

Comparison of the House and Senate Health Care Measures¹

	Senate Patient Protection and Affordable Health Care Act Senate Amendment 2786 to H.R. 3590	House of Representatives Affordable Health Care for America Act H.R. 3962
Current Status	The Senate passed the bill by a vote of 60-39 on 12/24/09.	The House of Representatives passed the bill by a vote of 220 to 215 on 11/7/09.
<u>OVERVIEW OF PROPOSED FEDERAL HEALTHCARE REFORM LEGISLATION</u>	<p>The Senate measure would require most U.S. citizens and legal residents to have health insurance. It creates state-based American Health Benefit Exchanges through which individuals can purchase coverage. Premium and cost-sharing credits would be available to individuals and families with income between 100-400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009). The bill would create separate Exchanges through which small businesses can purchase coverage. Employers would be required to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for most small employers. Health plans in the Exchanges, as well as individual and small group markets, would be subject to new regulations. Medicaid eligibility would be expanded to those with incomes up to 133% of the federal poverty level.</p>	<p>The House measure would require most individuals to have health insurance. It creates a national Health Insurance Exchange through which individuals and smaller employers can purchase health coverage. Premium and cost-sharing credits would be available to individuals and families with incomes up to 400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009). Employers would be required to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund. Certain small employers can obtain a tax credit to offset the costs of providing coverage. Health plans participating in the Exchange and small group insurance markets would be subject to new regulations. Medicaid eligibility would be expanded to those with incomes up to 150% of the poverty level.</p>

¹ All citations refer to the section numbers in the applicable bill. "PHSA" section numbers refer to sections of the Public Health Service Act that would be amended or added by the corresponding bill provision. "IRC" section numbers refer to sections of the Internal Revenue Code of 1986 that would be amended or added by the corresponding bill provision.

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<u>MARKET REFORMS</u>		
Guaranteed Issue	Require guarantee issue (Effective 1/1/2014) (§1201: PHSA §2702, §2703)	Require guaranteed issue (§212)
Guaranteed Renewals	Guaranteed renewal required (Effective 1/1/2014) (§1201: PHSA §2702, §2703)	Guaranteed renewal required (§212)
Rate Reform	No rate reform or community rating would apply in the self-insured space or to groups of 101 employees or less. In the individual and the small group markets, and in the Exchanges, allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio). Require risk adjustment in the individual and small group markets and in the Exchange. The use of information related to gun ownership for purposes of determining premium rates is expressly prohibited. (Effective 1/1/2014) (§1323: PHSA §2701, §1333)	Allow rating variation based only on age (limited to 2 to 1 ratio), premium rating area, and family enrollment. Require risk adjustment of participating Exchange plans. (§212)
Lifetime or Annual Coverage Limits	Individual and group health plans would be prohibited from placing lifetime limits on the dollar value of coverage. (Effective six months following enactment). Beginning in January 2014, individual and group health plans would be prohibited from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. (§1001: PHSA §2711)	Individual and group health plans would be prohibited from placing aggregate dollar lifetime limits on coverage. (Effective six months following enactment) (§222(a)(3))
Pre-Existing Conditions Limits	Group health plans and issuers in the individual and group markets will be prohibited from excluding coverage for pre-existing health conditions (§1201: PHSA § 2704).	A QHBP would be prohibited from excluding coverage for pre-existing health conditions, or placing limits on coverage based on health status, medical condition, claims experience, receipt of health care, medical history, genetic

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	<p>Not later than 90 days after enactment, the Secretary would establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals. Individuals would be eligible if they are U.S. citizens and legal immigrants with a pre-existing medical condition and have not had credible medical coverage for at least six months. The program would begin on the date the program is established and end on January 1, 2014. (§1101)</p> <p>Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit (\$5,950/individual and \$11,900/family in 2010).</p> <p>The Secretary would establish criteria for determining whether health insurance issuers and employment based health plans discouraged an individual from remaining enrolled in prior coverage based on that individual’s health status. (§1101)</p> <p>\$5 billion would be appropriated from the period of the program implementation to January 1, 2014 to pay claims and the administrative costs of the high-risk pool. (§1101)</p>	<p>information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or similar factors. (§211)</p> <p>A temporary national high-risk pool would be established to subsidize health care coverage for eligible individuals (and spouses and dependents) with a pre-existing medical condition. Individuals would be eligible if they have a pre-existing medical condition and have been uninsured for at least six months and was either:</p> <ul style="list-style-type: none"> • denied coverage for a pre-existing medical condition, or • offered terms that are limited based on the pre-existing condition, or • offered coverage at a premium rate that is above the premium rate for the high risk pool. <p>(Effective 1/1/2010)</p> <p>Premiums for the high-risk pool will be set at not higher than 125% of the prevailing rate for comparable coverage in the state and could vary by no more than 2:1 due to age; annual deductibles will be limited to \$1,500 for an individual; and maximum cost-sharing will be limited to \$5,000 for individuals. (Effective January 1, 2010 and until the Health Insurance Exchange is established) (§101).</p>
Rescissions	Prohibit insurers from rescinding coverage except in cases of fraud. (§ 1001; PHSA § 2712)	Prohibit insurers from rescinding coverage except in cases of fraud. (§103: PHS §2712 and 2742)
Requirements for New Policies	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,	No comparable provision

