A Comparative Analysis of Private Health Insurance Provisions of H.R. 3962 and Senate-Passed H.R. 3590

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Summary

On November 7, 2009, the U.S. House of Representatives approved health insurance reform legislation, H.R. 3962, the Affordable Health Care for America Act. On December 24, 2009, the U.S. Senate passed its version of health insurance reform, the Patient Protection and Affordable Care Act, in H.R. 3590, as amended by the Senate (hereafter referred to simply as H.R. 3590).

Individuals currently receiving health insurance through a large employer would likely see the least direct impact from the bills. The largest changes would occur in the private health insurance market for small businesses and for nongroup coverage (currently, insurance obtained directly from an insurance company, broker or agent). The most substantial of these reforms would not take effect until 2013 under H.R. 3962, and in 2014 under the Senate bill. At full implementation, the required private health insurance market reforms should be fully in place, along with subsidies to certain low- and moderate-income individuals ineligible for Medicaid. At full implementation, the bills would require most individuals to obtain and, in the House bill, for larger employers to offer and contribute toward health insurance. Although the Senate bill does not have an explicit "employer mandate," employers who do not offer coverage could face substantial penalties.

Shortly after enactment of either of the bills, all private health insurance would be subject to some new requirements. For example, health insurers could not offer coverage with unreasonable annual or lifetime limits on benefit payouts, and they could not cancel ("rescind") policies unless the policyholder had committed fraud. Many other provisions are detailed in the report.

After full implementation, although prior coverage could generally continue without meeting new requirements (at least for a period of time), new coverage would have to meet federal standards stipulated in the bills—and different requirements may apply depending, for example, on whether the coverage is nongroup or employment-based. The bills also call for an exchange available in each state, through which individuals not enrolled in (or, primarily in the Senate bill, not eligible for) other coverage, as well as small businesses, could choose from private health insurance plans. In addition, under the House bill, individuals obtaining coverage through an exchange could also choose a "public option" established by the Secretary of Health and Human Services (HHS). The public option would be appropriated start-up funding, but would ultimately have to be self-sustaining through the premiums charged. Payments to providers (doctors, hospitals) would be established through negotiations with the Secretary. The Senate bill would not include a public option. However, the Director of the Office of Personnel Management would enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans (MSQHPs) through each exchange in each state to provide individual, or in the case of small employers, group coverage. Both bills also provide start-up funding for cooperatives, which would be new, member-run, nonprofit entities that could offer health insurance through exchanges.

Under the Senate bill, any participation in the exchange requires verifying citizenship or legal residence status. Under H.R. 3962, such verification is only required for premium and cost-sharing subsidies. Under both bills, such subsidies would only be available through an exchange, for qualifying low- to moderate-income individuals. Both bills would prohibit the subsidies from paying any part of elective abortions. The House bill would also prohibit subsidies from going to a plan that covers elective abortions. Besides the subsidies to individuals, small businesses would be eligible for tax credits to help them pay toward their employees' coverage. The Congressional Budget Office (CBO) estimated the bills' costs would be fully offset in both the 5- and 10-year budget windows by increased excise taxes and other revenues and decreased spending.

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Introduction

On November 7, 2009, the U.S. House of Representatives approved health insurance reform legislation, H.R. 3962, the Affordable Health Care for America Act.[1]

Two Senate committees of jurisdiction also approved major health insurance reform legislation. The Senate Health, Education, Labor and Pensions (HELP) Committee reported S. 1679,[2] and the Senate Finance Committee reported S. 1796.[3] These bills were consolidated as S.Amdt. 2786, further amended on the Senate floor, and passed in the Senate on December 24, 2009, as H.R. 3590, the Patient Protection and Affordable Care Act (hereafter simply referred to as H.R. 3590, or the Senate bill).

This report compares many of the private health insurance provisions of H.R. 3962 and H.R. 3590. For each of the major private health insurance reforms, the report first gives a narrative description of the context and current law, then describes where the House and Senate bills make similar reforms and how their approaches differ. The narrative is then followed by more detailed tables comparing these provisions under the following major topics, with the primary CRS contact listed for each:

- **Table 1**. Reforms prior to full implementation. Mark Newsom, 7-1686.
- **Table 2**. Private health insurance market reforms at full implementation date. Bernadette Fernandez, 7-0322.
- **Table 3**. Essential benefits. Bernadette Fernandez, 7-0322.
- **Table 4**. Individual mandate: the requirement on individuals to maintain health insurance, with penalties and taxes for noncompliance. Hinda Chaikind, 7-7569.
- **Table 5**. Employer requirements to provide health insurance or potentially pay penalties. Hinda Chaikind, 7-7569.
- **Table 6**. Small business tax credit. Hinda Chaikind, 7-7569.
- **Table 7**. Health insurance exchanges [Chris Peterson, 7-4681], through which the following two items can only be offered:
  - **Table 8**. Premium and cost-sharing subsidies. Chris Peterson, 7-4681.
  - **Table 9**. Public health insurance option. Paulette Morgan, 7-7317; Multi-state qualified health plans. Hinda Chaikind 7-7569.
- **Table 10**. Cooperatives. Mark Newsom, 7-1686.
- **Table 11** Selected revenue provisions. Janemarie Mulvey, 7-6928.
- **Table 12**. Abortion. Jon Shimabukuro, 7-7990.

[1] CRS Report R40885, *Private Health Insurance Provisions of H.R. 3962*.

[2] CRS Report R40861, *Private Health Insurance Provisions of S. 1679*.

[3] CRS Report R40918, *Private Health Insurance Provisions of S. 1796, America's Healthy Future Act of 2009*.

- **Table 13**. Verification of immigration status and treatment of noncitizens for exchange coverage and subsidies. Ruth Wasem, 7-7342.
- **Table 14**. Other provisions.

When possible, the tables were formatted to make comparisons easier between the bills and thus may not follow the order of the legislative language. However, at the end of nearly every cell is the specific bill reference of the provision described and, if applicable, the portion of current law that is amended.

The first two tables (reforms prior to full implementation and private health insurance market reforms) and the last table contain columns describing current law. However, the other tables do not contain a current law column because little or no relevant current law exists. To the extent some context or current law exists for these other topics, it is provided in the narrative.

In this report, "the Secretary" refers to the Secretary of Health and Human Services (HHS), unless specified otherwise. Under H.R. 3962, "the Commissioner" refers to the Senate-confirmed Commissioner of the Health Choices Administration, a new executive branch agency (independent, similar to the Social Security Administration, SSA) who would establish standards for certain health insurance plans, establish and operate the federal health insurance exchange (though states would be permitted to create their own), and administer premium and cost-sharing subsidies for qualifying individuals. Other terms and acronyms used throughout this report are the following, with a description of how each applies to health insurance and financing under current law:

- ERISA: The Employee Retirement Income Security Act of 1974 provides for the federal regulation of private-sector employee benefit plans. [4] Besides the regulation of pension plans, ERISA also regulates welfare benefit plans that may provide, among other things, medical, surgical and other health benefits. ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans). In general, while ERISA regulates private-sector employee benefit plans and health insurance issuers providing group health coverage, it does not cover governmental plans, church plans, or plans with less than two participants.
- IRC: The Internal Revenue Code of 1986 is the primary source of U.S. tax law, pertaining to individuals, employers and others. The IRC regulates group health plans, including church plans, but does not regulate health insurers.
- PHSA: The Public Health Service Act includes many health related federal grant programs, but it also regulates group health plans, health insurance issuers providing group health coverage, coverage in the individual market, as well as some governmental plans.
- HIPAA: The Health Insurance Portability and Accountability Act of 1996 has numerous provisions affecting private health insurance, insurers, and employer-provided plans. HIPAA was the first major federal law to make numerous requirements specific to health insurance (e.g., restrictions on pre-existing condition exclusions, guaranteed availability and renewability of plans for certain

[4] CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*.

employers and individuals). HIPAA instituted its changes by amending ERISA, the PHSA, and the IRC to create analogous requirements pertaining to pre-existing conditions, for example, across the broadest spectrum of private health coverage.

- SSA: The Social Security Act contains the statutory requirements for certain federal domestic social programs, including Medicare (Title XVIII), Medicaid (Title XIX) and the Children's Health Insurance Program (CHIP, Title XXI).
- Group health insurance: Health insurance obtained by a group of people drawn together by an employer or other organization, such as a trade union. To affect group health insurance, federal law is typically amended in ERISA, the PHSA, and the IRC.
- Nongroup health insurance: Health insurance that individuals purchase not through a group, but directly from an insurer or through an insurance broker or agent. Sometimes referred to as "individual" or "individual market" insurance. To affect nongroup health insurance, federal law is typically amended in the PHSA.
- Small group health insurance: Group health insurance typically obtained by firms with between 2 and 50 workers, although some self-employed individuals are considered "groups of one" for health insurance purposes in some states. To affect small group health insurance, federal law is typically amended in ERISA, the PHSA, and the IRC.
- Self-insured health plans: A self-insured health plan is an employee benefit plan under which an employer provides health benefits directly to plan participants, as opposed to offering benefits through health insurance. Because self-insured plans do not provide benefits though an insurer, they cannot be regulated by the states (due to ERISA preemption). These plans are sometimes referred to as "self-funded plans." (Many employers with self-funded plans use insurers, for a fee, solely to assist with the administration of the health plan benefits—for example, to pay doctors and hospitals the insurer's negotiated rates—but the employer bears the financial risk.) To affect self-insured plans, federal law is typically amended in ERISA, the PHSA, and the IRC.
- Health insurance issuer: Under ERISA and the PHSA, a health insurance issuer is an insurance company, service, or organization that is licensed to engage in the business of insurance in a state and is subject to state laws that regulate insurance. This term does not include self-insured plans.
- Group health plans: A term general enough to include self-insured plans.
- NAIC: The National Association of [state] Insurance Commissioners.

Reforms Prior to Full Implementation

Health insurance reform is a major issue in the 111th Congress, driven predominantly by long-term and growing concerns around access, cost, and quality of care.[5] The practices of some health insurance companies have been cited as meriting immediate reform, such as unreasonable annual or lifetime limits,[6] rescissions,[7] and discrimination against individuals with pre-existing conditions.[8] The cost, reflected in rising health insurance premiums, and the quality of care have also been noted as significant concerns requiring immediate attention.[9] These issues and other items are featured in the immediate reform sections of both bills.

Some Common Features Between the Bills

As detailed in **Table 1**, both bills have provisions for immediate reforms that are either intended to be permanent (e.g., prohibition on rescissions) or are temporary programs before the main reforms take effect (e.g., high-risk pool program run by the Secretary). Both bills deal with the aforementioned concerns around abusive health insurance practices and would include:

- Restrictions on annual or lifetime limits on benefits for group or individual health plans.
- Prohibiting the practice of rescissions unless the member or policyholder has committed fraud.
- Creating a high-risk pool program for individuals with pre-existing conditions.

Both bills would also attempt to address cost issues involving health insurance premiums by requiring rebates when non-claims costs exceed a defined percentage. Health insurers would also have to publicly report financial data around their usage of premiums for coverage of services versus administrative costs, and would have to provide justification for premium rate increases. Other provisions would extend coverage in the group and individual markets to certain currently ineligible dependents, and would create a reinsurance program to assist employer plans with the cost of providing benefits to retirees who are 55 and older.

[5] For an in-depth review of health reform issues see CRS Report R40517, *Health Care Reform: An Introduction*.

[6] Annual or lifetime limits refer to the maximum dollar amount that a health plan will pay toward individuals' covered health care expenses.

[7] Rescission refers to the practice of health insurance companies dropping coverage, sometimes after a member or policyholder has become very sick and has filed claims for a substantial amount. Generally, in these cases the insurer carefully reviews the member or policyholder's application for coverage, and cites a discrepancy that permits canceling the contract. Rescission applies not only at the time of cancellation but for the entire period the policy was in effect, leaving the previously-enrolled individual financially responsible for all medical services received as if she was never covered.

[8] U.S. Congress, House Committee on Ways and Means, hearing on Health Reform in the 21st Century, 111th Congress, 1st Session, April 22, 2009 (Washington: GPO, 2009). U.S. Congress, House Committee on Education and Labor, hearing on Ways to Reduce the Cost of Health Insurance for Employers, Employees, and their Families, 111th Congress, 1st Session, April 23, 2009 (Washington: GPO, 2009).

[9] "American's Health Future Act of 2009," S.Rept. 111-89, Committee on Finance.

Some Differences

In general, the implementation dates prior to full implementation differ between the bills—with most of the House provisions taking effect for plan years beginning with 2010, and in the Senate bill for plan years beginning on or after the date that is six months after enactment. As detailed in **Table 1**, there are also several provisions in one bill, but not in the other. Only H.R. 3962 has immediate provisions that would reduce the look-back and exclusions periods for pre-existing conditions, define domestic violence as not being considered a pre-existing condition, prohibit plans from denying or delaying treatment for children with deformities, establish wellness program grants, and extend coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) until the exchange is operational in 2013. Only the Senate bill would, for example, do the following:

- Group health plans and health insurance issuers would be required to provide coverage for preventive health services.
- The Secretary would be required to develop standards for plans in the group and individual markets for providing their enrollees with a summary of benefits and coverage.
- Sponsors of group health plans (other than a self-insured plan) would be prohibited from establishing eligibility rules based on the salary of the employee.
- The Secretary would be required to develop regulations for the group and individual markets governing acceptable provider reimbursement structures that improve quality of care.
- Hospitals would be required to establish a list of standard charges for items and services in accordance with guidelines published by the Secretary.
- Group and individual plans would be required to have an effective appeals process as part of an immediate reform.
- Grants would be provided to states to establish supports to assist consumers with filing complaints and appeals regarding enrollment, and to resolve problems with obtaining premium credits.
- The plan or issuer would be required to permit the designation of any participating primary care provider or pediatrician who is available to accept the individual.
- If a group health plan or health insurance issuer covers emergency services they would be required to cover those services without the need for any prior authorization and without the imposition of coverage limitations irrespective of the provider's contractual status with the plan.
- Centers established to collect medical reimbursement data would be required to develop, and make publicly available, fee schedules and other database tools that fairly and accurately reflect market rates for medical services.

Private Health Insurance Market Reforms at Full Implementation Date

States are the primary regulators of the private health insurance market, though some federal regulation applies, mostly affecting employer-sponsored health insurance.

Both bills would establish new federal standards and requirements applicable to the private market, with the aim of increasing consumer access to health insurance, especially for persons with pre-existing health conditions and for other higher-risk groups. These standards and requirements relate to the offer, issuance, and renewal of insurance, applicable consumer protections, and costs borne by consumers, employers, and health plans. The effective date of these provisions is considered the "full implementation date," when exchanges must be available, premium subsidies are available to certain individuals, and mandatory Medicaid expansions must be instituted—under H.R. 3962, January 1, 2013, and under the Senate bill, January 1, 2014.

Some Common Features Between the Bills

As detailed in **Table 2**, both bills would establish federal market reforms, including a prohibition on coverage exclusions for pre-existing health conditions, guaranteed issue and renewability of insurance, rating restrictions, nondiscrimination based on health factors, and other issues. Nonetheless, both bills would allow for the application of state law to the private market, as long as such laws do not interfere with the application of the federal reforms. Both bills would establish consumer protections that impact the adequacy of provider networks, marketing practices of health insurers, grievance and appeals processes, and disclosure of plan information. Both bills would allow states to form compacts to facilitate the sale and purchase of health plans across state lines.

Some Differences

Under H.R. 3962, the effective date for most of these provisions would be January 1, 2013; under the Senate bill, the effective date would be January 1, 2014. Many of the market reforms specified in the Senate bill would amend Title XXVII of the Public Health Service Act. H.R. 3962 would not amend an existing statute for purposes of reforming the private market.

While each bill would establish a type of qualified plan that meets new federal standards, H.R. 3962 would require more plans to meet the qualified plan requirements than the Senate bill (see **Table 2**). Under H.R. 3962, all private health plans would eventually be subject to the qualified plan rules, except for grandfathered individual health insurance plans. The Senate bill would require only plans offered through the exchange to be qualified plans. The Senate bill would also provide an innovation waiver for states with respect to requirements relating to qualified health plans (QHPs), exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers.

While both bills include consumer protections (e.g., establishing processes to appeal coverage determinations, and providing consumers with plan information and assistance), many such protections under the Senate bill would become effective prior to full implementation of the

private market provisions. In contrast, H.R. 3962 would make effective its consumer protections at full implementation.

The Senate bill would establish a few programs to address the distribution of risk borne by health plans: reinsurance, risk corridors, and risk adjustment. In general, these programs would provide higher or extra payments to plans that experience greater claims relative to other plans, in order to encourage the offer to and enrollment of high-risk individuals. The Senate bill also would establish an option for states to contract to private plans to provide a basic health plan for low-income individuals not eligible for Medicaid.

Essential Benefits

While there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 cumulative benefit mandates imposed by the states. For example, federal law requires that group health plans and insurers that cover maternity care also cover minimum hospital stays for the maternity care, and if plans cover mastectomies they also must offer reconstructive breast surgery. States have adopted mandates requiring coverage of certain benefits (e.g., mammograms), health care providers (e.g., pharmacists), and populations (e.g., adopted children).

Each bill specifies categories of benefits that must be covered under qualified plans, including exchange plans. Also, each bill imposes cost-sharing limits, out-of-pocket spending limits, and special rules regarding annual and lifetime limits that are applicable to essential benefits.

Some Common Features Between the Bills

As detailed in **Table 3**, both bills would define benefit packages that would be provided by qualified plans. Such benefit packages would specify coverage for certain categories of essential benefits, and impose rules regarding cost-sharing, benefit limits, and actuarial values based on essential benefits.

Both bills would require the Secretary to adopt or specify essential benefits, based on broad categories of benefits listed in the bills. Most of the categories listed are the same in both bills: hospitalizations, outpatient/ambulatory services, prescription drugs, rehabilitation, mental health care, substance use disorder services, preventive services, maternity care, and pediatric care.

Some Differences

The Senate bill would specify maximum deductible amounts applicable to the essential health benefits package offered by small group plans, and would prohibit application of a deductible on preventive services (see **Table 3**). In contrast, H.R. 3962 would prohibit any cost-sharing on certain preventive services and vaccines recommended by specified federal entities.

While both bills would impose out-of-pocket spending limits, they specify the limits using different methods. H.R. 3962 would establish out-of-pocket limits for individual and family coverage during the first year of full implementation, then adjust them annually for inflation. The Senate bill, in contrast, would use the amounts specified in the tax code applicable to certain high-deductible health plans in those years.

H.R. 3962 would prohibit the application of an annual limit on essential benefits. The Senate bill would prohibit "restricted" annual limits from applying to essential benefits.

Individual Mandate

Currently federal law does not require individuals to have health insurance. Massachusetts, for example, requires certain individuals to have health insurance. The state imposes a penalty for each month individuals are without insurance, equal to 50% of the lowest premium for which they would have qualified, to be collected through withholding of state income tax refunds (with some exemptions allowed).

Most people in the United States have employer-sponsored health insurance. In 2008, 60% of the U.S. population had employment-based health insurance. Other individuals may choose to obtain coverage on their own in the nongroup market. Still others qualify for health coverage through Medicare, Medicaid and other government programs.

Some Common Features Between the Bills

As detailed in **Table 4**, both bills would mandate most individuals to have health insurance, with penalties for noncompliance for the first year of full implementation. Both bills would provide qualified low-income individuals with subsidies to help pay for the costs of their premiums and cost-sharing, while exempting other individuals such as non-resident aliens, individuals living and working outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, and others granted an exemption by the Secretary.

Some Differences

As detailed in **Table 4**, the penalty for non-compliance is different in the bills. The House bill would impose a potentially larger penalty, tied to the lesser of (1) 2.5% of the taxpayer's modified adjusted gross income (MAGI) over the amount of income required to file a tax return, and (2) the national average premium for applicable single or family coverage. The Senate bill would impose a penalty, when fully phased in (2016), of no more than $750 for the year for each individual, or up to 300% of the individual amount for the total for a family, indexed for inflation.

Employer Mandate

There is currently no federal requirement that employers offer health benefits. However, as noted above, many employers choose to provide health insurance as part of the total compensation package for their employees and, in many cases, their dependents. While ERISA does not require an employer to offer health benefits, it does mandate compliance with certain requirements if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims.

Some Common Features Between the Bills

As detailed in **Table 5**, both bills impose requirements on employers who offer health insurance and on those who choose not to, effective in the first year of full implementation. Some businesses would be exempt from the requirements, based on payroll or number of employees.

Some Differences

As detailed in **Table 5**, the House bill would mandate employers to provide health insurance, with penalties for non-compliance. Employers with aggregate wages under $500,000 that chose not to offer coverage would not be subject to penalties. The penalty would be phased in so that a firm with aggregate wages above $750,000 would pay 8% of its average wages. While the Senate bill would not specifically impose a mandate, it would create an employer responsibility that could also result in penalties for non-compliance. Only firms with more than 50 full-time employees could be subject to a penalty—but only if at least one of its full-time employees enrolled in an exchange plan *and* received a premium subsidy. A special rule would apply to those employers whose substantial annual gross receipts were attributable to the construction industry. For these employers, instead of using the 50 full-time employee count for the employer requirement, employers who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceeded $250,000 for such preceding calendar year would be subject to the employer requirements. The penalty imposed on an employer that did not offer coverage would be $750 per employee for all the full-time employees in 2014.

Figure 1 provides simplified examples for the first year of full implementation of how the bills' penalties could differ for an employer that did not offer health insurance. (This figure does not include the special rule for construction workers.) The top portion assumes that all the employer's workers are full time with annual wages of $50,000. The bottom portion is the same, but assumes annual wages of $14,872, which is the annual wage of an individual working 40 hours per week at $7.15 an hour, the current federal minimum wage. Given those wage levels, the figure illustrates how the penalty for not offering coverage would differ, depending on firm size. (Not illustrated in the figure is that under the Senate bill, an employer that did not offer coverage would not be subject to a penalty if none of its employees obtained federally subsidized exchange coverage. Thus, the figure assumes at least one employee obtains exchange subsidies.) While the example assumes a 40-hour workweek for employees in each bill, under the Senate bill, "full time" is defined as working on average at least 30 hours per week, and under the House bill "full time" would be determined by the Commissioner.

Even employers offering health insurance could be subject to penalties or fees under each bill. In the Senate bill, a firm offering health insurance with more than 50 full-time employees could pay a penalty if any of its full-time employees received a premium credit in the exchange (which could only occur in limited circumstances, described below in the section on premium and cost-sharing subsidies). In 2014, the annual penalty assessed to the employer for each such employee would be $3,000 ($250 per month). However, the total annual penalty for an employer would be limited to the total number of the firm's full-time employees times $750 ($62.50 per month). In the House bill, beginning in second full year of implementation, those employers with aggregate wages above $750,000 would be assessed 8% of average wages for the number of employees who decline the employer's health insurance and obtain exchange coverage, regardless of whether or not they receive a premium credit, with adjustments for small employers.

Small Business Tax Credit

Small businesses that choose to provide health insurance could be eligible for a credit toward their cost of health insurance. Depending on the bill, these businesses may be exempt from any employer responsibility to provide health insurance or any penalties for non-compliance. The bills would offer an incentive to small businesses by helping pay for their employees' coverage, by offering a credit toward the purchase of health insurance.

