



National Association of Health Underwriters

Comparison of the Comprehensive Health Reform Measures Passed By the United States Senate and House of Representatives January 3, 2010

	Senate Democratic Legislation, the Patient Protection and Affordable Care Act, H.R. 3590	House Democratic Legislation, The Affordable Health Care for America Act, H.R. 3962
	Status: Passed by the United States Senate (60-39) on December 24, 2009	Status: Passed by the United States House of Representatives (220-215) on November 7, 2009
Market Reforms	<p>Would require all individual health insurance policies and all fully insured group policies to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances.</p> <p>Requires the Secretary of DHHS, within a year of enactment of this bill, to conduct a study on the impact the market reforms in the bill will have on the large group market, if they increase adverse selection and if they will increase the incentive to self-fund.</p> <p>Requires the Secretary of Labor, within a year of the enactment of this bill, to begin annual studies on self-funded plans.</p> <p>Coverage must be offered on a guarantee issue basis in all markets and be guarantee renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited in all markets.</p>	<p>Would require all health plans, whether fully insured or self-funded, to issue coverage regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. Dependents would have to be covered to age 26.</p> <p>Would apply the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets.</p> <p>For all qualified health benefit plans, regardless of size, it would impose strict modified community rating standards consisting of variances only by family enrollment, geographic, and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of 2:1.</p> <p>No premium variations would be permitted for health status, gender, class of business, claims experience or any other factor not specifically described in the legislation.</p>

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	<p>Small group coverage is defined as up to 100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016.</p> <p>Prohibits any annual limits or lifetime limits in group or individual plans after 2014. Between now and then, the only limits allowed are for nonessential benefits.</p> <p>All group plans, except self-funded, would also be subject to cost-sharing limitations and preventive care would have to be covered first-dollar.</p> <p>Group and individual plans will have to have internal appeals processes.</p> <p>Group and individual plans will have to have an external appeals process that meets or exceeds state law on the subject, meets or exceeds the NAIC external review model act requirements or complies with a regulation the Secretary of DHHS will promulgate on the topic. Grants the Secretary of DHHS authority over the external review process and certification of plans.</p>	
<p>Exchanges/ Information Portals</p>	<p>Beginning no later than July 1, 2010, requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.</p> <p>Beginning January 1, 2014 each state must create an</p>	<p>The bill would create a national Health Insurance Exchange to purchase coverage to be administered by a new federal Agency, the "Health Choices Administration," governed by a Commissioner to be appointed by the President.</p> <p>The categories of people and businesses qualified to purchase coverage through the Exchange would be phased in over three year's time To up to 100 employees and the Commissioner has the authority to expand the exchange to</p>

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	<p>Exchange so as to facilitate the sale of qualified benefit plans to individuals. In addition the states must create “SHOP Exchanges” to help small employers purchase such coverage. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange.</p> <p>Beginning in 2014 would require employers to give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.</p> <p>The bill allows for grants to the states to create the exchanges, but they must be self-sustaining by January 1, 2015.</p> <p>Stand-alone child- only and dental plans would also be allowed to be offered through the state-based exchanges.</p> <p>States would have to consult with stakeholders in exchange development, including agents and brokers.</p> <p>Plans offering coverage through the exchange would have to submit premium increase justification through the exchange</p>	<p>larger groups after that.</p> <p>Once someone is deemed eligible to participate in the Exchange, they will remain eligible until they qualify for Medicare, regardless of their other coverage options.</p> <p>States would be allowed to transition their Medicaid populations to the Exchange—with appropriate supplemental wrap-around coverage—after five years.</p> <p>Also, states could establish their own Exchanges, provided that no more than one Exchange operates in any State. However, the new federal Commissioner would retain enforcement authority and could terminate the state Exchange at any time.</p> <p>Allows people to stay on COBRA without time limits until the exchange is up and running.</p> <p>There are also limitations on public funding in exchange policies relative to abortion services.</p>

