GROOM LAW GROUP

Both the House and Senate have now passed comprehensive health care reform bills. The House passed the "Affordable Health Care for America Act" (H.R. 3962) on November 7, 2009, while the Senate passed the "Patient Protection and Affordable Care Act" (H.R. 3590) on December 24, 2009. Since then, House and Senate Democratic leaders and the Obama administration have been working behind the scenes to attempt to reconcile the two bills and ready the legislation for final action.

Attached is a revised version of our side-by-side comparison of key provisions of the House and Senate-passed bills in the following areas:

- **Insurance Market Reforms**
- **Employer Responsibility**
- **Exchange**
- **Public Plan Option**
- **Individual Responsibility**
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A. ADMINISTRATION / ENFORCEMENT		
a. New Federal Agency	Establishes the "Health Choices Administration" ("HCA"), an independent executive branch agency headed by the Health Choices Commissioner. [AHCAA § 241] HCA shall establish qualified health benefits plan standards and operate the Exchange. [AHCAA §§ 242; 301(b)] A Health Benefits Advisory Committee is established to recommend covered benefits and plans. HHS shall adopt the recommended standards or propose alternative initial standards. [AHCAA §§ 223, 224]	No analogous provision.
b. State Role	The HCA shall consult with the National Association of Insurance Commissioners, state attorneys general and state insurance regulators regarding the standards and enforcement of standards for insured qualified health benefits plans. The HCA will also consult with appropriate state agencies regarding the administration of affordability credits and enrolling Medicaid-eligible individuals in Exchange plans. [AHCAA § 243(a)(1), (2), (3))] Any state attorney general may bring a civil action to secure monetary or equitable relief for violation of any provision of this title or regulations issued. ERISA § 514 continues to apply. [AHCAA § 257]	HHS shall award grants to states to establish or expand offices of health insurance consumer assistance or a health insurance ombudsman program. Effective date of enactment. (New PHSA § 2793)* [PPACA § 1002] See also Ombudsman / Health Insurance Ombudsman (p.2).
c. Enforcement of Benefit Plan Standards	HCA will coordinate with DOL, Treasury and state insurance regulators regarding the enforcement of qualified health benefit plan standards. [AACHA §§ 242(a); 243] HCA shall establish oversight procedures with respect to qualified health benefits plan entities that offer plans through the Exchange. Procedures shall include grievance and complaint procedures and may include the sanctions of § 242 (such as civil money penalties or suspension of enrollment) or termination of participation. [AHCAA § 304(c)(4)(A)-(C)]	States are generally responsible for the enforcement of standards relating to Exchanges. [PPACA §§ 1311; 1321]

* Throughout this chart "New" followed by a statutory citation means either an amended or newly added provision to a current statute.

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d. Annual Premium Review	HHS and the states will review annually increases (beginning in 2010) in health insurance coverage premiums. Insurers will justify an increase prior to review. HHS shall make increases and justifications public. [AHCAA § 104] See also Medical Loss Ratio Rebates and Cost Accounting (p.5).	HHS, with the states, shall annually review (beginning in 2010) unreasonable increases in health insurance coverage premiums. Health insurance issuers must justify to HHS and the relevant state any unreasonable premium increase prior to implementation. State insurance commissioners shall provide HHS with information regarding premium trends and make recommendations about excluding providers from the Exchange for premium increases. Beginning in 2014, HHS and the states shall monitor premium increases in and out of the Exchange. Effective date of enactment. (PHSA § 2794) [PPACA § 1003] See also Medical Loss Ratio Rebates and Cost Accounting (p.5).
e. Sanctions	The HCA may, in coordination with state insurance regulators and the DOL, sanction a qualified health benefits plan offering entity if it violates a requirement of the AHCAA. [AHCAA § 242(d)(1)] Sanctions may include civil monetary penalties, suspension of enrollment of individuals until the plan is compliant, suspension of payment to Exchange plans until the plan is compliant and termination of plan (in coordination with state regulators). [AHCAA § 242(d)(2)]	Current PHSA enforcement provisions (current PHSA § 2722) would continue to apply.
f. Ombudsman / Health Insurance Ombudsman	An Ombudsman shall be created within the HCA. The Ombudsman shall receive complaints and requests for information, and provide assistance to individuals. [AHCAA § 244] HCA may contract with outside entities to enroll and educate consumers about the Exchange and Exchange plans. [AHCAA § 305]	A state office of health insurance consumer assistance or health insurance ombudsman shall: • assist with the filing of complaints and appeals; • collect track and quantify problems encountered by consumers; • educate consumers on their rights and responsibilities regarding health care coverage; • assist consumers with enrollment; and • resolve problems with premium tax credits. Effective date of enactment. (New PHSA § 2793(c)) [PPACA § 1002]

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g. Administrative Simplification	Standardization of electronic administrative transactions is required. HHS will develop rules and guidelines. [AHCAA § 115]	Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer (EFT) payments). Requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. Adopts unique plan identifier and transaction standards for EFT. [PPACA § 1104]
B. GENERAL REFORM		
i. Market Reforms		
a. Offering Individual Policies	New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AHCAA § 202(c)(1)]	Health insurers may continue to offer coverage outside of the Exchange. [PPACA § 1312(d)]
b. Risk Pooling	Rating: Individual and small group coverage must be offered through the Exchange. Exchange plans must be qualified; qualified health benefits plans are subject to HCA and state rating rules. [AAHCA § 213(a)]. See Insurance Market Reforms, Plan Standards, Premium Rating Rules. Risk Adjustment: HCA will adjust the premium amounts payable to qualified health benefits offering entities to minimize the impact of adverse selection of individuals enrolled in Exchange-participating health benefits plans. [AHCAA § 306(b)] Qualified health benefit offering entities must participate in the risk pooling mechanism established by the HCA in order to participate in the Exchange. [AHCAA § 304(b)(6)] Reinsurance & Risk Corridors: Grants are available to states to establish reinsurance plans that subsidize a share of carrier losses within certain risk corridors. [AAHCA § 114(b)(3)]	Rating: States would be required to apply rating rules to the individual and small group market. Also applies to large group markets that offer coverage through the Exchange (where states permit such coverage). (New PHSA § 2701) [PPACA § 1201] Risk Adjustment: Each state shall assess a charge on plans in the individual and small group market (grandfathered plans excluded) if the actuarial risk of the enrollees is less than the average actuarial risk of enrollees in all plans in the state for that year (except self-insured plans). HHS, in consultation with the states, will establish criteria to carry out the risk adjustment. [PPACA § 1343] Reinsurance: By 2014, each state shall establish a reinsurance program. HHS, in consultation with NAIC, shall set standards. Health insurance issuers would be required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity. [PPACA §§ 1341; 10104] Risk Corridors: HHS shall establish a program of risk corridors in the

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		individual and small group market in 2013, 2014, and 2015, modeled after the program for regional participating provider organizations in Medicare Part D. [PPACA § 1342]
c. Health Care Choice Compacts	Starting in 2015, states may form Health Care Choice Compacts to allow for the purchase of individual health insurance across state lines. No later than 2014, the NAIC shall develop model rules for the creation of health care choice compacts. Compacts must provide that the state in which the consumer lives retains authority to address market conduct, unfair trade practices, network adequacy and consumer protection standards, grievances and appeals, fair claims payment requirements, prompt payment of claims, rate review and fraud. Insurers must be licensed in each state. Insurers must clearly disclose to individual policy holders that the policy may not be subject to all the laws and regulations of the policy holder's state. [AHCAA § 309]	No later than 2013, HHS, in consultation with the NAIC, shall issue regulations for the creation of health care choice compacts. Starting in 2016, states may form health care choice compacts to allow for the purchase of individual health insurance across state lines. Insurers selling policies through a health care choice compact would only be subject to the laws and regulations of the state where the policy is written or issued. However, compacts must provide that the state in which the consumer lives retains authority to address market conduct, unfair trade practices, network adequacy and consumer protection standards (which includes performance under the contract). Insurers must be licensed in each state or submit to the jurisdiction of each state. Insurers must clearly disclose to individual policy holders that the policy may not be subject to all the laws and regulations of the policy holder's state. [PPACA § 1333]
d. CO-OPs	CO-OP insurance cooperatives may provide insurance through the federal or a state-based Exchange. See Exchange CO-OPs (p.29).	HHS shall establish the Consumer Operated and Oriented Plan (CO-OP) program to create non-profit, member-run health insurance companies that operate in the individual and small group markets. In order to receive federal funds (loans granted and administered by HHS) to create a CO-OP, an organization must: • be organized as a non-profit, member corporation under State law; • limit substantially all its activities to the issuance of qualified health plans in the individual and small group market; • not be an existing organization that provides insurance as of July 16, 2009, and must not be an affiliate or successor of any such organization; • not be sponsored by a State, county, or local government, or any government instrumentality;

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		• incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference in its governing documents; • be subject to a majority vote of its members (i.e., beneficiaries), • be required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members (under regulations from HHS); and • use any profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to members. [PPACA §§ 1322; 10104]
e. Medical Loss Ratio Rebates and Cost Accounting	Each plan year, health insurance issuers in the individual, small or large group market shall provide rebates to enrollees of the amount by which the issuer's medical loss ratio is less than the level specified by the Secretary (not less than 85 percent). The provision sunsets after the first date that health insurance coverage is offered through the Exchange. (New PHSA § 2714; 2754) [AHCA § 102] See also Insurance Market Reforms, Annual Premium Review (p.2).	A health insurance issuer offering group or individual health insurance coverage shall publicly report (in a manner to be established by the Secretary through regulation) the percentage of total premium revenue that such coverage expends: • on reimbursement for clinical services provided to enrollees under such plan or coverage; • for activities that improve health care quality; and • on all other non-claims costs, including costs associated with compliance with the PPACA, with an explanation of the nature of such costs. (New PHSA § 2718(c)) [PPACA § 1001] A health insurance issuer offering group coverage shall provide an annual rebate to each enrollee if more than 15% of premium revenue is expended on non-claims costs (excluding taxes) or 20% (or lower by state regulation) for insurers offering coverage in the individual market. Insurance issuers shall report to HHS the ratio of incurred claims to earned premiums. (New PHSA § 2718(b)) [PPACA §§ 1001, 10701] Each hospital shall make public a list of the hospital's standard charges. (New PHSA § 2718(c)) [PPACA § 1001] See also Insurance Market Reforms, Annual Premium Review (p.2).

