# Timeline for Health Care Reform Implementation: Health Insurance Provisions

## The Commonwealth Fund

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*Health care reform legislation—the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act—includes numerous provisions to expand access to health insurance, improve the quality and comprehensiveness of coverage, and make coverage more affordable for all Americans. This timeline outlines when the various health insurance provisions will go into effect; click on the dates to see the provisions that will be implemented during that year.*

**2010** **2011** **2013** **2014** **2016** **2018**

**2010**

- **Young Adults on Parents' Health Plans.** Young adults may stay on their parents' health plans to age 26, effective six months after enactment. The provision applies to all health plans, and does not exclude young adults who are married.

- **Prohibition on Preexisting Condition Exclusions for Children.** Insurers are prohibited from excluding coverage of preexisting conditions for children in the individual market, effective six months after enactment.

- **Prohibition Against Rescissions.** Group health plans or insurance companies providing group or individual market coverage are prohibited from rescinding coverage once an enrollee is covered under a plan, except in the case of an individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact. Effective six months after enactment.

- **Prohibitions Against Lifetime Benefit Caps.** Group health plans or insurance companies providing group or individual market coverage are prohibited from setting lifetime limits on the dollar value of benefits and from setting unreasonable annual limits on the dollar value of benefits, effective six months after enactment. Annual limits will be banned completely in 2014.

- **Small Business Tax Credits.** Small businesses are eligible for new tax credits to offset their premium costs in 2010. Tax credits will be available for up to a two-year period, starting in 2010 for small businesses with fewer than 25 employees and with average wages under $50,000. The full credit will be available to companies with 10 or fewer employees and average wages of $25,000, phasing out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit will cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit will cover 50 percent of that contribution. Tax-exempt organizations will be eligible to receive the tax credits, though the credits are somewhat lower: 25 percent of the employer's contribution to premiums in 2010–13 and 35 percent beginning in 2014.

- **National High-Risk Pool.** People with preexisting conditions will be eligible for subsidized coverage through a national high-risk pool, beginning 90 days after enactment. People who have been uninsured for at least six months and who have a preexisting condition will be eligible for subsidized coverage through a temporary national high-risk pool, to be established by the secretary in 2010. High-risk pools will not impose preexisting condition exclusions and plans will be required to cover on average no less than 65 percent of medical costs (actuarial value) and to limit out-of-pocket spending to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies. Premiums will be set for a standard population and cannot vary by more than a factor of four based on age (i.e., 4:1 age bands). The secretary will receive $5 billion to carry out the program.

- **State Option to Expand Medicaid Eligibility.** States are given the option to cover parents and childless adults up to 133 percent of poverty and receive current federal matching contributions.

- **Limits on Share of Private Premiums Insurers Spend on Non-Medical Costs.** New limits will be set for the percent of premiums that insurers can spend on non-medical costs. Beginning in 2010, health plans are required to report the proportion of premiums spent on items other than medical care. Beginning in 2011, health plans in the large group market that spend less than 85 percent of their premiums on medical care and health plans in the small-group and individual market that spend less than 80 percent on medical care will be required to offer rebates to enrollees.

- **Annual Review of Premium Increases.** In 2010, effective immediately, the HHS secretary and states will establish a process for annual review of unreasonable premium increases. Health insurers will be required to submit to the secretary and the relevant state a justification for an unreasonable increase prior to implementation of

the increase. The information will be required to be posted on insurers' Web sites. The bill appropriates $250 million to the secretary for grants ($1m to $5m) to states between 2010 and 2014 to review and approve carrier premium increases. As a condition of receiving a grant, state insurance commissioners will be required to provide the secretary with information on trends in premium increases in the state and make recommendations to the state insurance exchanges on whether particular insurance carriers should be excluded from participation based on a pattern of excessive or unjustified premium increases.