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	would be required to comply with one of the four benefit categories. Existing individual and employer sponsored plans do not have to meet the new benefit standards. (Effective 1/1/2014)	
Non-Discrimination Standards	<ul style="list-style-type: none"> Beginning in 2011, no discrimination permitted based on the wages of employees Beginning in 2014, insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS (§1201: PHSA §2706)	<ul style="list-style-type: none"> The Health Choices Commissioner has the authority to set non-discrimination rules Requires mental health parity and substance abuse disorder benefits parity (§214)
Extension of Family Coverage to Older Dependents	Insurers that offer dependant coverage would be required to allow uninsured children to remain on their parents' health insurance up 26 years of age. (Effective 1/1/2011). (§1001: PHSA §2714)	Insurers would be required to allow uninsured children to remain on their parents' health insurance up 27 years of age. (§216)
Medical Loss Ratio (MLR)	<ul style="list-style-type: none"> Plans offering coverage in the group and individual markets (including grandfathered plans, but excluding self-insured plans) would be required to report the proportion of premium dollars that are spent on items other than clinical services and activities to improve quality of care (their "medical loss ratio") Individual plans and Small Group Markets (1-100 employees) must have a minimum MLR of 80% Large employers (101 or more employees) must have a minimum MLR of 85% Beginning in 2011, if minimums are not met, the issuer must provide a rebate to enrollees; the rebate will be equal to the difference between the 	Individual, small, and large group plans must have a minimum MLR of 85% beginning in 2010; plans that do not meet the minimum MLR requirement must provide a rebate to enrollees in an amount equal to the amount by which the plan's MLR falls short of the mandatory minimum MLR. Plans offered through the Exchange will be exempt from these requirements. HHS will establish a uniform definition of 'Medical Loss Ratio' in a health insurance issuer's book of business for the small and large group market. Such methodology will take into account the special circumstances of smaller plans, different types of plans, and newer plans. (§102: PHSA §2714, 2754)

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	<p>carrier’s MLR and the minimum MLR specified in the statute</p> <ul style="list-style-type: none"> It appears that the MLR requirement does not apply to Administrative Services Only (“ASO”) or ancillary coverage. <p>(§1331, §1001, §10101: PHSA §2718)</p>	
Premium Rate Review	<p>For plans other than employer-sponsored plans, the bill would establish a process for reviewing increases in health plan premiums and require plans to justify increases. States would be required to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. States may receive grants to support efforts to review and approve premium increases. (Effective beginning plan year 2010) (§1001: PHSA §2794)</p>	<p>For plans other than employer-sponsored plans, require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment) (§104)</p>
Merger of Individual and Small Group Markets	<p>Allow states the option of merging the individual and small group markets. (Effective 1/1/2014)</p>	<p>No comparable provision.</p>
Extension of COBRA Coverage	<p>No comparable provision.</p>	<p>Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (Effective upon enactment) (§113)</p>
Anti-trust exemption for health insurers	<p>No comparable provision.</p>	<p>Remove the anti-trust exemption for health insurers and medical malpractice insurers. (Effective upon enactment)</p>
Reinsurance	<p>Each state required to establish a temporary reinsurance program for individual and small group markets, by January 1, 2014. (§1341) Thereafter, reinsurance program for early retirees (see discussion below in “Subsidies to Employers –</p>	<p>No comparable provision. Reinsurance program for early retirees (see discussion below in “Subsidies to Employers – Reinsurance” section) ends when appropriations are exhausted.</p>

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	Reinsurance” section) would sunset.	
<u>EMPLOYER MANDATES</u>		
Large Employers	<p><u>Employers with more than 50 Employees:</u> Employers with more than 50 employees must offer coverage to their employees.</p> <p>Employers that <i>do not offer coverage</i> and have at least one full-time employee (defined as one working 30 or more hours/week) who receives a premium tax credit will be assessed a fee of \$750 per full-time employee.</p> <p>Employers <i>that offer coverage</i> but have at least one full-time employee receiving a premium tax credit will pay the lesser of up to \$3,000 for each employee receiving a premium credit or \$750 for each full-time employee.</p> <p>For employers that impose a waiting period before employees can enroll in coverage, require payment of \$400 for any fulltime employee in a 30-60 day waiting period and \$600 for any employee in a 60-90 day waiting period.</p> <p>(Effective 1/1/2014) (Section amended: §1511-1515; Laws amended: IRC and the Fair Labor Standards Act)</p>	<p>Employers are required to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. For Part-Time employees, the employer contribution will be a proportional amount. (Effective 1/1/2013) (Section amended: §411, §412, §421, §423, §511 and §512; Laws amended: IRC, PHS, ERISA)</p>
Small Employers	<p><u>Employers with less than 50 Employees:</u> Employers with 50 or fewer employees are exempt from any of the above penalties. Therefore, participation in the</p>	<p>Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than \$750,000:</p> <ul style="list-style-type: none"> • Annual payroll less than \$500,000: exempt

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	Exchanges is optional for such employers. (§1513) Exception: Construction Industry Employers with 5-50 full-time employees and whose annual payroll is in excess of \$250,000 will be subject to the above penalties if they fail to offer health care to their employees.	<ul style="list-style-type: none"> • Annual payroll between \$500,000 and \$585,000: 2% of payroll; • Annual payroll between \$585,000 and \$670,000: 4% of payroll; • Annual payroll between \$670,000 and \$750,000: 6% of payroll. (Effective 1/1/2013) (§411, §421, §423, §511 and §512)
Mandated Coverage Levels	The requisite level of coverage is “minimum essential coverage,” (§1513 (a) creating new 43 USC §4980H), which is defined as an “eligible employer sponsored plan,” (§1501 (b) creating new Internal Revenue Code sec. 5000A (f)(2)). An “eligible employer sponsored plan” is government-sponsored coverage, employer-sponsored coverage, and grandfathered health plans. (§1501 (b):IRC § 5000A (f)(2); see also §1304 (a)(3)).	Employers must provide the “essential benefits package” to satisfy the employer mandate. The requirements are defined in detail in Section 222. A new “Health Benefits Advisory Committee” will make recommendations as to the specific “essential benefit package” which must be provided and that guidance is intended to evolve over time (§223-§224). The bill nevertheless spells out minimum criteria that must be satisfied, including, for example, coverage for hospitalization, prescriptions, preventative care, and rehabilitative services; and subjects this coverage to limits on cost sharing (for example, co-pays for preventative services and lifetime payment limits both will be prohibited and annual total cost-sharing for an individual cannot exceed \$5,000 and for a family cannot exceed \$10,000) and a minimum actuarial value, all of which will be set by HHS in consultation with the new public-private Health Benefits Advisory Committee. The minimum benefits package must be offered regardless of whether the plan participates in the national Exchange; and the minimum benefits package serves as the standard against which compliance with the individual and employer mandates will be evaluated. (§222)
Automatic	Employers with more than 200 employees would be	Employers that offer coverage would be required to

