National Association of Health Underwriters

Comparison of the Comprehensive Health Reform Measures Addressed by the House and Senate Committees of Jurisdiction

October 9, 2009

	Senate Finance Committee Chairman's Mark America's Health Futures Act	**Senate HELP Committee Bill American Health Choices Act Passed by Committee July 15, 2009**	**House Democratic Tri-Committee Health Reform Bill, H.R. 3200, as Reported From the Three Committees of Jurisdiction in July 2009**
ERISA	The Mark requires employers of 200 or more employees to auto-enroll all eligible individuals into any available employer-sponsored health insurance plan. Employees may opt out if they have another source of coverage. 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 to buy coverage provisions in the Mark.	This legislation would create a minimum standard for benefit plans that would apply to all size groups (regardless of whether insured or self-funded).	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; (2) would permit states to adopt single-payer models that would preempt ERISA and mandate participation by self-funded groups (under a Dennis Kucinich sponsored amendment which passed the Education and Labor Committee); (3) would create new tax on self-funded groups to fund comparative effective research; and (4) would require federal approval of ERISA health plans (similar to the requirement for retirement plans under ERISA).
Employer Mandate	The Mark would not require employers to offer health	Employers must pay 60% of the premiums for employee coverage or	All employers must offer coverage through either Qualified Health

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	insurance coverage to their employees and/or dependents. Furthermore, under the provisions of the Mark, the only subsidy that non-Medicaid eligible individuals who receive qualified employer coverage are entitled to would be the federal tax exclusion of the value of those benefits from the employee's gross taxable income. However, if an employee is not offered coverage that has an actuarial value of 65% of minimal creditable coverage standards for the individual or small group markets (bronze level plan), or if the lowest cost employer-sponsored coverage offered exceeds 10 percent of the employee's income, then the employee could seek an affordability waiver from the state exchange and purchase exchange-based coverage using a low-income tax credit. Employers of more than 50 people who do not offer coverage will be required to pay a non tax deductible fine for every full-time	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. The fee for part-time employees is $375. Employers with 25 or fewer employees are exempt.	Benefit Plans (QHBPs) 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. In lieu of paying for coverage, the measure creates a "pay or play" option allowing the employer to pay instead 8% of wages to the Commissioner. 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.

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	employee (more than 30 hours a week) that receives a tax credit for health insurance coverage through a state-based exchange. The flat-dollar fee would be set by the Secretary of DHHS each year and be equal to the national average tax credit amount. Employers would pay the **lesser** of one of two amounts. The total of the annual average tax credit fee multiplied by the actual number of full-time employees receiving the tax credit or $400 multiplied by the total number of all full-time employees in the firm. Any fees collected from employers will not directly benefit their employees, but instead be deposited into U.S. general funds. Medicaid-eligible employees may opt out of employer-sponsored coverage at any time and elect Medicaid, and an employer will not be financially penalized for any employee that opts out of such private coverage and elects to receive Medicaid.		

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Individual Mandate	The Mark creates a requirement that effective in 2013, all American citizens and legal residents purchase qualified health insurance coverage. Qualified coverage includes public program coverage, coverage purchased through the individual market, or coverage offered in the small group market that is at least a bronze level plan. Large group and self-funded coverage must have first-dollar coverage of preventive care (except when value-based insurance design is used), no unreasonable lifetime or annual limits, or maximum out-of-pocket costs greater than the HSA current law limits. Individuals in grandfathered plans meet the terms of the mandate. Exemptions are provided for those with religious objections similar to what is allowed for Medicare and also for undocumented aliens. Individuals would be required to report on their federal income tax returns the months of the year for	The legislation creates a requirement that all individuals have health insurance coverage with a federal income tax penalty on any individual who does not have in effect qualifying coverage for any month during the year. Health plans must provide a return to individuals as documentation of coverage. Exemptions will also be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. The new tax penalty imposed for those who do not comply with the mandate would be 50% of the unsubsidized premium of a qualifying health plan providing the lowest level of acceptable coverage. The mandate is not applicable in states where Gateways are not yet operating.	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. The tax shall not exceed the applicable national average premium for individual or family coverage pro-rated for partial year failures. Acceptable coverage includes QHBPs, a grandfathered plan, Medicare, Medicaid, TRICARE and VA coverage. Any entity providing acceptable coverage to individuals must provide them with annual documentation of coverage, and regulations will be promulgated relative to hardship waivers and waivers for people with minimal lapses in coverage.