- **Rebates for Medicare Part D Enrollees in "Doughnut Hole."** In 2010, Medicare beneficiaries who reach the coverage gap, or doughnut hole, in prescription drug coverage ($2,830) are eligible to receive $250 rebates.[1] The coverage gap is phased out completely by 2020.

- **Elimination of Cost-Sharing for Preventive Care in Medicare and Private Plans.** Preventive care will be strengthened in both traditional Medicare and private plans. In 2010, cost-sharing for proven preventive care services is eliminated in both Medicare and private plans. Medicare beneficiaries will receive an annual wellness visit with no copayment beginning in 2011.

- **Employer Retiree Health Benefits Reinsurance.** Reinsurance will be available to employers providing retiree health benefits within 90 days of enactment.

**2011**

- **Discounts to Medicare Part D Enrollees in the Doughnut Hole.** Beneficiaries are eligible for 50 percent discounts on all brand-name drugs in the doughnut hole. Additional discounts on brand-name and generic drugs are phased in, to completely close the doughnut hole for all Part D enrollees by 2020.

- **Value of Employer Benefits Reported on W-2 forms**. Employers are required to disclose the value of benefits provided by the employer for each employee's health insurance coverage on W-2 forms.

- **Increased Tax on Non-Medical Distributions from Health Savings Accounts (HSAs).** The current tax on spending distributions from HSAs or Archer Medical Savings Accounts (MSAs) that are not used for qualified medical expenses is increased from 10 percent to 20 percent for HSAs and from 15 percent to 20 percent for Archer MSAs of the disbursed amount.

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[1] Under the "standard" Part D benefit, the coverage gap starts when the retail cost of a beneficiaries' medications reaches $2,830 and continues until the beneficiary has spent $4,550 in out-of-pocket costs (which would be reached when the covered cost of medications reaches $6,440). Most plans have some variant of the "standard" benefit, with many offering lower or no deductibles and alternative cost-sharing, and some offering coverage of at least some, usually generic, drugs when the coverage gap has been reached.

- **Over-the-Counter Drug Costs Reimbursement Restrictions in HRA, FSA, HSA plans.** Over-the-counter drugs not prescribed by a doctor cannot be reimbursed through a health reimbursement arrangement (HRA) or health flexible spending account (FSA). Such drugs cannot be reimbursed on a tax-free basis through an HSA or Archer MSA.

**2013**

- **Insurer Administrative Simplification Requirements.** Health plans must adopt and implement administrative simplification standards for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

- **Limits on Contributions to FSAs.** The amount of contributions to FSA plans is limited to $2,500 a year, indexed to the consumer price index for subsequent years.

- **Health Care Choice Compacts.** The secretary in consultation with the National Association of Insurance Commissioners will issue regulations by July 31, 2013, for the creation of health care choice compacts under which two or more states may enter into an agreement to allow for purchase of qualified health plans across state lines, beginning in 2016.

**2014**

- **Insurance Market Regulations.**
    - **New rating rules.** New federal rules for the individual and group markets, including requiring all insurance carriers to accept every individual who applies for coverage (guaranteed issue and renewability), and prohibiting rating on the basis of health status. Premiums can reflect age, but cannot vary by more than 3:1, tobacco use (maximum variation of 1.5:1), family composition, participation in a health promotion program, and geography. States will have the option to merge the pooling and rating requirements of the individual and small-group markets.
    - **Prohibitions on annual and lifetime limits and rescissions.** All annual limits on benefits would be prohibited beginning in 2014. Prohibitions on lifetime limits and rescissions begin in 2010.
    - **Limits on waiting periods.** All waiting periods for coverage to go into effect will be limited to 90 days, beginning in 2014.
    - **Risk pooling.** The legislation requires insurers to pool the risk of all individual enrollees in all plans inside and outside the exchanges, except people enrolled in existing, or "grandfathered," plans. It also requires insurers to pool the risk of all small-group enrollees inside and outside the exchange (except for plans that are grandfathered). If a state combines the individual and small-group markets, insurers will pool the risks of both individual and small-group enrollees inside and outside the exchanges.
    - **Risk adjustment.** To reduce the incentive for insurers in the individual and small-group markets to cherry-pick good health risks and increase

incentives for them to attract and care for chronically ill enrollees, the legislation creates a mechanism to equalize risks across patients, thereby compensating insurance carriers for high-cost patients. The legislation includes two temporary and one permanent risk-equalization programs: a state transitional reinsurance pool, a temporary federal risk corridor program, and a permanent state risk-adjustment program.

