

An Explanation of the Patient Protection and Affordable Care Act

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An Explanation of the Patient Protection and Affordable Care Act

WILTON B. HYMAN*

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I. INTRODUCTION

This Article examines the most significant provisions of the Patient Protection and Affordable Care Act,¹ as amended by the Health Care and Education Reconciliation Act,² which affect individuals, employers, healthcare-related entities and state governments. The focus is primarily on the healthcare-related provisions, although revenue raising provisions included within those acts are also examined.

The Patient Protection and Affordable Care Act (“PPACA”) was enacted on March 23, 2010,³ and represents the most ambitious piece of federal healthcare legislation since the Social Security Act was amended in 1965 to create Medicare and Medicaid.⁴ The PPACA will greatly improve the private health insurance system; however, it imposes a significant number of requirements and obligations on individuals, employers and the health insurance industry. The PPACA substantially reforms the health insurance industry,⁵ requires states to create Health Insurance Exchanges that will offer competing health insurance products to individuals and small businesses,⁶ makes significant changes to Medicare and Medicaid,⁷ and adds to the tax code a number of healthcare-related tax provisions.⁸

The most controversial provision in the PPACA is the “individual requirement,” which requires individuals to maintain health insurance coverage or else be subject to a penalty.⁹ Congress enacted the individual requirement pursuant to the Commerce Clause, finding that “[t]he individual responsibility requirement . . . is commercial and economic in nature, and substantially affects interstate commerce”¹⁰ One U.S. district court decision held that the individual requirement exceeded Congress’ commerce power because it regulates “inactivity,” the decision or

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (hereinafter PPACA).

2. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (hereinafter HCERA).

3. PPACA, Pub. L. No. 111-148, 124 Stat. 119.

4. See Carolyn Medina, *A One Page History of Medicare and Medicaid*, 62 TEXAS PUB. HEALTH J. 28, 28 (2010) (noting that Medicare and Medicaid were introduced in 1965).

5. See *infra* Part II.A.

6. See *infra* Part II.E.

7. See *infra* Part II.M.

8. See *infra* Part II.L, O.

9. PPACA § 1501(b) (to be codified as 42 U.S.C. § 5000A).

10. *Id.* § 1501(a)(1) (to be codified as 42 U.S.C. § 18091(a)(1)).

choice not to purchase insurance, rather than a voluntary “activity.”¹¹ In addition to finding the individual requirement unconstitutional, the District Court also declared the entire Act invalid due to the inability to sever the individual requirement from the other provisions of the PPACA.¹² An appellate court reversed on the severability issue, but upheld the finding that the individual requirement was unconstitutional.¹³

The standard for determining if an unconstitutional provision is severable from its remaining statutory provisions is whether Congress would have enacted those provisions independently of the invalid provision and whether those remaining provisions are “fully operative as a law.”¹⁴ If it is determined that Congress would have done so, then the remaining provisions of the legislation are allowed to stand.¹⁵

As to the constitutionality of the individual requirement, this is an issue which depends upon how one defines “activity.” Past Supreme Court cases dealing with “activities” having a substantial affect on interstate commerce involved voluntary activity, and provide support for the conclusion that the individual requirement is unconstitutional.¹⁶

In the event that the individual requirement is invalidated, its severability from the other provisions of the PPACA becomes paramount.¹⁷ In discussing the effects of the individual requirement on interstate commerce, Congress considered the PPACA’s prohibition of health insurance companies’ usage of preexisting conditions exclusions and the prohibition on using certain health-status factors in determining eligibility for (or the continuation of eligibility for) health coverage.¹⁸ Congress concluded that prohibiting insurance companies from using preexisting conditions exclusions and from using health-status factors in determining

11. *Florida v. U.S. Dep’t of Health and Human Serv.*, 780 F. Supp. 2d 1256, 1270, 1285-86 (N.D. Fla. 2011).

12. *Id.* at 1305.

13. *Florida v. U.S. Dep’t of Health and Human Serv.*, 648 F.3d 1235, 1328 (11th Cir. 2011).

14. *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)).

15. *Id.* (quoting *Buckley*, 424 U.S. at 108).

16. *See, e.g.*, *United States v. Lopez*, 514 U.S. 549, 558-59 (1995); *United States v. Morrison*, 529 U.S. 598, 608-09 (2000); *Hodel v. Va. Surface Mining & Reclamation Ass’n*, 452 U.S. 264, 276-77 (1981); *Perez v. United States*, 402 U.S. 146, 150 (1971).

17. The U.S. Supreme Court heard oral arguments on March 26-28, 2012 in several appeals of the 11th Circuit decision in *Florida v. U.S. Dep’t of Health and Human Serv.*, on the issues of the constitutionality of the individual mandate, whether the mandate is severable from the remaining provisions of the PPACA and whether the Medicaid expansion provisions included in the PPACA amount to coercion of the States under the Spending power. *Florida v. U.S. Dep’t of Health and Human Serv.*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, Nov. 14, 2011, (No. 11-393, 11-398 and 11-400).

18. *See* PPACA § 1201(2)(A) (to be codified as 42 U.S.C. § 300gg-3 and 42 U.S.C. § 300gg-4); *id.* § 1501(a)(2)(I) (to be codified as 42 U.S.C. § 18091(2)(I)).

(or continuing) eligibility for coverage, in the absence of the individual requirement, would result in “many individuals . . . wait[ing] to purchase health insurance coverage until they needed care,” creating an adverse selection concern.¹⁹ In addition, Congress found that the individual requirement was essential to creating insurance markets that allowed insurance products to be guaranteed issue.²⁰ These findings provide a reasonable basis for concluding that Congress would not have enacted the PPACA provisions prohibiting preexisting conditions exclusions or usage of health status-related factors in the absence of the individual requirement, due to their impact on health insurance risk pools and the health insurance market.²¹ Without the individual requirement, those prohibitions increase the likelihood of adverse selection, resulting in less healthy insurance risk pools and higher premium costs, the exact opposite of what Congress intended. The remaining provisions of the PPACA, however, are severable from the individual requirement and can operate independently. Therefore, they should remain in effect.²²

In order to properly analyze the severability issue, familiarity with the other provisions of the PPACA is necessary. The PPACA is complicated and far-reaching in its scope and impact because it encompasses a number of differing approaches to health care reform. In order to appreciate those aspects of the Act, a comprehensive evaluation is required.

The next section of this article will examine the most significant sections of the PPACA, starting with the health insurance industry reforms, the individual requirement, the Health Insurance Exchanges, the employer requirements, tax credits and cost-sharing reductions, the changes to Medicare and Medicaid, and finally, the revenue raising provisions.

19. PPACA § 1501(a)(2) (to be codified as 42 U.S.C. § 18091(2)(I), amended by PPACA § 10106(a)).

20. *Id.* (to be codified as 42 U.S.C. § 18091(2)(I), amended by PPACA § 10106(a)).

21. *But see*, State of Florida, et al v. U.S. Dept. of Health and Human Services, et al, 2011 U.S. App. LEXIS 16806, at 133-138 for a contrary conclusion on this issue.

22. State of Florida, et al. v. U.S. Dept. of Health and Human Services, et al., 2011 U.S. App. LEXIS 16806, at 131-133.

II. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

A. Subtitle A—Immediate Improvements in Health Care Coverage for All Americans: Individual and Group Market Reforms

No Lifetime or annual limits

Group health plans²³ and health insurance issuers²⁴ offering group or individual coverage for plan or policy years beginning on or after September 23, 2010 are prohibited from imposing “lifetime limits on the dollar value of” health insurance coverage.²⁵

Group health plans and health insurance issuers with plan or policy years beginning on or after January 1, 2014, are prohibited from imposing annual limits on the dollar value of benefits; however, for plan or policy years beginning before January 1, 2014, restricted annual limits can apply “with respect to the scope of benefits that are essential health benefits”²⁶ Lifetime or annual limits are allowed “on specific covered benefits that are not essential health benefits”²⁷

23. Group health plan means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) [29 U.S.C.S. § 1002(1)] to the extent that the plan provides medical care . . . to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. 42 U.S.C. § 300gg-91(a)(1).

24. Health insurance issuer “means an insurance company, insurance service, or insurance organization (including a health maintenance organization . . .) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance” 42 U.S.C. § 300gg-91(b)(2).

25. PPACA § 1001(5) (to be codified as 42 U.S.C. § 300gg-11(a)(1)(A), amended by PPACA § 10101(a)); *Id.* § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

26. PPACA § 1001(5) (to be codified as 42 U.S.C. § 300gg-11(a)(2), amended by PPACA § 10101(a)). “In defining the term ‘restricted annual limit’ . . . the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.” *Id.*

[A]nnual limits on the dollar value of benefits that are essential health benefits may not be less than the following amounts for plan years (in the individual market, policy years) beginning before January 1, 2014: For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000; For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and for plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million.

Patient Protection and Affordable Care Act, 75 Fed. Reg. 37188, 37191 (June 28, 2010) (to be codified at 45 C.F.R. 147.126(d)(1) (2010)).

27. PPACA § 1001(5) (to be codified as 42 U.S.C. § 300gg-11(b), amended by PPACA § 10101(a)).

Prohibition on rescissions

Group health plans and health insurance issuers are prohibited from rescinding group or individual coverage once an enrollee is covered, except in instances of “fraud or . . . intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.”²⁸ This provision applies to plan or policy years beginning on or after September 23, 2010.²⁹

Coverage of preventive health services

Group health plans and health insurance issuers must provide coverage, without any cost-sharing requirements, for: evidence-based medical care with an “A” or “B” rating from the United States Preventive Service Task Force; recommended immunizations from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; preventive care and screenings for infants, children, and adolescents, as recommended by the Health Resources and Services Administration; preventive care and screenings for women, as provided in guidelines from the Health Resources and Services Administration and must adhere to the recommendations of the U.S. Preventive Task Force on breast cancer screening, mammography, and prevention.³⁰

This provision took effect for plan or policy years beginning on or after September 23, 2010.³¹

Extension of dependent coverage

Group health plans and health insurance issuers that offer dependent coverage of children must provide coverage to the dependent children of plan enrollees while the child is under the age of 26.³² This provision took effect for plan or policy years beginning on or after September 23, 2010.³³

Uniform explanation of coverage documents and standardized definitions

Within twelve months after enactment, the Department of Health and Human Services (“HHS”) Secretary was required to develop uniform standards and terms for group health plans and health insurance issuers to

28. *Id.* (to be codified as 42 U.S.C. § 300gg-12). “A rescission is a cancellation or discontinuance of coverage that has retroactive effect.” Patient Protection and Affordable Care Act, 75 Fed. Reg. 37,188, 37,192-37,193 (June 28, 2010).

29. PPACA § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

30. *Id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-13(a)(1)-(5)).

31. *Id.* § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

32. *Id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-14(a), amended by HCERA § 2301(b)).

33. *Id.* § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

use in their summaries and explanations of health benefits and coverage provided to applicants, enrollees, policyholders or certificate holders.³⁴ The summary of benefits and coverage must not exceed four pages in length, must use culturally and linguistically-appropriate language and terminology that is understandable by an average enrollee, and describe the plan's coverage and cost-sharing for essential health benefits, other cost-sharing obligations (including deductibles, coinsurance and co-pays), renewability and continuation provisions, as well as include statements as to whether the plan provides minimum essential health coverage and covers at least sixty percent of allowed benefits costs.³⁵ Group health plans, health insurance issuers, and plan sponsors or administrators are required to comply with these uniform standards within twenty-four months of PPACA's enactment.³⁶

Ensuring the quality of care

The HHS Secretary, in consultation with health experts, must develop a reporting system that allows health insurance issuers to indicate how their plan benefits or reimbursement methods contribute to: improving health care outcomes through the use of quality of care reports, case management, care coordination, chronic disease management and medication and care compliance; reducing hospital readmissions through patient-centered education and counseling; promoting patient safety and reducing medical errors through the use of clinical guidelines, evidence-based medicine and health information technology, and encouraging wellness and health promotion activities.³⁷ The reports will be provided to health plan enrollees during every open enrollment period and will also be available on the Internet.³⁸

This provision took effect on September 23, 2010.³⁹

Bringing down the cost of health care coverage

Health insurance issuers (including grandfathered plans) offering group or individual coverage must submit to the HHS Secretary a report on the ratio of their incurred loss (insured claims paid or incurred, and changes

34. PPACA § 1001(5) (to be codified as 42 U.S.C. § 300gg-15(a), (d)(1)-(3), amended by PPACA § 10101(b)).

35. *Id.* (to be codified as 42 U.S.C. § 42 U.S.C. § 300gg-15(b)).

36. *Id.* (to be codified as 42 U.S.C. § 42 U.S.C. § 300gg-15(d)(1), (3)).

37. *Id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-17(a)(1)).

38. *Id.* (to be codified as 42 U.S.C. § 300gg-17(a)(2)(B), (C)).

39. PPACA § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

in loss reserves) to earned premiums each plan year.⁴⁰ The report must also provide their percentage of total premium revenue spent on: (1) “reimbursements for clinical services provided to [plan] enrollees;” (2) healthcare quality improvement activities (wellness programs); and (3) “non-claims costs, . . . excluding . . . taxes and licensing or regulatory fees.”⁴¹ This information will be provided on the DHHS website.⁴²

Beginning on January 1, 2011, health insurance issuers must pay a pro rata rebate to their enrollees if the ratio of premium revenue (excluding taxes, licensing or regulatory costs, and other adjustments) expended during the plan year on reimbursements for clinical services and activities that improve health care quality is less than eighty-five percent for issuers offering large group market coverage or eighty percent for issuers offering small group market or individual coverage.⁴³

In addition, all hospitals operating within the U.S. are required to publicize and update annually a list of their standard charges for items and services that they provide.⁴⁴

Appeals process

Group health plans and health insurance issuers offering group or individual coverage are required to create effective appeals processes for disputes concerning coverage determinations and insurance claims.⁴⁵ They are required to have an internal claims appeal process; provide notice of internal and external appeals processes and the availability of an office of health insurance consumer assistance or ombudsman; allow enrollees to access their files, present evidence, and continue providing coverage during the appeals process.⁴⁶

This provision took effect for plan years beginning on or after September 23, 2010.⁴⁷

40. *Id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-18(a), amended by PPACA § 10101(f)).

41. *Id.* (to be codified as 42 U.S.C. § 300gg-18(a)(1)-(3)).

42. *Id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-18(a)).

43. *Id.* (to be codified as 42 U.S.C. § 300gg-18(b)(1), amended by PPACA § 10101(f)).

44. PPACA § 1001(5) (to be codified as 42 U.S.C. § 300gg-18(e), amended by PPACA § 10101(f)).

45. *Id.* § 1001(4) (to be codified as 42 U.S.C. § 300gg-19, amended by PPACA § 10101(g)).

46. *Id.* (to be codified as 42 U.S.C. § 300gg-19, amended by PPACA § 10101(g)); *see id.* § 1001(5) (to be codified as 42 U.S.C. § 300gg-19(a)(2)-(b), amended by PPACA § 10101(g)) (providing standards concerning internal claims and appeals and external review). The HHS Secretary will award grants to states, allowing them to establish, expand or support offices of health insurance consumer assistance or a health insurance ombudsman. *Id.* § 1002 (to be codified as 42 U.S.C. § 300gg-93(a)).

47. *Id.* § 1004(a) (to be codified as 42 U.S.C. § 300gg-11 note).

Immediate information that allows consumers to identify affordable coverage options

By July 1, 2010, the HHS Secretary, in consultation with the states, had to establish “a mechanism, including an Internet website,” that would allow residents and small businesses to “identify” affordable health insurance options within the state.⁴⁸ The website would provide the means for obtaining information on the coverage options, including comprehensive health insurance coverage offered by issuers, Medicaid, CHIP, State high risk pools, the temporary high risk health insurance pool under PPACA section 1101, and coverage options available to small businesses, including the Internal Revenue Code (hereinafter IRC) § 45R tax credit and the temporary reinsurance program for early retirees under PPACA section 1102.⁴⁹ The Secretary must also develop a standard format for presenting information on the different coverage options listed on the website that includes the percentage of premiums used for nonclinical costs, premium costs, cost-sharing, and coverage eligibility and availability.⁵⁰

B. Subtitle B-Immediate Actions to Preserve and Expand Coverage

Immediate access to insurance for uninsured individuals with a preexisting condition

Within 90 days of enactment, the HHS Secretary was required to create temporary high-risk health insurance pools to be administered directly by HHS or through contracts with State or private nonprofit entities.⁵¹ Coverage under these pools, which will terminate on January 1, 2014, is available to persons lawfully present in the U.S. who have a preexisting medical condition and who have not had creditable coverage for the six-month period prior to applying for coverage in the high-risk pool.⁵²

Reinsurance for early retirees

Within 90 days of enactment, the HHS Secretary was required to create a temporary reinsurance program that would reimburse employment-based “group benefit plans providing health benefits” for some of the cost of covering early retirees and their spouses, surviving spouses, and their

48. PPACA § 1103(a) (to be codified as 42 U.S.C. § 18003(a)(1), amended by PPACA § 10102(b)(1)).

49. *Id.* (to be codified as 42 U.S.C. § 18003(a)(2), amended by PPACA § 10102(b)(2)).

50. *Id.* § 1103(b)(1) (to be codified as 42 U.S.C. § 18003(b)(1)).

51. *Id.* § 1101(a)-(b) (to be codified as 42 U.S.C. § 18001(a)-(b)); *see id.* § 1105 (to be codified as 42 U.S.C. § 1320d note).

52. PPACA § 1101(a), (d) (to be codified as 42 U.S.C. § 18001(a), (d)).

dependents.⁵³ Early retirees are defined as persons age 55 and older who are not eligible for Medicare and are former employees of the employer maintaining or contributing to (or who has made substantial contributions to fund) their coverage.⁵⁴ Employment-based health plans must apply to participate in the program, must utilize programs that reduce health care costs for plan participants with “chronic and high cost conditions[,]” must provide documentation of their actual medical claims costs, and must be certified by the HHS Secretary.⁵⁵ Reimbursements will cover 80% of early retiree health care costs, between \$15,000 and \$90,000.⁵⁶ The reimbursements must be used to lower the costs of the health plan (such as premiums, co-payments, deductibles, co-insurance and out-of-pocket costs for plan participants) and are not treated as gross income to the employer.⁵⁷ This program will end on January 1, 2014.⁵⁸

C. Subtitle C—Quality Health Insurance Coverage for All Americans

Prohibition of preexisting condition exclusions or other discrimination based on health status

Group health plans and health insurance issuers offering group or individual health insurance coverage are prohibited from using preexisting conditions exclusions with respect to their plans or coverage.⁵⁹ A preexisting conditions exclusion is “a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date.”⁶⁰

This provision took effect on September 23, 2010, for enrollees under the age of 19 whose plan or policy year began on or after that date.⁶¹ For all

53. *Id.* § 1102(a)(1) (to be codified as 42 U.S.C. § 18002(a)(1)); *id.* § 1102(a)(2)(B) (to be codified as 42 U.S.C. § 18002 (a)(2)(B), amended by PPACA § 10102(a)(1)); *id.* § 1105 (to be codified as 42 U.S.C. § 1320d note).

54. PPACA § 1102(a)(2)(C) (to be codified as 42 U.S.C. § 18002(a)(2)(C)).

55. *Id.* § 1102(b) (to be codified as 42 U.S.C. § 18002(b)).

56. *Id.* § 1102(c)(2)-(3) (to be codified as 42 U.S.C. § 18002(c)(2)-(3)). The reimbursement limits are adjusted for “the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers for the year . . . involved.” *Id.* § 1102(c)(3) (to be codified as 42 U.S.C. § 1102(c)(3)).

