DOWNLOAD PDF OUTLINES OF THE HEALTH INSURANCE ACT.

Chapter 1 : Summary of the Affordable Care Act | The Henry J. Kaiser Family Foundation

Feb 16, Â· WASHINGTON â€" House Republican leaders on Thursday presented their rank-and-file members with the outlines of their plan to replace the Affordable Care Act, leaning heavily on tax credits to.

Subsidies and abortion coverage Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest Hyde amendment. If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds for premiums or cost-sharing must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds. The credit phases-out as firm size and average wage increases. The credit will be available for two years. Reinsurance program Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Effective January 1, Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses health FSA or health reimbursement arrangement HRA , employer contributions to a health savings account HSA , and coverage for supplementary health insurance coverage, excluding dental and vision coverage. Effective January 1, Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. Effective January 1, Tax changes related to financing health reform Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule: Impose an annual fee on the health insurance sector, according to the following schedule: Effective January 1, Impose an excise tax of 2. Effective July 1, Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. Effective January 1, Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. Permit states to allow businesses with more than employees to purchase coverage in the SHOP Exchange beginning in States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. Funding available to states to establish Exchanges within one year of enactment and until January 1, Eligibility to purchase in the exchanges Restrict access to coverage through the Exchanges to U. Multi-state plans Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3: These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. This plan is only available in the individual market. These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan. Require risk adjustment in the individual and small group markets and in the Exchange. Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state

Medicaid agencies to determine eligibility for tax credits in the Exchanges. Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges. Abortion coverage Permit states to prohibit plans participating in the Exchange from providing coverage for abortions. Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted to save the life of the woman and in cases of rape or incest in states that allow such coverage to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions. Effective dates Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, Require the Secretary to define and annually update the benefit package through a transparent and public process. Effective January 1, Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. Effective January 1, Abortion coverage Prohibit abortion coverage from being required as part of the essential health benefits package. Requirement to report medical loss ratio effective plan year ; requirement to provide rebates effective January 1, Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. Effective beginning plan year Administrative simplification Adopt standards for financial and administrative transactions to promote administrative simplification. Effective dates vary Dependent coverage Provide dependent coverage for children up to age 26 for all individual and group policies. Effective six months following enactment Insurance market rules Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. Prior to January , plans may only impose annual limits on coverage as determined by the Secretary. Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26 and prohibit rescissions of coverage. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in , eliminate annual limits on coverage. Prior to , grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by for adults, and eliminate waiting periods for coverage of greater than 90 days by Effective six months following enactment, except where otherwise specified Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the individual market, in the Exchange, and in the small group market. See new rating and market rules in Creation of insurance pooling mechanism. Effective January 1, Require all new policies except stand-alone dental, vision, and long-term care insurance plans , including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. See description of benefit categories in Creation of insurance pooling mechanism. This deductible limit will not affect the actuarial value of any plans. Effective January 1, Limit any waiting periods for coverage to 90 days. Effective January 1, Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Effective January 1, through December Allow states the option of merging the individual and small group markets. Effective January 1, Consumer protections Establish an internet website to help residents identify health coverage options effective July 1, and develop a standard format for presenting information on coverage options effective 60 days following enactment. Develop standards for insurers to use in providing information on benefits and coverage. Compacts may only be approved if it is determined that the compact

will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January states have the option to expand enrollment beginning in , coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. Phase-in revised payments over 3 years beginning in , for plans in most areas, with payments phased-in over longer periods 4 years and 6 years for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in ; qualifying plans in qualifying areas receive double bonuses. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5. Cap total payments, including bonuses, at current payment levels. Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. Effective January 1, Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. If so, beginning January 15, , the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January , the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration. The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing including Parts A and B premiums , or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices through and clinical labs for one year will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, Effective upon enactment Allow providers organized as accountable care organizations ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. Shared savings program established January 1, Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs. Effective January 1, Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess preventable hospital readmissions. Effective fiscal year Medicaid Increase the Medicaid drug rebate percentage for brand name drugs to Effective January 1, Extend the drug rebate to Medicaid managed care plans. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for waivers. Effective October 1, Prohibit federal payments to states for Medicaid services related to health care acquired conditions. Effective July 1, Prescription drugs Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. Effective upon enactment Waste, fraud, and abuse Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs,

increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. Effective upon enactment Medical malpractice Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. Funding appropriated for five years beginning in fiscal year Medicare Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. Establish pilot program by January 1, ; expand program, if appropriate, by January 1, Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. Effective January 1, Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond Reports to Congress due January 1, Dual eligibles Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles.