- **Transitional reinsurance.** The legislation requires all states to establish a nonprofit reinsurance entity for 2014, 2015, and 2016 that will collect payments from all insurers in the individual and group markets and make payments to insurers in the individual market that cover high-risk individuals. The secretary will be required to establish federal standards for the determination of high-risk individuals, a formula for payment amounts, and contributions required of insurers. Contributions from insurers must amount to $25 billion over the three years. This is designed to counter adverse selection problems in the early years of the exchange. The nonprofit entity would use funds from insurers to support a reinsurance mechanism directed at individuals enrolled in plans offered through state exchanges.
- **Risk corridors.** The legislation requires the secretary to establish and administer a risk-corridor program for qualified health plans offered in the individual and small-group markets in 2014, 2015, and 2016. The program would be modeled after those applied to regional participating provider organizations in Medicare Part D. If "allowable costs" (total amount of costs that the plan incurred in providing covered benefits, reduced by administrative expenses) are between 97 percent and 103 percent of the "target amount" (the total annual premium, including subsidies, minus administrative expenses) plans would receive no payment. If allowable costs were higher than 103 percent of the target amount for the plan and year, the secretary would make a payment to the plan. Alternatively, if allowable costs were lower than 97 percent of the target amount, the plan would make a payment to the secretary.
- **Risk adjustment.** Under this permanent program, the legislation will require states to develop methods and criteria with the secretary by which they will require payments from health plans offered in the individual and small-group markets in which enrollees' had lower health risks, compared with all plans (excluding self-insured plans). In addition, the states will pay those health plans with higher risks (also excluding self-insured plans). The risk adjustment will apply to plans in individual and small-group markets but not grandfathered plans.

- **State Insurance Exchanges.** Each state is required to establish an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange by 2014 for individuals and small employers with 50 to 100 employees; after 2017,

states have the option of opening the small business exchange to employers with more than 100 employees. States can opt to provide a single exchange for individuals and small employers. Groups of states can form regional exchanges or states can form more than one in-state exchange, but the exchanges must serve a geographically distinct area. While the individual and small-group markets will not be replaced by the exchanges, the same market rules will apply inside and outside the exchanges. Premium subsidies can be used only for plans purchased through the exchanges. If the secretary of HHS determines in 2013 that a state will not have an exchange operational by 2014, the secretary is required to establish and operate an exchange in the state. In 2017, states will have the opportunity to opt out of the federal requirements to establish insurance exchanges through a five-year waiver, if they are able to demonstrate that they can offer all residents coverage at least as comprehensive and affordable as that required by the bill.

- **Federal responsibilities.** The HHS secretary's responsibilities with respect to the exchanges include: establishing certification criteria for "qualified health plans" that will be sold through the exchanges; requiring such plans to provide the essential benefits package; requiring that the licensed insurance carriers issuing plans offer at least one qualified health plan at the silver and gold levels and meet marketing requirements; ensuring a sufficient choice of providers; and ensuring that essential community providers are included in networks, are accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures. In addition, the secretary will develop a rating system for qualified health plans and a model template for an exchange's internet portal, and determine an initial and open enrollment period as well as special enrollment periods for people under varying circumstances. The secretary is also required to establish procedures under which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies. Such procedures may include the establishment of rate schedules for broker commissions paid by health plans offered through the exchange.
- **State responsibilities.** The state exchanges will be required to certify qualified health plans, operate a toll-free hotline and Web site, rate qualified health plans, present plan options in a standard format, inform individuals of the eligibility requirements for Medicaid and the Children's Health Insurance Program, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual requirement to have health insurance. Exchanges will be required to be self-sustaining by 2015 and will be allowed to charge assessments or user fees to participating health insurance issuers or otherwise generate funding to support their operations. The exchanges also will award grants to "navigators" who will educate the public about qualified health plans, distribute information on enrollment and subsidies, facilitate enrollment, and provide referrals on grievances. Navigators may include trade and professional organizations, farming and commercial fishing organizations,

