NASUAD
National Association of States United for Aging and Disabilities

AN ANALYSIS OF TITLE I - QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Summaries of Key Provisions in the "Patient Protection and Affordable Care Act" (HR 3590) as amended by the "Health Care and Education Reconciliation Act of 2010" (HR 4872) as of May 14, 2010

Initiative	Summary	Important Dates	State/Exchange Role	Exceptions/Requirements
PRIVATE INSURANCE REFORMS				
Extension of preventive coverage	Coverage will be provided and cost-sharing will be eliminated for evidence-based preventive services that are recommended by the US Preventive Services Task Force. (HR 3590, Sec. 1001, Sec. 2713).	Within 6 months of Enactment/Sept.23, 2010: This provision is effective (HR 3590, Sec. 1004).		A plan may provide coverage for services in addition to those recommended by the US Preventive Services Task Force, and a plan may also deny coverage for preventive services that are not recommended by the Task Force (HR 3590, Sec. 2713).
Extension of dependent coverage	Children up to age 26 will receive coverage under their parents' plan in all individual and group policies (HR 3590, Sec. 1001, Sec. 2714, as amended by HR 4872, Sec. 2301).	Within 6 months of Enactment/Sept.23, 2010: This provision is effective (HR 3590, Sec. 1004).		Insurers providing dependent coverage of children are not required to make coverage available for a child of a child receiving dependent coverage (HR 3590, Sec. 1001, Sec. 2714, as amended by HR 4872, Sec. 2301). Prior to 2014, only adult children with grandfathered group plans who are not eligible for employer-sponsored coverage may stay on their parent's plan (HR 3590, Sec. 1001, Sec. 2714, as amended by HR 4872, Sec. 2301).

Prohibition of lifetime and annual limits	Health plans, including existing individual and employer-sponsored plans, may not establish lifetime limits or unreasonable annual limits on the dollar value of benefits (HR 3590, Sec. 1001, Sec. 2711, as amended by HR 4872, Sec. 2301)	Within 6 months of Enactment/Sept.23, 2010: This provision is effective (HR 3590, Sec. 1004).		Group plans or health coverage that are not required to provide the essential health benefits may place annual or lifetime limits on specific covered benefits (HR 3590, Sec. 2711, as amended by HR 4872, Sec. 2301).
Prohibition of coverage rescission	Once an individual is enrolled in a health plan, including an existing individual or employer-sponsored plan, the enrollee's coverage may not be rescinded (HR 3590, Sec. 1001, Sec. 2712, as amended by HR 4872, Sec. 2301).	Within 6 months of Enactment/Sept.23, 2010: This provision is effective (HR 3590, Sec. 1004).		Coverage may be rescinded with respect to an individual committing fraud as prohibited by the terms of the plan (HR 3590, Sec.1001, Sec. 2712, as amended by HR 4872, Sec. 2301).
Prohibition of discrimination based on salary	Sponsors of group health plans may not base coverage eligibility of full-time employees on the total hourly or annual salary of the employee, or otherwise discriminate in favor of higher wage employees (HR 3590, Sec. 1001, Sec. 2716).	Within 6 months of Enactment/Sept.23, 2010: This provision is effective (HR 3590, Sec. 1004).		Plan sponsors may establish contribution requirements for enrollment that require higher-earning employees to contribute a higher dollar or percentage amount than lower-earning employees. (HR 3590, Sec. 1001, Sec. 2716).
Prohibition of pre-existing	Insurers will no longer be able to deny coverage or charge	Within six months of enactment/Sept.23,		Before 2014, only enrollees 19 years of age and younger will be protected by this prohibition (HR 3590, Sec. 1201,

