Compendium of Federal and State Health Insurance Reform Actions Required by the Affordable Care Act

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Prepared for the American Hospital Association by Teresa A. Brooks of Polsinelli Shughart, PC

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The Patient Protection and Affordable Care Act (PPACA) (P.L.111-148) and the Health Care and Education Reconciliation Act (Reconciliation Act) (P.L.111-152), together referred to the Affordable Care Act (ACA) significantly expand the federal government's involvement in health insurance oversight, standards setting and regulations. The new federal requirements are generally minimum standards that states may adopt and enforce through its laws and regulations. State laws that do not meet the federal minimum requirements will be pre-empted, i.e., the US Department of Health and Human Services (HHS) will assume regulatory authority for those particular provisions. If a state already has a requirement that meets the federal standards, or adopts one in the future, then the state would retain the authority to enforce it.

This Compendium outlines some of the major insurance market reform provisions of ACA and briefly outlines actions of the HHS Secretary, other federal agencies and stakeholders, including the NAIC, that will require state consideration and action. The major insurance reform provisions are divided into immediate insurance market reforms that take effect for plan/policy years beginning on/after September 23, 2010; market reforms that become effective after 2010; actions that transition to the Exchange; and, the Exchange. Each issue (with a citation to ACA) includes a description of the reform provision, the relevant agency(s) and stakeholder(s) involved, the timetable for implementation, and the regulatory actions to date.

Reform Provisions	Governmental Action
Immediate Insurance Market Reforms	
• Lifetime/Annual Dollar Limits • Preexisting Conditions for under 19 • Rescissions • Patient Protections • Dependent Coverage to Age 26 • Preventive Services Coverage • Internal/External Review	Federal minimum standards. States review current laws/regulations and may adopt/amend state laws/regulations to meet federal minimum standards, or consider imposing more stringent standards.
Grandfathered Plans	Potential state law/regulatory action to conform to federal rules governing grandfathered plans
Data Reporting	Potential state law/regulatory action to conform to Federal minimum standards
Health Insurance Consumer Assistance and Ombudsman Program	State may pursue federal grant to establish, expand or provide support for offices of health insurance consumer assistance or ombudsman programs
Enrollment Standards and Protocols	Federal minimum standards/grants to states to develop new or adopt existing technology systems to implement the Health Information Technology (HIT) enrollment standards.
Insurance Market Reforms After 2010	
• Pre-Existing Conditions • Non Discrimination • Guaranteed Issue/Renewability • Waiting Periods	Potential state law/regulatory action to conform to federal minimum standards. States may consider imposing more stringent standards.

Monitoring Premium Rate Review	States may establish a process based on federal standards for the annual review of 'unreasonable' increases in premiums, beginning with 2010 plan year. State may pursue Federal grant that requires additional data reporting requirements regarding plans. Discussion of premiums increases raises lead to consideration of more expansive state regulatory authority that could impact providers.
Medical Loss Ratio	Federal minimum standards for MLR, based on NAIC developed uniform definitions and methodologies for the reporting and calculation of rebates. State may increase the MLR for any of the markets, subject to HHS Secretary review of impact on the individual market.
Uniform Explanation of Coverage/Standard Definitions	Potential state law/regulatory action to conform to federal minimum standards/developed in conjunction with NAIC. Any state summary of benefits and coverage disclosure requirements cannot provide less information to consumers
Adjusted Community Rating	Federal minimum standard. States will define geographic rating areas for plan years beginning in 2014, subject to federal review for adequacy by HHS Secretary. States may adopt more stringent standards, such as pure community rating.
Assessment of Plan Value	Federal minimum standard
Quality reporting	Federal minimum standards; potential state action
Transition to Exchange	
Temporary High Risk "Preexisting Condition Insurance Plan" Program	State decides whether to operate the high risk pool. If so, may have to modify the state's high risk pools, to conform to federal insurance market reforms.
Temporary Reinsurance Program for Early Retirees	Federal program for employers.
Risk Pooling for the Individual and Small Group Markets	Federal law requires states to maintain for all non-grandfathered health plans to a single risk pool for each of the individual and small group markets. ACA preempts any state law that requires insurers to include grandfathered plans in these pools is preempted.
Risk Management Programs	Potential state law/regulatory action to conform to federal minimum standards that govern a risk adjustment mechanism that assesses and pays issuers in the state based on actuarial risk.
Transitional State Reinsurance Program for the Individual Market	Potential state law/regulatory action to conform to federal minimum standards. For the establishment and operation of a transitional reinsurance program that will be in effect for three years 2013 through 2015.
Web Portal for Health Coverage Information	Potential state law/regulatory action to conform to federal minimum standards for the development of a secure electronic interface that allows for the exchange of information to determine a consumer's eligibility for public program coverage, tax credits and other subsidies.
Application of Administrative Simplification to State Programs	Federal action to establish uniform form. Potential state law/regulatory action to create a state's own uniform enrollment form for the Exchange, Medicaid and CHIP programs or use the federally created uniform form.
The Exchange	
Exchange (s) by January 1, 2014	State law/regulatory action is required to conform to federal minimum standards for the scope, functions, regulatory scheme and financing of the Exchanges by 2014. Otherwise the Secretary shall establish and operate an Exchange in the state. State regulators, legislators and stakeholders will also have to respond to questions as whether the state should:

	• Operate two exchanges or a single Exchange • Enter in to a regional and/or interstate exchange (s) • Establish one or more subsidiary exchanges to serve distinct geographic areas • Authorize the exchange to enter into contracts with entities, not health insurers, to carry out one of more of the exchange responsibility. • Allow large employers to enter the exchange in 2017. • Modify the federal definition of large employer (firm at least 101 employees to 51 employees), and small employer (from between 1 to 100 employees to 1 to 50 employees) for plan years beginning January 1, 2016. • Adopt federal essential health benefits or expand the definition • Apply for waivers • Enter into Health Care Choice Compacts
Exchange: Essential Health Benefits	Potential state law/regulatory action to conform to federal minimum standards. State may expand the essential benefit package; however, the state is responsible for paying for the costs of additional state mandates beyond the federal benefit package for individuals enrolled in coverage offered through the Exchange or for individuals enrolled in multi-state qualified health benefit plans.
Exchange: Qualified Health Plans	Potential state law/regulatory action to conform to federal minimum standards. Only QHPs offered through the exchange are eligible for subsidies and tax credits.
Exchange: Navigator	Federal requirements that govern state contracts with Navigators.
Non-Discrimination Related to Providers	State enforcement of non-discrimination rules of providers
Consumer Operated & Oriented Plan (CO-OP Program	Potential state law/regulatory action to conform to Federal minimum standards related to the operation and sale of CO-OP coverage.
Multi-State Qualified Health Plans	Federal oversight through OPM. States may require that these plans comply with state mandated benefits law (but have to pay for it). Any state laws that do not apply to FEHBP plans will not apply to multi-state plans.
Waivers of Qualified Health Plans, Exchanges, and Cost-Sharing Reduction	State may apply for waiver of federal requirements.
Health Care Choice Compacts	Two or more states may enter into interstate compact to facilitate the sale of health insurance policies across state lines. Insurers would be able to sell policies in all compacting states using the laws and regulations of a primary state.
State Basic Health Program for Low Income Individuals and Tax Credits	Potential state law/regulatory action to conform to Federal minimum standards.

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*Health and Human Services (HHS), National Association of Insurance Commissioners (NAIC), Office of Personnel Management (OPM), Internal Revenue Service (IRS), National Center for Health and Vital Statistics (NCVHS), American Health Benefit Exchange and Small Business Health Options Program (SHOP) Exchange (Exchange), American Association of Actuaries (AAA).

Compendium

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
Immediate Insurance Market Reforms				
	Prior to full implementation in 2014, new plans in the non-group and small group market, and in some cases other plans, are subject to a number of insurance reform requirements which, to the extent they continue to apply beginning in 2014, will be required regardless of whether the plan is offered inside or outside an Exchange. The following insurance market reforms are immediately effective for plan years that begin on/after September 23, 2010 and apply to group health plans (issuers offering group coverage) or individual health insurance as specified.*	HHS Secretary created the Office of Consumer Information and Insurance Oversight (OCIIO) to develop policy, rules and conduct oversight of major market reforms.		Statement of Organization, Functions and Delegation of authority from the Secretary to OCIIO, 75 Fed. Reg. 20364 (April 19, 2010).
Lifetime & Annual Limits [ACA§1201; PHSA§2711]	Lifetime dollar limits: Prohibits lifetime dollar limits for essential health benefits (EHB). ∗All Plans. Annual dollar Limits: Prohibits annual dollar limits for essential health benefits, except allows for "restricted" annual dollar limits prior to January 1, 2014, on essential benefits and does not restrict use of annual dollar limits for covered benefits that are not essential health benefits, unless otherwise permitted under Federal or State law. ∗All Plans, except grandfathered individual market. Until the EHB package is developed by HHS, plans and insurers must make a good faith efforts" to comply with a reasonable interpretation of the term "essential health benefits" for purposes of applying "restricted" annual limits for plan years that begin on or before January 1, 2014. ➢ Annual/lifetime limits allowed for non-essential benefits and permits exclusion of all benefits for a condition (not consider exclusion an impermissible annual/life limit. ➢ Transitional reinstatement rules for certain individuals	Departments of HHS/Labor/Treasury (IRS) will issue rules that implement the insurance market reforms. ➢ HHS Secretary, and States, will develop an essential benefit package to which lifetime/annual limit prohibitions apply. ➢ Good faith compliance until essential health benefits are defined by HHS. Applicable to Immediate market reforms: NAIC letter to Sebelius and	Plans/policy years beginning on/after September 23, 2010.	Interim Final Rule (IFR) with comment, 75 Fed Reg 37188 (June 28, 2010) relates to Lifetime & Annual Limits, Rescissions, Patient Protection provisions. Effective August 27, 2010. IRS Notice of Proposed Rulemaking

∗The notation, in red highlight, after each provision indicates whether all plans or only certain types of health plans are affected by that provision. "All plans" includes group health plans (issuers offering group coverage) or individual health insurance including grandfathered plans. It does not include self-insured plans, unless specified.