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Enrollment Mandate	required to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. (Effective 1/1/2014) (§1511: FLSA §18A)	automatically enroll into the employer’s lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage. (Effective 1/1/2013) (§412)
Employer Responsibility Study	No comparable provision.	Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer Hardship exemption is appropriate. (Report due 1/1/2012) (§415)
Voucher	<p>Workers who qualify for an “affordability exemption” to the individual mandate but do not qualify for tax credits can take their employer contribution in lieu of coverage through a group plan and join an exchange plan.</p> <p>Employees qualify if their required contribution under the employer’s plan would be between 8 and 9.8 percent of their income, and the employee does not make more than 400% above the federal poverty level.</p> <p>Voucher amounts are excluded from taxation to the extent used to pay for insurance coverage, and must be equal to the contribution that the employer would have made to its own plan.</p> <p>The voucher can only be used to purchase coverage through the exchange, but any excess funds are paid to the employee. (§10108: IRC §139D)</p>	No comparable provision.
Waiting Period Penalty	A fee would be imposed on large-employers (101 employees or more) which require extended waiting periods (over 30 days) before employees could enroll in a plan. The fee is imposed for each full-time employee of the employer for whom the waiting period applies, not for all	No insurance carrier may impose a waiting period on certain children under CHIP. (§1734)

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	employees.	
	Employers that impose a waiting period before employees can enroll in coverage would be required to pay \$400 for any fulltime employee in a 30-60 day waiting period and \$600 for any employee in a 60-90 day waiting period. (§1201: PHSA §2708, §1511: FLSA §18A, §1513: IRC §4980H)	
	For waiting periods that exceeded 30 days, but not 60 days, the fee would be \$400 per applicable employee, and for waiting periods exceeding 60 days, the fee would be \$600. After 2014, these amounts would be indexed by a premium adjustment percentage for the calendar year. (§1201: PHSA §2708, §1511: FLSA §18A, §1513: IRC §4980H)	No comparable provision.
	No employer may impose a waiting period that exceeds 90 days. (§1201: PHSA §2708)	No comparable provision.
Mandated Appeals Process	Self-insured plans will be required to implement new mandated appeals processes (with both internal and external appeal rights for the denial of coverage claims) and to notify participants of these new rights. The rights include allowing participants to review their files, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the proceedings. HHS will establish minimum standards that will apply to the external appeals process component for self-insured plans; the States will set such rules for insured plans and HHS will have the authority to do so only to the extent a State does not do so. (§1001: PHSA §2719)	This provision is not immediate. A Qualified Health Benefit Provider (“QHBP”) would be required to provide timely grievance and appeals mechanisms in compliance with standards that would be established by the Commissioner. Internal claims and appeals processes would incorporate the existing ERISA requirements. The Commissioner would establish an external review process to provide an independent, de novo review of denied claims. Grievance and appeals standards would apply to QHBPs outside of the exchange only to the extent specified by the Commissioner. The Commissioner would appoint a Qualified Health Benefits Plan Ombudsman to receive and provide assistance with grievances. (§232, §234, §244)

SUBSIDIES TO

Senate
Patient Protection and Affordable Health Care Act
Senate Amendment 2786 to H.R. 3590

House of Representatives
Affordable Health Care for America Act
H.R. 3962

EMPLOYERS

**Small Businesses
Tax Credit**

Provide small employers with no more than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for employees with a tax credit.

- Phase I:
 - For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.
 - The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
 - The credit phases-out as firm size and average wage increases.²
 - Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.
- Phase II:
 - For tax years 2014 and later, for eligible small

- Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit for up to two years.
- The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less.
- The credit phases-out as firm size and average wage increases and is not permitted for employees earning more than \$80,000 per year.
(Effective 1/1/2013) (§521(a): IRC §45R(b),(c)and (e))

² For Phase I and II: For employers with 10-25 employees, the tax credit amount is reduced by multiplying the sum of the following two fractions:

(1) the number of full-time employees (more than 10) / 15, PLUS

(2) the average annual wages of the employer in excess of \$25,000 / \$25,000

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	<p>businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer’s contribution toward the employee’s health insurance premium if the employer contributes at least 50% of the total premium cost.</p> <ul style="list-style-type: none"> • The credit will be available for two years. • The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. • The credit phases-out as firm size and average wage increases.³ • Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer’s contribution toward the employee’s health insurance premium. <p>(§1421: IRC §45Q)</p>	
Reinsurance Program for Early Retirees	<p>A temporary reinsurance program would be created for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. The payments from the reinsurance program will be used to lower the costs for</p>	<p>A temporary reinsurance program would be created for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Payments from the reinsurance program will be used to lower the costs for</p>

³ For Phase I and II: For employers with 10-25 employees, the tax credit amount is reduced by multiplying the sum of the following two fractions:

- (1) the number of full-time employees (more than 10) / 15, PLUS
- (2) the average annual wages of the employer in excess of \$25,000 / \$25,000

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	enrollees in the employer plan. Congress would appropriate \$5 billion to finance the program. (Effective 90 days following enactment through 1/1/2014) (§1102)	enrollees in the employer plan. Congress would appropriate \$10 billion over ten years for the reinsurance program. (Effective 90 days after enactment) (§111)
Wellness Subsidies for Employers	Small employers that establish wellness programs would be eligible for grants for up to five years. (Funds appropriated for five years beginning in FY 2011) (§10408)	Small employers would be eligible for grants for up to three years for up to 50% of costs incurred for a “qualified wellness program” (defined below). Grant funds may only be used for costs attributable to the wellness program, and not to the health plan or health insurance coverage offered in connection with such a plan. Grants would be capped at \$150 per employee and a total of \$50,000 for an employer each year. A qualified wellness program means a program that is jointly certified by the Secretaries of HHS and Labor meets at least three out of four required components. These components pertain to health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (including smoking cessation and weight reduction) and having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. (Effective 2/1/2010) (§112)
	Technical assistance and other resources would be available to evaluate employer based wellness programs. Funds would be available to conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment) (§4303: PSHA §4102)	No comparable provision.
	Employers would be permitted to offer employees rewards	No comparable provision.