conditions	higher premiums based on pre-existing conditions. (HR 3590, Sec. 1201, Sec, 2704, as amended by Sec. 10103).	2010: These regulations will be effective with respect to children (HR 3590, Sec. 1201, as amended by Sec. 10103 and HR 4872, Sec. 2301).		as amended by Sec. 10103 and HR 4872, Sec. 2301). After 2014, these protections will be extended to adults. This applies to grandfathered group plans as well (HR 3590, Sec. 1201, as amended by Sec. 10103 and HR 4872, Sec. 2301).
Prohibition of discriminatory premium rates	Health plan premium rates may vary based on the number of family members, rating area, age and tobacco use only (HR 3590, Sec. 1201, Sec. 2701).	January 1, 2014: This provision is effective (HR 3590, Sec. 1253).	Each state must establish one or more geographical rating area (HR 3590, Sec. 1201, Sec. 2701).	The Secretary will review these rating areas, and if the state does not establish them adequately, the Secretary may do so (HR 3590, Sec. 1201, Sec. 2701).
Prohibition of excessive waiting periods	Waiting periods for all plans, including existing individual and employer-sponsored plans, will be limited to 90 days. (HR 3590, Sec. 1201, Sec. 2708, as amended by Sec. 10103 and HR 4872, Sec. 2301).	January 1, 2014: This provision is effective (HR 3590, Sec. 1253)		
IMMEDIATE ACCESS TO COVERAGE				
Temporary High Risk Pool	Eligible individuals will receive coverage of at least 65% of health care costs. The Secretary may either administer the program directly or establish contracts with states or non-	Within 90 days of enactment/June 21, 2010: The pool will be established (HR 3590, Sec. 1101).	In providing this coverage, states may operate a new high risk pool alongside a current state high risk pool, establish a new high risk pool, build upon other existing coverage programs, contract with the current	Eligible individuals are US Citizens and legal immigrants with pre-existing medical conditions who have been uninsured for at least six months (HR 3590, Sec. 1101). If a state opts to not provide this coverage, the Secretary will carry out the pool in that state (HR 3590, Sec. 1101).

	profit s to do so (HR 3590, Sec. 1101).	January 1, 2014: The program ends (HR 3590, Sec. 1101).	HIPAA carrier of last resort or other carrier (HR 3590, Sec. 1101).	Once the Exchanges are operational, the Secretary will provide for the transition of enrollees into a plan offered through an Exchange (HR 3590, Sec. 1101).
Temporary reinsurance program	Employers who provide coverage to Medicare-ineligible retirees over age 55, including the eligible spouses and dependents of the retiree, will be reimbursed for part of these costs (HR 3590, Sec. 1102, as amended by Sec. 10102).	Within 90 days of enactment/June 21, 2010: the program will be established (HR 3590, Sec. 1102, as amended by Sec. 10102). January 1, 2014: The program ends (HR 3590, Sec. 1102, as amended by Sec. 10102).		These employers will be reimbursed for 80 percent of the retiree claims between $15,000 and $90,000. The reimbursement amounts paid to a participating plan must be used to lower costs for the plan, and will not be treated as income (HR 3590, Sec. 1102, as amended by Sec. 10102). The Secretary has the authority to stop taking applications for participation in the program based on funding availability (HR 3590, Sec. 1102, as amended by Sec. 10102).
SHARED RESPONSIBILITY				
Individual Responsibility	Most U.S. citizens and legal residents will be required to maintain minimum essential coverage. Those who do not have coverage will pay a financial penalty (HR 3590, Sec. 1501 amended by Sec. 10106; as amended by HR 4872, Sec. 1002).	January 1, 2014: The tax penalties apply (HR 3590, Sec. 1501 amended by Sec. 10106; as amended by HR 4872, Sec. 1002).	The Exchange will certify exemptions from the individual responsibility requirement or from the penalty the requirement imposes (HR 3590, Sec. 1311).	Exemptions from the requirement and its penalties will be granted for several reasons, including to American Indians, those who have been uninsured for less than three months, if coverage is unaffordable, or because of religious objections (HR 3590, Sec. 1501 amended by Sec. 10106; as amended by HR 4872, Sec. 1002).