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	➢ IFR exempts Flexible Savings Arrangement from restrictions on annual limits and HSAs, MSA and HRAs not subject to restrictions. *All plans, except grandfathered individual market plans.	NAIC State survey of enforcement authority. Letter: http://www.naic.org/documents/index_health_reform_section_letter_kathleen_sebelius.pdf; Survey: http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf		(NPRM) cross-reference to temporary rules, 75 Fed. Reg. 37242 (June 28, 2010). See also: IFR & NPRM (June 17, 2010) related to impact on grandfathered plans Sebelius letter to Governors regarding authority to enforce patient protections. See also, Sub-Regulatory Guidance (September 3, 2010) for waiver of annual limits. http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf
Pre-existing conditions for child	Prohibition of Pre-existing Condition Exclusion for children under 19. Prohibits imposition of any pre-existing condition exclusion on coverage for a child under 19. The prohibition is effective for Plan years	Departments of HHS/Labor/Treasury (IRS) will issue rules that implement the	Plan/policy years beginning on/after	IFR (June 28, 2010). NPRM (June 28, 2010).

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[ACA§1201; PHSA 2704]	beginning on or after September 23, 2010 for enrollees under age 19 and Jan. 1, 2014 for all enrollees. *All plans, including self-insured, except grandfathered individual market plans.	insurance market reforms.	September 23, 2010, except for prohibition on pre-existing condition exclusion for adults (effective for plan/policy years applicable beginning on/after January 1, 2014.	Effective August 27, 2010. FAQs re pre-existing for kids: http://www.hhs.gov/ociio/regulations/children19/factsheet.html
Rescissions [ACA§§ 1001, 1004, 1255, 10103;Reconciliation§ 2301; PHSA § 2712]	Rescissions/Cancellations: Prohibits group health plans (and issuers offering group coverage) or individual health insurance coverage from rescinding coverage once the plan has been issued. Defined as cancellation or discontinuance of coverage that is retroactive. Coverage may be rescinded only for fraud or an intentional misrepresentation of material fact, as prohibited by the terms of coverage. Permits cancelations only with prior notice to the policyholder and only as permitted under Public Health Service Act. *All plans, including self-insured plans.	Departments of HHS/Labor/Treasury (IRS) will issue rules that implement the insurance market reforms. April 23, 2010 letter from HHS Secretary to WellPoint urging immediate implementation of prohibition on rescissions. Industry agreed.	Plans/policy years beginning on/after September 23, 2010.	IFR (June 28, 2010).
Patient Protections [ACA§§ 1001, 10101, 1004; PHSA§ 2719A]	Patient Protections: ➢ Choice of health care professional: A plan that mandates designation of primary care provider must allow choice of any participating primary care provider who is available, including pediatrician and access to gynecological care, and notice of the same. DOL model notice in IFR. ➢ Coverage of emergency services: If a plan provides coverage for emergency services, plan must provide coverage without prior authorization, regardless of the participating status of the provider, and at the in-network cost sharing level. o Permits balance billing for difference between providers' charges and amount collected from plan.	Departments of HHS/Labor/Treasury (IRS) will issue rules that implement the insurance market reforms.	Plans/policy years beginning on/after September 23, 2010.	IFR (June 28, 2010).

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	* All Plans (including self-funded), except grandfathered plans.			
Dependent Coverage [ACA§§ 1001, 1004; Reconciliation §2301;PHSA§ 2714]	Extension of Dependent Coverage to Age 26: Requires insurance that provides coverage of dependent adult children to continue coverage until child turns 26 years of age. * All Plans, including self-funded. Special rule for grandfathered plans (plan years beginning before January 14, 2014) if dependent is eligible for other employer-sponsored group health coverage, dependent may be excluded from grandfathered plan.	HHS/Labor/Treasury (IRS) issued rules. HHS Secretary requested plans to implement immediately rather than wait until required deadline in the law.	Plan/policy years beginning on/after September 23, 2010.	IFR with request for comments, 75 Fed Reg, (May 13, 2010). Effective July 12, 2010. NPRM by cross reference to temporary rules, 75 Fed Reg. 27141 (May 13, 2010).
Preventive Coverage [ACA§ 1001; PHSA§2713]	Preventive Services: Requires that all new group and individual health plans provide coverage without cost sharing requirements, e.g., copayment, coinsurance or deductible, for specified preventive services that are evidence-based: ➢ Those services that have a rating of A or B from US Preventive Services Task Force (USPSTF). ➢ Immunizations recommended by CDC. ➢ For infants, children and adolescents care and screenings provided for in comprehensive guidelines supported by HRSA. HHS is developing these guidelines and expects to issue them no later than August 1, 2011. Clarifications that affect providers: Plans may impose cost sharing in several circumstances, including, e.g., for office visit if the service is billed separately from an office visits or is tracked separately as individual encounter data, or the primary purpose of the office visit is the delivery of health care item or services unrelated to a preventive service. The regulations permit plans to develop guidelines for coverage that use value-based insurance designs as part of their offering of preventive health services. ➢ Provider input to guideline development.	HHS/Labor/IRS Also: USPSTF/CDC/HRSA HHS will establish a minimum interval (not less than 1 year) between the date on which certain recommendations or guidelines are issued regarding a preventive service and the plan year for which the coverage requirements become effective. The Secretary may develop guidelines to permit insurers to use value-based insurance designs.	Plan/policy years beginning on/after September 23, 2010.	IFR with comment period, 75 Fed. Reg. 41726 (July 19, 2010). Effective September 17, 2010. IRS NPRM, Fed Reg 75 Fed. Reg. 41787 (July 19, 2010).

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	*All plans (including self-funded), except grandfathered plans.			
Internal & External Review [ACA§ 1001; PHSA§ 2719]	Internal and external review. Requires plans to comply specific standards for the internal and external appeals, including the patient protections included in the NAIC's Uniform External Review Model. Positive for providers because it applies to a broad category of "adverse benefit determinations,' that is any denial, reduction or termination of, or failure to provide or make a payment for, a benefit based on certain factors, including: eligibility, non coverage; limits on covered benefits; and determination that benefits are experimental, investigational or not medically necessary or appropriate. Denial of "urgent care claim" must be provided within 24 hours after receipt of claim. The IFR establishes new federal minimum consumer protections for external appeals. The NAIC Model Act for external appeals is in compliance with the IFR, subject to a transition period, as described. *All plans (including self-funded) except grandfathered plan.	HHS /Labor/Treasury issued rules governing internal and external review. HHS Secretary required to update the internal appeal process, currently established by the states for the individual market. Labor Secretary to update internal appeals process for the group market. HHS Secretary required to establish minimum standards for external review, consistent with the NAIC Model. NAIC Model for external review deemed in compliance with IFR.	Plan/policy years on/after September 23, 2010. For plans years beginning before July 1, 2011, transition period for plans/ issuers that comply with existing State external appeals processes. For plan/policy years after July 1, 2011, State external review process must comply with minimum federal standards.	IFR with comment period, 75 Fed Reg. 54440 (July 23, 2010). Effective September 21, 2010.
Maintaining Existing Coverage (Grandfathered Plans) [ACA§§ 1251, 10103; Reconciliation Bill § 2301; PHSA§§ 2704, 2708, 2711, 2712, 2714,	Grandfathered provisions apply to group health plans or group or individual health insurance in which an individual was enrolled on March 23, 2010. Allows addition of family members without affecting grandfathered status. Applies grandfathered plan rules separately to each benefit package. Grandfather status would exempt a plan from the following insurance reforms: ➢ Discrimination based on salary (exempts only grandfathered group health plans) ➢ Public disclosure of claims data ➢ Annual reports on quality ➢ Internal/External appeals process	HHS/Labor/IRS issued rules regarding grandfathered plans.	Plans/policies with individuals enrolled on March 23, 2010. Varying dates for specific provisions	IFR with comment period, 75 Fed. Reg. 34538 (June 17, 2010). Generally effective June 14, 2010. IRS NPRM, 75 Fed. Reg. 34571

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2715,2718] (related grandfathered plans)	➢ Coverage of preventive services ➢ Annual limits on benefits (exempts only grandfathered individual market plans ➢ Pre-existing exclusion; discrimination for health factors (exempts only grandfathered individual market plans) ➢ Patient protections: primary care, emergency and obstetric/ gynecologist as primary care providers. ➢ Non-discrimination related to health status ➢ Guaranteed Issue ➢ Premium rate review ➢ Adjusted Community Rating ➢ Risk Pooling ➢ Transitional Reinsurance Program ➢ Cancer Clinical Trial mandate The following provisions apply to grandfathered plans: ➢ Pre-existing condition prohibition (only grandfathered group health plans) ➢ Excessive waiting periods (only grandfathered group health plans, applicable January 1, 2014) ➢ Lifetime dollar limits/Annual limits prohibition (only grandfathered group health plans) ➢ Rescissions prohibition ➢ Dependent coverage ➢ Uniform explanation of coverage & standardized definitions ➢ Medical Loss Ratio and accompanying standards ➢ Auto-Enrollment for Large Employers			(June 17, 2010). Comments & requests for public hearing due September 15, 2010.
Other Data Reporting from Plans [ACA§ 1001; PHSA§ 2715A]	<u>Plan Reporting requirements.</u> All plans must submit to HHS Secretary and the state insurance commissioner, and make available to public the following information in plain language: claims payment policies and practices; periodic financial disclosure; data on enrollment and disenrollment; data on number of claims denied; data on rating practices; information on cost sharing and payments with respect to out-of-network coverage; and other information, as determined by the HHS Secretary. Transparency gives states, public and providers information regarding	HHS Secretary, State Insurance Commissioner will collect data. HHS Secretary will specify additional information that must be submitted.	Plan/policy years beginning on/after September 23, 2010.	