community and consumer-focused nonprofit groups, chambers of commerce, unions, or licensed insurance agents or brokers.

- **Qualified employers purchasing through the exchange.** Employers that are qualified to offer coverage to their employees through the exchange may provide premium support for a level of coverage (e.g., bronze, silver, gold, platinum) and employees may choose a plan within the designated level.

- **Qualified Health Plans.** Qualified health plans are those that are certified by the exchanges, provide the essential benefit package, are licensed and in good standing, comply with market regulations, and offer at least one qualified plan at the silver and gold levels. Qualified health plans can be sold outside the exchange but the insurance issuer must charge the same premium for qualified plans sold within or outside the exchanges.
    - **Choice of qualified plans.** The legislation allows the sale of qualified private insurance plans or health care cooperative plans through the state exchanges. In addition, the federal Office of Personnel Management (OPM) will contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit. Individuals who are purchasing coverage on their own may buy coverage inside or outside of the exchange if they are not receiving premium subsidies.
        - **Multistate plans.** The legislation requires the OPM to contract with health insurers to offer at least two multistate qualified health plans (at least one nonprofit) through the exchanges in each state. OPM would negotiate contracts similar to the way in which it currently negotiates contracts for the Federal Employees Health Benefits Program (FEHBP) with respect to medical loss ratios (share of premium spent on medical claims and other clinical costs), profit margins, and premiums to be charged. OPM can prohibit multistate plans that do not meet standards for medical loss ratios, profit margins, and premiums. Multistate plans will be required to cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multistate plans to offer additional benefits, but they must pay for the additional cost. Multistate plans must comply with 3:1 age rating, except where states require more protective age rating. Multistate plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the legislation. FEHBP will maintain a separate risk pool and remain a separate program.
        - **Health cooperatives.** The legislation authorizes $6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurance companies. Health care cooperatives are nonprofit, consumer-governed organizations that provide insurance and

deliver health services. The grants will be available to new co-ops. Priority will be given to plans that operate on a statewide basis, utilize integrated care models, and have significant private support. The secretary shall ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state.

- **Premiums.** The legislation instructs state exchanges to require insurance carriers seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. The exchange is then required to take the information into consideration when determining whether to allow the sale of the plan through the exchange. The legislation requires state insurance commissioners to provide data on premium trends and make recommendations to the HHS secretary about whether certain insurance carriers should be excluded from the exchange based on a pattern of excessive premium increases. In addition, the legislation requires the secretary in conjunction with the states to monitor premium increases inside and outside the exchange beginning in 2014. In considering whether to open the exchanges to large employers (more than 100 workers) in 2017, states must consider trends in premium growth outside and inside the exchanges.
- **Quality improvement requirements.** The legislation includes a set of quality improvement reporting requirements for plans inside and outside the exchange. Activities to be reported on include: improving health outcomes through care coordination and medical home models; preventing hospital readmissions through a comprehensive program for hospital discharge; and implementing activities to improve patient safety, reduce medical errors, and promote health and wellness. The secretary will make reports by health plans available to the public. By 2015, qualified health plans will be allowed to enter into contracts with hospitals with fewer than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for hospital discharge.