Employer Responsibility	Employers with 50 or more employees are not required to offer coverage, but most will pay tax penalties for full-time employees who receive tax credits for purchasing health insurance through the Exchange (HR 3590, Sec. 1513 as amended by Sec. 10106; amended by HR 4872, Sec. 1003).	January 1, 2014: The tax penalties apply (HR 3590, Sec. 1513 as amended by Sec. 10106; amended by HR 4872, Sec. 1003).		Employers with more than 200 full-time employees must automatically enroll employees into the employer's lowest cost coverage plans if the employee does not select a plan. Enrolled employees may opt out of coverage (HR 3590, Sec. 1511, Sec. 18A).
CREATION AND STRUCTURE OF THE EXCHANGES				
The American Health Benefit Exchange	States will establish an American Health Benefit Exchange ("Exchange") that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (HR 3590, Sec. 1311).	Within one year of Enactment - January 1, 2015: The Secretary will award Planning and Establishment grants to states for establishing the Exchange (HR 3590, Sec. 1311). January 1: 2014: Each state will have established an American Health Benefit Exchange (HR 3590, Sec. 1311).	States must establish the Exchange and ensure that the Exchange will be self-sustaining (HR 3590, Sec. 1311). States may form regional or interstate Exchanges, allowing an Exchange to operate in more than one state (HR 3590, Sec. 1311). States may also form subsidiary Exchanges, allowing more than one Exchange to operate in a state (HR 3590, Sec. 1311).	Access to the Exchange will be limited to U.S. citizens and legal immigrants (HR 3590, Sec. 1311). If a state fails to create an Exchange, the Secretary will establish and operate an Exchange within that state (HR 3590, Sec. 1321). Each state in which a regional or interstate Exchange operates must permit its operation, and the Secretary must approve the Exchange (HR 3590, Sec. 1131). A state may establish one or more subsidiary Exchanges if each Exchange serves a sufficiently large distinct geographic area (HR 3590, Sec. 1311).

The Small Business Health Options Program	The SHOP Exchange is a separate Exchange from the American Health Benefit Exchange. Through the SHOP Exchange, qualified small employers may purchase coverage (HR 3590, Sec. 1311).	January 1, 2016: States may no longer elect to define a large employer as one with more than 50 employees (HR 3590, Sec. 1304). 2017: States may allow insurers in the large group market to offer qualified health plans through the SHOP Exchange. (HR 3590, Sec. 1312).	A state may merge the American Health Benefit and SHOP Exchanges (HR 3590, Sec. 1311). States may limit participation in the Exchange by defining a large employer as one with more than 50 employees, instead of one with more than 100 employees (HR3590, sec. 1304). States may expand participation in the SHOP Exchange to the large group market (HR 3590, Sec. 1312).	The merger of the SHOP and Individual Exchanges can only occur if the merged Exchange has adequate resources to assist the qualified individuals and qualified small employers (HR 3590, Sec. 1311). Insurers in the large group market are not required to participate in the Exchange (HR 3590, Sec. 1312). States may alter the definition of a large employer for plan years beginning before January 1, 2016 only (HR 3590, Sec. 1304). Until 2017, only small businesses with up to 100 employees may purchase coverage through the SHOP Exchange. (HR 3590, Sec. 1312).
BENEFITS AND COVERAGE IN THE EXCHANGE				
Benefit Structure	There will be four benefit categories of plans offered through the Exchange and in the individual and small group markets, as well as a separate catastrophic plan (HR 3590, Sec. 1302, as amended by Sec. 10104).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).		The catastrophic plan is available to those up to age 30, or to those who are exempt from the mandate to purchase coverage; it is only available in the individual market (HR 3590, Sec. 1302, as amended by Sec. 10104).
Qualified Health Benefit Plans	A qualified health benefits plan must offer at least the essential health benefits package, be offered by a qualified health	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	States may require that a qualified health plan offered in the state contain benefits in addition to the essential health benefits package (HR	If a state elects to impose coverage requirements on a qualified health plan that are in addition to those required by law, the state will assume the cost of these additional benefits (HR 3590, Sec. 1311).

