

PUBLIC LAW 111-148—MAR. 23, 2010

124 STAT. 119

Public Law 111-148  
111th Congress

An Act

Entitled The Patient Protection and Affordable Care Act.

Mar. 23, 2010  
[H.R. 3590]

*Be it enacted by the Senate and House of Representatives of  
the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

**TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

**“PART A—INDIVIDUAL AND GROUP MARKET REFORMS**

**“SUBPART II—IMPROVING COVERAGE**

“Sec. 2711. No lifetime or annual limits.

“Sec. 2712. Prohibition on rescissions.

“Sec. 2713. Coverage of preventive health services.

“Sec. 2714. Extension of dependent coverage.

“Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.

“Sec. 2716. Prohibition of discrimination based on salary.

“Sec. 2717. Ensuring the quality of care.

“Sec. 2718. Bringing down the cost of health care coverage.

“Sec. 2719. Appeals process.

Sec. 1002. Health insurance consumer information.

Sec. 1003. Ensuring that consumers get value for their dollars.

Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.

Sec. 1102. Reinsurance for early retirees.

Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1104. Administrative simplification.

Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

**PART I—HEALTH INSURANCE MARKET REFORMS**

Sec. 1201. Amendment to the Public Health Service Act.

**“SUBPART I—GENERAL REFORM**

“Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 2701. Fair health insurance premiums.

“Sec. 2702. Guaranteed availability of coverage.

Patient  
Protection and  
Affordable Care  
Act.  
42 USC 18001  
note.

(4) **PLAN REFERENCE.**—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) **CATASTROPHIC PLAN.**—

(1) **IN GENERAL.**—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) **INDIVIDUALS ELIGIBLE FOR ENROLLMENT.**—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) **RESTRICTION TO INDIVIDUAL MARKET.**—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) **CHILD-ONLY PLANS.**—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

42 USC 18023.

**SEC. 1303. SPECIAL RULES.**

(a) **SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.**—

(1) **VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.**—

(A) **IN GENERAL.**—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

Determination.

(B) ABORTION SERVICES.—

(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are 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.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are 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.

(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) EXCEPTIONS.—Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance

option. Services described in subparagraph (B)(ii) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.—

(i) IN GENERAL.—The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title—

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) SPECIAL RULES.—For purposes of clause (i)—

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) SEGREGATION OF FUNDS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

(C) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated

Cost estimate.

to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than \$1 per enrollee, per month.

(3) PROVIDER CONSCIENCE PROTECTIONS.—No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions. Abortions.

(b) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

SEC. 1304. RELATED DEFINITIONS.

42 USC 18024.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term “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 an employer.

(2) INDIVIDUAL MARKET.—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms “large group market” and “small group market” mean 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 (as defined in subsection



## **Nelson Provisions in Health-Care-Reform Law Could Jeopardize, Stigmatize Women's Access to Abortion Services**

In a last-minute deal, anti-choice Sen. Ben Nelson (D-NE) won inclusion of a number of abortion-related provisions in the health-care law passed by Congress and signed into law by President Barack Obama in March 2010.<sup>1</sup>

The pro-choice community believes that the right to choose should not be dependent on one's income level and that all funding bans on abortion are discriminatory and unfair. That said, the Nelson restrictions go even beyond the Hyde amendment, and may impose serious constraints on abortion coverage that could cause women to lose ground in health reform. Following is a summary of the Nelson language, other provisions regarding abortion coverage in the health-reform law, and the executive order issued by the Obama administration regarding implementation of these provisions.

### **The Nelson Language Establishes a Two-Payment Requirement**

The Nelson language ultimately may require consumers buying a health-insurance plan with abortion coverage in the exchange to make two separate financial transactions: one to purchase health coverage overall and another to pay for the actuarial value of abortion services specifically.