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	which they had 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. The penalty for not maintaining coverage is an excise tax of no more than $750 per adult in the household, and it will be phased in between 2013 and 2017. In addition to the exemptions from the mandate generally, there is an exemption from the excise tax penalty for individuals where their total cost of the lowest individual or employer plan option available to them (after taking into consideration subsides or employer contributions, if any) exceeds 8 percent of their AGI. Individuals impacted in this manner could purchase a "young and invincible" policy regardless of age. Also exempt from the penalty are those with incomes below 100% FPL, certain religious		

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	organizations, those experiencing hardship situations as defined by the Secretary of DHHS, American Indians and also for the year 2013 only, individuals with incomes at or below 133% of FPL.		
Ability to Keep Your Current Coverage	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 their dependents. Any individual who has a current policy actuarially equivalent to a "young and invincible" policy would be allowed to renew that coverage and it would be considered minimal creditable coverage under the Mark's individual mandate to obtain coverage. Small group plans would be allowed to phase in reform requirements over 5 years, but eventually all group plans, grandfathered or not, would be subject to the new rating rules.	Existing policies would only be able to be retained if the only change to the policy was to add or delete a dependent. Changes to deductibles, coinsurance, co-pays, and other cost-sharing would also be allowed if they were not deemed significant under rules to be developed by the Secretary.	Existing individual policies would only be able to be retained if the only change to the policy was to add or delete a dependent. 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.

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Market Reforms	The Mark would require all individual health insurance policies and all small group policies to abide by strict modified community rating standards with premium variations only allowed for age (4:1), tobacco use (1.5:1), family composition (range of 1:1-3:1 depending on family make-up), and geographic regions to be defined by the states. Taking into consideration all factors, premiums within a family category could not vary more than a 6:1 composite ratio. Coverage must be offered on a guarantee issue basis in these markets and be guarantee renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited. Relative to the guarantee issue provisions, the mark permits the Secretary of DHHS to grant capacity limits for carriers. Small group coverage is defined as 2-50 employees, but states are given the option of raising the definition of a small group to up to	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. For the individual and small group markets, it would impose strict modified community rating standards consisting of variances only by family structure, community rating area (defined by the HHS Secretary based on the recommendation of the NAIC), actuarial value of the benefit, tobacco use with the limitation that the variation not exceed 1.5:1, participation in qualified workplace wellness programs for employer-sponsored coverage, 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. 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. These	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. Would apply the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets. 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. 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.

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	100 employees. States may also elect to merge the rating and pooling of individual and small group markets. These reforms would be phased in on a state-by-state basis over a five year period beginning July 1, 2013 for the small group market, and the effective date for the individual market is unclear.	rating rules do not apply to large group or self-funded plans.	
Exchange	The Mark requires the creation of state-based exchanges starting July 1, 2010 to serve both the individual and small group markets, including the potential for states to develop either a merged exchange for both markets or an individual market exchange and SHOP exchange to serve the employer market. All individual and small group market insurers must participate in the state-based exchanges and they must be fully operational for individuals and small groups by July 1, 2013. Stand-alone child-only and dental plans would also be allowed to be offered through the state-based exchanges. The state exchanges will receive	The measure requires each state to establish a variation of a health insurance exchange that is termed a Gateway. If a state does not establish a Gateway within four years, the Secretary must establish one for them. The legislation provides for grants to states to establish their Gateways. The Gateways will use risk-adjustment mechanisms to remove incentives for plans to avoid offering coverage to those with serious health needs.	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. The categories of people and businesses qualified to purchase coverage through the Exchange would be phased in over five year's time. Individuals and groups up to 10 would be allowed the first year, groups up to 20 would be allowed the second year, and any size group if allowed by the Commissioner would be allowed in the 3rd and later years.