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f. Quality of Care Payment Structure	No analogous provision.	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall report on plan benefits and structures that provide incentives for: • the implementation of case management, care coordination, chronic disease management, and medication and care compliance activities for treatment or services under the plan or coverage; • the implementation of activities to prevent hospital readmissions, • improving patient safety and reducing medical errors through best clinical practices, evidence based medicine, and health information technology; and • the implementation of wellness and health promotion activities. Plans shall report to the Secretary annually. Reports shall be made available to enrollees at open enrollment. HHS may define exceptions to the above requirements for insurers that substantially meet the goals provided. Wellness program activities may include: smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, diabetes prevention. (New PHSA § 2717) [PPACA § 1001]
g. State Opt-Out	No analogous provision.	A state may apply to HHS and Treasury for a waiver of any of the following: • the establishment of qualified health plans; (§§ 1301-1304) • health benefit exchanges; (§§ 1311-1312) • reduced cost-sharing for individuals; (§ 1402) • refundable credit for coverage (new IRC § 36B); employer responsibility requirements (new IRC § 4980H), individual responsibility requirement (new IRC § 5000A) [PPACA § 1332]

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ii. Plan Standards		
a. Essential Benefits Must Be Offered	A qualified health benefits plan shall provide "essential benefits package" coverage. [AHCAA § 211] See Essential Health Benefits for requirements (p.12).	A health insurance issuer that offers health insurance coverage in the individual or small group market must include the essential health benefits package. (New PHSA § 2707) [PPACA § 1201] See Essential Health Benefits for requirements (p.12).
b. Qualified Health Benefits Plans / Qualified Benefit Plans	New health insurance coverage and employment-based health plans (group health plans, government plans and church plans as defined under ERISA) must meet affordable coverage, essential benefits and consumer protection standards. Plans that meet these standards are "qualified health benefit plans." [AHCAA § 201] New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AHCAA § 202(c)(1)] Certain plans are excused from or have a grace period before complying with these standards. See Grandfathered and Excepted Coverage, Grace Period for Employment-Based Plans (pp.11-12).	Group health plans and health insurance issuers offering group and individual health coverage must meet certain criteria. (See General Standards). Qualified health plans are certified through an Exchange, provides essential health benefits, are offered by licensed issuers that offers at least one silver and one gold plan in each Exchange in which it participates, charges the same premium rate for the same plan whether offered in or out of the Exchange, and complies with applicable Exchange regulations. [PPACA § 1301(a)] Self-insured plans and MEWAs are generally not included in the term "health plan." [PPACA § 1301(b)] Health insurers may continue to offer coverage outside of the Exchange. [PPACA § 1312(d)] Certain plans excused from complying with these standards. See Grandfathered and Excepted Coverage (p.12).
c. Preexisting Conditions	A qualified health benefits plan may not impose preexisting condition exclusions. [AHCAA § 211] Group health plans not yet subject to the qualified health benefits plan requirements may only impose a look-back period of 30 days and shorter preexisting conditions limitation period (3 months for regular enrollee or 9 months for a late enrollee) until the plan is subject to the Act's complete prohibition on preexisting condition limitations (as set forth in § 211). [AHCAA § 106] Domestic violence may not be considered a preexisting condition.	A group health plan and a health insurance issuer offering group or individual health insurance may not impose any preexisting condition exclusion. (New PHSA § 2704) [PPACA §§ 120] A temporary high risk health insurance pool shall be established to provide coverage for eligible individuals who had been denied health care coverage on the basis of a preexisting condition. The pool will exist until 2014 (when Exchanges are operational). Health insurance coverage in the pool shall cover not less than 65 percent of the total allowed costs of benefits. Out of pocket limits shall be not greater than the limit in IRC 223(c)(2), but may be modified. Individuals who are currently covered must be

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	[AHCAA § 107]	uninsured for six months before joining the high-risk pool. Incentives to disenroll risk by plans will be penalized. [PPACA § 1101]
d. Guaranteed Issue / Renewal / Rescissions	The provisions of PHSA §§ 2711, 2712 applies, with certain exceptions, to all individual and group health insurance coverage, including employment-based plans. [AHCAA § 212] Rescission is prohibited except in cases of fraud and independent external review of rescission determinations is required. (New PHSA § 2746) [AHCAA §§ 103; 212]	Health insurance issuers in the individual and group health insurance market in a state must accept every employer and individual who applies in the state. The issuer is not required to accept applicants outside of open or special enrollment periods. A health insurance issuer shall establish special enrollment periods for qualifying events in accordance with ERISA § 603. (New PHSA § 2702) [PPACA § 1201] Plan sponsors (other than self-insured sponsors) are prohibited from establishing eligibility rules based on salary. Rules that allow lower compensated employees to contribute less are allowed. (New PHSA § 2716) [PPACA § 1001] Group health plans and health insurance issuers offering group or individual coverage may not rescind coverage except in the case of fraud or intentional misrepresentation of material fact. (New PHSA § 2712) [PPACA § 1001]
e. Premium Rating Rules	A qualified health benefits plan's premium rates may vary only by: • age (within categories set by the HCA and not more from the highest to lowest than a 2 to 1 ratio); • area (as permitted by state insurance regulators, or the HCA in the case of Exchange plans); and • family enrollment (within state law limits and HCA rules). [AHCAA § 213(a)]	Premium rates in the individual or small group health market may vary only by: • family structure; • community rating area; • actuarial value of the benefit; • age (except it may not vary by more than 3 to 1); and • tobacco use (except it may not vary by more than 1.5 to 1). (New PHSA § 2701) If a state allows large groups to participate in the Exchange, these rules shall apply. [PPACA § 1201]
f. Dependent Coverage	A qualified health benefits plan shall make coverage available to dependent children under 27 years of age and not otherwise enrolled in a health benefits plan. [AHCAA § 216]	A group health plan or issuer of group or individual insurance that provides dependent coverage must allow dependent coverage to continue until the child turns 26. The Act also allows HHS to issue regulations regarding the scope of dependents that will fall under the age 26 requirement. This provision does not require a health plan or insurer to cover children of

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		children receiving dependent coverage. (New PHSA § 2714) [PPACA § 1001]
g. Discrimination in Health Care and Related Services	All health care and related services shall be provided without regard to personal characteristics extraneous to the provision of health care. The Secretary of HHS will promulgate regulations to enforce this provision. [AHCAA § 252]	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan against any health care provider. See also PPACA § 1558 (prohibition against retaliation). (New PHSA § 2706) [PPACA § 1201] Individuals are protected against discrimination under the Civil Rights Act, the Education Amendments Act, the Age Discrimination Act, and the Rehabilitation Act, through exclusion from participation in or denial of benefits under any health program or activity. [PPACA § 1557]
h. Information Regarding Coverage Options / Internet Portal	Exchange-participating health benefits plans must comply with HCA standards for accurate and timely disclosure of plan document, plan terms and conditions, claims payment policies and practices, financial disclosures, data on enrollment, disenrollment, number of claims denials, rating practices, information on cost-sharing and payments for out-of-network coverage and other information as determined by HCA. At a minimum, cost-sharing shall be made available via an internet website. DOL shall update its rules for employment-based plan disclosures. [AHCAA § 233]	HHS, in consultation with the states, will establish a mechanism, including a internet website, through which an individual may identify affordable health insurance coverage options. Information shall be in a standard format, including information required under new PHSA § 2718, eligibility, availability, premium rates and cost sharing, consistent with PHSA § 2715. [PPACA § 1103]
i. Lifetime Limits	Group health plans and health insurers may not impose aggregate dollar lifetime limits with respect to benefits payable under a plan. (New ERISA § 716) [AHCAA § 109] An essential benefits package may not impose lifetime cost limits on coverage of covered health care items and services. [AHCAA § 222]	Group health plans and health insurance issuers offering group or individual health insurance coverage may not establish lifetime limits on the dollar value of essential benefits for any participant or beneficiary. (New PHSA § 2711) [PPACA §§ 1001, 10101]
j. Network Adequacy	For qualifying health benefit plans that use a provider network, HCA will set network adequacy standards and set standards to provide transparency in the cost-sharing differentials between in-network and out-of-network coverage. Qualified health benefits plans must provide current listings of providers via the internet. [AHCAA § 215]	Network adequacy provisions apply to plans offered through Exchange. [PPACA § 1311(c)]

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k. Nondiscrimination in Benefits (including Mental Health Parity)	A qualified health benefits plan must comply with nondiscrimination requirements as established by the HCA. The HCA is instructed to build upon current nondiscrimination requirements in ERISA § 702, the PHSA § 2702 and the Code § 9802 (the prohibition against discrimination based on health status). [AHCAA § 214(a)] Parity in mental health and substance use benefits (PHSA § 2705) continue to apply unless otherwise superseded by the Act, regardless of whether the benefits are offered in the individual or group market. [AHCAA § 214(b)] A qualified health benefits plan may not impose any limit or condition with respect to an individual or dependent based on any "health status-related factors" (as defined in the PHSA § 2701(b)(1)(A)). [AHCAA § 211]	PHSA § 2726 (Parity in mental health and substance use disorder benefits) applies to qualified health benefit plans. [PPACA § 1311(j)] A group health plan and a health insurance issuer offering group or individual health insurance coverage, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual: • 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); • disability; or • any other health status-related factor determined appropriate by the Secretary. Wellness programs may condition a premium discount or rebate on an individual satisfying a standard that is related to a health status factor if the plan meets certain requirements. See Wellness programs (p.11). (New PHSA § 2706) [PPACA § 1201]
l. Notice of Changes	If costs or benefits in a qualified health benefit plan change during a plan year, 90 days notice to participants is required. [AHCAA § 217]	A group health plan or health insurance issuer must given at least 60 days notice if it makes any material modification in any of the terms of the plan or coverage. (New PHSA § 2715(d) [PPACA § 1001]
m. Preventive Care	Qualified health benefits plans must cover essential benefits. The essential benefits package must cover preventive care, among other services. [AHCAA §§ 221; 222(b)(8)] No cost-sharing is permitted for preventive care, including well-baby and well-child care. [AHCAA §§ 222(c); 303(c)(6)]	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for preventive coverage (as defined in the Act). HHS may develop guidelines for value-based insurance. (New PHSA § 2713) [PPACA § 1001]