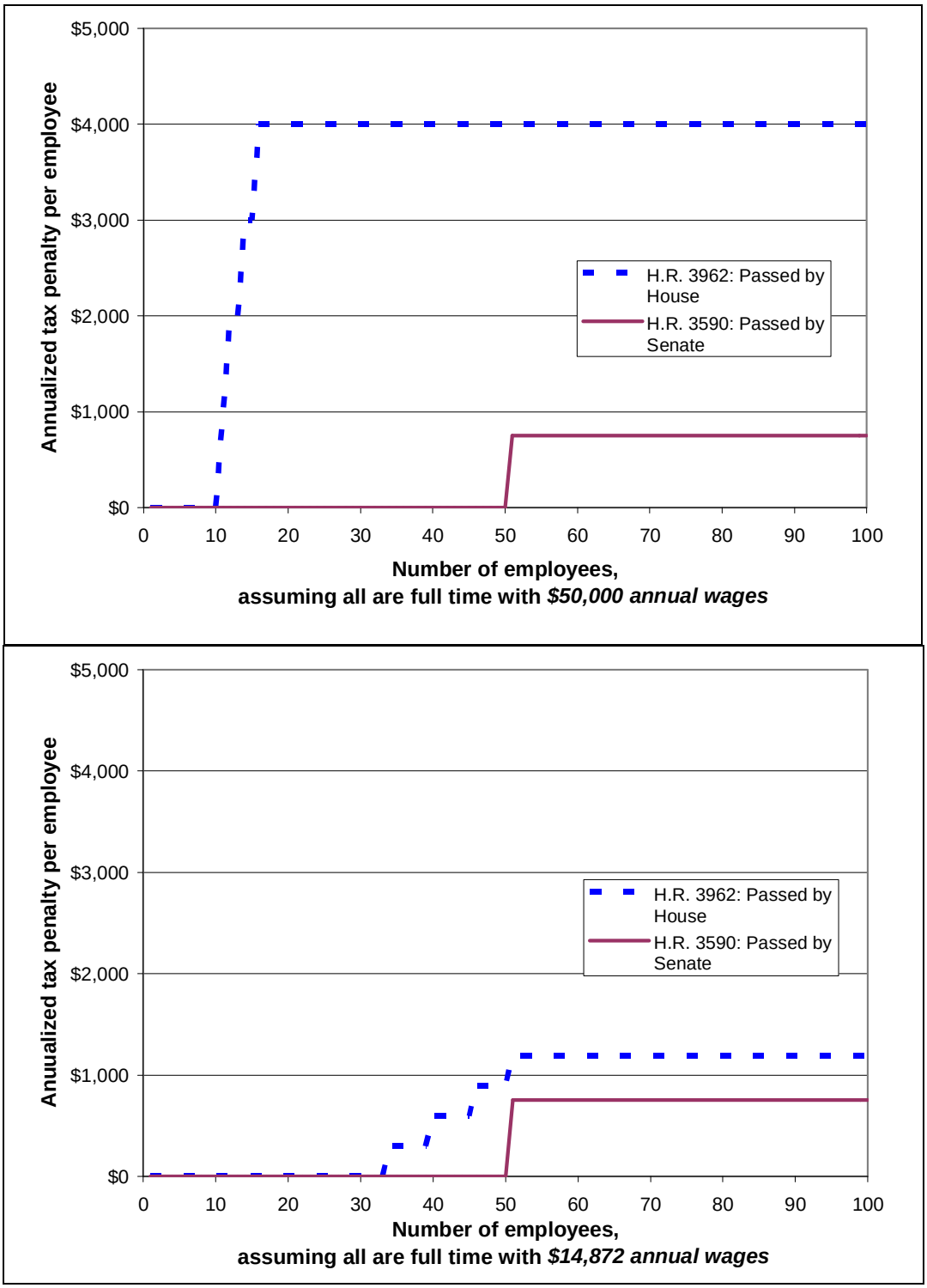
Some Common Features Between the Bills

As detailed in **Table 6**, in the first year of full implementation, both bills would offer their full credit to small businesses with 10 or fewer full-time employees and with average taxable wages of $20,000 or less. Both bills would phase out the tax credit for average employee compensation over $40,000 and as number of employees increased from 10 to 25.

Some Differences

As detailed in **Table 6**, the amount and duration of the credits are different in the two bills. The House bill would begin to phase out the credit as average employee compensation exceeded $20,000, while the Senate bill would begin to phase out the credit at $25,000. Additionally, only the Senate bill would also provide credits to non-profit organizations. Only the House bill would allow self-employed individuals to receive a credit.

Figure 1. Two Examples of Employer Penalties for Not Offering Coverage



Source: CRS analysis.

Notes: Potential penalties shown are for 2013 under H.R. 3962 and for 2014 under H.R. 3590. Additionally, analysis of Senate bill does not include the provisions relating to construction workers.

Health Insurance Exchanges

In addition to federalizing private health insurance standards, both bills would create health insurance exchanges, similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance, to facilitate the purchase of health insurance by certain individuals and small businesses.

Some Common Features Between the Bills

An exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). As detailed in **Table 7**, exchanges would have additional responsibilities as well, such as negotiating with plans and determining eligibility for and administering premium and cost-sharing subsidies.

Available exchange plans would be required to cover essential benefits and to limit cost-sharing/benefit-package options to a few standardized benefit tiers, designed for easier comparison (though the bills differ in the specific levels). States could establish their own exchanges or the federal government could establish exchanges in the states. In both bills, multiple states could form a single exchange. Exchanges could work with other entities, including state Medicaid agencies, to handle certain tasks, such as outreach, enrollment, and eligibility determinations.

Similar criteria between the bills for individuals' eligibility to enroll in an exchange plan are that individuals would have to reside in the state and not be eligible for Medicaid. Certain small employers could make coverage available to their workers through an exchange. Individuals eligible for coverage offered directly by an employer (that is, not through an exchange plan) could not apply their employer's contribution toward coverage in an exchange plan, which would deter people from dropping employer-sponsored insurance for exchange coverage.

Premium and cost-sharing credits for low- and moderate-income individuals (described in **Table 8**) would only be available through an exchange.

Some Differences

As detailed in **Table 7**, under the Senate bill, grants toward state exchanges would be awarded within one year of enactment (even though federal premium subsidies, fully implemented market reforms, and mandatory Medicaid expansions would not be in place until 2014); under H.R. 3962, exchanges with fully implemented market reforms and premium subsidies would be functioning in 2013. Under the Senate bill, after some start-up funding, exchanges would ultimately have to be self-sustaining through assessments on participating plans or premiums; under H.R. 3962, the exchanges would have permanent federal funding. After the exchange is fully operational, H.R. 3962 would require that new nongroup insurance be offered only through an exchange; the Senate bill permits nongroup plans to be offered outside an exchange.

Unlike the House bill, the Senate bill would require individuals seeking to obtain exchange coverage to prove they were lawful residents, even for individuals paying the entirety of their insurance premiums.

The Senate bill would initially permit states the option to either define "small employers" eligible to obtain exchange coverage as those with 100 or fewer employees or as those with 50 or fewer employees; H.R. 3962 would initially permit employers with up to 25 employees to be exchange-eligible. When eligible small employers opt for exchange coverage, employers could not limit workers' choice of plans under the House bill, but could limit plan selection to a particular benefit tier (e.g., silver) under the Senate bill.

Premium and Cost-Sharing Subsidies

Under current law, direct federal subsidies toward the purchase of private health insurance are often narrow in scope—for a limited group of individuals (usually based on some hardship, such as unemployment, or financial need) and/or for a particular amount of time. For example, the Health Coverage Tax Credit (HCTC) is for certain workers displaced by international trade and for retirees whose private pension plans were taken over by the Pension Benefit Guaranty Corporation.[10] The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5 as amended by the Department of Defense Appropriations Act, 2010, P.L. 111-118) included provisions to provide premium subsidies of 65% for health insurance coverage through COBRA for the unemployed; the subsidy is available for up to 15 months to certain unemployed individuals involuntarily terminated between September 1, 2008, and February 28, 2010. Both the HCTC and the COBRA subsidies are paid to individuals as tax credits.

Particularly under health insurance reform proposals where individuals may be required to obtain coverage, some individuals may need premium subsidies to help pay for coverage. However, even when individuals have health insurance, they may be unable to afford the cost-sharing (deductible and copayments) required to obtain health care. Thus subsidies may also be necessary to lower the cost-sharing.

Some Common Features Between the Bills

As detailed in **Table 8**, both H.R. 3962 and the Senate bill would make certain individuals eligible for premium and cost-sharing subsidies. Common eligibility criteria between the bills are that individuals must have income below 400% of the federal poverty level (FPL),[11] be enrolled in an exchange plan (not through a qualifying employer), and be citizens or lawful residents[12] who are not eligible for Medicaid.[13] Under both bills, when the premium and cost-sharing credits are first made available, they would only be available to individuals enrolled in the benefit tier

[10] CRS Report RL32620, *Health Coverage Tax Credit*.

[11] For a family of three in the 48 contiguous states in 2009, 400% FPL is $73,240. CRS computation based on "Annual Update of the HHS Poverty Guidelines," 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf.

[12] See **Table 13** for more information about the citizenship, lawful residence, and verification requirements.

[13] Under H.R. 3962, citizens and qualifying aliens would be eligible for Medicaid up to 133% FPL in 2013, when the premium credits would be available. Under the Senate bill, citizens and qualifying aliens would be eligible for Medicaid up to 150% FPL by 2014, when the bill's premium credits would be available.

with an actuarial value of approximately 70% (a "basic" plan in the House bill and a "silver" plan in the Senate).

Premium credits would be calculated to ensure that qualifying individuals pay no more than a certain percentage of their income toward one of the less expensive basic or silver exchange plans. If individuals choose a plan with a more expensive premium, they would be responsible for paying the difference.

Individuals eligible for premium subsidies would also be eligible for cost-sharing subsidies.

Some Differences

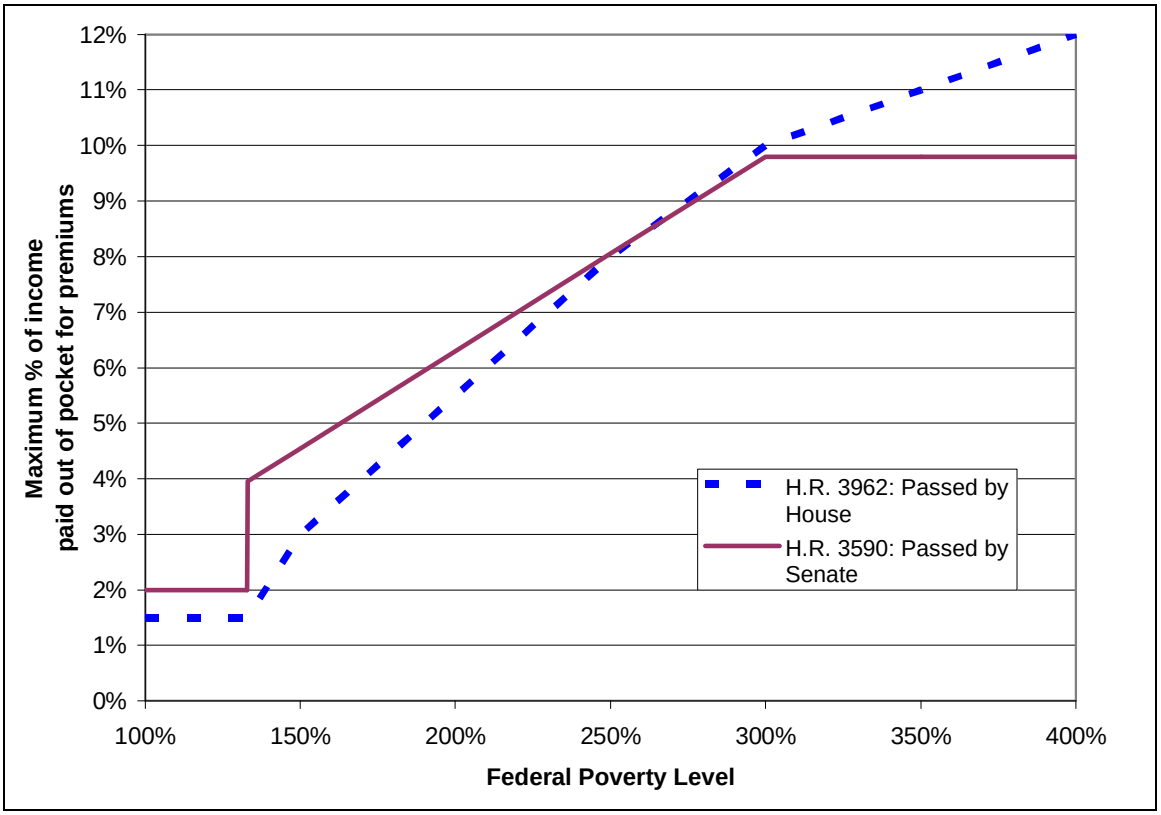
As detailed in **Table 8**, like the required exchange, market reform and exchange provisions, the premium and cost-sharing subsidies would be made available in 2013 under H.R. 3962 and in 2014 under the Senate bill. Under H.R. 3962, premium subsidies would be made directly from the federal government to insurers, while the Senate bill provides the premium subsidies in the form of advanceable, refundable tax credits to individuals.

Under H.R. 3962, individuals are not eligible for subsidies if they are eligible for employer-sponsored coverage as a full-time employee, or if they are *enrolled* in Medicare, Medicaid, coverage related to military service, an employer-sponsored plan, a grandfathered plan, or other coverage recognized by the Commissioner. Under the Senate bill, individuals are not eligible for subsidies if they are *eligible* for that coverage—Medicare, Medicaid, CHIP, coverage related to military service, an employer-sponsored plan, a grandfathered plan, or other coverage recognized by the Secretary. An exception to the exclusion for those eligible for employer-sponsored coverage in 2014 and after exists in H.R. 3962, if the employee's contribution would exceed 12% of income in 2014, and in the Senate bill, if the employee's contribution would exceed 9.8% of income or if the plan pays for less than 60% of covered expenses.

The percentage of income that credit-eligible individuals would have to pay toward premiums differs between the bills. Below about 250% FPL, H.R. 3962 requires a smaller contribution (and thus larger credits) than under the Senate bill; however, between roughly 250% and 400% FPL, the Senate bill requires a smaller contribution by qualifying individuals toward premiums, as illustrated in **Figure 2**.

Figure 2. Maximum Out-of-Pocket Premiums for Eligible Individuals, by Federal Poverty Level

For first year credits are in effect—2013 for H.R. 3962, 2014 for H.R. 3590



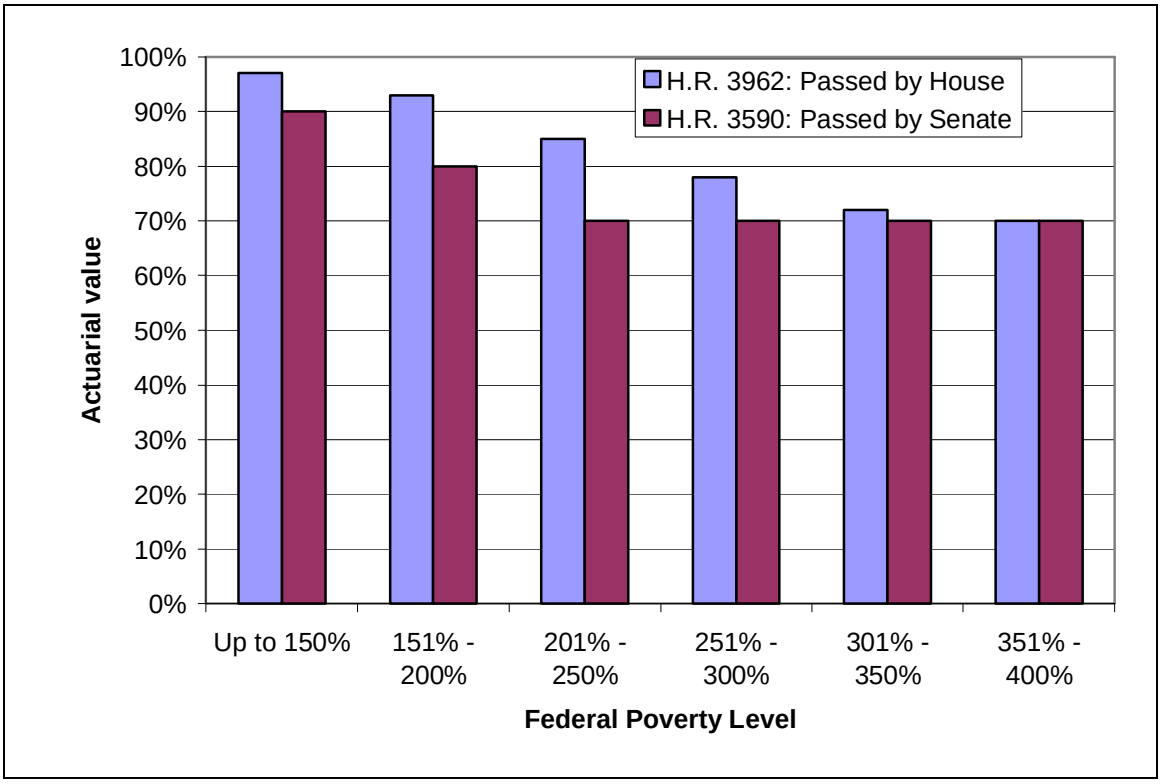
Source: CRS analysis.

Notes: Under the Senate bill, citizens and qualifying legal residents at or below 133% FPL would be eligible for Medicaid rather than premium credits. H.R. 3962 would extend Medicaid coverage to 150% FPL.

Compared to the Senate bill, H.R. 3962 would generally provide greater cost-sharing subsidies, as illustrated in **Figure 3**, which shows the percentage of covered expenses to be paid by the plan (i.e., actuarial value) after the cost-sharing subsidies are taken into account.

Figure 3. Actuarial Values Reflective of Cost-Sharing Subsidies, by Federal Poverty Level

For first year credits are in effect—2013 for H.R. 3962, 2014 for H.R. 3590



Source: CRS analysis.

Public Health Insurance Option/Multi-State Qualified Health Plans

One issue that has received congressional attention is whether or not to include either a publicly sponsored health insurance plan or plans similar to those offered to Members of Congress and federal employees through the Federal Employees Health Benefits Program (FEHBP), and if so, to what extent should such offerings be required to follow the same rules as private insurers.

Currently, Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program. These include eligibility rules, financing (including determination of payroll taxes and premiums), required benefits, payments to health care providers, and cost-sharing amounts. However, even within this public plan, CMS subcontracts with private companies to carry out much of the administration of the program.

Under FEHPB, the Office of Personnel Management (OPM) is authorized to contract with insurance carriers; approve qualified health benefits plans for participation in the program; negotiate with plans about benefit and premium levels; determine the times and conditions for

open seasons during which eligible individuals may elect coverage or change plans; make information available to employees concerning plan options; apply administrative sanctions to health care providers who have committed certain violations; and administer the financing of the program. OPM is responsible for maintaining the funds that hold contingency reserves for the plans and the fund that receives premium payments from enrollees and employing agencies, from which premiums are disbursed to participating plans.

Some Common Features Between the Bills

The public option in the House bill and the multi-state health qualified health plans in the Senate bill could only be offered through the exchange.

Some Differences

As detailed in **Table 9**, the House bill would require the Secretary to establish a public health insurance option available only to individuals eligible to purchase insurance through an exchange. The Secretary would be given start-up funding and the authority to enter into contracts for the establishment and administration of the public option. Premiums for the public option would be set according to new market reform rules at a level sufficient to cover the cost of medical claims, administration, a contingency margin, and repayment of the start-up funding. Payment rates for providers would be established through negotiations with the Secretary. The House bill would not allow states to opt out of the public option. Under H.R. 3962, the provider network for the public option would be established by deeming Medicare-participating providers to also be providers under the public option, unless the providers opted out in a process established by the Secretary. The House bill would allow providers to participate in the public option either as preferred or non-preferred providers, which would allow non-preferred providers to bill for amounts above the established payment rates in a manner similar to physician participation rules under Medicare.

The Senate bill does not include a public option. The Director of OPM would enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans (MSQHPs) through each exchange in each state. Such plans would provide individual, or in the case of small employers, group coverage. A health insurance issuer would be required to agree to offer a MSQHP that met the requirements in each exchange in each state. States could require additional benefits, but there would be no additional premium tax credit provided for the state-only mandated benefits. Enrollees in a MSQHP would be treated as a separate risk pool from FEHBP.

Consumer Operated and Oriented Plan (CO-OP) Program

Non-profit health insurance cooperatives have been promoted as entities that could help address concerns around health care cost, quality, and consumer focus.[14] The incentives of a cooperative

[14] Health insurance cooperatives can either be collectively owned or governed. The former is a mutual insurance company, and the latter is a non-profit health insurance company with a member controlled board of directors that cooperatively governs the organization, but is neither compensated nor holds an equity stake in the firm.

are assumed to align with members' interests around lower cost and higher quality. However, according to the National Cooperative Business Alliance (NCBA), there are very few health insurance cooperatives currently operating.[15] There are no current law incentives or funds for the creation of new health insurance cooperatives.

Advocates of the CO-OP program argue that cooperatives would address the three categories of concern by returning retained earnings[16] directly to its members, or by investing in plan members via lower premiums, lower cost-sharing, expanded benefits, and innovations such as wellness programs, chronic disease management, and integrated care.[17] This model of health insurance has shown some promise with respect to quality in case studies of Group Health Cooperative of Seattle and HealthPartners of Minnesota.[18]

Opponents assert that cooperatives have not been successful in most of the country and that evidence is lacking that cooperatives would make health insurance more affordable.[19] Citing the recent management issues at Blue Cross Blue Shield of North Dakota (BCBS-ND), which is a cooperative (in particular, a mutual insurer), some consumer advocates have noted that cooperatives do not always work in the interests of consumers.[20] North Dakota Insurance Commissioner Adam Hamm, after a recent investigation of BCBS-ND, stated that "[t]he bottom line is that health care premiums are for health care, they are not for expensive retirement parties, corporate jets, risky hotel investments or a compensation structure that rewards senior management regardless of BCBS's financial performance."[21]

Some Common Features Between the Bills

Both the Senate bill and H.R. 3962 propose establishing the CO-OP program to encourage the creation of new health insurance cooperatives. As detailed in **Table 10**, both the Senate bill and H.R. 3962 would appropriate funding, $6 billion and $5 billion respectively, to assist with cooperatives' start-up costs and to meet solvency requirements. Ultimately, the goal of the program would be to foster the creation of new non-profit, health insurance cooperatives in one or more states. Both bills propose that:

- Grants would only be made to qualified plans.

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[15] August 5, 2009, NCBA letter to Senator Rockefeller http://commerce.senate.gov/public/_files/NCBACoopResponseLetter080509.pdf.

[16] Retained earnings are the net earnings not paid out as dividends, but retained by the company to be reinvested in its core business or to pay debt.

[17] Senator Kent Conrad, "FAQ about the Consumer-Owned and -Oriented Plan (CO-OP)," available online at http://conrad.senate.gov/issues/statements/healthcare/090813_coop_QA.cfm.

[18] D. McCarthy, K. Mueller, and I. Tillmann, "Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home," The Commonwealth Fund, July 2009, and D. McCarthy, K. Mueller, and I. Tillmann, "HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda," The Commonwealth Fund, June 2009.

[19] CNN, "Negotiations over health insurance co-ops at impasse," June 23, 2009, available online at http://www.cnn.com/2009/POLITICS/06/23/health.care/index.html.

[20] "North Dakota Scandal Raises Concerns About Health Co-op Route," Karl Vick, *Washington Post*, October 10, 2009, available online at http://www.washingtonpost.com/wp-dyn/content/article/2009/10/09/AR2009100904085.html.

[21] "Hamm releases Blue Cross Blue Shield target exam report," available online at http://www.nd.gov/ndins/communications/pressreleases/detail.asp?newsID=204.

- Grants would only be made to cooperatives operating as a not-for-profit, member-run insurance company.
- Cooperatives that offered insurance on or before July 16, 2009, would be prohibited from receiving funds.
- Cooperatives would be required to incorporate ethical and conflict of interest standards designed to protect against insurance industry involvement and interference.
- State governments would be prohibited from sponsoring a cooperative that could receive grants under the proposed program.
- Cooperatives receiving grants from the CO-OP program would be required to be governed by the majority vote of their membership.
- Cooperatives receiving grants from the program would be required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to their members.

Some Differences

As detailed in **Table 10**, the two bills differ primarily around the administrative structure and oversight of the grant program. Under the Senate bill, the HHS Secretary would be charged with administration and oversight of the program, whereas H.R. 3962 would establish the Commissioner in that role. The Senate bill would also establish an Advisory Board to assist the Secretary in making grant decisions. This provision does not exist in the House bill. The Senate bill alone would also permit CO-OP grantees to establish a private collective purchasing council to increase cost efficiencies.