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	initial federal start-up funding but will be self-sustaining in future years. While the rest of Mark defines small employer coverage as 50 employees or less unless the threshold is raised to 100 by a state, the exchange provisions would allow small businesses in all states with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2015. Beginning in 2017, states could allow businesses with more than 100 employees to purchase coverage in the SHOP exchange. The individual low-income tax credits created by the Mark 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. States could create regional exchanges to serve multiple states using the interstate		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. States would be allowed to transition their Medicaid populations to the Exchange—with appropriate supplemental wrap-around coverage—after five years. 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.

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	compact provisions of the Mark. The Mark creates specific requirements for the Secretary of DHHS and the states in establishing the exchanges, including standardized applications, quality information, formats for presenting insurance options available through the exchange, and marketing requirements (through an NAIC model). 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 Beginning July 1, 2013, 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.		
State-Level Opt Out	Beginning in 2015, the Mark allows states to apply for a waiver	No provision.	No provision.

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Provisions	to opt out of certain aspects of the Act, through a process similar to what states currently use for Medicaid and CHIP waivers. In order to be eligible for a waiver the state must: (1) provide coverage at least as comprehensive as the exchange coverage requirements that is developed with citizen input; (2) cover all residents; (3) have comprehensive legislation or a detailed plan for implementation prepared; and (4) submit a 10-year budget that is deficit-neutral to the federal government. The state program must also be able to demonstrate that it lowers health care spending growth, improves delivery system performance, provides affordable coverage choices for all citizens, expands out-of-pocket cost protections, provides coverage to the same number of uninsured and not increase the federal deficit.		
Essential Benefits	The Mark establishes a standard of minimum creditable coverage based on four benefit categories (bronze, silver, gold and platinum)	The Secretary will determine (1) the schedule of items and services that constitute the essential health care benefits eligible for credits including	A new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General,

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	of varying actuarial values. All individual and small group insurers would have to offer, at minimum, plans in the silver and gold values. All individual and small group policies issued (except for grandfathered plans) would have to include coverage of the following services: preventive and primary care, emergency services, hospitalizations, physician services, outpatient services, same day surgery and related anesthesia, diagnostic imaging and screenings, maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy and mental health and substance abuse services that meet at least minimum standards set by state and federal laws. Also, if a health insurer rates for tobacco use, they must also provide coverage for comprehensive tobacco cessation programs.	the amount, duration, and scope of such items and services; (2) the coverage that should be considered minimum qualifying coverage and (3) the conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels. At a minimum, these benefits must include: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, pediatric services, including oral and vision care. The maximum out-of-pocket limit will be roughly equivalent to the out-of-pocket maximum for an HSA qualified high deductible health plan for the year involved. The Secretary will establish a standard under which coverage is deemed to be unaffordable only if the premium is greater than 12.5% of the AGI of the individual involved. In this case, the individual would be eligible for affordability credits. The bill	will recommend a benefit package based on standards set in the law. 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. 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 and substance use services, maternity care, well baby and well child care and oral health, vision, and hearing services, equipment and supplies up to 21 years of age. 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. There will be three levels (actuarially equivalent) of coverage. The basic package will look at the

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	In addition to the benefits that must be included, there can be no cost-sharing for preventive care services (except for cases of value-based insurance design), and plans may not include annual or lifetime limits on any benefits. Also, there must be parity in cost-sharing over a wide range of service categories (except for cases of value-based insurance design). Each level of coverage must meet its own actuarial value of the mandatory covered services and its own cost-sharing requirements based on an indexed version of the current HSA law limits. Bronze level policies must equal 65% of the value of the reference benefits, silver 70%, gold 80% and platinum 90%. A separate "young and invincible policy" catastrophic-only policy would be available for those 35 and younger. The catastrophic coverage level would be the current HSA law limit and preventive benefits would be exempt from the deductible.	language currently requires such credits to be provided through the exchange rather than flowing through the employer-sponsored plan. Regarding the level of benefits that must be provided for the services above, the Secretary will establish tiers of cost sharing. The first tier has coverage not less than 76% of the total allowed costs of the benefit and the out-of-pocket limit can't be greater than the HSA qualified high deductible health plan that year. Tier two cost sharing would be 84% of the benefit level and out-of-pocket limits equal to half of the amount for tier one. The third tier is 94% of the benefit level and out-of-pocket amounts equal to 20% of tier 1.	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). The enhanced package will consist of the same benefits, but with 15% cost-sharing. The premium plan will be designed so that benefits are actuarially equivalent to 95% of the value of the reference benefits.