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	plan design, operations and practices. *All plans.			
Office of Health Insurance Consumer Assistance/ Ombudsman Program [ACA§ 1002; PHSA§ 2793]	Office of Consumer Assistance/Ombudsman. The HHS Secretary will distribute $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman program to perform the following tasks: ➢ Assist with filing of complaints and appeals ➢ Collect, track and quantify problems and inquires ➢ Educate consumer on their rights and responsibilities ➢ Assist consumer with enrollment in plans ➢ Resolve problems with obtaining subsidies As a condition of receiving a grant, the state must collect and report data on the types of problems and inquires that are encountered by consumers. The data will be used to identify areas where enforcement action is necessary and shall be shared with State insurance regulators and the Secretaries of Labor and Treasury.	HHS Secretary has established a grant program for states. The program will become an important component of the Exchange operation. HHS/DOL/Treasury guidance regarding the programs and state will decide how the offices relate to state governmental and the Exchange. States that receive grants are required to collect and report data re consumer problems.	Effective September 2010. Beginning 2014, the program must help resolve problems with premium credits for Exchange coverage.	On July 29, 2010, HHS Secretary announced $29 million grant program. Deadline for applications, September 10, 2010.
Enrollment Standards and Protocols [ACA§1561; PHSA§ 3021]	Enrollment Standards & Protocols. The Secretary, in consultation with the Office of the National Coordinator (ONC) (HIT Policy Committee and the HIT Standards Committee), is required to develop interoperable and security standards and protocols that facilitate the electronic enrollment of individual in federal and state health and human services program. Requires standards and protocols to include: ➢ Electronic matching against federal and state data as evidence for eligibility ➢ Simplication and submission of electronic documentation ➢ Reuse of stored eligibility information ➢ Capability for individual to apply, recertify and manage eligibility information online ➢ Ability to expand enrollment systems to integrate new program, rules and functionalities ➢ Notification of eligibility, recertification and other needed communication; and ➢ Other functionalities need to provide these eligible with a	HHS Secretary, with the ONC (HIT Policy and Standards Committees), is required to develop standards governing interoperability and protocols that facilitates enrollment in state and federal programs. Enrollment and eligibility determinations are important components of the Exchange that will be important for hospitals. States will be negotiating with the HHS Secretary over the use of Exchange funding for HIT-	No later than 180 days of enactment.	The National Coordinator appointed the Enrollment Workgroup of the HIT Policy. Workgroup scheduled to finalize standards recommenda-tions by September 30, 2010.

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	streamline enrollment process. Secretary is required to award grants to eligible entities, defined as states and local governments that apply to develop new and adopt existing technology systems to implement the HIT enrollment standards. The Secretary may identify other entities that could qualify, but if that entity is awarded the grant, it will be required to share the enrollment technology.	related hardware and software.		
Insurance Market Reforms Effective after 2010				
A number of additional insurance market reforms applicable to group health plans (issuers offering group coverage) or individual health insurance become effective for plan/policy years beginning after 2010				
Pre-Existing Condition for Adults [ACA§§ 1201, 10103 (e); PHSA§2704]	Prohibition of Pre-existing condition exclusions. Prohibits imposition of any pre-existing condition exclusion on coverage for all, including adult. Effective for Plan years beginning on or after Jan. 1, 2014. Effective for plan years beginning on/after September 23, 2010, for enrollees under age 19. *All plans, except grandfathered individual plans.	HHS/DOL/Treasury will issue rules that govern market reforms .	Plan/policy years beginning on/after January 1, 2014.	Interim Final Rule (IFR) with comment, 75 Fed Reg 37188 (June 28, 2010).
Non-discrimination [ACA §§ 1201, 1255; 10103; PHSA§ 2705]	Health Status: Prohibits establishing any rule for eligibility based on the following health status-related factors of an individual or a dependent: health status; medical condition (including both physical and mental; claims experience; receipt of medical care; genetic information; evidence of insurability; disability; and any other health status-related factor determined as appropriate by the Secretary. * All plans, except grandfathered plans.	Allows HHS Secretary to establish open and special enrollment period to mitigate the potential for adverse selection.	Plan/policy years beginning on/after January 1, 2014.	
Guaranteed issue [ACA § 1201; PHSA§ 2702]	Guaranteed Issue: Mandates the health insurance issuers accept every employer and individual in the State that applies for coverage. Permits open or special enrollment periods. Requires establishment of special enrollment period for "qualifying event" (under section 603 of ERISA) that conform to rules promulgated by the Secretary. *All plans, except self-funded and grandfathered plans.		Plan/policy years beginning on/after January 1, 2014.	
Renewability [ACA §§ 1201;1255,	Renewability: Requires health insurance issuers offering coverage in the individual or group market to renew or continue in force coverage at the option of the plan sponsor or individual.		Plan/policy years beginning on/after January	

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10103; PHSA§ 2703]	*All plans.		1, 2014.	
Waiting Periods [ACA §§ 1201, 1255, 10103; PHSA § 2708]	Waiting Periods: The waiting periods for group plans is limited to 90 days. *All plans.		Plan/policy years beginning on/after January 1, 2014.	
Monitoring Premium Rate Review [ACA§§ 1003, 1004; PHSA§ 2794]	Premium increases of health insurance coverage offered through an Exchange and outside of an Exchange will be monitored and reviewed by the Secretary, in conjunction with the states. Health insurance issuers are required to submit to the Secretary and the State a justification for unreasonable premium increases before the implementation of the increase and post that information on their websites. ➢ Discussion of rate review and MLR (discussed below) may stimulate discussion of whether state should enact legislation to authorize provider rate review. Federal funding. A total of $250 million in grants is available from HHS to States to strengthen State rate review efforts. Grants will be available over a five year period, beginning with March 23, 2010, and ending in 2014. States must meet minimum federal rate review procedures to strengthen the insurance department's actuarial capacity. States are eligible for $1 million grants during round 1. Round 2 grants from the $250 million pool will be available in 2011. To receive a grant, a state, through its Commissioner of Insurance, is required to provide the Secretary with information about trends in premium increases of health insurance coverage in premium rating areas in the State; and make appropriate recommendations to the State Exchange about whether particular health insurance issuers should be excluded from participation due to a pattern or practice of excessive or unjustified premium increases.	Beginning in plans year 2010, the HHS Secretary, in conjunction with the states, is required to establish a process for the annual review of "unreasonable" premium increases for health insurance coverage. Requires HHS Secretary to implement review program to award grants to states to assist with review of "unreasonable" increases during the 5-year period beginning FY 2010. DHHS Secretary will issue rules governing the process. NAIC submit comments to Secretary and must report on authority. When Exchanges are operational, Secretary, with the States, will monitor premium increases offered inside and outside of the Exchange. ➢ The information on the premium increases and	Plan year beginning in 2010, program established. June 7, 2010, Secretary solicited grant applications from states for monitoring premium increases. Grants are available from HHS Secretary to States through the State Commissioner of Insurance beginning 2010. Round 2 grants will be available in 2011. Plan/policy years beginning in	Request for Information, 75 Fed. Reg. 19335 (April 14, 2010). Grant solicitation: http://www.hhs.gov/ociio/initiative/final_premium_review_grant_solicitation.pdf FAQs: http://www.hhs.gov/ociio/initiative/grant_proposal_review_qa_7-1-2010.html

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	Grants may be used for reviewing, and if appropriate under State law, approving premium increases; providing information and recommendations to the Secretary; and establishing medical reimbursement data centers at academic or other nonprofit institutions. The medical reimbursement data centers are important because of its functions, data collection and public disclosure, that include: ➢ Develop fee schedules and other database tools that reflect market rates for medical services and the geographic differences in the rates; ➢ Use the best statistical methods and data processing technology to develop fee schedules and other database tools; ➢ Regularly update the fee schedules and other database tools to reflect changes in charges for medical services; ➢ Make health care cost information publicly available through the internet; ➢ Regularly publish information on the statistical methods used to analyze health charge data and make such data available to researchers and policy makers; and ➢ Adopt law to ensure that the center is independent and free from all conflicts of interest. Medical reimbursement data centers may not compel health insurance issuers to provide data to the center. States are required to account for any excessive premium growth outside of an Exchange (as compared to the rate of growth inside an Exchange) when determining whether to offer qualified health plans in the large group market through an Exchange. *All plans, except group self-funded plans and grandfathered plans.	justifications will be publicly disclosed. ➢ States report on trends in premium increases and recommendations to Exchange re plan participation. Secretary will establish the formula for determining the amount of grants to be awarded to states. HHS is not requiring states to enact prior approval rate review, and states could use grant money to institute more oversight over premium increases.	2014, the Secretary and States will monitor premium increases of health insurance offered both in and out of the Exchange. Secretary Sebelius awards $46 million to states: http://www.hhs.gov/news/press/2010pres/08/20100816a.html	
Medical Loss Ratio [ACA§§ 1001, 1004, 1251, 1563,	The law establishes medical loss ratio obligations (MLR) on health insurance issuers, that if not met would require rebates. Beginning for plan years after September 23, 2010, health insurance issuers offering group or individual health insurance coverage will be required to submit	Requires all plans, except self-funded plans, to submit to HHS Secretary a report of the incurred loss (or incurred claims) plus	The MLR provision generally applies to plan years	HHS Secretary Request for Information [75 Fed. Reg. 19297

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10101, 10103; PHSA § 2718]	a report to HHS related to each plan year on the MLR (the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums). The report is required to include the percent of total premium revenue after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that the coverage expends on: ➢ Reimbursement for clinical services; ➢ Activities that improve health care quality; and ➢ All other non-claims costs, including an explanation of the nature of the costs and excluding federal and state taxes and licensing or regulatory fees. MLRs apply to health insurance issuers as follows: ➢ 85% for health insurance issuers offering coverage in the large group market, or a higher percent if required by a state; and ➢ 80% for health insurance issuers offering coverage in the small group market or in the individual market, or a higher percent if required by a state. Health insurance issuers offering group or individual insurance coverage that do not meet the MLRs are required to provide annual rebates to each enrollee on a pro rata basis with respect to each plan year. The annual rebate amount is equal to the product of the amount by which the coverage does not meet the MLR by the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and accounting for receipts for risk adjustment, risk corridors, and reinsurance) for the plan year. Beginning on January 1, 2014, the calculation of MLRs will be based on the averages of premiums expended on claims and the total premium revenue for each of the previous three years.	loss adjustment expense to earned premiums, with respect to each plan year. Requires HHS Secretary to make MLR reports from plans available on the HHS website. MLR Standards. The Secretary, in conjunction with NAIC, is required to issue rules to enforce the requirements related to the reports and MLR and may provide for penalties. Subject to the certification of the Secretary, NAIC will establish uniform definitions for the activities reported, standard methods for measuring the activities and which activities improve health care quality. ➢ By December 31, 2010, NAIC is required to develop uniform definitions of the categories of expenses and standardized methodologies for calculating measure of them ➢ NAIC committees, task forces and workgroup engage in the developing of definitions, including form to be used by plans for reporting,	beginning on/after September 23, 2010. By December 31, 2010, NAIC will establish uniform definitions for the activities reported, standard methods for measuring the activities and which activities improve health care quality. Beginning January 1, 2011, mandates that plans pay an annual rebate to each enrollee. Beginning on January 1, 2014, the calculation of minimum MLR will be based on the averages of premiums expended on	(April 14, 2010)]. April 12, 2010 Letter from Secretary Sebelius to NAIC that accelerates the timeframe for the NAIC recommendation from December to June 1, 2010. http://www.healthreform.gov/newsroom/naicletter.html. NAIC letter to HHS on June 1, 2010, regarding its progress on developing the rules for MLRs, and asking for additional time to produce its final proposal.