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n. Treatment of Children with Deformities / Diseases / Injuries	Group health plans and health insurers that offer surgical benefits must cover in-and out-patient diagnosis of a minor child's congenital or developmental deformities, diseases, or injuries. [AHCAA § 108]	No analogous provision.
o. Wellness Programs	Wellness program grants would be provided to small employers. [AHCAA, § 112] No analogous increase in HIPAA wellness incentive limits.	Codifies current HIPAA wellness rules, but increases the wellness incentive limit from 20% to 30%. Labor, HHS and Treasury may promulgate regulations to effectuate this section and have discretion to increase limit to 50%. (New PHSA § 2705) [PPACA § 1201]
p. Limitations on Requiring Referrals or Authorizations	No analogous provision.	A group health plan may not require a referral or preauthorization for and must provide the same level of cost-sharing as is normally provided for: • Emergency care in a hospital where the plan offers coverage for some services. (New PHSA 2719A) • Female participants who seek coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in such care. (New PHSA 2719A(d)) [PPACA § 10101]
q. Clinical Trial Participation	No analogous provision.	An insurer may not discriminate against an individual for participating in a clinical trial. If plan covers qualified individual, it may not deny or impose additional conditions for participation in clinical trial. (New PHSA § 2709) [PPCAC §10103]
iii. Exceptions		
a. Grandfathered and Excepted Coverage	Individual health insurance coverage that is offered and in force before January 1, 2013 is grandfathered, as long as no new individuals are enrolled (except dependents) and the issuer does not change "any" terms. [AHCAA § 202] New individual health insurance coverage offered on or after January 1,	Group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of the Act is grandfathered indefinitely. Provisions for the enrollment of family members and new employees in grandfathered health plans are included. The terms or benefits of a grandfathered health plan are not required to remain the same. [PPACA

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	2013 must be offered through the Exchange. [AHCAA § 202(c)(1)] Limited benefit plans (such as coverage that provides only dental, vision, counseling, flexible spending arrangements) are not required to meet the standards of a qualified health plan. [AHCAA § 202(c)(2)] Excepted benefits (as defined in ERISA § 773(c) and PHSA § 2791(c)), such as specified disease coverage, are not included in the definition of health insurance coverage and may continue to be offered outside of the Exchange and priced separately from health insurance overage. [AHCAA §§ 102(b)(1)(B); 102(c)(2); 121(b)(3)] Excepted benefits do not have to meet the essential benefits requirements. [AHCAA § 202(b)] Under the Act, neither limited benefit plans nor excepted benefit plans are considered acceptable coverage for an employment-based health plan. [AHCAA § 102(b)] Grandfather rules only apply to some provisions in bill, not all. Grandfather rules generally do not apply to revenue raisers or administrative simplification.	§§ 1251(d); 1401] For health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of this title, the Act shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. [PPACA § 1251(d)] Grandfather rules only apply to some provisions in bill, not all. Grandfather rules generally do not apply to revenue raisers or administrative simplification.
b. Grace Period for Employment-Based Plans	Employment-based health plans in effect as of December 31, 2012 are not grandfathered indefinitely, but have a grace period, to be determined by the HCA, but no less than 5 years, to meet the requirements of a qualified health benefits plan, including the essential benefit requirements. [AHCAA § 202(b)]	No analogous provision, but see Grandfathered and Excepted Coverage above. (Group health plans may be grandfathered indefinitely.)
iv. Essential Benefits		
a. General Standards	A qualified health benefits plan shall provide coverage that meets at least the standards of the "essential benefits package." [AHCAA § 221(a)] An essential benefits package must provide the required benefit coverage, comply with cost-sharing, annual and lifetime cost limitations, provide an adequate network, and be equivalent to the average prevailing employer-	The essential health benefits package provides coverage for the essential health benefits, limits cost-sharing, and provides bronze, silver, gold or platinum level of coverage. [PPACA § 1302] A plan may offer benefits in excess of the essential benefits. [PPACA § 1302(b)(5)]

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	sponsored coverage. [AHCAA § 222] A qualified health benefits plan that is offered outside of the Exchange may offer benefits in addition to essential benefits. Premium-plus plans offered through the Exchange may offer benefits in addition to essential benefits. Excepted benefits may be offered under a separate policy. [AHCAA § 221(b)] Qualified health benefits plans may subcontract with insurers for the provision of dental, vision, mental health and other benefits or services. [AHCAA § 221(d)] Abortion may not be covered as part of the essential benefits package. [AHCAA § 222(e)]	Coverage of abortion services is voluntary; no public funding (including premium credits) may be used for abortion for which federal funding is currently prohibited. [PPACA § 1303]
b. Minimum Required Coverage	An essential benefits package must cover: • hospitalization; • outpatient hospital and outpatient clinic services (including ER services); • doctors' and health professional visits (and costs incident to such visits, including home care, as appropriate); • prescription drugs; • rehabilitation services; • mental health and substance use disorder services; • preventive services; • maternity care; • well baby and well child care and oral health, and vision and hearing services for children under 21 years of age; and • durable medical equipment, prosthetics, orthotics and related supplies. [AHCAA § 222(b)(1)-(11)]	Essential benefits, consist at least the following: • ambulatory patient services; • emergency services; • hospitalization; • maternity and newborn care; • mental health and substance abuse services; • prescription drugs; • rehabilitative and habilitative services and devices; • laboratory services; • preventive and wellness services; and • pediatric services, including oral and vision care. HHS is required to establish the complete list of essential benefits. [PPACA § 1302(b)] Qualified health plans offered in the Exchange shall also offer the same plan as a child-only plan. [PPACA § 1302(f)]

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v. Essential Benefits Plan Levels		
a. Basic Plan / Bronze Level	The basic plan offered in the Exchange shall be designed to provide the lowest premium with the highest cost-sharing. Under the basic plan, benefits will equivalent to approximately 70% of the value of the essential benefits package without cost-sharing. Benefits under the basic plan will be modified for affordable credit eligible individuals. [AHCAA § 303(c)]	Bronze level coverage would be equal to the actuarial value of 60 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(A)]
b. Enhanced Plan / Silver Level	The enhanced plan offered in the Exchange will provide the mid-point in premiums and cost-sharing between the basic and premium plan. The enhanced plan shall be designed to provide benefits that are equivalent to approximately 85% of the value of the essential benefits package without cost-sharing. [AHCAA §§ 223(b)(5)-(6); 303(c)]	Silver level coverage would have an actuarial value of 70 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(B)]
c. Premium Plan / Gold Level	The premium plan offered in the Exchange will provide the highest premium with the lowest cost-sharing. The premium plan shall be designed to provide benefits that are equivalent to approximately 95% of the value of the essential benefits package without cost-sharing. [AHCAA §§ 223(b)(5)-(6); 303(c)]	Gold level coverage would have an actuarial value of 80 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(C)]
d. Premium Plus Plan / Platinum Level	Premium plan offered in the Exchange that also provides additional benefits. HCA shall establish the benefit level standards for plans offering benefits in addition to the essential package (like oral health and vision care). [AHCAA § 303(c)]	The platinum benefit package would have an actuarial value of 90 percent of the full actuarial value of the benefits provided under the plan. [PPACA § 1302(d)(1)(D)]
e. "Young Invincible" (Catastrophic Plan)	No analogous provision.	Young invincible policy limited to those 30 years or younger or and individual that has a certification that the individual is exempt from the individual responsibility requirement (IRC § 5000A) because coverage is unaffordable or presents a financial hardship and provides essential benefits but imposes cost-sharing in an amount equal to section 223(c)(2)(A)(ii), except that 3 primary care visits are covered. [PPACA § 1302(e)]

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Provision	**House**	**Senate**
vi. Essential Benefits Cost-Sharing		
a. Cost-Sharing	No cost-sharing is permitted for preventive care, including well-baby and well-child care. [AHCAA §§ 222(c)] Annual out of pocket expenses are limited to $5,000/individual and $10,000/family in 2013. [AHCAA § 222(c)(2)]	Beginning in 2014, health plans shall not impose cost-sharing amounts greater than the dollar amounts in effect under IRC § 223(c)(2)(A)(ii) (high deductible health plans, currently $5,000 for an individual/$10,000 for a family). After 2014, cost-sharing amounts are limited to the 2014 limit, plus an amount calculated under the Act. Employer-sponsored plans in the small group market may not impose deductibles over $2,000/individual and $4,000/other, increased by the maximum reimbursement amount available under an FSA and increased annually by an amount calculated under the Act. Plans may not apply deductibles to benefits under new PHSA § 2713 (preventive care). [PPACA § 1302(c)]
b. Annual and Lifetime Limits	Essential benefits packages may not impose annual or lifetime limits on coverage of covered health care items and services. [AHCAA § 222(a)(c)] Annual out of pocket expenses are limited to $5,000/individual and $10,000/family in 2013. The limits are indexed to the CPI. [AHCAA § 222(c)(2).]	A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish lifetime or annual limits on the dollar value of essential benefits for any participant or beneficiary. Until plan years beginning on or after 1/1/2014, restricted annual limits on essential benefits, as determined by HHS, are permitted. (New PHSA § 2711) [PPACA § 1001, 10101]
C. CONSUMER PROTECTIONS		
i. General		
a. Fair Marketing Practices	The HCA shall establish fair marketing standards that all qualified health benefit plans must follow. [AHCAA § 231]	No rule of broad applicability, but see Exchange for applicable provisions to Exchange plans (p.26).
b. Prompt Claims Payment	Qualified health benefit plans must comply with the prompt payment of claims requirements that Medicare Advantage (Medicare Part C) programs must follow. [AHCAA § 235]	No rule of broad applicability, but see Exchange for applicable provisions to Exchange plans (p.26).