Chapter 2 : NPR Choice page

This is a compilation of the Health Insurance Act that shows the text of the law as amended and in force on 1 August (the compilation date). The notes at the end of this compilation (the endnotes) include information about amending laws and the amendment history of provisions of the compiled law.

Keeping in mind the length of the Patient Protection and Affordable Care Act, we have separated our section-by-section analysis of the law from our basic summary of each title. If you keep reading this page, you will get a basic overview of the law and each title contained within it. What is the Affordable Care Act? Since being signed into law, additional rules and regulations have expanded upon the law. We have attempted to update our summaries with those changes. The Affordable Care Act is a long, complex piece of legislation that attempts to reform the healthcare system. Reforms include new benefits, rights and protections, rules for Insurance Companies, taxes, tax breaks, funding, spending, the creation of committees, education, new job creation and more. Please note that the law gives power to ongoing efforts by Health and Human Services and other Government programs to reform health care in many cases. Titles of the Affordable Care Act The Affordable Care Act addresses the following topics in detail â€" each topic is a title, which contains sections of provisions that reform our health care system: Having a basic understanding of the law will help you to digest the details below. The Affordable Care Act helps to reform the healthcare system by giving more Americans access to quality, affordable health insurance, and helps to curb the growth of healthcare spending in the U. The ACA protects consumers from some of the worse abuses of the health care and insurance industries. This helped over 32 million Americans afford health care who could not get it before and made coverage more affordable for many more. The law spreads risk equally to all insured to end discrimination. In the past, you could be discriminated against based on gender or health status. Costs could differ wildly due to factors like age. There are new rules for businesses. Luckily our Summary of Provisions of the Patient Protection and Affordable Care Act breaks down those pages into about 5 pages of text. Do you want to skip the Affordable Care Act Summary and just read the bill? Affordable Care Act Summary of Titles and Provisions The Affordable Care Act is it is broken down into titles; each title is broken down into subtitles; subtitles are broken down into sections that contain provisions or amendments to other laws. Provisions are the parts of the law that affect Americans. Our goal will be to break down each title, subtitle, section, and provision to give you a complete, yet simplified, understanding of exactly what the Affordable Care Act does. Many of these provisions worked as temporary fixes until the provisions could be fully implemented. The next four subtitles deal with the insurance exchanges, cost assistance, rules for businesses, mandates, and some miscellaneous provisions. Below we discuss where the related provisions stand today. Learn about the benefits of Obamacare. Before the ACA, it was common practice to find a reason such as an honest mistake on an application to drop patients when the cost of their care got too great. As of no one could be charged more or dropped from coverage due to having a pre-existing condition. This started in Today a simple, standardized document makes comparing insurance options easy. Today you have the right to a rapid appeal. The first title states that the Affordable Care Act puts individuals, families and small business owners in control of their own healthcare. The Affordable Care Act reduces what most people will pay for health care by capping out of pocket expenses and requiring all preventative care to be fully covered and without cost to the individual. These plans have to compete for your business, thus helping to regulate cost and quality. The Affordable Care Act keeps insurance companies honest by setting clear rules that rein in the worst insurance industry abuses. Some aspects of the law that went into effect starting in American families and small business owners have begun to experience the benefits of this common-sense reform: More Power for Consumers:

Chapter 3 : Health Insurance Act

The Affordable Health Care Act also referred to as Obama Care states that for a company that has fifty employees or more, there is a need for the company to offer health insurance to the workers. Therefore, the company is obligated by law to have an insurance plan for its employees and this is not just a matter of choice of whether the company.