There are also important differences with respect to appropriations, the tax code, and the relationship of CO-OP plans to the exchange and the reformed market. Under the Senate bill, $6 billion, $1 billion more than the House bill, would be appropriated to fund the program. In both bills, CO-OP grantees would be required to be not-for-profit plans, but under the Senate bill, the IRC would be amended so that a CO-OP grantee's tax-exempt status would be contingent upon compliance with the regulations of the CO-OP program. Under the Senate bill, insurers' plans offered inside an exchange could also be offered outside the exchange; thus, CO-OP plans could potentially be offered outside of an exchange. In the House bill, however, CO-OP program grants would be specifically limited to health insurance cooperatives that provide insurance through an exchange.

Selected Revenue Provisions

The House and Senate bills include a number of provisions to raise revenues in order to pay for expanded health insurance coverage. Some of these provisions are directly related to current health insurance coverage, and some are indirectly related. The bills' revenue provisions are similar in that they include a combination of excise taxes, high-income surcharges, and limitations on tax-advantaged health accounts. They differ largely in how these taxes are levied and the magnitude of tax.

Some Common Features Between the Bills

Both the House and Senate proposals modify current tax advantaged accounts used for health care spending. As detailed in **Table 11**, they both limit flexible spending account (FSA) contributions to $2,500 per account, increase penalties for non-qualified health savings account (HSA) distributions from 10% to 20% for those under age 65, and change the definition of medical expenses for FSAs, HSAs and health reimbursement accounts (HRAs) to exclude over-the-counter prescriptions not prescribed by a physician.

Some Differences

While both bills impose excise taxes, they vary based on whom the tax is levied on and the extent of the tax. As detailed in **Table 11**, the Senate bill imposes a 40% excise tax on insurers of high-cost health plans (defined as those with premiums exceeding $8,500 for single coverage and $23,000 for family coverage in 2014) as well as an additional tax on health insurers based on their market share. The Senate bill also imposes an excise tax on pharmaceutical manufacturers, while the House bill does not. While both proposals levy an excise tax on medical device manufacturers, the House bill imposes a sales tax of 2.5% on each non-retail sale of devices; the Senate version levies an excise tax of $2 billion in the first few years of implementation, and each device manufacturer pays a share based on the size of their sales. The House does not have this provision. Finally, the Senate bill imposes a 10% excise tax on indoor tanning services; this provision is not in the House bill.

Further, while both impose tax surcharges on high-income taxpayers, they vary in whether tax is through the federal income tax or through payroll taxes. As detailed in **Table 11**, the House bill imposes a 5.4% surcharge on individuals with modified gross income over $500,000 for singles and $1 million for families. The Senate bill increases the Hospital Insurance portion of the payroll tax by 0.9 percentage points on wages in excess of $200,000 for singles and $250,000 for joint filers.

Abortion

H.R. 3962 and H.R. 3590 include provisions that address the coverage of abortion by health benefits plans that would be available through an exchange. H.R. 3962 also discusses coverage by a government-run health insurance option. Both measures distinguish between two types of abortions: abortions for which federal funds appropriated for HHS may be used, based on the law in effect six months prior to a plan year; and abortions for which such funds may not be used, based on the law in effect six months prior to a plan year. The distinction between the two types of abortions is premised on an existing funding restriction commonly referred to as the "Hyde Amendment." In 1976, Representative Henry J. Hyde offered an amendment to the Departments of Labor and Health, Education, and Welfare Appropriation Act, 1977, that restricted the use of appropriated funds to pay for abortions provided through the Medicaid program.[22] Since 1976, similarly restrictive provisions have been included annually in the appropriations measures for the Departments of Labor, HHS, and Education.

[22] P.L. 94-439, § 209, 90 Stat. 1418, 1434 (1976) ("None of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.").

Section 507 of the Consolidated Appropriations Act, 2010, restricts the use of FY2010 funds appropriated for HHS. Section 507(a) states: "None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion."[23] An exception to the general prohibition on using appropriated funds for abortions is included in section 508(a) of the measure:

> The limitations established in the preceding section shall not apply to an abortion –
>
> (1) if the pregnancy is the result of an act of rape or incest; or
>
> (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.[24]

In other words, FY2010 funds appropriated for HHS could be used to pay for an abortion if a pregnancy is the result of an act of rape or incest, or if a woman's life would be endangered if an abortion were not performed. Such funds are unavailable, however, for elective abortions.

Some Common Features Between the Bills

As detailed in **Table 12**, H.R. 3962 and H.R. 3590 would restrict the use of federal funds to pay for elective abortion services. Federal funds could be used, however, for abortions for which the expenditure of federal funds appropriated for HHS is permitted. Both measures include provisions to prohibit discrimination against health care providers and health care entities that refuse to provide, pay for, provide coverage of, or refer for abortions. In addition, both measures would preserve state laws regarding the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements. Federal conscience protection and abortion-related antidiscrimination laws, including Title VII of the Civil Rights Act of 1964, would not be affected by either measure.

Some Differences

As detailed in **Table 12**, H.R. 3962 would restrict coverage for elective abortions by a qualified health benefits plan. If a plan includes such coverage, the entity that offers the plan would be required to offer another plan that is identical in every respect, except that it does not cover elective abortions. Under H.R. 3962, individuals would be permitted to purchase separate supplemental coverage for elective abortions, but such coverage would have to be paid for entirely with funds not authorized or appropriated by the measure. Because H.R. 3962 does not permit any federal funds, including exchange premium subsidies, to be used to purchase either a plan that includes coverage for elective abortions or supplemental coverage for elective abortions, the measure does not include fund segregation requirements. In contrast, H.R. 3590 would allow coverage of elective abortions by exchange plans, but would require enrollees in plans that include such coverage to make two separate premium payments: one payment that reflects an amount equal to the portion of the premium for coverage of services other than elective abortions;

[23] H.R. 3288, 111th Cong. § 507(a) (2009).

[24] H.R. 3288, 111th Cong. § 508(a) (2009).

and another payment that reflects an amount equal to the actuarial value of the coverage of elective abortions.

Verification of Immigration Status and Treatment of Noncitizens for Exchange Coverage and Subsidies

Among the many difficult issues in health reform are those surrounding noncitizen eligibility and verification provisions.[25] A noncitizen is anyone who is not a citizen or national of the United States and is synonymous with the terms *alien* and *foreign national*. Noncitizens include those in the United States permanently (e.g., legal permanent residents, refugees), those in the country temporarily (e.g., students, temporary workers), and those who are in the country without authorization.[26] The Immigration and Nationality Act (INA) defines which noncitizens are legally present in the United States.[27]

Some Common Features Between the Bills

As detailed in **Table 13**, legal permanent residents (LPRs) are treated similarly to U.S. citizens under both bills. LPRs are mandated to obtain health insurance, are eligible to purchase insurance through the exchange, and are eligible for the premium and cost-sharing subsidies if they meet the other eligibility requirements. This consistency of treatment holds regardless of when they entered the United States or whether they came initially as refugees or asylees.

Unauthorized aliens would not be eligible for the federal premium and cost-sharing subsidies in either of the bills.

Both bills would use the individual's name, social security number, and date of birth and would rely on the Social Security Administration and the Department of Homeland Security to verify citizenship and immigration status. The actual mechanics of the verification would differ as discussed below.

Some Differences

As detailed in **Table 13**, H.R. 3962 would expressly require the Commissioner to verify citizenship and immigration status of individuals seeking premium and cost-sharing subsidies. (Under the House bill, such verification would not be required of exchange-participating individuals who are *not* seeking federal subsidies.) The House bill would extend, with modifications, the citizenship verification procedures as well as the noncitizen verification procedures that currently apply to Medicaid and other federal means-tested programs to the citizenship and immigration determination for the proposed premium and cost-sharing

[25] CRS Report R40889, *Noncitizen Eligibility and Verification Issues in the Health Care Reform Legislation*, by Ruth Ellen Wasem.

[26] The three main components of the unauthorized resident alien population are (1) aliens who overstay their nonimmigrant visas, (2) aliens who enter the country surreptitiously without inspection, and (3) aliens who are admitted on the basis of fraudulent documents.

[27] 8 U.S.C. §1101 et seq.

subsidies.[28] Among the modifications would be to enable the Commissioner to make the eligibility determination. The Senate bill would rely on procedures currently used by Medicaid (§1902(e) of the SSA) for individuals whose claims of citizenship or immigration status are not verified with federal data.[29] (The Senate bill would require such verification of all individuals seeking exchange coverage, regardless of whether they would be federally subsidized or would pay premiums entirely on their own.)

H.R. 3962 would exempt nonresident aliens from the individual mandate to obtain health insurance; however, H.R. 3962 would require all noncitizens who meet the IRC definition of resident alien (i.e., nonimmigrants, and unauthorized aliens who meet the substantial presence test) to obtain health insurance. The House bill contains no express restrictions on noncitzens—whether legally or illegally present, or in the United States temporarily or permanently—accessing and paying for coverage available through an exchange. The Senate bill *expressly* exempts unauthorized aliens from the mandate to have health coverage and bars them from the health insurance exchange.

The proposed policies toward nonimmigrants (those admitted temporarily for a limited purpose, such as students, visitors, or temporary workers) are more nuanced, in large part because some classes of nonimmigrants reside legally in the United States for extended periods of time, some are employed and taxed as a result of those earnings, and some are on a track to become LPRs.

[28] §1137(d) of the SSA. For further discussion of current law on Medicaid citizenship verification, see CRS Report RS22629, *Medicaid Citizenship Documentation*, by Ruth Ellen Wasem.

[29] Section 1411 of H.R. 3590.

Table 1. Reforms Prior to Full Implementation

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill		Sections 101-115	Sections 1001-1105
Laws amended		ERISA, IRC, PHSA, SSA	PHSA
Effective date, unless otherwise specified		For plan years beginning on or after January 1, 2010	For plan years beginning on or after the date that is 6 months after enactment.
No lifetime or annual limits	States have the primary responsibility of regulating the business of insurance and may define state benefit mandates. However, federal law requires that private health insurance include certain benefits and protections, for services covered by a plan. HIPAA requires, for example, that group health plans and insurers provide parity in annual and lifetime limits for any offered mental health benefits. However, there are no specific prohibitions on unreasonable lifetime or annual limits.	The bill would require that group or individual coverage would not have an aggregate dollar lifetime limit with respect to essential benefits payable under the plan or coverage. Aggregate dollar lifetime limits would be defined as a dollar limitation on the total amount that may be paid with respect to benefits under the plan or health insurance coverage for an individual or other coverage unit on a lifetime basis. *§109: ERISA §716, IRC §9815, and PHSA §§2709 and 2756*	Group health plans and health insurance issuers offering group or individual plans would be prohibited from establishing lifetime or annual limits on the dollar value of benefits for any participant or beneficiary. With respect to plan years beginning prior to January 1, 2014, group health plans and health insurance issuers may only establish a restricted annual limit with respect to the scope of benefits that are essential health benefits as determined by the Secretary. In defining the restricted annual limit, the Secretary would ensure that there is access to needed services available with minimal impact on premiums. Nothing in this section would prohibit a group health plan or health insurance coverage from placing annual or lifetime limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted by federal and state law. *§1001as amended by §10101 : PHSA § 2711*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Prohibition on rescissions	HIPAA permits nonrenewal or discontinuation of coverage due to, among other things, fraud or intentional misrepresentation. Health insurers have been found to use this provision to rescind coverage based on answers given in the application that are deemed to be inaccurate. Some states regulate the application process.	No later than 90 days after enactment, the Secretary would issue guidance implementing the prohibition on rescission in the group and individual markets. This guidance would limit the situations in which an insurer may rescind, or cancel, a person's health insurance policy. Rescissions would still be permitted in cases where the covered individual committed fraud. If a health insurance issuer determines to rescind coverage they would be required to provide the individual with notice prior to the effective date of the rescission, and would be required to provide the opportunity for a review by an independent, external third party under procedures specified by the Secretary. If individuals request a review, their coverage would remain in effect until the independent reviewer determines that the coverage may be rescinded. *§103: PHSA §§2703, 2712, 2742, and 2746*	The bill would generally prohibit rescissions for a group health plan and a health insurance issuer offering group or individual health insurance coverage. Rescissions would still be permitted in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. A cancellation of coverage in this case would require prior notice to the enrollee. *§1001: PHS §2712*
Coverage of preventive health services	Mandated benefits regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and can include requirements involving preventive health services. Such rules vary from state to state.	The House bill contains a preventive health services provision conceptually similar to the Senate bill in terms of utilizing the evidence based recommendations of the United States Preventive Services Task Force and the recommendations of the Centers for Disease Control and Prevention. However, the House bill would not be part of the immediate reforms, would not include the Health Resources and Services Administration (HRSA), would not include the breast cancer provisions, and would not provide specific authority to the Secretary to promulgate guidelines allowing a group health plan and a health insurance issuer to utilize value-based insurance designs. The House provision would take effect beginning in plan year	Under the bill, group health plans and health insurance issuers in the group and individual markets would be required to provide coverage for preventive health services and would not impose any cost sharing requirements for them. These preventive services would include: ● evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force (USPSTF); ● immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); ● for infants, children, and adolescents,

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		2013. See §222 **Table 3- Categories of essential benefits**.	evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and ● with respect to women, such additional preventive care and screenings not described by the USPSTF as provided in comprehensive guidelines supported by HRSA. A plan or issuer would be permitted to cover or deny additional services not recommended by the USPSTF. For the purposes of this section the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention would be considered the most current other than those issued in or around November 2009. The Secretary would be permitted to develop guidelines to allow a group health plan and a health insurance issuer offering group or individual health insurance coverage to utilize value-based insurance designs. *§1001, as amended by S. Amdt. 2791 and 2808 : PHSA §2713*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Extension of dependent coverage	Federal law does not define who qualifies for dependent coverage under employer sponsored insurance or individual health insurance policies. Under federal law, fully insured and self-insured group plans can define dependency in the group health plan. However, some states have defined who is eligible for dependent coverage under fully insured group health plans, as well as individual health insurance policies.	A group health plan and a health insurance issuer offering coverage in the group or individual markets that provided dependent coverage would extend that coverage until the individual is 27 years of age. The group health plan or health insurance issuer would be permitted for dependent coverage to increase premiums consistent with the standard established by the Secretary for family coverage. *§105: PHSA §§2703 and 2746, ERISA §704, and IRC §9804*	A group health plan and a health insurance issuer offering coverage in the group or individual markets that provided dependent coverage would extend that coverage to unmarried adult children until the individual is 26 years of age. A health plan or a health insurance issuer would not be required to make coverage available for a child of a child receiving dependent coverage. The Secretary would be required to promulgate regulations to define the dependents to which coverage would be made available.*§1001: PHS §2714*
Development of uniform explanation of coverage documents	States may regulate the summary of benefits documents that plans send to their members. Federal law regulates these documents for federal programs such as Medicare Advantage, but there are no broad federal standards for private plans in the group and individual markets.	No provision.	No later than 12 months after enactment, the Secretary would develop standards for plans in the group and individual markets for providing their enrollees with a summary of benefits and coverage. These standards would preempt state law. Each plan would provide the summary to an applicant at the time of application, to an enrollee prior to the time of enrollment or re-enrollment, and to a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate. *§1001: PHS §2715*
Prohibition of discrimination based on salary	Section 105 of the IRC permits certain amounts received under accident and health plans to be excluded from the computation of taxable income. This exemption is only permissible if, in general, 70% or more of all employees are eligible to benefit under the plan, and all benefits provided for participants who are highly compensated individuals are also provided	No provision.	Under the bill, the sponsor of a group health plan (other than a self-insured plan) would be prohibited from establishing rules relating to health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee. In no way would eligibility rules be permitted to discriminate in favor of higher wage employees. The rules and

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	for all other participants. Certain employees may be excluded including: employees who have not completed 3 years of service; employees who have not attained age 25; part-time or seasonal employees; employees not included in the plan who are included in unit of employees covered by an agreement between employee representatives and one or more employers which the Secretary finds to be a collective bargaining agreement, and employees who are nonresident aliens and who receive no earned income from the employer which constitutes income from sources within the United States. Highly compensated individuals are defined as one of the 5 highest paid officers, a shareholder who owns more than 10% in value of the stock of the employer, or among the highest paid 25% of all employees eligible to participate.		definitions of section 105(h) of the IRC would similarly apply to this provision. *§1001as amended by §10101: PHSA §2716*
Ensuring the quality of care	Among other federal laws intended to prevent discrimination, HIPAA established certain requirements that are intended to prevent group health plans and group health insurance issuers from discriminating against individual participants or beneficiaries based on a health factor. In particular, HIPAA prohibits a group health plan or health insurance issuer from basing coverage eligibility rules on health-related factors including health status (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. In addition, a group health plan or health insurance issuer may not require that an individual pay a higher premium or contribution than another "similarly	No provision.	Under the bill, no later than two years after enactment, the Secretary, in consultation with certain experts, would be required to develop and implement reporting requirements for use by plans in the group and individual markets with respect to coverage benefits and health care provider reimbursement structures that: ● improve health outcomes through use of quality reporting, case management, care coordination and chronic disease management; ● implement activities to prevent hospitalization readmissions; ● implement activities to improve patient safety and reduce medical errors through the use of best clinical practices, evidence based medicine, and health information

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	situated" participant, based on these health-related factors. HIPAA also clarifies that group health plans and health insurance issuers offering group health coverage may establish premium discounts or rebates or modify otherwise applicable copayments or deductibles (i.e., rewards) in return for adherence to wellness programs. HIPAA regulations provide a framework for structuring these wellness programs and divide wellness programs into two categories. First, if a wellness program provides a reward based solely on participation in a wellness program, or if it does not provide a reward, the program complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. Second, if a reward is based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements. Among these additional requirements, a reward offered by this type of wellness program must not exceed 20% of the cost of employee coverage under the plan (i.e., the amount paid by the employer and the employee for that employee for coverage).		technology; and ● implement wellness and health promotion activities. The Secretary would be required to promulgate regulations that provide criteria for determining whether a reimbursement structure meets these elements. This section also contains provisions relating to gun rights. A wellness or promotion activity could not require disclosure or collection of any information relating to lawfully possessed firearms or ammunition. The authority provided to the Secretary under the amendment (or an amendment to the proposed legislation) could not be construed to authorize and could not be used for the collection of information relating to the lawful ownership, possession, use, or storage of a firearm or ammunition, or to maintain records of individual ownership or possession of a firearm or ammunition. A health plan would be prohibited from increasing premium rates, denying health insurance coverage, and reducing or withholding a discount, rebate, or reward offered for participation in a wellness program on the basis of or on reliance on the lawful ownership, possession, use or storage of a firearm or ammunition. *§1001as amended by §10101: PHSA §2717*
Reducing health insurance premiums and increasing value	Many states require public reporting of health insurance financial data such as medical loss ratios (MLR), and require approval of premium rate increases and public release of the justification for the requested increase. Medical loss ratios generally refer to the percentage of premium dollars that are spent on medical care as opposed to administrative costs	The bill would create a requirement that each health insurance issuer that offers coverage in the small or large group markets would provide a rebate to its enrollees if the coverage has a medical loss ratio (MLR) below a level specified by the Secretary (but not less than 85%). The Secretary would establish a uniform definition of the MLR including a	Issuers in the group and individual markets (including a grandfathered health plan) would be required to submit to the Secretary a report concerning the ratio of incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. The report would also include the percentage of total premium revenue, after

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	including profit. State regulations around accounting procedures for calculating MLRs vary.	methodology for calculating it. The methodology would take into account the special circumstances of smaller plans, different types of plans, and newer plans. The MLR would exclude state taxes and licensing and regulatory fees. The method for calculating a MLR would be established, with exceptions if necessary, to ensure adequate participation by issuers, competition in the health insurance market, and value for consumers. The provisions of this section would also apply to the individual market, except to the extent that the Secretary determined that the application of the MLR provision would destabilize the existing individual market. The provisions would sunset once plans are offered via the exchange. *§102: PHSA §§2714 and 2754*	accounting for risk adjustment, risk corridors, and payments for reinsurance, that the coverage expends on: ● reimbursement for clinical services; ● for activities that improve health care quality; and ● on all other non-claims costs including an explanation of the nature of such costs and excluding federal and state taxes, licensing, or regulatory fees. Beginning on January 1, 2014 , this calculation would be based on the averages of the premiums expended on the costs for each of the previous 3 years for the plan. The Secretary would make these reports available to the public. Beginning not later than January 1, 2011, a health insurance issuer offering group or individual health insurance coverage (including grandfathered health plans) would provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on clinical claims and health quality costs, after accounting for taxes, regulatory fees, risk adjustment, risk corridors, and reinsurance, is less than 85% in the large group market and 80% for the small group and individual markets. States would be permitted to increase the percentages, but the Secretary may adjust the state percentage for the individual market if it is determined that the application of 80% would destabilize the market. The Secretary would promulgate regulations enforcing the provisions of this section not later than January 1, 2011. *§1001 as amended by §10101: PHSA §2718*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Sunshine on health insurance premium rates	States have broad authority to regulate health insurance premiums and many have sunshine provisions with respect to rate increases.	As an initial review process, beginning in 2010, health insurance issuers would be required to submit a justification for any premium increases prior to implementation of the increase following a process developed by the Secretary and the states. The Secretary would ensure the public disclosure of information on premium rate increases and their justifications. For a continuing premium review process, state insurance commissioners would provide data to the Commissioner of the Health Choices Administration on premium increases and trends. States would make recommendations to the Commissioner concerning the exclusion of certain health insurance issuers from participation in the exchange based on a pattern of excessive or unjustified premium increases. Beginning in 2014, the Commissioner in conjunction with the states would, in the place of the initial review process conducted by the Secretary, monitor premium increases of health insurance coverage inside and outside of the additional larger employers eligible to participate in the exchange. From 2010-2014 the Secretary would provide grants to the states for premium monitoring activities. There would be appropriated to the Secretary $1 billion to be available for expenditure for these grants. *§104*	The Secretary would, in conjunction with the states, establish a process for the annual review of unreasonable increases in premiums for health insurance coverage beginning in the 2010 plan year. Health insurance issuers would be required to submit to the Secretary, and the relevant state, a justification for an unreasonable premium increase prior to implementation of the premium. Beginning with plan year 2014, the Secretary, in conjunction with the states, would monitor premium increases of health insurance coverage within and outside of the exchange. The Secretary would carry out a program of grants to states during the 5-year period beginning with FY 2010 for carrying out the premium review. There would be appropriated to the Secretary $250 million available for these grants. *§1003: PHSA §2794*
Reducing other health costs and increasing value		No provision.	Each hospital would for each year establish and update a list of the hospital's standard charges for items and services provided in accordance with guidelines developed by the Secretary. The list of charges would be made public. *§1001: PHS §2718*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Appeals process	Section 503 of ERISA (codified at 29 CFR § 2560.530-1) requires that employee benefit plans provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and to afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.	The House bill has an appeal process provision similar to the Senate bill, except that it would not build upon the procedures set forth 29 CFR § 2560.530-1 and it would not involve the states. The House provision is not part of the immediate reforms and would take effect beginning in the plan year 2013. See *§232* **Table 2-Grievance and appeals**.	The bill would require that a group health plan and a health insurance issuer in the group or individual markets would implement an effective appeals process for coverage determinations and claims. The process would at a minimum: ● have in effect an internal claims appeals process; ● provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable assistance; and ● allow an enrollee to review their file, present evidence and testimony and to receive continued coverage pending the outcome. To comply with the requirements, group plans would be expected to initially incorporate the claims and appeals procedures set forth at 29 CFR § 2560.530-1 and would update their processes in accordance with any standards established by the Secretary of Labor. To comply with the requirements, issuers offering individual health coverage would provide internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS. *§1001as amended by §10101: PHSA §2719*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Health insurance consumer information		No provision.	Authority is granted upon enactment, and applicable to FY2010, for the Secretary to award grants to states to establish, expand, or provide support to states that choose either to implement an Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman. There would be $30 million appropriated for the first fiscal year of the program and an authorization for appropriations, in such sums as necessary. The Secretary would establish criteria for the grant, and the Office of Health Insurance Consumer Assistance or Health Insurance Ombudsman would: ● assist with the filing of complaints and appeals; ● collect, track, and quantify problems and inquires; ● assist consumers with enrollment in a group health plan or health insurance coverage; and ● resolve problems with obtaining premium tax credits. *§1002: PHSA §2793*
High-risk pools for individuals with a pre-existing condition	Traditionally, the states have operated their own high-risk pools. Federal funding, most recently via the Omnibus Appropriations Act of 2009 (P.L. 111-8), has been available, but the operation of high-risk pools remains with the states.	The Secretary would establish a temporary national high-risk pool program to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and ending January 1, 2013. Individuals would be eligible if they reside in the State and are not covered by creditable coverage, and who, during the 6-month period ending on the date the individual applies for the high-risk pool coverage, applied for individual health insurance coverage and: ● was denied because of a pre-existing condition or health status; or ● was offered terms that limit the coverage for such a pre-existing condition; or ● was offered coverage at a premium rate that is above the premium rate for the	Not later than 90 days after enactment, the Secretary would establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals during the period beginning on the date the program is established and ending on January 1, 2014. Appropriations would be made in the amount of $5 billion for the period of the program implementation to January 1, 2014 to pay claims and the administrative costs of the high-risk pool. Individuals would be eligible if they are a citizen or national, or lawfully present in the US, have not been covered under creditable coverage during the six-month period prior to application for coverage in the high-risk pool, and have a pre-existing condition as determined following guidance

