

# Summary of the Major Provisions in the Patient Protection and Affordable Health Care Act

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On March 23, 2010, President Barack Obama signed into law comprehensive health care reform legislation, the Patient Protection and Affordable Care Act. The legislation previously had received approval from the Senate on December 24, 2009, and from the House on March 21, 2010. The following chart provides a summary of the major health insurance market reform, mental health, and addiction provisions of the law. **Please note: Revisions made to the law under the Health Care and Education Reconciliation Act, which Obama signed into law on March 30, 2010, appear in red text.**

<b>Patient Protection and Affordable Care Act (P.L. 111-148)</b>	
<b>HEALTH INSURANCE MARKET REFORMS</b>	
<b>High-Risk Health Insurance Pool Program</b>	Sec. 1101: Establishes a temporary high-risk health insurance pool program for U.S. citizens and legal immigrants who have a pre-existing condition and have lacked coverage for at least six months. Appropriates \$5 billion to finance the program (begins 90 days after enactment and ends on January 1, 2014).
<b>Pre-Existing Medical Conditions</b>	Sec. 2704: Prohibits discrimination by group or individual health plans against individuals who have pre-existing medical conditions or have had illnesses in the past (begins on January 1, 2014).
<b>Health Insurance for Young Adults</b>	Sec. 2714: Requires group and individual health plans to provide dependent coverage for young adults until age 26 (begins six months after enactment).  Sec. 2004: Allows all young adults who previously participated in foster care to qualify for Medicaid and all associated benefits, such as the Early Periodic Screening, Diagnosis, and Treatment Program, until age 25 (begins on Jan. 1, 2019)
<b>Lifetime and Annual Limits on Benefits</b>	Sec. 2711: Prohibits the establishment of lifetime limits on benefits by group and individual health plans (begins six months after enactment). Prohibits the establishment of annual limits on benefits by health plans

	(begins on January 1, 2014). Prior to 2014, allows health plans to impose annual limits on benefits as determined by the Department of Health and Human Services secretary.
<b>Mental Health and Addiction Parity</b>	Sec. 1311(j) and 1562(c)(4): Applies mental health and addiction parity to all health plans.
<b>Public Health Insurance Options</b>	<p>Sec. 1322: Establishes a Consumer Operated and Oriented Plan program to promote the creation of non-profit, member-administered co-operative health insurers to offer small group and individual health plans in all states.</p> <p>Sec. 1323: Establishes a community health insurance option that offers affordable, high-quality coverage in all states but allows states to pass a law to prohibit this option.</p> <p>Sec. 1324: Requires qualified health plans offered under the CO-OP program, coverage offered through a community health insurance option, and other qualified plans to adhere to all federal and state laws that apply to private insurers.</p>
<b>Individual Responsibility</b>	<p>Sec. 1501(5000A): Requires individuals to maintain minimum essential health insurance for themselves and applicable dependents in each month after 2013 or pay a penalty of \$95 or .5% of taxable income in 2014, \$350 or 1% of taxable income in 2015, \$750 or 2% of taxable income in 2016, and an indexed amount in subsequent years. For individuals younger than age 18, reduces penalties by half. Provides exemptions for individuals who cannot afford health insurance, those who have incomes less than the federal poverty level, members of Indian tribes, and those who lack coverage for less than three months in a year (begins on January 1, 2014).</p> <p><i>Reduces the flat penalty to \$325 in 2015 and \$695 in 2016, as well as increases the percentages for the penalty based on taxable income to 1% in 2014, 2% in 2015, and 2.5% in 2016. Changes the definition of the exemption for low-income individuals from those have incomes less than the federal poverty level to those who have incomes less than the tax filing threshold.</i></p>
<b>Employer Responsibility</b>	Sec. 1513: Requires employers that have more than 50 full-time employees, do not offer health insurance, and have at least one worker who receives premium assistance to make a payment of \$750 per full-time employee. For employers that have more than 50 full-time employees, offer health insurance, and have at least one worker who receives premium assistance, requires a payment of the lesser of \$3,000