Sweeping reforms have created a demand for health care law specialists. As a result, the specialty currently represents the fastest growing law practice in the United States. The health law field presently exists at the precipice of enormous change. Care providers must manage the legal implications that come with networked electronic health records EHRs and payments based on patient outcomes. Problems also arise due to patients traveling solely for specialized treatment, and growing pains attributable to newly merged and acquired health care organizations. These factors and more contribute to increasing litigation involving fraud, insurance disbursements and antitrust laws. The current environment requires a renewed focus on the part of health lawyers. To perform proficiently, practitioners must understand what is happening in the administrative, ethical and legislative components of the health care field. Many organizations have joined forces to compete effectively in the new operating environment. Additionally, disruptive medical innovations, such as biotechnology and treatment research, have created new concerns over ethics and privacy. As such, the responsibilities of health care lawyers have expanded from litigation defense to other areas such as compliance, risk assessment and contracts. The following five laws highlight a few of the most recent and significant game-changing regulations in the health care field. The act outlines specific guidelines for providers that deliver emergency services. If an individual has a medical emergency, such as an injury or active birth, the law obligates caregivers to stabilize the patient and provide treatment up to the point where the client remains stabilized. If the care provider cannot deliver this service, the law mandates that the provider transfer the patient to a capable facility. The Stark Law The Stark Law bars care providers from referring a patient to a peer or family member, but does provide for specific exceptions. The act covers payments issued by Medicare and Medicaid and prohibits claims for such referrals. This law applies to civil cases and exposes violators to False Claims Act culpability. The Stark Law encompasses referrals to primary care providers for specific health services, and does not require prosecutors to prove intent for overpayments. However, prosecutors must prove intent for intentional violations involving punitive recovery. The Anti-Kickback Statute The Anti-Kickback Statute bars offering, receiving or soliciting assets in return for federally subsidized medical patronage and covers referrals from anyone for any federal service. In part, the act addresses privacy and security of electronic health records. Offenders who violate the law unknowingly, initially receive the lowest fine and the opportunity to correct the offense in 30 days to avoid fines completely. The Genetic Information Nondiscrimination Act of Genome sequencing and other scientific developments have enabled researchers to produce incredible medical breakthroughs. While certain gene identifiers do not reveal ethnicity, some genetic traits emerge only among specific ethnic groups. Workplace discrimination performed by identifying ethnicity through genetic traits occurred so frequently that Congress intervened. As a result, the federal government created the Genetic Information Nondiscrimination Act to prevent employers and insurance agencies from discriminating against individuals based on genetic testing outcomes. The Genetic Information Nondiscrimination Act forbids health insurance and employment discrimination based on genomic information. The Departments of Labor, Health and Human Services along with the United States Treasury enforce the act as it applies to genetic information and health insurance. Health care innovation moves at such a tremendous pace that even the most legally astute care providers have difficulty keeping up with legal issues. While the Affordable Care Act sought to provide coverage for all U. As care providers settle in with new payment models, they will demand more health care legal professionals to keep organizations up-to-date and compliant with the law. Learn More To learn to speak the language of health law and distinguish your role as a leader with specialized health care compliance expertise, look to pursue a Master in Health Law and Policy from Hofstra Law.

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Chapter 4 : Donald Trump outlines plans for health insurance industry | Insurance Business

Outline of Sample Job Description by the Patient Protection and Affordable Care Act of (ACA). Outline of Sample Job Description Health Insurance Exchanges.

Chapter 5 : ObamaCare Summary : Obama Health Care Summary

Seven years ago, Americans were promised that the "Affordable" Care Act would make health insurance cheaper and health care more accessible. Well, I won't pretend to break any news here. The facts speak for themselves: Obamacare is not living up to its promises.

Chapter 6 : Affordable Care Act Summary

The act also reinforces parts of the civil and criminal sections of the Health Insurance Portability and Accountability Act (HIPAA). HITECH outlines four liability levels, each with increased punitive responses.

Chapter 7 : 5 Health Care Laws Protecting the Rights of Patients - Online Master's in Health Law and Polic

Republican presidential frontrunner Donald Trump has a plan for the health insurance industry he says will replace the Affordable Care Act with a system that promotes cheaper coverage for individuals.