

<b>Insurance Reforms</b>		
<b>Provision</b>	<b>H.R. 3590 - Patient Protection and Affordable Care Act (<i>*passed the Senate December 24</i>)</b>	<b>H.R. 3962 - Affordable Health Care for America Act (<i>*passed the House November 7</i>)</b>
<i>Antitrust Exemption for Insurers</i>	-no provision	-removes antitrust exemption for health insurers and medical malpractice insurers
<i>Benefit Package</i>	-plans in the individual or small group market must provide the essential health benefits package, effective 2014	-plans must meet the requirements of qualified health benefits plans, effective 2013 (five-year grace period provided for employer-sponsored plans)
<i>Dependent Coverage</i>	-requires insurers that offer dependent coverage to allow uninsured children to remain on their parents' health insurance up until the 26 <sup>th</sup> birthday, effective 2011	-requires health insurers to allow uninsured children to remain on their parents' health insurance up until the 27 <sup>th</sup> birthday
<i>Guaranteed Issue and Renewal</i>	-guaranteed issue and renewal required, effective 2014	-guaranteed issue and renewal required
<i>Insurance Rating</i>	-permits variation based only on tobacco use (1.5:1 limit), age (3:1 limit), family composition, and geographic area, effective 2014	-permits variation based only on geographic area, family size, and age (2:1 limit), effective 2013
<i>Lifetime/Annual Limits</i>	-small and large group market plans may not impose lifetime limits on coverage, effective 2011 -small and large group market plans may only establish "restricted annual limits" on coverage prior to 2014 -plans in the group market may not impose annual cost-sharing that exceeds the high-deductible health plan out-of-pocket limits, effective 2014	-no lifetime limits on health care benefits permitted
<i>Marketing Practices</i>	-qualified health plans must not use marketing practices that discourage the enrollment of individuals with significant health needs	-Health Choices Commissioner has the authority to define marketing standards for health plans
<i>Medical Loss Ratio (MLR)</i>	-health plans would be required to report the proportion of premium dollars that are spent on items other than medical care	-plans must have a minimum MLR of 85%, effective 2010 -applies to individual, small, and large group

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	-group plans must have an MLR of 85% -individual plans must have an MLR of 80% -effective 2011 through December 31, 2013 -rebates would be provided to enrollees if plans failed to have an acceptable MLR, effective 2011	markets -HHS to establish a uniform MLR definition
<i>National High Risk Pool</i>	-HHS will establish a temporary insurance program for uninsured people denied coverage due to pre-existing conditions within 90 days of enactment -effective until the creation of the insurance exchange	-temporary insurance program for uninsured people or those denied coverage due to pre-existing conditions, effective 2010 through the creation of the insurance exchange
<i>Non-Discrimination</i>	-no discrimination permitted based on the wages of employees, effective 2011 -insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS, effective 2014	-authority provided to Health Choices Commissioner to set non-discrimination rules -requires mental health parity and substance abuse disorder benefits parity
<i>Pre-Existing Conditions</i>	-prohibits excluding patients on the basis of pre-existing conditions, effective 2014 -immediate prohibition on excluding children on the basis of a pre-existing condition	-prohibits excluding patients on the basis of pre-existing conditions, effective 2013 -prior to 2013, the period by which plans can look back for pre-existing conditions is reduced from six months to 30 days
<i>Preventive Services</i>	-plans must provide coverage, without cost-sharing, for preventive services and immunizations, effective 2011	-no cost-sharing for preventive services, as defined by HHS
<i>Quality Reporting</i>	-insurance companies must report to HHS and the enrollees regarding a plans' implementation of the following activities: improving health outcomes through quality reporting; preventing hospital	-no provision