57. *Id.* § 1102(c)(4)-(5) (to be codified as 42 U.S.C. § 18002(c)(4)-(5)).

58. PPACA § 1102(a)(1) (to be codified as 42 U.S.C. § 18002(a)(1)).

59. *Id.* § 1201(2)(A) (to be codified as 42 U.S.C. § 300gg-3(a)).

60. Patient Protection and Affordable Care Act, 75 Fed. Reg. 37188, 37190 (June 28, 2010).

61. PPACA § 1253 (to be codified as 42 U.S.C. § 300gg note, amended by PPACA § 10103(e)).

other enrollees, this provision takes effect for plan or policy years beginning on or after January 1, 2014.⁶²

Fair health insurance premiums

Premiums charged for individual⁶³ or small group market⁶⁴ coverage may vary based only upon whether the coverage is individual or family coverage; based on the rating area within the State where the coverage is provided; based on age, with no greater a 3 to 1 ratio for adults, and for tobacco use with no greater than a 1.5 to 1 ratio.⁶⁵ These provisions also apply to all large group market⁶⁶ health coverage (not including large group market self-insured plans) if large group market health insurance issuers in the State are permitted to offer their coverage through a State Exchange.⁶⁷

This provision takes effect for plan years beginning on or after January 1, 2014.⁶⁸

Guaranteed availability of coverage

Health insurance issuers offering individual or group coverage within a State “must accept every employer and individual in the State that applies for such coverage.”⁶⁹ They are allowed to “restrict enrollment . . . to open and special enrollment periods[,]”⁷⁰ but they are prohibited from requesting or requiring individuals or family members to undergo genetic tests and

62. *Id.* (to be codified as 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

63. Individual market “means the market for health insurance coverage offered to individuals other than in connection with a group health plan.” *Id.* § 1304(a)(2) (to be codified as 42 U.S.C. § 18024(a)(2)).

64. Small group market means “the insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by . . . a small employer . . .” *Id.* § 1304(a)(3) (to be codified as 42 U.S.C. § 18024(a)(3)). Small employer “means . . . an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.” *Id.* § 1304(b)(2) (to be codified as 42 U.S.C. § 18024 (b)(2)).

65. PPACA § 1201(4) (to be codified as 42 U.S.C. § 300gg(a)(1)(iii)-(iv), (2)(A)); *see also id.* § 1201(4) (to be codified as 42 U.S.C. § 300gg(a)(4)-(5)).

66. Large group market means “the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer . . .” PPACA § 1304(a)(3) (to be codified as 42 U.S.C. § 18024(a)(3)). Large employer “means . . . an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.” *Id.* § 1304(b)(1) (to be codified as 42 U.S.C. § 18024(b)(1)).

67. *Id.* § 1201(4) (to be codified as 42 U.S.C. § 300gg(a)(5), amended by PPACA § 10103(a)).

68. *Id.* § 1253 (to be codified as 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

69. *Id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-1(a)).

70. PPACA § 1201(4) (to be codified at 42 U.S.C. § 300gg-1(b)(1)).

from requesting, requiring or purchasing genetic information for underwriting purposes or prior to an individual's enrollment.⁷¹

This provision takes effect for plan years beginning on or after January 1, 2014.⁷²

Guaranteed renewability of coverage

Except as otherwise provided, health insurers offering individual or group coverage must renew or continue the coverage at the option of the plan sponsor or individual.⁷³ Insurers are allowed to non-renew or discontinue coverage for nonpayment of premiums, fraud, violations of participation or contribution rates by the plan sponsor, the insurer's termination of market coverage, an enrollee's movement outside of the service area, or the cessation of association membership by the employer.⁷⁴

This provision takes effect for plan years beginning on or after January 1, 2014.⁷⁵

Prohibiting discrimination against individual participants and beneficiaries based on health status

Group health plans and health insurance issuers offering individual or group coverage may not establish rules that use "health status," "medical condition (physical or mental)," claims history, the "[r]eceipt of health care[.]" "[m]edical history[.]" "[g]enetic information[.]" "[e]vidence of insurability," "[d]isability" or any other factor determined by the HHS Secretary in determining the eligibility (or continued eligibility) of an individual or their dependent to enroll for coverage.⁷⁶

This provision takes effect for plan years beginning on or after January 1, 2014.⁷⁷

Non-discrimination in health care

Group health plans and health insurance issuers offering individual or group health coverage cannot discriminate against health care providers acting within the scope of their state license or certification; however, they

71. 42 U.S.C. § 300gg-4(a)(6), (c)(1), (d)(1).

72. PPACA § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

73. *Id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-2(a)).

74. 42 USC § 300gg-2(b).

75. PPACA § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

76. *Id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-4(a)).

77. *Id.* § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

are not obligated to contract with a care provider willing to accept the terms and conditions for participation under their plan or coverage.⁷⁸ Group health plans and health insurance issuers are allowed to vary reimbursement rates to health care providers based on “quality or performance measures.”⁷⁹

This provision takes effect for plan years beginning on or after January 1, 2014.⁸⁰

Comprehensive health insurance coverage

Health insurance issuers who offer individual or small group market health coverage must ensure that the coverage includes the “essential health benefits package”⁸¹ The essential health benefits package provides a broad range of health care services, limits the cost-sharing that may be imposed on insured individuals, and provides a specified level of benefits (based on the plan’s actuarial value), depending on the level of coverage.⁸²

Group health plans are prohibited from imposing annual cost sharing requirements that exceed the out-of-pocket limits for High deductible health plans,⁸³ provided under IRC sec. 223(c)(2)(A)(ii).⁸⁴ Group health plans are also prohibited from imposing annual deductibles in excess of \$2,000 for individual plans and \$4,000 for all other types of health plans.⁸⁵

This provision takes effect for plan years beginning on or after January 1, 2014.⁸⁶

Prohibition on excessive waiting periods

Originally, the PPACA prohibited group health plans and health insurance issuers offering group or individual health coverage from imposing waiting periods in excess of 90 days.⁸⁷ An amendment to this

78. *Id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-5(a)).

79. *Id.* (to be codified at 42 U.S.C. § 300gg-5(a)).

80. PPACA § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

81. *Id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-6(a)).

82. *Id.* § 1302 adding 42 USC § 18022(a), (b)(1), (c), (d)(1); *see also* 42 USC § 18022(a)(2)-(5) regarding the HHS Secretary’s obligations in defining essential health benefits.

83. *Id.* § 1201(4) adding 42 USC § 300gg-6(b); PPACA § 1302 adding 42 USC § 18022(c)(1).

84. For 2015 and subsequent years, the cost sharing limits will be adjusted based on increases in the average per capita premium for health insurance coverage. PPACA sec. 1302 adding 42 USC sec. 18022(c)(1)(B), (4).

85. PPACA sec. 1302 adding 42 USC sec. 18022(c)(2)(A). For plan years after 2014, the dollar amounts are adjusted based on increases in the average per capita premium for health insurance coverage. PPACA sec. 1302 adding 42 USC sec. 18022(c)(2)(B), (4).

86. PPACA § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

87. *See id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-7, amended by PPACA § 10103(b)).

provision eliminated the words “or individual,” making this restriction applicable only to group coverage.⁸⁸

This provision takes effect for plan years beginning on or after January 1, 2014.⁸⁹

Preservation of right to maintain existing coverage

Grandfathered health plans, which are group or individual health plans with enrolled participants as of the date of the PPACA’s enactment, are generally not subject to the provisions contained in Subtitles A and C of the PPACA; however, they are required to use uniform standards and terms in explaining plan benefits and coverage, comply with the requirements to ensure quality of care, are subject to the prohibitions on excessive waiting periods, rescission of coverage and the prohibition on lifetime dollar limits for plan benefits, and they must extend coverage to dependent children of plan enrollees.⁹⁰

The prohibitions on annual limits on the dollar value of health benefits and on preexisting conditions exclusions will also apply to grandfathered plans that are also group health plans, once those provisions take effect, beginning in 2014.⁹¹

Grandfathered plans offering group or individual coverage are allowed to enroll family members of plan participants, if the participant was enrolled as of the date of the PPACA’s enactment, their coverage was renewed after the PPACA’s enactment, and the family member’s enrollment was permitted by the terms of the plan that were in effect on the date of enactment.⁹² Grandfathered plans that provide group health coverage are allowed to enroll new employees and their family members.⁹³

This provision took effect on the date of the PPACA’s enactment.⁹⁴

88. *Id.* (to be codified at 42 U.S.C. § 300gg-7, amended by PPACA § 10103(b)).

89. *Id.* § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by PPACA § 10103(f)(1)).

90. *Id.* § 1251(a) (to be codified at 42 U.S.C. § 18011(a)(1)-(2), amended by PPACA § 10103(d)); PPACA § 1251(a) (to be codified at 42 U.S.C. § 18011(a)(4), amended by HCERA § 2301(a)).

91. *Id.* (to be codified at 42 U.S.C. § 18011(a)(4)(B)(i), amended by HCERA § 2301(a)).

92. *Id.* § 1251(b) (to be codified at 42 U.S.C. § 18011(b)).

93. *Id.* § 1251(a)(2), (c) (to be codified at 42 U.S.C. § 18011(a)(2), (c)).

94. *Id.* § 1253 (to be codified at 42 U.S.C. § 300gg note, amended by 10103(e)(1)).

*D. Affordable Coverage Choices for All Americans**Requirement to maintain Minimum Essential Coverage (the Individual Mandate)*

Applicable individuals, beginning in 2014, are required to maintain, on a monthly basis, minimum essential coverage for themselves and their dependents who are classified as applicable individuals.⁹⁵ The term “applicable individuals” includes all individuals, except those with a religious exemption, incarcerated individuals or individuals who are not lawfully present in the United States.⁹⁶

“Minimum essential coverage” includes government-sponsored health programs (such as Medicare, Medicaid, CHIP, TRICARE and Veterans’ Administration benefits), a health plan maintained or established for governmental employees, a small or large group market employer-sponsored plan, individual market plans, and grandfathered health plans.⁹⁷

If an applicable individual fails to maintain their own minimum essential coverage for one or more months, they are subject to a penalty.⁹⁸ The penalty also applies for each month that the applicable individual’s spouse or dependents, if they are not otherwise exempt, do not have minimum essential coverage.⁹⁹

The penalty amount for all violations during a taxable year equals the lesser of:

(1) The sum of all monthly penalty amounts “for months in the taxable year during which 1 or more such failures occurred.”¹⁰⁰ The penalty amount for each violation is 1/12 of the greater of the following amounts:

(a) “[T]he sum of the applicable dollar amounts for [each applicable] individual” not having minimum essential coverage during the month, or “300% of the applicable dollar

95. PPACA § 1501(b) (to be codified at I.R.C. § 5000A(a), (d), note).

96. *Id.* (to be codified at 26 U.S.C. § 5000A(d)).

97. *Id.* (to be codified at 26 U.S.C. § 5000A(f)(1)-(2)).

98. *Id.* (to be codified at 26 U.S.C. § 5000A(a), (b)(1), (3), (c)(1), amended by PPACA § 10106(b)(1), (2)).

99. *Id.* (to be codified at 26 U.S.C. § 5000A(b)(1), amended by PPACA § 10106(b)(1)); 26 U.S.C. § 5000A(b)(3).

100. PPACA § 1501(b) (to be codified at 26 U.S.C. § 5000A(c)(1)(A), amended by PPACA § 10106(b)(2)).

amount . . . for the calendar year with or within which the taxable year ends[,]” whichever is less,¹⁰¹ or

(b) “1[%] for taxable years beginning in 2014” (“2[%] for taxable years beginning in 2015[,]” and “2.5[%] for taxable years beginning after 2015”), of the amount by which the taxpayer’s household income exceeds their gross income amount specified under I.R.C. § 6012(a)(1),¹⁰² and

(2) “[T]he national average premium for” bronze level qualified health plan coverage for the family’s size, offered through an Exchange, “for plan years beginning in the calendar year with or within which the taxable year ends.”¹⁰³

The applicable dollar amount for determining the monthly penalty will be \$95 for 2014, \$325 for 2015 and \$695 for subsequent years; it will be indexed for inflation.¹⁰⁴ No penalty is imposed on applicable individuals for any month in which their required contribution for coverage exceeds 8% of household income.¹⁰⁵ Household income is adjusted gross income, increased by any tax-exempt interest and by “any amount excluded from gross income under section 911,” and includes the incomes of all persons included in determining the family’s size who were also required to file a tax return for the taxable year.¹⁰⁶ The required contribution is: (i) the portion of the annual premium which would be paid for individual coverage by an individual eligible to purchase coverage through an employer-sponsored group health plan or group coverage, which is maintained or established for government employees, or which is offered through the small or large group market, or, (ii) for individuals who are only eligible to purchase coverage on the individual market, the annual premium for the lowest cost bronze level individual policy available through an Exchange, reduced by the I.R.C. § 36B premium tax credit amount, “determined as if

101. *Id.* (to be codified at 26 U.S.C. § 5000A(c)(1)(A), (c)(2)(A), amended by PPACA § 10106(b)(2)).

102. *Id.* (to be codified at 26 U.S.C. § 5000A(c)(2)(B), amended by PPACA § 10106(b)(2) and HCERA § 1002(a)(1)).

103. *Id.* (to be codified at 26 U.S.C. § 5000A(c)(1)(B), amended by PPACA § 10106(b)(2)).

104. *Id.* (to be codified at 26 U.S.C. § 5000A(c)(3), amended by 10106(b)(3) and HCERA § 1002(a)(2)). But see PPACA § 1501(b) adding 26 U.S.C. § 5000A(c)(3)(C), which provides that the applicable dollar amount for applicable individuals under the age of 18 is one-half of the applicable amount for the calendar year.

105. PPACA § 1501(b) (to be codified at 26 U.S.C. § 5000A(e)(1)(A)).

106. *Id.* (to be codified at 26 U.S.C. § 5000A(c)(4)(C), amended by HCERA § 1004(a)(2)(A)).

the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year.”¹⁰⁷

In addition, no penalty is imposed on applicable individuals whose household income is less than their income tax filing threshold pursuant to I.R.C. § 6012(a)(1), who are members of an Indian tribe, who have suffered a hardship affecting their ability to obtain qualified health plan coverage, or during any month where, as of the last day of the month, they have been without “minimum essential coverage for a continuous period of less than three months.”¹⁰⁸

Every person providing minimum essential coverage to an individual must file a return providing the primary insured’s name, address, taxpayer identification number (TIN) and the TIN of other individuals covered under the policy.¹⁰⁹ The return must also include information on the dates of coverage and other information, based on whether the coverage is through an Exchange-based qualified health plan or an employer provided group health plan.¹¹⁰

Patient Protections

If a group health plan or health insurance issuer offering group or individual coverage requires or provides for the designation of a participating primary care provider, then plan participants, beneficiaries or enrollees must be permitted to choose any participating provider “who is available to accept such individual.”¹¹¹ If the plan or issuer requires or provides for the designation of a participating primary care provider for children, then the plan or issuer must permit the designation of a pediatric physician if the pediatrician participates in their network.¹¹²

Plans or issuers that provide obstetric or gynecologic care coverage and require the designation of a primary care provider are prohibited from requiring female participants, beneficiaries or enrollees to obtain authorizations or referrals prior to seeking care for “obstetrical or

107. *Id.* (to be codified at 26 U.S.C. § 5000A (e)(1)(B)). The individual must be eligible to purchase the employer-sponsored coverage or must be “eligible only to purchase minimum essential coverage” in the individual market for the Exchange-based coverage. *Id.*

108. *Id.* (to be codified at 26 U.S.C. § 5000A(e)(2)-(5), amended by HCERA § 1002(b)(2)).

109. PPACA § 1502(a) (to be codified at 26 U.S.C. § 6055(a), (b)(1)(B)(i)).

110. *Id.* (to be codified at 26 U.S.C. § 6055(b)(1)(B)(ii)-(iii)(II)); *see id.* § 1514(a) (to be codified at 26 U.S.C. § 6056) (providing a return requirement for applicable large employers subject to 26 U.S.C. § 4980H.).

111. *Id.* § 1001(5) (to be codified at 42 U.S.C. § 300gg-19a(a), amended by PPACA § 10101(h)).

112. *Id.* (to be codified at 42 U.S.C. § 300gg-19a(c)(1), amended by PPACA § 10101(h)).

gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.”¹¹³

Group health plans or health insurance issuers who provide or cover any emergency care benefits must cover emergency medical screening exams and emergency services necessary to stabilize the patient, without the need for prior authorization determinations and without regard to whether the care provider is a participating provider of emergency services.¹¹⁴

Ensuring that Consumers get value for their dollars

The HHS Secretary, in conjunction with the States, must develop an annual review process for unreasonable premium increases for health insurance coverage, which is to commence in the 2010 plan year.¹¹⁵ Health insurance issuers have to provide a justification to the Secretary and to State authorities for unreasonable increases prior to their taking effect and would also have to post this information on their website.¹¹⁶ Beginning with plan years in 2014, the HHS Secretary, along with the States, has the authority to monitor health insurance premium increases, whether they take place inside or outside of the Health Insurance Exchanges.¹¹⁷

Also, academic or nonprofit centers will be established to collect, analyze and disseminate medical reimbursement information obtained from health insurance issuers.¹¹⁸ The centers must use the collected information to develop fee schedules that reflect market rates for medical services (including geographic rate differences), must regularly update those fee schedules, publish information on the Internet that allows consumers to understand the amounts charged by health care providers for medical services, and publish information on the statistical methodologies used in analyzing the health care cost data.¹¹⁹ This information will be made available to health insurance “issuers, health care providers, . . . researchers, . . . policy makers, and the general public.”¹²⁰

113. PPACA § 1001(5)(to be codified at 42 U.S.C. § 300gg-19a(d)(1)-(2), amended by PPACA § 10101(h)).

114. *Id.* (to be codified at 42 U.S.C. § 300gg-19a(b)(1)(A)-(B), (2), amended by PPACA § 10101(h)).

115. *Id.* § 1003 (to be codified at 42 U.S.C. § 300gg-94(a)(1)).

116. *Id.* (to be codified at 42 U.S.C. § 300gg-94(a)(2)).

117. *Id.* (to be codified at 42 U.S.C. § 300gg-94(b)(2)(A)).

118. PPACA § 1003 (to be codified at 42 U.S.C. § 300gg-94(c)(1)(C), amended by PPACA § 10101(i)(1)(C)).

119. *Id.* (to be codified at 42 U.S.C. § 300gg-94(c)(1)(C), (d)(1), amended by PPACA § 10101(i)(1)(C), (2)).

120. *Id.* (to be codified at 42 U.S.C. § 300gg-94(c)(1)(C), amended by PPACA § 10101(i)(1)(C)).