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		high-risk pool. Appropriations would be made in the amount of $5 billion for fiscal years during the period of January 1, 2010 until the date on which the Exchange is established to pay claims and the administrative costs of the high-risk pool. The Secretary would establish criteria for determining whether health insurance issuers and employment-based health plans discouraged an individual from remaining enrolled in prior coverage based on that individual's health status. *§101*	issued by the Secretary. The Secretary would establish criteria to prevent issuers and plans from dumping members into the high-risk pool. *§1101*
Limitations on pre-existing conditions exclusions	Under HIPAA, a plan is allowed to "look back" 6 months for a condition that was present before the start of coverage in a group health plan. Coverage may be excluded for pre-existing conditions found via this look-back process for a period. HIPAA limits the preexisting condition exclusion period for most people to 12 months (18 months for late enrollment). The term "late enrollment" means, that a participant or beneficiary enrolls under the plan other than during the first period in which the individual is eligible to enroll under the plan, or during a special enrollment period. Special enrollment periods are generally afforded to an individual that did not enroll in coverage because he/she had other coverage at the time, but has now lost that other coverage.	For group coverage, the bill would reduce the look back period for preexisting conditions from 6 months to a 30-day period. The bill would also reduce the preexisting exclusion period from 12 to 3 months for timely enrollments, and 18 to 9 months for late enrollments. The immediate provisions would take effect for plan years beginning on or after January 1, 2010, but in the case of a group health plan maintained by 1 or more collective bargaining agreements, ratified before the date of enactment, this section would not apply to plan years beginning before the earlier of the date on which the last of the collective bargaining agreements terminates or 3 years after the date of enactment. *§106: ERISA §701(a), IRC §9801(a), and PHSA §2701(a)* The immediate provisions sunset at the full implementation date. See **Table 2-Coverage for pre-existing health conditions**.	The bill has a prohibition on preexisting conditions exclusions provision, but it would not be part of the immediate reforms. This provision would not involve reductions in the look back and exclusion periods like the House. The Senate provision would be part of the general reforms for plan years beginning on or after January 1, 2014. See *§1201* **Table 2-Coverage for pre-existing health conditions**.
Prohibition against post-retirement reductions in coverage	ERISA does not restrict an employer's right to reduce, eliminate, or make changes to health insurance coverage. The only	H.R. 3962 would require that every group health plan contain a provision that expressly bars the plan from reducing the	No provision.

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	protections a retiree, or an employee, might have are any contractual or union agreements that specify any requirements of health insurance.	benefits provided under the plan to a retired participant, or beneficiary of such participant, if such reduction affects the benefits provided to the participant or beneficiary as of the date the participant retired, unless such reduction is also made with respect to active participants. Nothing in this section would prohibit a plan from enforcing a total aggregate cap on amounts paid for retiree health coverage that is part of the plan at the time of retirement. *§110: ERISA §716*	
Reinsurance for early retirees		The Secretary would be required to create, within 90 days after enactment, a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents. A trust fund would be created and funds appropriated in an amount requested by the Secretary as necessary, except that the total would not exceed $10 billion. The Secretary would reimburse the plan for 80% of the portion of a claim above $15,000 and below $90,000 (adjusted annually for inflation). Amounts paid to the plan would be used to lower costs directly to participants in the form of premiums, co-payments, and other out-of-pocket costs, but could be not used to reduce the costs of an employer maintaining the plan. The Secretary would have the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under the reinsurance program in order to ensure that expenditures under the reinsurance program do not exceed the funds available.*§111*	Same as H.R. 3962 except that there would be appropriated $5 billion to carry out this program and the Secretary would have the authority to stop taking applications for participation in the program based on the availability of funding, but not the broader authority to take other steps in reducing expenditures in deficit situations. *§1102 as amended by §10102*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Immediate information to identify affordable coverage		Under the House bill, consumer information to make coverage choices would be provided by the Commissioner under the outreach and enrollment provisions for the exchange. The House provision would not be part of the immediate reforms. See *§305*.	The Secretary would be required, in consultation with the states, to establish, not later than July 1, 2010, an Internet portal for beneficiaries to easily access affordable and comprehensive coverage options. This portal would implement a standardized format for the presentation of information including eligibility, availability, premium rates, cost sharing, and the percentage of total premium revenues spent on health care compared to administrative costs. The Internet website would, to the extent practicable, provide ways for residents of, and small business in, any state to receive information on at least the following coverage options: ● health insurance coverage offered other than coverage that provides reimbursement for the treatment of a single disease or condition or an unreasonably limited set of diseases as determined by the Secretary; ● Medicaid coverage and CHIP; ● a state high-risk pool (if applicable); ● the high-risk pool program under section 1101; and ● coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the IRC, and other information specifically for small businesses regarding affordable health care options. *§1103 as amended by §10101*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Domestic violence not considered a pre-existing condition	Under the PHSA, individuals cannot be excluded from enrolling into coverage because of evidence of insurability (including conditions arising out of acts of domestic violence). However, the PHSA permits limitations or exclusions of benefits relating to a preexisting condition. There is no exception for acts of domestic violence in the definition of a preexisting condition.	The bill would require that in the group and individual markets, acts of domestic violence would be prohibited from being treated as a preexisting condition. *§107: ERISA §701(d)(3), PHSA §§2701(d)(3) and 2754, and IRC §9801(d)(3)*	The Senate bill has a prohibition on preexisting conditions exclusions, including a specific prohibition against exclusions based on domestic violence. The Senate provision however, would not be part of the immediate reforms. The Senate provision would be part of the general reforms for plan years beginning on or after January 1, 2014. See *§1201* **Table 2. Coverage for pre-existing health conditions**
Prohibiting denials and delays of necessary treatment for children with deformities	States have broad authority to make coverage mandates and requirements vary between states. There are a limited number of federal coverage mandates such as those for mental health parity at section 2705 of the PHSA.	The bill would require for both the group and individual markets, coverage of any outpatient and inpatient diagnosis and treatment for a minor child's congenital or developmental deformity, disease, or injury. A minor child would include any individual who is 21 years of age or younger. Treatment would be defined to include surgical procedures performed to improve function or to approximate a normal appearance. Such a term would not include cosmetic surgery performed to improve appearance or self-esteem. *§108: ERISA §715, IRC §9814, and PHSA §§2708 and 2755*	No provision.

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Wellness program grants	HIPAA clarifies that group health plans and health insurance issuers offering group health coverage may establish premium discounts or rebates or modify otherwise applicable copayments or deductibles (i.e., rewards) in return for adherence to wellness programs. HIPAA regulations provide a framework for structuring these wellness programs and divide wellness programs into two categories. First, if a wellness program provides a reward based solely on participation in a wellness program, or if it does not provide a reward, it complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. Second, if a reward is based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements. Among these additional requirements, a reward offered by this type of wellness program must not exceed 20% of the cost of employee coverage under the plan (i.e., the amount paid by the employer and the employee for that employee for coverage).	By July 1, 2010, the Secretaries of HHS and Labor would jointly award wellness program grants to small employers in an amount equal to 50% of the costs paid or incurred in connection with a qualified wellness program during the plan year. Allowable costs would be those attributable to the wellness program (excluding the cost of food), and not to the health plan or health insurance coverage offered in connection with such a plan. Grants for a given plan year would be capped at $150 per employee, could be provided for up to three years and would be capped at $50,000, in total, for an employer. A qualified wellness program means a program that is jointly certified by the Secretaries of HHS and Labor meets at least three out of four required components. These components pertain to health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (including smoking cessation and weight reduction) and having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. *§112*	Would largely codify an amended version of the HIPAA wellness program regulations. Wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward (or do not offer a reward) would not violate HIPAA, so long as participation in the programs is made available to all similarly situated individuals. Wellness programs with conditions for obtaining a reward that are based on an individual meeting a certain standard relating to a health factor, must meet additional requirements. Among these requirements, the reward must be capped at 30% of the cost of the employee-only coverage under the plan (instead of 20% under the current regulations), but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50%. The HHS Secretary, in consultation with the Secretaries of the Treasury and Labor, would establish a 10-state pilot program in which participating states would be required to apply the wellness program provisions to health insurers in the individual market. *§1201: PHSA §2705*

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Extension of COBRA	COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, because the employer usually pays part of the premium and they do not under COBRA continuation. However, COBRA continuation is typically less expensive compared to insurance in the individual market. COBRA establishes required periods of coverage for continuation health benefits. COBRA plans may provide longer periods of coverage beyond those required. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.	The bill would allow individuals to keep their COBRA coverage until exchange plans are available, in 2013. As soon as practicable after the date of enactment, the Secretary of Labor in consultation with the Secretaries of HHS and Treasury, and with plan administers that provide or administer COBRA continuation coverage, would establish rules for continued availability of COBRA continuation coverage. This provision would supersede any state (or political subdivision) law that would have the effect of limiting or precluding access to a state health benefits risk pool solely by reason of the extension of the COBRA coverage. *§113*	No provision.

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
State Health Access Program Grants	The State Health Access Program is a grant program created and funded under the Omnibus Appropriations Act of 2009 (P. L. 111-8). The program, operated by HHS, awards grants to states to help them expand access to affordable healthcare coverage for people who are uninsured. States may take a number of approaches, including: ● shared community coverage; ● reinsurance plans that subsidize a certain share of insurance carrier losses within a certain risk corridor; ● subsidized high-risk insurance pools; ● health insurance premium assistance; ● insurance connector authority that develops new, less expensive, portable benefit packages for small employers, part-time, and seasonal workers; ● automated enrollment systems for public assistance programs; and ● innovative strategies to insure low-income childless adults. Grants are made for 1 year and may be extended to 4 additional years, based on the availability of funds. Each state submits an annual report to the Secretary, assessing the state's use of funds and describing progress in meeting project goals.	The Secretary would provide grant program incentives for states to move forward with a variety of health reform initiatives prior to 2013. Grants could be used for state insurance exchanges, community coverage programs, reinsurance plan programs, transparent marketplace programs, automated enrollment programs, innovative strategies, and purchasing collaborative programs. *§114*	No provision.

Topics for Table 1	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Patient protections	Many states have laws defining network adequacy or the number and distribution of health care providers required to operate a health plan. States may also have "any willing provider" laws that require a health plan to contract for the delivery of health care services with any provider in the area who would like to provide such services to the plan's enrollees. Mandated benefits regulation of the private health insurance market is primarily done at the state level. State regulatory authority is broad in scope and can include requirements involving preventive health services. Such rules vary from state to state. Traditionally, health insurance plans pay out-of-network providers based on their usual and customary rate (UCR). The UCR is defined generally as the usual fee for a procedure charged by the majority of physicians with similar training and experience within the same geographical area. Private companies, such as Ingenix, generally collected and reported UCRs. However, on October 27, 2009, New York Attorney General Cuomo announced a settlement agreement with Ingenix that created a new not-for-profit company, FAIR Health, Inc., and a research network headquartered at Syracuse University to develop a new independent database for consumer reimbursement. There is no federal law regulating these activities.	The House bill would require that QHBPs that use a provider network would meet the network adequacy standards established by the Commissioner to ensure enrollee access to services. The House bill has no specific provisions with respect to designation of a primary care provider, emergency services, or obstetrical and gynecological care as the Senate bill has. The House network adequacy provision would not be part of the immediate reforms, but would take effect for plan years beginning in 2013. See *§ 215* The House bill has no provision with respect to academic or other non-profit institutions collecting medical reimbursement data.	Under the bill, if a group health plan or health insurance issuer in the group or individual markets requires or provides for designation by a participant, beneficiary or enrollee of a participating primary care provider, then the plan or issuer would be required to permit the designation of any participating primary care provider who is available to accept the individual. This same provision would apply for pediatric care. If a group health plan or health insurance issuer in the group or individual markets covers emergency services they would be required to cover those services without the need for any prior authorization and without the imposition of coverage limitations irrespective of the provider's contractual status with the plan. Patients would also have protected access to obstetrical and gynecological care. A group health plan or health insurance issuer in the group or individual markets would be prohibited from requiring authorization or referral by the plan, issuer, or any person in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical and gynecological care. Centers established at academic or other non-profit institutions to collect medical reimbursement data would be required to develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates. They would also be required to make these data and any statistical methodologies used publicly available. *§10101: PHSA §§2719A and 2794*

Table 2. Private Health Insurance Market Reforms at Full Implementation Date

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Location in bill		Sections 201, 202, 211-217, 231-237, 239, 251, 309	Sections 1201, 1251, 1253, 1301, 1311, 1321, 1324,1333, 1341-1343
Law amended			Public Health Service Act (amends Title XXVII)
Effective date of market reforms ("full implementation"), unless specified otherwise)		Beginning January 1, 2013. *§201(b)*	Plan years beginning on or after January 1, 2014. *§1255, as amended (and redesignated from §1253) by §10103(f)*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Qualified plans	Current law: Existing federal and state law and regulations concerning the private market generally distinguish between coverage obtained from the group market and coverage obtained from the individual market. In turn, some laws and regulations distinguish between small groups and large groups. For example, the federal Health Insurance Portability and Accountability Act (HIPAA) defines small groups as those with 2-50 employees; however, some states include self-employed "groups of one" in their small group definition.	Beginning 2013, a qualified health benefits plan (QHBP) would be a health plan that meets the new federal requirements regarding private health insurance standards, essential benefits (including cost-sharing), as detailed in **Table 3. Essential Benefits**, and consumer protections. Only QHBPs may be offered in an exchange, but may be offered outside of an exchange. Existing employment-based plans must meet the QHBP standards by 2018, except for limited benefit plans. QHBPs include qualified health benefits plans offered through the CO-OP program or the Public Health Insurance Option. The Commissioner would allow a QHBP to provide coverage through a qualified direct primary care medical home plan, as long as the QHBP meets all applicable requirements and the medical home coordinates with the issuer offering the QHBP. *§§201(b), 202(b), 303, 310, 321*	A qualified health plan (QHP) would be a health plan that has been certified by each exchange through which such plan is offered as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, and provides the essential health benefits package (detailed in **Table 3. Essential Benefits**). A QHP issuer would be licensed and in good standing with each state in which it would offer coverage; would offer at least one QHP each providing silver and gold levels of coverage; would charge the same premium for a plan regardless if it was offered in or out of the exchange (including through an insurance agent); and would comply with regulations applicable to exchanges. QHPs include qualified health plans offered through the CO-OP program or the Community Health Insurance Option. *§1301* An individual would not be compelled to enroll, or not enroll, in a QHP or participate in the exchange. A qualified individual could enroll in any QHP, except in the case of a catastrophic plan (described below). A QHP, or exchange, would be prohibited from imposing a penalty on an individual who cancels enrollment in such a plan because the individual becomes eligible for minimum essential coverage (previously defined) or minimum essential coverage becomes affordable to that person. *§1312(d)(3)-(4)*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Consumer choice and employer offer of qualified plans		Employers who are qualified to offer coverage through the exchange may comply with the employer mandate by offering any QHBP offered through the exchange. Employees of such employers would be able to choose any QHBP available to them. *§302(e)*	Individuals would be allowed to enroll in any QHP available to them. Employers who are qualified to offer coverage through an exchange would be allowed to offer any level of coverage (bronze, silver, gold, or platinum). Employees of such employers would be able to choose any QHP that offers the level of coverage elected by such employers. *§1312(a)*
Grandfathered plans		Existing individual health insurance plans would be grandfathered indefinitely, as long as there are no changes to the terms or conditions of the coverage, except as required by law. Grandfathered individual health insurance plans would be prohibited from enrolling new individuals after the full implementation date, unless such individuals are dependents of an enrollee who had such coverage prior to that date. Existing group health insurance plans would be grandfathered until 2018 at which time they would be required to comply with the QHBP standards, except for limited benefit plans. *§202(a)-(b)*	On date of enactment, existing individual and group plans would be grandfathered. Enrollees could continue and renew enrollment in a grandfathered plan indefinitely. Enrollment would be limited to those who were currently enrolled, their families, or for grandfathered employer-sponsored insurance to new employees and their families. Grandfathered plans would still be subject to a couple of market reforms: uniform explanation of coverage documents and reporting of medical loss ratio and other information. See **Table I, "Development of uniform explanation of coverage documents"** and **"Reducing health insurance premiums and increasing value."** *§1001: PHSA §§2716, 2718* Existing group plans subject to one or more collective bargaining agreements would be grandfathered until the date on which the agreement terminates, at which time the immediate reforms and private market reforms would apply. *§1251, as amended by §10103(d)-(e)*
Coverage for pre-existing	The federal Health Insurance Portability and Accountability Act (HIPAA) limits the	A QHBP would be prohibited from excluding coverage for pre-existing health	Group health plans and issuers in the individual and group markets would be

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
health conditions	period of time when coverage for pre-existing health conditions may be excluded under group coverage for individuals who meet HIPAA eligibility criteria. HIPAA prohibits such coverage exclusions for HIPAA-eligible individuals with coverage in the individual market. Some states have imposed requirements regarding coverage for pre-existing health conditions for covered persons who are not eligible for HIPAA protections.	conditions, or placing limits on coverage based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or similar factors. *§211* A relevant provision, which would modify current HIPAA standards applicable to pre-existing coverage exclusions, would be implemented before the full implementation date, and sunset at the implementation of Sec. 211. See **Table 1, "Limitations on pre-existing conditions exclusions."** *§106* Another relevant provision, which would prohibit an act of domestic violence from being regarded as a pre-existing condition, would be implemented before the full implementation date, and would not sunset. See **Table 1, "Domestic violence not considered a pre-existing condition."** *§107*	prohibited from excluding coverage for pre-existing health conditions. For enrollees under age 19, this provision would become effective beginning 6 months after date of enactment. *§1201: PHSA §2704, as amended by §10103(e)*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Guaranteed issue, guaranteed renewability, and health insurance rescissions	HIPAA requires that coverage sold to all small groups (2-50 employees) must be sold on a guaranteed issue basis—that is, the issuer must accept every small employer that applies for coverage. Also, HIPAA guarantees the availability of a plan to HIPAA-eligible individuals seeking coverage in the individual market. HIPAA guarantees the renewability of coverage in the individual and group markets for all enrollees. "Guaranteed renewal" in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor (e.g., employer) or individual coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable.	Individual and group health coverage would be offered on both a guaranteed issue and guaranteed renewal basis. Health insurance rescissions would be prohibited, except in cases of fraud. *§212*	Individual and group health insurance issuers would be required to offer coverage on a guaranteed issue and guaranteed renewal basis. *§1201: PHSA §§2702, 2703* A relevant provision, which would prohibit rescissions except in instances of fraud, would be implemented before the full implementation date, and would not sunset. See **Table I, "Prohibition on rescissions."** *§1001: PHSA §2712*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Rating rules	There are no federal rating rules for the private health insurance market. Most states currently impose premium rating rules on insurance carriers in the small group market, and some states have such rules in the individual market. The spectrum of existing state rating rules ranges from pure community rating to adjusted (or modified) community rating, to rate bands, to no restrictions. Under pure community rating, all enrollees in a plan pay the same premium, regardless of their health, age or any other factor related to insurance risk. As of December 2008, only two states (New Jersey and New York) use pure community rating in their nongroup markets, and only New York imposes pure community rating rules in the small group market. Adjusted community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key factors such as age or gender. Rate bands allow premium variation based on health, but such variation is limited according to a range specified by the state. Rate bands are typically expressed as a percentage above and below the index rate (i.e., the rate that would be charged to a standard population if the plan is prohibited from rating based on health factors). Some states have enacted rating rules in the individual and small group markets that include geography as a characteristic on which premiums may vary. In these cases, the state has established rating areas. Typically, states use counties or zip codes to define those areas.	A QHBP would be required to determine premiums using adjusted community rating rules. Premiums would be allowed to vary based only on age (by no more than a 2:1 ratio based on age categories specified by the Commissioner), premium rating area (as permitted by states or the Commissioner), and family enrollment (so long as the ratio of family premium to individual premium is uniform, as specified under state law and consistent with Commissioner rules). *§213*	The Senate Amendment would impose adjusted community rating rules, but only on issuers in the individual and small group markets, with some exceptions. Premiums for those markets would vary based only on the following risk factors: self-only or family enrollment; rating area, as specified by the state; age (by no more than a 3:1 ratio across age rating bands established by the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC)), and tobacco use (by no more than 1.5:1 ratio). If a state allows large group issuers to offer coverage through that state's exchange, these rating rules apply to all coverage in that market, except for self-insured plans. *§1201: PHSA §2701, as amended by §10103(a)* Any issuer in the individual or small group market would be required to consider all enrollees in all plans offered by the issuer in the applicable market as members of a single risk pool, including enrollees not enrolled in such plans offered through the exchange. *§1312(c)*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Non-discrimination in health insurance coverage based on health factors	HIPAA established federal rules regarding non-discrimination based on health status-related factors. It prohibits group issuers from establishing rules for eligibility and premium contributions based on health status-related factors. Those factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability. In addition, the Genetic Information Nondiscrimination Act of 2008 prohibits issuers in the individual health insurance market from establishing eligibility rules (including continued eligibility) based on an individual's genetic information. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, requires parity in coverage for large groups (more than 50 employees) by prohibiting disparities in the coverage of physical illnesses and mental health and substance abuse problems in terms of annual or lifetime dollar limits on mental health benefits, treatment limitations and out-of-network coverage.	A QHBP would be required to comply with standards established by the Commissioner prohibiting discrimination in health benefits and benefit structures that build on existing HIPAA nondiscrimination rules. Existing rules concerning (1) no requirement on group plans to provide mental health benefits, and (2) no impact of limited mental health parity on terms and conditions relating to the amount, duration, or scope of mental health benefits, would apply to QHBPs, regardless of whether coverage is offered in the individual or group market. *§214*	Group health plans and issuers in the individual and group markets would be prohibited from basing eligibility (including continued eligibility) for coverage on health status-related factors. Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the Secretary. However, the offering of premium discounts or rewards based on enrollee participation in wellness programs would be permitted, so long as the conditions for obtaining such reward meets standards specified in the section. *§1201: PHSA §2705* A related provision, which would prohibit insurance eligibility rules based on salary, would be implemented before the full implementation date, and would not sunset. See **Table 1, "Prohibition of discrimination based on salary."** *§1001: PHSA §2716, as amended by §10101*
Provider network adequacy	HIPAA established special rules for plans that establish networks of health care providers. HIPAA allows small group issuers to (1) limit the employers that apply for coverage to those firms with eligible individuals who live or work in the network service area, and (2) deny coverage to small employers if the issuer demonstrates (if required) to the state that it has limited provider capacity due to obligations to existing enrollees and is applying this decision uniformly without regard to claims	A QHBP that uses a provider network would be required to comply with network adequacy standards that may be established by the Commissioner. Such a QHBP would provide a current listing of all providers in its network on the plan's website and the exchange's website. *§215*	The Secretary would, by regulation, establish criteria for the certification of qualified health plans. A QHP would be certified if it ensured a sufficient choice of health care providers, and provided enrollees with information on the availability of in-network and out-of-network providers, among other requirements. *§1311(c)*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	experience or health status-related factors. HIPAA also prohibits a small group issuer that has denied coverage in any service area to offer small group coverage in that area for 180 days after the denial.		
Fair marketing requirements	States have established fair marketing standards to prohibit insurers from marketing their insurance products only to healthy individuals and groups.	The Commissioner would establish uniform marketing standards for QHBPs. Such standards would apply to QHBPs outside of the exchange only to the extent specified by the Commissioner. *§§231, 234*	A QHP offered through the exchange would meet marketing requirements and not employ practices that would discourage enrollment by individuals with significant health needs. *§1311(c)*
Grievance and appeals	ERISA does not require an employer to offer health benefits, but does mandate compliance to certain standards if an employer chooses to offer health benefits, such as procedures for appealing denied benefit claims to the plan ("internal appeals"). In addition, as of February 2008, 44 States and the District of Columbia mandate the independent review of benefit denials by an entity outside of the health plan ("external review").	A QHBP would be required to provide timely grievance and appeals mechanisms in compliance with standards that would be established by the Commissioner. Internal claims and appeals processes would incorporate the existing ERISA requirements. The Commissioner would establish an external review process to provide an independent, de novo review of denied claims. Nothing in this section would be construed as affecting the availability of judicial review under state law for adverse decisions. *§232* Grievance and appeals standards would apply to QHBPs outside of the exchange only to the extent specified by the Commissioner. *§234* The Commissioner would appoint a Qualified Health Benefits Plan Ombudsman to receive and provide assistance with grievances. among other responsibilities. *§,244*	A relevant provision, concerning internal and external appeals processes, would be implemented before the full implementation date, and would not sunset. See **Table 1, "Appeals process."** *§1001: PHSA §2719* Another relevant provision, regarding grants to states for the establishment/expansion of a health insurance ombudsman, would be implemented before the full implementation date; authority would be applicable to FY 2010 only. See **Table 1, "Health insurance consumer information."** *§1002: PHSA §2793*
Information transparency and plan disclosure	ERISA requires applicable health plans (as well as other "welfare benefit" plans) to	A QHBP would be required to notify plan enrollees of any decrease in coverage or	A relevant provision, concerning the development of standards applicable to the

