsurance risk pool will be established.	
		Health Human Services (HHA) reporting of employee coverage status	
2015		Plans to certify compliance with HIPAA <u>EDI standards</u>	
2017		States may allow employers with more than 100 employees to purchase coverage in the exchange	
2018		40% Excise tax on high-cost plans: <ul style="list-style-type: none"> ✓ Medical FSAs ✓ HRAs ✓ HSAs—excludes dental and vision 	
2020			Close Doughnut hole

Outstanding Items

1. HIPAA Title I
2. Definition of “Essential” Benefits

Action Items

1. Strong Network Affiliation
 - a. Pay for Performance
 - b. Centers of Excellence
2. Smart Plan Designs
 - a. Meet all minimum new plan standards
 - b. Update Plan Documents and Summaries (including Section 125 Plans)
 - c. Medical
 - d. Prescription
3. Innovative Wellness Programs
4. Retiree Health Solutions
 - a. Pre Sixty-five
 - b. Post Sixty-five
 - i. Advantage Plan rate stabilization impact
 - c. Retiree Drug Subsidy Tax Impact (most governmental entities not taxable)
5. Claim Audits
6. On-Line Eligibility Systems
7. Evidence Based Management
 - a. Medical
 - b. Prescriptions
8. Chronic Disease State Management
 - a. Professional Health Coaching
 - b. Gaps in Care Management
9. Review Health Benefits for Pre Sixty-five Retirees
10. Funding Arrangement
 - a. Evaluate mandates and increase compensation costs
 - b. Stop Loss
 - c. Expanding Coverage Costs
 - i. No limits
 - ii. Shorter waiting periods
 - iii. Direct Add on fees such as the fee for comparative effectiveness research program
 - iv. Administrative costs: Prepare W2 with Health information, voucher distribution, legal /consultant support, increased auditing, medical management and monitoring requirements
 - v. Provider Cost shifting due to losses from lower reimbursement rates from Medicare and Medicaid
11. Evaluate Collective Bargaining Agreements
 - a. Determine when plans currently covering collectively bargained employees may be affected
12. Consider Prescription Containment Strategies
 - a. Generic Incentive
 - b. Restrictions to formulary
 - c. Expansion of Step Therapy
 - d. Expansion of Medication Therapy Management (MTMP programs)
13. CLASS Act (Community Living Assistance Services and Supports Act)
 - a. Creation of federal consumer driven, long term care insurance program for the elderly and disabled including daily living skills

14. Definitions
 - a. Full-time employee 2,080 hours a year
 - b. Part-time employees with benefits 30 hours or more a week
 - c. Seasonal workers 120 days or less
15. Underwriting
 - a. Both bills discuss: area factor variance due to cultural diversity/community rating/adjusted community rating, equivalent gender factors, age factor capped, 85% to 90% loss ratio rebate or rate stabilization, prohibition/cap of 50% increase on pre-existing, prohibition/reasonableness on calendar/lifetime maximum limitations, guarantee issue, antitrust guidelines and promote transparency.
16. Benefit Equivalency
 - a. Bronze 60% OOP \$5,000/\$10,000; Silver70, Gold80, Platinum90 and catastrophic available for 25 years and younger. Tobacco Cessations, abortions, midwives, autism training, stress management. No cost share for dental, preventive, wellness and mental health.
17. Provider Networks
 - a. Network Adequacy, Performance networks and prompt payment guidelines
18. Oversight
 - a. Office of Coordination for Dual Eligible Beneficiaries, Benefit Advisory Committee, Physician Quality Reporting, Office of national Coordinator for Health Information Technology, Health and Human Services regulations, Health Insurance Ombudsmen Program, Patient Centered Outcomes Research Institute, Senate Health, Education, Labor and Pension Committee (HELP), Medical Advisory Council, CMS innovation center development, national Association of Insurance Commissioners
19. Fraud and Abuse
 - a. Duplicate Billings, Unbundling, Experimental, Coding/Modifier Accuracy/Charge Audits Increasing, Prior Authorizations Increasing and “Never Event” Management

Non-mentioned Timeline Items

1. Prohibition of physician owned hospital referrals
2. Readmission penalties to hospitals
3. Re-adjudication penalties to payors
4. Payment reforms for episodes of care
5. Medical home payments
6. Medicare and Medicaid equity payments
7. Medicaid drug prescription rebate programs
8. Biosimilar drug availability after 12 year period of exclusivity
9. Medical device manufacturer tax
10. Indoor tanning tax
11. Medicare benefit cuts