	<p>per employee who receives premium assistance or \$750 per full-time worker. Exempts employers that have 50 or fewer full-time employees from the requirements (begins on January 1, 2014).</p> <p><i>Changes the amount of the payment for employers that have more than 50 full-time employees, do not offer health insurance, and have at least one worker who receives premium assistance to \$2,000 per full-time employee and excludes the first 30 workers from the calculation. For employers that have more than 50 full-time employees, offer health insurance, and have at least one worker who receives premium assistance, changes the amount of the payment to the lesser of \$3,000 per employee who receives premium assistance or \$2,000 per full-time worker.</i></p>
<p><b>Excise Tax on Health Insurers</b></p>	<p>Sec. 9001: Imposes an excise tax of 40% on health insurers and health plan administrators for any plan with a premium that exceeds \$8,500 for single coverage and \$23,000 for family coverage. Applies the tax to the amount of the premium in excess of the threshold (begins on January 1, 2013).</p> <p><i>Raises the thresholds for the imposition of the tax to any health plan with a premium that exceeds \$10,200 for individual coverage and \$27,500 for family coverage and allows an increase in the amounts of the thresholds in the event that health care costs increase more than expected prior to the implementation of the tax. Changes the implementation date for the tax to January 1, 2018.</i></p>
<p><b>Community Living Assistance Services and Supports Program</b></p>	<p>Sec. 8002: Establishes a voluntary, public long-term care insurance program for the purchase of community living assistance services and supports by individuals who have functional limitations. Provides cash benefits of at least an average of \$50 per day (begins on January 1, 2011).</p>
<p><b>HEALTH INSURANCE EXCHANGES</b></p>	
<p><b>Individual and Small Group Market for Health Plans (Exchanges)</b></p>	<p>Sec. 1311: Requires the HHS secretary to award grants to states to establish American Health Benefit Exchanges by Jan. 1, 2014, with no grants awarded after January 1, 2015.</p> <p>Sec. 1321: Requires the HHS secretary to establish standards for Exchanges, qualified health plans, reinsurance, and risk adjustment. In the event that the HHS secretary on or before January 1, 2013, determines a state will not have an operational Exchange by 2014, allows the secretary to operate an Exchange in that state.</p>

<b>Eligibility for Participation in Exchanges</b>	Sec. 1312: Allows U.S. citizens and legal immigrants who are not incarcerated to participate in Exchanges. In addition, permits small businesses to participate in Exchanges. After 2017, allows large employers to begin to participate in Exchanges.
<b>Outreach and Enrollment Efforts</b>	Sec. 2201: Allows individuals to apply for, and enroll in, Medicaid, CHIP, or Exchanges through Web site administered by states.
<b>Essential Benefits Package (for Health Plans in Exchanges)</b>	<p>Sec. 1302: Requires all health plans in Exchanges to offer essential benefits, which include rehabilitative and habilitative services; and mental health and addiction services, such as behavioral health treatments.</p> <p>Sec. 1311: Allows states to require health plans in Exchanges to offer benefits in addition to the essential benefits.</p>
<b>Cost-Sharing in Exchanges</b>	Sec. 1302: Mandates that annual cost-sharing for health plans in Exchanges cannot exceed \$5,000 for individuals and \$10,000 for families but does not apply the caps to the cost of premiums. For small group health plans in Exchanges, limits deductibles to no more than \$2,000 for individuals and \$4,000 for families.
<b>Benefit Package Levels</b>	Sec. 1302: Defines levels of benefits offered by health plans in Exchanges based on the amount of cost-sharing required: Bronze (plans must pay for 60% of costs), Silver (70%), Gold (80%), and Platinum (90%). Allows health plans in Exchanges that do not offer Bronze, Silver, Gold, or Platinum levels of coverage to offer catastrophic coverage to individuals younger than age 30 or individuals exempted from the mandate because of a hardship waiver. Requires catastrophic coverage to include the essential benefits and at least three primary care visits but allows this coverage to require more cost-sharing.
<b>State Flexibility</b>	<p>Sec. 1332: After December, 31, 2016, allows states to apply for a waiver for as many as five years of requirements related to Exchanges, qualified health plans, and cost-sharing. Requires states to prove that waivers would provide comprehensive and affordable health insurance to at least a comparable number of residents as Exchanges would provide and that waivers would not increase the federal budget deficit.</p> <p>Sec. 1333: By July 31, 2013, requires the HHS secretary to issue regulations for interstate Health Care Choice Compacts, which can begin operations after 2015. Allows the compacts to offer qualified health plans in all associated states but requires these plans to adhere to the consumer protection and other laws of each of the states.</p>
<b>Premium</b>	Sec. 1401(36B): Establishes premium assistance credits for individuals