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	Small employers offering coverage through the exchange would have to offer a plan with deductibles no more than $2000 individual/$4000 family unless the deductible amounts were offset with an HRA or other account-based plan. Out-of-pocket costs w be limited on a sliding scale for individuals between 100-400% of the FPL. Stand-alone dental plans must be allowed to offer the required pediatric dental coverage through the exchanges.		
HSAs, HRAs, FSAs	The Mark 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 Mark does change 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.	The bill does not impact any of these products. The essential benefits package clearly creates in its first tier, a tier that would accommodate the benefit requirements of HSAs. HRAs would not be prohibited as long as the underlying insurance package met at least the requirements of HSA qualified coverage. FSAs are not addressed in this bill.	The bill does not directly impact these provisions, but there is some question about whether the actuarial equivalents are sufficient to meet HSA qualified high deductible health plan requirements. Assurances were made during the mark-up process to House Energy and Commerce Committee members that when the tri-committee bills were merged that changes would be made to ensure that this would not be a problem.

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	This change means that over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs. The Mark also increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%). The Mark limits FSA contributions for medical expenses to $2,500 per year.		There was one change mentioned below relative to over the counter prescription drugs which would no longer be an allowed expense in any of these plans.
Government-Run Public Plan Option	The Mark does not create a new government-run public plan option to be offered to all individuals and employers purchasing coverage through the exchange. The Mark does 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.	The bill creates a new Community Health Insurance Option to be offered through the Gateway. It does not require health care providers to participate. The benefits offered may include state mandates but if they do, the state will be required to pay the difference in cost for individuals who are eligible for subsidies. The Community Health Insurance Option must set premiums that are sufficient to cover costs. The Secretary will negotiate rates for	The measure would create a government-run public plan option that would be made available to consumers purchasing coverage through the Exchange. The bill states the plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced, and premium plan options. Premiums will be established according to exchange rules for other plans. The Exchange will be initially financed by unlimited start-up

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	States would be required to contract with multiple private health plans to administer the plan, and the minimum benefit package and cost-sharing requirements would be the same for this population as in any state-based exchange. States would have to negotiate rates with providers and private participating insurers, provide at least two plan options and a minimum 85% loss ratio would be required for all participating plans. If a state elects this option, the basic health plan choices will 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. 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	providers that are not higher than the average reimbursement rates paid by private plans offered through the Gateway. The Secretary will establish a federal solvency standard. The minimum reserve fund will be equal at least to incurred but not reported claims. The plan will also be subject to the solvency standard of each state in which it is offered. An Ombudsman will be established to provide assistance to consumers. A fund will be established in Treasury to provide loans for initial operations that will include start-up costs and claims for 90 days after the plan has begun and risk corridor payments. Plans have 10 years to repay the fund. States are required to establish a public or non-profit entity to serve as a State Advisory Council to provide recommendations to the Secretary on the operations and policies of the community health insurance option in	funding provided by Secretary, but eventually it must be self-sustaining including establishment of reserves. The Secretary will negotiate rates for providers that are not lower than Medicare rates or higher than the average reimbursement rates paid by private plans offered through the Exchange. The public option will establish a formulary for prescription drugs and PBMS operating with the plan will be subject to new transparency requirements.