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	disclose and report certain plan information to enrollees and regulators. For example, plan administrators must provide to enrollees a written summary plan description (SPD) which contains the terms of the plan and the benefits offered, including any material modifications, and the SPD must be written in a manner that can be understood by the average enrollee. Certain plans must file an annual report with the Department of Labor, containing information about the operation, funding, assets, and investments of those plans.	increase in cost-sharing at least 90 days prior to the effective date of such changes. *§217* QHBPs in the exchange would be required to comply with disclosure standards established by the Commissioner concerning plan terms and conditions, claims payment policies, plan finances, claims denials, and other information as determined appropriate by the Commissioner. The Labor Secretary would harmonize such disclosure standards for application to group plans. The Commissioner would require such disclosures to be provided in plain language. QHBPs would be required to disclose cost-sharing requirements to enrollees and comply with standards established by the Commissioner to ensure transparency regarding reimbursements between the plan and health care providers. A pharmacy benefit manager (PBM), under contract with a QHBP, would be required to provide information to the Commissioner and QHBP: volume of prescriptions filled, aggregate average payments per prescription for mail order and retail sales, and other information. Information disclosed by a PBM would be considered confidential, and disclosure of such information would be prohibited except for specified purposes. On an annual basis, the Commissioner would develop a public report assessing the overall impact of PBMs on prescription drug prices and spending. Disclosure of a specific PBM, retailer, manufacturer or wholesaler, or other confidential or proprietary information would be prohibited. A PBM that fails to provide information required under this section or	disclosure of benefit and coverage information, would be implemented before the full implementation date, and would not sunset. See **Table I, "Development of uniform explanation of coverage documents."** *§1001: PHSA §2715* PBMs that manage prescription drug coverage under a contract with a Medicare Part D drug plan or a qualified health plan offered through an exchange would be required to share certain financial information with the Secretary, the plans the PBMs contract with through Medicare Part D, or the exchanges in a manner, form, and timeframe specified by the Secretary. Specifically, PBMs would be required to disclose information on: (1) the percent of all prescriptions that are provided through retail pharmacies compared to mail order pharmacies, and the generic dispensing rates for each type of pharmacy that is paid by the PBM under contract; (2) the aggregate amount and types of rebates, discounts or price concessions that the PBM negotiates on behalf of the plan and the aggregate amount of these that are passed through to the plan sponsor, and the total number of prescriptions dispensed; and (3) the aggregate amount of the difference between the amount the plan pays the PBM and the amount that the PBM pays the retail and mail order pharmacy, and the total number of prescriptions dispensed. This information would be considered confidential and would be protected by the Secretary. *§6005*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		knowingly provides false information would be subject to penalties specified in Sec. 1927(b)(3)(C) of the Social Security Act. *§233* The disclosure and transparency requirements would apply to QHBPs outside of the exchange only to the extent specified by the Commissioner. *§234*	
Timely payment of claims	Under Medicare Advantage (MA), private health plans are paid a per-person amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. MA plans include health maintenance organizations (HMOs) and private fee-for-service (PFFS) plans. MA PFFS plans are required to pay 95% of "clean claims" (defined as a claim that has no defect or impropriety, and is submitted with all the required documentation) within 30 days of receipt. The 30-day rule also applies to claims submitted to any MA organization by a provider who does not have a written contract with the plan. All other claims from non-contracted providers must be paid within 60 days. MA organizations that contract with providers (i.e., HMOs and PPOs) must include a prompt payment provision in their contracts.	QHBPs would be required to comply with the prompt pay requirements used under Medicare Advantage. *§235*	No provision.
Coordination and subrogation of benefits	While there are no federal statutes specifying primary and secondary payment rules when individuals are covered by multiple insurers in the private market, the Medicare program may provide an example. The Medicare Secondary Payer (MSP) program identifies specific conditions under which another party pays first and Medicare is only responsible for qualified secondary payments. It authorizes several methods to identify cases when an insurer	The Commissioner would establish standards for the coordination of benefits and reimbursement of payments in cases involving individual and multiple plan coverage. *§236*	No provision.

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	other than Medicare is the primary payer and to facilitate recoveries when incorrect Medicare payments have been made. Under certain conditions, the law makes Medicare the secondary payer to insurance plans and programs for beneficiaries covered through (1) a group health plan based on either their own or a spouse's current employment; (2) auto and other liability insurance; (3) no-fault liability insurance; and (4) workers' compensation situations, including the Black Lung program.		
Dependent coverage	Michelle's Law (P.L. 110-381) ensures that dependent students enrolled in post-secondary education who take a medically necessary leave of absence do not lose health insurance coverage. The federal law provides that a group health plan may not terminate a college student's health coverage because the student takes a leave of absence from school or changes to part-time status due to health conditions. The leave of absence must be medically necessary, begin while the student is suffering from a serious illness or injury, and would otherwise result in a loss of coverage. Many states currently require carriers to extend dependent coverage under a family policy to young adults until those individuals reach a certain age or no longer satisfy other eligibility criteria, e.g., full-time college enrollment. As of January 2009, 30 states had coverage rules for dependent adults in either the group market or individual market or both.	A QHBP would be required to provide to the policyholder the option of keeping qualified dependent children on the family's health insurance policy, as long as the child is under 27 years of age and is not enrolled in any other health plan. The QHBP would be allowed to increase premiums to provide coverage to such dependents, as long as the premiums are consistent with the rating rules specified in Sec. 213. *§216*	A relevant provision affecting health insurance coverage of dependent children would be implemented before the full implementation date, and would not sunset. See **Table I, "Extension of dependent coverage."** *§1001: PHSA §2714*
Interstate compacts	The federal McCarran-Ferguson Act affirms that states are the primary regulators of insurance, including health insurance. Laws regulating health insurance vary by state and cover a wide spectrum of issues, including licensure, solvency, benefit	Beginning on January 1, 2015, states would be allowed to form health care choice compacts for the purpose of facilitating the sale and purchase of individual health insurance plans across state lines. The Secretary would request the NAIC to	No later than July 1, 2013, the Secretary, in consultation with NAIC, would promulgate regulations for interstate health care choice compacts, which could be entered into beginning January 1, 2016. Under such compacts, QHPs would be offered in all

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	mandates, rating rules, and consumer protections.	develop model guidelines by January 1, 2014 for the creation of such compacts, which would subject coverage sold in multiple states participating in the compact to the laws and regulations of one primary state, but preserve the authority of each secondary state to enforce specific rules (e.g., consumer protection standards). By January 1, 2015, the Secretary would make grants available to states for activities related to regulating health insurance coverage sold in secondary states. H.R. 3962 would authorize for appropriations such sums as necessary to implement the compact provisions from FY2015 through FY2020. *§309*	participating states, but insurers would still be subject to the consumer protection laws of the purchaser's state. Insurers would be required to be licensed in all participating states and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's state. The bill would also require that states enact a law to enter into compacts and to obtain approval of the Secretary, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as would otherwise be provided. Moreover, the bill would require that the compact would not increase the federal deficit or weaken enforcement of state consumer protection laws. *§1333*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
State flexibility to establish a Basic Health Program	There is no existing federal law providing direct ongoing program financing to the states for health insurance coverage of low-income individuals not eligible for Medicaid either under standard criteria or via waivers. The Washington State Basic Health (BH) Plan program administered and financed by the Washington State Health Care Authority (HCA) started as a pilot program established by the Washington State Health Care Access Act of 1987.	No provision.	Would require the Secretary to create a state option for individuals who are not eligible for Medicaid, have not reached the age of 65, and whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved; or in the case of an alien lawfully present in the United States, whose income is not greater than 133 percent of the poverty line for the size of the family involved but who is not eligible for the Medicaid. A standard heath plan would be defined as a health benefits plan that the state contracts with that: ● would not be open for enrollment to those outside of the program; ● provides at least the essential health benefits; and ● has a medical loss ratio of at least 85%. The Secretary would transfer to the state an amount equal to 95% of the premium tax credits under section 36B of the IRC of 1986, and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals as if they were in the exchange. *§1331 as amended by §10104*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Waiver for state innovation			Beginning in 2017, the bill permits states to apply for a waiver for up to five years of requirements relating to QHPs, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. The state applying for the waiver would be required to enact a law, provide a 10-year budget plan ensuring budget neutrality for the federal government, and to comply with regulations that ensure transparency. The Secretary would be required to provide to a state the aggregate amount of tax credits and cost sharing reductions that would have been paid to residents of the state in the absence of a waiver. *§1332*
Reinsurance	Some states have established reinsurance policies to encourage the offer of private health insurance to individuals and groups of higher risk. Reinsurance typically is thought of as insurance for insurers. When issuing policies, an insurer faces the risk that the premiums it collects will not be sufficient to cover its expenses and generate profit. For a health insurer, unusually high health care claims could lead to significant financial loss. Reinsurance shifts the risk of covering such high expenses from the primary insurer to a reinsurer.	A relevant provision, regarding establishment of a temporary reinsurance program, would be implemented before the full implementation date, and would sunset when appropriations are expended. See **Table 1, "Reinsurance for early retirees."** *§111*	No later than January 1, 2014, each state would be required to establish a reinsurance program for the individual health insurance market. *§1341, as amended by §10104(r)* A relevant provision, regarding establishment of a temporary reinsurance program, would be implemented before the full implementation date, and would sunset on January 1, 2014. See **Table 1, "Reinsurance for early retirees."** *§1102, as amended by §10102*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Risk corridors	Risk corridor rules are used in a program for regional participating provider organizations under Part D of the Medicare program. Risk corridors refer to a mechanism which adjusts payments to plans according to a formula based on each plan's actual, allowed expenses in relation to a target amount. If a plan's expenses exceed a certain percentage above the target, the plan's payment is increased. Likewise, if a plan's expenses exceed a certain percentage below the target, the plan's payment is decreased.	No provision.	The Secretary would be required to establish and administer temporary risk corridors, under which payments to QHPs in the individual and small group markets would be made according to applicable risk corridor rules, based on the Medicare Part D program for regional participating provider organizations. *§1342*
Risk adjustment	In general, plan payments under Medicare Advantage are risk-adjusted to account for the variation in the cost of providing care. Risk adjustment is designed to compensate plans for the increased cost of treating older and sicker beneficiaries, and thus discourage plans from preferential enrollment of healthier individuals. The Medicare risk adjustment models take into account the variation in expected medical expenditures of the Medicare population associated with demographic characteristics (age, sex, current Medicaid eligibility, original Medicare eligibility due to a disability), as well as medical diagnoses.	No provision.	Each state would be required to adopt a risk-adjustment model, established by the Secretary, to apply risk adjustment to health plans and issuers in the individual and small group markets. Plans with enrollment of less than average risk would pay an assessment to the state. States would provide payments to plans with higher than average risk. *§1343*

Topics for Table 2	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Relation to other requirements		For coverage not offered through the exchange and employment-based plans, the new requirements under Title II of this bill (relating to QHBPs) would not supersede specified federal and state laws, as long as such laws do not prevent implementation of provisions related to the private health insurance market, as determined by the Commissioner. The application of Section 514 of ERISA, regarding the federal preemption of state laws that relate to employee benefit plans, would not be affected. For coverage offered through the exchange, the new requirements under Title II of this bill (relating to QHBPs) would not supersede any requirements under HIPAA (including requirements relating to genetic information non-discrimination and mental health parity) or state law, as long as such requirements do not prevent implementation of provisions related to the private health insurance market, as determined by the Commissioner. Individual rights and remedies under State laws would apply. *§251*	The private health insurance provisions would not preempt state law, as long as such laws do not prevent the application of such provisions. *§1321(d)* A state may require a QHP to offer benefits in addition to "essential health benefits." In such instances, the state would be required to make payments, to the enrollee or on behalf of the enrollee, to defray the cost of the additional benefits. *§1311(d), as amended by 10104(e)* (There is a similar provision in the House bill that only affects state mandated benefits for exchange plans. See **Table 7, "Health Insurance Exchanges,"** Standardized benefit tiers for exchange plans.) QHPs in the CO-OP program, under the Community Health Insurance Option, or as a nationwide plan, would be subject to certain federal and state laws applicable to private health insurers. Such laws would include: guaranteed renewal, rating, pre-existing conditions, nondiscrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan material or information. *§1324* State benefit mandates would continue to apply to coverage outside of an exchange. *§1312(d)(2)*

Table 3.Essential Benefits

Topics for Table 3	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 221-224	Sections 1201,1302
Law amended		PHSA (amends title XXVII)
Effective date	Beginning January 1, 2013 for all new private health plans. By 2018 for existing group health plans. *§§201(b), 202(b)*	Plan years beginning on or after January 1, 2014. *§1255, as amended (and redesignated from §1253) by §10103(f)*
Benefits package	QHBPs would be required to provide the essential benefits package. Exchange plans would be required to offer coverage that complies with the essential benefits package standards (Sec. 222), and provides specified levels of coverage (Sec. 303). QHBPs not offered through the exchange could offer benefits in addition to the essential benefits package. The essential benefits package would cover specified items and services, prohibit cost-sharing on preventive services, limit annual out-of-pocket spending, prohibit annual and lifetime benefit limits on covered health care items and services, comply with network adequacy standards, and be equivalent in its scope of benefits to the average employer health plan in 2013 (as certified by CMS's Office of the Actuary). *§§221, 222(a)* A relevant provision, that would prohibit lifetime limits with respect to essential benefits, would be implemented before the full implementation date, and would not sunset. See **Table I, "No lifetime or annual limits."** *§109*	QHPs and plans offered in the individual and small group markets would be required to provide the essential health benefits package. The essential health benefits package would refer to a health plan that would provide coverage for "essential health benefits," would not exceed out-of-pocket and deductible limits specified in the bill, and would not impose a deductible on preventive services. The Secretary would ensure that the scope of essential health benefits is equal to the scope of benefit provided under a typical employer plan, as determined by the Secretary(as certified by CMS's Office of the Actuary). *§§1201: PHSA § 2707(a),1302(a),1302(b)(2)* A relevant provision, affecting lifetime and annual benefit limits, would be implemented before the full implementation date, and would not sunset. See **Table I, "No lifetime or annual limits."** *§1001: PHSA §2711, as amended by §10101*

Topics for Table 3	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Categories of essential benefits	The essential benefits package would provide coverage, at a minimum, for the following categories of benefits: ● hospitalization; ● outpatient hospital and clinic services, including emergency department services; ● services of physicians and other health professionals; ● services, equipment, and supplies incident to the services of a physician or health professional in clinically appropriate settings; ● prescription drugs; ● rehabilitative and habilitative services; ● mental health and substance use disorder services; ● certain preventive services (no cost-sharing permitted) and vaccines; ● maternity care; ● well baby and well child care *and* oral health, vision, and hearing services, equipment, and supplies for those under age 21; and ● durable medical equipment, prosthetics, orthotics, and related supplies. *§222(b)* A relevant provision, concerning coverage for treatment for children with deformities, would be implemented before the full implementation date, and would not sunset. See **Table 1, "Prohibiting denials and delays of necessary treatment for children with deformities."** *§108*	The essential health benefits package would provide coverage, at a minimum, for the following categories of benefits: ● hospitalization; ● ambulatory patient services; ● emergency services; ● prescription drugs; ● rehabilitative and habilitative services and devices; ● mental health and substance use disorder services, including behavioral health treatment; ● preventive and wellness and chronic disease management; ● maternity and newborn care; ● pediatric services, including oral and vision care; and ● laboratory services. *§1302(b)* A relevant provision, concerning coverage for preventive health services, would be implemented before the full implementation date, and would not sunset. See **Table 1, "Coverage of preventive health services."** *§1001 : PHSA §2713*
Cost-sharing for essential health benefits	The essential benefits package would not include cost-sharing for preventive items and services recommended (with a grade A or B) by the Task Force on Clinical Preventive Services, and vaccines recommended by the Centers for Disease Control and Prevention. To the extent possible, the Secretary would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee). *§222(c)*	Plans providing the essential health benefits package would be prohibited from applying a deductible to preventive health services. *Small group health plans* providing the essential health benefits package would be prohibited from imposing a deductible greater than $2,000 for self-only coverage, or $4,000 for any other coverage in 2014; deductible limits would be annually adjusted thereafter. *§1302(c)*

Topics for Table 3	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Out-of-pocket spending limit	The annual out-of-pocket limit in 2013 for the essential benefits package would be no more than $5,000 for an individual and $10,000 for a family, adjusted annually for inflation. *§222(c)*	A health plan providing the essential health benefits package would be prohibited from imposing an annual out-of-pocket limit that exceeds the maximum thresholds permissible for high deductible health plans (HDHPs) that qualify for Health Savings Accounts (HSAs). (For 2009, the out-of-pocket maximum for health savings account-qualified HDHPs is $5,800 for single coverage and $11,600 for family coverage.) *§1302(c)*
Annual/lifetime benefit limits	The essential benefits package would be prohibited from including any annual or lifetime limits on covered health care items and services. *§222(a)(3)* A relevant provision, that would prohibit lifetime limits with respect to essential benefits, would be implemented before the full implementation date, and would not sunset. See **Table I, "No lifetime or annual limits."** *§109*	A relevant provision, affecting lifetime and annual benefit limits, would be implemented before the full implementation date, and would not sunset. See **Table I, "No lifetime or annual limits."** *§1001: PHSA §2711, as amended by §10101*
Authority for determining essential benefits	The Health Benefits Advisory Committee, a private-public panel of medical and other experts, would be established to recommend benefit standards and periodic updates to the HHS Secretary. The Advisory Committee would recommend initial benefit standards no later than one year after enactment. The Secretary would adopt an initial set of benefit standards, through the rulemaking process, no later than 18 months after enactment. The Commissioner would specify the variation allowed for cost-sharing levels in basic, enhanced, and premium plus plans, based on the essential benefits package. Cost-sharing may vary up to 10% for each benefit category specified. *§§222(c)(3), 223, 224*	The Secretary would define and periodically update coverage that provides essential health benefits. The Secretary would ensure that the scope of the essential health benefits is equal to the scope of benefits under a typical employer-provided health plan, as certified by the Chief Actuary of the Centers for Medicare and Medicaid Services. *§1302(b)*
Actuarial value based on essential benefits	For provisions regarding benefits standardized according to actuarial values based on essential benefits, see **Table 7. Health Insurance Exchanges, "Standardized benefit tiers for exchange plans."** *§303*	For provisions regarding benefits standardized according to actuarial values based on essential benefits, see **Table 7. Health Insurance Exchanges, "Standardized benefit tiers for exchange plans."** *§§1301(a)(1)(C)(ii),1311(b)(2)(B)(ii)*

Table 4. Individual Mandate

Topics for Table 4	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Section 501	Section 1501
Law amended	Creates new Section 59B in IRC	Creates new Section 5000A in IRC
Effective date	1/1/13 *§501*	1/1/14 *§1501*
Is there an individual mandate to have health insurance	Yes, most individuals would be required to maintain acceptable coverage, defined as coverage under a qualified health benefits plan (QHBP), an employment-based plan, a grandfathered nongroup plan, part A of Medicare, Medicaid, military coverage (including Tricare), veteran's health care program, services for members of Indian tribes (through the Indian Health Service, a tribal organization or an urban Indian organization), and coverage as determined by the Secretary in coordination with the Commissioner. *§501: IRC §59B(d)*	Yes, most individuals would be required to maintain minimum essential coverage for themselves and their dependents, defined as coverage under part A of Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the TRICARE for Life program, the veteran's health care program, the Peace Corps program, an eligible employer sponsored plan, plans in the individual market, a grandfathered health plan, and any other health benefits coverage, such as a state health benefits risk pool, as recognized by the Secretary in coordination with the Secretary of Treasury. Eligible employer sponsored plans would include local, state or federal government plans, any other plan or coverage offered in the small or large group market, and grandfathered plans. Minimum essential coverage would not include coverage of excepted benefits as defined in the Public Health Service Act (PHSA) such as coverage for only accident or disability income, limited scope dental or vision benefits, coverage for specific illnesses, or Medicare supplemental health insurance. *§1501: IRC Ch.48 §5000A(a) and (f)*

Topics for Table 4	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Penalty for non-compliance	Yes, individuals who did not meet mandate for themselves and their children could be required to pay a tax, prorated for the time the individual (or family) does not have coverage during the year, equal to the lesser of (1) 2.5% of the taxpayer's modified adjusted gross income (MAGI) over the amount of income required to file a tax return, or (2) the national average premium for applicable single or family coverage. *§501: IRC §59B(a) and (b)*	Individuals who did not meet mandate for one or more months would be required to pay a penalty for themselves and their dependents, for each month they were in non-compliance. The penalty would be the lesser of (1) the sum of the monthly penalty amount (calculated as the lesser of (a) the per person penalty amount, but no more than 300% of the per person penalty in total for the taxpayer and any dependents, or (b) 0.5% of household income for a tax year beginning in 2014, 1.0% for a tax year beginning in 2015, and 2% thereafter);or (2) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through an exchanges for plan years beginning in the calendar year with or within which the taxable year ends. The per-person, annual dollar penalty would be phased in—$95 in 2014, $495 in 2015, reaching $750 in 2016 (adjusted for inflation thereafter). The monthly penalty amount, for any dependents under the age of 18, would be reduced by one-half. Taxpayers who did not pay a required penalty would not be subject to any criminal prosecution or penalty. The Secretary could not file notice of lien or levy on any property, *§1501: IRC §5000A(b),(c) and (g), as amended by §10106(b)(1)*