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	States are required to ensure adequate participation by health insurance issuers, competition in the health insurance market and value for consumers so that premiums are used for clinical services and quality improvement when determining the MLRs. In this context NAIC is working on a transition approach that could be implemented on a state-by-state basis. All hospitals must establish and make public a list of its standard charges for items and service, include for diagnosis-related groups. *All plans, except self-funded plans.	➢ Expect ongoing debate over activities that are included in the definition of quality activities. The Secretary may adjust the MLR applicable to health insurance issuers offering coverage in the small group or individual markets if the Secretary determines that the application of an 80% MLR may destabilize the individual market in a state.	claims and the total premium revenue for each of the previous three years.	
Uniform Explanation of Coverage Documents and Standardized Definitions [ACA§§1001, 1004, 1251, 10103; PHSA§2715]	Health insurance issuers offering health insurance coverage in the United States and, in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan, are required to provide a summary of benefits and coverage explanation in accordance with the standards developed by the Secretary. The summary must contain: uniform definitions of insurance and medical terms ➢ A description of coverage and cost sharing for each category of essential health benefits and other benefits ➢ Exception, reductions and limitations on 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 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	The Secretary, in consultation with NAIC, health insurers, health care professionals, patient advocates and other qualified individuals, will develop standards related to the summary of benefits and coverage. ➢ HHS Secretary required to consult with NAIC and working group of interested stakeholders, consumers, plans, providers) ➢ NAIC will submit to Secretary by March 2011, effective March 2012. ➢ Provider input is important to ensure that the definitions of medical terms, e.g., rehabilitation or inpatient hospitals are accurate.	No later than March 23, 2011, the Secretary will develop standards for use in compiling and providing a summary of benefits and coverage explanation. By March 23, 2012, health insurance issuers offering health insurance coverage and, in the case of self-insured group plans, plan	

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	The law expressly preempts any state summary of benefits and coverage disclosure requirements that provide less information to consumers. The information must be provided to the following: ➢ Applicants at the time of application, ➢ Enrollees at the time of enrollment or reenrollment, and ➢ Policyholders or certificate holders at the time of issuance of the policy or delivery of the certificate The standards will include requirements related to appearance, language and contents. A group health plan or health insurance issuer is required to provide notice of material modifications to the terms of a plan or coverage that are not reflected in the most recently provided summary of benefits and coverage at least 60 days before the date on which the modification will become effective. *All plans.	The Secretary is required to periodically review and update the standards developed. The Secretary will promulgate regulations providing for the development of standards for the definitions of insurance-related terms and medical terms used in health insurance coverage.	sponsors or designated plan administrators, will be required to provide a summary of benefits and coverage explanation to applicants, enrollees and policyholders or certificate holders.	
Adjusted Community Rating [ACA§§ 1201, 1255, 10103; PHSA§ 2701]	The law requires adjusted community rating and limits premium variation for group and individual health insurance to the following factors: Family structure; rating areas; age (not more than 3 to 1); and tobacco use (not more than 1.5 to 1). Prohibits use of any factor (s) not specifically identified. States are required to define the rating areas, subject to HHS Secretary review for adequacy. HHS Secretary and NAIC will establish standard age bands. Family coverage, rating variations for age and tobacco use shall be applied based on the portion of the premium that is attributable to each family member covered under the plan *All plans, except self-funded and grandfathered plans.	HHS Secretary, in consultation with NAIC, is required to define age band for rating purposes. NAIC will assist Secretary; may develop models for States. States are required to establish the rating areas, subject to HHS Secretary review of the rating areas for adequacy.	Plan years beginning on/after January 1, 2014.	
Assessment of Health Plan	The Secretary, in consultation with stakeholders including health insurance issuers, health care consumers, employers, health care	The HHS Secretary is required to submit a report to Congress	By September 23, 2011,	

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Value [ACA§ 10329]	providers and other entities identified by the Secretary, will develop a method to measure health plan value The method to measure health plan value must consider: ➢ Overall cost to enrollees under the plan; ➢ Quality of care provided for under the plan; ➢ Efficiency of the plan in providing care; ➢ Relative risk of the plan's enrollees as compared to other plans; ➢ The actuarial value or other comparative measure of the benefits covered under the plan; and ➢ Other factors the Secretary determines are relevant.	on the method developed to measure health plan value.	Secretary will submit Report to Congress.	
Quality Reporting [ACA §1001; PHSA §2717]	Plans must submit annual reports to HHS Secretary regarding benefits under the health plans that inform the Secretary of the following: ➢ Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management ➢ Implement activities to prevent hospital readmission ➢ Implement activities to improve patient safety and reduce medical errors ➢ Implement wellness and health promotion activities The Plans will be tracking the impact of benefit design on health outcomes and impact on readmissions and patient safety. * All plans, except grandfathered plans.	HHS Secretary in consultation with experts in health care quality and stakeholders will develop guidance. HHS Secretary will make reports available to public through Web Portal. See discussion on 19-20.	By March 23, 2012	
Transition to Exchange				
Temporary High Risk Pool Program, "Pre-Existing Condition Insurance Plan" Program" [ACA§ 1101]	HHS Secretary will establish a temporary high risk health insurance pool program, also known as the "Pre-Existing Condition Insurance Plan," (Pre-Ex Plan) to provide health insurance coverage for eligible individuals until January 1, 2014. There is $5 billion to fund pools through 2013. The Secretary may carry out the program directly or through contracts to eligible entities. Maintenance of Effort. As a condition of the contract, a State must agree	The Secretary is required to establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged individuals from remaining enrolled in prior coverage based on the individuals' health status. The Secretary will issue	The temporary Pre-Ex Plan program established within 90 days of enactment, and generally will end on January 1, 2014.	IFR with comment period published 75 Fed Reg 45014 (July 30, 2010. Regulations effective July 30, 2010. http://edocket.access.gpo.gov/201

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	that it will not reduce the amount it spends annually for the operation of one or more State high risk pools during the year preceding the year in which it enters into the contract. A qualified high risk pool must satisfy the following criteria: ➢ Have no preexisting condition exclusions; ➢ Cover at least 65 percent of total allowed costs; ➢ Have an out of pocket limit not more than the limit for high deductible health plans; ➢ Use adjusted community rating with a maximum variation for age of 4:1; ➢ Have premiums established at a standard rate for a standard population; and ➢ Meets other requirements established by the Secretary. Eligible individuals for the purpose of the temporary Pre-Ex Plan program include individuals: ➢ Who are citizens, nationals or lawfully present in the United States; ➢ Who have not been covered under creditable coverage during the 6-month period before the date on which the individual is applying for coverage through the high risk pool; and ➢ Who have a pre-existing condition, as determined under guidance issued by the Secretary. Penalties: Issuers or employment-based health plans will be required to reimburse the program for medical expenses incurred by a Pre-Ex Plan program for an individual who the Secretary finds was encouraged to disenroll from health benefits coverage before enrolling in coverage through Pre-Ex Plan program based on factors including at least the following: ➢ For prior coverage offered through an employer, the provision	guidance regarding pre-existing conditions that qualify an individual for participation in a Pre-Ex Plan. For the states that have requested that the federal government run their Pre-Ex Plan., the program will be operated by HHS in conjunction with the Office of Personnel Management (OPM) and the USDA's National Finance Center. HHS has contracted with the Government Employees Health Association (GEHA) to administer the Pre-Ex Plan. GEHA is a long-time insurer for federal employee health care. The Secretary is required to establish an appeals process for individuals to appeal a determination under a high risk pool program as well as procedures to prevent against waste, fraud and abuse.		0/pdf/2010-18691.pdf Regulations were announced July 30, 2010, regarding the Pre-Ex Plan program. http://www.ofr.gov/OFRUpload/OFRData/2010-18691_PI.pdf; White House blog re IFR http://www.whitehouse.gov/blog/2010/07/29/insurance-americans-with-pre-existing-conditions April 2, 2010 Letter to Governors and Insurance Commissioners regarding interest in participating in the temporary Pre-Ex Plan program. http://www.hhs.g

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	of financial consideration for disenrollment by the employer, group health plan or the issuer. ➢ For prior coverage obtained directly from an issuer or under an employment-based health plan, (1) the provision of financial consideration for disenrollment by the issuer, or (2) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program, the prior coverage is no longer being actively marketed by the issuer or the prior coverage is a policy for which duration of coverage from issue or health status are factors that can be considered when determining premiums at renewal. Coverage of eligible individuals under a Pre-Ex Plan in a state will terminate on January 1, 2014, except that coverage may continue if the Secretary determines that it is necessary to avoid a lapse in coverage.			ov/news/press/2010pres/04/20100402b.html Primary contact was required to be submitted to CMS by April 9, 2010. Letter of intent to submit an application to contract with HHS to operate a Pre-Ex Plan program was required to be submitted by April 30, 2010. http://www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html
Temporary Reinsurance Program for Early Retirees [[ACA§ 1102]	Temporary Reinsurance program for Early Retirees. HHS Secretary 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. Payment under the program must be used to lower costs of the plan. HHS has $5 billion to fund the program. The program is being implemented and employers are filing applications to participate. There is an issue whether the $5 billion will be sufficient to permit all	HHS Secretary has developed guidance materials and application forms for the program.	Effective June 1, 2010; HHS accepting applications for funding on June 29, 2010.	IFR published 75 Fed Reg. 24450 (May 5, 2010). Effective June 1, 2010. On June 29, 2010, the HHS published the official ERRP Program