I. INSURANCE MARKET REFORMS		
Provision	**House**	**Senate**
c. Coordination of Benefits	The HCA shall establish standards for the coordination of benefits for individuals with multiple plan coverage. [AHCAA § 236]	No analogous provision.
d. Subrogation of Benefits	The HCA shall establish standards for subrogation of benefits and reimbursement of payments. [AHCAA § 236]	No analogous provision.
e. Advance Care Planning	Qualified health benefits plans must disseminate information related to end-of-life planning in individuals enrolled in Exchange-participating health benefits plans and shall present individuals with the option to establish advanced directives. [AHCAA § 240]	No analogous provision.
f. State Prohibitions on Discrimination Against Health Care Providers	The Act does not supersede current or future state laws that prohibit qualified health benefits plans from discriminating against health care providers. [AHCAA § 238]	No analogous provision regarding state law, but new PHSA provision prohibiting discrimination in health care. See Insurance Market Reforms, General Reform, Plan Standards, Discrimination in Health Care and Related Services (p.9).
g. Applicability of Consumer Protections to Non-Qualified Health Benefits Plans	The HCA shall determine to what extent the fair marketing practices (§231), appeals procedures (§ 232), and disclosure requirements (§ 233) apply to qualified health benefit plans that are not being offered through the Exchange. [AHCAA § 234]	No analogous provision.
ii. Appeal and Grievance Procedures		
a. Appeal and Grievance Procedures Required	All qualified health benefit plan offering entities must provide for grievance and appeal mechanisms as established by the HCA. [AHCAA § 232(a)]	A group health plan and a health insurance issuer offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations and claims. Participants must have the ability to receive continued coverage during the review process. (New PHSA § 2719) [PPACA §§ 1001, 10101]
b. Internal Claims and Appeals	An entity offering a qualified health benefits plan must follow the ERISA § 503 claims procedures (as set forth 29 CFR § 2560.503-1) and as updated by the HCA. [AHCAA § 232(b)]	A group health plan and a health insurance issuer must have an effective internal appeals process including notice to enrollees of available appeals processes, along with an opportunity to review their file and present evidence. (New PHSA § 2719) [PPACA §§ 1001, 10101]

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Provision	**House**	**Senate**
c. External Review	The HCA shall establish an external review process that provides for independent, de novo and binding review of claims denied under the internal claims procedure. [AHCAA §§ 232(c)]	The external appeals process must include the consumer protections in the NAIC Uniform Review Model Act and the minimum standards established by HHS. (New PHSA § 2719) [PPACA §§ 1001, 10101]
d. State Judicial Review	Judicial review under state law remains available for claims denied under the internal or external review process, except ERISA § 514 (preemption) will continue to apply to employment-based plans. [AHCAA § 232(e)]	Act does not add provision regarding state judicial review.
e. Qualified Health Benefits Plan Ombudsman	HCA shall appoint a Qualified Health Benefits Plan ombudsman to receive complaints, grievances and requests for information, provide assistance, and submit annual reports to Congress. [AHCAA § 244]	No analogous provision. But see Ombudsman / Health Insurance Ombudsman (p.2).
iii. Plan Disclosures		
a. Plan Disclosures / Uniform Summary of Benefits	A qualified health benefits plan in the Exchange must provide required disclosures in a timely and accurate manner, including using plain language, and providing information on participant rights and cost-sharing. The HCA will provide guidance. [AHCAA § 233(a)] The DOL will update and harmonize the plan disclosure rules for employment-based plans. [AHCAA § 233(b)] Pharmacy benefit managers that contract with qualified health benefits plans must provide certain information annually to the plan and the HCA. [AHCAA S 233(c)]	Within 24 months of enactment, group health plans (including self-insured health plans) and health insurance issuers offering group or individual health insurance coverage shall use HHS standards for the provision of summary of benefits and coverage explanations. HHS will consult with NAIC to develop standards. Standards shall ensure that outline of coverage: • is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font; • is presented in a manner determined to be understandable by the average health plan enrollee; • includes uniform definitions of standard insurance terms as well as a description of the coverage, including dollar amount for benefits as identified by HHS; and • includes the exceptions, reductions and limitations on coverage; • includes the cost-sharing provisions; • includes the renewability and continuation of coverage provisions; • includes examples of common benefit scenarios; • includes a statement whether the plan provides minimum essential benefits; • includes a statement that the outline is a summary; and

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Provision	**House**	**Senate**
		• includes a contact number for the consumer and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained. Requirements apply to grandfathered plans as well. Electronic delivery is acceptable. Notice of modification in a plan is required within 60 days. These standards preempt any related state standards that require an outline of coverage. An entity that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense. (New PHSA § 2715) [PPACA § 1001]
b. Contracting Reimbursement	A qualified health benefits plan must comply with standards established by the HCA to ensure the transparency related to reimbursement arrangements. [AHCAA § 233(b)]	No analogous provision.
c. Pharmacy Benefit Managers Transparency	Pharmacy benefit managers that contract with qualified health benefits plans must provide certain information annually to the plan and the HCA. [AHCAA S 233(c)]	Requirements apply to Medicare Advantage plans. (New SSA § 1150A) [PPACA § 6005]
D. RELATION TO CURRENT LAWS		
a. Whistleblower Protections	Employees are protected from retaliation from their employer for reporting violations of the Act. Remedies are those available under the Consumer Product Safety Act. Employer is defined to include those engaged in activities governed by the Act. [AHCAA § 253]	No analogous provision.
b. Collective Bargaining	Nothing in the division (Division A - Affordable Health Care Choices) supersedes any obligation to collectively bargain over the terms of employment related to health care. [AHCAA § 254]	For health insurance coverage maintained pursuant to one or more collective bargaining agreements that were ratified before the date of enactment of this title, the Act shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. [PPACA § 1251(d)]

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c. Hawaii Prepaid Health Care Act	Preserves the current ERISA preemption exemption for the Hawaii Prepaid Health Care Act. Coverage under the Hawaii Prepaid Health Care Act will be treated as a qualified health benefits plan providing acceptable coverage. [AHCAA § 256]	Nothing in the Act modifies or limits the current ERISA exemption for Hawaii's Prepaid Health Care Act. [PPACA § 1560(b)]
d. ERISA Preemption	For coverage not offered through the Exchange and for employment-based plans, ERISA's preemption provisions continue to apply. [AHCAA § 251(a)(2)]	No provision explicitly saves or eliminates ERISA preemption for plans outside of an exchange.
e. HIPAA Portability	The AHCAA preserves HIPAA for Exchange Plans, Non-Exchange Plans and Employer-based plans, including requirements relating to portability, access and renewability, prohibiting discrimination based on health status, Newborns' and Mothers' Health Protection Act, Mental Health Parity requirements and the Women's Health and Cancer Rights Act, and GINA (Title XXVII of the PHSA), unless their requirements prevent the application of a requirement of the AHCAA. [AHCAA § 251]	HIPAA continues to apply, as amended.
f. COBRA	COBRA benefits extended for individuals with coverage on or after the date of enactment who would lose COBRA coverage because their coverage period expired (the individual reached the statutory maximum period of coverage) until the individual was eligible for acceptable coverage or an Exchange plan. Other COBRA terminating events continue to apply. [AHCAA § 113]	No analogous provision.
g. Cafeteria Plans	No analogous provision.	Exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees. (New IRC § 125(j)) [PPACA § 9022]
h. IRC Amendments Related to Beneficiaries	Contributions for coverage provided by employers to eligible beneficiaries (defined as "any individual who is eligible to receive benefits or coverage under an accident or health plan") may be excluded from income under certain circumstances under § 106 (*e.g.*, domestic partners and same-sex spouses). Deductions for dependent health insurance costs are expanded. Certain benefits provided to members of VEBAs are extended to eligible	No analogous provision.

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Provision	**House**	**Senate**
	beneficiaries. FSA and HSA reimbursement will be expanded through guidance to eligible beneficiaries. Effective December 31, 2009. [AHCAA § 571]	
i. State and Federal Laws Regarding Abortion and Title VII of the Civil Rights Act	No state laws regarding abortion are preempted by the Act; the Act has no effect on federal laws regarding abortion or Title VII of the Civil Rights Act of 1964. [AHCAA § 258] No federal agency or state or local government that receives federal funds may discriminate against providers that do not provide coverage of or referrals for abortion. Limits are placed on using federal funds for plans that provide abortion benefits. [AHCAA §§ 259, 265]	State laws regarding the prohibition or requirement of coverage, funding or procedural requirements for abortions are not preempted. Federal conscience protections and abortion-related antidiscrimination laws are not affected. Title VII of the Civil Rights Act of 1964 would also not be affected by the bill. [PPACA § 1303(b)] A state may opt to prohibit abortion coverage from being offered through exchanges within that state. [PPACA §§ 1303, 10103]
j. State Medical Malpractice Laws	The Act does not modify or impair state medical malpractice laws. [AHCAA § 261]	Sense of the Senate provision only. [PPACA § 6801]
k. Emergency Medical Treatment and Active Labor Act	Section 1867 of the Social Security Act (EMTALA), which requires health care providers to provide emergency services, is unaffected by the Act. [AHCAA § 1908]	Section 1867 of the Social Security Act (EMTALA), which requires health care providers to provide emergency services, is unaffected by the Act. [PPACA § 1303(c)]
l. McCarran-Ferguson Act	Antitrust laws will apply with respect to the business of health and medical malpractice insurance. [AHCAA § 262]	No analogous provision.

II. EMPLOYER RESPONSIBILITY		
Provision	**House**	**Senate**
A. EMPLOYER MANDATE		
a. Health Coverage Participation Requirements	**Rule** Employer generally must: • offer all employees option of individual and family health coverage under a qualified health benefits plan; and • make required contributions to coverage (generally a minimum of 72.5% of the lowest cost premium for individual coverage and 65% for family (spouse + qualifying children) coverage for full-time employees). [AHCAA § 412(b)(1)] A proportional minimum contribution required for part-time employees will be determined by the HCA. [AHCAA § 412(b)(3)] or • make a contribution in lieu of coverage, if an employee declines employer coverage but obtains coverage through the Exchange. [AHCAA § 411] Employer must provide for auto enrollment in the employer-sponsored health benefit plan at the lowest applicable premium. Employees must be allowed to opt-out of coverage. [AHCAA § 412(c)] Employer must also provide HCA, Labor, HHS, and Treasury, as applicable, information to ascertain whether the employer has complied with the health coverage participation requirements [AHCAA § 412(a)(3)] **Penalty** Beginning in 2014, if an employee declines coverage from the employer but obtains coverage through the Exchange, the employer shall make a required contribution to the Exchange (generally 8% of wages paid, but a sliding scale for small employers). [AHCAA § 411(a)(3)] ERISA § 502 (civil enforcement provision) is amended to add civil penalties against employers who fail to meet the health coverage participation requirements, but any penalty will be coordinated with the excise tax	**Rule** Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage with the opportunity to opt-out. (New FLSA § 18A) [PPACA § 1511] Employers must notify employees (i) about the Exchange, (ii) that employees may be eligible for premium assistance and cost-sharing reduction if the employer's contribution to an employer-sponsored plan is less than 60% of the costs, and (iii) that if the employee chooses coverage through the Exchange, the employee will lose the employer's contribution to coverage. (New FLSA § 18B) [PPACA § 1512] Plans provided through the Exchange are qualified under a cafeteria plan only for qualified employers that offer a choice of Exchange plans to their employees. (New IRC § 125(f)(3)) [PPACA § 1515] Employers must include the aggregate cost of employer-sponsored coverage on an employee's W-2. (New IRC § 4980I) [PPACA § 9002] Employers that offer minimum essential coverage through an employer-sponsored plan and pay any portion of such coverage must provide free choice vouchers to qualified employees to purchase qualified health plan coverage through the Exchange. Qualified employees eligible for free choice vouchers are those whose required contribution for minimum essential coverage through the employer's plan exceeds 8% but is less than 9.8% of the employee's taxable income for the year, whose household income is less than 400% FPL and who do not participate in a health plan offered by the employer. The income thresholds are indexed. The amount of the voucher is the most generous amount the employer would have contributed for self-only (or family, if applicable) coverage