Topics for Table 4	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Exemptions to individual mandate	Exempted individuals would include nonresident aliens, individuals who live and work outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax-filing purposes, and others granted an exemption by the Secretary. *§501: IRC §59B(c)*	Exempted individuals would include individuals with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals. No penalty would be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes, individuals whose household income did not exceed 100% of the federal poverty level (FPL), or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a QHP. Individuals whose required contribution for a calendar year exceeds 8% of household income would be exempt from the penalty. For tax years after 2014, the 8% would be adjusted to reflect the excess rate of premium growth and the rate of income growth for the period. Certain individuals who would otherwise be subject to the mandate, but are residing outside of the United States, as well as bona fide residents of any possession of the United States, would be considered to have minimum essential coverage and therefore not subject to the penalty. *§1501: IRC §5000A(d), (e) and (f) as amended by §10106(d)*
Congressional Findings	No provision.	Includes Congressional findings that address the constitutionality of an individual mandate to obtain health insurance. *§1501 as amended by §10106*

Table 5. Employer Mandate

Topics for Table 5	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 411, 412, 421, 423, 511 and 512	Sections 1502, 1511, 1512, and 1513
Laws amended	IRC, PHSA, ERISA	IRC, Fair Labor Standards Act
Effective date	January 1, 2013. *§421, §423, §511, §512*	January 1, 2014. *§1502, §1513*
Is there an employer mandate?	Yes, the bill would require certain employers either to offer individual and family coverage under a QHBP (or continue current employment-based plans) to their employees or to pay a set amount into an exchange, with some exceptions. Employers would include private-sector employers, churches, and federal, state, local and tribal governments. *§411, §412, §421, §423, § 511and §512*	No, but the bill would impose certain requirements and potential penalties on employers who do not offer coverage. All employers with more than 50 full-time employees (defined as employees working on average at least 30 hours per week and excluding seasonal workers) who did not provide coverage could be required to pay a penalty for certain employees, as well as employers who provide access to coverage, but fail to meet certain requirements. A special rule would apply to those employers whose substantial annual gross receipts were attributable to the construction industry. For these employers, instead of using the 50 full-time employee count for the employer requirement, employers who employed an average of at least 5 full-time employees on business days during the preceding calendar year and whose annual payroll expenses exceeded $250,000 for such preceding calendar year would be subject to the employer requirements. The same exclusions would apply for the seasonal workers of construction industry employers. *§1513 as amended by §10106(f)*
General penalty for not offering health insurance	Employers with aggregate wages over $750,000 that chose not to offer coverage would be subject to an excise tax equal to 8% of the average wages paid by the employer (exceptions discussed below). *§412 and §512*	A firm with more than 50 employees (or an applicable construction employer) that chose not to offer health insurance could be subject to a penalty if any of its full-time employees were enrolled in an exchange plan for which a premium credit is paid. In 2014, the penalty assessed to the employer would be equal to the number of full-time employees times 1/12 of $750, for any applicable month. After 2014, the applicable payment amount would be indexed. No penalty would be imposed for any month with respect to any employee who has a free choice voucher. *§1513 as amended by §10108*
Potential penalty or other action even if an employer offers some health insurance	Beginning in 2014, for employees who decline the employer's qualifying coverage, those employers with aggregate wages above $750,000 would be assessed 8% of average wages for the number of employees who decline and obtain exchange coverage, with adjustments for small employers as described below. The employer's excise tax for these individuals would go into the Exchange but would not apply toward their premiums.	An employer (either an applicable large or construction employer) that offers its employees coverage could be subject to penalties, if one or more of its full-time employees were enrolled in a QHP for which a premium credit is paid, for that employee. In 2014, the annual penalty assessed to the employer for each such employee would be $3,000 ($250 per month). However, the total annual penalty for an employer would be limited to the *total* number of the firm's full-time

Topics for Table 5	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	The Secretary, in coordination with the Commissioner, could terminate an employer's election to provide health insurance if the employer was in substantial non-compliance with the health coverage participation requirements. If an employer fails to satisfy the health coverage participation requirements for any employee, their would be a tax for each such failure of $100 per day, other than failures corrected within 30 days and non-intentional failures. Total annual penalty could not exceed the lesser of 10% of the amount the employer spent on health plans or $500,000. *§411, §421, §423, § 511and §512*	employees times $750 ($62.50 per month). The penalties would be calculated on a monthly basis, and the dollar amounts would be indexed after 2014. Thus, for example, an employer with 100 full-time employees of whom 30 received credits for the year would be subject to a penalty. For 2014, the penalty amount would be $3,000 for each of the 30 credit-receiving employees, or $90,000. However, because the limitation on an employer penalty is equal to the *total* number of full-time employees (100) multiplied by $750, which in this case is $75,000, the employer would pay only $75,000 (the lesser of $75,000 and the $90,000 calculated penalty). *§1513*
Exemptions or special rules for small employers	The required level of excise tax for smaller employers that chose not to offer coverage would depend on a firm's aggregate wages (AW) for the preceding calendar year: ● 0% if AW does not exceed $500,000 ● 2%, if AW exceeds $500,000 but does not exceed $585,000 ● 4% if AW exceeds $585,000 but does not exceed $670,000 ● 6% if AW exceeds $670,000 but does not exceed $750,000 ● 8%, if AW exceeds $750,000 *§411, §413, §512*	The requirements only apply to firms with more than 50 full-time employees (defined as employees working on average at least 30 hours per week and excluding seasonal workers). An employer would not be considered to employ more than 50 full-time employees if the workforce exceeds 50 for 120 days or less during the calendars year and the employees in excess of 50 during 120 day were seasonal. *§1513*
Requirements for employers offering health insurance	For employers offering health insurance, the following rules would apply: ● Employers could offer employment-based coverage or, for certain small businesses, they could offer coverage through an exchange. ● Current employment-based health plans grandfathered for 5 years, after which time any plan offered by an employer would have to meet (and could exceed) the requirements of the essential benefits package. ● Employers would have to contribute at least 72.5% of the lowest-cost QHBP or current employment-based plan they offered (65% for those electing family coverage), prorated for part-time employees. ● Salary reductions used to offset required employer contributions would not count as amounts paid by the employer. *§411, §412*	For employers offering health insurance, the following rules would apply: ● Large employers could offer full-time employees the opportunity to enroll in a group health plan. Small employers could offer full-time employees and their dependents coverage in a group plan or in an exchange plan. ● Current employment-based plans would be grandfathered. ● An employer would not be treated as meeting the employer requirements, if at least one full-time employee is enrolled in an exchange plan and is receiving a premium credit because the employee's required contribution exceeds 9.8% of the employee's household income. *§1513*

Topics for Table 5	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Auto-enrollment	Employers would automatically enroll their employees into the plan for individual coverage with the lowest associated employee premium, unless the employee selected a different plan or opted out of employer coverage. Employers would be required to provide written notice detailing the employee's rights and obligations relating to auto enrollment. *§412*	Firms with more than 200 full-time employees that offer coverage would automatically enroll new full-time employees in a plan (and continue enrollment of current employees). Automatic enrollment programs would be required to include adequate notice and the opportunity for an employee to opt out. *§1511*
Information requirements	Employers would be required to provide certain information to the IRS and to employees to show compliance with health participation requirements. *§412*	Employers would be required to file certain information to the IRS and to employees, regardless of whether or not they provided health insurance. Employers would also be required to provide notice to employees about the existence of the exchange, including a description of the services provided by the exchange. *§1502, §1512*
Waiting periods	No provision.	A fee of $600 (indexed after 2014) per full-time employee would be imposed on applicable large employers that required extended waiting periods (over 60 days) before employees could enroll in a minimum essential coverage under an employer-sponsored plan. *§1513 as replaced by §10106(e)*
Affiliated groups and other special employer groups	Under regulations prescribed by the Secretary (for certain employers who are part of a group of employers treated as a single employer under the IRC), separate elections to offer health insurance could be made with respect to (1) separate lines of business and (2) full-time employees and employees who are not full-time. *§421, §511*	No provision.
Free choice vouchers	No provision.	An employer who offers minimum essential coverage and pays any portion of the costs of such plan would provide free choice vouchers to each qualified employee. A qualified employee would be one whose required contribution to the employer plan is greater than 8% and less than 9.8% off the employee's household income for the taxable year, whose household income is not greater than 400% of the FPL for the relevant family size, and who does not participate in the plan offered by the employer. Beginning after 2014, the 8% and 9.8% would be indexed by the rate of premium growth. The amount of a voucher would be equal to the monthly portion of the cost of the employer plan which would have been paid by the employer if the employee were covered under the plan for which the employer pays the largest portion of plan costs, for either self or , if elected by the employee, family coverage. The cost of any health plan would be determined under rules similar to section 2204 of the PHSA (relating to premiums for continuation

Topics for Table 5	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		coverage), except that the amount would be adjusted for age and category of enrolment, as established through regulation by the Secretary. An exchange would credit the amount of a voucher to the monthly premium of a qualified health plan in which the qualified employee is enrolled, and the employer would pay the exchange the credited amount. If the amount of the voucher exceeded the premium, the excess would be paid to the employee. For employees, the amount of the voucher that did not exceed the premium would be excluded from gross income. For employers, the amount of the voucher would be treated as compensation for personal services actually rendered. The voucher would be taken into account in determining the premium credit. No penalty would be imposed on am employer with respect to any employee who was provided a voucher. *§1108(f): IRC §139D*

Table 6. Small Business Tax Credit

Topics for Table 6	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Location in bill	Section 521	Section 1421
Law amended	Creates new Section 45R in IRC	Creates new Section 45R in IRC
Effective Date	January 1, 2013. *§521*	January 1, 2010 (including carrybacks of credits). *As amended by §10105 and §1421(f)*
Maximum amount and duration of credit	50% credit toward the employer share of the cost of qualified employee health coverage, for no more than two taxable years. *§521(a): IRC §45R(a)and(b)*	35% credit (2010-2013) and 50% credit (beginning in 2014 for no more than two consecutive taxable years) of the lesser of (1) the employer premium contribution toward plans offered by the employer through an exchange, or (2) the contribution the employer would have made if each of those same employees had enrolled in a QHP with a premium equal to the average (determined by the Secretary) for the small group market in the rating area in which the employee enrolls for coverage. (For 2010-2013, "average" would be determined by the Secretary based on the average premium for the small group market in the state, or area in the state, in which the employer offers health insurance). *§1421(a): IRC §45R(b) and (g) as amended by §10105*
Employer eligibility	Certain small businesses with a tax liability. Small businesses with 10 or fewer full-time employees and with average taxable wages of $20,000 or less could claim the full credit amount. *§521(a): IRC §45R(a) and (b)*	Certain small businesses, not restricted to those with a tax liability would be eligible. Small employers would have to contribute at least 50% of the cost of premiums towards a qualified health plan. Small businesses with 10 or fewer full-time employees and with average taxable wages of $25,000 or less could claim the full credit amount. *§1421(a): IRC §45R(a) and (d) as amended by §10105*
Phase-out of credit	Phased out as average employee compensation increases from $20,000 to $40,000 and as number of employees increases from 10 to 25. Employees would be counted if they received at least $5,000 in compensation, but the credit could not apply toward insurance for employees whose compensation exceeds $80,000 (highly compensated employees). After 2013, adjustments for inflation would be applied to the average employee compensation and to the limit on highly compensated employees. *§521(a): IRC §45R(b),(c)and (*e)	Phased out as average employee compensation increases from $25,000 to $40,000 and as the number of full-time employees increases from 10 to 25. Full-time employees would be calculated by dividing the total hours worked by all employees during the tax year by 2,080 (with a maximum of 2,080 hours for any one employee). Seasonal workers would be exempt from this calculation. Average annual wages would be determined by dividing the aggregate amount of wages paid by the employer by the number of full-time-equivalent employees, for the taxable year.*§1421(a): IRC §45R(c) and (d) as amended by §10105*

Topics for Table 6	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Special rules, if any, for non-profits organizations	Non-profit organizations would be ineligible. *§521(b)*	Non-profit organizations would be eligible. Credit amount would be the lesser of (1) a 25% credit (2010–2013) and a 35% credit (beginning in 2014), or (2) the amount of employer-paid payroll taxes (including the Medicare contribution) for the relevant calendar year. *§1421(a): IRC §45R(f)and (g) as amended by §10105*
Special rules for self-employed individuals	Could be eligible. *§521(a): IRC §45R(f)*	Not eligible. *§1421(a): IRC §45R(e)*

Table 7. Health Insurance Exchanges

Topics for Table 7	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 241-244, 301-308	Sections 1311-1321
Law amended		
Earliest possible date of exchange establishment	January 1, 2013, when federal private health insurance market reforms, premium subsidies, and Medicaid expansions must be in effect. *§302(c)*	Within one year of enactment (or as soon as possible thereafter), Secretary must provide grant awards to states for establishing their exchange. Exchanges must be established in states by January 1, 2014, when federal private health insurance market reforms, premium subsidies, and Medicaid expansions must be in effect. *§1311*
Who has primary responsibility (or opportunity) to establish and operate exchanges	The Commissioner. *§241*	States, if they adopt the private market reforms. States already operating an exchange prior to 1/1/10 that insures a percentage of the population projected to be covered nationally by the bill would be presumed to meet the standards, unless the Secretary determines otherwise. *§1311, §1321(e)*
Who may also establish or operate an exchange	States, with Commissioner's approval. States already operating an exchange prior to 1/1/10 would be presumed to meet the standards, unless the Commissioner determines otherwise. *§308*	The Secretary, if state so chooses, or automatically by 1/1/2014 as a federal fallback. *§1321*
Startup funding for exchanges	Federal funds (in the case of a state-based exchange, federal funds via matching grants). *§§307, 308*	Federal funds, available until 1/1/2015. *§1311(a)*
Operating funding for exchanges	Federal funds (in the case of a state-based exchange, federal funds via matching grants). *§§307, 308*	Assessments or user fees on participating plans. Exchanges to be self-sustaining by 1/1/2015. *§1311(d)(5)*
Exchange functions	The following tasks are generally for the Commissioner (or usually states, when a state operates an exchange):	The exchange would be a government or nonprofit entity that would make qualified health plans (and stand-alone dental plans) available to qualified individuals and employers and that would do the following:

Topics for Table 7	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	● Certify, recertify, decertify plans as offering qualifying coverage. ● Accept bids and negotiate and enter into contracts with insurers (including denying "excessive premiums and premium increases"). ● Facilitate outreach to and enrollment of eligible individuals and employers (including establishing open enrollment period generally sometime during September to November). ● Provide information for comparing plan benefits and assist consumer with their choices regarding premiums and out-of-pocket cost-sharing. ● Establish a toll-free hotline and a website. ● Establish a risk-pooling mechanism. ● In coordination with state insurance regulators, establish oversight and enforcement of plans. ● Provide process to automatically enroll subsidy-eligible applicants in a plan if none is chosen. *§301(b), §§303-6*	● Certify, recertify, decertify plans as offering qualifying coverage, based on criteria set by the Secretary in regulation. ● Establish open enrollment periods based on criteria set by the Secretary. ● Provide standardized information for comparing plan benefits and plan ratings (based on criteria set by the Secretary). ● Establish and make available an online calculator for individuals to estimate their premium and cost-sharing subsidies, if any. ● Establish a toll-free hotline and a website. ● Certify exemptions from the individual mandate and transfer the list of such individuals to the Treasury Secretary (see also *§1401: IRC §36B(c)(2)(C)*). ● Publish average costs of licensing, regulatory fees, and any other payments required by the exchange (as well as administrative costs and monies lost to waste, fraud and abuse) on a website. ● Keep an accurate accounting of all activities, receipts and expenditures and annually submit a report to the Secretary. ● Establish and fund Navigators (i.e., entities that can conduct public education on qualified health plans, distribute information about enrollment and subsidies, facilitate enrollment in plans, provide referrals for certain enrollees—all in a culturally and linguistically appropriate manner to the needs of those served by exchanges), based on standards set by the Secretary. *§1311(c)(4), (c)(5), (d), (i), §1313(a)(1)*
Medicaid "screen and enroll" (i.e., individuals determined to be eligible for Medicaid must be enrolled in Medicaid)	The Commissioner "shall provide for the enrollment of the individual under the State Medicaid" program *if* the individual applies for a subsidy in the exchange but is determined to be eligible for Medicaid. *§305(e)*	Exchanges would inform individuals of eligibility requirements for Medicaid, the Children's Health Insurance Program (CHIP), or any other state or local health insurance program and "enroll such individuals in such program." *§1311(d)(4)(F)*
Authority to contract with other entities to perform exchange functions	In consultation with the Secretary, the Commissioner would enter into a memorandum of understanding with every state coordinating enrollment of individuals in exchange plans or Medicaid. *§305(e)(2)*	States could permit exchange to contract with an "eligible entity" to carry out exchange functions. An "eligible entity" would be a state Medicaid agency or an entity incorporated or subject to the laws of a state(s) with demonstrated experience in individual and small group

Topics for Table 7	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		health insurance markets and benefits, but not a health insurer or a member of the same controlled group of corporations as a health insurer. *§1311(f)(3)*
Additional or specific requirements of qualifying plans seeking to offer coverage through an exchange (beyond applicable requirements in **Table 1** and **Table 2**)	● Be licensed in the state. ● Provide for affordable premiums. ● Implement and coordinate with plans on premium and cost-sharing credits. ● Generally accept all enrollment. ● Participate in risk-pooling arrangement. ● Include essential community providers and culturally and linguistically appropriate services and communications. ● Implement special rules for Indian enrollees and health care providers. ● Implement program integrity standards established by the Commissioner. ● Offer adequate provider network. *§304(b)*	● Be licensed and in good standing to offer health insurance in the state. ● Justify any premium increase prior to its implementation, which the exchange could consider to determine whether it would be offered through the exchange. ● Generally accept all enrollment and not market or design benefits to discourage enrollment by those with significant health needs. ● Include essential community providers that served predominantly low-income medically underserved individuals. ● Offer adequate provider network. ● Report on, be accredited by, and participate in various quality initiatives. ● Beginning 1/1/2015, when contracting with a hospital with more than 50 beds, contract with only those using a patient safety evaluation system and a mechanism to ensure discharged patients receive patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional. When contracting with other providers, contract only with those implementing health care quality improvements required by the Secretary through regulation. The Secretary may adjust the number of hospital beds or establish other "reasonable exceptions" to these requirements. *§1301(a)(1), §1311(c)(1), §1311(e),(g),(h)*
Exchange-eligible individuals	State residents not offered coverage directly by an employer as a full-time employee, and not eligible for Medicare, Medicaid or, in 2013, CHIP. Once individuals qualify for and enroll in an exchange plan, they could continue enrollment in that plan—unless they became eligible for Medicare or Medicaid (in which case the	Lawfully residing state residents not eligible for Medicaid or CHIP, and who are not incarcerated (except individuals pending disposition of charges). *§1312(f)(1), §1311(d)(4)(F)*

Topics for Table 7	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Commissioner would have some transition flexibility), or other circumstances as the Commissioner may provide. *§302*	The only plans the federal government would make available to Members of Congress (i.e., any member of the House or Senate) or congressional staff (i.e., all full-time and part-time employees employed by the official office of a Member of Congress, whether in or outside of Washington, DC) would be health plans created by this legislation or offered through an exchange. *§1312(d)(3)(D)*
Exchange-eligible employers, for enrollment of employees in exchange plans	In 2013, up to 25 employees. In 2014, up to 50 employees. In 2015, up to 100 employees, though the Commissioner could permit even larger employers. Once employers qualify for and enroll employees in an exchange plans, the employer would continue to be considered exchange eligible—unless the employer offered direct coverage not through an exchange. Exchange-participating employers would have to make all employees eligible for exchange coverage. *§302*	Before 2016, state choose: up to 50 or up to 100 employees. In 2016, up to 100 employees. In 2017, states could allow large employers to obtain coverage through an exchange (but could not be required to do so). Exchange-participating employers would have to make all *full-time* employees eligible for exchange coverage. *§1312(f)(2), §1304*
Choice of plans for individuals in exchange through an employer	Employees could choose any plan in any benefit tier, though individual could be responsible for any additional premiums. *§302(e)(6)(B)*	Employees could choose any plan in the benefit tier (e.g., silver) specified by the employer. *§1312(a)(2)*
Required employer contribution for employers offering coverage through exchange	For full-time employees (prorated for part-time employees), 72½% for single coverage (65% for family coverage) of the "reference premium" (generally the three basic plans with the lowest premiums in the area). *§302(e)(6)(A)*	No provision.
Standardized benefit tiers for exchange plans	In an area, insurers must offer only one basic plan, which must meet essential benefits package (e.g., actuarial value of approximately 70%). Insurers then may offer one enhanced plan (i.e., actuarial value of approximately 85%), then may offer one premium plan (i.e., actuarial value of approximately 95%), then may offer one or more premium-plus plans, which also provide additional benefits, such as adult oral health and vision care. Cost-sharing levels would be specified by the Secretary for each benefit category, although plans would be permitted to vary the cost-sharing from the specified levels by up to 10%.	In an area, insurers must offer at least one silver plan (actuarial value of approximately 70%) and at least one gold plan (actuarial value of approximately 80%). Insurers then may offer bronze plans (actuarial value of approximately 60%) and platinum plans (actuarial value of approximately 90%). Dental-only would also be permitted, if the plan provides required pediatric dental benefits. Plans would determine their specific cost-sharing levels, subject to the requirements regarding actuarial value, essential benefits, etc.