If implemented in its most restrictive iteration, this provision presents several problems:

- It has the potential to create a major administrative burden for consumers. Requiring individuals to write two checks in order to purchase a plan that includes abortion coverage - a benefit that most plans already offer - is a new, unnecessary hassle.
- It unfairly treats abortion coverage as a separate and distinct - even stigmatized - benefit. Nowhere else in the law are individuals required to make two separate payments for other sensitive, personal health services.
- It imposes significant disincentives on insurance companies that want to include abortion services in their coverage. The language requires insurance plans to process double the number of financial transactions and to establish parallel administrative processes to track and properly deposit these additional payments. In the long term, these burdens could severely limit women's ability to obtain abortion coverage within the exchange. In fact, an independent analysis found that the requirement that individuals make two separate payments "could be expected to chill issuers' willingness

to sell products that cover a range of medically indicated abortions,” and that “the more logical response would be not to sell products that cover abortion services.”<sup>2</sup>

### **The Nelson Language Encourages and Empowers States to Block Abortion Coverage**

The Nelson language requires state insurance commissioners to determine whether health plans are in compliance with the law's requirements to segregate funds. (As a reminder, the law would create a firewall to separate public funds from private premiums that can be used to cover abortion-related services.) However:

- Absent explicit federal regulations to the contrary, this authority could allow a politically minded anti-choice commissioner to create administrative hurdles that would dissuade insurers from covering abortion or make it virtually impossible to be in compliance with the law.
- If the plans are deemed to be out of compliance, it may threaten their ability to participate in the exchange.
- The law does allow individuals and plans to appeal the commissioner's decision to a court of law. However, pursuing a lawsuit can be prohibitively expensive.

The Nelson language also includes a provision explicitly inviting states to enact their own, Stupak-like restrictions on abortion coverage in their state insurance markets.<sup>3</sup> Although a few federal courts have found that states already have this power, the political intent of Sen. Nelson's language seems clear: to encourage states to ban all private insurance coverage for abortion. At the time the Nelson restrictions were adopted, six states already prohibited abortion coverage in the private insurance market: ID, KY, MO, ND, OK, RI.<sup>4</sup> (Rhode Island has two separate insurance prohibition laws; courts have declared one unconstitutional and unenforceable and the other partially unconstitutional and unenforceable.) In the months since passage of the Affordable Care Act, five states have enacted bans that make abortion coverage entirely unavailable in their health-insurance exchanges, even for women paying with their own, private dollars: AZ, LA, MS, MO, TN.<sup>5</sup> Looking ahead, nine additional states are particularly vulnerable to similar policy attacks given their anti-choice legislatures and governors (AL, GA, MI, NE, OH, SD, TX, UT, and WI).

### **Other Abortion-Coverage Provisions in the Health-Reform Law**

#### *The Nelson Provisions Ban Federal Funding for Abortion and Maintain the Hyde Amendment*

The law bans federal funds from being used to pay for abortion coverage by insurance plans in the exchange, except where the pregnancy threatens the life of the woman or the pregnancy is the result of rape or incest.<sup>6</sup> Section 1303(b)(1)(B)(i) of the law states: “The services described in this clause are 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.”<sup>7</sup> This direct reference

to the Hyde amendment means that the same restrictions on federal funds in Medicaid and other federal health programs will be applied to the health-insurance exchange. The Hyde amendment has blocked federal funds from covering abortion services for low-income women receiving Medicaid for more than 30 years.

#### *The Nelson Provisions Require Strict Segregation of Funds*

The law requires insurance plans in the exchange to establish a separate account that is maintained solely for the deposit of premiums for abortion services and for any expenditure related to those services.<sup>8</sup> It also requires plans to use accepted accounting procedures to maintain the separation of funds for coverage of abortion services.<sup>9</sup>

Some argue that if the federal government provides a subsidy to an individual who uses his or her own funds to purchase a plan that covers abortion services, then the government is indirectly paying for such services.<sup>10</sup> This is incorrect. In fact, there are many programs that receive federal funds that already effectively segregate private funds used for abortion services. In addition, there are several other circumstances where “firewalls” are used to ensure that federal funds are not used for unauthorized purposes.

- For example, 17 states and the District of Columbia cover the cost of abortion services beyond those permitted under the Hyde amendment.<sup>11</sup> The Department of Health and Human Services has long recognized that states may provide this coverage by paying for it from an account that is completely separate from any federal funds or the state’s Medicaid matching funds.<sup>12</sup> As long as there is no crossover between state funds used to pay for abortion coverage and federal monies, no commingling occurs.
- In addition, because the Constitution mandates separation of church and state, the federal government cannot fund sectarian activities. However, many religious organizations receive federal funding for secular activities that they provide to the community. For example, the Catholic Church has a long history of seeking government funding, including support for Catholic schools, hospitals, and programs run by Catholic Charities.<sup>13</sup> In those arrangements, the church is able to manage funds from separate sources to ensure that tax dollars do not finance religious practices. If separation of federal funds and private dollars works for the church hierarchy, then it should also work for women’s reproductive-health care.