<p><b>Assistance Credits, Caps on Out-of-Pocket Costs for Health Plans in Exchanges</b></p>	<p>and families that have incomes at or less than 400% of the federal poverty level and enroll in health plans in Exchanges. For individuals or families with incomes at or less than 133% of the poverty level, requires that the credits cover premium costs that exceed 2% of their income (begins on January 1, 2014).</p> <p>Sec. 1402: Caps standard out-of-pocket costs for health plans in Exchanges at \$5,950 for individuals and \$11,900 for families. For individuals and families that receive premium assistance credits, lowers the caps on out-of-pocket costs to one-third of the standard level for those with incomes between 100% and 200% of the federal poverty level, one-half of the standard level for those with incomes between 200% and 300% of the poverty level, and two-thirds of the standard level for those with incomes between 300% and 400% of the poverty level (begins on January 1, 2014).</p>
<p><b>MEDICAID AND CHIP</b></p>	
<p><b>Medicaid Expansion</b></p>	<p>Sec. 2001: Mandates that state Medicaid programs cover all individuals who are younger than age 65 and have incomes at or less than 133% of the federal poverty level. Provides limited Medicaid benefits packages to newly eligible individuals and requires states to design these packages based on rules for benchmark plans established in 2005. These benefit packages must include parity for mental and physical health services, but they are not required to offer the same level of coverage or range of services as traditional Medicaid (begins on January 1, 2014).</p> <p>From 2014 to 2016, requires the federal government to pay 100% of the cost of Medicaid coverage for newly eligible individuals, with the level of this contribution to decrease from 2017 to 2018. After 2018, provides states with an increase of 32.3 percentage points in their federal Medicaid assistance percentage for coverage of newly eligible individuals. Requires states to maintain current Medicaid income eligibility levels until January 1, 2014, but allows for possible exemptions for states with budget deficits. For children, requires states to maintain current Medicaid income eligibility levels through September 30, 2019.</p> <p><i>Changes the share of the cost of Medicaid coverage for newly eligible individuals covered by the federal government to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in subsequent years. Changes the date through which states must maintain current Medicaid income eligibility levels for children to December 31, 2015.</i></p>
<p><b>CHIP</b></p>	<p>Sec. 2101: Requires states to maintain current income eligibility levels</p>

	for CHIP through September 30, 2019. From 2015 to 2019, provides states with a 23 percentage point increase in their federal CHIP match rates, with a cap at 100%.
<b>Medicaid Medical Home Pilot</b>	Sec. 2703: Allows states to enroll Medicaid beneficiaries with chronic conditions, which include serious and persistent mental illness, into medical homes as part of pilot projects. Authorizes grants of as much as \$25 million to help states plan and implement these projects (begins on January 1, 2011).
<b>Medicaid Accountable Care Organization Pilot Program</b>	Sec. 2706: Establishes a demonstration project that will allow qualified pediatric providers to receive recognition and payments under Medicaid as accountable care organizations, as well as permit ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to the program (begins on January 1, 2012).
<b>Medicaid Emergency Psychiatric Demonstration Project</b>	Sec. 2707: Requires HHS to establish a three-year Medicaid demonstration project to reimburse certain institutions for mental disease for services provided to beneficiaries who are between ages 21 and 65 and require medical assistance to stabilize an emergency psychiatric condition. Authorizes \$75 million for the project (begins on October 1, 2011).
<b>Medicaid Community-Based Services</b>	<p>Sec. 2401: Establishes a Community First Choice Option through which state Medicaid programs can offer community-based attendant services and supports to beneficiaries who otherwise would require the level of care offered in a hospital, nursing home, or intermediate care facility for the mentally retarded (begins on October 1, 2010).</p> <p><b>Changes the implementation date of the benefit to October 1, 2011.</b></p> <p>Sec. 2402: Allows states to provide more types of home- and community-based services to Medicaid beneficiaries with higher levels of need through a state plan amendment, rather than a waiver, and to extend full coverage to beneficiaries who receive HCBS under a state plan amendment.</p> <p>Sec. 10202: Establishes the State Balancing Incentive Payments Program to increase the proportion of Medicaid beneficiaries who receive long-term care outside of institutional settings. For states that qualify, provides FMAP increases for medical assistance expenditures for long-term care services and supports provided to Medicaid beneficiaries outside of institutional settings.</p>
<b>MEDICARE</b>	