Topics for Table 7	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	Benefits beyond the essential benefits package that states require insurers to include would continue to apply to exchange plans, if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any net increase in premium credits attributable to the benefit mandate.*§303*	*§1301(a)(1)(C)(ii), §1311(b)(2)(B)(ii)*
Payment of premiums	Individuals would submit premium payments directly to their insurer, not to the Commissioner or the exchange. *§305(b)(4)*	Individuals could submit premium payments directly to their insurer or to the exchange. *§1312(b)*
Other varying treatment of individuals vs. small businesses	No provision.	States could establish a separate exchange for qualifying small employers (a "SHOP" exchange), to which the Secretary would provide technical assistance to states to encourage small business participation. A state could create a single exchange if resources were adequate for both groups. *§1311(a)(5), (b)*
Permissible exchange geography besides state level	The Commissioner could permit multi-state exchanges. No more than one exchange could operate in any state. §308	The Secretary could permit multi-state exchanges. Multiple exchanges could operate in a state ("subsidiary exchanges") if each exchange served a distinct geographic area that was adequately large. *§1311(f)(1), (2)*
Treatment of plans in the nongroup and small-group markets *outside* the exchange	Except for grandfathered plans, beginning in 2013, new nongroup plans must be offered only through an exchange. *§202(c)(1)*	Plans offered in the exchange could also be offered outside the exchange if the exact same premium was charged. *§1301(a)(1), §1312(d)*
Treatment of health insurance agents and brokers	Exchange plans would be available for purchase from agents and brokers. *§100(c)(9), §305(g)*	A state could allow agents and brokers to enroll individuals in exchange plans and to assist individuals apply for premium and cost-sharing subsidies. *§1312(e)*
Oversight of exchanges	Inspector General for the Health Choices Administration. *§1647*	The Secretary. *§1313*

Table 8. Premium and Cost-Sharing Subsidies

Topics for Table 8	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 341-347	Sections 1401-1415
Law amended		IRC, for providing premium subsidies as tax credits.
First year premium and cost-sharing credits are available	2013	2014
Individuals' eligibility for premium and cost-sharing subsidies (For more detail on requirements and verification of citizenship or legal presence, see **Table 13**)	To qualify for premium and cost-sharing subsidies, individuals must: ● Be citizens or certain other lawfully present individuals, ● Be enrolled in an exchange basic plan (actuarial value of 70%) not through an employer, and ● Have income below 400% FPL. To qualify, individuals must not be *enrolled* in any of the following: ● Medicare, ● Medicaid, ● Coverage related to military service, ● An employer-sponsored plan, ● A grandfathered plan, or ● Other coverage recognized by the Commissioner. To qualify, individuals must not be *eligible* for the following: ● Employer-sponsored coverage for which the full-time employee would receive an adequate employer contribution, or ● Medicaid. Beginning in the second year of premium credits (2014), an exception for those full-time employees eligible for employer-sponsored coverage would exist if individuals' payment toward premiums would exceed 12% of their income. Beginning in 2015, individuals could receive premium subsidies for plans in tiers besides basic, but they would then have to pay any additional premiums and would also be ineligible for cost-sharing subsidies. *§342, §341(c)*	To qualify for premium and cost-sharing subsidies, individuals must: ● Be citizens or certain other lawfully present individuals who file tax returns, ● Be enrolled in an exchange silver plan (actuarial value of 70%) not through an employer, and ● Have income below 400% FPL. To qualify, individuals *must not be eligible* for any of the following: ● Medicare, ● Medicaid (or CHIP), ● Coverage related to military or Peace Corps service, ● An employer-sponsored plan, ● A grandfathered plan, or ● Other coverage recognized by the Secretary. Beginning in the first year of premium credits (2014), an exception for those employees eligible for employer-sponsored coverage would exist if individuals' payment toward premiums would exceed 9.8% of their income or if the plan pays for less than 60% of covered expenses. *§1401: IRC§36B*

Topics for Table 8	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Calculation of premium credit amount	Premium credits would be calculated to ensure that qualifying individuals pay no more than a certain percentage of their income toward the "reference premium" (average premium of the three lowest-cost basic exchange plans available in the area, potentially excluding plans with extremely limited enrollment). Individuals choosing a plan with a more expensive premium would be responsible for the difference. The bill specifies the maximum out-of-pocket premium as a percent of income as follows: ● Up to 133% FPL—1.5% of income, ● 150% FPL—3% of income, ● 200% FPL—5.5% of income, ● 250% FPL—8% of income, ● 300% FPL—10% of income, ● 350% FPL—11% of income, ● 400% FPL—12% of income. The Commissioner would establish the percentages on a linear scale between the points specified above. After 2013, the maximum-income percentages would be indexed to ensure the government's share of premiums paid does not increase. *§343.*	Premium credits would be calculated to ensure that qualifying individuals pay no more than a certain percentage of their income toward the second lowest cost silver exchange plans available in the area. Individuals choosing a plan with a more expensive premium would be responsible for the difference. The bill specifies the maximum out-of-pocket premium as a percent of income in a formula for those between 133%-300% FPL so that following amounts would result: ● Up to 133% FPL—2% of income, ● 133.01% FPL—4% of income, ● 150% FPL—4.6% of income, ● 200% FPL—6.3% of income, ● 250% FPL—8.1% of income, ● 300% FPL—9.8% of income, ● 350% FPL—9.8% of income, ● 400% FPL—9.8% of income. The exact percentage would be calculated as part of individuals' tax returns. After 2014, the maximum-income percentages would be indexed by how much premiums grew faster than incomes. *§1401: IRC§36B*
Payment of premium subsidies	By the exchange Commissioner directly to insurers on behalf of qualified individuals. *§341(a)(1)(2)*	Directly to individuals through advanceable, refundable tax credits. *§1401: IRC§36B*

Topics for Table 8	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Calculation of cost-sharing subsidies	Cost-sharing subsidies would be based on basic plans (actuarial value of 70%) reducing out-of-pocket maximums for cost-sharing (e.g., deductibles and copays) and increasing their actuarial values to specified levels for qualified individuals. The bill specifies out-of-pocket maximums for cost-sharing in 2013 for single coverage as follows: ● Up to 150% FPL—$500, ● 151% - 200% FPL—$1,000, ● 201% - 250% FPL—$2,000, ● 251% - 300% FPL—$4,000, ● 301% - 350% FPL—$4,500, ● 351% - 400% FPL—$5,000. Family coverage out-of-pocket maximums would be double these amounts. The bill specifies the actuarial values as follows: ● Up to 150% FPL—actuarial value of 97%, ● 151% - 200% FPL—actuarial value of 93%, ● 201% - 250% FPL—actuarial value of 85%, ● 251% - 300% FPL—actuarial value of 78%, ● 301% - 350% FPL—actuarial value of 72%, ● 351% - 400% FPL—actuarial value of 70%. The Commissioner would specify the cost-sharing for each income range that plans would have to implement to meet the criteria above. *§§343-344*	Cost-sharing subsidies would be based on silver plans (actuarial value of 70%) reducing out-of-pocket maximums for cost-sharing (e.g., deductibles and copays) and potentially increasing their actuarial values to specified levels for qualified individuals. The bill specifies out-of-pocket maximums for cost-sharing in 2014 based on the highest out-of-pocket maximum permitted for high-deductible health plans that qualify for Health Savings Accounts (HSAs). (For 2009, the out-of-pocket maximum for HSA-qualified HDHPs is $5,800 for single coverage and $11,600 for family coverage.) The cost-sharing subsidies would reduce those amounts for 2014 as follows: ● Up to 200% FPL—reduction of two-thirds, ● 201% - 300% FPL—reduction of one-half, ● 301% - 400% FPL—reduction of one-third. Additional cost-sharing subsidies, if necessary, would be provided to ensure the plan cost-sharing was as follows: ● Up to 150% FPL—actuarial value of 90%, and ● 151% - 200% FPL—actuarial value of 80%. If the HSA-related reductions caused the actuarial values to exceed the levels above, or for those between 201%-400% FPL to exceed 70%, then the out-of-pocket maximums would be raised accordingly. *§1402*
Payment of cost-sharing subsidies	By exchange Commissioner directly to insurers on behalf of qualified individuals. *§341(a)(1)(2), §344(d)*	By the Secretary directly to insurers on behalf of qualified individuals. *§1402(c)(3)*

Table 9. Public Health Insurance Option/Multi-State Qualified Health Plan

Topics for Table 9	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 321-331	Section *§10104: §1334(a)*
Law amended		
Who establishes the public option/ multi-state qualified health plan	The Secretary. *§321(a)*	The Director of the Office of Personnel Management (OPM). *As amended by §10104: §1334(a)*
Availability	The public option would only be available through an exchange. *§321(b)*	The Director would enter into contracts with health insurance issuers (which could include a group of issuers affiliated either by common ownership and control or by common use of a nationally licensed service mark) to offer at least 2 multi-state qualified health plans (MSQHPs) through each exchange in each state (without regard to statutes requiring competitive bidding). Such plans would provide individual, or in the case of small employers, group coverage. *As amended by §10104: §1334(a)*
Individual eligibility	Any individual eligible to purchase insurance through the exchange may enroll in the public option. Enrollment would be voluntary. In general, any employee, including a Member of Congress, could forgo employment-based health insurance and choose instead to enroll in health insurance through any Exchange plan, including both public and private plans. *§329, §330*	Any individual eligible to purchase insurance through the exchange could enroll in a MSQHP. Enrollment would be voluntary and individuals could be eligible for premium credits and cost-sharing assistance. *As amended by §10104: §1334(c)(2)*
Application of exchange rules	The public option would be required to meet the requirements that apply to all exchange plans, including those related to benefits, provider networks, consumer protection and cost-sharing. With respect to the offer of the public option through the exchange, the Secretary would be treated as the entity offering exchange-participating plans (QHBPs). *§321*	A health insurance issuer would be required to agree to offer a MSQHP that met the requirements in each exchange in each state; be licensed in each state and subject to all requirements of state law not inconsistent with this section (including the standards and requirements that a state imposes that do not prevent the application of a requirement of relating to health insurance coverage in the Public Health Service Act or a requirement of this title); comply with the minimum standards prescribed for carriers offering health benefits plans under FEHBP (if not in conflict with a provision of this title); and met other requirements as determined appropriate by the Director, in consultation with the Secretary. *As amended by §10104: §1334(b)*
Benefit levels	The public option would offer basic, enhanced, and premium plans, and may offer premium-plus plans. *§321(b)*	A MSQHP would meet the requirements of this subsection if, the Director determined that the plan offered a uniform benefits package in each state consisting of the essential benefits; the plan met all requirements of this title with respect to a qualified health plan, including requirements relating to the offering of the bronze, silver, and gold levels of coverage and catastrophic coverage in each state exchange; the plan met the rating requirements of this Act (except

Topics for Table 9	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		for certain state rating requirements); and the issuer offered the plan in all geographic regions, and in all states that adopted adjusted community rating before the date of enactment of this Act. *As amended by §10104: §1334(c)*
Establishment of Treasury Account	An account for receipts and disbursements for operation of the public option would be established in the U.S. Treasury. *§322(b)*	No provision.
Establishment of premiums	The Secretary would establish geographically adjusted premiums that comply with premium rules established by the Commissioner at levels sufficient to cover medical claims, administration, a contingency margin (see below), and repayment of start-up funds. *§322* The Secretary would collect data necessary to establish premiums, and other purposes. *§321(e)*	No provision.
Contingency margin	Premiums established before 2015 would be required to take into account a contingency margin of not less than 90 days of estimated claims. For premiums starting in 2015, the Secretary would solicit recommendations from the American Academy of Actuaries on the amount of a contingency fund. *§322(a)*	No provision.
Start-up funds	$2 billion would be appropriated to the Secretary for the establishment of the public option. An additional appropriation would be transferred to the fund to cover 90 days worth of claims based on estimated enrollment. The amounts would be repaid within 10 years. *§322(b)*	No provision.
Solvency provisions	The public option would be prohibited from receiving federal funds if it became insolvent. *§322(b)*	No provision.
Establishment of payment rates	The Secretary would be required to negotiate payments for providers, items, and services, including prescription drugs. Payment rates in aggregate would not be allowed to be lower than rates under Medicare, and not higher than average rates paid by other qualified health benefit offering entities. The Secretary would be required to implement payment and delivery system reforms under the public option that had been determined successful under other parts of this Act. *§323 and §324*	No provision.

Topics for Table 9	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Provider networks	Medicare-participating providers would be providers for the public option, unless they chose to opt out in a process established by the Secretary through a rule-making process that included a public notice and comment period. *§323(b)* Physicians who are licensed, certified, or otherwise permitted to practice under state law would be able to participate in the public option as preferred or non-preferred providers; preferred physicians would be prohibited from balance-billing (that is, billing for amounts above the established rates), while non-preferred physicians could balance-bill up to 115% of a reduced payment rate. Non-physician providers would be prohibited from balance-billing. *§325*	No provision.
Authority to contract	The Secretary would be allowed to enter no-risk contracts for the administration of the public option, in the same way the Secretary enters into contracts for the administration of Medicare. Functions would include, subject to restrictions: ● Determination of payment amounts. ● Making payments. ● Beneficiary education and assistance. ● Provider consultative services. ● Communication with providers. ● Provider education and technical assistance. *§321(c)*	Each contract for an MSQHP would be for at least 1 year, and could be automatically renewed if neither party provided notice to terminate. The Director would ensure that the benefits coverage was in accordance with the types of coverage provided under PHSA 2701(a)(1)(A)(i) – relating to fair health insurance premiums. At least one contract would be with a non-profit entity. The Director would implement this subsection similar to the way the Director implements the contracting provisions with respect to carriers under the Federal employees health benefit program (FEHBP) - through negotiating with each MSQHP on (1) medical loss ratio; (2) profit margin; (3) premiums to be charged; and (4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. The Director could prohibit the offering of any MSQHP that did not meet these terms and conditions. In entering into contracts under this subsection, the Director would ensure that there is at least one MSQHP that does not provide coverage of abortion services described in §1303(b)(1)(B)(i) of this Act. Approval of a contract could be withdrawn only after notice and an opportunity for a hearing to the issuer. *As amended by §10104: §1334(a)*
Ombudsman	The Secretary would create an office of the ombudsman, which would have duties similar to those of the Medicare Beneficiary Ombudsman. *§321(d)*	No provision.

Topics for Table 9	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Consumer protections	Enrollees would have access to federal courts for the enforcement of rights in the same manner that Medicare beneficiaries have with respect to the Medicare program. *§321(g)*	No provision.
Fraud and abuse	Provisions of civil law identified by the Secretary (in consultation with the Inspector General) that impose sanctions with respect to fraud, waste and abuse under Medicare would apply to the public option. *§326*	No provision.
HIPAA requirements and health information privacy and security	HIPAA's administrative simplification standards for electronic transactions, and health information privacy and security would apply to the public option. *§327, §328*	No provision.
Veterans Affairs	The Secretary would be required to enter into a memorandum of understanding with the Secretary of Veterans Affairs for the collection of costs associated with nonservice-connected care provided in VA facilities to public health insurance enrollees. *§331*	No provision.
Additional state required benefits	No provision.	States could require additional benefits, but there would be no additional premium tax credit provided for the state-only mandated benefits. The states would make payments to an individual enrolled in a multi-state plan or on behalf of such an individual to defray the cost of additional benefits. For states with age rating requirements that are lower than 3:1, the state could require the exchange to only permit MSQHPs that comply the state's more protective age rating requirements. *As amended by §10104: §1334(f)*
Certification	No provision.	A MSQHP offered under a contract would be deemed to be certified by an exchange. *As amended by §10104: §1334(d)*
Phase-In	No provision.	The Director would enter into a contract with a health insurance issuer if the issuer offered the plan in at least 60% of states in the first year, at least 70% in the second year, at least 85% in the third year, and in all states thereafter. *As amended by §10104: §1334(e)*
Other duties of the Director	No provision.	The requirements of the FEHBP program would only apply to MSQHPs to the extent that they were not in conflict with the requirements of this Act. *As amended by §10104: §1334(f)*

Topics for Table 9	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Applicability	No provision.	The Director could not reduce financial or personnel resources to the functions of OPM related to the administration of FEHBP. Enrollees in a MSQHP would be treated as a separate risk pool from FEHBP. The Director could establish separate units or offices within OPM, to ensure that the administration of MSQHPs did not interfere with the administration of FEHBP. The Director could appoint additional personal to carry out activities under this section. The Director would ensure that the program under this section is separate from FEHBP. FEHBP plans would not be required to offer a MSQHP. *As amended by §10104: §1334(g)*
Advisory committee	No provision.	The Director would establish an advisory board to provide recommendations. A significant percentage of the members of the board would be comprised of enrollees in a MSQHP or their representatives. *As amended by §10104: §1334(h)*
Authorization of Appropriations	No provision.	Such sums as necessary would be authorized to be appropriated to carry out this section. *As amended by §10104: §1334(i)*

Table 10.Consumer Operated and Oriented Plan (CO-OP) Program

Topics for Table 10	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Section 310	Section 1322
Law amended		None for the program administration. The tax provision amends section 501(c) of the IRC. *§1322(h)*
Effective date	Not later than 6 months after enactment. *§310(a)*	An Advisory Board formed not later than three months after enactment. *§1322(b)(3)*
Date when grant awards are made	Not later than 36 months after enactment. *§310(b)*	The Secretary would award not later than July 1, 2013. *§1322(b)(2)(D)*
Who has primary responsibility to establish and operate the CO-OPs	The Commissioner. *§310(a)*	The Secretary. *§1322(a)*
Specific limits on responsible authority	No provision.	The Secretary would not be permitted to: ● participate in any negotiations between qualified health insurance issuers and any health care providers or drug manufacturers; ● establish or maintain a price structure for any benefits; and ● interfere with the competitive nature of providing health benefits. *§1322(f)*
Advisors to program	Secretary of the Treasury. *§310(a)*	A 15-member Advisory Board appointed by the Comptroller General. *§1322(b)(3)(A)*
Appropriations	$5 billion. *§310(b)(7)*	$6 billion. *§1322(g)*
Use of loans and grants	Would provide loans for assistance in meeting start-up costs and grants to provide assistance in meeting solvency requirements of the States. *§310(b)(1)*	Would provide loans for assistance in meeting start-up costs and grants to provide assistance in meeting solvency requirements of the states. *§1322(b)*
Conditions for participation	A grant or loan would not be awarded unless the following conditions are met: ● The cooperative would be a not-for-profit, member organization with the membership being made up entirely of beneficiaries of the insurance coverage offered by the cooperative. ● The organization or a related entity could not have been operating on or before July 16, 2009. ● The cooperative's governing documents would incorporate ethics and conflict of interest standard protecting against insurance industry involvement and interference.	A grant or loan would not be awarded unless the following conditions are met to be a qualified health insurance issuer: ● The cooperative would be a nonprofit, member organization under state law. ● The organization or a related entity could not have been operating on or before July 16, 2009. ● The cooperative's governing documents would incorporate ethics and conflict of interest standard protecting against insurance industry involvement and interference.

Topics for Table 10	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	● The cooperative would not be sponsored by a State government. ● Substantially all the activities of the cooperative would consist of the issuance of qualified health plans through an exchange. ● The cooperative would be licensed to offer insurance in each state it is offering a plan. ● A majority vote of its members would govern the cooperative. ● The cooperative would operate with a strong consumer focus, including timeliness, responsiveness, and accountability to its members. ● Any profits made would be used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to its members. *§310(b)(2)(A)-(I)*	● The organization would not be sponsored by a state or local government or any political subdivision of either. ● The substantially all of the activities of the organization would consist of the issuance of qualified health plans in the individual and small group markets. ● The cooperative would meet all of the requirements that other issuers of qualified health plans are required to meet in any state, including solvency and licensure requirements, rules on payments to providers, network adequacy rules, rate and form filing rules, and any applicable state premium assessments. ● A majority vote of its members would govern the cooperative. ● The cooperative would operate with a strong consumer focus, including timeliness, responsiveness, and accountability to its members. ● Any profits made would be used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to its members. ● The cooperative would coordinate with the implementation of state insurance reforms required by this bill. *§1322(c)(1)-(6)*
Priorities in making grants and loans	The Commissioner would give priority to cooperatives that: ● operate on a statewide basis; ● use an integrated delivery system; and ● have a significant level of financial support from nongovernmental sources. *§310(b)(3)*	In the context of ensuring there would be sufficient funding to establish at least one CO-OP insurance issuer in each State, and taking into account the recommendations of the Advisory Board, the Secretary would give priority to cooperatives that: ● operate on a statewide basis; ● use an integrated delivery system; and ● have a significant level of financial support from nongovernmental sources. *§1322(b)(2)(a)*
Interaction with exchanges	CO-OP grants would specifically be for qualified cooperatives provided through an exchange. *§310(a), (b)(2)(E)*	CO-OP grantees would be required to be qualified health plans, which are required to be part of an exchange, but may also be offered outside of the exchange. *§1322(b), (c)*
Tax exemptions	Would require a CO-OP grantees to be not-for-profit, but does not create a new tax exemption or amend tax code. *§310(a), (b)(2)*	Would amend the Internal Revenue Code on 1986 to establish a new category in the list of exemptions under Section 501(c). Would require compliance with program requirements as a condition of the tax exemption. *§1322(h): IRC § 501(c)(29)*
Restrictions on use of funds	No provision.	CO-OP grantees would be restricted from using grant and loans for attempting to influence legislation or for marketing. *§1322(b)(2)(c)*
Collaboration with other cooperatives	Nothing in this section would be construed to prevent a cooperative in one state from integrating with a cooperative established in another state(s) for the administration, issuance of	CO-OP participants would be permitted to establish a private purchasing council for collective purchasing arrangements for items and services that increase administrative and other cost efficiencies

Topics for Table 10	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	coverage or other activities related to acting as a QHBP. Nothing in this section would be construed as preventing a state from taking actions to permit such integration. *§310(b)(4)*	including claims administration, health information technology, and actuarial services. This council could not set payment rates to providers and would not preempt applicable antitrust law. *§1322(d)*
Amortization of grants and loans	The Secretary would provide for the repayment of grants or loans to the Treasury in an amortized manner over a 10-year period. *§310(b)(5)*	Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary would promulgate regulations with respect to the repayment of loans and grants in a manner that is consistent with state solvency regulations and other similar state laws that may apply. In promulgating such regulations, the Secretary would provide that such loans would be repaid within 5 years and such grants would be repaid within 15 years, taking into consideration any appropriate state reserve requirements, solvency regulations, and requisite surplus note arrangements that must be constructed in a state to provide for such repayment prior to awarding such loans and grants. *§1322(b) as amended by §10104*
Repayment for violations of terms of the program	If a cooperative violated the terms of the CO-OP program and fails to correct the violation within a reasonable period of time, as determined by the Commissioner, the cooperative would be required to replay the total amount of any loan or grant received plus interest at a rate that would be determined by the Secretary. *§310(b)(6)*	If the Secretary determines that a cooperative has failed to meet any of the requirements and has failed to correct such failure within a reasonable period of time then the cooperative would be required to repay to the Secretary an amount equal to the sum of 110% of the aggregate amount of loans and grants received plus interest on the aggregate amount of loans and grants received. The Secretary would also notify the Secretary of the Treasury of any determination of a failure that results in the termination of an issuer's tax-exempt status. *§1322(c)(iii)*

Table 11. Selected Revenue Provisions

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in the bill		Sections 531-534, 551-555	Sections 9001-9017 and Sec. 10901-10906
Law amended		IRC	IRC
Surcharge on high income individuals	Current federal tax rates increase with income. The marginal tax rates vary from 10% of taxable income for very low income taxpayers to 35% for high-income taxpayers. Among higher income taxpayers in 2009: Married filers with adjusted gross income over $372,950 pay $100,894.50 plus 35% of the excess over $372,950 in federal taxes. Single filers with adjusted gross income over $372,950 pay $108,216 plus 35% of the excess over $372,950 In addition to federal tax rates, both employees and employers each pay a payroll tax of 7.65%. Of which 6.2% is for Old Age Survivors and Disability Insurance and 1.45% to for Hospital Insurance to finance Medicare Part A.	The bill would impose a tax equal to 5.4% on modified adjusted gross income (AGI) that exceeds $500,000 for single filers and $1 million for joint filers. Effective date: Date of enactment of this Act. *§551* Raises $460.5 billion over 10 years.	The Senate bill would impose an additional payroll tax of 0.9 percentage points on high-income workers with wages over $200,000 for single filers and $250,000 for joint filers Since employers will not know the wages of a spouse, they are directed to collect these revenues from all workers with wages exceeding $200,000. Excess withholding among joint filers would be reconciled on tax returns. The 0.9 percentage point tax would also be levied on payroll for self-employed if their incomes exceed the specified thresholds. The self-employed would not be allowed to deduct this additional tax as a business expense. Effective for taxable years after December 31, 2012. *§9015 as amended by §10906* Raises $86.8 billion in revenues over 10 years.
	Excise Taxes		
Excise tax on high-cost plans		No provision.	The bill would impose an excise tax of 40% on health insurers and health plan administrators for coverage that exceeds certain thresholds ($8,500 single coverage and $23,000 for family coverage in 2013). Effective January 1, 2013. Thresholds indexed by growth in the Consumer Price Index (CPI) plus 1% in subsequent years. Health insurance coverage subject to the excise tax is broadly defined to include not only the employer and employee premium

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
			payments for health insurance (including self-insured plans), but also premiums paid by the employee and the employer for dental and vision. In addition, tax-advantaged accounts such as flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement accounts (HRAs) are also specified as health insurance coverage and subject to the excise tax. Alternative Thresholds: Retired taxpayers (ages 55 to 64) and those working in high-risk professions (including longshore workers) are subject to higher thresholds ($9,850 for single coverage and $26,000 for family coverage). For individuals residing in high-cost states the thresholds would be phased in between 2013 and 2016 starting from 20% higher initially and 5% higher by 2015. §9001 Raises $148.9 billion over 10 years.

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Annual fee on health insurers		No provision.	An annual fee would be imposed on all health insurers based on their market share. The fee would be applied to net premiums written. The annual fee allocated across health insurers would be $2 billion in 2011, $4 billion in 2012, $7 billion in 2013, $9 billion in 2014-1016 and $10 billion thereafter. The fee would not apply to self-insured plans, federal, state or government entities or non-profit insurers. It does apply to companies or organizations that underwrite government-funded insurance (i.e., Medicaid managed care plans, Federal Employees Health Benefits Program [FEHBP]). The effective date is January 1, 2011. *§9010 as amended by §10905* Raises $59.6 billion over 10 years.
Limit on executive pay of health insurance providers		No provision.	Covered health insurance providers would not be able to deduct compensation above $500,000 per year. This income threshold would include deferred compensation. This provision would be effective for compensation paid in taxable years beginning after 2012 with respect to services performed after 2009. *§9014* Raises $0.6 billion in revenues over 10 years.