E. Affordable Choices of Health Benefit Plans (the Health Insurance Exchanges)

By January 1, 2014, each State must have a Health Insurance Exchange, established as a State agency or a State-established nonprofit, to assist qualified individuals and qualified employers enrolling in qualified health plans.¹²¹ Exchanges can only offer qualified health plans.¹²²

Qualified individuals are United States citizens, nationals, or lawfully present individuals seeking to enroll in an individual market qualified plan in their respective State Exchange.¹²³ Qualified employers are small employers who “elect[] to make all [their] full-time employees eligible for 1 or more” small group market qualified health plans offered through an Exchange.¹²⁴ “[Q]ualified individual[s] may enroll in any qualified . . . plan [that is] available to [them] and for which [they are] eligible.”¹²⁵ Qualified employers can subsidize employee health benefits at a chosen level of coverage (bronze, silver, gold or platinum), from which employees are able to select a qualified health plan within that coverage level.¹²⁶

Health insurance issuers are allowed to offer coverage outside of the Exchange and qualified individuals and qualified employers are allowed to purchase health insurance outside of the Exchange as well.¹²⁷

The Exchanges must be self-sustaining by January 1, 2015, and are allowed to collect assessments or user fees from participating health insurance issuers to raise funds.¹²⁸ Regional and Interstate Exchanges are also allowed to operate in “more than one State” if each State in which the Regional or Interstate Exchange operates provides authorization for it and the HHS Secretary approves it.¹²⁹

Health plans must be certified by the Exchange, which requires that the plan: satisfy certain marketing standards; provide a “sufficient choice of [health care] providers[;]” include care providers who serve low-income,

121. *Id.* § 1311(b)-(d) (to be codified at 42 U.S.C. § 18031(b)-(d)(1)-(2)(B)(i)).

122. *Id.* § 1311(d)(2)(B)(i) adding 42 USC sec. 18031(d)(2)(B)(i).

123. PPACA § 1312(f) (to be codified at 42 U.S.C. § 18032(f)(1)-(2)(A), (3)). “Qualified individuals” does not include incarcerated individuals. *Id.* § 1312(f) (to be codified at 42 U.S.C. § 18032(f)(1)(B)).

124. *Id.* (to be codified at 42 U.S.C. § 18032(f)(1)-(2)(A), (3)). Small employer “means...an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding year and who employs at least 1 employee on the first day of the plan year.” *Id.* § 1304(b)(2) adding 42 USC sec. 18024(b)(2).

125. *Id.* (to be codified at 42 U.S.C. § 18032(a)(1), amended by PPACA § 10104(i)(1)).

126. PPACA § 1312(a)(2) (to be codified at 42 U.S.C. § 18032(a)(2)); *see also id.* § 1302(d) (to be codified at 42 U.S.C. § 18022(d)).

127. *Id.* § 1312(d)(1) (to be codified at 42 U.S.C. § 18032(d)(1)).

128. *Id.* § 1311(d)(5)(A) (to be codified at 42 U.S.C. § 18031(d)(5)(A)).

129. *Id.* § 1311(f)(1) (to be codified at 42 U.S.C. § 18031(f)(1)).

medically underserved individuals; “be accredited with respect to [its] performance on clinical quality measures . . . and . . . patient experience ratings[;]” “implement a quality improvement strategy” that ties increased reimbursements to the use of healthcare quality initiatives, reduced hospital readmissions, improved patient safety and reductions in medical errors, and the use of wellness programs; use a uniform enrollment form for individuals and small businesses, and document its plan benefits in a standard format.¹³⁰

The certification process also involves the Exchange determining whether offering the health plan is in the interest of qualified individuals and employers and requires health plans seeking certification to provide a justification for any premium increases prior to the increases taking effect.¹³¹ The Exchange may take justifications for the rate increase and information provided by the State in regard to “patterns or practices of excessive or unjustified premium increases” into account in determining whether to offer the plan through the Exchange.¹³²

Health plans seeking certification must submit to the Exchange, the HHS Secretary, the State insurance commissioner, and disseminate publicly, information on their “[c]laims payment policies and practices[,]” “financial disclosures[,]” enrollment and disenrollment data, the number of denied claims, “[i]nformation on cost-sharing[,]” and “[o]ther information as determined . . . by the [HHS] Secretary.”¹³³

The Secretary must develop a rating system for Exchange-based qualified health plans that evaluates the plans based on quality and price.¹³⁴ A health plan’s rating will be determined by the Exchange.¹³⁵ The Exchange is also required to: recertify and decertify qualified health plans; provide a toll-free help line; provide standardized comparative data on qualified health plans on the Internet; use a standard format to present health plan options; notify individuals of the eligibility requirements for Medicaid, CHIP and applicable State or local public programs and enroll them in any of those programs if they are eligible; establish a mechanism for enrollees to determine their actual cost of coverage after applying the IRC sec. 36B premium tax credit and the PPACA sec. 1402(a) cost-sharing reduction;

130. PPACA § 1311(c)(1)(A)-(H), (d)(4)(A), (e)(1), (g)(1) (to be codified at 42 U.S.C. § 18031(c)(1)(A)-(H), (d)(4)(A), (e)(1), (g)(1)).

131. *Id.* § 1311(e) (to be codified at 42 U.S.C. § 18031(e)); *see also id.* § 1311(e) (to be codified at 42 U.S.C. § 18031(e)(3), amended by PPACA § 10104(f) (imposing additional disclosure requirements on health plans seeking certification as a qualified health plan)).

132. *Id.* § 1311(e)(2) (to be codified at 42 U.S.C. § 18031(e)(2)).

133. *Id.* § 1311(e) (to be codified at 42 U.S.C. § 18031(e)(3)(A), amended by PPACA § 10104(f)(2)).

134. PPACA § 1311(c)(3) (to be codified at 42 U.S.C. § 18031(c)(3)).

135. *Id.* § 1311(d)(4)(D) (to be codified at 42 U.S.C. § 18031(d)(4)(D)).

provide certification that individuals are exempt from the individual responsibility requirement or penalty under IRC sec. 5000A and establish a Navigator program.¹³⁶

The Exchanges must provide to the Treasury Department the names and TINs of all individuals receiving certifications exempting them from the individual responsibility requirement or penalty, and of employees eligible for the IRC sec. 36B premium tax credit due to their employer not providing minimum essential coverage, or providing minimum essential coverage which was determined to be unaffordable or that did not provide the required minimum actuarial value.¹³⁷ The Exchanges must also report the names and TINs of individuals who report a change in employers and of each individual “who ceases coverage under a qualified health plan during a plan year . . . [.]”¹³⁸

For states that do not elect to adopt or implement by January 1, 2014 the standards established for operating Exchanges, or that the Secretary determines, on or before January 1, 2013, will not have an Exchange operational by January 1, 2014, the Secretary may establish and operate an Exchange within that State or contract with a nonprofit entity to operate the Exchange.¹³⁹

F. Qualified Health Plans

A “qualified health plan” is a health plan that is certified by an Exchange,¹⁴⁰ that “provides the essential health benefits package[.]”¹⁴¹ and is offered by an issuer who “is licensed and in good standing . . . in each State in which [it] offers . . . coverage[.]” who “agrees to offer at least one qualified health plan in the silver . . . and gold level in each . . . Exchange[.]” “agrees to charge the same premium . . . for . . . qualified

136. *Id.* § 1311 (d)(4)(A)-(C), (E)-(H), (K) (to be codified at 42 U.S.C. § 18031(d)(4)(A)-(C), (E)-(H), (K)); *see also* 42 U.S.C. § 18031(i) (describing the requirements of the Navigator program, which provides grants to entities that disseminate information on and facilitate enrollment in qualified health plans); *see also id.* § 1396w-3(b) (providing “Enrollment simplification and coordination with State health insurance exchanges. . .”); *see also id.* § 256a (explaining the Patient Navigator Program); *see generally id.* § 18083(a), (b)(1)(A), (e) (explains the streamlined procedures allowing applicants to the Exchange to be evaluated for and enrolled into Medicaid, CHIP, or other programs, if they meet the program’s eligibility requirements).

137. PPACA § 1311(d)(4)(I)(i)-(ii) (to be codified at 42 U.S.C. § 18031(d)(4)(I)(i)-(ii)).

138. *Id.* § 1311(d)(4)(I)(iii) (to be codified at 42 U.S.C. § 18031(d)(4)(I)(iii)).

139. *Id.* § 1321(a)(1)(A), (b), (c)(1)(A)-(B)(i) (to be codified at 42 U.S.C. § 18041(a)(1)(A), (b), (c)(1)(A)-(B)(i)). *But see id.* § 1321(e)(1) (to be codified at 42 U.S.C. 18041(e)(1)) (explaining the application of this section to states with operating health insurance exchanges prior to January 1, 2010).

140. *Id.* § 1301(a)(1)(A) (to be codified at 42 U.S.C. 18021(a)(1)(A)); *see also id.* § 1311(c)(1), (d)(4)(A), (e)(1) (to be codified at 42 U.S.C. § 18031(c)(1), (d)(4)(A), (e)(1)).

141. *Id.* § 1301(a)(1)(B) (to be codified at 42 U.S.C. § 18021(a)(1)(B)).

health plan[s][,]” whether offered through the Exchange, an agent, or directly from the issuer, and “complies with the regulations developed by the [HHS] Secretary” and any other requirements of that particular Exchange.¹⁴²

“Qualified health plans” are deemed to include CO-OP plans created under PPACA sec. 1322 and multi-State plans under PPACA sec. 1334, unless otherwise provided.¹⁴³

G. The Essential Health Benefits Requirements

The “essential health benefits package” includes essential health services, as determined by the HHS Secretary, and must cover: ambulatory services, emergency care, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services, lab services, preventive and wellness services and chronic disease management, and pediatric care.¹⁴⁴

On December 16, 2011, HHS announced a proposal to allow each State to define “essential health benefits” by selecting one of four benchmark health plans, with the selected plan serving as a “reference plan”, establishing the scope of the health services and limitations of a “typical employer plan” offered in that State.¹⁴⁵ “[H]ealth insurance issuers could adopt the scope of services and limits of the State benchmark, or vary it within [certain] parameters”¹⁴⁶ The four benchmark plans for 2014 and 2015 are: “(i) the largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market; (ii) any of the largest three State employee health benefit plans by enrollment; (iii) any of

142. *Id.* § 1301(a)(1)(C) (to be codified at 42 U.S.C. § 18021(a)(1)(C)).

143. PAACA § 1301(a)(2) (to be codified as at 42 U.S.C. § 18021(a)(2), amended by PPACA § 10104(a) (eliminating the Community Health Insurance Option plans under PPACA § 1323 from being treated as a “qualified health plan” and including multi-State plans under PPACA § 1334).

144. *Id.* § 1302 (a)(1), (b)(1) (to be codified at 42 U.S.C. 18022(a)(1), (b)(1)); *see also id.* § 1302(b)(2)-(5) (to be codified at 42 U.S.C. §18022(b)(2)-(5)) (regarding the HHS Secretary’s obligations in defining essential health benefits).

145. Essential Health Benefits Bulletin, Ctr. for Consumer Info. and Ins. Oversight (Oct. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. The “scope of benefits provided under a typical employer plan” requirement is necessary due to the PPACA’s requirement that “[t]he [HHS] Secretary shall ensure that the scope of the essential benefits . . . is equal to the scope of benefits provided under a typical employer plan” *See* PPACA § 1302 adding 42 USC § 18022(b)(2)(A).

146. Essential Health Benefits Bulletin, Ctr. for Consumer Info. and Ins. Oversight (Oct. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. “Similar to CHIP, we intend to propose that a health insurance issuer have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits provided they continue to offer coverage for all 10 statutory EHB categories. Any flexibility provided would be subject to a baseline set of relevant benefits, reflected in the benchmark plan as modified.” *Id.* at 12.

the largest three national FEHBP plan options by enrollment; or (iv) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.”¹⁴⁷ The selected benchmark plan would serve as the “essential health benefits” standard for qualified health plans offered within the State’s Exchanges and for individual and small group market health plans offered outside of the Exchange.¹⁴⁸ If a State fails to select a benchmark health plan, then the default benchmark is “the largest plan by enrollment in the largest product in the State’s small group market.”¹⁴⁹

The essential health benefits package requires health plans to limit annual cost-sharing amounts for self-only and family plans for plan years beginning in 2014 to the dollar limits provided for High deductible health plans under IRC sec. 223(c)(2)(A)(ii).¹⁵⁰ For subsequent years, the cost-sharing limits will be adjusted based on increases in the average per capita premium for health insurance coverage.¹⁵¹ Cost-sharing includes “deductibles, coinsurance, copayments,” and required payments from an insured person for qualified medical expenses (as defined in IRC sec. 223(d)(2)) in connection with covered essential health benefits.¹⁵² Cost-sharing does not include health care premiums, costs for out-of-network providers or costs for non-covered services.¹⁵³

Annual deductibles for employer-sponsored small group market health plans cannot exceed “\$2,000 [for] plan[s] covering a single individual . . . and \$4,000 [for all] other plans.”¹⁵⁴ For plan years after 2014, the dollar

147. Essential Health Benefits Bulletin, Ctr. for Consumer Info. and Ins. Oversight (Oct. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. For the 2016 year and beyond, HHS will assess the benchmark process “based on evaluation and feedback.” *Id.* at 9. “‘Products’ is defined as ‘the services covered as a package by an issuer, which may have several cost-sharing options and riders as options. A ‘plan’ refers to the specific benefits and cost-sharing provisions available to an enrolled consumer.” *Id.* at n.26.

148. Essential Health Benefits Bulletin, Ctr. for Consumer Info. and Ins. Oversight (Oct. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. “The Affordable Care Act requires all issuers subject to the EHB standard in section 1302(a) to cover each of the 10 benefit categories. If a category is missing in the benchmark plan, it must nevertheless be covered by health plans required to offer EHB.” *Id.* at 10.

149. Essential Health Benefits Bulletin, Ctr. for Consumer Info. and Ins. Oversight (Oct. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

150. PPACA § 1302(a)(2), (c)(1)(A) (to be codified at 42 U.S.C. § 18022(a)(2), (c)(1)(A)).

151. *Id.* § 1302(c)(1)(B), (4) (to be codified at 42 U.S.C. § 18022(c)(1)(B), (4)) (the premium adjustment percentage is the percentage by which the previous year’s average per capita premium for health insurance in the U.S. exceeds the average per capita premium for 2013).

152. *Id.* § 1302(c)(3)(A) (to be codified at 42 U.S.C. § 18022(c)(3)(B)).

153. *Id.* § 1302(c)(3)(B) (to be codified at 42 U.S.C. § 18022(c)(3)(B)).

154. *Id.* § 1302(c)(2)(A) (to be codified at 42 U.S.C. § 18022(c)(2)(A)).

amounts are adjusted based on increases in the average per capita premium for health insurance coverage.¹⁵⁵

The essential health benefits package requires health plans to offer coverage in either the bronze, silver, gold or platinum level of coverage, each of which is tied to the actuarial value of the benefits the plan is designed to provide.¹⁵⁶ The bronze level plan must provide coverage “that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value” of the plan benefits.¹⁵⁷ “[A] plan with an actuarial value of [60]% . . . means that for a standard population, the plan will pay [60]% of their health care expenses, while the enrollees themselves will pay [40]% through some combination of deductibles, copays, and coinsurance. The higher the actuarial value, the less patient cost-sharing the plan will have on average.”¹⁵⁸

For the silver plan, the actuarial value increases to 70 percent; for the gold plan, 80 percent, and the platinum plan, 90 percent.¹⁵⁹

Catastrophic Plans

Health plans that do not satisfy the actuarial values for the bronze through platinum levels of coverage, but meet certain requirements, are treated as meeting the actuarial value requirements.¹⁶⁰ These “catastrophic” health plans must cover the essential health benefits items and services, but only after the insured “has incurred cost-sharing expenses . . . equal to” the cost-sharing limit for High deductible health plans under IRC sec. 223(c)(2)(A)(ii) and must cover “at least three primary care visits” during a plan year.¹⁶¹ These plans are only allowed for individuals who have not reached age 30 before the plan year begins or who have been certified as exempt from the individual responsibility requirement of IRC sec. 5000A due to the affordability exemption of 5000A(e)(1) or the hardship

155. PPACA § 1302(c)(2)(B), (4) (to be codified at 42 U.S.C. § 18022(c)(2)(B), (4)).

156. *Id.* § 1302(a)(3), (d)(1) (to be codified at 42 U.S.C. § 18022(a)(3), (d)(1)); *see also id.* § 1201(4) (to be codified at 42 U.S.C. § 300gg-6(a)-(d)).

157. *Id.* § 1302(d)(1)(A) (to be codified at 42 U.S.C. § 18022(d)(1)(A)).

158. *What the Actuarial Values in the Affordable Care Act Mean*, THE HENRY J. KAISER FAMILY FOUNDATION (Apr. 2011), www.kff.org/healthreform/upload/8177.pdf. “The percentage a plan pays for any given enrollee will generally be different from the actuarial value, depending upon the health care services used and the total cost of those services. And, the details of the patient cost-sharing will likely vary from plan to plan.” *Id.*

159. PPACA § 1302(d)(1)(B)-(D) (to be codified at 42 U.S.C. § 18022(d)(1)(B)-(D)).

160. *Id.* § 1302(a)(3), (e)(1) (to be codified at 42 U.S.C. § 18022(a)(3), (e)(1)).

161. *Id.* § 1302(e)(1)(B) (to be codified at 42 U.S.C. § 18022(e)(1)(B)).

exemption of 5000A(e)(5).¹⁶² Catastrophic plans can only be offered in the individual health insurance market.¹⁶³

Abortion Coverage

States may enact legislation prohibiting qualified health plans operating in their Exchanges from offering abortion coverage.¹⁶⁴ In states where such legislation is not enacted, qualified health plans are not required to cover abortion services as part of their essential health benefits package.¹⁶⁵ “Abortion services” is defined to include abortions that are permitted with the use of federal funds and abortions that not are permitted with federal funds.¹⁶⁶ The distinction between federally-funded and non-federally funded abortions is tied to the Hyde Amendment, which is reauthorized each year in appropriations bills which fund the Department of HHS.¹⁶⁷ The Hyde Amendment restricts the use of federal funds for abortions, except in cases of rape, incest or life endangerment.¹⁶⁸

Originally, the PPACA required the HHS Secretary to ensure that each Exchange offered at least one qualified health plan that covered both types of abortions and at least one qualified health plan that did not cover abortions prohibited from using federal funds, however, this requirement was removed.¹⁶⁹

For qualified health plans that cover non-Federally funded abortions, the plan issuer is not allowed to use any amount attributable to the IRC sec. 36B premium tax credit, the sec. 1402 cost-sharing reduction or any advance payments pursuant to those sections to pay for those abortion

162. *Id.* § 1302(e)(1)-(2) (to be codified at 42 U.S.C. § 18022(e)(1)-(2)).

163. *Id.* § 1302(e)(3) (to be codified at 42 U.S.C. § 18022(e)(3)).

164. PPACA § 1303 (to be codified at 42 U.S.C. § 18023(a)(1), amended by PPACA § 10104(c); *id.* § 1303 (to be codified at 42 U.S.C. § 18023(a)(2), amended by PPACA § 10104(c)) (allowing states to repeal laws prohibiting the offering of abortion services through Health Exchanges).

165. *Id.* (to be codified at 42 U.S.C. § 42 U.S.C. 18023(a)(1), (b)(1)(A)(i), amended by PPACA § 10104(c)).

166. *Id.* (to be codified at 42 U.S.C. 18023(b)(1)(B)(i)-(ii)), amended by PPACA § 10104(c) (applying more specifically, to “abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved” and to “abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved”).

167. National Abortion Federation, *Public Funding for Abortion: Medicaid and the Hyde Amendment*, PROCHOICE.ORG (2006), http://www.prochoice.org/about_abortion/facts/public_funding.html.