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<p>of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. The rewards may take the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided.</p> <p>Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective 1/1/2014) A state pilot program will be created by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. The program would be expanded in 2017 if it is effective. Reporting on effectiveness and impact of wellness programs would be required. (Report due three years following enactment) (§1201: PHSA §2705)</p>	
<p><u>REVENUE</u> <u>GENERATING</u> <u>PROVISIONS</u></p>	
<p>Excise Tax on “Cadillac Plans” A 40% excise tax would be imposed on insurers of employer-sponsored health plans with aggregate values that exceed \$8,500 for individual coverage and \$23,000 for family coverage, indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point. (Effective 1/1/2013).</p> <p>Threshold amounts would be increased for retired individuals age 55 and older who are not eligible for</p>	<p>No comparable provision.</p>

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<p>Medicare and for employees engaged in high-risk professions by \$1,350 for individual coverage and \$3,000 for family coverage.</p> <p>Initially, the threshold amount is increased by 20% in the 17 states with the highest health care costs. The increase is reduced by half each year until it is phased out in 2015. (Effective 1/1/2013). (§9001: IRC §4980I)</p>	
<p>The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market, except for coverage eligible for the deduction for self-employed individuals. (Effective 1/1/2013). (§9001: IRC §4980I)</p>	<p>No comparable provision.</p>
<p>Health insurance coverage subject to the excise tax is broadly defined to include not only the employer and employee premium payments for health insurance (including self-insured plans), but also premiums paid by the employee and the employer for dental and vision. In addition, tax advantaged accounts such as flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement accounts (HRAs) are also specified as health insurance coverage and subject to the excise tax. (§9001: IRC §4980I). Note, however, that the tax is calculated based on the <u>aggregate</u> premium amount for each employee for all relevant coverage they have (e.g., major medical plus dental plus vision).</p> <p>It is the employer’s responsibility to calculate the amount of benefits that are subject to the tax and calculate the tax, except in the case of multi-employer plans, in which case</p>	<p>No comparable provision.</p>

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	the bill imposes the responsibility on the plan sponsor. (§ 9001: IRC § 4980I (c)(4)) .	
	Voluntary products that provide economic benefits - disability, indemnity, and policies that trigger payment based on the condition and not the filing of health claims are all explicitly exempt. (§9001: IRC §4980I)	No comparable provision.
	The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. (§9001: IRC §4980I)	No comparable provision.
Tax on High Income Individuals	Imposes a 0.9% increase in the Medicare wage tax for single taxpayers with income in excess of \$200,000 and couples filing jointly with incomes in excess of \$250,000. (§3308: SSA §1860D-13(a))	Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding \$500,000 and families with modified adjusted gross income exceeding \$1,000,000. (Effective 1/1/2011) (§551)
Executive Compensation	The deductibility of executive and employee compensation would be limited to \$500,000 per applicable individual for health insurance providers. (Effective 1/1/2010) (§9014: IRC §162(m))	No comparable provision.
Treatment of HSAs and MSAs	The tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses would be increased to 20% (from 10% for HSAs and from 15% for Archer MSAs) of disbursed amount. (Effective 1/1/2011) (§9004: IRC §223(f)(4)(A))	The tax on distributions from a health savings account that are not used for qualified medical expenses would be increased to 20% (from 10%) of the disbursed amount. (Effective 1/1/2011) (§ 533).
	Only prescribed drugs would be permitted to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective 1/2011) (§9003)	Permit only prescribed drugs to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective 1/2011) (§531)

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FSA Contributions	The amount of contributions to a flexible spending account (FSA) for medical expenses would be limited to \$2,500 per year, adjusted for inflation. (Effective 1/1/2011) (§9005: IRC §125)	The amount of contributions to a flexible spending arrangement for medical expenses would be limited to \$2,500 per year. (Effective 1/1/2013) (§532)
Medical Expense Deductions	The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. The increase for individuals age 65 and older would be waived for tax years 2013 through 2016. (Effective 1/1/2013) (§9013: IRC §213)	No comparable provision.
New Taxes and Fees for Various Sectors of the Health Care Industry including Insurers	<ul style="list-style-type: none"> • Third-party administrators and health insurers must bear a pro rata share of a three year aggregate industry fee to fund a transitional reinsurance program that will total \$12 billion in 2014, \$8 billion in 2015, and \$5 billion in 2016; (§1341(b)) • 10% sales-type tax on indoor tanning services; (§10907: IRC §5000B) • A new fee on both health insurers and self-insured plans of \$2 per covered beneficiary to fund comparative research initiatives (§6301); • \$2.3 billion annual fee on the pharmaceutical manufacturing sector (effective for sales after 12/31/2008); (§9008) • \$2 billion annual fee on the medical device manufacturing sector (effective for sales after 12/31/2009); (§9009) • Annual fee imposed on all health insurers (excluding 	Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (Effective 1/1/2013) (§552)

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	<p>self-insured plans), based on their market share. The fee will be assessed based on net premiums written (but not TPA fees), starting in 2011. The total amount of the fee levied across all health insurers will be \$2 billion in 2011, \$4 billion in 2012, \$7 billion in 2013, \$9 billion in each of 2014, 2015 and 2016, and \$10 billion in 2017 and thereafter. There is an exemption from the annual fee for certain non-profit insurers with a medical loss ratio of at least 90% in every market segment served and that average 92% across all market segments, including individual, small group and large group plans. (See discussion of minimum medical loss ratios and associated carrier rebate requirement at page 4 above). The same exception applies to mutual companies with at least 40% of the market share in any state. (§9010)</p>	
Taxation of Retiree Drug Subsidies	<p>Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. (§9012)</p>	<p>Currently, certain employers are eligible for Federal subsidies with respect to prescription drug benefits provided to retirees and the subsidies are excluded from gross income. The bill would eliminate the provision allowing employers to deduct these expenses for which they are subsidized. (§534)</p>
Comparative Effectiveness Research	<p>A private, nonprofit entity, the Patient-Centered Outcomes Research Institute, would be established. The bill would prohibit the Institute or HHS from mandating coverage or reimbursement policies based on the Institute’s research. The comparative effectiveness program will be funded by appropriations and an annual fee</p>	<p>A new Center at the Agency for Healthcare Research and Quality, would be created and supported by a combination of public and private funding that will conduct, support and synthesize comparative effectiveness research. (§1402)</p> <p>The trust fund for the comparative effectiveness research</p>