- **Essential Benefits.**
  - **Benefit package.** The legislation defines an essential health benefits package that all qualified health plans must cover, at a minimum. The benefit requirements do not apply to grandfathered plans or self-insured plans. The package will be determined by the HHS secretary and must include, at a minimum, ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; and chronic disease

management. In addition, the plans must cover pediatric services, including vision and oral care.

- **Four benefit categories**. The legislation establishes four benefit categories—bronze, silver, gold, and platinum—all of which will have the essential health benefits package. Policies cannot be sold in the small-group and individual market or exchanges that do not meet the actuarial standards for the benefit categories established by law. All carriers selling in the individual and small-group markets are at least required to offer silver and gold plans. The bronze package will represent minimum creditable coverage with an actuarial value of 60 percent (i.e., covering 60 percent of enrollees' medical costs) with out-of-pocket spending limited to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies. The silver benefit package will have an actuarial value of 70 percent and the same out-of-pocket limits; the gold package will have an actuarial value of 80 percent and the same out-of-pocket limits, and the platinum package will cover 90 percent of costs with the same out-of-pocket limits. A catastrophic benefit package could be made available for adults younger than age 30, similar to HSA-eligible, high-deductible plans, with the essential benefits package, preventive services excluded from the deductible as under current HSA law, three primary care visits, and cost-sharing to HSA out-of-pocket limits. People who are unable to find a plan with a premium that is 8 percent or less of their income will be able to purchase the young adult plan as well, regardless of age. Deductibles of greater than $2,000 for individuals and $4,000 for families will be prohibited in the small-group market.

- **Premium Subsidies.** Premium subsidies for qualified health plans purchased through the exchange will be available for individuals and families earning between 133 percent ($29,327 for a family of four) and 400 percent of poverty ($88,200 for a family of four), based on the second-lowest cost silver plan in the area where the individual resides. Families with incomes between 133 percent of poverty will be eligible for premium subsidies for plans purchased through the exchanges (those with incomes up to 133 percent of poverty will become eligible for Medicaid). Premium contributions are limited as a share of income to:

  Up to 133% FPL: 2.0%
  133%–150% FPL: 3.0–4.0%;
  150%-200% FPL: 4.0–6.3%
  200%–250% FPL: 6.3%–8.05%
  250%-300% FPL: 8.05%–9.5%
  300%–400% FPL: 9.5%

  - **Growth in subsidies.** Starting in 2015, the subsidies will be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. Starting in 2019, the legislation will constrain the growth in subsidies if premiums are growing faster than the consumer

price index, unless spending is more than 10 percent below current Congressional Budget Office projections. For families and individuals with incomes under 400 percent of poverty, premium increases will not exceed $400.

- **Study on affordability**. Within five years of enactment of the legislation, the comptroller general will conduct a study and report to Congress on the affordability of health insurance, including: the effect of the premium subsidies on expanding and maintaining coverage, the availability of affordable health plans, whether the affordability standards for determining whether employees with employer plans are eligible for subsidized coverage through the exchanges are appropriate and whether they can be lowered without substantially increasing federal costs or reducing employer-provided coverage, and the ability of individuals to maintain essential health benefits coverage.

- **Cost-Sharing Subsidies and Out-of-Pocket Limits.** Limits will be placed on the amount of cost-sharing for families with low and moderate incomes. Subsidies will limit cost-sharing such that the costs covered by the silver plan (70 percent of costs covered) will increase to:
  100%–150% FPL: 94%
  150%–200% FPL: 87%
  200%–250% FPL: 73%
  Out-of-pocket expenses will be capped for families earning between 100 percent and 200 percent of poverty at one-third of the HSA limit, or $1,983 for individuals and $3,967 for families. For families earning between 200 percent and 300 percent of poverty, out-of-pocket expenses will be capped at one-half of the HSA limit, or $2,975 for individuals and $5,950 for families. For those with incomes between 300 percent and 400 percent of poverty, within the same actuarial value, out-of-pocket expenses will be capped at two-thirds of the HSA limit, or $3,967 for individuals and $7,933 for families. The secretary shall adjust the out-of-pocket limits if necessary to ensure that the limits do not cause the actuarial values to increase above those specified above. Cost-sharing is eliminated for preventive services.