168. *Id.*

169. PPACA § 1303(a)(1)(D)(i) (to be codified at 42 U.S.C. 18023(a)(1)(D)(i), removed by PPACA § 10104(c)).

services.¹⁷⁰ In addition, the plan issuer must collect from each enrollee who pays their own premiums a separate payment for the portion of the premium paid for health services not including abortion coverage (reduced by any IRC sec. 36B tax credit and sec. 1402 cost sharing reduction) and a separate payment for the portion of their premium used to pay for the actuarially determined value of the abortion coverage.¹⁷¹ The plan issuer must also establish “allocation accounts” for enrollees receiving IRC sec. 36B tax credits, sec. 1402 cost sharing reductions or advance payments pursuant to either section.¹⁷² The segregated premium payments collected from the enrollee for health services (not including abortion coverage) and for the abortion coverage must be deposited into separate accounts and can only be used for the health services for which that account is maintained.¹⁷³

H. State Flexibility Relating to Exchanges

Consumer Operated and Oriented Plan Program (CO-OP)

The HHS Secretary will award grants and loans, no later than July 1, 2013, to persons applying to become qualified nonprofit health insurance issuers, which are tax-exempt nonprofit corporations created for the purpose of issuing qualified health plans in the individual and small group market.¹⁷⁴ The nonprofit must use the loaned funds for start-up expenses and the grant funds to satisfy State solvency requirements.¹⁷⁵ The Secretary must award loans and grants in a manner that ensures that there is sufficient funding for the creation of a qualified nonprofit health insurance issuer in each State.¹⁷⁶ The nonprofit’s governance must be “subject to [the] majority vote of its

170. *Id.* § 1303 (to be codified at 42 U.S.C. § 18023(b)(2)(A), amended by PPACA § 10104(c)); *see also id.* (to be codified at 42 U.S.C. § 18023(b)(3)(A), amended by PPACA § 10104(c)) (noting that qualified health plans providing coverage for non-Federally funded abortions “shall provide notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage”).

171. *Id.* (to be codified at 42 U.S.C. § 18023(b)(2)(B),(D), amended by PPACA § 10104(c)); *see also id.* (to be codified at 42 U.S.C. § 18023(b)(2)(B), amended by PPACA 10104(c)) (explaining that separate deposits for each payment are also required for enrollees whose premiums are paid by employee payroll deposit).

172. PPACA § 1303 (to be codified at 42 U.S.C. § 18023(b)(2)(C)(i), amended by PPACA § 10104(c)).

173. *Id.* (to be codified at 42 U.S.C. § 18023(b)(2)(C)(ii), amended by PPACA § 10104(c)); *see also id.* (to be codified at 42 U.S.C. § 18023(b)(2)(E), amended by PPACA § 10104(c)) (requiring state health insurance commissioners to ensure that health plans comply with the account segregation requirements).

174. *Id.* § 1322(a)(2), (b)(1), (b)(2)(D), (c)(1) (to be codified at 42 U.S.C. § 18042(a)(2), (b)(1), (b)(2)(D), (c)(1)); *but see id.* § 1322(b) (to be codified as 42 U.S.C. § 18042(b)(3), amended by PPACA 10104(l), (regarding the repayment of loans and grants)).

175. *Id.* § 1322(b)(1) (to be codified at 42 U.S.C. 18042(b)(1)).

176. PPACA § 1322(b)(2)(A)(iii) (to be codified at 42 U.S.C. § 18042(b)(2)(A)(iii)).

members” and it must have a strong consumer-oriented focus and use its profits “to lower premiums, . . . improve benefits or . . . improve the quality of . . . care [provided] to its members.”¹⁷⁷ The nonprofit must also comply with all requirements applicable to other issuers of qualified plans in the States in which they operate.¹⁷⁸

An organization is ineligible to be a “qualified nonprofit health insurance issuer if [it] or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009. . . .”¹⁷⁹ Organizations sponsored by State or local governments, or by a political subdivision or instrumentality of either are ineligible to be qualified nonprofit health insurance issuers.¹⁸⁰

I. State Flexibility to Establish Alternative Programs

Basic Health Program for Low-Income Individuals Not Eligible for Medicaid

States may contract to offer standard health plans to eligible individuals, defined as state residents under age 65 who are ineligible to enroll in Medicaid, for benefits equivalent to the essential health benefits if their “household income exceeds 133[%] [of], but . . . [is not greater than] 200[%] of” their respective poverty level income, and they are ineligible for “minimum essential coverage...or [are] eligible for . . . employer-sponsored” coverage which is deemed unaffordable because their household income is less than their income tax filing threshold under IRC sec. 6012(a)(1).¹⁸¹ Eligible individuals are not allowed to enroll in a qualified health plan offered through an Exchange.¹⁸²

The standard health plan must provide, at a minimum, the essential health benefits and monthly premium and cost-sharing requirements must not exceed certain limits.¹⁸³ States would use a competitive process in

177. *Id.* § 1322(c)(3)(A), (C), (4) (to be codified at 42 U.S.C. § 18042(c)(3)(A), (C), (4)).

178. *Id.* § 1322(c)(5) (to be codified at 42 U.S.C. 42 U.S.C. § 18042(c)(5)).

179. *Id.* § 1322(c)(2)(A) (to be codified at 42 U.S.C. 42 U.S.C. § 18042(c)(2)(A)).

180. *Id.* § 1322(c)(2)(B) (to be codified at 42 U.S.C. § 18042(c)(2)(B)).

181. PPACA § 1331(a)(1), (c)(1), (e)(1) (to be codified at 42 U.S.C. § 18051(a)(1), (c)(1), (e)(1)); *see also id.* § 1331 (to be codified at 18051(e)(1)(B), amended by PPACA § 10104(o)(2)) (adding the definition of “eligible individuals” persons who are “alien[s] lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid program . . . by reason of such alien status”).

182. *Id.* § 1331(e)(2) (to be codified at 42 U.S.C. § 18051(e)(2)).

183. *Id.* § 1331(a)(2), (b)(2) (to be codified at 42 U.S.C. § 18051(a)(2), (b)(2)). The monthly premium must not exceed the cost of the applicable second lowest cost silver plan available to the individual through an exchange and the cost-sharing obligation must not exceed that of a platinum plan for the eligible individual if his household income is not in excess of 150% of the respective poverty level

contracting with the health plans and would negotiate premium levels, cost-sharing requirements and health benefits.¹⁸⁴

Standard health plans would provide coordinated care and care management services to enrollees, incentives for preventive care, managed care services and performance measures related to care quality and improving health care outcomes.¹⁸⁵ States providing standard health plans are eligible for funding, which must be used to reduce premiums and cost-sharing or to provide additional benefits to standard health plan enrollees.¹⁸⁶ States are also allowed to enter into regional compacts, allowing eligible individuals residing in different States to obtain coverage from out-of-state standard health plan issuers.¹⁸⁷

Waiver for State Innovation

For plan years beginning on or after January 1, 2017, States may apply for a waiver from all or any of the following: the qualified health plan requirements; the essential health benefits requirements; the abortion rules; the State Health Insurance Exchange requirement; the consumer choice provisions; the financial integrity rules of PPACA sec. 1313; the sec. 1402 cost sharing reduction, the IRC sec. 36B tax credit, the 4980H reporting requirement and the IRC sec. 5000A individual mandate and penalty provision.¹⁸⁸

In order to receive the waiver, the HHS Secretary must determine that the State's plan "will not increase the [f]ederal deficit" and will cover a comparable number of residents with coverage that is equivalent to and as affordable as would be the case if the provisions of Title I of the PPACA applied.¹⁸⁹ States which receive waivers are entitled to funding equal to any disallowed tax credits and cost-sharing reductions that their residents and

income for his family size, or the cost-sharing required under a gold plan for the eligible individual whose household income exceeds 150% of their respective poverty level income. *Id.* § 1331(a)(2)(A) (to be codified at 42 U.S.C. § 18051(a)(2)(A)).

184. PPACA § 1331(c)(1) (to be codified at 42 U.S.C. § 18051(c)(1)). "A State may provide that persons eligible to offer standard health plans under a basic health program . . . may include a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program." *Id.* § 1331(g) (to be codified at 42 U.S.C. § 18051(g)).

185. *Id.* § 1331(c)(2) (to be codified at 42 U.S.C. § 18051(c)(2)).

186. *Id.* § 1331(d)(1)-(3) (to be codified at 42 U.S.C. § 18051(d)(1)-(3)); *but see id.* § 1331 (to be codified at 42 U.S.C. § 18051(d)(3)(A)(i), amended by PPACA § 10104(o)(1)).

187. PPACA § 1331(c)(3)(B) (to be codified at 42 U.S.C. § 18051(c)(3)(B)).

188. *Id.* § 1332(a)(1)-(2) (to be codified at 42 U.S.C. § 18052(a)(1)-(2)); *but see id.* § 1332(e) (to be codified at 42 U.S.C. § 18052(e)) (providing a 5 year limit for waivers, "unless the State requests a continuation . . .").

189. *Id.* § 1332(b)(1) (to be codified at 42 U.S.C. 18052(b)(1)).

small businesses would have been entitled to, but are ineligible for, “due to the structure of the State plan”¹⁹⁰

State Healthcare Compacts

On or after January 1, 2016, health care choice compacts are permitted, allowing one or more individual market qualified health plans to be offered to the residents of the two or more member states.¹⁹¹ The qualified health plan would be subject to the laws and regulations of the state where the plan was written or issued, however the laws of the purchaser’s state of residence would apply to issues concerning “market conduct, . . . trade practices, network adequacy, consumer protection . . . [and] contract [disputes]”¹⁹² The health plan issuer would have to be licensed in each compact State in which the plan is offered or would have to submit to each State’s jurisdiction concerning market and trade practices, network adequacy, consumer protection, and contract issues.¹⁹³ The plan issuer would also have to notify purchasers that all of the laws and regulations of their state of residence may not apply to the policy.¹⁹⁴ States must enact legislation specifically authorizing them to enter into a health care choice compact agreement.¹⁹⁵

Multi-State Plans

The Director of the Office of Personnel Management (OPM) must contract with issuers who would offer at least two multi-State qualified health plans through every Exchange in each state.¹⁹⁶ The multi-State plans will offer individual and small group coverage.¹⁹⁷ The Director is charged with implementing the multi-State plans in a manner similar to that used by the Director in contracting with health insurance carriers operating within

190. *Id.* § 1332(a)(3) (to be codified at 42 U.S.C. § 18052(a)(3)).

191. PPACA § 1333(a)(1)(A), (4) (to be codified at 42 U.S.C. § 18053(a)(1)(A), (4)).

192. *Id.* § 1333(a)(1)(A), (B)(i) (to be codified at 42 U.S.C. § 18053(a)(1)(A), (B)(i)).

193. *Id.* § 1333(a)(1)(B)(i)-(ii) (to be codified at 42 U.S.C. § 18053(a)(1)(B)(i)-(ii)).

194. *Id.* § 1333(a)(1)(B)(iii) (to be codified at 42 U.S.C. § 18053(a)(1)(B)(iii)).

195. *Id.* § 1333(a)(2) (to be codified at 42 U.S.C. § 18053(a)(2)); *but see* PPACA § 1333(a)(3) (to be codified at 42 U.S.C. 18053(a)(3)) (regarding the HHS Secretary’s approval of health care choice compacts).

196. PPACA § 1334(a)(1) (to be codified at 42 U.S.C. § 18054(a)(1)), amended *by id.* § 10104(q); *see also id.* § 1334 (to be codified at 42 U.S.C. 18054(a)(3), amended by 10104(q)) (noting at least one contract must be with a non-profit entity).

197. *Id.* § 1334(a)(1) (to be codified at 42 U.S.C. § 18054(a)(1), amended by PPACA § 10104(q); *see also id.* § 1334(c)(3)(A) (to be codified at 42 U.S.C. § 18054 (c)(3)(A), amended by 10104(q)) (explaining that individuals enrolled in multi-State plans are eligible for the IRC § 36B tax credit and the PPACA § 1402 cost sharing reduction).

the Federal Employees Health Benefit Program (FEHBP).¹⁹⁸ The Director's implementation responsibility includes negotiating the "medical loss ratio[,] "profit margin[,] "premium[] . . . charge[]" and "other terms and conditions of coverage" with each multi-State plan.¹⁹⁹ The Director must also ensure that at least one multi-State plan does not provide coverage for non-Federally funded abortion services.²⁰⁰

Health insurance issuers are eligible to contract with the Director if they are licensed in each State and subject to all State law requirements, comply with the minimum standards for FEHBP health benefit plans, satisfy other requirements of the Director, and if, in the Director's determination: (i) "the plan offers a benefits package that is uniform in each State [which] consists of the essential benefits" health package; (ii) "the plan meets all requirements [for] qualified health plan[s], including requirements relating to the offering of . . . bronze, silver, and gold levels of coverage and [for] catastrophic coverage in each State Exchange;" (iii) "unless more restrictive age rating requirements are mandated at the State level, the issuer provides for determinations of premiums for coverage . . . bas[ed] [on] the rating requirements of . . . Public Health Service Act" sec. 2701 (regarding fair health insurance premiums) and (iv) "the issuer offers the plan in all geographic regions, and in all States that have adopted adjusted community rating prior to the date of [the PPACA's] enactment"²⁰¹

With the exception of the eligibility requirements that health issuers comply with the minimum standards for FEHBP health benefit plans and satisfy other requirements of the Director, all other eligibility requirements for multi-state plans are to be disregarded and the Director is required to contract with a health issuer "for the offering of a multi-State qualified health plan" if the "issuer offers the plan in at least 60[%] of the States" during its first year, "in at least 70[%] of the States" during the second year, "at least 85[%] of the States" during the third year and "offers the plan in all States" in each subsequent year.²⁰²

198. *Id.* § 1334(a)(4) (to be codified at 42 U.S.C. § 18054(a)(4), amended by PPACA § 10104(q)).

199. *Id.* (to be codified at 42 U.S.C. § 18054(a)(4), amended by PPACA § 10104(q)).

200. *Id.* § 1334(a)(6) (to be codified at 42 U.S.C. § 18054(a)(6), amended by PPACA § 10104(q)).

201. PPACA § 1334(b)-(c)(1)(A)-(D) (to be codified at 42 U.S.C. § 18054(b)-(c)(1)(A)-(D), amended by PPACA § 10104(q)).

202. *Id.* § 1334(b)-(c), (e) (to be codified at 42 U.S.C. § 18054(b)-(c), (e), amended by PPACA § 10104(q)).

*J. Small Business Tax Credit**Small Business Tax Credit for Employee Health Insurance Expenses*

Eligible small employers, defined as employers with 25 or fewer full-time employees, who pay average annual wages not in excess of \$50,000, and are required to make non-elective contributions at a uniform percentage of at least 50% of the premium cost for each employee enrolled in an Exchange-based qualified health plan (offered by the employer), are entitled to a small employer health insurance credit.²⁰³ The credit is equal to 50% (35% for tax-exempt eligible small employers) of the lesser of:

- (i) “the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year” under an Exchange-based qualified health plan offered by the employer, or
- (ii) “the aggregate amount of nonelective contributions which the employer would have made during the taxable year . . . if each employee taken into account under . . . (i) had [instead] enrolled in a qualified health plan which had a premium equal to the average premium . . . for the small group market in the rating area in which the employee enrolls for coverage.”²⁰⁴

The amount of the credit is reduced once the number of full-time employees exceeds 10 and is phased out completely once the number of full-time employees reaches 25.²⁰⁵ The credit is also reduced if the employer’s average annual wages exceeds \$25,000 (increased by an annual cost of living adjustment for taxable years after 2013) and phases out once the average annual wage equals \$50,000 (increased by the cost of living adjustment after 2013).²⁰⁶

The 50% (35% for tax-exempt eligible small employers) credit is allowed for the two consecutive taxable years beginning with the first

203. *Id.* § 1421(a) (to be codified at 26 U.S.C. § 45R(a), (d)(1), (3)(B)(i), (4), (e)(3)); *id.* § 1421(a) (to be codified at 26 U.S.C. § 45R(d)(3)(B), amended by PPACA § 10105(e)(1)); *see also* 26 U.S.C. § 45R(e)(3) (noting the employer contribution must not be pursuant to a salary reduction arrangement); *see also* PPACA § 1421(d)(1) (to be codified as amended at 26 U.S.C. § 280C(h)) (disallowing a deduction for premiums paid by the employer which equal the amount of the credit determined under 26 U.S.C. § 45R(a)); *but see id.* § 1421(f) (to be codified at 26 U.S.C. § 38 note, amended by PPACA § 10105(e)(4)) (explaining the effective date of I.R.C. § 45, which applies to amounts paid or incurred in taxable years beginning after December 31, 2009).

204. PPACA § 1421(a) (to be codified at 26 U.S.C. § 45R(b)).

205. *Id.* (to be codified at 26 U.S.C. § 45R(c)(1)).

206. *Id.* (to be codified at 26 U.S.C. § 45R(c)(2), (d)(3), amended by PPACA § 10105(e)(1)).

taxable year in which the employer offers an Exchange-based qualified health plan to its employees.²⁰⁷

For taxable years beginning in 2010-2013, a reduced credit, 35% for eligible small employers (25% for tax-exempt eligible small employers), will be allowed for the lesser of, the employer's non-elective premium contributions for employee health insurance or the aggregate amount the employer would have paid based on the average premium for small group market health insurance coverage in the State, as determined by the HHS Secretary.²⁰⁸

K. Employer Responsibilities

Employer requirement to inform employees of coverage options

Employers subject to the Fair Labor Standards Act²⁰⁹ must provide written notice to new employees (and current hires by March 1, 2013) informing them of the Health Insurance Exchange, including a description of the Exchange's services, and how the employee may contact the Exchange for assistance.²¹⁰ If the employer's health plan covers less than 60% of the total allowed costs of benefits, the written notice must inform the employee that they may be eligible for the Internal Revenue Code section 36B premium tax credit and a section 1402 cost sharing reduction if they purchase an Exchange-based qualified health plan.²¹¹ The employer must also notify employees that if they purchase an Exchange-based qualified health plan "and the employer does not offer a free choice voucher," that they may lose the employer's contribution to the employer-provided coverage and that some or all of that contribution may be excludable from Federal income tax.²¹²

Employers with "more than 200 full-time employees [who] offer[] [their] employees enrollment in 1 or more health benefits plans [must] automatically enroll new full-time employees in one of the plans

207. *Id.* (to be codified at 26 U.S.C. § 45R(e)(2), (g)(1)).

208. *Id.* § 1421(a) (to be codified at 26 U.S.C. § 45R(g)(1)-(2), amended by PPACA § 10105(e)(2)). *But see* 26 U.S.C. § 45R(g)(3).

209. "The Fair Labor Standards Act applies only in situations where (1) a true employer/employee relationship exists, (2) the requirements for either individual or enterprise coverage are met, and (3) the work is performed in the United States or a U.S. possession or territory." *Coverage Under the Fair Labor Standards Act*, AMERICANBAR.ORG, <http://www.americanbar.org/content/dam/aba/migrated/labor/basics/flsa/papers/kearns.authcheckdam.pdf>. *See* 29 USC §§ 203(d), (g), (r), (s); 206-207; 213.

210. PPACA § 1512 (to be codified at 29 U.S.C. § 218b(a)(1)).

211. *Id.* (to be codified at 29 U.S.C. § 218b(a)(2)).