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	readmissions; improved patient safety and reduced medical errors; and wellness and health promotion activities -reporting required within two years of enactment -HHS may impose penalties for failure to report -effective 2011	
<i>Rescission</i>	-insurance companies prohibited from rescinding coverage, except in cases of fraud or intentional misrepresentation of material fact, effective 2011	-insurance companies may not rescind coverage except in instances of clear and convincing fraud, effective July 1, 2010
<i>Sunshine on Premium Increases</i>	-establishes an annual review process that requires insurers to submit justifications for premium increases, effective 2010	-establishes an annual review process that requires insurers to submit justifications for premium increases, effective 2010

<b>Health Insurance Exchange</b>		
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<i>Establishment, Purpose, and Duties of Exchange</i>	-states required to establish an American Health Benefit Exchange by January 1, 2014 -the exchanges will facilitate the purchase of qualified health plans and establish a Small Business Health Options Program (SHOP) to assist small employers in obtaining coverage for employees -states may combine the individual and SHOP exchanges -an exchange may only be a governmental agency or non-profit entity established by a state -states may form regional exchanges with other	-national Health Insurance Exchange established within the new Health Choices Administration -Health Choices Commissioner will establish standards, accept bids, negotiate and enter into contracts with qualified plans, and conduct outreach and enrollment of eligible individuals and employers -states may operate a state-based exchange in lieu of the national Health Insurance Exchange (subject to the approval of the Health Choices Commissioner) -states may form interstate compacts to facilitate the purchase of health insurance, effective 2015

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	<ul style="list-style-type: none"> <li>states, subject to approval of each state legislature</li> <li>-states may establish subsidiary exchanges within the state</li> <li>-HHS will establish an exchange in a state if that state fails to do so by 2014</li> <li>-states may form interstate compacts to facilitate the purchase of health insurance, effective July 1, 2013</li> </ul>	
<i>Eligibility</i>	<ul style="list-style-type: none"> <li>-qualified employers and qualified individuals are eligible to obtain coverage through an exchange</li> <li>-small employers with 100 or less employees may enroll in the exchange</li> <li>-employers with over 100 employees may obtain coverage through an exchange, at the discretion of each state, effective 2017</li> </ul>	<ul style="list-style-type: none"> <li>-non-Medicare/Medicaid eligible individuals without health insurance may obtain coverage in the exchange</li> <li>-small employers with 25 or fewer employees may obtain coverage in 2013, 50 or fewer employees in 2014, and 100 or fewer employees in 2015</li> <li>-employers with more than 100 employees may be eligible in 2015 or beyond, subject to the Health Choices Commissioner</li> </ul>
<i>Benefit Packages</i>	<ul style="list-style-type: none"> <li>-four benefit categories would be available: bronze, silver, gold, and platinum - based on the actuarial value of the plans</li> <li>-all plans must provide basic services</li> <li>-actuarial value of bronze plan is 60%, silver is 70%, gold is 80%, and platinum is 90%</li> <li>-states may require additional benefits to be covered</li> </ul>	<ul style="list-style-type: none"> <li>-basic plan must be offered by any entity participating in the Exchange (i.e., essential benefits package and 70% actuarial value)</li> <li>-an entity also may offer enhanced, premium, and premium-plus plans</li> </ul>
<i>Public Health Insurance Option</i>	<ul style="list-style-type: none"> <li>-no public health insurance option</li> <li>-the Office of Personnel Management will contract with private insurers to offer at least two national or multi-state plans to be offered in the Exchanges of each state</li> <li>-the Consumer Operated and Oriented Plan (CO-OP)</li> </ul>	<ul style="list-style-type: none"> <li>-HHS to establish a public health insurance option to be offered solely within the Health Insurance Exchange, starting in 2013</li> <li>-must be self-sustaining after initial \$2 billion funding</li> <li>-payment rates will be negotiated by HHS</li> </ul>