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	employers who qualify to participate. *All Plans, including group self-funded and grandfathered plans.			Application, official ERRP Application Instructions, and Application Submission Dos and Don'ts. http://www.hhs.gov/ociio/regulations/errp/index.html.
Risk Pool [ACA§ 1312]	Risk Pooling Applicable to Individual and Small Group Markets Individual Market Pool. Insurers are required to pool the risk of all enrollees in all plans (except for grandfathered health plans) offered in the individual market, regardless of whether enrollees enroll in the plans through an Exchange. * All plans, except grandfathered plans. Small/Group Market Pool. Insurers are required to pool the risk of all enrollees in all plans (except for grandfathered health plans) offered in the small group market, regardless of whether enrollees enroll in the plans through an Exchange. *All plans, except self-funded small group, grandfathered and large group plans. A state may not require grandfathered health plans to be included in a pooled individual market or small group market.	A State has flexibility to merge the individual and small group insurance markets.	Effective January 1, 2014.	
Risk Management Programs: Risk Corridor Program [ACA§ 1342]; Risk Adjustment	Transitional Risk Corridor Payment Adjustment Program. The law requires the HHS Secretary to establish a risk corridor payment adjustment program for "qualified health plans" in the individual or small group market for Calendar Years (CY) 2014, 2015, and 2016. The program is intended to adjust payments in those markets among plans based on a ratio of the plan's costs to the plan's aggregate premiums. The program is modeled on risk corridors under Medicare Part D for regional Preferred Provider Organizations (PPOs).	The Secretary, in consultation with states, will establish and administer a risk-corridor program for qualified heath plans offered in the individual and small group markets in 2014, 2015 and 2016. The Secretary is required to pay to	Applicable to "qualified health plans" in CYs 2014, 2015 and 2016 only.	

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[ACA§1343]	Payments will be based on allowable costs and the target amount. ➢ Allowable costs are the total costs (other than administrative costs) of the plan in providing benefits covered by the plan. Allowable costs are reduced by any risk adjustment and reinsurance payments received. ➢ The target amount is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan. Participating plans must pay the Secretary the following: ➢ An amount equal to 50% of the excess of 97% of the target amount over the allowable costs if the plan's allowable costs for any plan year are less than 97% but not less than 92% of the target amount. ➢ An amount equal to the sum of 2.5% of the target amount plus 80% of the excess of 92% of the target amount over the allowable costs if the plan's allowable costs for any plan year are less than 92% of the target amount. *All plans, except self-funded in small group market and grandfathered plans. <u>Risk Adjustment Program.</u> The Secretary, in consultation with NAIC, is required to establish criteria and methodology to carry out a risk adjustment process. States will be required to impose a charge on health plans and health insurance issuers, not limited to plans in the Exchange, if the actuarial risk of the enrollees of those plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in the state for the year. The state is required to pay plans in the individual and small group markets if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in the state for the year that are not self-insured group health plans.	the plans the following: ➢ An amount equal to 50% of the target amount in excess of 103% of the target amount if a participating plan's allowable costs for any plan year are more than 103%, but not more than 108% of the target amount. ➢ An amount equal to the sum of 2.5% of the target amount plus 80% of allowable costs in excess of 108% of the target amount if a participating plan's allowable costs for any plan year are more than 108% of the target amount. HHS, in consultation with the states, will develop the criteria and methods to be used in implementing the risk adjustment program. ➢ Similar to methods and criteria used in the Medicare Choice Program and Prescription Drug Benefit Program. Amounts paid under this program will be reduced by any amounts paid under the State's	No specific effective date, but considered effective on March 23, 2010.	

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	The risk adjustment assessment and payments are limited to health plans or health insurance issuers providing coverage in the individual or small group market with respect to that plan. *All plans, except self-funded in large group market and grandfathered plans.	reinsurance program.		
Transitional State Reinsurance Program for Individual Market[ACA§ 1341]	Transitional State Reinsurance Program. Beginning January 1, 2014, when the Pre-Ex Plan program phases out, states are required to adopt a reinsurance program and establish (or contract with at least one reinsurance entity to carry out) the program in compliance with the regulations established by the Secretary. States must adopt state law or regulations for the reinsurance program. A reinsurance entity is a not-for-profit tax exempt organization that helps stabilize premiums for coverage in the individual market in a State during the first three years of operation of an Exchange by carrying out a reinsurance program. As a condition of issuing commercial, major medical health insurance policies or administering benefit plans in years 2014 – 2016, all health insurance plans must contribute to the reinsurance program for individual policies. The contributions of insurers and group health plans may be required to be paid in advance or periodically, and the method for determining the amount of the required contributions of insurers and group health plans may be based on the percentage of revenue of each issuer and for self-insured plans, the total costs of providing benefits to enrollees; or on a specified amount per enrollee. Contribution requirements applicable to insurers and group health plans must proportionally reflect each insurer's fully insured commercial book of business for all major medical products as well as the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator. ➢ For 2014, the aggregate contribution for all states must equal $10 billion, plus an additional $2 billion reflecting a proportionate additional contribution from each issuer.	The Secretary, in consultation with NAIC, and with recommendations from the American Academy of Actuaries (AAA), is required to establish Federal standards governing the transitional reinsurance program. The standards will include a method to identify high risk individuals; formula for determining the amount of payments to insurers that insure high-risk individuals; method for determining the level of contribution from each insurer and group health plan; and method for distributing funds. HHS Secretary shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.	No later than January 1, 2014, states are required to adopt a reinsurance program and establish (or contract with) at least one applicable reinsurance entity. Effective for plan years beginning in 2014 through 2016, insurers and third party administrators, on behalf of group health plans, will be required to make payments to the reinsurance entities.	

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	➢ For 2015, the aggregate contribution for all states must equal $6 billion plus an additional $2 billion reflecting a proportionate additional contribution from each issuer. ➢ For 2016, the aggregate contribution for all states must equal $4 billion plus an additional $1 billion reflecting a proportionate additional contribution from each issuer. The payments collected by the reinsurance entity will be used to make reinsurance payments to insurers that cover high-risk individuals in the individual market during the three-year period beginning on January 1, 2014. Grandfathered individual plans are eligible to receive payments. Amounts remaining unspent as of December 2016 may be used to make reinsurance payments under any reinsurance program of a state in the individual market in effect in the 2-year period beginning on January 1, 2017. A state may have more than one reinsurance entity to carry out the reinsurance program within the state. Two or more states have the option of entering into agreements for a reinsurance entity to carry out a reinsurance program in all of the participating states. *All plans in individual market, except grandfathered plans.			
Web Portal for Health Coverage Information [ACA§§ 1103, 1105, 10102]	The HHS Secretary will establish a mechanism, including a website, through which individuals and small businesses can identify affordable health insurance coverage options in a state. Internet Portal lays the foundation for the Exchange. The website will provide at least the following health insurance coverage information: ➢ Health insurance coverage; ➢ Medicaid coverage; ➢ Coverage under the state's Children's Health Insurance Program; ➢ Coverage under a State health benefits high risk pool; ➢ Medicare	The HHS Secretary may establish the website directly or through contracts with qualified entities. The Secretary will issue further guidance regarding submission regarding performance ratings, MLR, appeals, etc. The Secretary, in consultation with the states, will develop a standardized format to be used for the presentation of	On July 1, 2010, the Secretary (with the states) implemented the Web Portal. Initially, the Web Portal provides summary information regarding plans. Within 60 days	IFR with comment period were issued, 75 Fed Reg. 24470 (May 5, 2010). Fact Sheet: http://www.hhs.gov/ociio/gatheringinfo/factsheet.html; http://www.hhs.gov/ociio/gatherin

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	➢ Coverage within the small group market; including reinsurance for early retirees, tax credits and other information for small businesses regarding affordable health care options. The standard format to be used to present information related to the coverage options will be consistent with the standards adopted for the uniform explanation of coverage and will include at least: ➢ Percentage of total premium expended on nonclinical costs; ➢ Eligibility; ➢ Availability; ➢ Premium rates; and ➢ Cost-sharing. *All plans, except grandfathered plans.	information related to the coverage options. The Web Portal is being implemented in three phases. Phase 1-Issuers required to submit no later than May 21st information for individual & small group markets. Phase 2 (October 1, 2010) issuers required to submit no later than September 3rd pricing and benefit information; Phase 3 (ongoing) reporting obligation continue on an annual basis and within 30 days for plan changes/new products.	of the date of enactment, the Secretary will develop a standardized format to be used for the presentation of information related to the coverage options.	ginfo/index.html
Application of Administrative Simplification to State Programs [ACA 1104, 1105, 10109; SSA 1171]	The HHS Secretary is required to develop operating rules for electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions. The standards will be consensus-based and reflect business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Secretary is required to solicit input before January 1, 2012 regarding (1) whether standards and operating rules that are adopted apply to the health care transactions associated with workers' compensation and other program and (2) could standardized forms apply to financial audits required by health plans, federal and state agencies, including state auditors, the Office of the Inspector General and the Center for Medicare and Medicaid Services and other relevant entities. Penalties for noncompliance: Health plans required to comply with HIPAA operating rules adopted by Secretary by April 1, 2014, or penalty	HHS Secretary will adopt standards and operating rules. NCVHS will review operating rules developed by the nonprofit entity and make recommendations to HHS Secretary. HHS Secretary required to issue final rule establishing a unique health plan identifier based on NCVHS that must be effective October 1, 2012. Secretary required to establish standard for electronic fund transfer that must be adopted no later than January 1, 2012 and	Rules adopted by July 1, 2011 will become effective January 1, 2013 Deadlines for the adoption and implementation of various operating rules: - Eligibility verification & claims status: adopted by July 1, 2011 and effective January 1, 2013 - Claims remittance, payment and electronic funds	