<p><b>Medicare Part D</b></p>	<p>Sec. 3301: Requires pharmaceutical companies to provide a 50% discount to Medicare Part D beneficiaries for brand-name medications and biologics purchased in the “donut hole” coverage gap (begins on July 1, 2010).</p> <p><b>Changes the implementation date of the requirement to January 1, 2011.</b></p> <p>Sec. 3305: Requires HHS to transmit Medicare Part D formulary and coverage information to low-income subsidy beneficiaries who were automatically reassigned to new Part D plans.</p> <p>Sec. 3307: Codifies the current six classes of clinical concern.</p> <p>Sec. 3309: Eliminates cost-sharing for Medicare beneficiaries who receive care under an HCBS program and otherwise would require institutional care.</p>
<p><b>Specialized Medicare Advantage Plans for Special Needs Individuals</b></p>	<p>Sec. 3205: Extends the Special Needs Plan program through 2013 and requires SNPs to obtain approval from the National Committee for Quality Assurance. On January 1, 2001, allows HHS to apply a frailty payment adjustment to fully integrated, dual-eligible SNPs that enroll frail Medicare beneficiaries and requires an evaluation of Medicare Advantage risk adjustment for chronically ill beneficiaries. Requires SNPs to obtain approval from the National Committee for Quality Assurance after 2011. After 2012, mandates that dual-eligible SNPs contract with state Medicaid programs. Requires HHS to transition Medicare beneficiaries enrolled in SNPs that do not meet statutory target definitions by January 1, 2013.</p>
<p><b>Medicare Accountable Care Organizations</b></p>	<p>Sec. 3022: Allows ACOs that meet quality of care standards and reduce costs to share in a portion of their savings to Medicare (begins on January 1, 2012)</p>
<p><b>Medicare Medical Home Pilot Program</b></p>	<p>Sec. 3502: Establishes a program to create and fund the development of community health teams to support the creation of medical homes through increased access to comprehensive, community-based, and coordinated care (begins by January 1, 2012).</p>
<p style="text-align: center;"><b>WORKFORCE AND OTHER PROVISIONS</b></p>	
<p><b>Co-Location of Primary and Specialty Care in Community-Based Behavioral Health</b></p>	<p>Sec. 5604: Authorizes \$50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.</p>

<b>Settings</b>	
<b>National Health Service Corps</b>	Sec. 5207: Authorizes specific funding amounts for the National Health Service Corps, with funding to increase from \$320,461,632 in 2010 to \$1,154,510,336 in 2016. After 2016, adjusts funding annually “by the product of (A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and (B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.”
<b>Training for Behavioral Health Professionals</b>	Sec. 5306: Allows the HHS secretary to award grants to schools for the development, expansion, or improvement of training programs in social work, graduate psychology programs, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health. Authorizes funding for the grants from 2010 to 2013.
<b>Loan Repayment for Pediatric Behavioral Health Specialists in Underserved Areas</b>	Sec. 5203: Establishes and authorizes funds for a Pediatric Specialty Loan Repayment Program for individuals who are employed in health professional shortage or medically underserved areas for at least two years and provide pediatric medical subspecialty; pediatric surgical specialty; or child and adolescent mental and behavioral health services, which include substance abuse prevention and treatment services.
<b>Educating Primary Care Providers About Behavioral Health</b>	Sec. 5405: Establishes and authorizes funds for a Primary Care Extension Program to educate primary care providers about preventive medicine; chronic disease management; mental and behavioral health services, which include substance abuse prevention and treatment services; and evidence-based and evidence-informed therapies and techniques.
<b>Community Transformation Grants</b>	Sec. 4201: Authorizes competitive grants to eligible entities for programs that promote individual and community health and prevent the incidence of chronic disease. Includes programs to prevent or reduce the incidence of mental illness.
<b>Community Health Workforce Grants</b>	Sec. 5313: Authorizes grants to eligible entities to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers.
<b>National Health Care Workforce Commission</b>	Sec. 5101: Establishes a National Health Care Workforce Commission to evaluate education and training programs to determine whether they will meet the expected demand for health care workers in the future; identify barriers to improved coordination of these programs at the

	<p>federal, state, and local levels and recommend proposals to address these issues; and encourage innovations in these programs to address population needs, changes in technology, and other environmental factors (begins by September 30, 2010)</p>
<p><b>Federal Definition of Community Mental Health Centers</b></p>	<p>In Section 1861 of the Social Security Act, changes the definition of community mental health centers to include a requirement that these facilities provide at least 40% of their services to individuals who do not qualify for benefits under Medicare and excludes from the definition of partial hospitalization services provided by CMHCs or other entities any services provided in the homes of individuals or in inpatient or residential settings (begins on or after the first day of the first calendar quarter that begins at least 12 months after enactment).</p>