212. *Id.* (to be codified at 29 U.S.C. § 218b(a)(3), amended by PPACA § 10108(i)(2)).

offered”²¹³ The new employees’ enrollment is subject to any legally authorized waiting period and the employer must continue the enrollment of its current employees in its health plan.²¹⁴ The automatic enrollment program must provide adequate notice and allow any automatically enrolled individuals the opportunity to opt out of the coverage.²¹⁵

“Applicable large employers,” employers who had an average of at least 50 full-time employees on business days during the preceding year, are subject to an assessable payment if they “fail[] to offer [their] full-time employees (and their dependents) the opportunity to enroll in . . . an . . . employer-sponsored group plan” and one or more of their “full-time employee[s] . . . [is] certified” as enrolled in an Exchange-based qualified health plan and is allowed the Internal Revenue Code section 36B premium tax credit or receives the section 1402 cost-sharing reduction.²¹⁶ The assessable payment is determined on a monthly basis and equals the number of full-time employees for the month (reduced by 30), multiplied by \$166.66 (1/12 of \$2,000).²¹⁷

Applicable large employers who offer their full-time employees (and their dependents) the opportunity to enroll in their employer-sponsored group plan are also subject to an assessable payment if any of their full-time employees is certified as enrolling in an Exchange-based qualified health plan and is allowed or receives the IRC sec. 36B premium tax credit or receives the sec. 1402 cost-sharing reduction.²¹⁸ The assessable payment equals the number of certified full-time employees who are allowed or

213. *Id.* § 1511 (to be codified at 29 U.S.C. § 218a). This provision applies to employers subject to the Fair Labor Standards Act. *See* 29 U.S.C. § 218a.

214. PPACA § 1511 (to be codified at 29 U.S.C. § 218a).

215. *Id.* (to be codified at 29 U.S.C. § 218a).

216. *Id.* § 1513(a) (to be codified at 26 U.S.C. § 4980H(a), (c)(2)); *see* 26 U.S.C. § 4980H(c)(2)(C)(ii) (providing rules for employers not in existence during preceding year); *see* PPACA § 1513(a) (to be codified at 26 U.S.C. § 4980H(c)(4)(A), amended by PPACA § 10106(f)(1)) (defining full-time employees as persons, “with respect to any month,” who are employed an average of at least 30 hours per week); *see id.* § 1514(a) (to be codified at 26 U.S.C. § 6056(a)) (providing that applicable large employers “required to meet the requirements of section 4980H with respect to its full-time employees during a calendar year” are required to file a return meeting the requirements of 26 U.S.C. § 6056(b)); *see id.* § 1411(e)(4)(B)(iii) (to be codified at 42 U.S.C. § 18081(e)(4)(B)(iii)) (regarding employer notification of potential penalty assessment); *see id.* § 1513(a) (to be codified at 26 U.S.C. § 4980H(c)(2)(E), amended by HCERA § 1003(c)) (taking into account the hours of service performed by part-time workers in determining whether the employee threshold is met).

217. *Id.* § 10106(f)(2) (to be codified at 26 U.S.C. § 4980H(c)(2)(D)(i)(I), amended by HCERA § 1003(a)); PPACA § 1513(a) (to be codified at 26 U.S.C. § 4980H(a), (c)(1), amended by HCERA § 1003(b)(2)).

218. *Id.* (to be codified at 26 U.S.C. § 4980H(b)(1)); *id.* § 1411(a)(e)(4)(B)(iii) (to be codified at 42 U.S.C. § 18081(e)(4)(B)(iii)); *id.* § 1501(b) (to be codified at 26 U.S.C. § 5000A(f)(1)-(2)); *id.* § 1401(a) (to be codified at 26 U.S.C. § 36B(c)(2)(C)(i)-(iii)). *But see id.* § 1513(a) (to be codified at 26 U.S.C. § 4980H(b), (c)(2)(B), amended by PPACA § 10108(i)(1)(A)) (providing an exception from the penalty for employers providing Free Choice Vouchers pursuant to 42 U.S.C. § 18101).

receive the tax credit or cost-sharing reduction for the month multiplied by \$250 (1/12 of \$3000).²¹⁹

Employers are prohibited from retaliating against employees because the employee (or someone acting at their request) received an Internal Revenue Code section 36B tax credit or cost-sharing reduction; provided information to the employer, the Federal Government or the State Attorney General of an act or omission that the employee reasonably believed to be a violation of title 29 of the U.S. Code or participated in a proceeding concerning such violation.²²⁰

Free Choice Vouchers

Any employer who offers minimum essential coverage through an employer-sponsored group plan and pays any of the group plan's costs must provide "free choice vouchers" to its qualified employees.²²¹ A "qualified employee" is an employee whose required contribution for coverage under the employer-sponsored plan is greater than 8% of, but "does not exceed 9.8[%] of [their] household income[.]" whose household income is not greater than 400% of their applicable poverty level amount and who does not participate in their employer's health plan.²²²

The voucher is used as a credit towards the employee's monthly premiums for any Exchange-based qualified health plan in which the employee has enrolled.²²³ The employer is responsible for paying the voucher credit amount to the Exchange.²²⁴ The credit amount equals the monthly payment that the employer would have paid towards the health plan costs to cover the employee, assuming that the employee was covered in the employer-provided plan for which the employer "pays the largest portion of the cost."²²⁵ If the voucher credit amount exceeds the premium for the Exchange-based qualified health plan that the employee enrolls in, then the excess is paid to the employee.²²⁶ The voucher credit is excluded

219. PPACA § 1513(a) (to be codified at 26 U.S.C. § 4980H(b)(1)(B), amended by HCERA § 1003(b)(1)), (d). HCERA § 1003(a) amends 26 U.S.C. § 4980H(d)(2)(D), as added by PPACA § 10106(f)(2), to limit the assessable payment to an overall limitation based on the number of full-time employees reduced by 30.

220. *Id.* § 1558 (to be codified at 29 U.S.C. § 218c(a)).

221. *Id.* § 10108(a)-(b) (to be codified at 42 U.S.C. § 18101(a)-(b)). *Id.* § 1514(a) (to be codified at 26 U.S.C. § 6056(f), amended by PPACA § 10108(j)(2)) (making employers subject to the return requirements of § 6056 if any employees' required contribution for coverage exceeds 8% of their wages).

222. *Id.* § 10108(c)(1) (to be codified at 42 U.S.C. § 18101(c)(1)).

223. PPACA § 10108(d)(2) (to be codified at 42 U.S.C. § 18101(d)(2)).

224. *Id.* (to be codified at 42 U.S.C. § 18101(d)(2)).

225. *Id.* § 10108(d)(1)(A), (2) (to be codified at 42 U.S.C. § 18101(d)(1)(A), (2)).

226. *Id.* § 10108(d)(3) (to be codified at 42 U.S.C. § 18101(d)(3)).

from the employee's gross income to the extent that it does not exceed the premiums for the qualified health plan²²⁷ and employers are entitled to a deduction for their voucher payments.²²⁸ This provision applies to vouchers provided after December 31, 2013.²²⁹

L. Premium Tax Credits and Cost-Sharing Reductions

Refundable Tax Credit providing premium assistance for coverage under a Qualified Health Plan

Applicable taxpayers, individuals whose household income equals or exceeds 100% of, but is not greater than 400% of their family's applicable poverty level income, are entitled to an income tax credit equal to their premium assistance credit amount for the taxable year.²³⁰ Household income is equal to modified adjusted gross income, which is adjusted gross income, increased by any tax-exempt interest and by "any amount excluded from gross income under [Internal Revenue Code] section 911."²³¹ Included in household income are the modified adjusted gross incomes of the applicable taxpayer and all other persons who were included in determining the family's size and who were required to file an income tax return for the taxable year.²³²

The premium assistance credit amount is the sum of the monthly premium assistance amounts, determined from the total number of months during the taxable year that the taxpayer, their spouse and any dependents have qualified health plan coverage through an Exchange, as of the first day of each month, with premiums paid by the taxpayer or with the section 1412(a) advance payment credit.²³³ The premium assistance amount for any coverage month is equal to the lesser of:

227. *Id.* § 10108(f)(1) (to be codified at 26 U.S.C. § 139D).

228. PPACA § 10108(g)(1) (to be codified at 26 U.S.C. § 162(a)).

229. *Id.* § 10108(g)(2) (to be codified at 26 U.S.C. § 162(a) note).

230. *Id.* § 1401(a) (to be codified at 26 U.S.C. § 36B(a), (c)(1)(A)); *id.* § 1401(a) (to be codified at 26 U.S.C. § 36B(c)(1)(A), amended by PPACA § 10105(b)); *see also id.* § 1411(b)(1)-(3) (to be codified at 42 U.S.C. § 18081(b)(1)-(3)) (detailing the information required from the applicable taxpayer in order to receive the tax credit); *see also* PPACA § 1415 (to be codified at 42 U.S.C. § 18084).

231. *Id.* § 1401(a) (to be codified at 26 U.S.C. § 36B(d)(2)(B), amended by HCERA § 1004(a)(2)(A)).

232. *Id.* (to be codified at 26 U.S.C. § 36B(d)(1)-(2)(A)).

233. *Id.* (to be codified at 26 U.S.C. § 36B(b)(1), (c)(2)(A)). 26 U.S.C. § 36B(c)(3)(A) (providing that, for purposes of this section, "qualified health plan" does not include catastrophic plans).

- (1) the monthly premiums for individual market qualified health plan coverage for the taxpayer, their spouse and any dependents, acquired through a State Health Insurance Exchange, or
- (2) “the excess (if any) of”
- (i) the taxpayer’s adjusted monthly premium for the second lowest cost individual market silver plan available through the Exchange (“the applicable lowest cost silver plan”), over
 - (ii) “an amount equaling 1/12 of the product of the applicable percentage and the taxpayer’s household income for the taxable year.”²³⁴

The applicable percentage is determined from the initial premium percentage and the final premium percentage, which are provided by the taxpayer’s income tier. The income tiers assign an initial and final premium percentage, based on the taxpayer’s household income, measured as a percentage of Federal Poverty Level (FPL) income, ranging from 100% to 400% of the FPL.²³⁵ The taxpayer’s applicable percentage is then calculated on a “sliding scale in a linear manner,” equal to the percentage within the initial and final premium percentages that is at the same percentile as that of their household income relative to their income tier.²³⁶ For example, if a taxpayer’s household income is 175% of their applicable FPL income, then they are within the 150% to 200% income tier, which has an initial premium percentage of 4% and a final premium percentage of 6.3%.²³⁷ Since their household income is at the 50th percentile within the income tier, their applicable percentage will be at the 50th percentile between their initial and final premium percentages, with an applicable percentage of 5.15%.²³⁸

234. *Id.* § 1401(a) (to be codified at 26 U.S.C. § 36B(b)(2), (b)(3)(C)).

235. PPACA § 1401(a) (to be codified at 26 U.S.C. § 36B(b)(3)(A)(i), amended by HCERA § 1001(a)(1)). The income tiers, initial premium percentages and final premium percentages are:

Income Tier	Initial Premium Percentage	Final Premium Percentage
Up to 133% of FPL	2.0%	2.0%
133% up to 150% of FPL	3.0%	4.0%
150% up to 200% of FPL	4.0%	6.3%
200% up to 250% of FPL	6.3%	8.05%
250% up to 300% of FPL	8.05%	9.5%
300% up to 400% of FPL	9.5%	9.5%

Id. (to be codified at 26 U.S.C. § 36B(b)(3)(A)(i), amended by HCERA § 1001(a)(1)).

236. *Id.* (to be codified at 26 U.S.C. § 36B(b)(3)(A)(i), amended by HCERA § 1001(a)(1)).

237. *Id.* (to be codified at 26 U.S.C. § 36B(b)(3)(A)(i), amended by HCERA § 1001(a)(1)).

238. *See id.* (to be codified at 26 U.S.C. § 36B(b)(3)(A)(i), amended by HCERA § 1001(a)(1)).

The credit does not apply during any month in which an individual is eligible for government-sponsored coverage (Medicare, Medicaid, CHIP, etc.), coverage under a group plan established for governmental employees or an employer-sponsored small or large group market plan, a grandfathered health plan, coverage in a State high risk pool or has a free choice voucher.²³⁹ Employees who are eligible for, but not covered, under a group plan for governmental employees, an employer-sponsored small or large group market plan or a group market grandfathered health plan are entitled to the credit if their required contribution for such coverage exceeds 9.5% of their household income or if the plan's share of "the total allowed costs of benefits" is less than 60%.²⁴⁰

Married couples must file a joint return in order to receive the credit.²⁴¹ In addition, the credit does not apply to insurance premiums paid for individuals not lawfully present in the United States who are allowed as a personal exemption deduction under Internal Revenue Code section 151.²⁴² This limitation also applies to the taxpayer and their spouse, if they are not lawfully present in the United States and are allowed as a personal exemption deduction under Internal Revenue Code section 151.^{242 243}

This provision applies to taxable years ending after December 31, 2013.²⁴⁴

Reduced Cost-Sharing for Individuals Enrolled in Qualified Health Plans

Eligible insureds, individuals enrolled in a silver level individual market qualified health plan through an Exchange, whose household income exceeds 100% of, but is not greater than 400% of their family's respective poverty level income, will receive a reduction in their plan's cost-sharing (as determined under the dollar limits provided under Internal Revenue Code § 223(c)(2)(A)(ii)) from the plan issuer.²⁴⁵ Eligible insureds with

239. PPACA § 1401(a) (to be codified at 26 U.S.C. § 36B(b)(1)-(2),(c)(2)(B)-(C)(iii)); *id.* § 1501(b) (to be codified at 26 U.S.C. § 5000A(f)(1)-(2)); *id.* § 10108(h)(1) (to be codified at 26 U.S.C. § 36B(c)(2)(D)).

240. *Id.* (to be codified at 26 U.S.C. § 36B(c)(2)(C)(i)-(iii), amended by HCERA § 1001(a)(2)(A)). *Id.* § 1501(b) adding 26 USC § 5000A(f)(1)(B), (2).

241. PPACA § 1401(a) (to be codified at 26 U.S.C. § 36B(c)(1)(C)).

242. *Id.* (to be codified at 26 U.S.C. § 36B(e)(1)-(2)).

243. *Id.* (to be codified at 26 U.S.C. § 36B(e)(1)-(2)). *See also* 26 U.S.C. § 151(a)-(c).

244. PPACA § 1401(e) (to be codified at 26 U.S.C. § 36B note).

245. *Id.* § 1402(a)-(c) (to be codified at 42 U.S.C. § 18071(a)-(b)); *see also id.* § 1402(f)(1)-(2) (to be codified at 42 U.S.C. § 18071(f)(1)-(2)); *see id.* § 1402(c)(4) (to be codified at 42 U.S.C. § 18071(c)(4)) (providing that the cost sharing reductions do not apply to benefits offered in addition to the essential health benefits by the plan under PPACA § 1302(b)(5) (to be codified at 42 U.S.C. § 18022(b)(5)), or required by the State under PPACA § 1311(d)(3)(B) (to be codified at 42 U.S.C. §

household income in excess of 100% of, but not greater than 200% of their family's applicable poverty level income, are entitled to a two-thirds reduction in their out-of-pocket cost-sharing amount.²⁴⁶ Those with household incomes in excess of 200% of, but not greater than 300% of their families' applicable poverty level income will receive a cost-sharing reduction of one-half of their annual out-of-pocket amount.²⁴⁷ Eligible insureds whose household income is greater than 300% of, but not greater than 400% of their families' poverty level income will receive a cost-sharing reduction of one-third of their annual out-of-pocket costs.²⁴⁸

Eligible insureds whose family household income is not less than 100% of, but not greater than 150% of their applicable poverty level income are entitled to additional cost-sharing reductions which increase the health plan's share of total allowed costs of benefits to 94%.²⁴⁹ Those with household incomes greater than 150% of, but not more than 200% of their families' applicable poverty level income are entitled to additional cost-sharing reductions that would increase the plan's share of total allowed costs of benefits to 87%.²⁵⁰ Eligible insureds with household incomes greater than 200% of, but not more than 250% of their families' applicable poverty level income are entitled to additional cost-sharing reductions that would increase the plan's share of total allowed costs of benefits to 73%.²⁵¹

Health insurance issuers are entitled to reimbursement for the value of all cost-sharing reductions.²⁵²

The cost-sharing reductions are not allowed for coverage during any month unless it was a "coverage month" for which a credit pursuant to the Internal Revenue Code section 36B premium tax credit was allowed to the insured or to an applicable taxpayer on behalf of the insured.²⁵³ No cost-

18031(d)(3)(B)); *see also id.* § 1411(b)(1)-(3) (to be codified at 42 U.S.C. § 18081(b)(1)-(3)) (listing information required from the eligible insured); *see also id.* § 1415(2) (to be codified at 42 U.S.C. § 18084(2)).

246. PPACA § 1402(c)(1)(A)(i) (to be codified at 42 U.S.C. § 18071(c)(1)(A)(i)); *see id.*, § 1302(c)(1) (to be codified at 42 U.S.C. § 18022(c)(1)) (providing the "annual limitation on cost-sharing," to which the two-thirds reduction is applied).

247. PPACA § 1402(c)(1)(A)(ii) (to be codified at 42 U.S.C. § 18071(c)(1)(A)(ii)).

248. *Id.* § 1402(c)(1)(A)(iii) (to be codified at 42 U.S.C. § 18071(c)(1)(A)(iii)).

249. *Id.* § 1402(c)(2)(A) (to be codified at 42 U.S.C. § 18071(c)(2)(A), amended by HCERA § 1001(b)(2)(A)).

250. *Id.* § 1402(c)(2)(B) (to be codified at 42 U.S.C. § 18071(c)(2)(B), amended by HCERA § 1001(b)(2)(B)).

251. *Id.* § 1402(c)(2) (to be codified at 42 U.S.C. § 18071(c)(2)(C), amended by HCERA § 1001(b)(2)(C)).

252. PPACA § 1402(c)(3)(A) (to be codified at 42 U.S.C. § 18071(c)(3)(A)).

253. *Id.* § 1402(f)(2) (to be codified at 42 U.S.C. § 18071(f)(2)).

sharing reduction is allowed for eligible insureds who are not lawfully present in the United States.²⁵⁴

M. Role of Public Programs

Medicaid coverage for lowest income populations

Beginning on January 1, 2014, individuals whose modified adjusted gross income (or household income for individuals in families with two or more persons) is not greater than 133% of their applicable poverty level income are eligible for Medicaid, if they are under age 65, not entitled to or enrolled for benefits under Parts A or B of Medicare, not pregnant, and are not eligible for Medicaid under Social Security Act section 1904(a)(10)(A)(i)(I)-(VII).²⁵⁵ They must receive benchmark coverage (FEHBP's standard Blue Cross/Blue Shield coverage, State Employees' health coverage, coverage through the state HMO plan with the largest commercial (non-Medicaid) enrollment, or any other coverage approved by the HHS Secretary) or benchmark equivalent coverage.²⁵⁶

Requirement to maintain Medicaid Eligibility Standards Until State Exchange is Fully Operational

As a condition for states to receive Federal quarterly payments for Medicaid during the period beginning on the date of the PPACA's enactment until the date that the HHS Secretary determines that a State Exchange is fully operational, a State may not "have in effect eligibility standards, methodologies, or procedures under the State plan . . . or under any waiver of such plan . . . that are more restrictive" than those that were in effect on the date of the PPACA's enactment.²⁵⁷ This condition only applies to quarterly payments that are to be made during that period.²⁵⁸

From January 1, 2011 until December 31, 2013, this condition for Federal quarterly payments does not apply to "nonpregnant, non-disabled adults who are eligible for medical assistance under the State plan or under

254. *Id.* § 1402(e)(1)(A), (2) (to be codified at 42 U.S.C. § 18071(e)(1)(A), (2)).

255. *Id.* § 2001(a)(1) (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)); *id.* § 2002(a) (to be codified at 42 U.S.C. § 1396a(e)(14)).