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	exchange.	the State.	
Cooperatives	The Mark authorizes $6 billion in federal funding for Consumer Operated and Oriented Plan (Co-op) program to create non-profit member-run health insurance companies in one or more states. 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. If Co-ops do not initially form in every state, the Secretary of DHHS over a five-year period will be authorized to use planning grants to encourage the creation of new Co-ops or the expansion of existing Co-ops.	Not addressed.	The Commissioner is authorized to provide grants for the establishment of non-profit member-based health insurance cooperatives that can be offered either through the national exchange or through state based exchanges.
Risk Adjustment	Within a year of enactment, any individual who has been uninsured for at least 6 months	States are required to set up a system for risk adjustment across state markets. If states have a higher risk	The bill requires the Commissioner to establish for the exchange "a mechanism whereby there is an

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	and has a preexisting medical condition can receive coverage through a high risk pool, which may be a national high risk pool or a state high risk pool that will exist until 2013 and be funded through a $5 billion federal appropriation. Premiums will be capped at 100% of the bronze level plan premiums. As the market reforms take effect in 2013, all plans in the individual and small group markets will be subject to a system of risk adjustment by rating area. The Secretary of DHHS will certify the entities capable of conducting risk adjustment and states can either pick from those entities, use a DHHS certified model to develop their own program, or develop their own program using their own cost-effective model. Risk adjustment entities may not be owned or operated by insurance companies. After risk adjustment is applied, reinsurance and risk corridors will apply to these markets. Reinsurance	profile than the average risk in the state, they will be eligible for additional funding from the state to offset their excess costs. If a state has a lower than average risk profile, they will be required to pay an assessment to the state. This will be administered similar to Part D. Payments will be calculated on a retrospective basis. The risk adjustment applies across markets in a state, and is not limited to the Gateway. It does not apply to self-funded plans. Carriers are directed to pool their individual market risks in the Gateway and outside the Gateway together, and their group market risks together but are not required to co-mingle individual and group market risks.	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.

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	From 2013-2015 a reinsurance program would be in effect for the individual market and all carriers would be required to contribute $20 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. 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. The Mark also requires insurers to contribute an addition $5 billion during 2013-2015 to apply reinsurance to employer-sponsored retiree coverage 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. Risk Corridors		

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	After reinsurance is applied, risk corridors 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 cots that exceed 103% and require payment on a staggered basis from those with costs less than 97 percent.		
Minimum Loss Ratios	The Mark does not establish minimum loss ratio (MLR) requirements for insurers except for an 85% MLR requirement in the optional state basic health programs to serve low-income individuals between 133-200% FPL. However, the measure does require all insurers to disclose the proportion of premium dollars spent on items other than medical care and report such information in a standardized and consumer transparent format.	For all fully insured health plans, the measure requires insurers to track reimbursements for clinical services, activities that improve health care quality and all other non-claims costs. This provision does not apply to self-funded plans.	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.
New Regulatory Entities	The Mark 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	The Gateways are the only new federal coverage entity in the second draft of the bill. States are required to establish State	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

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	council, and a state ombudsman to help with issues associated with the state-based exchange, among others.	Advisory Councils to monitor the community health insurance option.	"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. 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. 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.
Medicaid Expansion	The Mark would expand Medicaid coverage to all individuals with incomes up to 133% of the FPL effective January 1, 2014. States would be required to maintain	This provision was removed and referred to the Finance committee.	Would expand Medicaid coverage to all individuals with incomes up to 133% of the FPL. This expansion would be shared by states and the federal government.

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	current Medicaid income eligibility levels for all populations upon enactment of this measure would be phased out beginning when the state-based exchanges become fully operational and would fully end on January 1, 2014. The cost of the expansion would be shared by states and the federal government, with additional federal-level assistance defraying state expenses for the newly eligible beneficiaries, including even more additional assistance for "high need" states that meet specified criteria. Effective July 1, 2013, 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. The Mark would also retain the current CHIP program structure under an enhanced federal cost		