	insurance issuer, and be certified. (HR 3590, Sec. 1301).		3590, Sec. 1311).	An Exchange may not make available any plan that is not a qualified health plan (HR 3590, Sec. 1311).
Essential Health Benefits Package	The essential health benefits package will provide a comprehensive set of services (HR 3590, Sec. 1302, as amended by Sec. 10104).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	Plans offered in the Exchanges will be required to offer benefits meeting this minimum set of standards (HR 3590, Sec. 1301).	The benefits package must cover at least 60 percent of the actuarial value of the covered benefits and limit annual cost-sharing to the current law limits (HR 3590, Sec. 1302, as amended by Sec. 10104).
Certification of Qualified Health Benefit Plans	The Secretary will establish the criteria for certifying a health benefit plans as qualified (HR 3590, Sec. 1301).	January 1, 2014: This provision Is effective (HR 3590, Sec. 1311).	Each Exchange will implement procedures consistent with the Secretary's criteria in certifying health plans (HR 3590, Sec. 1311).	The plan must meet the certification criteria issued by each Exchange through which the plan is offered (HR 3590, Sec. 1301) Health plans seeking certification must make periodic disclosures of financial relationships (HR 3590, Sec. 1303, as amended by Sec. 10104). To be certified, a plan must use the uniform enrollment form and the standard coverage presentation format (HR 3590, Sec. 1311).
ENROLLMENT IN THE EXCHANGE				
Voluntary enrollment	Enrollment in the Exchange by a qualified individual is voluntary. An individual will not be compelled to enroll in a qualified health plan or participate in an Exchange (HR 3590, Sec. 1312).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	States may allow agents or brokers to enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the state (HR 3590, Sec. 1312).	Health insurance issuers may offer health plans to qualified individuals or employers outside of the Exchange (HR 3590, Sec. 1312). Qualified employers and individuals may enroll in plans offered outside of the Exchange (HR 3590, Sec. 1312).

Premium Subsidies and Cost-Sharing Reductions	Premium subsidies will be available to help eligible individuals purchase insurance through the Exchange. Cost-sharing subsidies will also be available to limit out of pocket spending for low income people (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001).	January 1, 2014: This provision is effective (HR 3590, Sec. 1401).	States may make payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions for which an individual is eligible (HR 3590, Sec. 1412).	Premium credits and cost-sharing will be limited to U.S. citizens and legal immigrants with incomes between 133 percent and 400 percent FPL. (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001). The subsidies an individual receives will not be considered income for determining the individual's eligibility to participate in any federal or state program that is financed in whole or in part by federal funds (HR 3590, Sec. 1415). Employees offered coverage by their employers will not be eligible for premium credits unless the employer plan is unaffordable (HR 3590, Sec. 1401, as amended by Sec. 10105 and HR 4872, Sec. 1001).
Streamlining enrollment in public programs	The Secretary will establish a system under which state residents may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable state health subsidy programs (HR 3590, Sec. 1413). The system will also ensure that if an individual applying to an Exchange is determined to be eligible for participation in the state Medicaid or CHIP programs, that the individual	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will inform individuals of eligibility requirements for the state Medicaid program, CHIP, or any applicable state or local public program (HR 3590, Sec. 1311). If the Exchange, through screening applications, determines that an individual is eligible for participation in a qualifying state health subsidy program, the Exchange will enroll the individual in the corresponding program. (HR 3590, Sec. 1311).	An applicable state health subsidy program includes premium tax credits and cost-sharing reductions, a state Medicaid program, a CHIP program, and a state program establishing qualified basic health plans (HR 3590, Sec. 1413).

	will be enrolled to receive such assistance (HR 3590, Sec. 1413).			
Standard Enrollment Form	The Secretary will develop and provide to each state a single form that individuals may use to apply for enrollment in all applicable state health subsidy programs (HR 3590, Sec. 1413).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	A state may develop and use its own form as an alternative to the one developed by the Secretary (HR 3590, Sec. 1413).	A state may only use an alternative form it if is consistent with standards to be set by the Secretary (HR 3590, Sec. 1413). For programs not using household income as the basis of eligibility, the Secretary may allow states to use a supplemental form to make this determination (HR 3590, Sec. 1413).
Data Exchanges	States will share data securely among state health subsidy programs in order to determine eligibility for all such programs based on a single application (HR 3590, Sec. 1413).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	Each state will develop a secure, electronic interface for data sharing (HR 3590, Sec. 1413). Each applicable subsidy program will participate in the data exchange (HR 3590, Sec. 1413).	The data matching programs will determine eligibility for individuals who are either receiving assistance from a state health subsidy program, or who are applying to receive such assistance (HR 3590, Sec. 1413).
Navigator Program	Grant recipients will educate the public about qualified health plans and enrollment procedures, including the availability of tax credits and subsidies (HR 3590, Sec. 1311). The program will refer enrollees with questions or concerns about their plan or coverage to the appropriate state agency. (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, sec. 1311).	The Exchange will establish the Navigator program and award grants to eligible entities (HR 3590, sec. 1311).	Eligible entities must either have existing relationships, or the ability to quickly establish relationships, with consumers likely to qualify for participation in the Exchange (HR 3590, Sec. 1311). Such entities may include trade, industry and professional associations, agriculture organizations, community and consumer focused non-profits, chambers of commerce, unions, small business development centers, licensed insurance agents and brokers. Health insurance issuers are not eligible to be navigators (HR 3590, Sec. 1311).