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	can be applied: $1 per covered life until certification is complete; not to exceed $20 per covered life (not to exceed $40 per covered life, if the plan knowingly provided inaccurate or incomplete inform). At least every three years, the Secretary is required to solicit input from entities, including the National Committee on Vital and Health Statistics, the Health Information Technology Policy Committee and the Health Information Technology Standards Committee, and other standard setting organizations and stakeholders, on uniformity in financial and administrative activities and whether such activities should be considered financial and administrative transactions for which the adoption of standards and operating rules would improve the operation of the health care system and reduce administrative error.	effective by January 1, 2014. Secretary required to establish transaction standard for health claims attachments that must be final by January 1, 2013 and effective by January 1, 2016.	transfer: adopted by July 1, 2012 effective by January 1, 2014; - Other operating rules, including health claims or equi information, enrollment and dis-enrollment in health plans, health plans premium payments and referral certification and authorization: adopted by July 1, 2014 and effective by January 1, 2016.	
The Exchange				
Exchange [§§ 1311, 1304, 1321]	Overview: States are required to establish health insurance exchanges, including American Health Benefit Exchange ("Exchanges") for the individual market and Small Business Health Options Program Exchanges ("SHOP Exchange") for the small employer market that will make available qualified health plans to individuals and employers who are qualified to purchase through the Exchange(s). ➢ Exchange(s) must to be operational by January 1, 2014. ➢ If the state chooses not to establish an Exchange the federal government will operate one. ➢ State has the option to combine the two Exchanges into one Exchange. Funding Opportunity for the State: Beginning in 2011, grants are available from HHS to States to defray some of the costs associated with establishing the Exchanges. Those funds may be awarded from March	HHS Secretary, in consultation with NAIC, is required to promulgate rules setting standard related to Exchanges, qualified health plans, reinsurance and risk adjustment programs and other requirements. Exchange may establish additional requirements. See discussion below ➢ HHS must provide technical assistance to States to facilitate small business participation in SHOP Exchanges. ➢ Opportunities to states, consumers, providers, health	Exchanges must be operational by January 1, 2014. State notification to HHS regarding establishment of Exchange by January. 1, 2013. If not implemented, HHS Secretary will establish/operate Exchange.	Request for Comments-re Exchange-issues, 75 Fed Reg 48544 (August 3, 2010). Comments due October 4, 2010. http://www.hhs.gov/news/press/2010pres/07/20100729a.html ; Request for Information http://www.hhs.gov/ociio/initiative/exchange_faq.html.

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	2010 through– January 1, 2015. ➢ NAIC, State Insurance Commissioners are heavily involved in securing funding for Exchange planning and startup activities. ➢ States are negotiating with HHS over the amount and use of funds for planning and start-up. Several grant cycles are contemplated. ➢ By January 1, 2015, the Exchange must be financially self-sustaining. ➢ Exchanges will look for ways to finance its operations and support its functions, e.g. States are required to allow Exchanges to charge assessments or user fees to insurers. o The Exchange is required to publish certain costs and payments and may try to impose reporting requirements on providers and health systems o Providers are required to report charges <u>Administration</u>: Exchange can be operated by either a governmental agency, quasi governmental or a nonprofit entity established by the State ➢ Special legislation may be required. ➢ The state may permit an Exchange to contract with an entity to carry out certain responsibilities of the Exchange. <u>Functions of the Exchange</u> are determined by the State based on minimum standards established by ACA, and after consultation with stakeholders. These functions include at a minimum the following: ➢ Certify, recertify and decertify health plans as Qualified Health Plans (QHP). Secretary will development system to rate qualified health plans offered through an Exchange in each benefit level based on quality and price. ➢ Toll-free hotline to respond to assistance requests ➢ Maintain an Internet website for enrollees and prospective enrollees to compare information regarding qualified health	plans and other stakeholders to engage in the discussion of the nature and functions and operations of the exchange. HHS is authorized to make renewable grants to States to help pay costs associated with establishing Exchanges. Short timeframe for Exchange: ➢ 2010-2011, State applies for grants to planning and development activities. ➢ By 2012, State must test its Exchange model ➢ By 2013, HHS determines whether State will be able to meet the Exchange criteria by 2014. ➢ 2014, Exchange must be operational. See discussion of QHP on pages 36-37. See discussion of Web Portal on page 27.	Federal grants available to states within one year of enactment [2011] and may be renewed prior to 2015 if State demonstrates progress in meeting Exchange requirements. No federal grants to States after January 1, 2015. No payments for operational costs after start-up completed. Must be self-sustaining by January 1, 2015. Implementation January 1, 2014. By January 1, 2013, if the HHS Secretary determines that a State will not meet Exchange criteria, HHS	

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	plans ➢ Assign a rating to each qualified health plan offered through the Exchange. Secretary will develop a system to rate QHPs offered through the Exchange based on quality and price. ➢ Use standardized format for presenting health benefit plan options in the Exchange ➢ Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under IRC and any applicable cost-sharing ➢ Grant certifications regarding exemptions from the individual responsibility requirement or penalty; ➢ Transfer information to the Department of Treasury on issued certifications related to exemptions from the individual responsibility requirement or penalty, employees eligible for the premium tax credit, and individuals that have changed employers or have ceased coverage under a qualified health plan during the year; ➢ Provide employers with information on employees eligible for the premium tax credit who cease coverage under a qualified health plan during the plan year; and ➢ Establish a Navigator program based on standards developed by HHS Secretary, in collaboration with the States. <u>Essential Health Benefits (EHB).</u> Plan offerings through the Exchange will be based on the EHB) that are defined by the HHS Secretary, based on a list of services in the law. States may expand the list of essential health benefits; however, the States will be responsible for paying the cost of those additional health benefits. ➢ Cost sharing limits include limits on deductibles, coinsurance, copayment, similar charges and other expenditures required of an insured individual for expenses that are qualified medical expenses. Cost sharing does not include premiums, balance billing amounts for non-network providers or spending for non-covered services.	See discussion of Standards and Definitions on pages 18-19. See discussion of Navigator program on pages 37-38. HHS Secretary required to issue rules that define EHB (using criteria in the law). Secretary must ensure that the scope of EHB is equal to typical employer coverage, as determined in conjunction with the Labor Secretary based on a survey. CMS Chief Actuary must certify that the standard is met. HHS' report (including Actuary certification) to	will establish and operate an Exchange in the State. NAIC to submit to Secretary by March 2011, effective for plans beginning March 2012.	

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
	➢ Coverage Levels based on cost-sharing: Bronze (60% of full actuarial; value of benefits provided under the plan); Silver level (70% of full actuarial value); Gold level (80% of full actuarial value); and Platinum level (90% of full actuarial value). <u>Quality Improvement Programs:</u> Qualified health plans are required to implement a payment structure that provides increased reimbursement or incentives for quality improvement activities. QHPs are required to periodically report activities taken to implement the payment structure to the Exchange. ➢ Beginning January 1, 2015, unless an exception is authorized, a QHP may only contract with: (1) a hospital with more than 50 beds if the hospital uses a patient safety evaluation system and implements a mechanism ensuring that each patient receives a comprehensive program for hospital discharge or (2) a health care provider if the provider implements mechanisms required by the Secretary improve health care quality. ➢ Opportunity for hospitals to assist in development of guidelines for quality improvement, exceptions and bed size that qualifies for an exception. <u>Information Technology/Enrollment</u>: States must develop a secure, electronic interface that allows for the Exchange of information to determine a consumer's eligibility for public program coverage, tax credits, and other subsidies ➢ Coordination between enrollment in Exchange and other State funded health programs, e.g., Medicaid, CHIP. Exchange may contract with Medicaid for enrollment, eligibility and how to coordinate with QHPs in Exchange.	Congress that EHBP meets the standard. See discussion of EHB on pages 33-35. HHS Secretary, in consultation with stakeholders/experts in health care quality, will develop guidelines for the payment structure. HHS Secretary may issue rules that (1) change the number of beds that trigger the patient evaluation system requirement for hospitals; (2) require health care providers to implement quality improvement mechanisms; or (3) establish exception to the requirements related to hospitals and health providers. HHS Secretary and HIT Policy and Standards Committees charged with developing standards. Secretary shall award grants to develop new or adopt existing technologies. NAIC to submit criteria for uniform enrollment form to be used in Exchanges.	Quality: Beginning on January 1, 2015, QHP may only contract with hospitals that have patient safety & quality improvement programs required by the Secretary. By September 2010, Secretary develops standards and protocols for enrollment.	

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
	➢ Whether there are federal funds to enhance and support existing Medicaid MIS system ➢ Provider input in the development impact of State information systems and enrollment/coverage and subsidies. Offices of Consumer Assistance or Ombudsman: State may pursue Federal funding to establish, expand, or provide support for offices of health insurance consumer assistance or ombudsman programs and, as a condition for receiving the grant, imposes reporting and data collection requirements. There is $30 million in grants for the first fiscal year. Risk Management Mechanism: Establish a risk adjustment mechanism to assess issuers whose actuarial risk for a year is less than the average actuarial risk of all enrollees in the State and pay issuers whose actuarial risk for a year is greater than average. Adjusted Community Rating. Law requires states to adopt adjusted community rating and limits premium variation for group and individual health insurance. State Decisions Regarding Exchange: ➢ Whether to establish an Exchange ➢ Whether Exchange is nonprofit or state agency. ➢ Will it include both individual and small employers (100 or fewer employees) ➢ What is the role/function of the Exchange? o Interaction and relationship to other state agencies, e.g., Medicaid for purposes of enrollment, eligibility, income? o Whether can/will contract with state agencies/outside vendors for specific functions o Additional functions for the Exchange, e.g., consumer-focused, purchaser of health services, etc. ➢ What are regulations inside and outside Exchange?	Direct appropriation to HHS for $30 million in grants to states for first fiscal year. See discussion of Consumer Assistance on page 13. See separate discussion of Risk Management Program, Risk Pooling and Reinsurance Program on pages 24-25. NAIC to consult on definition of age bands and rating areas. NAIC to provide assistance to Secretary and models for States. See discussion on pages 19-20. State may elect to provide only one Exchange for both Exchange and SHOP Exchange services to both individuals and qualified small employers. States are permitted to establish subsidiary Exchanges if each Exchange serves a geographically distinct area and each area meets a minimum	Grants are available until expended. Before January 1, 2016, State may change classification of employers.	Consumer Assistance & Ombudsman. Grants available to states announced July 29, 2010.