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Provision	**House**	**Senate**
	provisions to prevent duplicative penalties. [AHCAA § 421(b)] An excise tax of $100 per day/per employee will be imposed on employers who fail to satisfy the health coverage participation requirements, subject to limitations based on exercising reasonable diligence and correcting errors within 30 days. [AHCAA § 422(b); 511(b)]	under the employer's plan. Employers shall pay this amount to the Exchange; the Exchange will credit the amount to the monthly premium of the Exchange plan elected by the employee. If the voucher amount exceeds the Exchange plan premium, the difference is paid to the employee. Employers may deduct the amount paid in vouchers as an amount paid for personal services. Employers that provide free choice vouchers will not be assessed a penalty under 4980H with respect to those employees that receive vouchers. (New IRC 139D) [PPACA § 10108] **Penalty** Employers (with on average at least 50 employees) who do not offer minimum essential coverage to full-time employees (i.e., average of 30 hours per week) and have at least one employee receiving premium assistance are subject to a $750 annual fee for each full-time employee employed. Employees offered coverage by an employer where the plan's share of the costs of benefits provided is less than 60 percent or the premium exceeds 9.8 percent of the employee's income are not considered to have minimum essential coverage and are eligible for the premium assistance credit (if income is within 100-400% of the FPL). Employers with more than 50 employees who offer coverage to full-time employees (and dependents) and have at least one full-time employee obtain premium assistance will pay the lesser of $3,000 for each employee receiving assistance or $750 per employee for each full-time employee employed. Employers with an average of at least 50 employees that require a waiting period before enrollment longer than 60 days will pay $600 for each full-time employee. (New IRC § 4980H) [PPACA § 1513]

II. EMPLOYER RESPONSIBILITY		
Provision	**House**	**Senate**
b. Small Business and Hardship Exemptions from Penalties	Small businesses are exempt from or pay a graduated tax in lieu of coverage; employers whose annual payroll does not exceed $500,000 are exempt; sliding scale from 2 to 6 % of payroll for employers whose payroll between $500,000 and $750,000. [AHCAA §§ 413(b); 512]	For purposes of the shared responsibility section, the term "employer" means an employer that employs an average of at least 50 employees (for more than 120 days, if employer hires seasonal workers). Employers with fewer than 50 employees are not required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. [PPACA § 1513]
c. Prohibition Against Steering to the Exchange	The HCA, in coordination with the Secretaries of Labor, HHS, and Treasury have the authority to set rules to prevent employers from steering employees to the Exchange. [AHCAA § 414]	No analogous provision.
d. Prohibition Against Reducing Retiree Benefits	Group health plans (as defined by ERISA) are prohibited from reducing the benefits provided under the plan to retirees after retirement unless the same reduction is made with respect to active employees as well. [AHCAA § 110]	No analogous provision.
e. Prohibition Against Retaliation	No analogous provision.	Prohibits employers from discriminating against employees who receive premium tax credits. (New FLSA § 18C) [PPACA § 1558]
B. REPORTING / DISCLOSURE REQUIREMENTS		
a. Government Reporting Requirements	Every person who provides acceptable coverage to an individual shall make a return to the Treasury as proof that the individual is covered. (New IRC § 6050X) [AHCAA § 501(b)]	Health plans providing qualified health insurance must file a return regarding health insurance coverage including the number of months during which the individual was covered. Health plans shall also provide this information in writing to covered individuals. (New IRC § 6056) [PPACA § 1514] Amends Fair Labor Standards Act (FLSA) to provide that employers to which the Act applies must provide each employee at the time of hiring (or within 90 days of a state establishing or participating in Exchanges for current employees) written notice of the availability of the Exchange, including a description of the services provided. (New FLSA § 18B) [PPACA § 1512]

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Provision	**House**	**Senate**
b. Employer Election Requirements	Amends ERISA to provide that employers may elect to be subject to the health coverage participation requirements. (New ERISA § 801) An employer who makes such an election will be treated as having established a group health plan, subject to the Act. (New ERISA § 802(a)) The Secretary may terminate any election in cases of substantial noncompliance. (New ERISA § 805) The Secretary shall issue such regulations as necessary. (New ERISA § 806) The ERISA amendments adding Part 8 are effective as of December 31, 2012. [AHCAA § 421] Amends IRC to provide procedures for employer to elect to be subject to the health coverage participation requirements and excise tax provisions. [AHCAA §§ 422, 511, 512] Amends the PHSA to provide procedures for employers to elect to be subject to the health coverage participation requirements. (New PHSA § 2793) An election shall be treated as the establishment of a group health plan. (New PHSA § 2793(b)) Employers may make separate elections for full- and part-time employees. (New PHSA § 2793(d)) Civil penalties of $100/day per employee may be assessed for failure to satisfy the health coverage participation requirements, with limits on the penalties if the employer would not have discovered the failure using reasonable diligence or if the failure is corrected within 30 days. (New PHSA § 2793(f)) [AHCAA § 423]	No analogous provisions.
C. SUBSIDIES / CREDITS		
a. Small Business Credit	Credit for small businesses that offer qualified health coverage to qualified employees (those that made at least $5000 a year from that employer). (New IRC 45R(a)) The credit is up to 50% of the amount paid by the small employer. No credit allowed for highly compensated (income of $80,000/year) employees. Credit allowed for 2 years only. (New IRS 45R(c)(2)) [AHCAA § 521] The credits shall increase by a cost of living adjustment. (New IRC § 45R(f)(5) [AHCAA § 521(a)]	A sliding scale tax credit is available for small employers with fewer than 25 employees and average annual wages of less than $50,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost or 50 percent of a benchmark premium. (New IRC § 45R) [PPACA §§ 1421; 10105]

II. EMPLOYER RESPONSIBILITY		
Provision	**House**	**Senate**
b. Retiree Coverage Reimbursement	Temporary program would reimburse eligible employers that sponsor retiree coverage 80 percent of claims between $15,000 and ends at $90,000. It would reinsure only the claims for individual between the ages 55 to 64 year old who are not active workers or dependents of active workers and who are not Medicare-eligible. Reimbursement must be used to reduce costs, premium or cost-sharing of plan participants. [AHCAA § 111]	Temporary program would reimburse eligible employers that sponsor retiree coverage 80 percent of claims between $15,000 and ends at $90,000. It would reinsure only the claims for individual between the ages 55 to 64 year old who are not active workers or dependents of active workers and who are not Medicare-eligible. Reimbursement must be used to reduce costs, premium or cost-sharing of plan participants. [PPACA § 1102]
c. Wellness Programs Grants	HHS may make grants to small employers to defray costs of a qualified wellness program. [AHCAA § 112]	No analogous provisions.

III. EXCHANGE		
Provision	**House**	**Senate**
A. ADMINISTRATION / STRUCTURE		
a. Establishment	A national "Health Insurance Exchange" will be established under the direction of the HCA to facilitate access to health insurance coverage. [AHCAA § 301] A "Health Insurance Exchange Trust Fund" is created to operate the Exchange and provide affordability credits. [AHCAA § 307] A state (or group of states) may operate a state or regional "State-based Health Insurance Exchange" with approval from the HCA. The HCA may not approve of a state-based Exchange and may terminate Exchanges that fail to meet these requirements. [AHCAA § 308]	By January 1, 2014, states must establish an American Health Benefit Exchange to facilitate the purchase of qualified health plans. The Act provides for the establishment of a SHOP Exchange that • is a governmental or non-profit entity; • offers only qualified benefit plans; • allows limited scope dental benefits to be sold through the Exchange • implements procedures for the certification of health plans; • provides a telephone hotline and internet website; • uses a standardized format for the presentation of health benefit plan options; • make a calculator available to calculate costs, including after a premium tax credit; • certify individuals are exempt from the individual responsibility requirement; • provide required information to Treasury and employers; and • establish a Navigator program. Regional, Interstate or Subsidiary Exchanges may be established. States may merge an Exchange and a SHOP Exchange. [PPACA § 1311]
b. Federal / State Duties	In coordination with the appropriate state and federal officials, HCA shall: • establish certification standards and certify plans; [AHCAA § 304] • contract with Exchange providers; [AHCAA § 304] • enforce applicable requirements; [AHCAA § 304] • conduct outreach to inform and educate individuals and employers about the Exchange and Exchange plan options; [AHCAA § 305] • determine whether individuals and employers are eligible; [AHCAA § 305] • establish and carry out an enrollment process, including automatic enrollment for certain individuals who lose acceptable coverage;	HHS shall: • establish regulations regarding plan certification; • develop a rating system for qualified health plans offered through an Exchange; • continue to operate and update the internet portal required by PPACA § 1103(a) and provide a template to interested states; • establish enrollment periods; • establish market-based incentive guidelines; and • establish Navigator standards. [PPACA § 1311] States may elect to have in effect federal standards for the operation of

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	[AHCAA § 305] • provide information and assistance to consumers regarding Exchange plans; [AHCAA § 305] • assist small employers with the Exchange, including contracting with small employee benefit arrangements; [AHCAA § 305] • coordinate the distribution of affordability credits; and [AHCAA § 206] • adjust premium amounts (risk pooling). [AHCAA § 206(b)]	Exchanges or state laws or regulations that HHS determines are acceptable. If a state does not implement the necessary requirements, HHS shall establish and operate the Exchange. [PPACA § 1321(c)]
c. Plans Offered	An "Exchange Participating Health Benefits Plan" is a Qualified Health Benefits Plan offered through the Exchange. [AHCAA § 201(c)] Plans within the Exchange must offer specified benefits packages as specified by the HCA. [AHCAA § 221(b)] See Insurance Market Reforms, General Reform, Essential Plan Levels (p.14).	Only qualified health plans may be offered through the Exchange. Limited scope dental benefits are permitted, if the plan also provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J). [PPACA § 1311(d)(2)(B)].
d. Criteria for Certification to Participate in the Exchange	Entities must: • be licensed under the law in each state that service is provided; • provide data to the HCA as required; • implement affordability credits; • provide affordable premiums; • accept all enrollments (subject to limited exceptions, such as capacity); • participate in the HCA's risk pooling arrangement; • use essential community providers (as established under the PHSA § 340(B)(a)(4) & SSA § 1927(c)(1)(D)(i)(IV), as amended); • provide culturally and linguistically appropriate services; • comply with the special rules with respect to Indian enrollees and Indian health care providers; • establish program integrity standards; and • comply with any other additional requirements as specified by the HCA. [AHCAA § 304(b)(1)-(11)]	HHS shall establish criteria for certification requiring that a plan: • meet marketing requirements and not employ marketing practices that discourage individuals with significant health needs from enrolling; • ensure a wide choice of providers (including essential community providers that serve low-income, medically underserved individuals), and provide information on the availability of in- and out-of-network providers; • include essential community providers in networks; • be accredited; • implement a quality improvement strategy; • utilize a uniform enrollment form and the standard format established to present health benefits plan options; and • provide required plan quality performance data. An Exchange must also determine that making such a plan available is in the interest of qualified individual and employers in the state, and require health plan to submit a justification for any premium increase prior to