Revenue Components

Spending	Revenue
Individuals subsidies, exchanges and related spending: \$464	Medicare Cuts: \$455
Medicaid and children's coverage expansion: \$434	Increased Medicare taxes: \$210
Small employer tax credits: \$40	Taxes on insurers, drug manufacturers and medical device sales: \$107
	Employer penalties: \$89
	Other tax increases: \$103
Total: \$938 billion	Total: \$964 billion

Comply and Opt Out Provisions

111th Congress

The Patient Protection and Affordable Care Act (H.R. 3590) House Resolution Public Health Service Act (PHSA) Interface with Healthcare Reform Bills Awaiting US Code by Subject Groups

Title I - Quality, Affordable Health Care for All Americans

Subtitle A - Immediate Improvements in Health Care Coverage for All Americans

Some elections still available to non-Federal governmental plans under 42 USC 300gg-21

Opt Out Provision	Non Opt Out Provision
Part A: Individual and Group Market Reforms; Section 1001 - Amendment to the Public Health Service Act; Subpart II: Improving Coverage	Subtitle C: Quality Health Insurance Coverage for All Americans; Part I: Health Insurance Market Reforms; Section 1201: Amendment to the Public Health Acts; Subpart I: General Reform
OLD opt-out (2721 of PHSA or 42 USC 300gg-21) applied to subparts 1 through 3 as follows:	Subpart 1
Subpart 1	<ul style="list-style-type: none"> ➤ 2704 of the PHSA- Prohibition of preexisting condition exclusions or other discrimination based on health status. ➤ 2705 of the PHSA- Prohibiting discrimination against individual participants and beneficiaries based on health status. ➤ 2706 of the PHSA- Non-discrimination in health care.
<ul style="list-style-type: none"> ➤ 2701 of the PHSA - 42 USC 300gg- Increased portability through limitation on preexisting condition exclusions ➤ 2702 of the PHSA - 42 USC 300gg-1- Prohibiting discrimination against individual participants and beneficiaries based on health status 	
Subpart 2	
<ul style="list-style-type: none"> ➤ 2704 of the PHSA - 42 USC 300gg-4- Standards relating to benefits for mothers and newborns ➤ 2705 of the PHSA - 42 USC 300gg-5- Parity in mental health and substance use disorder benefits ➤ 2706 of the PHSA - 42 USC 300gg-6-Required coverage for reconstructive surgery following mastectomies ➤ 2707 of the PHSA - 42 USC 300gg-7-Coverage of dependent students on medically necessary leave of absence 	
Subpart 3 (provisions applicable only to health insurance issuers)	
<ul style="list-style-type: none"> ➤ 2711 of the PHSA - 42 USC 300gg-11- Guaranteed availability of coverage for employers in group market ➤ 2712 of the PHSA - 42 USC 300gg-12- Guaranteed renewability of coverage for employers in group market ➤ 2713 of the PHSA - 42 USC 300gg-13-Disclosure of information 	
NEW opt-out (2735 of PHSA) applies only to subpart 2 as follows (new provisions in red):	
Subpart 2	
<ul style="list-style-type: none"> ➤ 2711 of the PHSA- No lifetime or annual limits ➤ 2712 of the PHSA- Prohibition on rescissions ➤ 2713 of the PHSA- Coverage of preventive health services ➤ 2714 of the PHSA- Extension of dependent coverage ➤ 2715 of the PHSA- Development and utilization of uniform explanation of coverage documents and standardized definitions. ➤ 2716 of the PHSA- Prohibition of discrimination based on salary. ➤ 2717 of the PHSA- Ensuring the quality of care. ➤ 2718 of the PHSA- Bringing down the cost of health care coverage. ➤ 2719 of the PHSA- Appeals process ➤ 2725 of the PHSA- Standards relating to benefits for mothers and newborns ➤ 2726 of the PHSA- Parity in mental health and substance use disorder benefits ➤ 2727 of the PHSA- Required coverage for reconstructive surgery following mastectomies ➤ 2728 of the PHSA -Coverage of dependent students on medically necessary leave of absence 	