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
	➢ Whether to mandate additional benefits. ➢ Whether to establish multistate Exchange. o State are permitted to operate in multiple states if permitted by state law, and approved by the Secretary. ➢ Whether to establish subsidiary Exchanges. ➢ Whether to merge Exchanges (individual & small employer) ➢ Whether to change classification of employers. o For plan years beginning before January 1, 2016, a State may elect to classify employers with at least 51 employees as large employers and employers with no more than 50 employees as small employers. ➢ Whether to seek waiver from Exchange requirements on or after January 2017.	size requirement. See Waiver discussion on pages 43-44.		
Exchange: Essential Health Benefit Package [ACA1302, 1311, 10104]	All qualified health benefits plans offered in the Exchanges will be required to provide coverage that meets or exceeds the standards of an essential health benefits package (EHB). Requirements of an essential benefits package include the minimum benefits, limits for cost-sharing and levels of coverage. At a minimum, an essential benefits package must provide coverage for the following categories of services: ➢ Ambulatory patient services; ➢ Emergency services; ➢ Hospitalization; ➢ Maternity and newborn care; ➢ Mental health and substance use disorder services; ➢ Prescription drugs; ➢ Rehabilitative and habilitative services and devices; ➢ Laboratory services; ➢ Preventive and wellness services and chronic disease management; and ➢ Pediatric services, including oral and vision care. Cost-sharing limits include: limits on deductibles, coinsurance,	HHS Secretary is required to use a notice/comment process to define the EHB package (EHB), using the criteria in the law. ➢ NAIC will consult with HHS. HHS Secretary will issue rules regarding the actuarial value & level of coverage of plans. Secretary must consider employer contributions to health savings accounts and ensure that the scope of benefits offered in an EHB package is equivalent to the scope of benefits provided under a typical employer plan. The CMS Chief Actuary must certify that the standard is met, and HHS is required to report to		

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	copayments, similar charges, and other expenditures with respect to covered essential health benefits required of an insured individual for expenses that are qualified medical expenses. However, cost-sharing does not include premiums, balance billing amounts for non-network providers or spending for non-covered services. Coverage must fall into one of four benefit levels that are defined based on cost sharing: ➢ Bronze level plan- Coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. ➢ Silver level plan- Coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan. ➢ Gold level plan - Coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan. ➢ Platinum level plan - Coverage provides benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan ➢ In addition, health plans offering coverage through an exchange must offer a child-only policy (under 21) and may offer a catastrophic only policy to young adults under 30. o Plans that offer catastrophic coverage will be exempt from the general rule related to the level of coverage that must be provided. o These plans may only be offered in the individual market and enrollment is restricted to Individuals under the age of 30; or Individuals exempt from the requirement to maintain minimum coverage. Federally Qualified Health Center (FQHC). If a plan enrollee receives services or items from an FQHC, the entity providing the plan must pay the FQHC at a minimum the amount it would have received from	Congress. The Labor Secretary will conduct a survey of employer-sponsored coverage to determine the typical benefits covered by employers. The HHS Secretary is required to develop guidelines to provide for a de minimis variation in actuarial valuations used in determining the level of coverage of a plan.		

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	Medicare or Medicaid for providing the item or service. EHB are the minimum standards. States must contract with private insurers to provide at least the essential benefits package required by the law. States may require that qualified health plans offer benefits in addition to the essential health benefits, but must defray the cost of any additional benefits. Mental health parity applies to qualified health plans. With regard to clinical trials, the law prohibits the denial, limitation of, or the imposition of additional conditions on coverage for routine patient costs for items and services furnished in an approved clinical trials. An approved clinical trial includes Phase I, II, III, and IV trials. Clarifies that the mandate coverage does not include: coverage for the investigational item, device or service; items and services provided solely for data collection and analysis; and/or a service that is inconsistent with widely established standards of care. *All plans, except grandfathered plans.			
Exchange: Qualified Health Plans [ACA §§1301, 1303, 10104]	A qualified health plan (QHP) includes a plan that is certified, provides the essential health benefits package, and is offered by a health insurance issuer that: ➢ Is licensed and in good standing to offer health insurance coverage in the State; ➢ Agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in the Exchange; ➢ Agrees to charge the same premium for each qualified health plan regardless of whether the plan is offered through an Exchange or directly from the issuer or through an agent; ➢ Complies with regulations established by the Secretary and other requirements established by the Exchange. Certification requirements include, but are not limited to, the following: ➢ Marketing requirements;	The HHS Secretary will issue rules establishing criteria for the certification of health plans as QHPs. The Secretaries of HHS and Labor are required to develop and issue jointly guidance in plain language. The Labor Secretary is required to update and harmonize the rules related to the disclosures by group health plans, plan terms and conditions, and periodic financial disclosure with the standards established by		Executive Order 13535 regarding abortion, 75 Fed Reg 15599 (March 29, 2010).

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	➢ Having an adequate choice of providers; ➢ Generally including essential community providers that primarily serve low-income medically-underserved individuals within health insurance plan networks; ➢ Accreditation requirements; ➢ Implementing quality improvement strategies; ➢ Utilizing a uniform enrollment form and a standard format for presenting health benefit plan options; ➢ Providing information on quality measures for health plan performance that incorporates a payment structure that provides increased reimbursement and other incentives; and ➢ Submitting annual pediatric quality reporting measures to the Secretary. An Exchange may also certify a health plan as a QHP if in addition to meeting the requirements for certification; the Exchange determines that making the plan available is in the interest of qualified individuals and employers. An Exchange must require a health plan seeking certification to submit a justification for a premium increase prior to implementing the increase, and may take this information into account when determining whether to make the plan available through the Exchange. The plan will be required to post such information on its website. An Exchange must require health plans seeking certification to submit certain information in plain language on claims, finances, enrollment, rating practices, payments, and enrollee rights, to the Exchange, HHS and the State insurance commissioner and make the information public Nothing requires a QHP contract with a provider if the provider refuses to accept the generally applicable payment rates of the plan. Medical Home. Qualified health plans may provide coverage through a qualified direct primary care medical home plan that satisfies criteria established by the Secretary as long as (1) the plan meets all other	the HHS Secretary.		

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	applicable requirements and (2) the services covered by the medical home are coordinated with the entity offering the qualified health plan. Qualified health plans may vary premiums by rating area. Abortion. If a qualified health plan covers abortion services for which public funding is prohibited, the plan must provide notice to its enrollees of such coverage at the time of enrollment and the issuer: it may not use the tax credit or any cost-sharing reduction for the payment of such services; and it must establish allocation accounts and adhere to segregation requirements for funds; and the QHP must estimate the actuarial value of the abortion services.			
Exchange: Navigators [ACA§§ 1311, 10104]	Navigators. The Secretary is required to award grants to States to enable the state or the Exchange to establish or operate a navigator program. The grant would enable the state or Exchanges to contract with private and public entities to perform the following functions: ➢ conduct public education activities to raise awareness of the program; distribute fair and impartial information concerning enrollment in qualified health plans and the availability of credits; ➢ facilitate enrollment in a qualified health plan; provide referrals to state agencies for any enrollee grievance complaint or questions regarding their health plan, coverage, or a coverage determination; and ➢ provide information that is culturally and linguistically appropriate. Eligibility criteria. An entity must demonstrate that it has existing relationships with employers and employees, consumers and self-employed individuals likely to be eligible to participate in the program. Entities may include trade, industry and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer focused nonprofit groups, chambers of commerce, unions, small business development centers and	The Secretary will establish standards for navigators. The Secretary will collaborate with states and develop standards to ensure that information made available by navigators is fair, accurate and impartial.		

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	other entities the Secretary determines are capable. Navigator may not be a health insurance issuer or receive any consideration either directly or indirectly from any health insurance issuers in connection with the participation of any employer in the program or the enrollment of any eligible employee in health insurance coverage. Grants under the program must be made from the operational funds of the Exchange and not federal funds received by the state to establish the Exchange.			
Non-Discrimination of Providers [ACA§1201; PHSA§2706]	Non-Discrimination of Providers. The law prohibits discriminating against a health provider who is acting within the scope of license or certification under state law; however, it is not an "any willing provider provision. A group health plan, a health insurance issuer, or the Secretary may establish varying reimbursement rates based on quality or performance measures.	Health plans (issuers offering group coverage) or individual health insurance coverage and the Secretary may vary payment rates based on quality or performance measures the Secretary may establish.		
Risk Management Activities [ACA§§§1312, 1341, 1342, 1343]	The law incorporates a number of risk management and rating provisions aimed at reducing the risk of adverse selection. Risk Corridor Payments Risk Adjustment Program Transitional State Reinsurance Program	See Risk Management activities/reinsurance on pages 24-27.	As soon as practical after enrollment. No later than January 1, 2014, states required to adopt transitional reinsurance program. State reinsurance program must be based on federal standards and enter into a contract with entity to carry out the federal	

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			reinsurance program.	
Consumer Operated and Oriented Plan (CO-OP) Program [ACA§§1322, 10104]	The HHS Secretary will establish the Consumer Operated and Oriented Plan (CO-OP) program that provides grants and loans to operate as a qualified nonprofit health insurance issuer. The qualified nonprofit health insurer is required to enter into an agreement with the Secretary under which it must meet all applicable requirements of the program that include: ➢ Organized under state law as a nonprofit member corporation primarily engaged in the issuance of qualified health plans in the individual and small group markets in each state where it is licensed to issue such plans; ➢ Have a governance subject to a majority vote; ➢ Have governing documents incorporating ethics and conflict of interest standards; ➢ Operate with a strong consumer focus in accordance with regulations promulgated by the Secretary; ➢ Meet all the requirements applicable to QHPs; ➢ Use any profits to lower premiums, improve benefits, or to improve quality; and ➢ Include on their tax returns the amount of the reserves required by each state where licensed and the amount of the reserves on hand. The law places the following restrictions on an organization that qualifies as a qualified nonprofit health insurance issuer: ➢ The organization, or its related entity, may not have been a health insurance issuer on July 2009, nor can it be sponsored by a state or local government. ➢ May only offer health plans in states with market reforms in effect. ➢ May establish a private purchasing council to enter into collective purchasing agreements for items and services that	The HHS Secretary is required to issue rules that establish the CO-OP program and that relate to repayment of loans and grants. The HHS Secretary is required to award through the CO-OP program to persons applying to become qualified nonprofit health insurance issuers (1) loans to assist with start-up costs and (2) grants to assist with solvency requirements. Decisions regarding loans and grants must: (1) consider the recommendations of the Advisory Board, (2) give priority to applicants that will offer qualified health plans on a statewide basis, use integrated care models and have significant private support, and (3) ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state. In a state where there are no applicants to become a qualified nonprofit health insurance issuer, HHS is permitted to	By July 1, 2013, HHS Secretary required to award the loans and grants under the CO-OP programs. By July 1, 2013, and before awarding loans and grants under the CO-OP program, the HHS Secretary is required to issue regulations related to the repayment of the loans and grants.	Notice of letters of nomination, 75 Fed. Reg. 17918 (April 8, 2010) due April 30, 2010. Federal Register Notice, 75 Fed. Reg. 35816 (June 23, 2010). GAO appointment of members of the CO-OP Advisory Board - http://www.gao.gov/press/co_op2010jun23.html Advisory Board members were appointed on June 23, 2010.