#### *The Nelson Provisions Include Other Abortion-Related Restrictions*

The health-reform law has the following additional abortion-related provisions:

- *Sets conditions on abortion coverage in the exchange :*
  - Insurance plans participating in the exchange would determine whether or not to provide abortion coverage.<sup>14</sup>

- As readers will recall, the law does not include a public option. Instead, the Office of Personnel Management will administer two or more private plans. One of these plans must not provide abortion coverage. The other(s) may, at their choice.<sup>15</sup>
- *Includes refusal rights:* The law would grant broad license to individuals and facilities to refuse to provide, pay for, or refer for abortion services.<sup>16</sup>

### **Executive Order Regarding Abortion-Coverage Provisions in the Health-Reform Law**

In order to win the support of several anti-choice lawmakers in the House, the Obama administration issued an executive order confirming that the Hyde amendment, which denies abortion care to millions of low-income Americans, remains in force under the health-reform law.<sup>17</sup> Such an order was unnecessary, since the law would not have affected the enforceability of the Hyde amendment. The order also discusses plans for implementing the Nelson restrictions, including a requirement that the secretary of the Department of Health and Human Services develop model implementation guidelines within 180 days. These guidelines are intended to instruct state health insurance commissioners on how to ensure insurance plan compliance with the law's requirement that no federal funds be used for abortion care.

### **Conclusion**

The health-reform law takes significant steps toward bringing more than 30 million Americans into a health-care system that will include coverage for many reproductive-health services. However, the Nelson language imposes unacceptable new restrictions on abortion coverage that could result in most private health insurers no longer offering coverage for abortion. Improving health-care coverage for all Americans should not come at the price of restricting women's access to reproductive-health services.

January 1, 2011

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#### **Notes**

<sup>1</sup> P.L.111-148, 111th Cong. (2010).

<sup>2</sup> Sara Rosenbaum, *Abortion provisions in the Senate Managers Amendment* (Dec. 21, 2009) at <http://www.talkingpointsmemo.com/documents/2009/12/gwu-analysis-of-nelson-provision.php?page=1> (last visited Oct. 25, 2010)

<sup>3</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(a)(1).

<sup>4</sup> NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (20th ed. 2011), at [www.WhoDecides.org](http://www.WhoDecides.org).

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- <sup>5</sup> NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (20th ed. 2011), at [www.WhoDecides.org](http://www.WhoDecides.org).
- <sup>6</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(b)(2).
- <sup>7</sup> P.L. 111-148, 111th Cong. (2010), at §1303(b)(1)(B)(i).
- <sup>8</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(b)(2)(C).
- <sup>9</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(b)(2)(D).
- <sup>10</sup> Shailagh Murray and Lori Montgomery, *Senate Health-Care Bill Diverges From House on Key Provisions*, THE WASHINGTON POST, Nov. 19, 2009, at <http://www.washingtonpost.com/wp-dyn/content/article/2009/11/18/AR2009111802014.html> (last visited Oct. 25, 2010)
- <sup>11</sup> NARAL Pro-Choice America Foundation, *Who Decides? The Status of Women's Reproductive Rights in the United States* (20th ed. 2011), at [www.WhoDecides.org](http://www.WhoDecides.org).
- <sup>12</sup> Letter from Department of Health and Human Services Health Care Financing Administration to State Medicaid Directors of Feb. 12, 1998. (Re: changes to the Hyde Amendment. "If a state wishes to reimburse managed care providers or organizations to provide additional abortions, it must do so under a separate contract or arrangement using monies unrelated to Federal, state or local Medicaid matching dollars. However, this should not be construed as restricting the ability of any managed care provider to offer abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a state's or locality's contribution of Medicaid matching funds).")
- <sup>13</sup> See, e.g., Catholic Charities USA, *Annual Report 2009*, at <http://www.catholiccharitiesusa.org/NetCommunity/Document.Doc?id=2331> (last visited Oct. 25, 2010).
- <sup>14</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(b)(1)(a).
- <sup>15</sup> P.L. 111-148, 111th Cong. (2010) at § 1334(a)(6).
- <sup>16</sup> P.L. 111-148, 111th Cong. (2010), at § 1303(b)(4).
- <sup>17</sup> Press Release, White House, *Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act* (March 21, 2010).