256. PPACA § 2001(a)(2)(A) (to be codified at 42 U.S.C. § 1396a(k)(1)). *See* 42 U.S.C. § 1396u-7(b)(1)-(2) (providing definitions of "benchmark" and "benchmark-equivalent" coverage).

257. PPACA § 2001(b)(2) (to be codified at 42 U.S.C. § 1396a(gg)(1)). This requirement applies until September 30, 2019 for changes to Medicaid "eligibility standards, methodologies, and procedures" applicable to "any child who is under 19 years of age (or such higher age as the State may have elected)." *Id.* § 2001(b)(2) (to be codified at 42 U.S.C. § 1396a(gg)(2)). *See also id.* § 2101(b)(1) (to be codified at 42 U.S.C. § 1397ee(d)(3)).

258. *Id.* § 2001(b)(2) (to be codified at 42 U.S.C. § 1396a(gg)(1)).

a waiver . . . whose income exceeds 133[%] of” their applicable poverty level income, “if, on or after December 31, 2010, the State certifies to the [HHS] Secretary that . . . [it] has a budget deficit” during the fiscal year in which the certification is made or that a budget deficit is projected during the succeeding fiscal year.²⁵⁹

N. Improving the Quality and Efficiency of Health Care

Hospital Value-Based purchasing program

Incentive payments will be made to hospitals, beginning on October 1, 2012, for each Medicare patient discharged during the fiscal year if the hospital satisfies certain quality of care measures and meets specified performance standards based on those measures.²⁶⁰ The HHS Secretary will create a methodology to assess a hospital’s performance on the quality of care measures that will be used to determine the “hospital[’s] performance score.”²⁶¹ The methodology used in determining the hospital performance score will determine the distribution of incentive payments among hospitals, and hospitals with the highest scores will receive the largest incentive payments.²⁶²

The HHS Secretary will also publicize information concerning individual hospitals’ performance under the program as well as aggregated information on the number of hospitals receiving incentive payments and the range and amount of such payments.²⁶³

Value-Based Payment Modifier for Physicians

The HHS Secretary must create a payment modifier that will enhance Medicare payments to physicians or physician groups, based on the quality of care they provide relative to the cost of care.²⁶⁴ The HHS Secretary will

259. PPACA § 2001(b)(2) (to be codified at 42 U.S.C. § 1396a(gg)(3)). “Upon submission of such a certification to the Secretary, the requirement . . . shall not apply to the State with respect to any remaining portion of the period” from January 1, 2011 until December 31, 2013. 42 U.S.C. § 1396a(gg)(3).

260. PPACA § 3001(a)(1) (to be codified at 42 U.S.C. § 1395ww(o)(1)(A)-(B), (2), (3)). For fiscal year 2014, the quality of care measures will also incorporate efficiency measures, such as “Medicare spending per beneficiary”, for purposes of determining incentive payments. *Id.* (to be codified at 42 U.S.C. § 1395ww(o)(2)(B)(ii)); *see id.* (to be codified at 42 U.S.C. § 1395ww(o)(2)(A), amended by PPACA § 10335).

261. *Id.* § 3001(a)(1) (to be codified at 42 U.S.C. § 1395ww(o)(5)(A)).

262. *Id.* (to be codified at 42 U.S.C. § 1395ww(o)(5)(B)).

263. PPACA § 3001(a)(1) (to be codified at 42 U.S.C. § 1395ww(o)(10)).

264. *Id.* § 3007(2) (to be codified at 42 U.S.C. § 1395w-4(p)(1)). *See also id.* § 5501(a)(1) (to be codified at 42 U.S.C. § 1395(x)) (providing an incentive payment to primary care practitioners for primary care services furnished on or after January 1, 2011 and before January 1, 2016).

develop quality of care measures to evaluate the care furnished to patients and will evaluate cost “based on a composite of appropriate measures of costs established by the Secretary.”²⁶⁵ “Costs” is defined as “expenditures per individual”²⁶⁶ The payment modifier is to be applied “in a manner that promotes systems-based care”²⁶⁷ and will apply to physicians and physician groups deemed suitable by the HHS Secretary on January 1, 2015 and become applicable to all physicians and physician groups by January 1, 2017.²⁶⁸

Physician Compare Website

By January 1, 2011, the HHS Secretary must develop a website “with information on physicians enrolled in Medicare” pursuant to SSA sec. 1866(j) (applies to payments for inpatient rehabilitation hospital care) and “other eligible professionals who participate in the Physician Quality Reporting Initiative” under SSA sec. 1848 (applies to payments for physician services).²⁶⁹ By January 1, 2013, the Secretary must put in place a plan to publicize through the website information on physician performance that provides comparable information on physician “quality and patient experience measures.”²⁷⁰

Payment adjustment for conditions acquired in hospitals

Beginning in fiscal year 2015, and for subsequent fiscal years, Medicare payments for hospital discharges occurring during the fiscal year will be reduced by 1% for short- term stay, acute care hospitals that are within the top quartile of hospitals, relative to the national average, where patients acquire a condition during their stay.²⁷¹ Prior to each fiscal year, hospitals within the top quartile will receive confidential reports from the HHS Secretary on its record of hospital acquired conditions.²⁷² The HHS Secretary will also post on the Internet information on the hospital acquired conditions of each affected hospital.²⁷³

265. *Id.* § 3007(2) (to be codified at 42 U.S.C. § 1395w-4(p)(2)(A)-(B)(i), (3)).

266. *Id.* (to be codified at 42 U.S.C. § 1395w-4(p)(8)(A)).

267. PPACA § 3007(2) (to be codified at 42 U.S.C. § 1395w-4(p)(5)).

268. *Id.* (to be codified at 42 U.S.C. § 1395w-4(p)(4)(B)(iii)(II)).

269. *Id.* § 10331(a)(1) (to be codified at 42 U.S.C. § 1395w-5(a)(1)).

270. *Id.* § 10331(a)(2) (to be codified at 42 U.S.C. § 1395w-5(a)(2)). This provision applies to physicians enrolled in Medicare under 42 U.S.C. § 1395cc(j). *Id.* § 10331(a)(1) (to be codified at 42 U.S.C. § 1395w-5(a)(2)).

271. PPACA § 3008(a) (to be codified at 42 U.S.C. § 1395ww(p)(1), (2)(A)-(B), (3)); *see also id.* § 2702(b) (to be codified at 42 U.S.C. § 1396b-1(b)) (providing for payment adjustments for “health-care acquired conditions” in the Medicaid program).

272. *Id.* § 3008(a) (to be codified at 42 U.S.C. § 1395ww(p)(5)).

273. *Id.* (to be codified at 42 U.S.C. § 1395ww(p)(6)(A), (C)).

Hospital Readmissions Reduction Program

Short-term stay, acute care hospitals with “excess readmissions,” defined as discharged patients who are readmitted within a specified time frame to the same or a different hospital as a result of certain types of medical conditions or procedures, are subject to reductions in their Medicare discharge payments.²⁷⁴ The payment reductions apply to fiscal years beginning on or after October 1, 2012.²⁷⁵

The HHS Secretary will also post the readmission rates of all applicable hospitals on the Hospital Compare Internet website.²⁷⁶

Medicare Shared Savings Program for Accountable Care Organizations

By January 1, 2012, the HHS Secretary must create a “shared savings program” in which Accountable Care Organizations (ACO) are accountable for, and coordinates the provision of health care services for, Medicare fee-for-service beneficiaries assigned to the ACO.²⁷⁷ An ACO is an affiliated group of health care providers and suppliers operating under a system of common governance.²⁷⁸ ACOs can be made up of physicians or practitioners in group practice, a network of individual medical practices, a partnership or joint venture between a hospital and physicians and practitioners, or a hospital employing physicians and practitioners.²⁷⁹

ACOs are responsible for the “quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it[,]” agree to participate in the program for at least three years, must have a legal structure that allows the ACO to receive and distribute shared savings to the participating health care providers, and must have sufficient numbers of primary care providers to care for the Medicare beneficiaries assigned to it.²⁸⁰ To satisfy eligibility requirements, an ACO must be assigned at least 5,000 Medicare beneficiaries.²⁸¹

274. *Id.* § 3025(a) (to be codified at 42 U.S.C. § 1395ww(q)(1), (5)(A), (C)-(E)).

275. PPACA § 3025(a) (to be codified at 42 U.S.C. § 1395ww(q)(1)).

276. *Id.* (to be codified at 42 U.S.C. § 1395ww(q)(6)(A), (C)).

277. *Id.* § 3022 (to be codified at 42 U.S.C. § 1395jjj(a)(1)(A), (c)).

278. *Id.* (to be codified at 42 U.S.C. § 1395jjj(b)(1)).

279. *Id.* (to be codified at 42 U.S.C. § 1395jjj(b)(1)(A)-(D), (h)(1)).

280. PPACA § 3022 (to be codified at 42 U.S.C. § 1395jjj(b)(2)(A)-(D)). The ACO must also provide the HHS Secretary with information concerning the physicians and practitioners participating within it in order to facilitate the assignment of Medicare beneficiaries, have a “leadership and management structure that includes clinical and administrative systems” and “promote evidence-based medicine[,] [provide] report[s] on quality and cost measures, . . . coordinate care” and demonstrate that it satisfies specified patient-centeredness criteria. 42 U.S.C. § 1395jjj(b)(2)(E)-(H).

281. PPACA § 3022 (to be codified at 42 U.S.C. § 1395jjj(b)(2)(D)).

ACOs that meet certain quality performance standards are eligible for shared savings to the extent that the estimated average per capita Medicare expenditures for their Medicare beneficiaries is, at a minimum, a specified percentage below the ACO's applicable benchmark.²⁸² The shared savings are paid in addition to any payments that service providers and suppliers are already entitled to under the traditional fee-for-service program.²⁸³ The HHS Secretary will determine the benchmark for each ACO based on recent Medicare expenditure data for the ACO's assigned beneficiaries.²⁸⁴ ACOs entitled to the shared savings will receive a percentage of the difference between the estimated per capita Medicare expenditures and the applicable benchmark, with the remainder of the savings retained by Medicare.²⁸⁵

Medicare Advantage payment

Section 1853 of the Social Security Act provides the payment method for Medicare Advantage (MA) plans, which are also referred to as Medicare+Choice.²⁸⁶ MA plans are paid in advance each month for their plan enrollees.²⁸⁷ The plans provide private health insurance coverage to Medicare enrollees, instead of the traditional Medicare plan which compensates health care providers on a fee-for-service basis.²⁸⁸

In order to participate in Medicare Advantage, insurers must provide bids for the costs of covering plan enrollees.²⁸⁹ Beginning in 2006, MA monthly payments depended on whether the plan's bid amount was less than, or, was equal to or in excess of the "MA area-specific non-drug monthly benchmark amount."²⁹⁰

If the bid amount, called the "unadjusted MA statutory non-drug monthly bid amount," was less than the "MA area-specific non-drug monthly benchmark amount," then the MA plan was paid the bid amount, subject to certain adjustments, plus an allowable rebate.²⁹¹ If the bid amount equaled or exceeded "the MA area-specific non-drug monthly

282. *Id.* (to be codified at 42 U.S.C. § 1395jjj(a)(1)(B), (d)(1)-(2)).

283. *Id.* (to be codified at 42 U.S.C. § 1395jjj(d)(1)(A)).

284. *Id.* (to be codified at 42 U.S.C. § 1395jjj(d)(1)(B)(ii)).

285. *Id.* (to be codified at 42 U.S.C. § 1395jjj(d)(2)); *see also* 42 U.S.C. § 1395jjj(d)(3) (providing for sanctions against ACOs which avoid at-risk patients in order to reduce the likelihood of increased health care costs).

286. 42 U.S.C. § 1395w-23(a)(1)(A); *id.* § 1395w-21(a)(2)(i), (ii); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, Sec. 201(a)-(b).

287. 42 U.S.C. § 1395w-23(a)(1)(A).

288. *Id.* § 1395w-21(a)(2).

289. *Id.* § 1395w-24(a)(1)(A).

290. *Id.* § 1395w-23(a)(1)(B)(iii).

291. *Id.* § 1395w-23(a)(1)(B)(i)-(ii); *see also* 42 U.S.C. § 1395w-24(b)(3)(C), (b)(4)(C).

benchmark amount,” then the plan was paid “the MA area-specific non-drug monthly benchmark amount,” subject to certain adjustments.²⁹²

For 2011, “the MA area-specific non-drug monthly benchmark amount” was “1/12 of the applicable amount determined under” SSA sec. 1853(k)(1) for 2010, which was the greater of (i) “102% of the annual MA capitation rate . . . for the previous year[.]” (ii) “the annual MA capitation rate . . . for the previous year increased by that year’s national per capita MA growth percentage.”²⁹³ The greater of those two amounts will be increased by the 2011 national per capital MA growth percentage.²⁹⁴

For the 2012 plan year, the MA area-specific non-drug monthly benchmark amount will be 1/12 of a blended benchmark.²⁹⁵ The blended benchmark is the sum of: (i) “1/2 of the applicable amount [determined] for the area” for 2012 (under SSA sec. 1853(k)(1)(B)), plus (ii) 1/2 of 100% of the fee for service costs for the area, multiplied by the applicable percentage.²⁹⁶ The applicable percentage is determined based upon whether the area’s fee for service costs places it within the highest, second highest, third highest or the lowest quartile, relative to other areas.²⁹⁷ Areas ranked in the highest quartile for the previous year have an applicable percentage of 95%, the second highest quartile, 100%, the third highest quartile, 107.5%, and areas ranked in the lowest quartile have an applicable percentage of 115%.²⁹⁸

For subsequent years, the blended benchmark amount is determined by the area’s fee for service costs multiplied by the applicable percentage.²⁹⁹

Part D Prescription Drug Benefit

Medicare Part D provides subsidized prescription drug coverage to Medicare beneficiaries.³⁰⁰ Benefits under the program became available on

292. *Id.* § 1395w-23(a)(1)(B)(ii).

293. HCERA § 1102(b)(1) (to be codified at 42 U.S.C. § 1395w-23(j)(1)(A)); 42 U.S.C. § 1395w-23(c)(1)(C)(v), (k)(1)(B)(i). If 2010 is a specified year, pursuant to SSA § 1853(c)(1)(D)(ii), then the applicable amount under § 1853(k)(1) is the greater of (i) 102% of the annual MA capitation rate for the previous year, (ii) the annual MA capitation rate for the previous year, increased by that year’s national per capita MA growth percentage, or (iii) 100% of the fee-for-service costs. 42 USC § 1395w-23(c)(1)(C)(v), (D)(i), (k)(1)(B)(ii).

294. *Id.* § 1395w-23(k)(1)(B)(i)

295. HCERA § 1102(b)(1) amending 42 USC § 1395w-23(j)(1)(A).

296. *Id.* § 1102(b)(2) (to be codified at 42 U.S.C. § 1395w-23(n)(1)(A), (2)(A), (E)).

297. *Id.* (to be codified at 42 U.S.C. § 1395w-23(n)(2)(B)-(C)). The fee for service amount is “adjusted to take into account the phase-out in the indirect costs of medical education capitation rates described in subsection [1853](k)(4).” *Id.* amending 42 USC § 1395w-23(n)(2)(A)(i).

298. *Id.* (to be codified at 42 U.S.C. § 1395w-23(n)(2)(B)).

299. HCERA § 1102(b)(2) (to be codified at 42 U.S.C. § 1395w-23(n)(1)(B), (2)(A)).

300. 42 U.S.C. § 1395w-101(a)(1), (3)(A).

January 1, 2006.³⁰¹ Medicare beneficiaries enrolled in the traditional Medicare fee-for-service program can enroll in a prescription drug plan (PDP) in their geographic region, but, persons enrolled in a Medicare Advantage plan must receive prescription drug coverage through their Medicare Advantage plan (MA-PD).³⁰²

Standard Prescription Drug Coverage under Part D includes: (i) a \$250 deductible, adjusted for the annual percentage increase in the per capita Part D drug expenditures among Part D eligible individuals,³⁰³ (ii) a 25% coinsurance obligation for drug costs in excess of the deductible and up to an initial coverage limit of \$2,250, adjusted for the Part D annual percentage increase,³⁰⁴ (iii) an annual out of pocket amount, or “donut hole,” of \$3,600, adjusted for the Part D annual percentage increase, for drug costs exceeding the \$2,250 coverage limit,³⁰⁵ and, (iv) after satisfying the donut hole, the enrollee will pay the greater of a 5% coinsurance amount or a copayment of \$2 for generic drugs and \$5 for non-generics.³⁰⁶

Coverage under Part D applies to drugs requiring a prescription and insulin, and to smoking cessation drugs, pursuant to the PPACA.³⁰⁷ Under the Standard Drug Coverage, enrollees will be charged the “negotiated prices” for drugs, which is the price paid to the pharmacy or mail order service dispensing the drug to the plan enrollee, less any discounts, price concessions, rebates and direct or indirect subsidies passed on by the PDP or MA-PD plan sponsor to the enrollee.³⁰⁸

Coverage for Drugs in the Coverage Gap

PDP or MA-PD enrollees who are not enrolled in a qualified retiree PDP, are ineligible for an income subsidy under SSA sec. 1860D-14(a) and who have reached or exceeded the initial coverage limit of \$2,250, but have not exceeded the annual out-of-pocket amount of \$3,600 (and are within the donut hole), are entitled to reductions on the costs of drugs covered under Part D.³⁰⁹ For generic drugs, the enrollee has a 93% coinsurance percentage for 2011, which decreases by 7% for each year from 2012 through 2019, and will have a 25% coinsurance percentage for 2020 and succeeding

301. *Id.* § 1395w-101(a)(2).

302. *Id.* § 1395w-101(a)(1)(A), (B)(i)-(iv), (b)(1)(B)(i).

303. *Id.* § 1395w-102(b)(1)(A)(i)-(ii).

304. *Id.* § 1395w-102(b)(2)(A)(i), (3)(A)(i)-(ii)

305. 42 U.S.C. § 1395w-102(b)(4)(B)(i)(I)

306. *Id.* § 1395w-102(b)(4)(A)(i)(I)-(II).

307. *Id.* § 1395w-102(e)(1)-(2)(A).

308. *Id.* § 1395w-102(d)(1)(A)-(B); 42 C.F.R. § 423.100 (2010) (defining “negotiated prices”).

309. HCERA § 1101(b)(3)(C) (to be codified at 42 U.S.C. § 1395w-102(b)(2)(C)-(D)); *see also* PPACA § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(g)(1)).

years.³¹⁰ For non-generic drugs, the benefit does not take effect until 2013 when enrollees will have a coinsurance rate equal to the difference between a declining “applicable gap percentage,” which will be 97.5% for 2013, gradually reduced to 75% for 2020 and succeeding years, minus the 50% “discount percentage.”³¹¹

Increase in monthly beneficiary premiums for higher income enrollees

An enrollee’s monthly premium payment for Part D prescription drug coverage is the base beneficiary premium, increased by premiums for supplemental drug benefits, a late enrollment penalty, and reduced by low-income assistance subsidies provided pursuant to SSA sec. 1860D-14.³¹² Beginning in 2011, the monthly premium will increase for Part D enrollees whose modified adjusted gross income for the year exceeds \$80,000 (or \$160,000 for joint returns).³¹³ Modified adjusted gross income “means adjusted gross income, determined without regard to [IRC] sections 135, 911, 931, . . . 933[,]” increased by the taxpayer’s tax exempt interest.³¹⁴ The increase in the monthly beneficiary premium is determined on a sliding scale, as the taxpayer’s modified adjusted gross income exceeds the \$80,000 and \$160,000 income thresholds.³¹⁵ Determinations of any income-related premium increase are made by the Social Security Commissioner.³¹⁶

Medicare Coverage Gap Discount Program

The HHS Secretary was responsible for creating a program whereby drug manufacturers must agree to provide price discounts to applicable

310. HCERA § 1101(b)(3)(C) (to be codified at 42 U.S.C. § 1395w-102(b)(2)(C)(ii)). “Coinsurance” is “[t]he percentage of allowed charges for covered services that you’re required to pay. For example, the health insurance may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%.” HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/c/coinsurance.html>. (last visited Apr. 13, 2012).