Health Information and Technology	The Secretary will help to develop standards and protocols to streamline and facilitate the electronic enrollment of individuals in federal and state programs (HR 3590, Sec. 1561, Sec. 3021).	Within 180 days of enactment: The standards will be developed (HR 3590, Sec. 1561, Sec. 3021).	Sates may be required to incorporate the standards or protocols into health information and technology investments in order to receive federal funds for such investments (HR 3590, Sec. 1561, Sec. 3021).	The standards for electronic enrollment will allow for electronic matching against existing federal and state data, as well as the digitization of documents, and reuse of stored eligibility information (HR 3590, Sec. 1561, Sec. 3021). Individuals and their designees will receive notification and verification of eligibility, and will be able to apply, recertify and manage their eligibility information online (HR 3590, Sec. 1561, Sec. 3021).
CONSUMER CHOICE IN THE EXCHANGE				
Uniform Outline of Coverage	The Secretary will develop uniform standards for health plan issuers to use in summarizing coverage plans (HR 3590, Sec. 2715).	Within 12 months of enactment: The standards will be developed (HR 2590, sec. 2715).	The uniform standards that the Secretary develops will preempt less inclusive state standards (HR 3590, Sec. 2715).	The coverage and benefit summaries must be presented in a way that is clearly understandable by the average plan enrollee (HR 3590, Sec. 2715).
The Secretary's Internet Portal	The Secretary, in consultation with the states, will establish a website for individuals to identify affordable health insurance coverage options (HR 3590, Sec. 1103).	July 1, 2010: The website will be established (HR 3590, Sec. 1103).	The Secretary will assist states in developing their own websites (HR 3590, Sec. 1311).	The internet portal must allow residents and small businesses to access information about health insurance coverage offered by health insurance issuers, Medicaid Coverage, Title XXI of the Social Security Act, a state high risk pool, and the national high risk pool. (HR 3590, Sec. 1103).
Standardized Format for Comparing Benefit Plans	The Secretary will develop a standard format to help consumers compare benefit plans (HR 3590, Sec. 1103).	Within 60 days of enactment: The format will be created (HR 3590, Sec. 1103).		The format will be used to present information relating to the coverage options included on the Secretary's Internet portal (HR 3590, Sec. 1103).

The Exchange's Internet Portal	The Secretary will provide the Exchange with a model template for an internet portal to assist consumers in making easy health insurance choices. (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will maintain a website through which enrollees of qualified health plans may obtain standardized comparative information on such plans (HR 3590, Sec. 1311).	The portal will be used to direct consumers to health plans, to determine eligibility for tax credits or cost-sharing reductions, and to present standardized information regarding qualified health plans, including rating systems (HR 3590, Sec. 1311). For each qualified health plan offered through the Exchange, the model template will include access to the uniform outline of coverage and a copy of the plan's written policy (HR 3590, Sec. 1311).
Rating System for Qualified Health Benefit Plans	The Secretary will develop a rating system to rate qualified health plans offered through the Exchanges based on quality and price (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will make the quality rating system accessible to individuals and employers through the Exchange's internet portal (HR 3590, Sec. 1311). The Exchange will assign a rating to each qualified health plan offered through the Exchange (HR 3590, Sec. 1311)	There will be a rating system for each benefits level (HR 3590, Sec. 1311).
Enrollee Satisfaction System	The Secretary will develop an enrollee satisfaction survey system to evaluate enrollee satisfaction with qualified health plans offered through an Exchange (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will make the results of the survey accessible through the Exchange's internet portal (HR 3590, Sec. 1311).	This requirement applies to plans with 500 or more enrollees (HR 3590, Sec. 1311). The data must be compiled for consumers in such a manner that will allow them to easily compare satisfaction levels among plans (HR 3590, Sec. 1311).