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<p>imposed on all health insurance policies (§6301) Upon date of enactment, the bill would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5). (§6302)</p>	<p>program would be established with dedicated amounts going to both the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission. Fees would be assessed on sponsors of private insurance to be transferred to the Comparative Effectiveness Research Trust Fund. (§1802)</p>
<p><u>INDIVIDUAL MANDATES</u></p> <p><u>Mandate:</u></p> <ul style="list-style-type: none"> Require U.S. citizens and legal residents to have qualifying health coverage. (§1501) <p><u>Penalty:</u></p> <ul style="list-style-type: none"> For individuals without coverage, a tax penalty of the greater of \$750 per year up to a maximum of three times that amount (\$2,250) per family or 2% of household income would apply. The penalty will be phased-in according to the following schedule: \$95 in 2014, \$495 in 2015, and \$750 in 2016 for the flat fee or .5% of taxable income in 2014, 1.0% of taxable income in 2015, and 2% of taxable income in 2016. (§1501) After 2016, the penalty will be increased annually by the cost-of-living adjustment. (§1501) <p><u>Exemptions:</u></p> <ul style="list-style-type: none"> Exempted individuals would include nonresident aliens, individuals who live and work outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax filing purposes, and 	<p><u>Mandate:</u></p> <ul style="list-style-type: none"> Require individuals to have “acceptable health coverage”. (§501) <p><u>Penalty:</u></p> <ul style="list-style-type: none"> For individuals without coverage, a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange would apply. (§501) <p><u>Exemptions:</u></p> <ul style="list-style-type: none"> Exempted individuals would include individuals with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals. No penalty would be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes, individuals whose household income did not exceed 100% of the federal poverty level (FPL), or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a

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<p>others granted an exemption by the Secretary. (§1501)</p>	<p>QHP.</p> <ul style="list-style-type: none"> • Individuals whose required contribution for a calendar year exceeds 8% of household income would be exempt from the penalty. For tax years after 2014, the 8% would be adjusted to reflect the excess rate of premium growth and the rate of income growth for the period. • Certain individuals who would otherwise be subject to the mandate, but are residing outside of the United States, as well as bona fide residents of any possession of the United States, would be considered to have minimum essential coverage and therefore not subject to the penalty. <p>(Effective 1/1/2013) (§501)</p>
<p><u>SUBSIDIES TO INDIVIDUALS</u></p> <p>Individuals and families with incomes between 100-400% FPL would be eligible for refundable and advanceable premium credits to purchase insurance through the Exchanges. The premium credits would be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL, except that for those with incomes between 100-133% FPL, the premium contribution is limited to 2% of income. (Individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) (§1401: IRC §36B)</p>	<p>Individuals and families with incomes up to 400% FPL would be eligible for affordability premium credits to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: (Effective 1/1/2013) (§343)</p> <ul style="list-style-type: none"> • 133-150% FPL: 1.5 - 3% of income • 150-200% FPL: 3 - 5.5% of income • 200-250% FPL: 5.5 - 8% of income • 250-300% FPL: 8 - 10% of income • 300-350% FPL: 10 - 11% of income • 350-400% FPL: 11 - 12% of income

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<p>Premium contributions for those receiving subsidies would be increased annually by the rate of premium growth from the preceding year. (§1401: IRC §36B)</p> <p>Cost-sharing subsidies would be provided to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. American Indians with income less than 300% FPL will not be subject to any cost-sharing requirements. (§1402)</p>	<p>Affordability premium credits would be indexed after 2013 to maintain the ratio of government to enrollee shares of the premiums over time. (§343)</p> <p>Affordability cost-sharing credits would be provided to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: (Effective 1/1/2013) (§343)</p> <ul style="list-style-type: none"> • 133-150% FPL: 97% • 150-200% FPL: 93% • 200-250% FPL: 85% • 250-300% FPL: 78% • 300-350% FPL: 72% • 350-400% FPL: 70% <p>Lower the out-of-pocket spending limits would be established in the essential benefits package (\$5,000/individual and \$10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: (Effective 1/1/2013)</p> <ul style="list-style-type: none"> • 133-150% FPL: \$500/individual; \$1,000/family • 150-200% FPL: \$1,000/individual; \$2,000/family • 200-250% FPL: \$2,000/individual; \$4,000/family • 250-300% FPL: \$4,000/individual; \$8,000/family • 300-350% FPL: \$4,500/individual; \$9,000/family • 350-400% FPL: \$5,000/individual; \$10,000/family

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		(\$341-347)
Premium and Cost-Sharing Credits	The availability of premium credits and cost-sharing subsidies through the Exchanges would be limited to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employees share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits. Provisions related to the premium and cost-sharing subsidies are effective 1/1/2014. (§1401-1415)	The availability of premium and cost-sharing credits would be limited to US citizens and lawfully residing immigrants who meet the income limits and are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid (except those eligible to enroll in the Exchange), TRICARE, or VA coverage (with some exceptions). Individuals with access to employer-based coverage are eligible for the premium and cost sharing credits if the cost of the employee premium exceeds 12% of the individuals' income. (§341)
Verification of Citizenship	Both income and citizenship status must be verified in determining eligibility for the federal premium credits. (§1411)	Both income and citizenship status must be verified in determining eligibility for the federal premium and cost-sharing credits. (§341)
Abortion Coverage	Federal premium or cost-sharing subsidies may not be used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest. 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. (§1303, §4101, §10401)	Federal premium subsidies may not be used to purchase a health plan in the Exchange that includes coverage for abortions except to save the life of the woman or in cases of rape or incest. Individuals receiving federal subsidies may purchase supplemental coverage for abortions but that coverage must be paid for entirely with private funds. (§222(e), 258, 259, 265, 304(d))
Voucher Program	Workers who qualify for an "affordability exemption" to the individual mandate but do not qualify for tax credits can	No comparable provision.