311. HCERA § 1101(b)(3)(C) (to be codified at 42 U.S.C. § 1395w-102(b)(2)(D)).

312. 42 U.S.C. § 1395w-113(a)(1)(A), (C)-(E). The base beneficiary premium is also increased for above average bids to cover plan enrollees and reduced for below average bids. *Id.* § 1395w-113(a)(1)(B)(i)-(iii).

313. PPACA § 3308(a)(1) (to be codified at 42 U.S.C. § 1395w-113(a)(7)(A), (C)); *Id.* § 3308(b)(1)(C) (to be codified at 42 U.S.C. § 1395w-113(a)(1)(F)); 42 U.S.C. § 1395r(i)(6). The income thresholds are adjusted for inflation, however, from 2011 until 2019, the threshold amounts applicable for those years will be the threshold amount determined for 2010. *Id.* § 1395w-113(a)(7)(A); PPACA § 3402 (to be codified at § 42 U.S.C. § 1395r(i)(6); 42 U.S.C. § 1395r(i)(5), (6)).

314. PPACA § 3308(a)(1) (to be codified at 42 U.S.C. § 1395w-113(a)(7)(A), (C); 42 U.S.C. § 1395r(i)(4)(A)).

315. PPACA § 3308(a)(1) (to be codified at 42 U.S.C. § 1395w-113(a)(7)(B); 42 U.S.C. § 1395r(i)(3)(C)(i)).

316. PPACA § 3308(a)(1) (to be codified at 42 U.S.C. § 1395w-113(a)(7)(D)).

beneficiaries in order to have their drugs covered under the Part D program.³¹⁷ Applicable beneficiaries are individuals enrolled in a PDP or MA-PD drug plan who are not enrolled in a qualified retiree PDP, are ineligible for the SSA sec. 1860D-14 income-related subsidy, and whose drug costs have reached or exceed the initial coverage limit but have not exceeded the out-of-pocket threshold, at the time the drug is dispensed.³¹⁸

The discount price will be available at the point-of-sale and applies to non-generic drugs requiring a prescription and included on the PDP or MA-PD formulary, available under the PDP or MA-PD plan benefits in the absence of a formulary, or are provided under an exception or by appeal.³¹⁹ The discounted price is “50[%] of the negotiated price[,]” which is the price that would otherwise be paid by the plan enrollee to the pharmacy or mail order service dispensing the drug, “reduced by [any] discounts, rebates, . . . price concessions, and direct or indirect” subsidies passed on by the drug plan sponsor to the plan enrollee at the point of sale.³²⁰ The discount price is to be applied before drug coverage or financial assistance determinations under other programs are made in regards to the purchase or provision of the drug.³²¹ If, however, a PDP or MA-PD plan enrollee has supplemental prescription drug coverage under their plan, then the discounted price will not apply until after the supplemental benefits have been applied towards the purchase of the drugs.³²²

Drug manufacturers must enter into agreements with the HHS Secretary to participate in the Medicare Coverage Gap Discount Program, however, the administration of the program and the manufacturer’s compliance is performed by a third party contractor.³²³

317. *Id.* § 3301(a) (to be codified at 42 U.S.C. § 1395w-153(a)); *id.* § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(a), (b)(1)). *But see* 42 U.S.C. § 1395w-153(c) (providing an exception to the requirement that the manufacturer have an agreement in place with HHS in order for its drugs to be covered under Part D). *See also, id.* § 1395w-114a(c)(1), (d)(1), (3) (regarding the requirement that the discount program be administered by a third party contractor); *see also* Cynthia G. Tudor & Tom Hutchinson, *Medicare Coverage Gap Discount Program Beginning in 2011*, CTRS. FOR MEDICARE & MEDICAID SERVS., 1 (Apr. 30, 2010), https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2011CoverageGapDiscount_043010.pdf.

318. PPACA § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(g)(1)).

319. *Id.* (to be codified at 42 U.S.C. § 1395w-114a(b)(1)(A)-(B), (g)(2)).

320. *Id.* (to be codified at 42 U.S.C. § 1395w-114a(g)(4)(A)); 42 C.F.R. § 423.100 (2010) (defining “negotiated price”).

321. PPACA § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(c)(1)(A)(v)).

322. 42 U.S.C. § 1395w-102(a)(2); PPACA § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(c)(2)).

323. PPACA § 3301(b) (to be codified at 42 U.S.C. § 1395w-114a(a), (b)(1), (c)(1), (d)(1), (3)).

*Independent Payment Advisory Board (formerly known as the
Independent Medicare Advisory Board)*

The PPACA creates an “Independent Payment Advisory Board.”³²⁴ The Board’s sole purpose is to “reduce the per capita rate of growth in Medicare spending” by proposing recommendations to reduce costs.³²⁵ The Board’s power is tied to a three-year cycle in which the first year is called the “determination year,” the second year is the “proposal year” and the third year in the cycle is the “implementation year.”³²⁶ The Board’s authority is triggered when the Chief Actuary for the Center for Medicare & Medicaid Services (CMS) estimates, during the determination year, that the projected per capita growth rate for Medicare during the implementation year will exceed that year’s target growth rate.³²⁷ The Chief Actuary will make its determination before “April 30, 2013 and annually thereafter”³²⁸ If the projected growth rate exceeds the target rate, then, during the proposal year, the Board is required to develop and submit to the President and Congress “detailed and specific proposals” to reduce the Medicare per capita growth rate.³²⁹ The HHS Secretary is required to implement those proposed recommendations on August 15th of the proposal year, unless Congress enacts legislation prior to August 15th superseding the Board’s recommendations for that proposal year or enacts a joint resolution, introduced by February 1, 2017 and passed by August 15, 2017, which discontinues the automatic implementation process for the 2020 implementation year and for subsequent implementation years.³³⁰

The Board’s proposals must include recommendations that will reduce, on a net basis, Medicare program spending during the implementation year by an amount that is “at least equal to” that year’s “applicable savings

324. *Id.* § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(a), amended by PPACA § 10320(b)); 42 U.S.C. § 1395kkk(k)(1) (creating a “consumer advisory council to advise the Board on the impact of payment policies . . . on consumers”).

325. PPACA § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(b), (c)(2)(A)(i)).

326. *Id.* (to be codified at 42 U.S.C. § 1395kkk(b)(1)-(2)).

327. *Id.* (to be codified at 42 U.S.C. § 1395kkk(b)(1)-(2), (c)(6)).

328. *Id.* (to be codified at 42 U.S.C. § 1395kkk(c)(6)(A)).

329. *Id.* (to be codified at 42 U.S.C. § 1395kkk(b)(2), (c)(1)(A), (2)); PPACA § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(c)(3)(A)(i), amended by PPACA § 10320(a)(1)(D)); *see also id.* § 3401 (to be codified at 42 U.S.C. § 1395kkk(n)-(o), amended by PPACA § 10320(a)(5)) (requiring the Board to produce an annual public report “containing standardized information on system-wide health care costs, patient access to care, utilization, and quality of care” and bi-annual advisory recommendations to slow the growth of national health expenditures (not including Federal health care programs)).

330. *Id.* § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(b)(3), (c)(3)-(4), (e)(1), (3), (f)(1), (2)(F), (3)); *see id.* § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(e)(3)(B), amended by PPACA § 10320(a)(3)(B)); *see id.* § 3403(e) (to be codified at 42 U.S.C. § 1395kkk(e)(3)(B), amended by PPACA § 10320(a)(3)) (creating a “Limited additional exception” to the Secretary’s authority to implement the proposed recommendations).

target.”³³¹ The proposals cannot include recommendations “to ration health care, raise revenues or Medicare beneficiary premiums under section [1818, 1818A, or 1839,] increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”³³² The proposals may reduce Medicare payments under Parts C and D by reducing certain direct subsidy payments for MA and PDP plans, denying or removing high bids for PDP coverage in calculating the national average monthly bid amount and reducing payments related to certain administrative expenses and performance bonuses for MA plans.³³³

In developing and submitting its proposals, the Board must “give priority to recommendations that extend Medicare[’s] solvency[,]” “improve health care delivery . . . and . . . outcomes[,]” “protect and improve Medicare beneficiaries’ access to necessary and evidence-based items and services[,]” and reduce Medicare spending on “sources of excess cost growth”³³⁴ In addition, the proposals must be designed so that the implementation of the Board’s recommendations “would not be expected to” increase the total amount of net Medicare program spending over the 10-year period, beginning with the implementation year, as compared to the total amount of net Medicare spending “that would have occurred absent such implementation.”³³⁵

Patient-Centered Outcomes Research

In order to fund a Patient-Centered Outcomes Research Trust Fund, a fee is imposed on accident or health insurance policies issued with respect to individuals residing in the U.S. and on self-insured plans providing accident or health coverage.³³⁶ The fee is computed by multiplying \$2 by the “average number of lives covered under the policy[,]” or self-insured plan, for policy years ending after September 30, 2012 (the fee is reduced to \$1 for policy years ending during fiscal year 2013).³³⁷ The fee is paid by the policy issuer of the group or individual accident or health policies or by the plan sponsor for self-insured plans.³³⁸ The obligation to pay the fee does not apply to policy years ending after September 30, 2019.³³⁹ Medical

331. PPACA § 3403(a)(1) (to be codified at 42 U.S.C. § 1395kkk(c)(2)(A)(i), (c)(6)-(7)).

332. *Id.* (to be codified at 42 U.S.C. § 1395kkk(c)(2)(A)(ii)).

333. *Id.* (to be codified at 42 U.S.C. § 1395kkk(c)(2)(A)(iv)).

334. *Id.* (to be codified at 42 U.S.C. § 1395kkk(c)(2)(B)).

335. *Id.* (to be codified at 42 U.S.C. § 1395kkk(c)(2)(C)).

336. PPACA § 6301(e)(2)(A) (to be codified at 26 U.S.C. §§ 4375(a), (c)(1); 4376(a), (c)).

337. *Id.* (to be codified at 26 U.S.C. §§ 4375(a); 4376(a)).

338. *Id.* (to be codified at 26 U.S.C. §§ 4375(b), (c)(1); 4376(b)(1)).

339. *Id.* (to be codified at 26 U.S.C. §§ 4375(e); 4376(e)).

coverage provided through Medicare, Medicaid, SCHIP, and medical coverage established by Federal law for members of the Armed Forces, veterans, and members of Indian tribes are exempt from the fees.³⁴⁰

Sense of the Senate regarding Medical Malpractice

No medical malpractice reform provisions were included in the PPACA. The PPACA does include a “[S]ense of the Senate” resolution which encourages States to utilize different approaches to addressing medical malpractice issues and encourages Congress to “consider establishing” State demonstration projects to evaluate alternatives to the current litigation system.³⁴¹

Community Living Assistance Services and Supports (CLASS Act)

The CLASS Act established “a national voluntary insurance program for purchasing community living assistance services and supports”³⁴² Benefits would have been paid to eligible beneficiaries when a determination was made by a licensed health care practitioner that, for a continuous period exceeding ninety days: the beneficiary (i) is unable to perform at least two or three activities of daily living (eating, toileting, bathing, dressing, etc.) without substantial assistance, (ii) “requires substantial supervision to protect [them] from threats to health and safety due to substantial cognitive impairment[,]” or (iii) “has a level of functional limitation similar . . . to the . . . limitations described in . . . (i) or (ii).”³⁴³

An “eligible beneficiary” is an individual enrolled in the CLASS program, who has paid premiums to maintain enrollment and, as of the date on which the determination is made, has paid premiums for at least sixty months, has earned wages or income for at least three years during the sixty month period equal to the amount necessary to receive credit for a quarter of coverage under Social Security Act section 213(d), and has paid premiums for twenty-four consecutive months if he or she had a lapse in payments lasting more than three months, which occurred between the date of his or her enrollment and the date of the determination.³⁴⁴

340. *Id.* § 6301(e)(2)(A) (to be codified at 26 U.S.C. § 4377(b)(3)).

341. PPACA § 6801(2)-(3); *see id.* § 10607 (to be codified at 42 U.S.C. § 280g-15(a)) (authorizing State Demonstration Grants for the “development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations”).

342. *Id.* § 8002(a)(1) (to be codified at 42 U.S.C. § 3001l).

343. *Id.* (to be codified at 42 U.S.C. §§ 3001l-1(3)); 3001l-2(a)(1)(C)).

344. *Id.* (to be codified at 42 U.S.C. § 3001l-1(6)(A)).

The Obama Administration has recently announced that it will repeal the CLASS program due to concerns about its financial sustainability.³⁴⁵

O. Revenue Provisions

Excise Tax on High-Cost Employer-Sponsored Health Coverage

For taxable years beginning after December 31, 2017, a tax equal to 40% of the “excess benefit” applies to employees receiving excludable employer-provided group health coverage.³⁴⁶ The “excess benefit” is the sum of the monthly excess amounts computed during the taxable year.³⁴⁷ The “monthly excess amount” is the excess of the monthly cost of the employer-provided coverage over “\$10,200 multiplied by the health cost adjustment percentage” for self-only coverage, or “\$27,500 multiplied by the health cost adjustment percentage” for other types of coverage.³⁴⁸

The “health cost adjustment percentage” equals “100 percent plus the excess (if any) of—(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 . . . exceeds such cost for plan year 2010, over (II) 55 percent.”³⁴⁹

The excess benefit is calculated by the employer, but the tax is paid by the coverage provider, which will either be the insurance issuer, the employer, or the plan administrator, depending on the type of coverage provided.³⁵⁰ This tax applies to “employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.”³⁵¹

345. See Robert Pear, *Health Law to Be Revised by Ending a Program*, N.Y. TIMES, Oct. 14, 2011, available at <http://www.nytimes.com/2011/10/15/health/policy/15health.html?hp>.

346. PPACA § 9001(c) (to be codified at 26 U.S.C. § 4980I note, amended by HCERA § 1401(b)(1)); *id.* § 9001(a) (to be codified at 26 U.S.C. § 4980I(a), (b)(1), (d)(1)(D)). The tax also applies to self-employed group health plans where a deduction under 26 U.S.C. § 162(l) applies. 26 U.S.C. § 4980I(d)(1)(D); *see also id.* § 106 (excluding employer-provided accident and health insurance from gross income).

347. PPACA § 9001(a) (to be codified at 26 U.S.C. § 4980I(b)(1)).

348. *Id.* § 9001(b)(3)(B) (to be codified at 26 U.S.C. § 4980I(b)(3)(B), amended by HCERA § 1401(a)(1)); *id.* § 9001(b)(3)(C) (to be codified at 26 U.S.C. § 4980I(b)(3)(C)(i), amended by HCERA § 1401(a)(2)(A)-(B)); *id.* § 9001(a) (to be codified at 26 U.S.C. § 4980I(b)(1)-(3)(C)(i), (f)(1)).

349. *Id.* § 9001(a) (to be codified at 26 U.S.C. § 4980I(b)(3)(C)(ii), amended by HCERA § 1401(a)(2)(C)).

350. PPACA § 9001(a) (to be codified at 26 U.S.C. § 4980I(c)(1)-(2), (4)).

351. *Id.* (to be codified at 26 U.S.C. § 4980I(d)(1)(C)).

Inclusion of cost of Employer-Sponsored Health Coverage on W-2

This provision requires an employee's W-2 form to include the aggregate cost of employer-provided group health coverage, beginning in 2011.³⁵²

Distributions for medicine qualified only if for prescribed drug or insulin

For Health Savings Accounts (HSAs) and Archer MSAs, amounts paid for medicine or drugs are treated as "qualified medical expenses" only if it requires a prescription or is insulin.³⁵³ The PPACA also increases the tax rate for amounts paid or distributed from these accounts, that are not used for qualified medical expenses, from 10% to 20% for HSAs and 15% to 20% for Archer MSAs.³⁵⁴ For Flexible Spending Arrangements and Health Reimbursement Arrangements, medicine and drugs are reimbursable medical expenses only if they are a prescribed drug or insulin.³⁵⁵

These changes apply after December 31, 2010.³⁵⁶

Limitation on health flexible spending arrangements under cafeteria plans

"[I]f a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement," it is not treated as an excludable qualified benefit under a IRC section 125 cafeteria plan unless the plan provides that an employee "may not elect for any taxable year to have salary reduction contributions in excess of \$2,500 made to such arrangement."³⁵⁷ This change applies to taxable years after December 31, 2012.³⁵⁸

Additional Requirements for Charitable Hospitals

This provision amends IRC section 501(r) by providing that 501(c)(3) hospital organizations will not be treated as tax-exempt unless they satisfy

352. *Id.* § 9002(a) (to be codified at 26 U.S.C. § 6051(a)(14)).

353. *Id.* § 9003(a)-(b) (to be codified at 26 U.S.C. §§ 220(d)(2)(A); 223(d)(2)(A); *id.* § 9003(c) (to be codified at 26 U.S.C. § 106(f) (defining "qualified medical expenses").

354. PPACA § 9004(a)-(b) (to be codified at 26 U.S.C. §§ 220(f)(4)(A); 223(f)(2)(A)).

355. *Id.* § 9003(c) (to be codified at 26 U.S.C. § 106(f)).

356. *Id.* § 9003(d)(1) (to be codified at 26 U.S.C. § 220 note); *id.* § 9003(d)(2) (to be codified at 26 U.S.C. § 106 note); *id.* § 9004(c) (to be codified at 26 U.S.C. § 220 note).

357. PPACA § 9005(a)(2) (to be codified at 26 U.S.C. § 125(i)); *see id.* § 10902(a) (to be codified at 26 U.S.C. § 125(i)(2)) (providing for inflation adjustments for the \$2,500 salary reduction limitation).

358. *Id.* § 10902(b) (to be codified at 26 U.S.C. § 125 note, amended by HCERA § 1403(a)).

requirements related to their community needs assessment, their financial assistance and billing policies, and their billing collection practices.³⁵⁹ With the exception of the community health needs assessment, which applies to taxable years beginning two years after the PPACA's enactment, the other requirements apply to taxable years beginning after the PPACA's enactment.³⁶⁰

Section 501(r) applies to organizations operating a hospital licensed, registered, or recognized by a State and to organizations whose tax exemption is determined by the Treasury Secretary to be based upon the provision of health care as the organization's principal function or purpose.³⁶¹

The community health needs assessment requires the organization to periodically examine the health needs of the community that it serves, to receive input from "persons who represent the broad interests of the community served by the hospital facility," and to adopt an implementation strategy to address those identified health needs.³⁶² The community health needs assessment must be performed during the taxable year or during either of the two preceding taxable years.³⁶³ Hospitals subject to IRC section 501(r) which fail to satisfy the community health needs assessment requirements are subject to a \$50,000 tax.³⁶⁴

The organization must have a written financial assistance policy which includes the eligibility requirements for assistance, whether the assistance includes free or discounted care, "the basis for calculating amounts charged to patients," the methods of applying for assistance, the actions the organization may take in the event of non-payment, and a written policy requiring the organization to provide emergency medical care regardless of an individual's financial eligibility under the policy.³⁶⁵ The organization must also "widely publicize" the policy within the community that it serves.³⁶⁶

To comply with the billing requirement provisions, individuals eligible for financial assistance under the organization's policy cannot be charged more than the "amounts generally billed" to insured individuals for "emergency or other medically necessary care" and the organization must

359. *Id.* § 9007(a) (to be codified at 26 U.S.C. § 501(r)(1)).