Office of Consumer Assistance or Health Insurance Ombudsman programs	An office of consumer assistance or a health insurance ombudsman program will serve as an advocate for consumers in each state (HR 3590, Sec. 1002, Sec. 2793).	Enactment/March 23, 2010: This provision is effective (HR 3590, Sec. 1004).	States must establish, expand, or provide support for the office or program (HR 3590, Sec. 1002, Sec. 2793).	The office or ombudsman will assist consumers in filing appeals and complaints, collect data to quantify consumer inquiries, educate consumers on their rights and responsibilities in respect to coverage plans, provide information and referral to help consumers enroll in coverage and resolve problems with obtaining premium tax credits (HR 3590, Sec. 1002, Sec. 2793).
Consumer Assistance Hotline	The Exchange will have a toll-free telephone hotline (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will provide for the operation of a toll-free telephone hotline (HR 3590, Sec. 1311).	The hotline will respond to requests for assistance (HR 3590, Sec. 1311).
Coverage Calculator	Exchanges will provide a calculator for determining the actual cost of coverage (HR 3590, Sec. 1311).	January 1, 2014: This provision is effective (HR 3590, Sec. 1311).	The Exchange will establish this calculator and make it available electronically coverage (HR 3590, Sec. 1311).	The calculator will determine the actual cost of coverage after the application of any premium tax credits or cost-sharing reductions (HR 3590, Sec. 1311).
STATE FLEXIBILITY IN THE EXCHANGE				
Basic health programs for low-income individuals not eligible for Medicaid	The Secretary will establish a basic health program under which a state may offer at least the essential health benefits to eligible individuals instead of offering these individuals coverage through an Exchange (HR 3590, Sec. 1331).		States must coordinate this program with other state administered health programs, such as the State Medicaid program. (HR 3590, Sec. 1331). Individuals receiving this coverage may not participate in the Exchange (HR 3590, Sec. 1331).	Eligible individuals are those who are not eligible to enroll in the State Medicaid program, whose household income is between 133 and 200 FPL, who are under the age of 65, and who would be eligible for premium subsidies in the Exchange, were they allowed to participate (HR 3590, Sec. 1331). The monthly premiums in the basic health plan must not be more than what the individual would pay through the Exchange (HR 3590, Sec. 1331).

Waiver for State Innovation	States may waive certain coverage requirements within the state (HR 3590, Sec. 1332).	Within 180 days of Enactment: The Secretary will promulgate rules relating to the waivers (HR 3590, Sec. 1332). January 1, 2017: States may apply for waivers beginning on or after this date (HR 3590, Sec. 1332).	To receive a waiver, a state must enact a law providing for the state's actions under the state innovation waiver. A state may appeal this law and terminate the authority provided under the waiver, opting out of the program (HR 3590, Sec. 1332).	The waivers may last up to five years, and states may request a waiver continuation (HR 3590, Sec. 1332). The coverage requirements that may be waived are (i) Part I of subtitle D, (ii) Part II of subtitle D, (iii) Sec. 1402, (iv) Sec. 36B, 4980H and 5000A of the Internal Revenue Code of 1986 (HR 3590, Sec. 1332). States must demonstrate that the waiver's coverage plan is at least as comprehensive, affordable and widespread as the qualified plans offered through the Exchanges, and the state's plan must not increase the federal deficit (HR 3590, Sec. 1332).
Health Care Choice Compacts	Under these compacts, multiple states may agree to offer a qualified health plan that would only be subject to the laws of the state where the plan was created (HR 3590, Sec. 1333).	July 1, 2013: By this date, the Secretary will issue regulations for the creation of the compacts (HR 3590, Sec. 1333). January 1, 2016: A health care compact may not take effect before this date (HR 3590, Sec. 1333).	States will be able to form health care choice compacts, enabling insurers to sell policies in any state that participates in the compact (HR 3590, Sec. 1333). To enter into an agreement, the state must enact a law authorizing the state to do so (HR 3590, Sec. 1333).	The compact must provide coverage that is at least as comprehensive, affordable and widespread as that provided through qualified health plans offered through the Exchanges. Additionally, the compact may not increase the Federal deficit. (HR 3590, Sec. 1333). The issuer of a qualified health plan to which a compact applies must be licensed in each state in which it offers the plan under the compact, or must submit to the jurisdiction of each such state (HR 3590, Sec. 1333).
Nationwide Plans	Qualifying issuers in the individual or small group markets may offer a nationwide qualified health plan in more		A state may enact a law to opt out of this option. This opt out would remain effective until the state revoked the law (HR 3590, Sec. 1333).	To qualify as a nationwide plan, the plan must offer a benefits package that is uniform and each state, the issuer must be licensed in each state in which it offers the plan and meet all the requirements of a qualified health