- **Increase in Small Businesses Tax Credit.** Beginning in 2014, the full tax credit will cover 50 percent of the employer premium contribution. Tax credits will be available for up to a two-year period for small businesses with fewer than 25 employees and with average wages under $50,000, to offset the cost of their premiums. The full credit will be available to companies with 10 or fewer employees and average wages of $25,000, and will phase out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. Tax-exempt organizations will be eligible to receive the tax credits, though they are somewhat lower: 35 percent of the employer premium contribution beginning in 2014.

- **Medicaid Expansion.**
  - **Medicaid eligibility**. Income eligibility for Medicaid is expanded to all adults and children up to 133 percent of poverty, or $29,327 for a family of four and $14,404 for an individual.

  - **Medicaid payments to states for coverage expansion.** Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates in all states (except in "expansion states" that have already expanded Medicaid to both parents and non-pregnant childless adults to 100 percent FPL): 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter. In the case of expansion states, reduces the state share of the costs of covering non-pregnant childless adults by 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, and 90 percent in 2018. In 2019 and thereafter, expansion states will bear the same state share of the costs of covering non-pregnant childless adults as non-expansion states (e.g., 7% in 2019, 10% thereafter).

- **Individual Requirement to Have Health Insurance.** Beginning in 2014, people will be required to have minimal essential coverage through public programs, the military, employers, the individual market, or the insurance exchanges. People who cannot demonstrate on a tax form that they have such coverage will be required to pay a penalty equal to the greater of $95 or 1 percent of taxable income in 2014, $325 or 2 percent of taxable income in 2015, and $695 or 2.5 percent of taxable income in 2016, up to a cap of the national average bronze plan premium. Families will pay a penalty of half the amount for children up to a cap of $2,085 per family. People with incomes below the tax filing threshold ($9,350 for single coverage and $18,700 for a couple) and those who cannot find a premium that is less than 8 percent of their income are exempt.

- **Employer Responsibility.** The legislation does not include an employer mandate but imposes penalties on employers with more than 50 workers whose employees are eligible for premium subsidies through the exchanges. Among employers with more than 50 full-time equivalent workers who do not offer health insurance, the legislation will require a payment of $2,000 per full-time employee (those working more than 30 hours per week) if an employee becomes eligible for a premium subsidy through the exchanges. The first 30 full-time workers in a company are not considered in the penalty. For firms that offer coverage and have more than 50 full-time equivalent workers: if a full-time worker is determined to be eligible for premium subsidies through the exchange either because his/her premium contribution exceeds 9.5 percent of income or his coverage does not meet the minimum creditable benefit standard (plan covers at least 60 percent of an enrollee's costs), the company must pay the lesser of $3,000 for each full-time worker who receives such a premium subsidy through the exchange or $2,000 for each full-time employee.
  - **Free choice vouchers**. Employers that offer coverage and contribute to the cost of coverage are required to offer "free choice vouchers" to employees with incomes below 400 percent of poverty to purchase health plans through the exchange. The value of the voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan

would be between 8 and 9.8 percent of their income.[2] Free choice vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.

- **Children's Health Insurance Program Reauthorization (CHIP).** Extends current reauthorization period of CHIP for two years, through 2015, and include a 23 percentage point increase in federal medical assistance percentage rates from 2016 through 2019.

