

Provision	Notes	Division Action	Applicability	Effective Date
Annual and Lifetime Limits	<p>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.</p> <p>Individuals who lost coverage under a plan because they reached the lifetime maximum must be given notice that lifetime limits no longer apply and be given a special enrollment period for enrollment under the same terms and conditions as a similarly situated individual who did not lose coverage because they exhausted a lifetime limit.</p> <p>Annual limits on essential benefits are limited to:</p> <ul style="list-style-type: none"> • \$750,000 for plan years beginning 9/23/2010-9/23/2011 • \$1.25 million for plan years beginning 9/23/2011-9/23/2012 • \$2 million for plan years beginning 9/23/2013-12/31/2013 <p>In determining whether an individual has reached the annual limit benefits, a plan may only take into account essential benefits. A plan may petition HHS for relaxation of the limits on annual limits if they would cause significant decrease in access to benefits or premium increases.</p>	Review coverage forms for compliance	<p>Lifetime limits: All plans</p> <p>Annual limits: All plans except grandfathered individual market plans</p>	Sept. 23, 2010
Rescissions	<p>Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage.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.</p> <p>HHS released an interim final rule on June 21.</p> <p>Rescissions are defined as any retroactive cancellations of coverage, except for those attributable to failure to pay premiums or contributions. These rules do not apply to prospective cancellations.</p> <p>A plan must provide at least 30 days advance written notice to each participant who would be affected prior to rescinding coverage.</p>	Review coverage forms for compliance	All plans	Sept. 23, 2010
Coverage of preventive health services	<p>Plans must provide coverage without cost-sharing for:</p> <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 	Review coverage forms for compliance	All non-grandfathered plans	Sept. 23, 2010

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	<ul style="list-style-type: none"> Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration Preventive care and screenings for women supported by the Health Resources and Services Administration <p>Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.</p>			
Extension of adult dependent coverage	<p>Plans that provide dependent coverage must extend coverage to adult children up to age 26. Carriers are not required to cover children of adult dependents. The Secretary will define which adult children coverage must be extended.</p> <p>For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.</p> <p>Regulatory Guidance: HHS released an interim final rule on May 13, 2010.</p> <p>The rule requires a plan or issuer to give a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment might otherwise occur.</p>	Review coverage forms for compliance	All plans	Sept 23, 2010
Preexisting condition exclusions	<p>A plan may not impose any preexisting condition exclusions.</p> <p>Regulations: HHS released an interim final rule on June 21. Plans may not impose any exclusion of benefits (including a denial of coverage) limit coverage based upon a preexisting condition, for an individual under age 19.</p>	Review coverage forms for compliance	All plans except grandfathered individual market plans	Sept 23, 2010 for under 19.
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</p>		All fully insured plans, including grandfathered plans	01/01/11

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	<p>markets.</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>			
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: All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.</p>		All non-grandfathered plans	Sept. 23, 2010
Patient Protections	<p>A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians.</p> <p>If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.</p> <p>A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.</p> <p>Regulations: HHS released an interim final rule on June 21.</p> <p>Any cost-sharing requirement for emergency services provided out-of-network cannot exceed cost-sharing requirements for in-network emergency services. Enrollees may, however, be required to pay, in addition to the in-network cost-sharing, any excess provider charges beyond the greater of: the following:</p> <ul style="list-style-type: none"> The median amount negotiated with in network providers for the emergency service negotiated; The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of- 	Review coverage forms for compliance	All non-grandfathered plans	Sept. 23, 2010

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	<p>network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed;</p> <ul style="list-style-type: none"> • The amount that would be paid my Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed. <p>Any cost-sharing other than a copayment or coinsurance, such as a deductible, if that requirement applies to out-of-network benefits.</p> <p>A plan that requires the designation of a primary care provider must provide a notice to each participant of the terms of the plan regarding this designation, and any rights under this section. This notice must be provided with the summary plan description or other description of benefits, or in the case of an individual policy, when the issuer provides a primary subscriber with a policy, certificate, or contract. The regulation provides model language.</p>			
<p>Health insurance consumer assistance offices and ombudsmen</p>	<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>	<p>Application for grants not available as of July 16, 2010</p>		<p>Date of enactment</p>
<p>Ensuring that consumers get value for their dollars</p>	<p>The Secretary, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online.</p> <p>The Secretary shall award \$250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services.</p>	<p>Alaska chose not to apply for this grant</p>	<p>All non-grandfathered fully-insured plans</p>	<p>2010 plan year</p>

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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. 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> <p>Regulatory Guidance: HHS distributed a Solicitation for State Proposals to Operate Qualified High Risk Pools on May 10.</p> <p>Individuals may satisfy the preexisting condition criterion for eligibility by providing evidence of a denial of coverage, that coverage is available only with an exclusionary rider, or the presence of certain medical conditions specified by the state and approved by HHS.</p> <p>Funds will be allocated on a non-competitive basis according to population, number of uninsured individuals, and geographic cost variations. HHS will establish accounts for states to draw down funds for benefit claims. Administrative expenses will be limited to 10% of the total state allocation.</p> <p>Regulatory Guidance: HHS released an interim final rules on May 5, 2010.</p> <p>The rules interpret the provision to require reimbursements to be made to the plan sponsor, rather than to the insurer providing coverage if the group health plan is fully-insured.</p>	<p>Alaska chose to operate a federal plan by allowing ACHIA to contract as the administrator</p>		<p>90 days after enactment</p>

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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 	Alaska provided the required information		<p>07/01/10</p> <p>60 days after enactment</p>
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions.	Review coverage forms for compliance	All plans except grandfathered individual market plans	6 months after enactment for individuals 19 and under. Plan years beginning 01/01/14 for all others.
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-Lifetime limits only • 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)

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	<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. A Change made to coverage to conform to these subtitles is not considered termination of an agreement.</p>			
<p>Affordable choices of health benefits plans</p>	<p>Grants will be made available to states in amounts to be specified by the Secretary of HHS for planning and activities related to establishing an Exchange. Grants may be renewed if the State is making progress in establishing an Exchange and the market reforms. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees or other means. The Secretary is also directed to provide technical assistance to states on facilitating participation of small employers in SHOP exchanges.</p> <p>Each state shall establish, as a governmental agency or nonprofit entity, an American Health Benefit Exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (referred to as a “SHOP Exchange”) to assist qualified employers in facilitating the enrollment of employees in small group qualified health benefits plans states. States may choose to establish a single Exchange that performs both functions. States may jointly form regional Exchanges or may form multiple subsidiary exchanges if each one serves a distinct geographic area. Exchanges may contract with entities with demonstrated experience in the individual and small group markets and in benefits coverage if the entity is not an insurer or controlled by an insurer, or with the state Medicaid agency.</p> <p>Exchanges must consult with relevant stakeholders, including consumers, those with experience facilitating coverage in qualified health plans, representatives of small businesses, state Medicaid offices, and advocates for enrolling hard-to reach populations.</p> <p>Exchanges may sell qualified health plans that provide only the essential benefits package, except that states may require additional benefits if it defrays enrollees for the additional cost of these benefits.</p>			<p>Beginning not later than 1 year after the date of enactment, lasting until 01/01/15</p> <p>01/01/14</p>
<p>Automatic enrollment for employees of large employers</p>	<p>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.</p>		<p>Employers with more than 200 full-time employees</p>	