	than one state. (HR 3590, Sec. 1333).		plan (HR 3590, Sec. 1333). The issuer must comply with filing and notice requirements, and the plan must be offered in all participating states (HR 3590, Sec. 1333).
Multi-State Plan	The Office of Personnel Management, which administers the Federal Employees Health Benefit Program, may contract to offer multi-state plans in the Exchange. (HR 3590, Sec. 1334, as amended by Sec. 10104).		Each multi-state plan must be licensed in each state in which it is operational, and it must meet the requirements of a qualified health plan (HR 3590, Sec. 1334, as amended by Sec. 10104). The plans will be distinct from the Federal Employees Health Benefit Program, and will also have a separate risk pool (HR 3590, Sec. 1334, as amended by Sec. 10104).
Community Health Insurance Option	The Secretary will establish an option for Exchanges to offer coverage that provides value, choice, competition and stability of affordable, high quality coverage throughout the United States. The Secretary my treat all enrollees as members of a single pool, and these plans must offer at least the essential health benefits (HR 3590, Sec. 1323).	A state may enact a law to opt out of this option. This opt out would remain effective until the state revoked the law (HR 3590, Sec. 1323). States may offer additional benefits through this option (HR 3590, Sec. 1323). States will designate a public or non-profit entity to serve as the State Advisory Council (HR 3590, Sec. 1323).	Health care providers and individuals are not required to participate in a community health insurance option, and there will be no penalties for non-participation (HR 3590, Sec. 1323). If a state elects to impose coverage requirements that are in addition to those required by law, the state will assume the cost of the additional benefits. (HR 3590, Sec. 1323). The State Advisory Council will provide recommendations to the Secretary on the operations and policies of the state's community health insurance option (HR 3590, Sec. 1323).
Consumer Operated and	The federal funds awarded through the CO-OP program will	July 1, 2013: The loans and grants will begin	The Secretary will award loans to qualified nonprofit health insurance issuers through the program to assist

Oriented Plan	assist in the establishment of a non-profit, member run health insurance option in each state (HR 3590, Sec. 1322).	to be distributed (HR 3590, Sec. 1322).		the issuers in meeting start up costs and solvency requirements (HR 3590, Sec. 1322). In the Co-OP, only qualified non-profit health insurance issuers may offer qualified health plans through the individual and small group markets in the states (HR 3590, Sec. 1322).
Wellness Program Demonstration Project	A 10-state demonstration project will allow participating states to offer incentives to individuals who participate in qualifying health promotion and disease prevention programs (HR 3590, Sec. 2705).	July 1, 2014: The program will be established (HR 3590, Sec. 2705).	Participating states may permit premium discounts, rebates or deductibles for participation in the program (HR 3590, Sec. 2705).	The state's project may not decrease coverage, increase tax credits, or increase cost-sharing costs to the federal government (HR 3590, Sec. 2705). The demonstration program may be expanded after the first three years it is operational (HR 3590, Sec. 2705).