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	program permits the creation of non-profit, member-run health insurance companies; HHS would award grants and loans to CO-OPs	-HHS may utilize innovative payment initiatives and delivery system reforms -Medicare providers presumed to participate unless they opt-out -Health Choices Commissioner to establish a CO-OP program within 6 months of enactment and provide loans and grants to eligible non-profit entities
<i>Funding</i>	-HHS will award grants to states to establish an exchange -each exchange must be self-sustaining beginning January 1, 2015 (assessments and user fees on insurance issuers permitted)	-Health Insurance Exchange Trust Fund created to operate the Exchange -funded by appropriations and enforcement of individual and employer mandate
<i>Assistance for Certain Individuals</i>	-premium credits and cost-sharing reductions available for individuals and families below 400% of FPL	-premium and cost-sharing affordability credits available for individuals and families below 400% of FPL

<b>Individual &amp; Employer Responsibility</b>		
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<i>Individual Responsibility</i>	-individuals must obtain minimum essential coverage for them and their dependents, effective 2014 -hardship and religious exemptions permitted	-individuals must obtain acceptable health insurance coverage for themselves and their dependents, effective 2013 -hardship and religious exemptions permitted
<i>Qualified Coverage</i>	-minimum essential coverage includes government-sponsored coverage, employer-sponsored care, grandfathered health plans, and plans offered in the	-acceptable coverage includes grandfathered or employer-sponsored insurance, government insurance (e.g., Medicare, VA), and "qualified

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	<p>individual market</p> <ul style="list-style-type: none"> <li>-grandfathered coverage includes coverage in which an individual was enrolled as of the date of enactment</li> <li>-a qualified health plan provides the essential health benefits package, limits annual cost-sharing to the high-deductible health plan limit, limits the annual deductible for small group market plans to \$2,000 (individual) and \$4,000 (families), no cost-sharing for preventive services or immunizations</li> <li>-“Young Invincibles” catastrophic coverage available as follows: only individuals under age 30 are eligible; does not provide health care benefits until the individual has incurred annual cost-sharing equal to the high-deductible health plan limit; provides at least three primary care visits; and no cost-sharing for preventive services</li> </ul>	<p>coverage” offered in the exchange</p> <ul style="list-style-type: none"> <li>-grandfathered coverage includes: individual health insurance coverage as of 2013, (subject to limits on new enrollment and premium increases); and employer-sponsored health insurance until 2018</li> <li>-qualified health benefits plans must follow the following requirements: no pre-existing conditions denial; guaranteed issue and renewal; no rescissions; age rating limited to 2:1; variation limited to family composition and geographic area; dependent coverage until age 27; 90 notice required for cost increases or coverage decreases; covers the essential health benefits package; annual \$5,000 (individual) or \$10,000 (family) limit on cost-sharing; no cost-sharing for preventive services; no annual or lifetime limits; minimum actuarial value of 70%; uniform marketing standards; and timely grievance and appeals mechanisms</li> </ul>
<i>Individual Penalty</i>	<ul style="list-style-type: none"> <li>-failure to obtain minimum essential coverage will result in a tax as follows: \$95 in 2014; \$350 in 2015; \$750 in 2016 and beyond (indexed by a cost-of-living adjustment)</li> <li>-the penalty amount will also be applied for any dependents that do not have minimum essential coverage</li> <li>-no penalty applied to individuals who qualify for hardship or religious exemptions</li> </ul>	<ul style="list-style-type: none"> <li>-failure to obtain acceptable health care coverage will result in a 2.5% tax on the modified adjusted gross income of the individual</li> <li>-no penalty applied to individuals who qualify for hardship or religious exemptions</li> <li>-penalty effective 2013</li> <li>-sliding-scale limits on annual out-of-pocket expenditures</li> </ul>
<i>Employer Responsibility</i>	<ul style="list-style-type: none"> <li>-employers with greater than 200 employees must automatically enroll all new employees in health care</li> </ul>	<ul style="list-style-type: none"> <li>-employers must offer a qualified health benefits plan or current employer-sponsored insurance</li> </ul>

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	<p>coverage</p> <ul style="list-style-type: none"> <li>-employers with more than 50 employees must offer coverage to their employees</li> </ul>	<p>employers must contribute at least 72.5% of the premium for full-time employees (for individual coverage) and at least 65% of the premium for full-time employees (for family coverage)</p> <ul style="list-style-type: none"> <li>-a salary reduction to pay for coverage is not treated as an acceptable employer contribution</li> <li>-for part-time employees, the employer contribution will be a proportional amount</li> <li>-employers must contribute 8% of an employer's average wages to the Health Insurance Exchange Trust Fund for each employee who obtains coverage through the Exchange</li> <li>-employers must meet essential health benefits standards for employer-sponsored coverage, effective 2018</li> </ul>
<i>Employer Penalty</i>	<ul style="list-style-type: none"> <li>-for employers with more than 50 employees that do not offer coverage and have at least one employee receiving the premium assistance tax credit, they will be fined the lesser of \$750 multiplied by the number of employees or \$3,000 for each employee receiving the tax credit</li> <li>-large employers (more than 50 employees) will pay a \$600 fine for implementing a waiting period that exceeds 60 days for employees who wish to enroll in coverage (fine assessed per employee that experiences the excessive waiting period)</li> </ul>	<ul style="list-style-type: none"> <li>-for employers not offering health insurance to employees, the following tax penalty will be assessed, effective 2013</li> <li>-8% tax on wages for employers with annual payrolls exceeding \$750,000</li> <li>-6% tax on wages for employers with annual payrolls between \$670,000 and \$750,000</li> <li>-4% tax on wages for employers with annual payrolls between \$585,000 and \$670,000</li> <li>-2% tax on wages for employers with annual payrolls between \$500,000 and \$585,000</li> <li>-no penalty for employers with annual payrolls that do not exceed \$500,000</li> </ul>

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<b>Tax Provisions (Credits &amp; Revenue Raisers)</b>		
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<i>Individual Tax Credits</i>	-premium credits and cost-sharing reductions available for individuals and families below 400% of FPL	-affordability credits available to individuals and families up to 400% of FPL who are not enrolled in employer-sponsored coverage -affordability credits available if employer-sponsored coverage costs greater than 12% of income -premium and cost-sharing affordability credits may only be used for basic plans in 2013 and 2014; premium credits may be used after 2014 for enhanced or premium plans -premium affordability credits (capped at 12% of income), actuarial value enhancements (up to 97%), and cost-sharing affordability credits (from \$500 to \$5,000) are available on a sliding scale up to 400% of FPL
<i>Small Business Credits</i>	-tax credits equal to 50% of the amount paid by a small employer for employee health coverage -limited to firms with 25 or fewer full-time employees and with average annual wages below \$50,000 -full credit phases out for employers with more than 10 full-time employees or average annual wages between \$25,000 and \$50,000 -tax credits available beginning in 2010	-tax credit equal to 50% of the amount paid by a small employer for employee health coverage -phased out for employers with 10-25 employees -phased out for employers with average annual wages between \$20,000 and \$40,000 -credits available beginning in 2013 (capped at two years per firm)
<i>Income Taxes</i>	-increases the hospital insurance payroll tax by 0.9% on individuals earning over \$200,000 and couples earning \$250,000, effective 2013	-5.4% tax on modified adjusted gross income that exceeds \$1,000,000 (joint filers) and \$500,000 (single filers)
<i>Insurance Fees (i.e., "Cadillac" plan tax)</i>	-40% excise tax on employer-sponsored health coverage that exceeds \$8,500 for an individual and \$23,000 for families, effective 2013	-fees assessed on sponsors of private insurance to be transferred to the Comparative Effectiveness Research Trust Fund
<i>Flexible Spending</i>	-contributions to FSAs are capped at \$2,500	-contributions to FSAs are capped at \$2,500

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