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Annual fee on branded prescription pharmaceutical manufacturers and importers		No provision.	An annual fee would be imposed on certain manufacturers and importers of branded prescription drugs (including biological products and excluding orphan drugs). The total fee would be $2.3 billion a year and imposed on each entity based on their annual sales. *§9008* Raises $22.2 billion in revenues over 10 years.
Annual fee on medical device manufacturers		A tax of 2.5% of a price determined as specified would be imposed on the first taxable sale (including certain leases and uses) of a medical device. The tax would not apply to devices sold to (or of the type and quantity typically sold to) consumers by retail establishments. *§552* Raises $20.0 billion over 10 years.	An annual fee would be imposed on certain manufacturers and importers of medical devices (that generally cost more than $100 and are subject to more stringent safety and effectiveness controls by the Food and Drug Administration). The total fee would be $2 billion from 2011 to 2017 and $3 billion thereafter. The fee would be levied on device manufacturers based on their annual sales. For sales of not more than $5 million, no tax would be levied. For sales of more than $5 million and less than $25 million, 50% of sales would be subject to the excise tax. For sales of more than $25 billion, 100% would be subject to the excise tax. *§9009 as amended by §10904* Raises $19.3 billion over 10 years.
Excise tax on elective cosmetic medical procedures		No provision.	Imposes a 5% tax on cosmetic surgery to be paid by the individual on whom procedure is performed. Effective for procedures performed on or after January 1, 2010. §9017 Raises $5.8 billion over 10 years.
Modifications to Tax-Advantaged Accounts and Itemized Deductions for Health Care			

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Limitation on health flexible spending accounts (FSAs)	Health FSAs are employer-established benefit plans that reimburse employees on a pre-tax basis for specified health care expenses (e.g. deductibles, co-payments, and non-covered expenses). Under current law, it is at the discretion of each employer to set limits on FSA contributions.	H.R. 3962 would limit the amount of annual FSA contributions to $2,500 per person effective January 1, 2013. This threshold would be indexed to inflation in subsequent years. *§532* Raises $13.3 billion over 10 years.	Same as H.R. 3962, except for effective date which would be January 1, 2011. *§9005 as amended by §10902* Raises $13.3 billion over 10 years.
Raise penalty for non-qualified HSA distributions	HSAs are also tax-advantaged accounts that allow individuals to fund unreimbursed medical expenses on a pre-tax basis. Eligible individuals establish and fund accounts when they have a qualifying high deductible health plan and no other health plan (with some exceptions). Unlike FSAs, HSAs may be rolled over and the funds accumulated over time. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. Those not used for qualified medical expenses are taxable as ordinary income and are subject to an additional 10% penalty tax for individuals under age 65.	H.R. 3962 would increase the penalty on non-qualified distributions from 10% to 20% of the disbursed amount for individuals under age 65. Effective date: January 1, 2011. *§533* Raises $1.3 billion over 10 years	Same provision. *§9004*
Modify definition of medical expenses for FSAs, HSAs, and HRAs.	Under current law, qualified medical expenses for FSAs, HSAs, and HRAs can include over-the-counter medications.	H.R. 3962 would not allow over-the counter prescriptions to be covered by these tax-advantaged accounts unless they are prescribed by a physician. Effective date: January 1, 2011. *§531* Raises $5.0 billion over 10 years.	Same provision. *§9003*

Topics for Table 11	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Eliminate deductions for retiree expenses allocable to Medicare Part D subsidy	Under current law, employers providing prescription drug coverage to retirees that meet federal standards are eligible for subsidy payments from the federal government. These qualified retiree prescription drug plan subsidies are excludible from the employer's gross income for the purposes of regular income tax and alternative minimum tax calculations. The employer is also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses.	Employers would be required to coordinate the subsidy and the deduction for retiree prescription drug coverage. In this provision, the amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received. Effective date: January 1, 2013. *§534* Raises $2.2 billion over 10 years.	Same provision, except different effective date: January 1, 2011. *§9012* Raises $5.4 billion over 10 years.
Raise threshold for itemized medical expenses	Taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI). Medical expenses include health insurance premiums paid by the taxpayer, but also can include certain transportation and lodging expenses related to medical care as well as qualified long-term care costs, as well as long-term care premiums that do not exceed a certain amount.	No provision.	Would increase the threshold from 7.5% to 10% of AGI for taxpayers who are under age 65. Effective date: January 1, 2013. Taxpayers over age 65 would be temporarily excluded from this provision and still be subject to the 7.5% limit for the time period 2013 and 2016. *§9013* Raises $15.2 billion over 10 years.

Note: Revenue estimates are from the Joint Committee on Taxation JCX-53-09 and JCX-61-09.

Table 12. Abortion

Topics for Table 12	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 222(e), 258, 259, 265, 304(d)	Section 1303
Law amended		
Coverage of abortion services by qualified health plans	The issuer of a qualified health benefits plan would determine whether the plan provides coverage for either elective abortions or abortions for which the expenditure of federal funds appropriated for HHS is permitted. However, if a plan includes coverage for elective abortions, the entity that offers the plan must offer another plan that is identical in every respect, except that it does not cover elective abortions. *§222(e)(2), 265(c)(3)*	A state could elect to prohibit abortion coverage in Exchange plans if the state enacts a law that provides for such a prohibition. The issuer of a qualified health plan would determine whether or not the plan provides coverage for elective abortions, as well as abortions for which the expenditure of federal funds appropriated for HHS is permitted. *§1303(a), (b)(1)*
Coverage of abortion services by the public option	The Secretary would determine whether the public option provides coverage for either elective abortions or abortions for which the expenditure of federal funds appropriated for HHS is permitted. *§222(e)(2)*	No provision.
Use of federal funds for abortion services	Would prohibit federal funds from paying for an abortion or covering any part of the costs of any health plan that includes coverage of abortion, except in cases where a pregnancy is the result of an act of rape or incest, or where a woman's life would be endangered if an abortion were not performed. An affordability credit could not be used to purchase coverage under a health benefits plan or to purchase separate supplemental coverage for elective abortions. *§265(a), (b)*	The issuer of a qualified health plan that provides coverage for elective abortions could not use any amount attributable to a premium assistance credit or cost-sharing reduction to pay for such abortions. *§1303(b)(2)(A)*

Topics for Table 12	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Segregation of funds	No provision.	The issuer of a qualified health plan that provides coverage for elective abortions would be required to collect two separate payments from each enrollee in the plan: one payment that reflects an amount equal to the portion of the premium for coverage of services other than elective abortions; and another payment that reflects an amount equal to the actuarial value of the coverage of elective abortions. The plan issuer would be required to deposit the separate payments into separate allocation accounts that consist solely of each type of payment and that are used exclusively to pay for the specified services. State health insurance commissioners would ensure compliance with the segregation requirements in accordance with applicable provisions of generally accepted accounting requirements, OMB circulars on funds management, and GAO guidance on accounting. To determine the actuarial value of the coverage for elective abortions, the plan issuer would estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including such coverage. The estimate may take into account the impact on overall costs of including coverage for elective abortions, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care. The per month cost must be estimated as if coverage were included for the entire population covered and may not be less than $1 per enrollee, per month. *§1303(b)(2)*
Notice to enrollees	No provision.	A qualified health plan that provides coverage for elective abortions would be required to provide notice of such coverage to enrollees as part of the summary of benefits and coverage explanation at the time of enrollment. The notice, any plan advertising used by the issuer, any information provided by the Exchange, and any other information specified by the Secretary would provide information only with respect to the total amount of the combined payments for elective abortion services and other services covered by the plan. *§1303(b)(3)*
Provider conscience protections	Would prohibit a federal agency or program, and any state or local government that receives federal financial assistance under H.R. 3962 from: ● subjecting any individual or institutional health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions; or ● requiring any health plan created or regulated under H.R. 3962 (or any amendment made by the bill) to subject any individual or	Would prohibit qualified health plans offered through an Exchange from discriminating against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions. *§1303(b)(4)*

Topics for Table 12	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	institutional health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. *§259*	
Preemption of state and federal laws regarding abortion	State laws regarding the prohibition or requirement of coverage or funding for abortions, and state laws involving abortion-related procedural requirements would not be preempted. Federal conscience protection and abortion-related antidiscrimination laws, as well as Title VII of the Civil Rights Act of 1964, would also not be affected by H.R. 3962. *§258*	Same as H.R. 3962. *§1303(c)*

Table 13. Verification of Immigration Status and Treatment of Noncitizens for Exchange Coverage and Subsidies

Topics for Table 13	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Primary location in bill	Sections 341, 347, 501	Sections 1312, 1401, 1411, 1412
Law amended	IRC, regarding the individual mandate	IRC, regarding the individual mandate
Individual mandate to obtain health coverage	All citizens and noncitizens who meet the IRC definition of resident alien would be subject to the individual mandate. Nonresident aliens would be exempt. *§501: IRC§59B(c)(2)*	All citizens, nationals and individuals who are lawfully present would be subject to the individual mandate. *§1501(b): IRC§5000A(d)(3)*
Access to health exchange	There is no express restrictions on noncitzens—whether legally or illegally present, or in the United States temporarily or permanently—accessing and paying for coverage available through the health insurance exchange.	Exchange eligibility would be limited to individuals who are a citizen or national of the United States or are lawfully present in the United States. As a result, unauthorized aliens would be barred from the health insurance exchange. *§1312(f)(3)*
Eligibility for premium and cost-sharing subsidies	Those eligible would be "an individual who is lawfully present in a State in the United States (other than as a nonimmigrant described in a subparagraph (excluding subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act)." The only nonimmigrants who would be eligible to obtain subsidies would be those trafficking victims, crime victims, fiancées of U.S. citizens, and certain V visaholders who have had applications for LPR status pending for three years. *§341(b)(4)* Unauthorized aliens would not be eligible for the premium and cost-sharing subsidies: "Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States." *§347*	Lawfully present aliens who meet the income requirements but are barred from Medicaid because of alienage would be eligible for the premium and cost-sharing subsidies. *§1401(a)* Unauthorized aliens would not be eligible for the premium and cost-sharing subsidies. *§1412(d)*
Verification of status	With modifications, the citizenship verification procedures as well as the noncitizen verification procedures of §1137(d) of the SSA that currently apply to Medicaid and other federal means-tested programs would apply to the citizenship and immigration determination for the proposed premium and cost-sharing subsidies. *§341*	The Social Security Administration would verify the name, social security number, and date of birth of the individual. For those claiming to be U.S. citizens, the claim will be considered substantiated if the claim of citizenship is consistent with SSA data. For individuals who do not claim to be U.S. citizens but claim to be lawfully present in the United States, the claim will be considered substantiated if the claim of lawful presence is consistent with Department of Homeland Security (DHS) data. It would rely on that procedures currently used by Medicaid (i.e., §1902(e) of the SSA) for individuals whose claims of citizenship or immigration status are not verified with federal data. *§1411*

Table 14. Other Provisions

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Reporting requirements/ promulgation of regulations regarding coverage of prevention and wellness activities		No provision.	The Secretary would be required to develop reporting requirements for group health plans and health insurance issuers with respect to plan or coverage benefits and health care provider reimbursement structures that, among other things, implement "wellness and health promotion activities." Health plans and insurance issuers would be required to annually submit to the Secretary and enrollees a report on whether the benefits under the plan or coverage satisfy these and other elements. This section also would require the Secretary to promulgate regulations providing criteria for determining whether a reimbursement structure meets these elements. Under this section, wellness and health promotion activities could include personalized wellness and prevention services "that are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants...." These activities could include wellness and prevention efforts such as smoking cessation, weight management, nutrition, and healthy lifestyle support. This section also contains provisions relating to gun rights. Among these provisions, a wellness or health promotion activity (as referenced above) could not require disclosure or collection of any information relating to (A) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
			property of an individual; or (B) the lawful use, possession, or storage of a firearm or ammunition by an individual. *§1001 as amended by section 10101(e) (creating Sec. 2717 of the PHSA)*
Incentives in employer-provided wellness programs	Among the federal laws that apply to wellness programs, HIPAA clarifies that group health plans and health insurance issuers offering group health coverage may establish premium discounts or rebates or modify otherwise applicable copayments or deductibles (i.e., rewards) in return for adherence to these programs. HIPAA regulations provide a framework for structuring these wellness programs and divide wellness programs into two categories. First, if a wellness program provides a reward based solely on participation in a wellness program, or if it does not provide a reward, the program complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. Second, if a reward is based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements. Among these additional requirements, a reward offered by this type of wellness program must not exceed 20% of the cost of employee coverage under the plan (i.e., the amount paid by the employer and the employee for that employee for coverage).	No provision.	Section 1201 (creating sec. 2705 of the PHSA) would amend section 2702 of the PHSA to largely codify an amended version of the HIPAA wellness program regulations. Wellness programs that do not require an individual to satisfy a standard related to a health factor as a condition for obtaining a reward (or do not offer a reward) would not violate HIPAA, so long as participation in the programs is made available to all similarly situated individuals. Wellness programs with conditions for obtaining a reward that are based on an individual meeting a certain standard relating to a health factor, would have to meet additional requirements. Among these requirements, the reward must be capped at 30% of the cost of the employee-only coverage under the plan (instead of 20% under the current regulations), but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50%. The HHS Secretary, in consultation with the Secretaries of the Treasury and Labor, would establish a 10-state pilot program in which participating states would be required to apply the wellness program provisions to health insurers in the individual market. *§1201, §1562 as amended by §10107 (applying the provisions of §1201 to group health plans and health insurance issuers under ERISA and the IRC)*
Wellness program grants to		The Secretaries of HHS and Labor would	The Secretary of HHS would be required

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
employers		be required to establish a grant program to help small employers (to be defined) cover 50% of the costs of providing employee wellness programs. Allowable costs would be those attributable to the wellness program (excluding the cost of food), and not to the health plan or health insurance coverage offered in connection with such a plan. Grants for a given plan year would be capped at $150 per employee. Grants could be provided for up to three years and would be capped at $50,000, in total, for an employer. A qualified wellness program would be jointly certified by the Secretaries of HHS and Labor as meeting several criteria, including (1) being consistent with current evidence-based research and best practices; (2) being culturally appropriate, and accessible for individuals with disabilities and with limited English proficiency, among others; (3) having a number of required components, including health awareness, health education, periodic screenings, employee engagement, and listed behavioral change activities (including smoking cessation and weight reduction); and (4) having supportive work policies regarding tobacco use, food choices, stress management, and physical activity. A program could not be certified unless each required program component were available to all employees. Employee participation could not be mandated. Qualified programs could provide incentives for participation provided such incentives are not tied to the premium or cost-sharing of the individual under the health benefits plan. Any employee health information collected through the wellness program would be confidential and could not be used for purposes other than	to award grants to eligible employers to provide their employees with access to comprehensive workplace wellness programs. The grant program would be conducted for a 5-year period. Eligible employers would be defined as those that employ fewer than 100 employees who work 25 or more hours per week, and that do not provide a workplace wellness program as of the date of enactment. To receive a grant, such employers would be required to submit an appropriate application to the Secretary. The Secretary would be required to develop program criteria consistent with evidence-based research and best practices, considering the Guide to Community Preventive Service and the National Registry for Effective Programs. Wellness programs would have to be made available to all employees and include several specified components, including education, efforts to encourage participation, initiatives to change unhealthy behaviors, and supportive work environments. There would be authorized to be appropriated $200 million in total, to be available until expended, for FY2011 through FY2015. *§10408*

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		administration of the program. There would be authorized to be appropriated SSAN to carry out this section. *§112*	
Wellness program technical assistance, surveys, and evaluations		No provision.	Section 4303 would require the CDC Director to provide employers with technical assistance and other resources to evaluate workplace wellness programs, including measuring employee participation; developing standardized measures of factors that have a positive effect on health behaviors, outcomes, and expenditures; and evaluating the effect of programs on health outcomes, absenteeism, productivity, workplace injury rates, and medical costs. The Director also would be required to build evaluation capacity among workplace staff and provide resources, technical assistance, and consultation. The CDC Director would be required to conduct a national survey of employer-based health policies and programs, and to report to Congress on findings and recommendations for the implementation of effective policies and programs. In addition, the Secretary of HHS would be required to evaluate all programs funded through the CDC before conducting such an evaluation of privately funded programs, unless an entity with a privately funded wellness program requests such an evaluation. Finally, recommendations, data, or assessments carried out under this part could not be used to mandate requirements for workplace wellness programs. *§4303, as amended by §10404*

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Multiple employer welfare arrangements (MEWAs)	ERISA defines a MEWA as an employee welfare benefit plan or other arrangement that is established and maintained to provide specified benefits, including health insurance coverage, to the employees of two or more employers. According to the Department of Labor, although MEWAs can be provided through legitimate organizations, they are sometimes marketed using attractive but actuarially unsound premium structures that generate large administrative fees for the promoters. In 1983, following discovery of certain abuses and mismanagement of MEWA funds, Congress passed a special exception to ERISA preemption that allows states to regulate MEWAs under state insurance laws, subject to certain limitations. However, the Department of Labor has indicated that it continues to find instances of fraud and abuse with regard to MEWAs.	No provision.	Persons (in connection with MEWAs) would be prohibited from knowingly making false statements or representations in connection with the marketing or sale of the plan. MEWAs would be required to register with the Secretary of Labor before operating in a state. The Secretary would have the authority to adopt regulatory standards or issue orders that a person engaged in the business of providing insurance through a MEWA is subject to the laws of the state in which such person operates. The Secretary would be authorized to issue cease and desist orders against certain MEWAs if it appears that the alleged conduct of the MEWA is fraudulent, creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. *§§6601-6607: ERISA*
Medical malpractice	Medical malpractice liability reform has often been considered by Congress; however, it is the states that regulate or have implemented tort reform for medical malpractice lawsuits. Where states have enacted tort reform, provisions vary regarding statutes of limitation and caps on non-economic damages or punitive damages. Typical tort reform provisions also include modifying common law tort doctrines such as joint and several liability, contributory and comparative negligence, periodic payments, and the collateral source rule.	Would authorize the Secretary of Health and Human Services to make incentive payments to states that enact and implement effective alternative medical liability laws. The content of such a law would be one that includes provisions for either, or both, a certificate of merit or early offer program, and that does not limit attorneys' fees or impose caps on damages. In determining the effectiveness of such a law, the Secretary must consider whether it (1) makes the medical liability system more reliable through the prevention of, or prompt resolution of, disputes; (2) encourages the disclosure of health care errors; and (3) maintains access to affordable liability insurance.	Includes a "Sense of the Senate" with respect to medical malpractice. It expresses that the Senate believes: • health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance; • states should be encouraged to develop and test litigation alternatives while preserving an individual's right to seek redress in court; and • Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
		Nothing in the section would preempt or modify existing state laws that limit attorneys' fees or cap damage awards; nor would the provision impair a state's authority to establish such laws, or restrict the eligibility of a state for an incentive payment on the basis of such laws provided they are not established or implemented as part of an alternative medical liability law that meets the requirements described above. The Secretary would be required to submit to Congress an annual report on the progress states are making in enacting and implementing alternative medical liability laws and the effectiveness of such laws. The section would authorize to be appropriated such sums as necessary for the incentive payments, which would be used to improve health care in the state. *§2531*	medical malpractice claims. *§6801* Would authorize the Secretary of Health and Human Services to award demonstration grants to states for the development, implementation, and evaluation of alternatives to current tort litigation. A state desiring a grant would be required to develop an alternative that (A) allows for the resolution of disputes caused by health care providers or organizations, and (B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data. The Secretary is to provide technical assistance to the states including guidance on common definitions, non-economic damages, avoidable injuries, and disclosure to patients of health care errors and adverse events. The Secretary is to consult with a review panel composed of relevant experts appointed by the Comptroller General when reviewing applications. Each state receiving a grant is to submit a report to the Secretary covering the impact of the activities funded on patient safety and on the availability and price of medical liability insurance. The Secretary is similarly required to report to Congress. The provision would not limit any prior, current, or future efforts of any state to establish any alternative to tort litigation. It would appropriate $50,000,000 for 5 years beginning FY2011 to carry out this section. *§ 10607*.

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Medical Malpractice and Free Clinics	Under the Public Health Services Act, health professionals, officers, governing board members, or employees of a federally qualified health center are deemed employees of the Public Health Service. Thus, such individuals or entities cannot be sued for medical malpractice that was committed within the scope of employment. Any medical malpractice claim that, in the absence of this provision, could be brought against such an entity or individual may instead be brought against the United States. For the same purposes, health professionals who volunteer at free clinics and provide qualifying health services are deemed to be federal employees of the Public Health Service. However, board members, officers or other employees of free clinics are not extended the same liability protection.	No provision.	Would extend federal employee status to officers, governing board members, employees, or contractors of free clinics. *§ 10608*
End-of-life planning		QHBPs would be required to provide for the dissemination of information related to end-of-life planning to individuals who seek enrollment in Exchange-participating plans. QHBPs would also be required to present individuals with the option to establish advance directives and physician's orders for life sustaining treatment, according to state laws, as well as present information related to other planning tools. QHBPs would be prohibited from promoting suicide, assisted suicide, or the active hastening of death. *§240*	No provision.

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
Assisted suicide		No provision.	The federal government, any state or local government, or health care provider that receives federal financial assistance under this Act or any health plan created under this Act would be prohibited from subjecting an individual or institutional health care entity to discrimination based on not providing a health care item or service for the purpose of causing, or assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing. The HHS Office for Civil Rights would be designated to receive complaints of discrimination based on this section. *§1553*
Standards for electronic billing and other administrative transactions	To promote the growth of electronic record keeping and claims processing, HIPAA's Administrative Simplification provisions (SSA Sections 1171-1179) mandated the development of electronic format and data standards for specified administrative and financial transactions between providers and health plans. Updated standards to replace the versions currently in use were recently published. The compliance deadline for the updated standards is January 1, 2012. While the standards are intended to eliminate variation in electronic billing and other routine transactions, they include optional data/content fields that can accommodate plan-specific information. Providers often are faced with a multiplicity of implementation guides and plan-specific requirements and must customize transactions on a plan-by-plan basis. HIPAA also mandated the development of unique identifiers for providers, health plans, employers, and individuals for use in	Section 115 would require the Secretary, within two years of enactment, to adopt an additional set of administrative and financial transactions standards to help clarify, complete, and expand the existing HIPAA standards. The goal would be to create uniformity in the use of those standards. Within five years of enactment, the Secretary would have to submit to Congress a plan for implementing and enforcing the new standards. Until such time as the new standards are adopted, the Secretary would be required to adopt an interim companion guide (including operating rules) for each HIPAA transaction. The Secretary would be required to establish a unique health plan identifier and adopt a transaction standard for health claim attachments (one of the two HIPAA-specified transactions for which a standard has yet to be adopted). The section would amend the Medicare statute to require that all Part A and Part B payments, with some	Similarly, HIPAA's Administrative Simplification provisions would be amended with the intent of creating uniformity in the use of HIPAA electronic transactions standards. However, the Senate bill takes a different approach. It would establish a timeline, extending through mid-2014, for the adoption of a single set of operating rules for each HIPAA transaction for which there is an existing standard. It also would mandate the adoption of an electronic funds transfer (EFT) standard for the payment of health claims. By December 31, 2015, health plans would have to certify that their health information technology systems comply with the most current standards and operating rules. Health plans that failed to meet the certification requirements would be fined. The Secretary would be required to establish a unique health plan identifier and adopt a transaction standard and associated operating rules for health claim attachments (one of the two HIPAA-

Topics for Table 14	Current Law	H.R. 3962 (House-passed)	H.R. 3590 (Senate-passed)
	standardized transactions. Unique identifiers have been adopted for providers and employers, but not for health plans. Congress has blocked the development of a unique individual identifier.	exceptions, be made electronically as of January 1, 2015. *§115*	specified transactions for which a standard has yet to be adopted). The section would amend the Medicare statute to require that all Part A and Part B payments, with some exceptions, be made electronically as of January 1, 2014. *§1104* HIPAA's Administrative Simplification provisions would be further amended requiring the Secretary, by January 1, 2012, and every 3 years thereafter with input from specified groups, to consider adopting additional standards for financial and administrative transactions not already named under HIPAA (including certain specified activities) to improve the operation and efficiency of the health care system. In addition, the Secretary would be required to consider, and post online, revisions to the crosswalk between the 9th and 10th versions of the International Classification of Disease (ICD), and to post crosswalks of future ICD versions. *§10109*

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