- **Basic Health Program.** The legislation will require the secretary to establish a Basic Health Program, which would give states the option of pooling federal premium and cost-sharing subsidies for people earning between 133 percent and 200 percent of poverty to establish a non-Medicaid, state-based "standard health plan" offered by private insurers under contract. In this program, the state would create a competitive process for entering into contracts with standard health plans, including negotiating premiums, cost-sharing, and benefit packages directly with private health plans, and offer those policies to people earning between 133 percent and 200 percent of poverty who do not have affordable employer coverage. In negotiation, states would consider additional factors such as incentives for care coordination and management, use of preventive care services, and patient involvement in decision making. Standard health plans would be required to meet the essential benefit package requirements. States must ensure that eligible individuals do not pay higher premiums than they would pay in the exchange, and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with incomes below 150 percent of poverty or the gold plan for all other enrollees.[3] Individuals with incomes between 133 percent and 200 percent of poverty in states that create basic health programs would not be eligible for subsidies in the exchange. In addition, participating plans would be required to meet a minimum medical-loss ratio of 85 percent. State administrators would seek to contract with managed care systems and provide a choice of more than one plan. States could band together to form multistate risk pools for the purposes of negotiating with heath care systems.

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[2] The reconciliation bill (H.R. 4872) signed on March 30, 2010, lowered the highest premium cap for people with incomes between 300 and 400 percent of poverty from 9.8 in the Senate bill (H.R. 3590, The Patient Protection and Affordable Care Act) signed on March 23, 2010, to 9.5 percent of income. Consistent with that change, the reconciliation bill lowered the threshold premium contribution at which employees with employer coverage become eligible for premium subsidies through the insurance exchange from 9.8 to 9.5 percent of income. Presumably these changes in thresholds would also apply to free choice vouchers.

[3] The Senate bill (H.R. 3590, The Patient Protection and Affordable Care Act) signed into law on March 23, 2010, included this language and referred to cost-sharing subsidies for lower-income persons for plans offered through the exchange. Under the Senate bill, cost-sharing through the exchange would be capped at 90 percent for people with incomes between 100 and 150 percent of poverty, which is also the level of cost-sharing for the platinum plan, and 80 percent for people with incomes between 150 and 200 percent of poverty, which is also the level of the gold plan. The reconciliation bill (H.R. 4872) signed into law on March 30, 2010, increased cost-sharing subsidies for people in those income ranges from 90 percent to 94 percent and from 80 percent to 87 percent. Presumably the cost-sharing limits in the reconciliation bill will apply to the standard plans offered through state Basic Health Programs.

- **Ensuring Coverage for Individuals Participating in Clinical Trials.** Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

**2016**

- **Health Care Choice Compacts.** The legislation allows two or more states to form health care choice compacts to allow for purchase of qualified health plans across state lines, beginning in 2016. Insurers will be able to sell policies in any of the participating states and will be subject only to the laws and regulations of the state where the policy was written or issued, except for issues pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. However, insurers will have to be licensed in all states in the compact or comply as if they were licensed, and will have to clearly notify consumers that a policy may not be subject to all laws and regulations of the purchaser's state. Benefit packages will be required to be as comprehensive and protective from out-of-pocket costs as those offered through the insurance exchanges and the compacts cannot increase the federal deficit or weaken enforcement of new market regulations.

**2018**

- **Excise tax on high-cost employer-provided health plans becomes effective.** Insurers will face a 40 percent excise tax on health coverage with premiums in excess of $10,200 for an individual or $27,500 for family coverage. These thresholds are increased to $11,850 for individuals or $30,950 for families in the case of retirees over age 55, electrical or telecommunications repairmen, law enforcement or fire protection workers, out-of-hospital emergency medical providers, and those engaged in the construction, mining, agriculture, forestry, and fishing industries. Thresholds are subject to adjustment for an unexpected increase in medical costs prior to the effective date, and will be indexed for inflation by the consumer price index plus 1 percent, with additional adjustment based on age and gender profiles of covered employees. The tax is levied at the insurer level, with employers aggregating and reporting information for insurers indicating the amount subject to the excise tax.

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Democratic Policy Committee, Implementation Timeline Reflecting the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, available at http://dpc.senate.gov/healthreformbill/healthbill65.pdf.