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	<p>prior to implementation and the exchange could use this information and premium increase patterns to deny a carrier the ability to sell exchange-based policies.</p> <p>States could create multiple exchanges under specified circumstances.</p> <p>The individual low-income tax credits created would only apply to U.S. citizens or legal residents who purchase individual coverage through the exchange or do not have access to affordable employer-sponsored coverage and purchase policies through the exchange.</p> <p>Creates specific requirements for the Secretary of DHHS in establishing the exchanges, including standardized applications, quality information, formats for presenting insurance options available through the exchange, and marketing requirements.</p> <p>States could require additional mandated benefits on exchange-based policies, but would have to assume the additional cost of the subsidized coverage relative to the mandates they impose.</p> <p>The exchanges will be based on a model web-based portal to direct individuals to insurance options, provide a tax credit calculator and determine public program eligibility.</p> <p>Carriers must pool all risks in the individual market (inside and outside the exchange) in a single risk pool, excluding grandfathered plans.</p>	

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	<p>Carriers must pool all risks in the small group market (inside and outside the exchange) in a single risk pool, excluding grandfathered plans.</p> <p>States can elect to merge the two pools of risk.</p> <p>Individual and small group markets outside of the exchange are specifically permitted.</p> <p>Beginning July 1, 2014, all members of Congress and Congressional employees must purchase their employer-sponsored health insurance coverage through a state-based exchange rather than using the traditional Federal Employees Health Benefits Plan. However, there is no penalty to transfer to a minimum benefit plan offered outside the exchange if you are eligible.</p> <p>Initially the exchanges would be limited to individual and small group purchasers, but after January 1, 2017 states may allow large groups (over 100) to purchase coverage through the exchanges.</p> <p>Provides for some flexibility and NAIC interaction for state-based exchange creation.</p> <p>Calls for federal fall-back enforcement with the Secretary of DHHS to create an exchange for a state if a state does not create an exchange by January 1, 2014.</p> <p>Includes grandfathering provisions for existing state-based exchanges that meet specified criteria and were in existence before January 1, 2010.</p>	

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	<p>There are also limitations on public funding in exchange policies relative to abortion services.</p>	
<p>Essential Benefits</p>	<p>The bill requires the Secretary of DHHS to establish a standard of essential benefits that would be used to determine four types of coverage packages (bronze, silver, gold and platinum) of varying actuarial values. All individual and small group insurers would have to offer, at minimum, plans in the silver and gold values.</p> <p>The essential benefits determined by the Secretary must include coverage of the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.</p> <p>In addition to the benefits that must be included, there can be no cost-sharing for preventive care and there are specified cost-sharing limits for plans, with separate limits for self-only coverage and indexed deductible limitations for employer-sponsored plans.</p> <p>Each level of coverage must meet its own actuarial value of the mandatory covered services as determined by the Secretary of DHHS. Bronze level policies must equal 60% of the value of the benefits, silver 70%, gold 80% and platinum 90%.</p> <p>A separate catastrophic-only policy would be available for</p>	<p>A new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General, will recommend a benefit package based on standards set in the law.</p> <p>This new essential benefit package will serve as the basic benefit package for coverage in the exchange and over time will become the minimum quality standard for employer plans.</p> <p>The basic package will include preventive services and well child care with no cost-sharing, hospitalization, outpatient hospital and outpatient clinic services, including emergency department services, physician and other health professional services, prescription drugs, rehabilitative services, mental health, behavioral health and substance use services, durable medical equipment, prosthetics and orthotics, maternity care, well baby and well child care and oral health, vision, and hearing services, equipment and supplies up to 21 years of age.</p> <p>The out-of-pocket maximum will be \$5,000 for individuals and \$10,000 for families, indexed to the CPI. Copayments are preferred over co-insurance.</p> <p>There will be three levels (actuarially equivalent) of coverage. The basic package will look at the benefits above, as modified by the Health Benefits Advisory Committee, and be required to provide the required benefits, with no more than 30% cost-sharing (not counting premiums).</p>