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<p>take their employer contribution in lieu of coverage through a group plan and join an exchange plan. Employees qualify if their required contribution under the employer’s plan would be between 8 and 9.8 percent of their income, and the employee does not make more than 400% above the federal poverty level. The vouchers are excluded from taxation and must be equal to the contribution that the employer would have made to its own plan. The voucher can only be used to purchase coverage through the exchange but excess funds are paid to the employee. (§10108)</p>	

EXCHANGES

<p>Creation A state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges would be created for individuals and small businesses with up to 100 employees can purchase qualified coverage. The program would be administered by a governmental agency or non-profit organization, through which Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. 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 1/1 2015) (§1311)</p>	<p>A national Health Insurance Exchange would be created to, essentially, serve as a mechanism through which “qualified health benefits plans” (“QHBP”) can be offered to individuals and employers. A new Health Choices Administration (HCA) will set up and run the national Exchange, administer the market reforms required by the bill, and generally oversee the health insurance industry, in consultation with the states, and other federal agencies. In 2013, employers that may participate will be limited to those with 25 or fewer employees; in 2014, 50 or fewer employees; and in 2015, 100 or fewer employees. In 2015 and after, HCA also may permit larger employers to participate. (§301-302.)</p> <p>The Exchange will take bids and enter into contracts with entities to serve as providers of QHBPs that will be made available through the Exchange (§304), and the QHBPs must offer at least one “basic” plan for each service area, with</p>
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<p>Eligibility Access to coverage through the Exchanges would be restricted to U.S. citizens and legal immigrants who are not incarcerated. (§1311)</p>	<p>the option to offer an “enhanced,” “premium,” and “premium plus” plan for each service area as described above (§303).</p> <p>Access to coverage through the Exchange would be to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage.</p>
<p>Benefit Tiers Four benefit categories of plans plus a separate catastrophic plan would be offered through the Exchange, and in the individual and small group markets:</p> <ul style="list-style-type: none"> • Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010); • Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits; • Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits; • Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; (§1311) <p>Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that</p>	<p>Four benefit categories of plans would be offered through the Exchange:</p> <ul style="list-style-type: none"> • Basic plan includes essential benefits package and covers 70% of the benefit costs of the plan; • Enhanced plan includes essential benefits package, reduced cost-sharing compared to the basic plan, and covers 85% of benefit costs of the plan; • Premium plan includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; • Premium plus plan is a premium plan that provides additional benefits, such as oral health and vision care. (§303)

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	<p>prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. (§1311)</p> <p>Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:</p> <ul style="list-style-type: none"> • 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family); • 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family); • 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family). <p>These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan. (§1402)</p>	
Community Rating with the Exchange	A variation in rating would be allowed based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the Exchange. (§1201: PHSA §2701)	A Qualified Health Benefit Plan (QHBP) would be required to determine premiums using adjusted community rating rules. Premiums would be allowed to vary based only on age (by no more than a 2:1 ratio based on age categories specified by the Commissioner), premium rating area (as permitted by states or the Commissioner), and family enrollment (so long as the ratio of family premium to individual premium is uniform, as specified under state law and consistent with Commissioner rules). (§213)
Licensure, Marketing, and Other Requirements for Exchange Plans	Qualified health plans participating in the Exchange would be required to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform	Plans participating in the Exchange would be required to be state licensed (§238), report data as required, implement affordability credits (§304), meet network adequacy standards (§304), provide culturally and linguistically appropriate services (§304), contract with essential community providers and Indian health care providers

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<p>enrollment form and standard format to present plan information. (§1311)</p> <p>Qualified health plans would be required 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. (§1303 (f))</p>	<p>(§304), and participate in risk pooling (§306).</p> <p>Participating plans would be required to offer one basic plan for each service area and permit them to offer additional plans. (§303). Plans would be required to provide information related to end-of life planning to individuals and provide the option to establish advance directives and physician’s order for life-sustaining treatment. (§240).</p>
<p>The Exchanges must maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. (§4303) States must develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. (§1413)</p>	<p>Information would be provided to consumers and small employers to enable them to choose among plans in the Exchange, including establishing a telephone hotline and maintaining a website, and provide information on open enrollment periods and how to enroll. (§305)</p>
<p>The states would have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage would contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 85% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states</p>	<p>No comparable provision</p>

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	<p>creating Basic Health Plans will not be eligible for subsidies in the Exchanges. (§1331)</p> <p>Exchanges would be required to consider the reasonableness of premium rate increases when determining whether to certify and offer plans (§1003: PHSA §2794)</p> <p>Exchanges must submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges. (§1313)</p>	<p>In the bid solicitation process for entities to become QHBPs, bids must include justification for proposed premiums, and the HCA is authorized to deny “excessive premiums and premium increases.” (§304)</p> <p>QHBPs must comply with reporting obligations to be established by the HCA. (§ 304(b)). The HCA would also have the power to conduct random audits as well as targeted compliance audits in response to complaints to ensure full compliance by “qualified health benefits plans” with the new federal requirements. HCA also would have the power to impose the cost of audits on those audited and to impose sanctions for non-compliance. (§241-44)</p>
Abortion Coverage	<p>States would be permitted to prohibit plans participating in the Exchange from providing coverage for abortions. 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 are required 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. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than \$1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Plans participating in the</p>	<p>Private insurers that opt to provide a plan in the Exchange that covers abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest) must also offer an identical plan that does not cover abortions for which federal funding is prohibited. Private plans participating in the Exchange may offer supplemental coverage for abortions. Federal premium subsidies may not be used to purchase a plan or supplemental coverage that covers abortions beyond those permitted by federal law. Plans participating in the Exchanges are prohibited from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions. (§222(e), 258, 259, 265, 304(d))</p>

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	Exchanges are prohibited from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions. (§1303, §10104)	
Effective Date	Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective 1/1/2014.	Unless otherwise noted, provisions relating to the Health Insurance Exchange are effective 1/1/2013.
<u>PUBLIC OPTION</u>	The public option has been eliminated, and is replaced with a Multi-State Option as described below.	<p>A new public health insurance option would be created and offered through the Health Insurance Exchange. It must meet the same requirements as private QHBPs regarding benefit levels, provider networks, consumer protections, and cost-sharing. The “level playing field” requirement is weakened by the fact that states imposing additional mandates on the public and Exchange plans would be required to pay for the increased premium costs associated with such mandates (§ 303(d), §321).</p> <p>The public plan would offer basic, enhanced, and premium plans, and permit it to offer premium plus plans.</p> <p>The public plan would be prohibited from providing coverage for abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest).</p> <p>The public plan would be funded through revenues from premiums. The premiums will be set by HHS and are to be geographically adjusted and established in accordance with the premium rules for QHBPs participating in the Exchange, but set at a level to allow the program to fully finance itself plus a contingency margin.</p>

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<p><u>MULTI-STATE OPTION</u></p> <p>The Office of Personnel Management (OPM) would be required to contract with health insurance carriers to offer at least two multi-state qualified health plans through each state exchange. At least one of the plans must be offered by a non-profit entity and groups of insurers that are commonly owned/controlled or that operate under a common network name may join together to collectively offer a multi-state plan. The multi-state plans must cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multi-state plans to offer additional benefits, but must pay for the additional cost. The federal government will not bear any risk or provide any direct subsidies under these contracts but it will negotiate medical loss ratios, profit margins, premiums and other terms and conditions with the providers of the multi-state options; the offerors of the multi-state options would be entitled to brand their plans as</p>	<p>The public health insurance option would be required to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services. (§321-331)</p> <p>No comparable provision.</p>

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<u>CO-OP PROGRAM</u>	<p>such. The multi-state option plans must also maintain risk pools separate and apart from the federal employee plans if they offer both. (§1334)</p> <p>A CO-OP initiative would be established to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans.</p> <p>A grant or loan would not be awarded unless the following conditions are met to be a qualified health insurance issuer: 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.</p> <p>Any profits made would be used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to its members.</p> <p>The cooperative would coordinate with the implementation of state insurance reforms required by this bill.</p> <p>\$6 billion would be appropriated to finance the program and award loans and grants to establish CO-OPs by 7/1/2013. (§1322)</p>	<p>A Consumer Operated and Oriented Program (CO-OP) would be established to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange.</p> <p>A grant or loan would not be awarded unless the following conditions are met:</p> <ul style="list-style-type: none"> • The cooperative would be a not-for-profit, member organization with the membership being made up entirely of beneficiaries of the insurance coverage offered by the cooperative. • The organization or a related entity could not have been operating on or before July 16, 2009. • The cooperative’s governing documents would incorporate ethics and conflict of interest standard protecting against insurance industry involvement and interference. • The cooperative would not be sponsored by a State government. • Substantially all the activities of the cooperative would consist of the issuance of qualified health plans through an exchange. • The cooperative would be licensed to offer insurance in each state it is offering a plan.

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		Any profits made would be used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to its members. (Effective six months following enactment) (§310)
<u>EXPANSION OF PUBLIC PROGRAMS</u>	Medicaid would be available to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) (to be implemented in 2014). All newly eligible adults would be guaranteed a benchmark benefit package that at least provides the essential health benefits. States would be required to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. The program would be cover financing for the newly eligible individuals (those who were not eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. (§1331)	Medicaid would be available to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL. Medicaid coverage would be available for all newborns that lack acceptable coverage and provide optional Medicaid coverage to low income HIV-infected individuals (with enhanced matching funds) until 2013 and for family planning services to certain low-income women. Medicaid payment rates for primary care providers would be increased to 100% of Medicare rates by 2012. States must submit a state plan amendment specifying the payment rates to be paid under the state’s Medicaid program. The coverage expansions (other than the optional expansions) and the enhanced provider payments will be financed with 100% federal financing through 2014 and 91% federal financing beginning in year 2015. (Effective 1/1/2013) (§343)
<u>BENEFITS</u>	Group health plans (including employer-sponsored plans) and issuers in the individual and group markets would be	An essential benefits package would be created that provides a comprehensive set of services, covers 70% of the

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<u>MANDATES</u>	<p>required to provide coverage for preventive health services, including items or services rated “A” or “B” by the US Preventive Services Task Force, immunizations, and preventive care and screenings in Health Resources and Services Administration guidelines. (Effective for plan years beginning 6 months after date of enactment) (§1001: PHSA § 2713)</p> <p>An essential health benefits package would be created that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective 1/1/2014) (§1301, §1311)</p>	<p>actuarial value of the covered benefits, limits annual cost-sharing to \$5,000/individual and \$10,000/family, does not require cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. Preventive services must be included. Prohibit abortion coverage from being required as part of the essential benefits package. (Health Benefits Advisory Council report due one year following enactment; essential benefits package becomes effective (1/1/2013) (§303)</p>
Scope of Benefits Mandate	<p>All qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, would be required to offer at least the essential health benefits package. This requirement does not apply to employer-sponsored plans, and grandfathered individual plans. (Effective 1/1/2014)</p>	<p>All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. (Effective 1/1/2013)</p>
<u>REPORTS AND STUDIES</u>	<p>Requires the Secretary of Labor to prepare an annual report on various aspects of self-insured group health plans. (§1253)</p>	<p>Require a government study of the impact of employer responsibility requirements and recommend to Congress whether an employer Hardship exemption is appropriate. (Report due 1/1/2012)</p>

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	<p>Requires the Secretary of HHS to conduct a study of the fully-insured and self-insured group health plan markets to compare characteristics and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market. (§1254)</p> <p>Requires GAO to study the cost and affordability of qualified health plans offered through Exchanges. Directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans. (§1254)</p>	
<p><u>DISCLOSURES</u></p> <p>All plans must to disclose information such as claims payment policies and rating practices. Plans that are not offered through an Exchange must submit this information to the Secretary of HHS and the State insurance commissioner and make such information available to the public. (§1303)</p> <p>New annual Form 5500 reporting requirements will be imposed to enable the Department of Labor to satisfy its reporting obligations under the Act (enrollment benefits, number of participants, funding arrangements, and – for self-insured plans – assets, liabilities, expenses and investments) (§1253)</p> <p>New W-2 reporting obligations with respect to the cost of employer provided health care to satisfy the new “Cadillac” plan tax burdens described below (§9002)</p> <p>Prohibits the collection and disclosure of information related to gun ownership or use for purposes of</p>	<p>Employers would be required to provide the federal government with such information as it may require to determine whether the employer is meeting employer mandate obligations, and the government will conduct random periodic audits of employers and group plans to assess compliance. (§241-244, §412)</p> <p>Employers sponsoring group plans will be required to submit an election form indicating that they intend to use their plans to satisfy the mandate requirements. Section 421 establishes the procedures for this and also gives the Department of Labor the authority to issue new recordkeeping requirements to help with the enforcement of these requirements and provides the DoL with separate audit authority to ensure compliance with these requirements. If a plan is found to be out of compliance, the employer could be subject to the tax and excise tax penalties discussed above as well as separate civil penalties</p>	