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	increase administrative and cost efficiencies. ➢ But the council may not set payment rates for health care facilities or providers. ➢ Government representatives, including representatives of political subdivisions or instrumentalities, and representatives of organizations or related entities (or predecessors) that were health insurance issuers on July 16, 2009 may not serve on the board of directors of a qualified health insurance issuer or of a private purchasing council. To receive a loan or grant a qualified nonprofit health insurance issuer must be tax exempt and meet the following: ➢ Be in compliance with laws, regulations and agreements related to the loan or grant, ➢ Give notice to the Secretary that it is applying for recognition of its tax exempt status; ➢ Not use the net earnings to the benefit of any private shareholder or individual; ➢ Not engage in activities to influence legislation and ➢ Not participate in political campaigns. An Advisory Board, consisting of 15 members appointed by the Comptroller General, will be established to provide recommendations related to loans and grants made under the CO-OP program, and will terminate by December 31, 2015 or earlier if its duties are completed. Qualified health plans offered under the CO-OP program, multi-state qualified health plans and private health insurers will all be subject to the same specified Federal and state laws. They include: ➢ Guaranteed renewal; ➢ Rating; ➢ Preexisting conditions; ➢ Nondiscrimination;	award grants to encourage the establishment of qualified nonprofit health insurance issuers within the state or the expansion of a qualified nonprofit health insurance issuer from another state to the state. HHS Secretary is required to issue rules that require repayment of loans within 5 years and grants within 15 years and that is consistent with state solvency regulations and other similar applicable state laws. HHS Secretary is required to issue rules on the required consumer focus of qualified nonprofit health insurance issuers.		

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	➢ Quality improvement and reporting; ➢ Fraud and abuse; ➢ Solvency and financial requirements; ➢ Market conduct; ➢ Prompt payment; ➢ Appeals and grievances; ➢ Privacy and Confidentiality; ➢ Licensure; and ➢ Benefit plan material or information.			
Multi-State Qualified Health Plans [ACA §§1334, 10104]	Each Exchange, in a state, must offer at least two multi-state qualified health plans in that state. Multi-state qualified health plans will be required to meet certain requirements. ➢ Offer a uniform benefits package in each state consisting of the essential benefits; ➢ Satisfies all requirements related to qualified health plans, including the requirements related to offering bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange; ➢ Provides for determinations of premiums for coverage under the plan based on the rating requirements set forth in ACA; and ➢ Offers the plan in all geographic regions, and in all states that have adopted adjusted community rating before March 23, 2010. A State with an age rating requirement that is lower than 3:1 may require a multi-state qualified health plan to comply with the State's requirement. An insurer will be eligible to enter into a contract to offer a multi-state qualified health plan if the insurer: ➢ Agrees to offer a multi-state health plan that meets certain requirements; ➢ Is licensed in each state and subject to all requirements of state law that are consistent with the provision of ACA related to	The Director of the Office of Personnel Management (OPM) is required to enter into contracts with insurers to offer multi-state qualified health plans. ➢ There must be at least one contract with a non-profit entity. ➢ At least one multi-state plan may not provide abortion services. OPM is required to administer the contracts in the same way it administers contracts with carriers under the Federal Employees Health Benefit Program (FEHBP), that include negotiating with each plan regarding: a MLR; a profit margin; premiums to be charged; and other terms and conditions. OPM is required to enter into a		

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	multi-state qualified health plans; ➢ Complies with the minimum standards prescribed for carriers offering health benefits plans under FEHBP to the extent that such standards do not conflict with the ACA; ➢ Satisfies other requirements deemed appropriate. States may require that benefits in addition to essential health benefits are provided to enrollees of a multi-state qualified health plan, but must defray the cost of such additional benefits. Multi-state qualified health plans will be deemed to be certified by an Exchange.	contract with an insurer for the offering of a multi-state qualified health plan if: ➢ The insurer offers the plan in at least 60 percent of the States during the first year the insurer offers the plan; ➢ The insurer offers the plan in at least 70 percent of the States during the second year the insurer offers the plan; ➢ The insurer offers the plan in at least 85 percent of the States during the third year the insurer offers the plan; and ➢ The insurer offers the plan in all States by the fourth year. The OPM Director is required to take specific steps to ensure that the multi-State plans do not interfere with the continued support for FEHBP. The OPM Director is required to establish an advisory board to provide recommendations related to multi-state qualified health plans.		
Waivers Related to Qualified Health Plans, Exchanges,	Beginning on or after January 1, 2017, a state has the option to seek a State Innovator waiver of the following insurance market reforms that would be applicable for plan years beginning on or after that date: ➢ Qualified health plans;	The Secretaries of HHS and Treasury are required to issue rules related to waivers and the HHS Secretary must report annually to Congress on actions	Waivers may apply to plan years beginning on or after January 1, 2017	

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Cost-Sharing Reductions and Tax Credits [ACA § 1332]	➢ Exchanges; ➢ Cost-sharing reductions; and ➢ Tax credits. A state is required to enact a law providing for state actions under a waiver, including the implementation of a state plan. A waiver may be granted if the State plan will meet all of the following criteria: ➢ Provide coverage at least as comprehensive as the essential health benefits; ➢ Provide coverage and cost-sharing protections against excessive out-of-pocket spending ; ➢ Provide coverage to at least a comparable number of residents; ➢ Not increase the federal deficit. The Secretary of Treasury is required to provide the state, for the purpose of implementing the state plan under the waiver, with the aggregate amount of tax credits or reductions that would have been paid to individuals and small businesses in the state in the absence of the waiver. A waiver may not last for longer than 5 years unless a state requests a continuation of waiver.	taken with respect to applications for waivers. The HHS Secretary has 180 days of receiving a State's application to determine whether to grant a waiver. The Secretary is required to make a determination related to a request for a continuation of a waiver within 90 days. Rules/guidances related to waiver provision have no payment protection for providers.		
Health Care Choice Compacts [ACA §§ 1333, 10104] Outside Exchange)	Two or more states may enter into an agreement under a Health Care Choice Compact under which one or more qualified health plans could be offered in the individual markets in the States, and only be subject to the laws and regulations of the State in which the plan was written or issued. The issuer of the qualified health plan to which the compact applies must: ➢ Be subject to state requirements related to market conduct, unfair trade practices, network adequacy and consumer protection standards, ➢ Be licensed in each state in which it offers the plan or submit to the jurisdiction of each state with regard to the state	The Secretary is required to consult with NAIC and issue rules for the creation of Health Care Choice Compacts. NAIC to develop standards for voluntary interstate compact that permit sales across States lines. The Secretary may approve an interstate health care choice compact if it will: ➢ Provide coverage and cost-sharing protections against	By July 1, 2013, the Secretary is required to issue rules for the creation of Health Care Choice Compacts. States may enter into Health Care Choice	

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
	requirements that must be met, and ➢ Notify consumers that the policy may not be subject to all of the State laws and regulations. Before a state may enter into a compact, the state must enact legislation that authorizes it to enter into such an agreement. Health Care Choice Compacts may not take effect before January 1, 2016. State law will govern the relationship between the Compact and providers.	excessive out-of-pocket spending; ➢ Provide coverage to at least a comparable number of its residents; ➢ Not increase the Federal deficit; and ➢ Not weaken the enforcement of applicable State laws and regulations.	Compacts on or after January 1, 2016.	
State Basic Health Program for Low-Income Individuals [§§ 1331, 10104] Outside Exchange	States are allowed to offer one or more basic health program to provide health coverage to low-income individuals instead of offering those individuals coverage through a Health Insurance Exchange. Individuals eligible to participate are those who are not eligible for Medicaid and whose household income between 133% - 200% of FPL. The State has the option to establish a competitive process for contracting with standard health plans to provide essential health benefits to certain eligible individuals. For purposes of the program, an eligible individual is a resident of the state who is not eligible to enroll in the state's Medicaid program for benefits that at a minimum consist of the essential health benefits; Household income falls between 133 percent and 200 percent of the federal poverty level (FPL) (for aliens lawfully present in the United States, whose income is not greater than 133 percent of the FPL); not eligible for minimum essential coverage or is eligible for an employer-sponsored plan that is not affordable coverage; and under age 65. A standard health plan enrolls only eligible individuals: that provides at least the essential health benefits; and has a MLR of at least 85 percent. A state's contract negotiations will include: premiums and cost-sharing; of benefits in addition to the essential health benefits; consideration of	HHS is required to certify standard health plans that: ➢ The monthly premium amount does not exceed the amount that an eligible individual would have been required to pay under the applicable silver plan. ➢ The cost-sharing does not exceed the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the federal poverty level and the cost-sharing required under a gold plan for other eligible individuals. ➢ The benefits under the standard health plans cover at least the essential health benefits.	March 23, 2010.	

Issue & Citation	Requirements	Administrative Actions Required of HHS/Other Agencies/Stakeholders	Effective Date	Tracking Actions to Date
	innovative features such as care coordination and care management, incentives for preventive services and the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making; health care needs and resource differences; consideration of contracting with managed care systems or systems that incorporate features of managed care; and performance measures. Providers will be concerned with the nature and type of payment/delivery features approved under state contracts. The law requires the state to make multiple standard health plans available to eligible individuals in the state and may negotiate a regional compact with other states.	If a state basic health program meets the statutory requirements, the Secretary is required to transfer federal funds to the state to be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans in the state. The Secretary is required to conduct annual oversight activities with respect to each state program.		

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