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	<p>those 30 and younger.</p> <p>Plans can offer child-only coverage through the exchanges to meet the child-specific benefit provisions.</p> <p>Requires group and individual plans to cover emergency care services even if the provider is not a participating provider at in-network rates, using a reasonable layperson definition of emergency services.</p> <p>Requires plans that make beneficiaries establish a primary care provider to allow the beneficiary to set any available participating provider their primary care physician. Requires that pediatricians be allowed to be set as primary care providers.</p> <p>Prohibits the requirement of authorizations or referrals for OB/GYN services.</p> <p>Requires coverage of clinical trial participation.</p>	<p>The enhanced package will consist of the same benefits, but with 15% cost-sharing.</p> <p>The premium plan will be designed so that benefits are actuarially equivalent to 95% of the value of the reference benefits.</p>
<p>Government-Run Public Plan Option</p>	<p>The government-run public plan option was eliminated from the Senate bill by the Manager's amendment, but it creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM).</p> <p>At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards.</p>	<p>The measure would create a government-run public plan option that would be made available to consumers purchasing coverage through the Exchange.</p> <p>The bill states the plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced, and premium plan options.</p> <p>Premiums will be established according to exchange rules for other plans.</p>

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	<p>States can require that multistate plans offer additional benefits that are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules.</p> <p>Insurers who contract to be multistate plans must offer qualified coverage in 60% of states the first year of participation, working up to 100% of states by year four of participation.</p> <p>Although OPM also operates Federal Employees Health Benefits Plan (FEHBP), the two programs must have completely separate risk pools. Also OPM cannot divert funds or resources away from FEHBP to operate the multistate plan program.</p> <p>Also give states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer-sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars.</p> <p>Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits.</p> <p>If a state elects this option, the basic health plan choices will</p>	<p>The public plan will be initially financed by unlimited start-up funding provided by Secretary of DHHS, but eventually it must be self-sustaining.</p> <p>The Secretary will negotiate rates for providers that are not higher than the average reimbursement rates paid by private plans offered through the Exchange.</p> <p>Medicare providers will be assumed to participate, unless they specifically opt-out.</p> <p>The public option will establish a formulary for prescription drugs and PBMS operating with the plan will be subject to new transparency requirements.</p>

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	<p>be the only subsidized coverage options available to qualified state residents in this income bracket. Upper income individuals would still have access to subsidized private coverage options through the state-based exchange.</p> <p>States that do not create a basic health care plan would still have subsidized coverage available to residents in this income level and upper income levels through coverage purchased in the state exchange.</p> <p>Also establishes a HRSA grant 10-state demonstration project to create state-based non-profit/private partnerships to provide coverage to the uninsured at reduced fees.</p>	
Cooperatives	<p>Authorizes \$6 billion in federal funding to be distributed before July 1, 2013 for states to create Consumer Operated and Oriented Plan (Co-op) programs for non-profit member-run health insurance companies. The Co-op plans would compete on a level playing field (including by negotiating provider rates, meeting state solvency standards and complying with all applicable state laws for health insurers) with other private plan options in a reformed individual and small group health insurance market. In order to receive Co-op funding loans or grants, which will be distributed by the Secretary of DHHS, an organization must meet a number of specified criteria. Co-op start-up loans and grants must be repaid within 5-15 years.</p>	<p>Provides start-up loans to establish not-for-profit or cooperative plans that compete with private insurers and the public option in the Exchange.</p>
State-Level Opt Out Provisions	<p>Beginning in 2014, allows states to apply for a waiver for up to 5 years of requirements relating to qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers.</p> <p>The state would receive the aggregate amount of tax credits</p>	<p>No provision.</p>

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	<p>and cost-sharing reductions that would have been paid to residents of the state in the absence of a waiver.</p> <p>The state would be required by the DHHS Secretary to provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this title would provide; and that it will not increase the Federal deficit.</p>	
<p>Risk Adjustment</p>	<p>Within 90 days of enactment, any individual who has been uninsured for at least 6 months and has a preexisting medical condition can receive coverage through a high risk pool, which may be a national high risk pool created by DHHS or another arrangement made with a state by DHHS (state high risk pool) that will exist until January 1, 2014 and be funded through a \$5 billion federal appropriation. Premiums will be capped.</p> <p>As the market reforms take effect in January 2014, the temporary high-risk pool coverage will end and covered individuals will be transitioned to the exchanges.</p> <p>Within 90 days of enactment also creates a temporary reinsurance program to provide assistance to qualified employer-sponsored retiree health plans for early retirees (age 55-64). This program would reimburse employers retrospectively 80% of claims between \$15,000-90,000, which will be indexed for inflation. It will end on January 1, 2014 and be financed by a \$5 billion appropriation.</p> <p>Reinsurance From 2014-2016 a reinsurance program would be in effect for the individual and group markets and all carriers would be</p>	<p>The bill requires the new federal Health Choices Commissioner to establish for the exchange a mechanism whereby there is an adjustment made of the premium amounts payable” to plans to reflect differing risk profiles in a manner that minimizes adverse selection—and leaves to the Commissioner to determine all of the details of this mechanism.</p> <p>Creates an interim temporary national high-risk pool for those who have been uninsured and/or denied coverage due to preexisting conditions until the market reforms and exchange are fully implemented.</p>

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	<p>required to contribute \$25 billion total to a non-profit reinsurance entity over the two year period to finance the program. Reinsurance payments would be transparent to the individual and be made based on a list of 50-100 high-risk medical conditions to be developed by the American Academy of Actuaries.</p> <p>The reinsurance program would operate at the state level based on a model to be developed by the NAIC, with federal fallback enforcement through DHHS. State high risk pools can be converted for this purpose.</p> <p>Risk Corridors After reinsurance is applied, mandatory risk corridors in 2014-2016 modeled those used for PPO organizations in Medicare Part D will be provided to plans that choose to participate. These risk corridors would provide relief on staggered basis to plans with allowable cost that exceed 103% and require payment on a staggered basis from those with costs less than 97 percent.</p> <p>Risk adjustment applies to plans in the individual and group markets, but not to grandfathered health plans.</p>	
Employer Mandate	<p>Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of \$750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than \$250,000.</p>	<p>All employers must offer coverage through either Qualified Health Benefit Plans (QHBP) or grandfathered plans as permitted. Employers would be required to pay 72.5% of the cost of acceptable coverage for individuals and 65% for family coverage, and part-time employees must be covered on a pro-rated basis based on average hours worked.</p> <p>In lieu of paying for coverage, the measure creates a "pay or</p>

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	<p>An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay \$600 for any full-time employee subject to more than a 60- day waiting period.</p> <p>An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.</p>	<p>play" option allowing the employer to pay instead 8% of wages to the Commissioner.</p> <p>Small employers with annual payroll up to \$500,000 will be exempt from the requirement. Employers with \$500,001-\$585,000 in annual payroll would pay a fee of 2%, employers with annual payroll of \$585,001-\$670,000 would pay a fee of 4%, and employers with annual payroll of \$670,001-\$750,000 would pay a fee of 6% for non-compliance.</p>
<p>Individual Mandate</p>	<p>Requires that effective after December 31, 2013, all American citizens and legal residents purchase qualified health insurance coverage. Qualified coverage includes the multistate plans, coverage purchased through the individual market, and qualified employer-sponsored coverage, and Individuals in grandfathered plans meet the terms of the mandate.</p> <p>Exceptions are provided for religious objectors, individuals not lawfully present and incarcerated individuals.</p> <p>Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.</p> <p>Individuals would be required to report on their federal income tax returns the months of the year for which they had</p>	<p>The legislation creates an individual mandate to maintain acceptable coverage with a federal income tax penalty equal to 2.5% of the excess of the taxpayer's adjusted gross income over the threshold amount or the average premium in the exchange.</p> <p>The tax shall not exceed the applicable national average premium for individual or family coverage pro-rated for partial year failures.</p> <p>Acceptable coverage includes QHBPs, a grandfathered plan, Medicare, Medicaid, tribal coverage TRICARE and VA coverage.</p> <p>Any entity providing acceptable coverage to individuals must provide them with annual documentation of coverage.</p> <p>Hardship waivers are included.</p>

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	<p>qualified health insurance coverage. Health plans, including self-funded employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.</p> <p>The penalty for not maintaining coverage is an excise tax penalty of a flat dollar amount per person or a percentage of the individual's income equal to the higher of: (1) 2% of taxable (gross) household income capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family; beginning in 2016, or (b) a fixed dollar amount that phases in beginning with \$95 per person in 2015 to \$750 in 2016, with a 50% penalty for children up to an annual maximum of \$2250 in 2017.</p>	
ERISA	<p>Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage.</p> <p>Requires all employers provide notice to their employees informing them of the existence of an Exchange.</p> <p>Self-funded plans would be required to report coverage status data on all plan participants to the IRS annually as part of the individual mandate.</p> <p>Coverage plans must comply with the terms of the employer mandate (minimum standard for benefit plans) that would apply to all size groups (regardless of whether insured or self-funded) or pay a penalty.</p>	<p>This legislation would have a significant impact on self-funded group health plans in that it (1) would end ERISA's preemption by exposing self-funded groups to potential state criminal and civil actions.</p> <p>Would create new tax on self-funded groups to fund comparative effective research.</p> <p>Would require federal approval of ERISA health plans (similar to the requirement for retirement plans under ERISA).</p> <p>Would require all health plans, whether fully insured or self-funded, to issue coverage regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. Dependents would have to be covered to age 26.</p>

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	<p>Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.</p>	
<p>Ability to Keep Your Current Coverage</p>	<p>Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.</p>	<p>Existing individual policies would only be able to be retained if the only change to the policy was to add or delete a dependent.</p> <p>Group plans would be allowed to phase in reform requirements over 5 years, eventually these plans would have to change to meet the terms of the proposed individual and employer mandates.</p>
<p>HSAs, HRAs, FSAs</p>	<p>The bill assumes inclusion of consumer directed and account-based products like HSAs, HRAs and FSAs and clearly includes them in the outlines of minimal creditable coverage. The 60% minimum actuarial value for Bronze level plans should be sufficient to cover many account-based consumer directed high-deductible plans.</p> <p>The definition of medical expenses for purposes of employer provided health coverage (including HRAs, HSAs and FSAs) to the definition for purposes of the itemized deduction for medical expenses. This change means that over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs.</p> <p>The bill also increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).</p>	<p>The bill does not directly restrict HSAs, but 70 percent minimum actuarial value equivalents are insufficient to meet HSA qualified high deductible health plan requirements.</p> <p>Prohibition of over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs.</p> <p>Limits FSA contributions to \$2500 (not indexed for inflation).</p> <p>Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).</p>

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	<p>The bill limits FSA contributions for medical expenses to \$2,500 per year with the limit indexed for inflation.</p>	
<p>Minimum Loss Ratios</p>	<p>Starting on January 1, 2011, creates a minimum loss ratio requirement that applies to all fully insured plans including grandfathered plans. The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below). Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small group markets.</p> <p>The amendment creates a premium rebate to individuals for plans that fail to meet the minimum MLR. The calculation is independent of federal or state taxes and any payments as a result of the risk adjustment or reinsurance provisions.</p> <p>Requires the National Association of Insurance Commissioners (NAIC) to establish uniform definitions regarding the MLR and how the rebate is calculated by December 31, 2010.</p> <p>The legislation also gives the Secretary of DHHS, in conjunction with the states, new authority to monitor health insurance carrier premium increases beginning in 2010 to prevent unreasonable increases and publicly disclose such information. Carriers that have a pattern of unreasonable increases may be barred from participating in the exchange. In addition, \$250,000,000 is appropriated for state grants to increase their review and approval process of health insurance carrier premium rate increases.</p>	<p>All qualified health benefits plans will have to operate with a minimum loss ratio of 85%. If non-claims costs exceed 15%, beneficiaries must be rebated on a pro-rata basis for the excess.</p>
<p>New Regulatory Entities</p>	<p>The legislation provides \$30 million in federal funds to help states establish health insurance ombudsman offices or consumer assistance offices. These offices will provide</p>	<p>The measure provides for the creation of several new government entities to regulate the purchase of health insurance coverage including a new government agency, the</p>

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	<p>assistance with claims, appeals, provide uniform enrollment information and assist with questions about subsidies. The bill also requires or encourages the creation of a number of new state-level entities including the state-based exchanges, the Co-ops and their related purchasing council, among others.</p>	<p>“Health Choices Administration,” governed by a Commissioner who would be appointed by the President and charged with governing the Exchange, enforcing plan standards, and distributing taxpayer-funded subsidies.</p> <p>There would also be a Health Insurance Ombudsman appointed by the new Commissioner to receive and provides assistance with complaints, grievances, and requests for information; handle disenrollment problems; provide assistance to individuals selecting plans, and give assistance to individuals with affordability credits.</p> <p>Finally the bill would establish a new government health board called the “Health Benefits Advisory Committee,” chaired by the Surgeon General, to make recommendations on minimum federal benefit standards and cost-sharing levels.</p>
<p>Medicaid Expansion</p>	<p>Expands Medicaid coverage to all individuals with incomes up to 133% of the FPL effective January 1, 2014.</p> <p>Creates a new state option to provide Medicaid coverage through a state plan amendment beginning on January 1, 2011.</p> <p>States would be required to maintain current Medicaid income eligibility levels and funding for all populations upon enactment of this measure would be phased out beginning in January 2014 for the adult population and in 2019 for children.</p> <p>Requires that the federal government pay for the entire share of the Medicaid expansion for all states until 2017, then</p>	<p>Would expand Medicaid coverage to all individuals with incomes up to 150% of the FPL, eliminates the asset test for all groups except those receiving long-term care and prohibits the upper income Medicaid beneficiaries from obtaining other private coverage through the exchange. The cost of this expansion would be shared by states and the federal government.</p>

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	<p>phases out the increased federal match over time. Provides that the federal government will always pay for entire the Medicaid expansion population in perpetuity for the state of Nebraska.</p> <p>Expands Medicaid funding for the states of Vermont and Massachusetts.</p> <p>States would be required to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost-effective to do so, under terms outlined already in current law.</p> <p>Retains the current CHIP program structure under an enhanced federal cost match rate and requires reauthorization of CHIP by September 30, 2015.</p>	
<p>Individual Subsidies</p>	<p>Creates a complex system of sliding-scale tax credits for people with incomes between 100% and 400% of the FPL.</p> <p>The subsidies would only be available to legal U.S. residents and U.S. citizens who purchase individual coverage through the exchanges or do not have access to affordable employer-sponsored coverage and purchase policies through the Exchange.</p> <p>An employee with employer plan coverage that meets the standards of the coverage may not opt out of that coverage for subsidized coverage in the Exchange unless their income is 400% of FPL or below and their employer plan coverage is deemed unaffordable (exceed 9.8% of their family income) or is not valued at 60% of the actuarial value of the essential benefits package (bronze level coverage).</p>	<p>The legislation creates a complicated system of sliding-scale tax for people with incomes between 100% and 400% of the FPL.</p> <p>The subsidies would only be available through the Exchange.</p> <p>Funding will not be provided for individuals who are not lawfully present in the United States.</p> <p>Only available to individuals without employer-sponsored coverage or those whose share of their employer-sponsored coverage is more than 12% of their family income. Medicaid and Medicare eligible individuals cannot obtain a credit.</p>

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	<p>However, beginning in 2014, employers must give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.</p>	
<p>Small Business Assistance</p>	<p>Beginning in 2010, provides tax credits for qualified small employer contributions to purchase coverage for employees. Would apply to small employers with fewer than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. Small employers could receive a maximum credit of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost. The credit would phase out entirely for employers of more than 25 employees whose average annual salaries exceeded \$40,000.</p> <p>The credit is provided in two phases. In phase one the maximum credit amount is 35% of the employee's premium costs if employer contributes at least 50% of the premium costs or 50% of the benchmark premium. In phase two, the credit only applies if the small employer purchases coverage through the exchange and only applies for two years.</p>	<p>The bill provides a health insurance tax credit for small businesses, equal to 50 % of the cost of coverage for firms where the average employee compensation is less than \$20,000 for the first two years the employer provides coverage.</p> <p>Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers.</p> <p>Individuals with incomes of over \$80,000 do not count for purposes of determining the credit amount.</p>

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<p>Wellness Provisions</p>	<p>Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums.</p> <p>Establishes a 10-state pilot program to apply the rules to the individual market in 2014-2017 with potential expansion to all states after 2017. It also calls for a new federal study on wellness program effectiveness and cost savings.</p> <p>Creates grants for small employer-based wellness programs. Appropriates \$200 million in funding from 2011-2015.</p> <p>Establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.</p> <p>For Medicare beneficiaries, allows for coverage of an annual health risk assessment and expanded preventive care coverage.</p> <p>Provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions.</p> <p>Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers.</p>	<p>Creates grants for small employer-based wellness programs.</p> <p>Creates national task forces on evidence-based prevention and wellness.</p> <p>Increases Medicare and Medicaid beneficiary access to proven preventive care services.</p>

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	<p>Expresses the sense of the Senate that the Congress should work with the Congressional Budget Office to develop better methodologies for scoring prevention and wellness programs given that results may occur outside the 5 and 10 year budget windows.</p> <p>Requires the DHHS Secretary to evaluate the effectiveness of existing Federal health and wellness initiatives. The Secretary will consider whether such programs are effective in achieving their stated goals and evaluate their effect on the health and productivity of the Federal workforce.</p>	
<p>Agent Provisions</p>	<p>The bill assumes the use of health insurance agents and brokers and includes specific language to ensure that agents and brokers may sell coverage, enroll individuals and assist with subsidy implementation in the Exchanges.</p> <p>The measure also gives grants to states to contract with health coverage navigators could be private and public entities that could act as facilitators for those looking for health insurance coverage to provide information about Gateways. Entities eligible to become navigators may be licensed, although the licensing provisions are not explicit enough. Navigators include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, licensed agents and brokers, and others, but there is also language in the bill that states that Navigators can't be employed by health insurance carriers and language that may impact the navigator's ability to be paid a commission by the carriers.</p>	<p>Requires the federal Health Choices Commissioner to develop uniform marketing standards for all entities offering Qualified Health Benefit Plans.</p> <p>Specifically says that the role of agents and brokers will be unchanged in the bill and that all qualified health benefits plans must use agents, including the public plan.</p> <p>Grants authority to the Exchange's commissioner, in consultation with the Small Business Administration, will include within the exchange the following services: "Educational activities to increase awareness of the Health Insurance Exchange and available small employer health plan options; distribution of information to small employers with respect to the enrollment and selection process for health plans available under the Health Insurance Exchange, including standardized comparative information on the health plans available under the Health Insurance Exchange; distribution of information to small employers with respect to available affordability credits or other financial assistance; referrals to appropriate entities of complaints and questions</p>

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		relating to the Health Insurance Exchange; enrollment and plan selection assistance for employers with respect to the Health Insurance Exchange; and responses to questions relating to the Health Insurance Exchange.”
Coverage Across State Lines	<p>Allows for the creation of interstate compacts and national plans for the sale of similar insurance products in different states.</p> <p>Creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM).</p> <p>At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards.</p> <p>States can require that multistate plans offer additional benefits that are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules.</p> <p>Insurers who contract to be multistate plans must offer qualified coverage in 60% of states the first year of participation, working up to 100% of states by year four of participation.</p>	Allows for the creation of interstate compacts for the sale of similar insurance products in different states and provides grants to states creating compacts.
Medical Liability	Includes a sense of the Senate resolution supporting state demonstration projects.	Allows for a new voluntary state grant program to encourage states to implement alternatives to traditional medical

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Reform	<p>Provides \$50 million over five years in grant funding for state-based demonstration projects relative to medical liability alternatives.</p>	<p>malpractice reforms.</p>
Medicare Advantage	<p>Sets Medicare Advantage payments based on the average of the bids from Medicare Advantage plans in each market. Creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. Provides a four-year transition to new benchmarks beginning in 2011. Provides a longer transition of the amount of extra benefits available from plans to beneficiaries in certain areas where the level of extra benefits available is highest relative to other areas. New bidding process is expected to cut \$120 billion in funding to the MA program.</p> <p>Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare.</p> <p>Slightly extends the Medicare annual election period for Medicare Advantage and Part D enrollees by seven days and also moves it up to slightly earlier in the year, so that it will be October 15- December 7, rather than November 15- December 31.</p> <p>Eliminates the traditional MA OEP, but allows Medicare beneficiaries enrolled in MA or MA-PD plans to return to original Medicare in the first 45 days of the Calendar Year.</p>	<p>This legislation would reduce Medicare Advantage payment benchmarks to traditional Medicare fee-for-service levels over a three-year period.</p> <p>The bill also imposes requirements on Medicare Advantage plans to offer cost-sharing no greater than that provided in government-run Medicare, and imposes price controls on MA plans, limiting their ability to offer innovative benefit packages.</p> <p>Specifically, the bill requires MA plans to report their ratio of total medical expenses to overall costs (i.e. a medical loss ratio), requires plans with a medical loss ratio of less than 85 % to offer rebates to beneficiaries, prohibits plans with a medical loss ratio below 85 % for three consecutive years from enrolling new beneficiaries, and exclude plans with a medical loss ratio below 85 % for five consecutive years.</p> <p>Changes the annual election period to November 1- December 15.</p> <p>Eliminates the Part D donut hole over time and provides a 50% discount for enrollees in the donut hole immediately.</p>

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	<p>Enhances penalties for those who do not comply with the Medicare Advantage rules, including the marketing requirements.</p> <p>Provides protections against Medicare Advantage benefit cuts to residents of New York, Pennsylvania and Florida.</p>	
Long-term Care	<p>The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.</p> <p>There would be a five-year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at \$65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period. Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at \$50 per day.</p> <p>Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living. EMPLOYERS ARE REQUIRED TO PAYROLL DEDUCT THIS BENEFIT ON AN OPT-OUT BASIS.</p>	<p>The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.</p> <p>There would be a five year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at \$65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period.</p> <p>Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at \$50 per day.</p> <p>Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living. EMPLOYERS ARE REQUIRED TO PAYROLL DEDUCT THIS BENEFIT ON AN OPT-OUT BASIS.</p>
Financing the Reforms	<p>Excise tax of 40% would apply to insurance premiums in excess of \$8,500 for individuals and \$23,000 for families. For qualified retirees and individuals in high-risk professions, the thresholds would still be \$9,850, and \$26,000 for families.</p> <ul style="list-style-type: none"> • HSAs, HRAs and FSAs included in calculation • Amounts indexed annually for inflation 	<p>Surtax on the AGI of upper-income Americans of 5.4% for joint filers making \$1 million/single filers making \$500,000 or more beginning in 2011 and thereafter. .</p> <p>Prohibition of over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs.</p>

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	<ul style="list-style-type: none"> • 17 highest cost states allowed transitional higher amounts for 2013 (120%); 2014 (110%) and 2015 105%) <p>Increases the Medicare payroll tax from 2.9 percent to 3.8 percent for wages and self-employment income above \$200,000 (\$250,000 married). Current 2.9 percent rate retained for wages and self-employment income below this amount</p> <p>Increases penalty for “taxable distributions” for non-qualified medical expenses from HSAs (from 10% to 20%)</p> <p>Over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs.</p> <p>Limits FSA contributions for medical expenses to \$2,500 per year indexed for inflation.</p> <p>Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.</p> <p>Eliminates Medicare Part D deduction.</p> <p>Creates a new 10 percent excise tax on indoor tanning.</p> <p>Annual \$2 billion fee/tax on Rx manufacturers.</p>	<p>Limits FSA contributions to \$2500.</p> <p>Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).</p> <p>Pay or play payments from employers, as described above (</p> <p>Eliminates the tax deduction for retiree prescription drug coverage.</p> <p>2.5 percent excise tax on medical devices.</p> <p>Payments by employers to Exchanges</p> <p>Delaying Worldwide Interest Allocation until 2020</p> <p>Limiting eligibility for reduced treaty withholding rates based on residency of foreign parent</p> <p>Codification of Economic Substance Doctrine and penalties for underpayments.</p> <p>Payments from uninsured individuals.</p> <p>Cuts to Medicare Advantage Program.</p>

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	<p>Annual \$2 billion fee/tax on medical device manufactures. Beginning in 2011, imposes an annual \$6 billion fee/tax on health insurance companies with \$50 million in profits and assess the tax on a pro-rated basis to insurance companies based on profits. Carves out certain non-profit insurers from the insurer assessment</p> <p>Raises 7.5% AGI floor on medical expense deduction to 10%; AGI floor for 65+ remains at 7.5%.</p> <p>Prohibits health insurance companies from deducting any executive pay in excess of \$500,000 if at least 25 percent of its gross premium income is derived from health insurance plans that meet specified minimum requirements. Under current law, businesses can deduct up to \$1 million annually per executive.</p>	
Effective Dates	The majority of the provisions in the bill especially those relative to health insurance coverage, take effect on January 1, 2014. Effective dates by provision do vary, and different effective dates are noted in each section of the chart.	The majority of the provisions in the legislation would take effect on January 1, 2013, but effective dates do vary by provision and are noted when possible.

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