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<p>determining premium rates. (§2716)</p>	<p>of up to \$500,000. There is a provision exempting any employer from the civil penalties if the compliance failure was not discovered exercising “reasonable diligence” or if the non-compliance issue was corrected within 30 days of the discovery of the non-compliance issue. (§421)</p> <p>“Every person who provides acceptable coverage” (i.e. insurers and self-insured plans) will be required to provide a tax form to the covered individual containing information about the coverage (to be specified by HHS) and when it was in place during the prior year, and also to submit that information to the IRS. (§501)</p>
<p><u>PREVENTION AND WELLNESS</u></p>	
<p>National Strategy The National Prevention, Health Promotion and Public Health Council would be created to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation’s health. A Prevention and Public Health Fund would be established to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) (§1201: ERISA §702, PHS §2702, IRC §9802)</p>	<p>Develop a national strategy to improve the nation’s health through evidenced-based clinical and community-based prevention and wellness activities. Create task forces on Clinical Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (§112)</p>
<p>A grant program would be created to support the delivery of evidence-based and community-based prevention and</p>	<p>A grant program would be created to support the delivery of evidence-based and community-based prevention and</p>

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	wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. Funds would be appropriated for five years beginning in FY 2010. (§1201: ERISA §702, PHSA §2702, IRC §9802)	wellness services aimed at reducing health disparities. Community health workers would be trained to promote positive health behaviors in medically underserved communities. Grants would be provided to plan and implement programs to prevent obesity among children and their families. Funds would be appropriated for five years beginning FY 2011. (§112)
Wellness Grants for Small Employers	Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in FY 2011) (§10408)	Provide wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. Allowable costs would be those attributable to the wellness program, and not to the health plan or health insurance coverage offered in connection with such a plan. Grants for a given plan year would be capped at \$150 per employee, could be provided for up to three years and would be capped at \$50,000, in total, for an employer. A qualified wellness program is a program certified by HHS and meets at least three out of four required components. These components pertain to health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (smoking cessation and weight reduction) and having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. (Effective 2/1/2010) (§112)
Wellness Assistance for all Employers	Technical assistance and other resources would be provided to evaluate employer based wellness programs. HHS would conduct a national worksite health policies and programs survey, within two years following enactment, to assess employer-based health policies and programs.	No comparable provision.

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	(\$4303: PSHA §4102)	
Wellness Subsidies for all Employers	<p>Employers would be permitted to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. The rewards may take the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective 1/1/2014)</p> <p>A state pilot program will be created by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. The program would be expanded in 2017 if it is effective. Reporting on effectiveness and impact of wellness programs would be required. (Report due three years following enactment) (§1201: PHSA §2705)</p>	No comparable provision.
	<p>Qualified health plans would be required to provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, and preventive care for infants, children, and adolescents. (Effective six months following enactment)</p>	No comparable provision.
<u>OTHER SELECTED TOPICS</u>		
Nutritional	Chain restaurants and food sold from vending machines	Chain restaurants and food sold from vending machines

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Information Labeling	would be required to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment) (§4205)	would be required to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment) (§2572)
Medical Tort Reform	HHS would be authorized to award demonstration grants to states to test alternatives to civil tort litigation. Models would be required to emphasize patient safety, disclosure of health care errors and early resolution of disputes. Patients would be allowed to opt out at any time. HHS would be required to study effectiveness of the alternatives. (§6801)	<p>HHS would be authorized to make incentive payments to states that enact and implement effective alternative medical liability laws. The content of such a law would be one that includes provisions for either, or both, a certificate of merit or early offer program, and that does not limit attorneys’ fees or impose caps on damages. In determining the effectiveness of such a law, the Secretary must consider whether it (1) makes the medical liability system more reliable through the prevention of, or prompt resolution of, disputes; (2) encourages the disclosure of health care errors; and (3) maintains access to affordable liability insurance.</p> <p>Nothing in the section would preempt or modify existing state laws that limit attorneys’ fees or cap damage awards; nor would the provision impair a state’s authority to establish such laws, or restrict the eligibility of a state for an incentive payment on the basis of such laws provided they are not established or implemented as part of an alternative medical liability law that meets the requirements described above.</p> <p>The Secretary would be required to submit to Congress an annual report on the progress states are making in enacting and implementing alternative medical liability laws and the effectiveness of such laws. The section would authorize to be appropriated such sums as necessary for the incentive</p>

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<p>Long Term Care Includes the Community Living Assistance Services and Supports (CLASS) Act, which would require HHS to create a national, voluntary long term care insurance program that would provide a cash benefit to participants if they become unable to perform at least two activities of daily life, such as dressing and bathing. Workers would pay a monthly premium to buy coverage, most likely through their employer. They would have to pay into the program for at least five years before qualifying for benefits. The benefit would be at least \$50 a day. The program is intended to be self-supporting. HHS would determine premium amounts. (§8002)</p>	<p>payments, which would be used to improve health care in the state. (§2531)</p> <p>Includes the Community Living Assistance Services and Supports (CLASS) Act, which would require HHS to create a national, voluntary long term care insurance program that would provide a cash benefit to participants if they become unable to perform at least two activities of daily life, such as dressing and bathing. Workers would pay a monthly premium to buy coverage, most likely through their employer. They would have to pay into the program for at least five years before qualifying for benefits. The benefit would be at least \$50 a day. The program is intended to be self-supporting. HHS would determine premium amounts. (§544)</p>