360. *Id.* § 9007(f)(1)-(2) (to be codified at 26 U.S.C. § 501 note).

361. PPACA § 9007(a) (to be codified at 26 U.S.C. § 501(r)(2)(A)).

362. *Id.* § 9007(a) (to be codified at 26 U.S.C. § 501(r)(3)). The community needs assessment must be "made widely available to the public." *Id.* (to be codified at 26 U.S.C. § 501(r)(3)(B)(ii)).

363. *Id.* (to be codified at 26 U.S.C. § 501(r)(3)(A)).

364. *Id.* § 9007(b)(1) (to be codified at 26 U.S.C. § 4959).

365. PPACA § 9007(a) (to be codified at 26 U.S.C. § 501(r)(4)(A)(i)-(iv), (B)).

366. *Id.* (to be codified at 26 U.S.C. § 501(r)(4)(A)(v)).

prohibit the use of “gross charges,” which are the marked-up prices for hospital supplies and services.³⁶⁷

The hospital organization must also make reasonable efforts in determining whether an individual is eligible for financial assistance under its policy before taking “extraordinary collection actions” against that individual.³⁶⁸

In addition, each hospital organization subject to IRC section 501(r) must provide a description of its efforts in fulfilling its community needs assessment in its annual return³⁶⁹ and the Treasury Secretary, or their delegate, must review the community benefit activities of each hospital organization subject to IRC section 501(r) once every three years.³⁷⁰

Imposition of annual fee on branded prescription pharmaceutical manufacturers and importers

Manufacturers or importers of branded prescription drugs whose aggregate branded prescription drug sales to (or pursuant to coverage under) Medicare Part B or D, Medicaid, the Department of Defense or Veterans Affairs, and the TRICARE retail pharmacy program exceed \$5,000,000, are subject to an annual fee, beginning in 2011.³⁷¹ The fee for each entity is determined by multiplying the applicable amount by a fraction in which: (i) the numerator is a percentage (10, 40, 75 or 100%, depending on the dollar amount of branded drug sales) of the entity’s branded drug sales to specified government programs during the preceding year and, (ii) the denominator is the aggregate amount of branded drug sales determined under (i) for all entities subject to the fee.³⁷²

Appropriations equal to the amount of the collected fees will be added to the Medicare Part B trust fund.³⁷³ The fees are treated as an excise tax, but they are not deductible.³⁷⁴

367. *Id.* (to be codified at 26 U.S.C. § 501(r)(5); *see id.* § 10903(a) (to be codified at U.S.C. § 501(r)(5)(A)) (removing the language “the lowest amounts charged” and replacing it with “the amounts generally billed”).

368. *Id.* § 9007(a) (to be codified at 26 U.S.C. § 501(r)(6)).

369. PPACA § 9007(d)(1) (to be codified at 26 U.S.C. § 6033(b)(15)).

370. *Id.* § 9007(c) (to be codified at 26 U.S.C. § 501 note).

371. *Id.* § 9008(a)(1) (to be codified at 26 U.S.C. § 4001(a)(1), amended by HCERA § 1404(a)(1)); *id.* § 9008(a), (b)(2), (d)(1), (e) (to be codified at 26 U.S.C. § 4001(a), (b)(2), (d)(1), (e). “This section shall apply to calendar years beginning after December 31, 2010.” *Id.* § 9008(j) (to be codified at 26 U.S.C. § 4001(j), amended by HCERA § 1404(a)(4)).

372. PPACA § 9008(b)(1)-(2) (to be codified at 26 U.S.C. § 4001(b)(1)-(2), amended by HCERA § 1404(a)(2)(A)). The applicable amount is \$2,500,000,000 for 2011, \$2,800,000,000 for 2012-13, \$3,000,000,000 for 2014-16, \$4,000,000,000 for 2017, \$4,100,000,000 for 2018, and \$2,800,000,000 for 2019 and subsequent years. *Id.* § 9008(b)(2) (to be codified at 26 U.S.C. § 4001(b)(2), amended by HCERA § 1404(a)(2)(B)).

373. *Id.* § 9008(c) (to be codified at 26 U.S.C. § 4001(c)).

Excise Tax on Medical Device Manufacturers

A tax of 2.3% is imposed on the price of “taxable medical device[s] [sold] by its manufacturer, producer, or importer”³⁷⁵ “Taxable medical devices” are instruments, machines, or implements intended for human use,³⁷⁶ but does not include eyeglasses, contact lenses, hearing aids, and other devices which are “generally purchased by the general public at retail for individual use.”³⁷⁷ This provision applies to sales occurring after December 31, 2012.³⁷⁸

Imposition of annual fee on health insurance providers

Beginning in 2014, any entity in the business of providing health insurance for U.S. health risks, which are the health risks of a U.S. citizen or resident, or a person within the U.S. (but only for the period they are within the U.S.), may be subject to an annual fee.³⁷⁹

The fee only applies to entities whose net premiums written for U.S. health risks exceeded \$25,000,000 during the preceding year.³⁸⁰

The annual fee for each entity is determined by multiplying the applicable amount by a fraction in which: (i) the numerator is 50% (for entities whose net premiums exceed \$25,000,000 but do not exceed \$50,000,000) or 100% (for entities whose net premiums exceed \$50,000,000) of the previous year’s net premiums written for U.S. health risks, and (ii) the denominator is the aggregate amount determined under (i) for all entities subject to the fee.³⁸¹ The applicable amount is \$8,000,000,000 for 2014, \$11,300,000,000 for 2015-16, \$13,900,000,000 for 2017, and \$14,300,000,000 for 2018.³⁸² For years after 2018, “the

374. *Id.* § 9008(f) (to be codified at 26 U.S.C. § 4001(f)); I.R.C. § 275(a)(6).

375. HCERA § 1405(a)(1) (to be codified at 26 U.S.C. § 4191(a)).

376. *Id.* § 1405(a)(1) (to be codified at 26 U.S.C. § 4191(b)(1)); 21 U.S.C. § 321(h) (defining “device”).

377. HCERA § 1405(a)(1) (to be codified at 26 U.S.C. § 4191(b)(2)).

378. *Id.* § 1405(a)(1) (to be codified at 26 U.S.C. § 4191(c)).

379. PPACA § 9010(a)(1) (to be codified at 26 U.S.C. § 4001(a)(1), amended by HCERA § 1406(a)(1)); *id.* § 9010(c)(1) (to be codified at 26 U.S.C. § 4001(c)(1), amended by HCERA § 1406(a)(3)(A)); *id.* § 9010(a)(1), (c)(1), (d), (j) (to be codified 26 U.S.C. § 4001(a)(1), (c)(1), (d), (j), amended by (PPACA § 10905(f)(1) (5). “Health insurance” does not include insurance for accident, or disability, or both combined, long-term care insurance or insurance for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, or Medicare supplemental insurance. *Id.* § 9010(h)(3) (to be codified at 26 U.S.C. § 4001(h)(3), amended by PPACA § 10905(d)); *see also* 26 U.S.C. § 9832(c)(1)(A), (3).

380. PPACA § 9010(b)(1)-(2) (to be codified at 26 U.S.C. § 4001(b)(1)-(2), amended by PPACA § 10905(a)).

381. *Id.* (to be codified at 26 U.S.C. § 4001(b)(1)-(2), amended by PPACA § 10905(a)).

382. *Id.* § 9010(e)(1) (to be codified at 26 U.S.C. § 4001(e)(1), amended by HCERA § 1406(a)(4)).

applicable amount shall be the applicable amount for the preceding . . . year, increased by the rate of premium growth” as provided under IRC section 36B(b)(3)(A)(ii).³⁸³ The fees are treated as excise taxes and are not deductible.³⁸⁴

Elimination of Deduction for Expenses Allocable to Medicare Part D Subsidy.

This provision amends IRC section 139A by removing the second sentence, which allowed sponsors of qualified retiree prescription drug plans to deduct expenses allocable to determining the sponsors’ tax-excluded SSA section 1860D-22 special subsidy payment.³⁸⁵ This section takes effect in 2013.³⁸⁶

Modification of Itemized Deduction for Medical Expenses

This section amends IRC section 213 by only allowing a deduction for uncompensated medical care expenses that exceed 10% (instead of 7.5%) of a taxpayer’s adjusted gross income, beginning in 2013.³⁸⁷ During the taxable years 2013-2016, the 7.5% rate shall still apply if the taxpayer or their spouse “has attained age 65 before the close of such taxable year.”³⁸⁸

Limitation on Excessive Remuneration Paid by Certain Health Insurance Providers

Section 162(m)(5) limits a financial institution’s remuneration deduction for services performed by its CEO, its CFO, or each of the three highest compensated officers (not including the CEO and CFO) to \$500,000.³⁸⁹ This limitation applies during the employer’s “applicable taxable year,” which is any taxable year of the employer beginning October 3, 2008 until the expiration of the program on October 3, 2010, during which one or more of the employer’s troubled assets were acquired under the Troubled Asset Relief Program and the aggregate amount of assets acquired under TARP exceeded \$300,000,000.³⁹⁰

383. *Id.* § 9010(e)(2) (to be codified at 26 U.S.C. § 4001(e)(1), amended by HCERA § 1406(a)(4)); *see* 26 U.S.C. § 36B(b)(3)(A)(ii).

384. PPACA § 9010(f) (to be codified at 26 U.S.C. § 4001(f)); *see* 26 U.S.C. § 275(a)(6).

385. PPACA § 9012(a) (to be codified at 26 U.S.C. § 139A); *see* 26 U.S.C. § 139A.

386. PPACA § 9012(b) (to be codified at 26 U.S.C. § 139A note, amended by HCERA § 1407).

387. *Id.* § 9013(a) (to be codified at 26 U.S.C. § 213(a)); *id.* § 9013(d) (to be codified at 26 U.S.C. § 56 note); *see* 26 U.S.C. § 213(a).

388. PPACA § 9013(b) (to be codified at 26 U.S.C. § 213(f)).

389. 26 U.S.C. § 162(m)(5)(A), (D)-(E).

390. *Id.* § 162(m)(5)(B)(i), (C); *see* 12 U.S.C. § 5211(a). Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, sections 101(a), 111(c)-(d) and 120. The TARP Program was originally

Section 162(m)(5) also applies to “deferred deduction executive remuneration” paid during any taxable year for services performed during an applicable taxable year.³⁹¹ “Deferred deduction executive remuneration” is remuneration deductible by the employer in a taxable year subsequent to the applicable taxable year in which the services were performed.³⁹² An example of deferred deduction executive remuneration would be “nonqualified deferred compensation,” which is compensation paid subsequent to the performance of services and deductible by the employer in the taxable year in which it is paid to and reported by the employee.³⁹³ The deduction for deferred deduction executive remuneration is limited to \$500,000, reduced by (i) the executive remuneration paid to the employee during the applicable taxable year, plus (ii) any deferred deduction executive remuneration for those services which was taken into account under this provision in a preceding taxable year.³⁹⁴

PPACA section 9014(a) adds IRC section 162(m)(6) to the tax code, limiting remuneration deductions taken by health insurance providers.³⁹⁵ For taxable years beginning after December 31, 2012, health insurance issuers who receive 25% or more of their gross premiums from providing minimum essential coverage cannot deduct more than \$500,000 of the remuneration paid for services performed during the year by an officer, a director, an employee, or to other individuals who provide services for or on behalf of the insurer.³⁹⁶

Companies which issued health insurance and received premiums for providing coverage during taxable years beginning after December 31, 2009 and ending before January 1, 2013 are subject to a limitation on deferred deduction remuneration attributable to services performed during those taxable years, but paid in a taxable year beginning after December 31, 2012.³⁹⁷ The deduction is limited to \$500,000, reduced by: (i) the

scheduled to expire on December 31, 2009 under sec. 120(a) of the Emergency Economic Stabilization Act, however Treasury Secretary Timothy Geithner extended the TARP program until October 3, 2010, pursuant to his authority under section under 102(b). For the text of Secretary Geithner’s letter extending the TARP program, see *Treasury Department Releases Text of Letter from Secretary Geithner to Hill Leadership on Administration’s Exit Strategy for TARP*, U.S. DPT. OF TREASURY (Dec. 9, 2009), <http://www.treasury.gov/press-center/press-releases/Pages/tg433.aspx>.

391. 26 U.S.C. § 162(m)(5)(A)(ii).

392. *Id.* § 162(m)(5)(F).

393. See, e.g., 26 U.S.C. § 404(a)(5). “Since 1942 . . . an accrual method employer’s deduction for deferred compensation has been delayed until the compensation is includable in the employee’s gross income, ordinarily when it is paid . . .” BORIS I. BITTKER & LAWRENCE LOKKEN, *FEDERAL TAXATION OF INCOME, ESTATES AND GIFTS*, Vol. 2, 60-15 (2d ed. 1990).

394. 26 U.S.C. § 162(m)(5)(A)(ii).

395. PPACA § 9014(a) (to be codified at 26 U.S.C. § 162(m)).

396. *Id.* (to be codified at 26 U.S.C. § 162(m)(6)(A)(i), (B), (C)(i)(II), (D), (F)).

397. *Id.* (to be codified at 26 U.S.C. § 162(m)(6)(A)(ii), (B), (C)(i)(I), (D), (E)).

remuneration paid to the employee during the year the services were performed, plus (ii) the portion of the deferred deduction remuneration attributable to those services “which was taken into account under this clause in a preceding taxable year” or which would have been taken into account if this provision applied to deferred deduction remuneration paid after December 31, 2009.³⁹⁸

The limitation on deferred deduction remuneration also applies to deferred deduction remuneration attributable to services performed after December 31, 2012 if, during the taxable year in which the services were performed, the health insurance issuer received 25% or more of its gross health insurance premiums from providing minimum essential health insurance coverage.³⁹⁹

Additional Hospital Insurance Tax on High-Income Taxpayers

This provision adds an additional tax to the Hospital Insurance component of the FICA tax (and the SECA tax for self-employed individuals), which funds Medicare, equal to 0.9% on the incomes of married couples with wages over \$250,000 and single individuals with wages over \$200,000.⁴⁰⁰ This provision applies to remuneration received, and taxable years beginning, after December 31, 2012.⁴⁰¹

Unearned Income Medicare Contribution

For taxable years beginning after December 31, 2012, a tax of 3.8% is imposed on the lesser of an individual’s net investment income or the excess, if any, of their modified adjusted gross income over \$250,000 for joint filers and \$200,000 for single filers.⁴⁰² “Net investment income” is defined as the taxpayer’s “gross income from interest, dividends, annuities, royalties and rents,” gross income derived from a passive activity or the “trade or business of trading in financial instruments or commodities[,]” plus “net gain . . . attributable to the disposition of property” (not held in a

398. *Id.* (to be codified at 26 U.S.C. § 162(m)(6)(A)(ii)(I)-(II)).

399. *Id.* (to be codified at 26 U.S.C. § 162(m)(6)(A)(ii), (B), (C)(i)(II)).

400. PPACA § 9015(a)(1) (to be codified at 26 U.S.C. § 3101(b)(2), amended by PPACA § 10906(a)); *id.* § 9015(b)(1) (to be codified at 26 U.S.C. § 1401(b)(2)), amended by PPACA § 10906(b)); *see id.* § 9015(b)(2) (to be codified at 26 U.S.C. § 1401(b)(2)) (regarding the self-employment tax which disallows self-employed individuals from deducting the .9% increase in their SECA tax under IRC § 164(f)(1)).

401. *Id.* § 9015(c) (to be codified at 26 U.S.C. § 164 note).

402. HCERA § 1402(a)(1) (to be codified at 26 U.S.C. § 1411(a)(1), (b)); *id.* § 1402(a)(4) (to be codified at 26 U.S.C. § 1411 note).

trade or business described in IRC section 1411(c)(2)), reduced by any allowable deductions attributable to the income or gain.⁴⁰³

Modified adjusted gross income is adjusted gross income increased by “amount[s] excluded . . . under [IRC] section 911(a)(1),” reduced by “any deductions . . . or exclusions disallowed under [IRC] section 911(d)(6)”⁴⁰⁴

Modification of Section 833 Treatment of Certain Health Organizations

This provision eliminates a deduction available to Blue Cross and Blue Shield organizations and to other health insurance providers under IRC section 833(b) if they fail to use at least 85% of their total premium revenue “on reimbursement for clinical services provided to enrollees . . . during such taxable year”⁴⁰⁵ This provision applies to taxable years after December 31, 2009.⁴⁰⁶

Excise Tax on Indoor Tanning Services

Beginning on July 1, 2010, a 10% tax on the amount paid for indoor tanning services, whether paid by insurance or otherwise, is imposed on any individual “on whom the service is performed.”⁴⁰⁷ “Indoor tanning service” is defined as a “service employing any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.”⁴⁰⁸

III. CONCLUSION

The PPACA, at its most basic level, is a managed competition approach to health care reform, coupled with a mandate requiring most individuals to have health insurance coverage. Congress has set the terms and conditions for participation in the health insurance market, which will be regulated by

403. *Id.* § 1402(a)(1) (to be codified at 26 U.S.C. § 1411(c)(1)-(2)); *see* 26 U.S.C. § 1411(c)(2).

404. HCERA § 1402(a)(1) (to be codified at 26 U.S.C. § 1411(d)).

405. PPACA § 9016(a) (to be codified at 26 U.S.C. § 833(c)(5)).

406. *Id.* § 9016(b) (to be codified at 26 U.S.C. § 833 note).

407. *Id.* § 9017 (to be codified at 26 U.S.C. § 5000B(a), (c)(1), amended by PPACA § 10907(b)); *id.* (to be codified at 26 U.S.C. § 5000(B) note, amended by PPACA § 10907(d)); *see id.* (to be codified 26 U.S.C. § 5000B(c)(2)-(3), amended by PPACA § 10907(b)) (providing that the person receiving payment for the indoor tanning services is responsible for collecting the tax and is secondarily liable for taxes not collected at the time payment for the service is made).

408. PPACA § 9017 (to be codified at 26 U.S.C. § 5000B(b)(1) amended by PPACA § 10907(b)); *see id.* (to be codified at 26 U.S.C. § 5000B(b)(2), amended by PPACA § 10907(b)) (excluding “phototherapy . . . performed by a licensed medical professional” from the “indoor tanning service” definition).

the Secretary of HHS and the state Health Insurance Exchanges. The PPACA, however, relies primarily on the private health insurance industry to provide this expanded health insurance coverage. The PPACA incorporates a number of conservative healthcare reform policies, such as the individual requirement, compensating healthcare providers based on quality of care rather than the quantity of services, increased consumer access to information on health plan and physician quality, and tax credits to subsidize health insurance costs.

However, the PPACA also exemplifies the political compromises that were necessary in order for it to pass both houses of Congress, such as the removal of the public option and the inclusion of tax provisions which target high-income taxpayers and healthcare-related entities.

The political debate and the process that led up to the PPACA's enactment has significantly shaped public perception of the Act, which has unfortunately discouraged many from attempting to learn what is actually included in the legislation or from finding out whether the PPACA may actually be beneficial for the country. This is unfortunate because despite the many provisions included in the PPACA that some may object to, there are probably even more that those same persons may support. The PPACA is far from a perfect piece of legislation, however, any fair appraisal of it requires that it be evaluated and considered in the context of the many problems that it attempts to solve.