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	match rate and require reauthorization of CHIP by September 30, 2013.		
Individual Subsidies	The Mark creates a system of sliding-scale tax credits for people with incomes between 100% and 400% of the FPL. The subsidies would only be available to legal U.S. residents and U.S. citizens who purchase individual coverage through the exchange or do not have access to affordable employer-sponsored coverage and purchase policies through the Exchange. 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 or is not valued at 65% of the actuarial value of the essential benefits package.	The legislation creates a complicated system of sliding-scale subsides for people purchasing coverage through the Gateway with incomes between 100% and 400% of FPL. Funding will not be provided for individuals who are not lawfully present in the United States.	The legislation creates a system of sliding-scale tax for people with incomes between 100% and 400% of the FPL. The subsidies would only be available through the Exchange. Funding will not be provided for individuals who are not lawfully present in the United States. 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. Such employer coverage is deemed unaffordable for these individuals under the following circumstances: Coverage for employees with incomes between 133% and 150% of FPL is deemed unaffordable if premiums are more than 3% of annual income, 150% -200% of FPL at 5.5% of annual income, 200% -

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			250% of FPL at 8% of annual income, 250% - 300% of FPL at 10% of annual income, 300% - 350% of FPL at 11% of annual income, and 350% - 400% of FPL at 12% of annual income.
Small Business Assistance	The Mark provides tax credits for qualified small employer contributions to purchase coverage for employees. To be eligible for the full credit amount, an employer could have no more than 10 full-time employees whose average annual salaries did not exceed $20,000 (indexed for inflation). The credit would phase out entirely for employers of more than 25 employees whose average annual salaries exceeded $40,000. The credit is provided in two phases. In phase one (2011 and 2012) 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 (2013 and 2014), the credit only applies if the small employer purchases coverage through the	Provides small employers with a health options tax credit. Eligible employers must pay an average wage of less than $50,000 and must pay at least 60% of employee health expenses. Credit is $1,000 for each employee and $2,000 for an employee with family coverage. It is adjusted for group size and number of months covered. Bonuses are paid for larger employer payments.	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. Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers. Individuals with incomes of over $80,000 do not count for purposes of determining the credit amount.

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	exchange. The maximum credit amount would be 50% of the employee's premium costs if employer contributes at least 50% of the premium costs or 50% of the benchmark premium.		
Wellness Provisions	The Mark codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 30% of premium, with the potential for expansion of up to 50% with federal approval. The Mark also expands the wellness program rules to the FEHBP and sets up 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. For small businesses, the Mark establishes a $200 million five-year grant program for businesses with less than 100 employees to create workplace wellness programs.	The legislation allows participation in a workplace wellness program to be used as a rating factor in determining small group coverage rates. The legislation codifies and improves upon the HIPAA bona fide wellness program rules and increases for the value of workplace wellness incentives to 30% of premium, with the potential for expansion up to 50% with federal approval. Creates a temporary right choices program to provide uninsured adults with immediate access to preventive care services. Creates a prevention and public health investment fund. Creates a federal grant program to implement and evaluate proven community preventive health activities, reduce chronic diseases and address health disparities.	Employer-based wellness programs are not addressed by the legislation. Creates national task forces on evidence-based prevention and wellness. Increases Medicare and Medicaid beneficiary access to proven preventive care services.

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	For Medicare beneficiaries, the Mark allows for coverage of an annual health risk assessment and expanded preventive care coverage. It appropriates $100 million over five years to incent Medicare beneficiaries to participate in certain healthy lifestyles programs. For Medicaid recipients the Mark expands access to preventive care, medical homes and smoking cessation services. It also appropriates $100 million over five years to incent Medicaid beneficiaries to participate in certain healthy lifestyle programs and funds a $25 million demonstration project on childhood obesity.		
Agent Provisions	The Mark assumes the use of health insurance agents and brokers and includes specific language to ensure that agents and brokers may still sell. The Mark stipulates that there may not be a cost difference for individual and small group health insurance products, regardless of how the product is purchased—	While the legislation does not in any way prohibit or restrict the ability of state-licensed health insurance agents, brokers and consultants to market and service health insurance policies either inside or outside the Gateways, the measure does allow but does not require states to enter into contracts with "navigators" and provides them with federal support to do so.	Requires the federal Health Choices Commissioner to develop uniform marketing standards for all entities offering Qualified Health Benefit Plans. 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