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		implementation of such increase. [PPACA §§ 1311(c)(1); 1311(e)]
e. Coverage Outside of the Exchange	New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AHCAA § 202(c)(1)]	A health insurance issuer may offer health plans outside of the Exchange to qualified individuals or qualified employers. [PPACA § 1312(d)]
f. Automatic Enrollment	HCA will provide a process for certain Exchange-eligible individuals to be automatically enrolled in Exchange coverage. [AHCAA § 305(b)(3)]	No analogous provision.
g. Market Incentives	No analogous provision.	HHS shall develop guidelines to provide increased reimbursement or other incentives for improving health outcomes through case management and coordination, activities to prevent hospital readmission and improve patient safety, and the implementation of wellness and health promotion activities in plans offered through an Exchange. [PPACA §§ 1311(g); 10104]
h. Navigators	No analogous provision.	Exchanges will award grants to entities (*e.g.*, trade associations, licensed insurance agents and brokers) to conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance and referrals to consumer assistance office ombudsmen. HHS shall establish standards for navigators. Under such standards, health insurers are ineligible to serve as navigators, and a navigator may not receive any consideration from an insurer in connection with participation or enrollment of employees of qualified employers or individuals. [PPACA § 1311(i)]
i. Presumption that State Exchanges Meet Act's Requirements	States operating a State-based Exchange prior to January 1, 2010 that seek to operate a State-based Exchange under the Act shall be presumed by the HCC to meet the requirements of the Act unless the HCC determines, after assisting the State-based Exchange with compliance with the Exchange requirements, that it does not comply with the requirements. [AHCAA § 308(b)(2)]	A state operating a State-based Exchange prior to January 1, 2010 that has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Act, that seeks to operate a State-based Exchange under the Act shall be presumed by HHS to meet the requirements of the Act unless the HHS determines that it does not comply with the requirements. [PPACA § 1321(e)]

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Provision	**House**	**Senate**
j. Risk Pools	HCA will adjust the premium amounts payable to qualified health benefit offering entities to minimize the impact of adverse selection of individuals and employees enrolled in Exchange-participating health benefits plans. [AHCAA § 306(b)] Qualified health benefit offering entities must participate in the risk pooling mechanism established by the HCA in order to participate in the Exchange. [AHCAA § 304(b)(6)]	A health insurance issuer shall consider all enrollees in all health plans (except grandfathered plans) offered by the issuer in the individual market, including those who do not enroll through an Exchange, to be members of a single risk pool. A health insurance issuer shall consider all enrollees in all health plans (except grandfathered plans) offered by the issuer in the small group market, including those who do not enroll through an Exchange, to be members of a single risk pool. States may require the individual and small group markets to merge. [PPACA § 1312(c)]
k. Role of Brokers	Agents and brokers may offer exchange-participating health benefits plans. [AHCAA § 100(c)(9)]	Agents and brokers are permitted to serve as Navigators and may continue to enroll individuals in qualified health plans offered in an Exchange and assist in applying for premium tax credits and cost-sharing credits. [PPACA §§ 1311(i), 1312 (e)]
l. CO-OPs	HCA may make grants and loans for the operation of new "Consumer Operated and Oriented Plan" (CO-OP) insurance cooperatives that provide insurance through the federal or a state-based Exchange. Cooperatives must meet specified conditions (including non-profit status, licensing, conflict of interest, and governance standards) to be eligible for grants and participation in an Exchange. Cooperatives that fail to meet the standards will be required to repay any loan or grant received. [AHCAA § 310]	See Insurance Market Reforms, General Reform, CO-OPs (p.4).
m. Exchange-Participating National Plans / Multi-State Plans	HCA may contract to offer a qualified health benefit plan with the same benefits in every state as long as the entity offering the plan is licensed in each state and the benefits meet the applicable state requirements. [AHCAA § 304(c)(6)]	Office of Personnel Management shall contract with health insurance issuers to offer at least 2 multi-state qualified health plans through the Exchange in each state to provide individual and small group coverage. At least one contract shall be with a non-profit entity. Medical loss ratios, profit margins, premiums and other terms and conditions shall be implemented in a manner similar to the Federal Employee Health Benefit Program.

III. EXCHANGE		
Provision	**House**	**Senate**
		Plans offered must be uniform in each state, offer essential benefits, meet the requirements of a qualified health plan, including the requirements related to bronze, silver, gold and catastrophic levels of coverage. Individuals enrolled in a multistate plan are eligible for credits and subsidies in the same manner as individuals enrolled in a qualified health plan. States may offer additional benefits, but such benefits may not result in additional federal cost. The rating requirements of the amended PHSA apply, except that states that have age rating requirements more restrictive than 3:1 may require the multi-state plan to abide by the more restrictive rating. Contracts may be phased in: • in the first year, the plan must be offered in 60% of states, • in the second year, the plan must be offered in 70% of states, • in the third year, the plan must be offered in 85% of states, • in the fourth year, the plan must be offered in all states. [PPACA §§ 1334; 10104]
n. State Basic Health Plan	No analogous provision. But states may receive grants from HHS to establish programs to expand access to affordable health care coverage for uninsured populations within the state. [AAHCA § 114]	HHS will establish a basic health program under which states would be able to contract to offer plans for people with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL). Eligible individuals and families would have access to coverage options through the Basic Health Plans rather than through an Exchange. States may enroll the following income-eligible persons who: • are under age of 65; • do not have access to affordable employer sponsored coverage that meets minimum creditable coverage standards; • are residents of an area served by the plan;

III. EXCHANGE		
Provision	**House**	**Senate**
		• have gross family income above 133 percent and below 200 percent of FPL. [PPACA §§ 1331; 10104]
B. ELIGIBILITY		
a. Individual Eligibility	In general, all individuals are eligible to obtain coverage through the Exchange unless: • they are already enrolled in a qualified health benefits plan or other acceptable coverage. Transition rules apply in 2013-2015. After 2015, acceptable coverage includes a qualified health benefits plan, grandfathered health insurance coverage, coverage under a current group health plan, Medicare, Medicaid, coverage as a member of the armed forces including TRICARE, VA, and other coverage as determined by the HCA; [AHCAA § 302(d)(2)] or • they receive coverage under a group health plan as a full-time employees, if the group health plan meets the coverage and employer contribution requirements of § 412 (employer responsibilities to contribute to coverage). [AHCAA §§ 302(a); 302(d)(1)(B)] Once an individual enrolls in an Exchange plan, the individual remains Exchange-eligible unless the individual becomes eligible for Medicare, or in some cases, Medicaid, or other circumstances as the HCA may provide. [AHCAA § 302(d)(3)]	HHS will establish procedures for determining eligibility for Exchange participation and the receipt of premium tax credits or reduced cost-sharing. [PPACA § 1411] An individual that resides in a state with an Exchange and seeks to enroll in a qualified health plan in the individual market through the Exchange is a qualified individual. A qualified individual may enroll in any qualified health plan available and for which the individual is eligible. [PPACA § 1312(a), (f)]
b. Employer Eligibility	Employers are eligible to participate in the Exchange on a transition schedule, as follows: • 2013: employers with 25 or fewer employees [AHCAA §§ 302(c)(1) & (e)(4)] • 2014: employers with 50 or fewer employees [AHCAA §§ 302 (c)(2)] • 2015: employers with 100 or fewer employees and larger employers on a timetable determined by HCA (based on number of full-time employees). [AHCAA §§ 302 (c)(3)]	Qualified Employers may elect to make all full-time employees eligible for plans through the Exchange. Qualified Employers are limited to small employers (generally 100 employees or less) until 2017, when states may allow large employers to participate in the Exchange. States may treat employers with no more than 50 employees as small for plan years beginning before 2016. Once eligible, an employer remains eligible regardless of the number of employees employed. [PPACA §§ 1304(b), 1311, 1312(f)]

III. EXCHANGE		
Provision	**House**	**Senate**
	Once eligible and enrolling employees through the Exchange, an employer remains eligible regardless of the number of employees employed unless the employer offers an employer-based group health plan that is not an Exchange health plan. [AHCAA § 302(e)(5)]	
C. CONDITIONS ON PARTICIPATION		
i. Employers		
a. General	Employers may meet their health coverage participation and contribution requirements under § 412 through Exchange plans. [AHCA § 302(e)(6)(A)]	Small firms may opt to use the Small Business Health Options Program (SHOP) exchange as the enrollment option for their employees. [PPACA § 1311(b)]
b. Employee Choice	Participating employers must allow employees to choose any plan in the Exchange, including dependent coverage. [AHCAA § 302(e)(6)(B)]	Qualified Employers may contribute to coverage of employees by selecting any level of coverage available; employees may choose any plan within the level selected by the Qualified Employer. [PPACA § 1312(a)(2)] A qualified individual may enroll in any qualified health plan (except catastrophic plans are available only for those individuals who are eligible). [PPACA § 1312(a), (d)(3)(C)]
ii. Plans / Providers		
a. Benefit Levels Established	The HCA shall establish standards for 3 levels of benefits plans (basic, enhanced, premium) that may be offered through the Exchange. Standards may be offered for premium-plus plans. [AHCAA § 303(c)]	See Insurance Market Reforms, General Reform, Essential Benefit Levels (p.14).