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	through a agent or broker, directly sold through a carrier, or inside or outside the exchange. The Mark specifically ensures that the state insurance commissioners will continue to regulate agents and brokers in terms of licensing, marketing requirements and commissions. The NAIC is directed to develop a model regulation for the states to adopt relative to the structure and sale of products through the Exchanges, including the role of agents and brokers.	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 could include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, licensed agents and brokers, and others. The navigators would conduct public education activities, distribute information about enrollment and the availability of subsidies, and otherwise facilitate enrollment. They would be required to be appropriately trained for the type of advice being provided to consumers. Also requires the Secretary of HHS to develop marketing standards for the Gateway.	plan.
Medicare Advantage	The Mark would establish a new competitive bidding process for Medicare and reduce Medicare Advantage plan payments to base Medicare fee-for-service bid	Not addressed.	This legislation would reduce Medicare Advantage payment benchmarks to traditional Medicare fee-for-service levels over a three-year period.

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	levels with bonus payments for quality, performance improvement, care coordination and efficiency. MA plans and their addition benefits for seniors would be protected/grandfathered in areas where plan bids are at or below 85% of traditional fee-for-service Medicare. However, these plans would be required to participate in the new competitive bidding process.		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. 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.
Long-term Care	The long-term care provisions of this measure were stricken out during the mark-up process.	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. There would be a five year vesting period before participants would be	Although not included in the proposed legislation, an amendment has passed in the House Energy and Commerce Committee that would implement reforms similar to those approved in the HELP legislation. The bill creates a new national

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		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. 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. To promote the purchase of private long-term care insurance, the bill allows LTC insurance premiums to be included in Section 125 plans.	insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. 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. 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.

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Financing the Reforms	The principal means of financing the measure include a 40% excise tax on health insurance policies priced above $8k single/$21k family (with exemptions for certain indemnity policies), cuts to the Medicare Advantage program and industry-specific yearly nondeductible assessments on prescription drug manufacturers, medical device manufacturers, health insurers and clinical laboratories.	Although the HELP committee is not required to specify the exact methods of paying for its bill (this will be done by the Finance Committee), some new costs are clear. The new proposal does impose new tax penalties as described above for those who do not comply with an individual mandate. The new proposal also proposes new penalties for employers who do not provide approved coverage for their employees, as described above.	Surtax on the AGI of upper-income Americans, beginning with a 1% surtax on joint filers with incomes from $350,000-$500,000 for 2011 through 2012, and increasing to 2% in 2013 and thereafter; 1.5% for joint filers with incomes from $500,000-$2,000 in 2011 and 2012, increasing to 3% in 2013 and thereafter; and a top rate of 5.4% for joint filers making $1 million or more beginning in 2011 and thereafter (raises $544 billion). Prohibition of over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs (raises $8 billion) Pay or play payments from employers, as described above (raises $163 billion) Tax on employer plans to fund Comparative Effective Research (raises $2 billion) Payments by employers to Exchanges (raises $45 billion) Delaying Worldwide Interest Allocation until 2020 (raises $26

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			billion). Limiting eligibility for reduced treaty withholding rates based on residency of foreign parent (raises 7.5 billion). Codification of Economic Substance Doctrine and penalties for underpayments (raises $3.6 billion). Payments from uninsured individuals (raises $29 billion). Permanent reductions in the annual updates to Medicare's payment rates for most services (other than physician services yields $196 billion over 10 years). Setting payment rates in Medicare Advantage based on per capita Medicare spending in the fee for service sector (yields $156 billion). Changes to Medicare Part D that would establish a new rebate program for dual eligibles while expanding coverage in gap (yields $30 billion).
Effective Dates	The majority of the provisions in the Mark, especially those relative	Most of the provisions in the legislation become effective one year	The majority of the provisions in the legislation would take effect on

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	to health insurance coverage, take effect either on January 1, 2013 or July 1, 2013. Effective dates by provision do vary, and different effective dates are noted in each section of the chart.	after enactment, but effective dates do vary by provision and are noted when possible.	January 1, 2013, but effective dates do vary by provision and are noted when possible.

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