III. EXCHANGE		
Provision	**House**	**Senate**
b. Benefit Levels Offered	To participate in the Exchange, a provider must offer only one basic plan may be offered in each service area in which the provider operates. [AHCAA § 303(b)(1)] A provider may then offer: • one enhanced plan for said service area if a basic plan is offered; [AHCAA § 303(b)(2)] • one premium plan for said service area may be offered if an enhanced plan is offered; [AHCAA § 303(b)(3)] • additional benefits (vision, dental, etc) may be offered in a premium-plus plan or plans but the premium attributable to such additional benefits must be detailed separately. [AHCAA § 303(b)(4)] States may impose benefits mandates beyond the essential benefits package if the state reimburses the HCA for any additional affordability credit costs that result from increases in premiums on basic plans. [AHCAA § 303(d)]	An Exchange shall make available a qualified health plans. States may require additional benefits, but must assume the cost. To offer a qualified health plan through the Exchange, a provider must agree to offer at least one silver level and one gold level plan in the Exchange and must agree to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered inside or outside of the Exchange. [PPACA §§ 1301(a)(1); 1311(d)(2), (3)]
c. Cost-Sharing Levels	Permissible cost-sharing ranges will be established by the HCA and may not vary by more than 10% with respect to each benefit category. [AHCAA § 303(c)(6)]	Cost-sharing in essential benefits packages is limited beginning in 2014. Limits shall not exceed the limits on high deductible health plans (currently $5,000 for an individual; $10,000 for a family). Employer-sponsored plans in the small group market may not impose deductibles over $2,000/individual and $4,000/other, increased by the maximum reimbursement amount available under an FSA and increased annually by an amount calculated under the Act. [PPACA § 1302(c)]
d. Network Adequacy Cost-Sharing	If the HCA determines a network does not meet the HCA's standards, cost-sharing for any item or service that a participant receives out-of-network shall be equal to in-network cost-sharing. [AHCAA § 304(c)(3)]	No analogous provision.

IV. PUBLIC PLAN OPTION		
Provision	**House**	**Senate**
a. Establishment	HHS will develop a public health insurance option to be offered only in the Exchange beginning in 2013. [AHCAA § 321] Enrollment in the public option is voluntary. [AHCAA § 329] The public plan shall comply with the requirements applicable to an Exchange plan, including benefits, benefit levels, provider networks, notices, consumer protections and cost sharing. [AHCAA § 321(b)(2)]	No analogous provision. [PPACA §§ 10104, 1334]
b. "Level Playing Field"	The public option must comply with the Exchange-participating health benefits plan requirements, including benefits, benefit levels, provider networks, notices, consumer protections and cost-sharing. [AHCAA § 321(b)(2)]	Coverage offered by a private health insurer shall not be subject to any federal or state law if a CO-OP or multi-state qualified health plan is not subject to such law. Such laws are those relating to: • guaranteed renewal; • rating; • preexisting conditions; • non-discrimination; • 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. [PPACA § 1324]
c. Benefits Offered	The public health plan option shall offer the same benefit levels (basic, enhanced, premium) as private plans and may offer premium-plus plans. [AHCAA § 321(b)(3)]	No analogous provision.

IV. PUBLIC PLAN OPTION		
Provision	**House**	**Senate**
d. Premiums	Premiums shall be set by the Secretary to will comply with the premium rating rules for Exchange-participating plans (§ 213) and at a level sufficient to fully cover the cost plus administrative expenses with a contingency margin. [AHCAA § 322(a)]	No analogous provision.
e. Remedies	Public plan participants shall have the same access to federal court as Medicare beneficiaries. [AHCAA § 321(g)]	No analogous provision.
f. Administrative Contracts	The Secretary may enter into administrative contracts in the same way and to the same extent as under Medicare. [AHCAA § 321(c)]	No analogous provision.
g. Provider Participation	Health care providers participating in Medicare are participating providers in the public health insurance option unless they opt-out. [AHCAA § 323(b)] Two classes of physician providers shall participate – preferred and non-preferred. The Secretary shall negotiate the rates for preferred and non-preferred providers. Other providers may participate if the provider agrees to accept public option rates. [AHCAA § 325(c)] Providers that are excluded from participation in other federal health programs may be excluded from the public health option. [AHCAA § 325(d)]	No analogous provisions.
h. Provider Reimbursement Rates	HHS will negotiate provider reimbursement rates. Administrative and judicial review of provider rates is prohibited. [AACHA § 323]	No analogous provision.
i. Provider Payment Initiatives	Secretary may use incentive payments to encourage providers to provide greater quality and efficiency in the use of medical care. [AHCAA § 324]	No analogous provision.
j. Ombudsman	The Secretary shall establish an Ombudsman that has the same duties as the Medicare Beneficiary Ombudsman. [AHCAA § 321(d)]	No analogous provision.

IV. PUBLIC PLAN OPTION		
Provision	**House**	**Senate**
k. Fraud and Abuse	Medicare's fraud and abuse provisions apply to the public health insurance option. [AHCAA § 326]	No analogous provision.
l. Funding	A separate Treasury account and start-up funding of $2 billion will be established for the public health insurance option. The start-up funding shall be repaid within 10 years. TARP-like bailouts of the public option are prohibited. [AHCAA § 322(b)]	No analogous provision.
m. HIPAA Insurance Requirements	HIPAA insurance requirements (PHSA §§ 2701-2792) apply. [AHCAA § 327]	No analogous provision.
n. Administrative Simplification, Security and Privacy	Protections against wrongful disclosure of personal information, health information security requirements, and the electronic exchange of health information requirements of part C of SSA Title XI apply. [AHCAA § 328]	No analogous provision.

V. INDIVIDUAL RESPONSIBILITY		
Provision	**House**	**Senate**
A. INDIVIDUAL MANDATE		
a. Tax for Failure to Obtain Acceptable / Qualifying Coverage	A tax of 2.5% is imposed on the excess of modified adjusted gross income of individuals who fail to obtain acceptable coverage at any time during the tax year is imposed over the amount of income that subjects an individual to filing an income tax return. The tax is limited to not more than the average national premium for self-only coverage under a basic plan. The tax may be prorated for any periods during which the individual had acceptable coverage. [AHCAA § 501]	Individuals are required to maintain minimum essential coverage for each month beginning in 2014. Failure to maintain coverage for the entire year will result in a penalty. The monthly penalty is 1/12th of the lesser of: • The average cost of a bronze plan OR • The greater of: o 0.5% of the taxpayer's household income (for 2014), 1.0% (for 2015), 2.0% (for years after 2015) OR o The lesser of: ▪ a flat dollar amount (the lesser of $95 (for 2014), $495 (for 2015), $750 (thereafter) for all applicable individuals without coverage or 300% of the those amounts for the calendar year), or ▪ 300% of the flat dollar amount. The applicable penalty will be one-half of the amounts listed above for individuals under 18. [PPACA §§ 1501; 10106]
b. Acceptable / Minimum Essential Coverage Defined	Acceptable coverage includes coverage under a qualified health benefits plan, grandfathered health insurance coverage, on an individual or group basis (as defined in § 102), Medicare, Medicaid, coverage as a member of the armed forces, VA, and other coverage as determined by the HCA. [AHCAA § 302(d)(2)]	Minimum essential coverage includes Medicare part A, Medicaid, CHIP, TRICARE, VA, eligible employer-sponsored coverage, individual health plans, grandfathered health plans, and such other coverage as designated by HHS. [PPACA § 1501; New IRC § 5000A]
c. Exceptions	The tax does not apply to: • individuals who may be claimed as a dependent on another taxpayer's return; • nonresident aliens; • qualified individuals and qualifying children (as defined in IRC § 911(d)) residing outside the United States; • bona fide residents of United States possessions (as defined in IRC § 937(a)) will be treated as having acceptable coverage; or • individuals who have an exemption that certifies that they belong to	Exceptions to the individual responsibility requirement to maintain minimum essential coverage may be made for those with religious exemptions. Individuals not lawfully present in the United States and incarcerated individuals will be exempted from the individual responsibility requirement. Exemptions from the penalty will be made for those who cannot afford coverage (required contributions toward coverage exceed 8% of household income), taxpayers with income under 100 percent of the poverty level, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year. (New IRC § 5000A) [PPACA §§ 1501; 10106]

V. INDIVIDUAL RESPONSIBILITY		
Provision	**House**	**Senate**
	a religious group with established views in opposition to the acceptance of insurance benefits or medical care (as defined in IRC § 1402(g)(1)). An application for a religious exemption must be filed with Treasury. [AHCAA § 501]	
B. SUBSIDIES / CREDITS		
a. Administration of Credits	Individuals apply for affordability premium credits and affordability cost-sharing credits through HCA. The HCA may use state Medicaid agencies to make credit eligibility determinations. [AHCAA § 341(b)]	HHS will determine eligibility for Exchange participation, premium tax credits, reduced cost-sharing and individual responsibility exemptions. Appeals procedures will be provided; separate appeals of employer liability will also be provided. [PPACA § 1411] A program to determine and pay premium tax credits and cost-sharing reductions in advance will be established by HHS and Treasury. [PPACA § 1412(a)] States may make payments to or on behalf of individual for coverage under a qualified health plan through the Exchange in addition to any credits or cost-sharing reductions allowed under federal law. [PPACA § 1412(d)]
b. Use of Credits	Credits available only for Exchange plans. Affordability credits may only be used on the basic plan for first 2 years after effective date; in the third year and thereafter, HCA may then allow affordability credits for enhanced and premium plans, but individual must pay difference between premium of enhanced or premium plan and the basic plan. Cost-sharing credits may not be used for enhanced or premium plans. [AHCAA § 341(c)] Eligible individuals enrolled in Exchange-participating health benefits plans are eligible for affordability premium credits to be applied against the premium, and affordability cost-sharing credits to be applied as a reduction of the cost-sharing otherwise applicable to the plan. HCA will pay the affordability credits to the health insurer. [AHCAA § 341(a)] No cash rebate is available. [AHCAA § 341(e)]	Credits available only for Exchange plans. [PPACA §§ 1411(e)(2)(A)(i); 1412(a)(1)]

V. INDIVIDUAL RESPONSIBILITY		
Provision	**House**	**Senate**
c. Affordability Credit Eligibility	Generally, those eligible for affordability credits are individuals who are enrolled in Exchange-participating health benefit plans and who have incomes up to 400% of FPL, who are generally not Medicaid-eligible and are not enrolled in acceptable coverage other than an Exchange-participating health benefits plan. [AHCAA § 342(a)] Affordability premium credits are available to affordability credit eligible individuals with family incomes less than 400% of FPL. The amount of the premium credit is equal to the amount by which the premium for the plan exceeds the affordable premium amount, as determined by the Act and the HCA. [AHCAA § 343] Affordable cost sharing credit is in the form of a reduction in cost-sharing amounts and annual limitations of cost-sharing. The credit is available to affordability credit eligible individuals enrolled in Exchange plans and is based on family income tiers and annual limits on cost-sharing as set by the HCA. [AHCAA § 344] In general, full-time employees of employers who offer employee (or family, if applicable) coverage under a group health plan that meets the requirements of § 412 are not eligible for affordability credits. Beginning in 2014, if employer-provided coverage would cost more than 12% of an employee's current modified adjusted gross income, that employee would be eligible to obtain credits. HCA may establish exceptions for divorced or separated employees and dependents. [AHCAA §§ 342(a)(1)(A), 342(b)] Certain Medicaid-eligible individuals are eligible for affordability credits during a transition period. [AHCAA § 342(a)(1)(C)] Individuals must be citizens or lawfully present in the US to be eligible for affordability credits. [AHCAA §§ 341(b)(4); 347]	A premium assistance credit is available to individuals with incomes between 100 and 400% of the FPL who are not eligible for minimal essential coverage. The amount of the credit will be equal to the product of the premium cost of the second lowest cost silver plan multiplied by a percentage that is determined based on the tax payer's household income for the year. Employees offered coverage by an employer where the plan's share of the costs of benefits provided is less than 60 percent or the premium exceeds 9.8 percent of the employee's income are not considered to have minimum essential coverage and are eligible for the premium assistance credit (if income is within 100-400% of the FPL). Individuals must be lawfully present in the US to be eligible for the credit. [New IRC § 36B) [PPACA § 1401] Cost sharing assistance shall provide that cost-sharing maximum limits ($5,950/individuals and $11,900/families) for individuals in qualified health plans would be reduced to 1/3 for those between 100-200% FPL, 1/2 for those between 200-300% FPL, and 2/3 for those between 300-400% FPL. The plan's share of total allowed costs of benefits would be increased to 90% for those between 100-150 % FPL and to 80% for those between 150-200% FPL. Individuals must be lawfully present in the US to be eligible. [PPACA § 1402]
d. Free Choice Vouchers	No analogous provision.	Qualified employees are eligible to receive free choice vouchers to purchase qualified health plan coverage through the Exchange. Qualified employees are those whose required contribution for minimum

V. INDIVIDUAL RESPONSIBILITY		
Provision	**House**	**Senate**
		essential coverage through the employer's plan exceeds 8% but is less than 9.8% of the employee's taxable income for the year, whose household income is less than 400% FPL and who does not participate in a health plan offered by the employer. The income thresholds are indexed. The amount of the voucher is the most generous amount the employer would have contributed for self-only (or family, if applicable) coverage under the employer's plan. Employers shall pay this amount to the Exchange; the Exchange will credit the amount to the monthly premium of the Exchange plan elected by the employee. If the voucher amount exceeds the Exchange plan premium, the difference is paid to the employee. The amount of the voucher is not considered gross income to the employee. (New IRC § 139D) [PPACA § 10107]

VI. REVENUE RAISERS		
Provision	**House**	**Senate**
a. Additional Taxes on High Income Individuals	In addition to regular income taxes, taxpayers making a joint/surviving spouse return will be subject to a surtax of 5.4% of modified adjusted gross income that exceeds $1,000,000. Taxpayers not making a joint/ surviving spouse return will be subject to a surtax of 5.4% of modified adjusted gross income that exceeds $500,000. Effective for taxable years beginning after December 31, 2010. (New IRC § 59C) [AHCAA § 551(a)]	Additional payroll tax (hospital insurance tax) of 0.9% for individual wages over $200,000 and $250,000 for couples for both employees and employers. (New IRC § 3101(b)) [PPACA §§ 9015, 10906]
b. Tax Treatment of Reimbursement for Prescription Drugs and Insulin/Qualified Medical Expenses	The current law regarding health savings accounts, Archer medical savings accounts, health flexible spending accounts, and health reimbursement arrangements is amended to prohibit reimbursement for over-the-counter medication. Effective for expenses incurred after December 31, 2010. [AHCAA § 531]	The definition of qualified medical expense for HSAs, FSAs, and HRAs is amended to exclude over-the-counter medicine unless obtained with a prescription or is insulin. Effective for distributions paid for taxable years beginning after December 31, 2010 or expenses incurred in taxable years beginning after December 31, 2010. (New IRC §§ 223(d)(2); 220(d)(2)(A); 106(f)) [PPACA § 9003]
c. Excise Tax on High Cost Insurance	No analogous provision.	An excise tax of 40 percent would apply to the excess benefit of high cost employer-sponsored health insurance. The excess benefit is the value of the benefit in excess of $8,500 for single coverage and $23,000 for family coverage (indexed annually). This tax would be imposed on insurance companies, employers and/or plan administrators. The tax would apply to self-insured plans and plans sold in the group market. The threshold is increased for the 17 highest cost states for the first 3 years. An additional threshold amount is available for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. (New IRC § 4980I) [PPACA § 9001]
d. Additional Tax on HSA Distributions Not Used for Medical Purposes	The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount. Effective for distributions made after December 31, 2010. [AHCAA § 533]	The additional tax on distributions from an HSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount. (New IRC §§ 223(f)(4)(A); 220(f)(4)(A)) [PPACA § 9004]
e. Limiting FSAs	Salary reductions by an employee for a taxable year for purposes of coverage under a Health FSA under a cafeteria plan are limited to $2,500. This limitation is increased annually for cost of living increases. Effective	Salary reductions by an employee for a taxable year for purposes of coverage under a Health FSA under a cafeteria plan are limited to $2,500. This limitation is increased annually for cost of living increases. Effective for taxable years beginning after December 31, 2010. (New IRC § 125(i))

VI. REVENUE RAISERS		
Provision	**House**	**Senate**
	for taxable years beginning after December 31, 2012. [AHCAA § 532]	[PPACA §§ 9005, 10902]
f. Additional Requirements for 501(c)(3) Hospitals	No analogous provision.	501(c)(3) charitable hospital organizations would be required to conduct a community health needs assessment at least once every three years and adopt a strategy to meet these needs; each hospital would be required to adopt, implement and publicize a written financial assistance policy; each hospital would be required to bill patients who qualify for financial assistance no more than the amount generally billed to insured patients; the hospital would have to develop a policy limiting charges on certain procedures and the hospital would be required to take reasonable steps before extraordinary efforts regarding collections of debts. In addition, IRS would be required to review hospital's community benefit activities. (New IRC § 501(a)) [PPACA §§ 9007, 10903] The penalty for failure to meet these standards for any taxable year will be $50,000. Effective after the date of enactment. (New IRC § 4959) [PPACA § 9007]
g. Annual Fee on Manufacturers and Importers of Branded Drugs	No analogous provision.	A fee would be imposed on any entity that manufactures or imports branded prescription drugs. The penalty for failure to meet these standards for any taxable year will be $50,000. This fee is accessed on calendar years beginning after 2009. The Secretary of the Treasury would establish individual assessments by determining the relative market share for each covered entity in the preceding calendar year. (New IRC § 4959) [PPACA § 9008]
h. Tax on Sale of Medical Devices / Annual Fee on Manufacturers of Medical Devices	Tax equal to 2.5% for the first sale (other than resale) of any medical device after production, manufacture or importation. Applies to sales (and transactions treated as sales) after December 31, 2012. (New IRC § 4061) [AHCAA § 552]	A fee would be imposed on any person that manufactures or imports medical devices offered for sale in the United States; certain devices are excluded from the fee. The Secretary would establish individual assessments by determining the relative market share for each covered entity. Applies to sales after December 31, 2008 [PPACA § 9009]
i. Annual Fee on Health Insurance Providers	No analogous provision.	An annual fee would be applied to any entity engaged in the business of providing health insurance. A company or organization that underwrites policies for government-funded insurance is also treated as a U.S. health insurance provider. The CO-OPs are subject to the fee. Governmental

VI. REVENUE RAISERS		
Provision	**House**	**Senate**
		entities and self-insured employers are not subject to the fee nor are insurers with less than 25 million dollars in net premiums written during the previous calendar year. The fee applies with respect to premiums written after December 31, 2008. [PPACA § 9010, 10905]
j. Repeal Deduction for Certain Retiree Prescription Drug Plans	Eliminates the ability to deduct Medicare Part D expenses for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. Effective for taxable years beginning after December 31, 2010. [AHCAA §§ 534]	Eliminates the ability to deduct Medicare Part D expenses for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. Effective for taxable years beginning after December 31, 2010. (New IRC § 139A) [PPACA § 9012]
k. Amend Itemized Deduction for Medical Expenses	No analogous provision.	The threshold for the deduction is increased from the current 7.5% of AGI to 10% for taxable years beginning after December 31, 2012. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim expenses that exceed 7.5% AGI through 2016. (New IRC § 213) [PPACA § 9013]
l. Health Insurance Executive Compensation Limits	No analogous provision.	In the case of a covered health insurance provider, the tax deduction of compensation is limited to $500,000 for remuneration which is attributable to services performed by an officer, employee, director, and other worker or service provider performing services for or on behalf of a covered health insurance provider. This provision will apply to taxable years beginning after December 31, 2009 with respect to services preformed after such date. This applies to health insurance issuers for taxable years beginning after December 31, 2009 and before January 1, 2013 and any employer thereafter that is a health insurance issuer and with respect to which not less than 25% of gross premiums received are for providing minimum essential coverage. (New IRC § 162(m)) [PPACA § 9014]
m. Modification of § 833 Treatment	No analogous provision.	Organizations must have a medical loss ratio of 85% or higher to maintain nonprofit status under Code section 833. This applies to taxable years beginning after (New IRC § 833) [PPACA § 9016]
n. Tax on Indoor Tanning	No analogous provision.	Imposes a ten percent tax of the amount paid for indoor tanning services. Applies to procedures performed on or after January 1, 2010. The individual performing the procedure will collect the tax. (New IRC § 5000B) [PPACA § 10907]

VI. REVENUE RAISERS		
Provision	**House**	**Senate**
o. Worldwide Allocation of Interest	AHCAA §§ 553; 554.	No analogous provision.
p. Exclusion of Unprocessed Fuels from the Biofuels Credit	AHCAA § 555	No analogous provision.
q. Limit on Treaty Benefits	AHCAA § 561	No analogous provision.
r. Economic Substance Doctrine	AHCAA § 562	No analogous provision.
s. Penalties for Underpayment	AHCAA § 563	No analogous provision.
t. Corporate Information Reporting	No analogous provision.	Informational returns (*e.g.*, 1099s) will be required for payments over $600 made to corporations. (New IRC § 6041) [PPACA § 9006]

VII. SOURCES		
Provision	**House**	**Senate**
Internet Locations	http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3962.pcs:	http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.3590: