GROOM LAW GROUP

As of October 14, 2009, three bills have emerged as the leading health care reform packages—one in the House of Representatives (approved and amended by three committees) and two in the Senate. This chart compares:

- **the House Tri-Committee bill, the "America's Affordable Health Choices Act," as reported by the Ways & Means Committee on July 17, 2009, the Energy & Commerce Committee on July 31, 2009, and the Education & Labor Committee on July 17, 2009. Notable committee amendments are also included in the summary.**
- **the "Affordable Health Choices Act" from the HELP Committee, as introduced by Senator Harkin on September 17, 2009 (S. 1679) in a bill with all amendments incorporated, and**
- **the Senate Finance Committee's "America's Healthy Futures Act of 2009" as released by the Committee on October 2, 2009.**

We expect that over the next few weeks, these bills will be combined in their respective chambers.

Our side-by-side comparison focuses primarily on the proposed insurance market reforms, but it also addresses the provisions related to the individual and employer mandate, the Exchange/Gateway provisions, the public plan options, and revenue raisers.

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Table of Contents

I. Insurance Market Reforms 1
  A. Administration/Enforcement 1
    a. New Federal Agency
    b. Duties
    c. State Role
    d. Use of State Employees
    e. Enforcement of Benefit Plan Standards
    f. Audits
    g. Sanctions
    h. Ombudsman
    i. Consumer Assistance Grants
  B. General Reform 4
   i. Plan Standards 4
    a. Guaranteed Issue
    b. Guaranteed Renewability
    c. Recession
    d. Rating Limitations
    e. Same Cost Throughout the Year
    f. Copayments and Coinsurance
    g. Preventative Care
    h. Preexisting Conditions
    i. Adequacy of Provider Network
    j. Nondiscrimination and Mental Health Parity
    k. Wellness Programs
    l. Discrimination in Health Care Services
    m. Annual and Lifetime Limits
    n. Extension of Dependent Coverage
    o. Treatment of Children with Congenital or Developmental Deformity or Disorder
    p. General Effective Date
   ii. Market Reforms 12
    a. Method of Offering Individual Policies
    b. Rating Areas
    c. Risk Pooling
    d. Interstate Sale of Insurance/Health Care Choice Compacts
    e. National Plans
    f. CO-OPs

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g. Minimal Loss Ratio/Rebates and Cost Accounting
h. Discrimination Against Health Care Providers
i. Quality of Care Payment Structure/Coverage Restrictions
j. Prohibition Against Discrimination On Assisted-Suicide
k. Access to Therapies
l. State Opt-Out
m. State Basic Health

C. Qualified Health Benefits Plans / Creditable Health Insurance Coverage 20
a. New Coverage Requirements/Definitions
b. Grandfathered and Excepted Coverage
c. Restrictions on Grandfathered Coverage

i. Essential Benefits 22
a. General Standards
b. Minimum Required Coverage
c. No Dollar Limits on Coverage
d. Selection and Adoption of Covered Benefits
e. Discrimination Based on Religious Preference

ii. Essential Plan Levels 25
a. Basic Value (Basic Plan) (Bronze Level)
b. Enhanced Value (Enhanced Plan) (Silver Level)
c. Premium Value (Premium Plan) (Gold Level)
d. Premium Plus (Platinum Level)
e. "Young Invincible" (Catastrophic Plan)

iii. Essential Benefit Cost-Sharing 27
a. Cost-Sharing Definitions
b. Preventative Care Cost-Sharing
c. Annual and Lifetime Limits
d. Copayments Favored

D. Consumer Protections 28

i. General 28
a. Fair Marketing Practices
b. Prompt Claims Payment
c. Administrative Simplification
d. Coordination of Benefits
e. Subrogation of Benefits
f. Prescription Records
g. Pharmacy Benefit Manager Contract Conditions
h. End-of-Life Planning
i. Utilization Review

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ii. Appeal and Grievance Procedures 30
- a. Appeal and Grievance Procedures Required
- b. Internal Claims and Appeals
- c. External Review
- d. State Judicial Review

iii. Plan Disclosures 31
- a. Plan Disclosures
- b. Contracting Reimbursement
- c. Applicability of Consumer Protections to Non-Qualified Health Benefit Plans

E. Relation to Current Laws 33
- a. Whistleblower Protections
- b. Collective Bargaining
- c. Hawaii Prepaid Health Care Act
- d. ERISA Preemption
- e. HIPAA
- f. COBRA
- g. Cafeteria Plans
- h. State and Federal Laws Regarding Abortion and Title VII of the Civil Rights Act
- i. Emergency Medical Treatment and Active Labor Act (EMTALA)

II. Employer Responsibility 36

A. Employer Mandate 36
- a. Health Coverage Participation Requirements
- b. Automatic Enrollment
- c. Small Business and Hardship Exemptions from Penalties
- d. Prohibition Against Steering to Exchange
- e. Prohibition Against Reducing Retiree Benefits
- f. Exceptions for Self-Insured Plans
- g. Payroll Deductions from Premiums

B. Reporting / Disclosure Requirements 38
- a. Government Reporting Requirements
- b. Employer Election Requirements

C. Subsidies / Credits 40
- a. Small Business Credit
- b. Partnerships
- c. Self-Employed Credit
- d. Credit Adjustment for Inflation
- e. Retiree Coverage Reimbursement
- f. Employer Credit Effective Date

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III. Exchange / Gateway 43
a. Establishment
A. Administration / Structure 43
a. Plans Offered
b. Coverage Outside of the Exchange
c. Surcharges
d. Risk Adjustment Payments
e. Risk Pools
f. Federal HHS/HCA and/or State Duties
g. State Participation in Exchange/Gateway
h. Criteria for Certification
i. Market Incentives
j. Summary of Benefits
k. Presumption that State Exchanges Meet Act's Requirements
l. CO-OPs
m. State Single Payer System
n. Navigators
o. Role of Brokers
p. Automatic Enrollment
B. Eligibility 51
a. Individual Eligibility
b. Continuation of Individual Eligibility
c. Employer Eligibility
d. Continuation of Employer Eligibility
C. Conditions on Participation 54
i. Employers 54
a. General
b. Employee Choice
ii. Plans / Providers 54
a. Benefit Levels Established
b. Benefit Levels Offered
c. Cost-Sharing Levels
d. Network Adequacy Cost-Sharing
e. Limitations on Contracting with Hospitals

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IV. Public Plan Option 57
- a. Establishment
- b. "Level Playing Field" (Requiring Public Option to Comply with Requirements With Which Private Plans Must Comply)
- c. Benefits Offered
- d. Premiums
- e. Remedies

A. Administration 58
- a. Administrative Contracts
- b. Provider Reimbursement Rates
- c. Provider Payment Initiatives
- d. Ombudsman
- e. Fraud and Abuse
- f. Funding

B. Provider Participation 60
- a. Conditions on Participation
- b. Classes of Provider-Participants
- c. Excluded Providers

V. Individual Responsibility 62

A. Individual Mandate 62
- a. Tax for Failure to Obtain Acceptable/Qualifying Coverage
- b. Acceptable/Qualifying Coverage Defined
- c. Exceptions

B. Subsidies / Credits 64
- a. Administration of Credits
- b. Use of Credits
- c. Affordability Credit Eligibility

VI. Revenue Raisers 67
- a. Tax on High Income Individuals/Health Care Surcharge
- b. Adjustments on Rates
- c. Tax Treatment of Reimbursement for Prescription Drugs and Insulin/Qualified Medical Expenses
- d. Excise Tax on High Cost Insurance
- e. Addition Tax on HSA Distributions Not Used for Medical Purposes
- f. Limiting FSAs
- g. Additional Requirements for 501(c)(3) Hospitals
- h. Annual Fee on Manufacturers and Importers of Branded Drugs
- i. Annual Fee on Manufacturers of Medical Devices
- j. Annual Fee on Health Insurance Providers

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k. **Repeal Deduction for Certain Retiree Prescription Drug Plans**
l. **Amend Itemized Deduction for Medical Expenses**
m. **Health Insurance Executive Compensation Limits**
n. **Worldwide Allocation of Interest**
o. **Limit on Treaty Benefits**
p. **Economic Substance Doctrine**
q. **Penalties for Underpayment**
r. **Corporate Information Reporting**

VII. **Sources of Information 72**

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)[*]**	**Senate HELP Committee**	**Senate Finance Committee**
A. ADMINISTRATION / ENFORCEMENT			
a. New Federal Agency	Establishes the "Health Choices Administration" ("HCA") an independent executive branch agency. [AAHCA § 141]	No analogous provision.	No analogous provision.
b. Duties	The HCA shall: • establish plan standards, • operate the Exchange, including contract with qualified entities to offer health benefits plans through the Exchange, issue regulations for the administration of the Exchange, enroll individuals and employers in the Exchange, and • administer affordability credits. [AAHCA §§ 142; 201(b)]	HHS is generally responsible for the applicable federal requirements, through the amendments to the PHSA. [AHCA §§ 101, 142]	HHS is generally responsible for the applicable federal requirements, along with Treasury.
c. 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. [AAHCA § 143(a)(1), (2))]	States are generally responsible, through creating and administering Gateways, for applicable functions. [New PHSA § 3101(c)(1), (3)) [AHCA § 142] HHS will consult with states regarding applicable standards, including risk adjustment payments and oversight of enrollment and provide guidance to be used by Gateways in implementing applicable standards. (New PHSA §§ 3101(c)(5)(B), (6), 3101(e)) [AHCA § 142]	State insurance commissioners would provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, agent practices and training, market conduct), rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans by the Act, including providing oversight of plans with regards to federal rating rules and any additional state rating rules, facilitating risk-adjustment within service areas, and establishing rate schedules for broker commissions in the state exchanges. [AFHA, Chairman's Mark, Redline, 11] The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new federal law with

[*] Notable amendments from the committees are noted in the text.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			regards to federal health insurance rating, issuance and marketing requirements which will become the federal minimum standard without any further action. If the NAIC does not act within 12 months, HHS will issue regulations. States may adopt the Model regulation or different regulations with HHS approval. [AFHA, Chairman's Mark, Redline, 11] Failure to adopt the new minimum standards would result in federal preemption of conflicting state laws. [AFHA, Chairman's Mark, Redline, 11] States are prohibited from imposing more stringent regulatory requirements on certain health insurance issuers that are not applied to all issuers in the individual and small group markets. All entities offering health insurance would be subject to state regulatory requirements that exceed federal requirements established under this legislation.[AFHA, Chairman's Mark, Redline, 12]
d. Use of State Employees	The HCA may utilize state employees for the operation of a state-based health insurance exchange (§ 208) and the determination of eligibility for affordability credits (§ 241(b)(2)). [AAHCA § 142(f)]	States are generally responsible, through creating and administering Gateways, for applicable functions. States also act in conjunction with HHS. [AHCA § 142]	No analogous provision.
e. Enforcement of Benefit Plan Standards	The HCA will coordinate with HHS, DOL, Treasury and state insurance regulators regarding the enforcement of qualified health benefit plan standards. [AACHA § 142(a); § 143(a)] The HCA shall establish oversight procedures with respect to qualified health benefits plan entities that offer plans through the Exchange. Such procedures shall include grievance and complaint procedures and may include the sanctions of § 142 (such as civil money penalties or suspension of enrollment) or termination of participation.	States are generally responsible for certifying Gateway health benefit plans as qualified. (New PHSA §§ 3101(c)(3), 3101(d)) [AHCA § 142]	State insurance commissioners are generally responsible for requirements imposed on insured plans by the Act.[AFHA, Chairman's Mark, Redline, 12]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	[AAHCA § 204(c)(4)(A)-(C)]		
f. Audits	The HCA, in coordination with the states, shall audit qualified health benefits plans for compliance with Federal standards. [AAHCA § 142(b)(2)]	No analogous provision for audits of health plans. See Exchange/Gateway for other applicable audit provisions.	No analogous provision.
g. 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 AAHCA. [AAHCA § 142(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, termination of plan (in coordination with state regulators). [AAHCA § 142(d)(2)]	Current PHSA enforcement provisions (§ 2722) would continue to apply.	It appears that current PHSA enforcement provisions (§ 2722) would continue to apply.
h. Ombudsman	An Ombudsman shall be created. The Ombudsman shall receive complaints and requests for information, and provide assistance to individuals. [AAHCA § 144]	No analogous provision for general Ombudsman. But see Public Plan.	In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with private coverage in the individual and small group markets. [AFHA, Chairman's Mark, Redline, 46]
i. Consumer Assistance Grants	No analogous provision.	HHS shall award grants to states (or its Gateways) to establish offices of health insurance consumer assistance. (New PHSA § 3109) [AHCA § 142(b)]	Establishes a new competitive grant program to support consumer assistance organizations in each state. Grantee organizations would assist consumers in solving problems and navigating health insurance coverage transitions, as well as collect data on consumer encounters, and report to HHS on types of problems and inquiries. [AFHA, Chairman's Mark, Redline, 46]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
B. GENERAL REFORM			
i. Plan Standards			
a. Guaranteed Issue	With some exceptions, the Public Health Service Act's (PHSA) current guaranteed issue requirements for the group market will apply. (PHSA § 2711) Each health insurance issuer must accept every employer that applies for coverage and must enroll every eligible individual (whether coverage is offered through the Exchange or through an employer-based plan or otherwise). For employment-based plans, eligibility may be set by the employer's plan rules or as provided by the issuer as long as the rules are uniformly applicable within the state and in accordance with State law. (PHSA § 2711) The PHSA's current special network and minimum participation and contribution rules will not apply. [AAHCA § 112]	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. HHS will establish regulations to govern open and special enrollment periods. As is the case currently, plans that offer individual or group coverage through a network plan may also limit coverage to those that live, work or reside in the network service area and may deny coverage to new enrollees if the network will not have the necessary service or financial capacity to provide adequate services to those enrollees. Capacity denials will result in the plan being suspended from offering coverage within the service area for 180 days. (New PHSA § 2702; effective as of the date that a state becomes "participating" or an "establishing" state.) [AHCA §§ 101, 135] Prohibits group health plans or issuers offering group or individual health insurance coverage from establishing eligibility rules based on salary. Rules that allow lower compensated employees to contribute less coverage are allowed. (New PHSA § 2720A) [AHCA § 121]	Issuers in the individual and small group market would be required to accept every individual who applies, unless the plan has a capacity limit that would be exceeded. [AFHA, Chairman's Mark, Redline, 2]
b. Guaranteed Renewability	With some exceptions, the PHSA's current guaranteed renewability rules (PHSA § 2712) apply. If a health insurance issuer offers health insurance coverage in the group market in connection with a group health plan,	An issuer in the individual or group market must renew or continue coverage at the option of the group or the individual, except in cases of: • nonpayment,	Issuers in the individual and small group market would be required to renew or continue coverage and rate those policies on the same factors used when the policy was initially issued. [AFHA, Chairman's Mark, Redline, 12]

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I. INSURANCE MARKET REFORMS			
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	the issuer must renew or continue such coverage at the option of the plan sponsor. Insurers may discontinue coverage for: • nonpayment, • fraud, • if it is ceasing to provide coverage in the market according to PHSA rules and state law, or • if in the case of a network plan, there are no longer enrollees in the issuer's service area. Issuers may not fail to renew coverage for violation of participation or contribution rules, or because the employer is no longer a member of the association under which the coverage was provided. [AAHCA § 112]	• fraud, • issuer termination of all coverage in market, • participant moves outside of the service area, • association membership, in cases where coverage is made on the basis of bona fide membership, ceases, or • in the case of group plans, the plan sponsor has failed to comply with a material plan provision relating to employer contributions or group participant rules, pursuant to applicable state law. (New PHSA § 2703) [AHCA § 101]	
c. Rescission	Rescission is prohibited except in cases of fraud and independent review of rescission determinations is required. Rescission provisions are effective beginning October 1, 2010. [AAHCA §§ 112, 162]	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such coverage except in cases of fraud or intentional misrepresentation of material fact. Coverage may be cancelled only as permitted under § 2702(c) and § 2742(b). (New PHSA § 2703(b)) [AHCA § 101]	Issuers in the individual and small group market would be prohibited from rescinding health coverage. [AFHA, Chairman's Mark, Redline, 2]

d. Rating Limitations	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).
	[AAHCA § 113(a)]
		Premium rates in the individual or 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 2 to 1),
		• tobacco use (except it may not vary by more than 1.5 to 1), and
		• participation in a health promotion or disease prevention program (see Wellness programs).
		[New PHS § 2701(a)]
			Premium rates in the individual and small group market may vary only by the following characteristics and within the following limits:
			• family enrollment,
			  ◦ single (1 to 1)
			  ◦ adult with child (1.8 to 1)
			  ◦ two adults (2 to 1)
			  ◦ family (3 to 1)
			• age (4 to 1), and
			• tobacco use (1.5 to 1).

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
		Further, premium rates shall not vary with respect to the particular plan or coverage involved by health status-related factors, gender, class of business, claims experience, industry or any other factor not specifically listed, except with respect to wellness programs. HHS will establish, by regulation, a minimum size for community rating areas for the purposes of this section. (New PHSA § 2701(b), effective as of the date that a state becomes "participating" or an "establishing" state.) [AHCA § 101; 135(b)] An issuer of group or individual insurance may not require any individual to pay a premium or contribution which is greater the premium or contribution for a similarly situated individual on the basis of any health status-related factor. The prohibition applies to individuals and dependents. (New PHSA § 2706(b); effective as of the date that a state becomes "participating" or an "establishing" state.) A group health plan or issuer offering group health insurance may not adjust premiums or contribution amounts for the group based on genetic information, nor require any individual or family member to undergo genetic testing. All plans, including non-federal and small group plans, must comply with these prohibitions. (New PHSA § 2706(b)(3); (c); effective as of the date that a state becomes "participating" or an "establishing" state.) [AHCA § 101] Nothing in the Act prohibits the use of utilization management techniques that are currently, commonly used. [AHCA § 133(b)]	Premiums may vary among geographic areas, but not within areas. Aggregating all the permissible factors, premiums within the family category could not vary by more than 6 to 1. [AFHA, Chairman's Mark, Redline, 2]
e. Same Cost Throughout the Year	**EL Amendment** would require qualified health benefit plan costs to remain the same during a plan year unless the change increases coverage or lowers costs to the enrollee.	No analogous provision.	No analogous provision.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	[EL AAHCA § 117]		
f. Copayments and Coinsurance	When cost-sharing levels for the basic, enhanced and premium plans are established, copayments, rather than coinsurance, should be provided for to the maximum extent possible. [AAHCA § 122(c)(2)(C)]	No analogous provision.	No analogous provision.
g. Preventative Care	No cost-sharing is permitted for preventative care, including well-baby and well-child care. [AAHCA §§ 122(c); 203(c)(6)] The essential benefits package must cover preventative care, among other services. [AAHCA § 122(b)]	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 (other than minimal cost sharing in accordance with guidelines developed by the Secretary) for preventative coverage (as defined in the Act). (New PHSA § 2708) [AHCA § 101] Preventative women's health care (guidelines for coverage to be developed by Health Resources and Services Administration) must be covered with minimal cost (cost guidelines to be developed by HHS). (New PHSA § 2709) [AHCA § 101]	All individual and small group market plans must provide preventative care, with no cost-sharing, exception in cases where "value-based insurance" design is used. [AFHA, Chairman's Mark, Redline, 22]
h. Preexisting Conditions	A qualified health benefits plan may not impose any preexisting condition exclusion (as defined in the PHSA § 2701(b)(1)(A)). [AAHCA § 111] **EL Amendment** would amend ERISA to provide a shorter look-back (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 § 111). Effective 6 months after Act enacted, with provisions for collective bargaining agreements. [EL AAHCA § 166] **EC Amendment** would amend PHSA to provide a shorter look-back (30 days) and shorter preexisting conditions	A group health plan and a health insurance issuer offering group or individual health insurance may not impose any preexisting condition exclusion. (New PHSA § 2705; effective as of the date that a state becomes "participating" or an "establishing" state.) [AHCA §§ 101; 135]	Issuers in the individual and small group market would be prohibited from excluding coverage for preexisting health conditions. [AFHA, Chairman's Mark, Redline, 2] Within a year of enactment, any uninsured individual who had been denied health care coverage on the basis of a preexisting condition can enroll in a high-risk pool that will exist until 2013. Premiums for the high risk pool will be based on the rating factors for the individual market and will be 100% of the premium for the Bronze plan. Individuals who are currently covered must be uninsured for six months before joining the high-risk pool. Premium subsidies will be provided. [AFHA, Chairman's Mark, Redline, 2]

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Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	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 § 111). [EC AAHCA § 165 (Sutton 039)]		
i. Adequacy of Provider Network	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. [AAHCA § 115]	Network adequacy provisions apply to plans offered through Gateways. (New PHSA § 3101(l)(c)) [AHCA § 142]	See Interstate Sale of Insurance.
j. Nondiscrimination and 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). [AAHCA § 114(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. [AAHCA § 114(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 § 2791(d)(9)). [AAHCA § 111]	Retains the current PHSA requirements relating to: • coverage of newborns and mothers (New PHSA § 2717), • parity in mental health and substance use disorder benefits (New PHSA § 2718), • reconstructive surgery coverage following mastectomies (New PHSA § 2719), and • coverage of dependent students on medical leaves of absence. (New PHSA § 2720). [AHCA §§101; 133] 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,	Plans available in the individual and small group market would be required to provide mental health and substance abuse services that meet or exceed current federal and state standards. [AFHA, Chairman's Mark, Redline, p 22]

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Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
		• 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. (New PHSA § 2706(a)) [AHCA § 101]	
k. Wellness Programs	**EL Amendment** would provide wellness program grants to qualified employers in connection with a qualified wellness program, as certified by the Department of Labor, and consists of at least three of the following wellness components: health awareness, employee engagement, behavioral change, and supportive environment components. Qualified employers means an employer that offers a qualified health benefits plan to every employee including each employee required to be offered coverage under a qualified health benefits, and meets the health coverage participation requirements as defined in § 312. [EL AAHCA, § 2552]	Wellness programs that are designed to promote health or prevent disease and do not base a rebate or reward on an individual satisfying a standard that is related to a health status factor and are made available to all similarly situated individuals are acceptable. (New PHSA §§ 2706(b)(1) [AHCA § 101] Rewards that pay for memberships at fitness centers, rewards for diagnostic testing, waiving copayments or deductibles for preventative care, smoking cessation programs (if the program is implemented without regard to whether the individual ceases smoking), and health education seminars are examples of acceptable wellness rewards if they are available to all similarly situated individuals. (New PHSA §§ 2706(b)(2) [AHCA § 101] Wellness programs that condition a reward or rebate on satisfying a health status related factor are acceptable if: • the reward does not exceed 30 percent of the cost of employee-only coverage under the plan (or 30 percent of employee + dependents if employee + dependents are enrolled and eligible for rewards), • the program is reasonably designed to promote health or prevent disease, • eligible individuals have the opportunity to qualify at	Group health plans and health insurance issuers offering coverage in group markets would be allowed to provide rewards, including insurance premium discounts or rebates, based on an individual or an employee's participation in wellness programs. Wellness programs which provide rewards based on an individual satisfying a standard that is related to a health factor must meet certain requirements. Rewards would be capped at 30% of the employee-only coverage under the plan, but also provide protections for plan participants that cannot meet the applicable standard due to a medical condition or because it is medically inadvisable to do so and would allow the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to take the percentage up to 50% for adherence to or participation in a reasonably designed program of health promotion and disease prevention. A reward can be in the form of discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. Programs which reward based on the attainment of certain

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
		least once a year, • the full award is available to all similarly situated individuals (a reasonable alternative must be made available to individuals for whom it is unreasonably difficult to meet the requirement), and • wellness program terms are adequately disclosed. Prior wellness programs that meet all applicable regulations and are operating as of the effective date of this section may continue for as long as the previous regulations remain in effect. Labor, HHS and Treasury may promulgate regulations to effectuate this section, including increasing the award available to up to 50 percent of the cost of coverage if appropriate. (New PHSA § 2706(b)(3)) [AHCA § 101]	health standards would need to meet the following criteria: • Be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. The plan or issuer shall evaluate the program's reasonableness at least once per year. • Provide individuals eligible for the program the opportunity to qualify for the reward under the program at least once a year. • Ensure that the reward must be available to all similarly situated individuals. If someone's medical condition keeps them from achieving a reward under the program, or if it is medically inadvisable for them to try to achieve the reward, then a reasonable alternative standard for obtaining the reward must be made available. • Plan materials describing the terms of the wellness program must disclose the availability of the reasonable alternative standard for similarly situated individuals, or the possibility that the standard will be waived. [AFHA, Chairman's Mark, Redline, 95]
l. Discrimination in Health Care and Related Services	Prohibits discrimination in the provision of health care and health insurance coverage. The Secretary of HHS will promulgate regulations to enforce this provision. [AAHCA § 152]	Essential health care benefits include a requirement of non-discrimination in health care. [AHCA § 3103] See also New PHSA §§ 2705 (prohibiting discrimination based on health status), 2706 (same).	No analogous provision.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
m. Annual and Lifetime Limits	An essential benefits package may not impose annual or lifetime cost limits on coverage of covered health care items and services. [AAHCA § 122] Annual out of pocket expenses are limited to $5,000/individual and $10,000/family in 2013. The limits are indexed to the CPI. [AAHCA § 122(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 benefits for any participant or beneficiary. Effective date delayed until HHS certifies that this requirement will not result in fraud and abuse. (New PHSA § 2711) [AHCA § 101]	Individual and small group market plans could not impose lifetime limits on coverage or annual limits on any benefits. [AFHA, Chairman's Mark, Redline, 2]
n. Extension of Dependent Coverage	No analogous requirement.	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; however, this provision does not require a health plan or insurer to cover children of children receiving dependent coverage. (New PHSA § 2710) [AHCA § 101]	No analogous requirement.
o. Treatment of Children with Congenital or Developmental Deformity or Disorder	**EC Amendment** would require health insurance issuers offering group or individual health insurance that offer surgical coverage to provide coverage for outpatient and inpatient medically necessary treatment of a minor child's congenital or development deformity, disease or injury. Pre-authorization or pre-certification requirements are permitted. Cosmetic surgery to improve self-esteem coverage is not required. Effective January 1, 2010 [(New PHSA §§ 2708, 2754) EC AAHCA § 163 Gordon (Gordon06_001)]	No analogous provision.	No analogous provision.
p. General Effective Date	No analogous provision.	Unless otherwise provided, provisions in subtitle A (provisions applicable to individual and group markets) are effective for plan years beginning on or after 1 year following the date of enactment. [AHCA § 135]	Small group market requirements will be phased in for a period of up to five years, beginning July 1, 2013, as determined by each state with approval from HHS. [AFHA, Chairman's Mark, Redline, 3]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
ii. Market Reforms			
a. Method of Offering Individual Policies	New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AAHCA 102(c)(1)]	Qualified individuals may purchase qualified health plans through Gateways. (New PHSA § 3101(b)) [AHCA § 142(b)] Licensed health insurers may continue to offer coverage outside of Gateways, but each state's requirements continue to apply. (New PHSA § 3101(l)) [AHCA § 142(b)]	Effective 2013, all private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must be available in a newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements). [AFHA, Chairman's Mark, Redline, 18]
b. Rating Areas	Premium rating areas as permitted by state insurance regulators or the HCA. [AAHCA § 113(a)(2)]	Community rating areas as established by HHS. (New PHSA § 2701(a)(2)) [AHCA § 101]	State insurance commissioners would define rating areas. HHS would review rating areas for adequacy. Rating areas would be risk adjusted within each area and across all plans in each individual and small group market. [AFHA, Chairman's Mark, Redline, 12]
c. Risk Pooling	HCA will adjust the premium amounts payable to qualified health benefit offering entities to minimize the impact of adverse selection of individuals enrolled in Exchange-participating health benefits plans. [AAHCA § 206(b)] Qualified health benefit offering entities must participate in the risk pooling mechanism established by the HCA in order to participate in the Exchange. [AAHCA § 204(b)(5)]	Risk pooling requirements applicable to Gateways. See Exchange/Gateways, below.	Rating: States would be required to apply rating rules to the individual market and the small group market (groups of 1-50, or 100 at option of the state). States would be able to merge the individual and small group pools for rating purposes. Risk Adjustment: All plans in the individual and small group market would be subject to the same risk adjustment. HHS will qualify entities capable of risk adjustment; such entities shall not include insurance carriers. States may develop their own risk adjustment, but it must produce similar results and may not increase federal costs. Reinsurance: As a condition of issuing commercial, major medical health insurance policies or administering benefit plans for major medical coverage in years 2013, 2014, and 2015, all health insurance issuers would be required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity. States are

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			responsible for enforcing this requirement, but federal law would preempt any conflicting state law provisions. Reinsurance funds would be used to reinsure high risk individuals through exchanges. Risk Corridors: After reinsurance is applied, in the case of a plan that offers coverage in the individual and small group market in 2013, 2014, and 2015, risk corridors modeled after that applied to regional Participating Provider Organizations in Medicare Part D will be provided if a plan chooses to participate. [AFHA, Chairman's Mark, Redline, 8-12]
d. Interstate Sale of Insurance/Health Care Choice Compacts	No analogous provision.	No analogous provision, but allows for regional Gateways.	No later than 2013, the NAIC shall develop model rules for the creation of 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. Health care choice compacts may exist between two or more states. Once compacts have been agreed to, insurers would be allowed to sell policies in any state participating in the compact. 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. Effective July 1, 2013 except as

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			otherwise designated. [AFHA, Chairman's Mark, Redline, 13]
e. National Plans	No analogous provision.	No analogous provision.	National plans, with uniform benefits (preempting state benefit mandates), may be offered across state lines. Issuers must be licensed in every state in which they operate would be regulated by the states in terms of solvency and other key consumer protections and would offer coverage through the state exchanges. States may opt-out of the national plan. Premiums for national plans will be determined based on rating rules in each state and will reflect geographic variation among rating areas. National plans would be subject to the requirement to offer silver and gold benefit levels. If an insurer offers a national plan(s) in one state, it must offer the same plan(s) in any other state in which it chooses to participate. [AFHA, Chairman's Mark, Redline, 13]
f. CO-OPs	**EC Amendment** would provide that the HCA may make grants and loans for the operation of "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. [EC AAHCA § 251 Ross (BlueDog3_002) & (BlueDogOmnibus)] Also provides definitions of "member" with respect to cooperatives and includes cooperatives in the definition of a health benefits plan, a qualified health benefit plan offering entity, and a qualified health benefits plan. [EC AAHCA § 253 Ross (BlueDog3_002) &(BlueDogOmnibus)]	No analogous provision.	The Consumer Operated and Oriented Plan (CO-OP) program to create non-profit, member-run health insurance companies that serve individuals in one or more states. CO-OPs would 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, • 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, • incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference in its governing documents,

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			• not be sponsored by a State, county, or local government, or any government instrumentality, • limit substantially all of its activities to the issuance of qualified health benefit plans in the individual and small group markets in each State in which it is licensed to issue such plans, • 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. Effective the date of enactment. [AFHA, Chairman's Mark, Redline, 14]
g. Minimum Loss Ratio/Rebates and Cost Accounting	A qualified health benefit plan must meet specified medical loss ratios (the ratio of medical expenditures to insurance premiums) as defined by the HCA. An entity offering a qualified health benefit plan must rebate premiums to enrollees if the medical loss ratio is less than a specified percentage set by the HCA (e.g. the ratio must be less than 85% or the plan must rebate the amount over 85% to enrollees). The minimum medical loss ratio applies to group and individual coverage. Minimum loss ratio requirements apply for plan years beginning on or after January 1, 2011. [AAHCA §§ 116, 161]	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, • taxes, license and regulatory fees (including Gateway surcharges), and • on all other non-claims costs, including costs associated with compliance with the AHCA, with an explanation of the nature of such costs. Effective on the date of enactment. (New PHSA § 2704) [AHCA § 101]	Beginning in 2010, health plans would be required to report the proportion of premium dollars that are spent on items other than medical care. [AFHA, Chairman's Mark, Redline, 47]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)[*]**	**Senate HELP Committee**	**Senate Finance Committee**
h. Discrimination Against Health Care Providers	No analogous provision.	A group health plan and a health insurance issuer are prohibited from offering group or individual health insurance coverage that discriminates with respect to participation or coverage against health care providers acting within the scope of that provider's license or certification under state law. However, a group health plan and a health insurance issuer offering group or individual health insurance coverage is not required to contract with any willing provider and a group health plan, and a health insurance issuer offering group or individual health insurance coverage may continue to vary reimbursement rates. (New PHSA § 2713) [AHCA § 101]	No analogous provision.
i. Quality of Care Payment Structure/Coverage Restrictions	A qualified health benefit plan may not restrict coverage for any reason unrelated to clinical appropriateness. However, plans may use cost-sharing. [AAHCA § 121(c)]	A group health plan and a health insurance issuer offering group or individual health insurance coverage shall develop and implement an incentive reimbursement structure. The structure should reflect the payment policy of the Medicare and the Children's Health Insurance Program to promote high quality health care. The incentive structure should 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, • the implementation of wellness and health promotion activities, • child health measures under section 1139A of the	Quality of care requirements applicable to Basic Health Plans. [AFHA, Chairman's Mark, Redline, 16]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
		Social Security Act, and • culturally and linguistically appropriate care, as defined by HHS. No plan or issuer shall be prohibited from providing payment for a treatment or procedure it chooses to cover. HHS may define exceptions to the above requirements for insurers that substantially meet the goals provided. (New PHSA § 2707) [AHCA § 101]	
j. Prohibition Against Discrimination on Assisted-Suicide	No analogous provision.	The federal government, state or local government, or health care providers that receive federal funds under this Act (or an amendment made by this Act) may not discriminate on the basis that entity or individual does not provide assistance for suicide, euthanasia or mercy killing. [AHCA § 189B]	Federal funds may not be used to pay for assisted suicide. Conscience protections offered for providers and plans refusing to offer assisted suicide services. [AFHA, Chairman's Mark, Redline, 86]
k. Access to Therapies	No analogous provision.	HHS shall not promulgate any regulation that creates unreasonable barriers to treatment, impedes timely access to care, interferes with treatment option communications, restricts disclosure of relevant information from provider to patients, violates informed consent principles, or limits the availability of treatment for the full duration of a patient's needs. [AHCA § 189C]	No analogous provision.
l. State Opt-Out	No analogous provision.	No analogous provision.	Beginning in 2015, states will have an opportunity to apply for a waiver to opt out of certain aspects of this Act. States may be granted a waiver if the state applies to the Secretary to provide health care coverage that is at least as comprehensive as required under the Act. For a waiver, states must meet the requirements of the Act such as that all residents have affordable, quality insurance coverage shall be eligible for a waiver of applicable Federal health-related program requirements.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			In order to be eligible to receive a waiver under this section, states must demonstrate that: • the state plan provides health care coverage to its residents that is at least as comprehensive as the coverage required under an exchange plan and with citizen input through a referenda or similar means, • the state plan will ensure that all residents have coverage, • the state submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a comprehensive description of the State legislation or plan for implementing the State-based health plan, and • the state submits a ten-year budget for the plan that is budget neutral to the Federal government. The Secretary must grant an application only if it meets criteria consistent with that of the America's Healthy Future Act, including that it shall lower health care spending growth, improve the delivery system performance, provide affordable choices for all its citizens, expand protections against excessive out-of-pocket spending, provides coverage to the same number of uninsured and not increase the Federal deficit. The Secretary would determine the scope of a waiver granted to a State under this section, including which Federal laws and requirements will not apply to the State under the waiver. Waiver authority only relates to laws under the authority of the Secretary of HHS and does not apply to laws like the Civil Rights Act, ERISA, and American's with Disabilities Act or any other federal law or regulation which is not under the jurisdiction of the Secretary of HHS. [AFHA, Chairman's Mark, Redline, 14]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)[*]**	**Senate HELP Committee**	**Senate Finance Committee**
m. State Basic Health Plan	No analogous provision.	No analogous provision.	States would be able to establish a federally-funded, non-Medicaid state plan for people with incomes above Medicaid eligibility but below 200 percent of the federal poverty level (FPL). States may negotiate with health care systems for coverage options. Eligible individuals and families would have access to coverage options through the Basic Health Plans rather than through an exchange. ***Funding.*** A state's Basic Health Plan funding level would be based on the value of individual tax credits and cost sharing subsidies that would otherwise have been made. ***Eligibility.*** The Basic Health Plan would be available to people with incomes from 133 to 200 percent of federal poverty level. States could enroll the following income-eligible persons in their Basic Health Plan, as of July 1, 2013, 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, • have gross family income above 133 percent and below 200 percent of FPL, • choose to obtain basic health care coverage from a participating health care plan, and • remain current in payment of their share of the premiums. Minimum benefit package and premium cost sharing levels in the Basic Health Plan would be set at the levels provided in the Making Coverage Affordable section of the Act. The premium assistance for the eligible population would be available through the Basic Health Plan instead of through the tax credits

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			otherwise provided. The population above 200 percent of FPL would have access to tax credits as available in the Act. To the extent a state chooses to create a Basic Health Plan, no tax credit subsidy would be available to individuals otherwise eligible as members of the covered enrollee population. Tax credit subsidies would be available to citizens of states that have chosen not to create Basic Health Plans. [AFHA, Chairman's Mark, Redline, 15]
C. QUALIFIED HEALTH BENEFITS PLANS / CREDITABLE HEALTH INSURANCE COVERAGE			
a. New Coverage Requirements/ Definitions	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." [AAHCA § 101] New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AAHCA § 102(c)(1)] **EL Amendment** excludes TRICARE (the military health plan) coverage from definition of 'employment based health plans.' [EL AAHCA § 100(c)(6)(C)] **EC Amendment** provides that the combination of stand-alone dental or vision coverage and a qualified health benefit plan without such coverage shall be treated as satisfying the requirements of the essential benefits package. [EC AAHCA § 102(c)(3) Melancon (Melancon5_001)]	Group health plans and health insurance issuers offering group and individual health coverage must meet certain criteria, including guaranteed issue, guaranteed renewability, and prohibitions on health-status underwriting, annual and lifetime benefit limits and preexisting condition limitations. (See General Standards). Licensed health insurers may continue to offer coverage outside of Gateways. (New PHSA § 3101(l)) [AHCA § 142(b)]	Four benefit categories would be available: bronze, silver, gold and platinum. No policies could be issued in the individual or small group market (other than grandfathered plans) that do not meet the actuarial standards described below. All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories. [AFHA, Chairman's Mark, Redline, 22]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
b. Grandfathered and Excepted Coverage	Individual health insurance coverage that is offered and in force before January 1, 2013 is grandfathered. [AAHCA § 102] Employment-based health plans in effect as of December 31, 2012 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. [AAHCA § 102(b)(1)(A)] Limited benefit plants (such as coverage that provides only dental, vision, counseling, flexible spending arrangements) are not required to meet the standards of a qualified health plan. [AAHCA § 102(b)(1)(B)(i)] 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. [AAHCA §§ 102(b)(1)(B); 102(c)(2); 121(b)(3)] Under the Act, neither limited benefit plans nor excepted benefit plans are considered acceptable coverage for an employment-based health plan. [AAHCA § 102(b)] **EC Amendment** would add that stand-alone dental and vision coverage may continue to be offered. [EC AAHCA § 102(c)(3) Melancon (Melancon5_001)]	Individuals are not required to terminate coverage in effect prior to January 1, 2013 and dependents may be enrolled in such coverage. [AHCA §§ 131] Family members and new employees may continue to join employer provided health plans that are in effect prior to January 1, 2013. [AHCA §§ 131] Collectively bargained agreements that are ratified prior to the Act's enactment are exempt until the date on which the last collective bargaining agreement related to coverage terminates. [AHCA §§ 131] Risk adjustment procedures (§ 142) do not apply to existing plans. [AHCA §§ 131] Grandfathered coverage is exempted from the Act's requirements unless the coverage is "significantly changed" as determined by Health and Human Services (HHS). [AHCA §§ 131]	Individuals and groups who wish to renew coverage in an existing policy would be permitted to do so, including individuals with existing policies equal in value to the "young invincible" plans, which satisfy the personal responsibility requirement. Beginning July 1, 2013, federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with approval from the Secretary. Plans may continue after the transition period, subject to the rating rules. [AFHA, Chairman's Mark, Redline, 12]
c. Restrictions on Grandfathered Coverage	Only individuals who are covered as of December 31, 2012 may be enrolled in a grandfathered individual plan; no individuals may be enrolled subsequent to December 31, 2012. [AAHCA § 102(a)(1)(A)] Only dependents of individuals who are covered as of December 31, 2012 may	Only family members and new employees may continue to join employer provided health plans that are in effect prior to January 1, 2013. [AHCA §§ 131] Grandfathered coverage is exempted from the Act's requirements unless the coverage is "significantly changed"	Plans could continue to offer coverage in a grandfathered policy, but only to those who were currently enrolled, dependents, or to new employees and their dependents for employer-based coverage. No tax credits would be offered for grandfathered plans.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	be enrolled in a grandfathered individual plan on or after January 1, 2013. [AAHCA § 102(a)(1)(B)] Unless required by law, the issuer may not change terms & conditions, including benefits and cost-sharing (deductibles, coinsurance, copayments & similar charges (does not include premiums or out of network payment differential)) from those in effect on December 31, 2013. [AAHCA § 102(a)(2)] Premium increases must be at same rate as for all enrollees in the same risk group, as specified by the HCA. [AAHCA § 102(a)(3)]	as determined by Health and Human Services (HHS). [AHCA §§ 131]	[AFHA, Chairman's Mark, Redline, 12]
i. Essential Benefits			
a. General Standards	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-sponsored coverage. [AAHCA § 122] A qualified health benefits plan shall provide coverage that meets at least the standards of the "essential benefits package." [AAHCA § 121(a)] A qualified health benefits plan that is offered outside of the Exchange may offer benefits in addition to essential benefits. [AAHCA § 121(b)(1)] Premium plans offered through the Exchange may offer benefits in addition to essential benefits. [AAHCA § 121(b)(2)] Excepted benefits may be offered under a separate policy. [AAHCA § 121(b)(3)]	A group health plan or issuer offering group or individual coverage must cover preventative care. Only "minimal cost-sharing", as determined by HHS, is allowed for preventative care. Preventative care consists of: • items or services rated 'A' or 'B' by the United States Preventative Services Task Force, • immunizations recommended by the Centers for Disease Control and Prevention, and • preventative care and screening for infants, children and adolescents as provided for by the Health Resources and Services Administration. (final provision effective for plan years beginning on or after January 1, 2010). (New PHSA § 2708) [AHCA § 101] Also sets standards for group health plans and issuers offering group or individual health insurance coverage. Also establishes minimum coverage required for plans	All health insurance plans in the individual and small group market must provide the minimum required coverage, no cost-sharing for preventative care services (with exceptions), no annual or lifetime cost limitations and any insurer that rates based on tobacco usage must cover comprehensive tobacco cessation programs (including counseling and pharmacotherapy). [AFHA, Chairman's Mark, Redline, 22]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
		offered through state Gateways. (See Plans Offered through the Gateway/Exchange)	
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, • preventative services, • maternity care, and • well baby and well child care and oral health, and vision and hearing services for children under 21 years of age. [AAHCA § 122(b)(1)-(10)] **EL Amendment** would add the following to the essential benefits package: • certain mental health and substance abuse services (including Screening, Brief Intervention, and Referral to Treatment (SBIRT)), • vaccines recommended by the Centers for Disease Control and Prevention, and • durable medical equipment, prosthetics, orthotics and related supplies. [EL AAHCA § 122(b)(8), (11)] **EC Amendment** would add "treatment of a congenital or	Minimum required coverage for <u>Gateway</u> plans only. Qualified health plans must be certified and provide at least the essential benefits, consisting of: • 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, • preventative and wellness services, and • pediatric services, including oral and vision care. HHS is required to establish the complete list of essential benefits. (New PHSA § 3103(a)(1)(A)) [AHCA § 142(b)} Coverage limited to a single condition, or "an unreasonably limited set of diseases or conditions" do not meet the conditions of a qualified health plan. (New PHSA § 3103(a)(1)(A)) [AHCA § 142(b)] States may require additional benefits, if state assumes additional costs. (New PHSA § 3101(c)(2)(F)(ii)) [AHCA § 142(b)] Mental health parity (§ 2716) applies to qualified health plans offered through Gateways. (New PHSA § 3101(q)) [AHCA § 142(b)]	Minimum required coverage <u>for individual and small group</u> market plans: • preventive and primary care, • emergency services, • hospitalization, • physician services, • outpatient services, • day surgery and related anesthesia, • diagnostic imaging and screenings (including x-rays), • maternity and newborn care, pediatric services (including dental and vision), • medical/surgical care, • prescription drugs, • radiation and chemotherapy, and • mental health and substance abuse services that at least meet minimum standards set by Federal and state laws. HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually. [AFHA, Chairman's Mark, Redline, 22] Pediatric dental benefits in the non-group and small group markets (in and outside an exchange) may be separately offered and priced from other required health benefits. Coverage for these benefits may be provided by state-licensed stand-alone dental-only carriers that meet requirements of section 2791(c)(2)(A) of the Public Health Services Act. Stand-alone dental-only together with a qualified health plan that provides all of the other required benefits would satisfy the required benefit standard. Tax credits and cost sharing

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	developmental deformity, disease or injury" to the well-child care requirement. [EC AAHCA § 122(b)10 Gordon (Gordon6_001)]		assistance for the required pediatric dental health benefits would be designed to ensure they do not total more than they would have otherwise been under this Mark. [AFHA, Chairman's Mark, Redline, 18]
c. No Dollar Limits on Benefits	An essential benefits package must not impose annual or lifetime cost limitations. [AAHCA § 122]	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 benefits for any participant or beneficiary. (New PHSA § 2711) [AHCA § 101]	Health insurance plans in the individual and small group market may not impose annual or lifetime cost limitations. [AFHA, Chairman's Mark, Redline, 22]
d. Selection and Adoption of Covered Benefits	The Health Benefits Advisory Committee (HBAC) shall be established with the Surgeon General as Chair. The HBAC shall recommend covered benefits (including categories of covered treatments) and levels of cost-sharing for the plans. [AAHCA §§ 123(a), (b)] The HBAC must provide its first recommendation regarding initial benefits standards no later than 1 year after enactment of the Act. [AAHCA § 123(b)(2)] The HBAC will recommend benefit standards to HHS. HHS may adopt the recommendation or reject it, the providing the HBAC the opportunity to modify the recommendation. Public input will be a part of developing the recommendations. Within 18 months of the enactment of the Act, HHS must propose regulations either adopting the HBAC recommendations or, if HHS has rejected the HBAC recommendations and provided HBAC the opportunity to modify, HHS shall propose and adopt initial benefit standards. Any regulation adopted must be consistent with § 122 and 123(b)(5). Regulations shall be through notice and comment rulemaking (5 U.S.C. § 553). [AAHCA §§ 123(b)(3);124]	An advisory commission shall advise HHS on the essential benefits package (offered through Gateways). (New PHSA § 3103(b)) [AHCA § 142]	Secretary of HHS would be required to define and update the categories of covered treatments, items and services within benefit classes no less than annually through a transparent and public process that allows for public input, including a public comment period.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	The HCA shall specify the benefits available in each plan level each year. [AAHCA § 203] **EL Amendment** specifies with greater detail who should be considered for membership in the HBAC. [EL AAHCA § 123(a)(5)] **EC Amendment** specifies with greater detail who should be considered for membership in the HBAC. [EC AAHCA § 123(a)(5)]		
e. Discrimination Based on Religious Preference	**EL Amendment** would prohibit HCA from discriminating in approval or coverage of a health care service based on the service's religious or spiritual content if payment for the service is an allowed deduction under IRC § 213(d). [EL AAHCA § 125] **EC Amendment** would prohibit HCA from discriminating in approval or coverage of a health care service based on the service's religious or spiritual content if payment for the service is an allowed deduction under IRC § 213(d). [EC AAHCA § 125]	Essential benefits shall include a requirement that prohibits the Administrator of the Gateway or a qualified health benefit plan offered through the Gateway, from denying individual benefits for religious reasons. [AHCA § 3103]	No analogous provision.
ii. Essential Benefits Plan Levels			
a. Basic Value (Basic Plan) (Bronze Level)	The basic plan 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. [AAHCA §§ 122(c)(3); 203(c)]	Gateway basic plan shall provide reimbursement for 76 percent of the total allowed costs and out-of-pocket costs not more than IRC § 223(c)(2). (New PHSA § 3111(a)(1)(A)) [AHCA § 151]	Bronze package (the minimum creditable coverage), would be equal to the actuarial value of 65 percent with an out-of-pocket limit up to $5,950 for individuals and $11,900 for families in 2010, indexed to the per capita growth in premiums for the insured market as determined by HHS. For those between 100-200 percent of federal poverty level, the out-of-pocket limit equal to one-third of the $5,950 for individuals and $11,900 for families in 2010. For those between 200-300 percent of FPL, the benefit will include an

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I. INSURANCE MARKET REFORMS			
Provision	House (Tri-Committee)*	Senate HELP Committee	Senate Finance Committee
			out-of-pocket limit equal to one-half of that limit. For those between 300-400 percent of FPL, within the same actuarial value, the benefit will include an out-of-pocket limit equal to two-thirds of the HSA current law limit. [AFHA, Chairman's Mark, Redline, 23]
b. Enhanced Value (Enhanced Plan) (Silver Level)	The enhanced plan 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. [AAHCA § 123(b)(5)(A)]	Gateway plan shall provide reimbursement of basic plan +8 (84%) and out of pocket limit not greater than 50% of basic plan amount. (New PHSA § 3111(a)(1)(B)) [AHCA § 151]	Silver would have an actuarial value of 70 percent with the out-of-pocket limits for the bronze (minimum creditable coverage) level. For those between 100-200 percent of federal poverty level, the out-of-pocket limit equal to one-third of the $5,950 for individuals and $11,900 for families in 2010. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of that limit. [AFHA, Chairman's Mark, Redline, 23]
c. Premium Value (Premium Plan) (Gold Level)	The premium plan 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. [AAHCA § 123(b)(5)(B)]	Gateway plan shall provide reimbursement of basic plan +17 (93%) and out of pocket limit not greater than 20% of basic plan amount. (New PHSA § 3111(a)(1)(B)) [AHCA § 151]	Gold would have an actuarial value of 80 percent with the out-of-pocket limits for the bronze (minimum creditable coverage) level. For those between 100-200 percent of federal poverty level, the out-of-pocket limit equal to one-third of the $5,950 for individuals and $11,900 for families in 2010. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of that limit. [AFHA, Chairman's Mark, Redline, 23]
d. Premium Plus (Platinum Level)	HCA shall establish the benefit level standards for plans offering benefits in addition to the essential package (like oral health and vision care). [AAHCA §§ 123(b)(1)(B); 203(c)(1)(B)]	No analogous provision.	The platinum benefit package would have an actuarial value of 90 percent with the out-of-pocket limits for the bronze (minimum creditable coverage) level. For those between 100-200 percent of federal poverty level, the out-of-pocket limit equal to one-third of the $5,950 for individuals and $11,900 for families in 2010. For those between 200-300 percent of FPL, the benefit will include an

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			out-of-pocket limit equal to one-half of that limit. [AFHA, Chairman's Mark, Redline, 23]
e. "Young Invincible" (Catastrophic Plan)	No analogous provision.	No analogous provision.	Policy limited to those 25 years or younger and consists of a catastrophic only policy in which the catastrophic coverage level would be set at the Health Savings Account current law limit, but preventative care benefits would be exempt from the deductible. [AFHA, Chairman's Mark, Redline, 23]
iii. Essential Benefits Cost-Sharing			
a. Cost-Sharing Definitions	Cost-sharing is defined in the Act as including deductibles, coinsurance, copayments & similar charges, but it does not include premiums or out of network payment differentials or spending for non-covered services. [AAHCA § 100(c)(4)] Cost-sharing is generally permitted, with exceptions (for example, preventative care). Cost-sharing range for each tier (basic, enhanced, premium) may not exceed 10%. [AAHCA § 203(c)(6)]	No analogous provision.	No analogous provision.
b. Preventative Care Cost-Sharing	No cost-sharing is permitted for preventative care, including well-baby and well-child care. [AAHCA §§ 122(c); 203(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 (other than minimal cost sharing in accordance with guidelines developed by the Secretary) for preventative coverage (as defined in the Act). (New PHSA § 2708) [AHCA § 101]	All health insurance plans in the individual and small group market must provide no cost-sharing for preventative care services (with limited exceptions). [AFHA, Chairman's Mark, Redline, 22]
c. Annual and Lifetime Limits	Annual out of pocket expenses are limited to $5,000/individual and $10,000/family in 2013. The limits are indexed to the CPI. [AAHCA § 122(c)(2).] Essential benefits packages may not impose annual or lifetime limits on coverage of covered health care items and services. [AAHCA § 122(a)(3).]	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 benefits for any participant or beneficiary. (New PHSA § 2711) [AHCA § 101]	All health insurance plans in the individual and small group market must provide no annual or lifetime cost limitations). [AFHA, Chairman's Mark, Redline, 22]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
d. Copayments Favored	When cost-sharing levels for the basic, enhanced and premium plans are established, copayments, rather than coinsurance, should be provided for to the maximum extent possible. [AAHCA § 122(c)(2)(C)]	No analogous provision.	No analogous provision.
D. CONSUMER PROTECTIONS			
i. General			
a. Fair Marketing Practices	The HCA shall establish fair marketing standards that all qualified health benefit plans must follow. [AAHCA § 131]	See Exchange/Gateway for applicable provisions to Gateway plans.	State insurance commissioners would provide oversight of plans with regard to consumer protections. [AFHA, Chairman's Mark, Redline, 11] The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation regarding marketing requirements. [AFHA, Chairman's Mark, Redline, 11] Failure to adopt the new minimum standards would result in federal preemption of conflicting state laws. [AFHA, Chairman's Mark, Redline, 11]
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. [AAHCA § 135]	See Exchange/Gateway for applicable provisions to Gateway plans.	No analogous provision.
c. Administrative Simplification	A qualified health benefit plan must follow administrative simplification provisions (standardizing electronic financial and administrative transactions as added by § 163(a)). [AAHCA § 137] **EC Amendment** would amend the Social Security Act to add operating rules to the administrative simplification provisions. [(New SSA § 1173B) EC AAHCA § 137	See Exchange/Gateway for applicable provisions to Gateway plans.	Act would accelerate the adoption of HIPAA standards and add additional requirements relating to certification of compliance. HHS would establish a committee to periodically update HIPAA standards. [AFHA, Chairman's Mark, Redline, 204]

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	Baldwin (Progressives_004)]		
d. Coordination of Benefits	The HCA shall establish standards for the coordination of benefits for individuals with multiple plan coverage. [AAHCA § 136]	No analogous provision.	No analogous provision.
e. Subrogation of Benefits	The HCA shall establish standards for subrogation of benefits and reimbursement of payments. [AAHCA § 136]	No analogous provision.	No analogous provision.
f. Prescription Records	**EL Amendment**: qualified health benefit plans to maintain and treat prescription information in accordance with specific requirements in the Act (e.g., limited licensing and use). [EL AAHCA § 138]	No analogous provision.	No analogous provision.
g. Pharmacy Benefit Manager Contract Conditions	**EC Amendment** would require qualified health benefit plans that enter into contracts with pharmacy benefit managers to submit information relating to the volume of prescriptions filled, pricing, and sales to the HCA and plan offering the benefit. [EC AAHCA § 133(d) (Progressive_004)]	No analogous provision.	Pharmaceutical benefit managers who contract with Medicare or through the exchanges would be required to share information to HHS and with plans, including retail vs. mail order sales, generic rates, rebates, discounts and price concessions. [AFHA, Chairman's Mark, Redline, 161]
h. End-of-Life Planning	**EC Amendment** would provide that entities that offer qualified health benefit plans must: • provide for dissemination of information related to end-of-life planning to individuals seeking to enroll in Exchange plans, • give individuals with the option to establish advanced directives and physician's orders for life sustaining treatment, and other planning tools, and • not promote suicide, assisted suicide, or the active hastening of death. [EC AAHCA § 138 Ross (BlueDog03_002) &(BlueDogOmnibus)]	The Community Health Insurance Option would be prohibited from limiting access to end of life care. [AHCA § 3106(b)(3)(F)]	No analogous provision.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
i. Utilization Review	**EC Amendment** would require a qualified health benefits plan and a qualified health benefits plan offering entity to conduct utilization review, including monitoring use, clinical necessity, appropriateness, efficacy and efficiency of health care services. Outside entities may be used to conduct the review. Utilization review shall also include prior authorization procedures, concurrent review procedures and denial of benefits. [EC AAHCA § 138 Burgess (#36A)]	No analogous provision.	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. [AAHCA § 132(a)] **EC Amendment** would eliminate the appeal and grievance procedures (internal claims, external review) and the applicability of state review and add detailed new provisions (§§ 139 (internal review), 140 (external appeals)). [EC AAHCA §§ 132, 139, 140 Burgess (#36A)]	All qualified health benefit plans must make available to all enrollees a detailed description of the grievance and appeals process. (New PHSA § 3101(m)(1)(E)(vi)) [AHCA § 142(b)]	Plans and health insurance carriers offering coverage in an exchange would be required to have an internal claims appeal process. [AFHA, Chairman's Mark, Redline, 18] In 2010, states would be required to establish an ombudsman office to act as a consumer advocate for those with coverage in individual and small group markets. Policyholders whose health insurers have rejected claims and who have exhausted internal appeals would be able to access the ombudsman office for assistance. [AFHA, Chairman's Mark, Redline, 38]
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. [AAHCA § 132(b)] **EC Amendment** would add detailed new provisions governing internal appeals, including time limits. [EC AAHCA §139 Burgess (#36A)]	See Exchange/Gateway for relevant provisions.	State insurance commissioners would continue to oversee any applicable grievance procedures. [AFHA, Chairman's Mark, Redline, 11] See also Exchange/Gateway for relevant provisions.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)[*]**	**Senate HELP Committee**	**Senate Finance Committee**
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. [AAHCA §§ 132(c)(1), 132(c)(2)] **EC Amendment** would add detailed new provisions governing external appeals; such provisions will apply to all acceptable coverage, including qualified health benefit plans. External review is available for claims denied on the basis of medical necessity/appropriateness and when the claim is denied where the coverage denial is based on medical judgment. A state may provide designated entities for external review. The Secretary of Labor (for group health plans) or the applicable state (for heath insurance issuers) shall provide certification of qualified external appeal entities. Penalties of up to $1,000 a day may be assessed against plans that fail to follow the decision of the external reviewer. Further penalties may be assessed for a pattern of failure to follow these requirements. Participants, beneficiaries and enrollees continue to have the remedies under federal and state laws that are currently available, including judicial review. [EC AAHCA §140 Burgess (#36A)]	No analogous provision.	State insurance commissioners would continue to oversee any applicable external review requirements. [AFHA, Chairman's Mark, Redline, 11]
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. [AAHCA § 132(d)]	Act does not add provision regarding state judicial review.	Act does not add provision regarding state judicial review.
iii. Plan Disclosures			
a. Plan Disclosures	A qualified health benefits plan must provide required disclosures in a timely and accurate manner, including in	A health insurance issuer must make reasonable disclosures to employers and individuals regarding:	Utilization of uniform outline of coverage documents would be mandated for all health insurance issuers (including a group

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)[*]**	**Senate HELP Committee**	**Senate Finance Committee**
	plain language. The HCA will provide guidance. [AAHCA § 133(a)] Advanced notice of any plan changes is required. [AAHCA § 133(c)] **EL Amendment** would require that a health plan identify to plan participants providers of services that are trained and accredited in integrative medicine. [EL AAHCA § 133(d)]	• the issuer's right to change premium rates, including the factors that may affect changes in premium rates • the benefits and premiums available under all health insurance coverage for which the employer or individual is qualified. (New PHSA §3101(s)(2)) [AHCA § 101] Plans or issuers offering coverage that fails to meet the minimum qualifying coverage must notify enrollees and prospective enrollees of the failure prior to enrollment. (New PHSA § 2712) [AHCA § 101]	health plan). NAIC would 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 the following benefits: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, physician services, prevention and wellness services, prescription drugs, other benefits, as identified by the NAIC, and • includes the exceptions, reductions and limitations on coverage; the cost-sharing provisions; the renewability and continuation of coverage provisions; a statement that the outline is a summary of the policy; and 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. 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. [AFHA, Chairman's Mark, Redline, 48]
b. Contracting Reimbursement	A qualified health benefits plan must comply with standards established by the HCA to ensure the transparency related to reimbursement arrangements. [AAHCA § 133(b)]	No analogous provision.	No analogous provision.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
c. Applicability of Consumer Protections to Non-Qualified Health Benefit Plans	The HCA shall determine to what extent the fair marketing practices (§131), appeals procedures (§ 132), and disclosure requirements (§ 133) apply to qualified health benefit plans that are not being offered through the Exchange. [AAHCA § 134]	No analogous provision.	State insurance commissioners would continue to oversee any consumer protection requirements applicable to insured plans. All entities offering health insurance would be subject to state regulatory requirements that exceed federal requirements specified in the Act. [AFHA, Chairman's Mark, Redline, 12]
E. 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. [AAHCA § 153]	No analogous provision.	No analogous provision.
b. Collective Bargaining	Nothing in the Act supersedes any obligation to collectively bargain over the terms of employment related to health care. [AAHCA § 154]	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. [AHCA § 131(f)]	No analogous provision.
c. Hawaii Prepaid Health Care Act	**EL Amendment** would preserve the current ERISA preemption exemption for the Hawaii Prepaid Health Care Act. [EL AAHCA § 156]	Nothing in the Act modifies or limits the current ERISA exemption for Hawaii's Prepaid Health Care Act. [AHCA § 186]	No analogous provision.
d. ERISA Preemption	For coverage not offered through the Exchange and for employment-based plans, ERISA's preemption provisions continue to apply. [AAHCA § 151(a)(2)]	No provision explicitly saves or eliminates ERISA preemption for plans outside of an exchange.	No provision explicitly saves or eliminates ERISA preemption for plans outside of an exchange.
e. HIPAA	The AAHCA 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,	No specific preservation clause, but HIPAA continues to apply.	HIPAA continues to apply, as amended.

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
	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 AAHCA. [AAHCA § 151(a)(1), (b)]		
f. COBRA	COBRA is preserved for Non-Exchange Plans and Employer-based plans unless its requirements prevent the application of a requirement of the AAHCA. [AAHCA § 151(a)(1)] **EL Amendment** would extend COBRA benefits for individuals who would otherwise lose COBRA coverage because their coverage period expired (the individual reached the statutory maximum period of coverage) until the individual was eligible for coverage under an employer-based plan or an Exchange plan. [EL AAHCA § 167]	No specific preservation clause, but COBRA appears to survive, as amended.	No specific preservation clause, but uses COBRA rules to calculate value of insurance coverage. [AFCA, Chairman's Mark, Redline, 235]
g. Cafeteria Plans	No analogous provision.	No analogous provision.	Provides a safe harbor from current nondiscrimination requirements for cafeteria plans for eligible small employers. The safe harbor also applies to the nondiscrimination requirements for group term life insurance, coverage under a self insured group health plan, and benefits under a dependent care assistance program. The safe harbor requires that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum flex-credit contribution requirements. All employees (with specific exceptions) must be eligible to participate in and select any benefit available in the cafeteria plan. Eligible employers are those who employed an average of 100 or fewer employees on business days during either of the preceding two years. Effective after December 31, 2010. [AFHA, Chairman's Mark,

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I. INSURANCE MARKET REFORMS			
Provision	**House (Tri-Committee)***	**Senate HELP Committee**	**Senate Finance Committee**
			Redline, 6]
h. State and Federal Laws Regarding Abortion and Title VII of the Civil Rights Act	**EC Amendment** would add provision that no state laws regarding abortion are preempted by the Act and the Act has no effect on federal laws regarding abortion or Title VII of the Civil Rights Act of 1964. [EC AAHCA § 2 Capps (Abortion-Combo_11B)]	No analogous provision.	State laws regarding the prohibition or requirement of coverage or funding for abortions are not preempted. Federal conscience protections and abortion-related antidiscrimination laws would not be affected by the bill. Title VII of the Civil Rights Act of 1964 would also not be affected by the bill. [AFHA, Chairman's Mark, Redline, 31]
i. Emergency Medical Treatment and Active Labor Act	No analogous provision.	No analogous provision.	Section 1867 of the Social Security Act (EMTALA), which requires health care providers to provide emergency services, is unaffected by the Act. [AFHA, Chairman's Mark, Redline, 31]

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)†**	**Senate HELP**	**Senate Finance**
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). [AAHCA § 312(b)(1)] A proportional minimum contribution required for part-time employees will be determined by the HCA. [AAHCA § 312(b)(3)] 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. [AAHCA § 312(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). [AAHCA § 311(a)(3)] ERISA § 502 (civil enforcement provision) is amended to	**Rule** Employers must offer qualifying coverage. This includes that employers must contribute at least 60% of monthly premiums for employees. Self-employed individuals are deemed to be a qualified employer unless the individual elects to be considered a qualified individual. (New PHSA § 3101(i)) [AHCA § 142(b)] **Penalty** Employers with more than 25 employees who do not offer qualifying coverage (§ 3103) or who pay less than 60 percent of their employees' monthly premiums are subject to a $750 annual fee per uninsured full-time employees and $375 per uninsured part-time employees. For employers subject to the assessment, the first 25 workers will be exempted. Beginning in 2013, the penalty amounts will be adjusted using the Consumer Price Index. (New PHSA § 3115) [AHCA § 163]	**Rule** Employers that offer employees health coverage that costs employees less than 10% of their income will not pay a penalty. **Penalty** All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. For each full time employee (employees working 30 hours or more each week) enrolled in a state exchange and receiving a tax credit, the employer would be required to pay a flat dollar amount set by HHS. The flat dollar amount would be equal to the national average tax credit. The assessment is capped for all employers at an amount equal to $400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange credit). The employer would pay the lesser of the flat dollar amount multiplied by the number of employees receiving a tax credit or a fee of $400 per employee paid on its total number of employees. An eligible employer may offer coverage through a state exchange.

† Notable amendments from the committees are noted in the text.

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)†**	**Senate HELP**	**Senate Finance**
	add civil penalties against employers who fail to meet the health coverage participation requirements, but any penalty will be coordinated with the excise tax provisions to prevent duplicative penalties. [AAHCA § 321(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. [AAHCA § 322(b); 411]		Effective July 1, 2013. [AFHA, Chairman's Mark, Redline, 38-39]
b. Automatic Enrollment	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. [AAHCA § 312(c)]	No analogous provision.	Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, if they are able to demonstrate that they have coverage from another source (for example, through a public program such as Medicare, Medicaid or the Children's Health Insurance Program or as a dependent in a spouse or other family member's health benefits). [AFHA, Chairman's Mark, Redline, 36]
e. Small Business and Hardship Exemptions from Penalties	Small businesses are exempt from or pay a graduated tax in lieu of coverage. [AAHCA §§ 313(b); 412] Small businesses are exempt from or pay a graduated tax in lieu of coverage; employers whose annual payroll does not exceed $250,000 are exempt; sliding scale from 2 to 6 % of payroll for employers whose payroll between $250,000 and $400,000. [AAHCA §§ 313(b); 412] **EL Amendment** would provide a hardship exemption for employers, providing a 2 year waiver from the participation requirements upon a showing to the HCA that meeting the requirements would result in job losses that would negatively impact the employer or the community. [EL	Employers with 25 or fewer employees are exempt from penalties and are eligible for program credits in section 3112. (New PHSA § 3115) [AHCA § 163] For purposes of the shared responsibility section, the term "employer" means an employer that employs more than 25 employees (for more than 120 days, if employer hires seasonal workers). (New PHSA § 3115(f)) Independent contractors are not counted as employees for determining whether an employer meets the requirements to be an employer under this section. [AHCA § 163]	Employers with 50 employees or fewer are not required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. [AFHA, Chairman's Mark, Redline, 38]

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)†**	**Senate HELP**	**Senate Finance**
	AAHCA § 311(b)]		
f. 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. [AAHCA § 314]	No analogous provision.	No analogous provision.
g. Prohibition Against Reducing Retiree Benefits	**EL Amendment** would prohibit group health plans (as defined by ERISA) 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. [EL AAHCA § 165]	No analogous provision.	No analogous provision.
h. Exceptions for Self-Insured Plans	Provisions generally apply.	New PHSA §§ 2701 (rating rules), 2702 (guaranteed availability) and 2704 (cost accounting) do not apply to self-insured plans. The provisions of subpart 1 of part A of the PHSA continue to apply as if the PHSA was not amended. (New ERISA § 715(b); new IRC § 9815(b)) [AHCA § 132]	Provisions generally apply.
i. Payroll Deductions for Premiums	No analogous provision.	No analogous provision.	For employed individuals who purchase health insurance through a state exchange, the premium payments would be made through payroll deductions. [AFHA, Chairman's Mark, Redline, 26]
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. [AAHCA § 401(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 § 6055) [AHCA § 161(b)] 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	An employer would be required to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2. To the extent that the employee receives health insurance coverage under multiple plans, the employer would disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement). Effective for taxable years after December

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)[†]**	**Senate HELP**	**Senate Finance**
		establishing or participating in Gateways for current employees) written notice of the availability of the Gateway, including a description of the services provided. (New FLSA § 18A) [AHCA § 162]	31, 2009. [AFHA, Chairman's Mark, Redline, 234]
b. Employer Election Requirements	Amends ERISA to provide that employers may elect to be subject to the health coverage participation requirements. (ERISA § 801) An employer who makes such an election will be treated as having established a group health plan, subject to the Act. (ERISA § 802(a)) The Secretary of Labor shall audit a sampling of employers and group health plans for compliance with the health coverage participation requirements. (ERISA § 802(b)) The health coverage participation requirements are defined in the Act. (ERISA § 803) The Secretary may terminate any election in cases of substantial noncompliance. (ERISA § 805) The Secretary shall issue such regulations as necessary. (ERISA § 806) [AAHCA § 321(a)] The ERISA amendments adding Part 8 are effective as of December 31, 2012. [AAHCA § 321(d)] Amends IRC to provide procedures for employer to elect to be subject to the health coverage participation requirements and excise tax provisions. [AAHCA §§ 322(a), 411, 412] Amends the PHSA to provide procedures for employers to elect to be subject to the health coverage participation requirements. (§ 2793) An election shall be treated as the establishment of a group health plan. (§ 2793(b)) Employers may make separate elections for full- and part-time employees. (§ 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. (§ 2793(f)) [AAHCA § 323]	No analogous provision.	No analogous provision.

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)[†]**	**Senate HELP**	**Senate Finance**
C. SUBSIDIES / CREDITS			
a. Small Business Credit	Credit for small businesses that offer qualified health coverage (acceptable health coverage offered by employer that makes an election to provide health coverage that meets the requirements of § 311) 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; credit phased out in case of employer with 10 to 25 employees; credit is phased out in case of an employer with average employee wages of $20,000 to $40,000 annually. (New IRC 45R(b)) No credit allowed for highly compensated (income of $80,000/year) employees. (New IRS 45R(c)(2)) [AAHCA § 421]	Beginning in 2010, employers with 50 or fewer full-time workers who pay 60 percent or more of their employees' health insurance premiums may receive tax credits. Credit amounts are based on the type of employee coverage, the size of the employer, and the proportion of time the employer paid employee health insurance expenses, and are available for up to 3 years. (New PHSA § 3112) [AHCA § 151]	A tax credit for a qualified small employer for contributions to purchase health insurance for its employees would be available. A qualified small employer for this purpose would be an employer with no more than 25 full time equivalent employees employed during the employer's taxable year, and whose employees have annual full time equivalent wages that average no more than $40,000. The full amount of the credit would be available only to an employer with ten or fewer full-time equivalent employees and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return, so the employer would be responsible for payment of the employer's contribution to the premiums during the year. The credit would be available for the first two years for any qualified small business offering health insurance. After December 31, 2012, the credit would be available only for coverage purchased through an exchange. If a state has not adopted an Exchange, the employer is not eligible for the credit. The credit would be phased out for employers with more than 10 full-time equivalent employees, but no more than 25. The credit would also be phased out for employers for whom the average wage per employee is between $20,000 and $40,000. Self-employed, partners and co-proprietors are not small businesses for the purpose of the credit.

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)[†]**	**Senate HELP**	**Senate Finance**
			Effective July 1, 2013. [AFHA, Chairman's Mark, Redline, 29-30] Organizations exempt from tax under section 501(a) by reason of being described in section 501(c)(3) (i.e., charitable organizations) that would otherwise qualify for the small business tax credit are eligible to receive the credit. [AFHA, Chairman's Mark, Redline, 30]
b. Partnerships	For partnerships that have one or more qualified employees (those that made at least $5000 a year from that employer), each partner shall be treated as an employee. (New IRC § 45R(f)(1)) Any deduction otherwise allowable with respect to amounts paid for health insurance coverage shall be reduced by the amount of the credit allowed. (New IRC § 45R(f)(3)) [AAHCA § 421(a)]	No analogous provision.	No analogous provision.
c. Self-Employed Credit	Any deduction otherwise allowable with respect to amounts paid for health insurance coverage shall be reduced by the amount of the credit allowed. (New IRC § 45R(f)(3)) [AAHCA § 421(a)]	Self-employed individuals who do not receive credits for purchasing coverage through the Gateway are eligible for small business credits. (New PHSA § 3112) [AHCA § 151]	No analogous provision.
d. Credit Adjustment for Inflation	The credits shall increase by a cost of living adjustment. (New IRC § 45R(f)(4) [AAHCA § 421(a)]	No analogous provision.	No analogous provision.
e. Retiree Coverage Reimbursement	Eligible and participating employers may be reimbursed for health insurance coverage of retirees, spouses and dependents. Reimbursement must be used to reduce cost-sharing of plan participants. Program is temporary and substantially similar to HELP program. [AAHCA § 164]	A temporary reinsurance program is established to reimburse employers who provide health benefits to retirees (those older than 55 but not yet eligible for Medicare) and their dependents who live in states that have not yet established Gateways. Program is substantially similar to House program. [AHCA § 181]	A 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. Eligible employers are those offering coverage that is appropriate for a mature population between 55 and 64, offers preventative benefits, has

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II. EMPLOYER RESPONSIBILITY			
Provision	**House (Tri-Committee)**[†]	**Senate HELP**	**Senate Finance**
			demonstrated programs to generate cost-savings for those with chronic and high-cost conditions, and can show actual cost of medical claims. [AFHA, Chairman's Mark, Redline, 234]
f. Employer Credit Effective Date	December 31, 2012 [AAHCA § 421(d)]	No analogous provision.	No analogous provision.

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)**[‡]	**Senate HELP**	**Senate Finance**
a. Establishment	A national "Health Insurance Exchange" will be established under the direction of the HCA to facilitate access to health insurance coverage. [AAHCA § 201]	"American Health Benefit Gateways" will be established in each state to facilitate the purchase of health insurance; grants will be awarded by HHS to assist states in establishing Gateways. (New PHSA § 3101(a), (b)) [AHCA §§ 142(a), (b)] Gateways must establish procedures for certification, disclosure of plan information, utilize administrative simplification measures (§ 222), enter into agreements with Navigators (New PHSA § 3105), facilitate the purchase of coverage for long-term services, respond to complaints about coverage, provide a toll free number and website. (New PHSA § 3101(c)(3)) [AHCA § 142(b)]	States must establish an exchange for individual and small group insurance that complies with the requirements set forth in the federal law. If a state does not establish an exchange within 24 months of enactment, HHS shall contract with a non-governmental entity to establish a state exchange that complies with the federal legislation. [AFHA, Chairman's Mark, Redline, 11] Beginning in 2013,All private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must be available in a newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements). [AFHA, Chairman's Mark, Redline, 18]
A. ADMINISTRATION / STRUCTURE			
a. Plans Offered	An Exchange Participating Health Benefits Plan is a Qualified Health Benefits Plan offered through the Exchange. [AAHCA § 201(c)] Plans within the Exchange must offer specified benefits packages as specified by the HCC. [AAHCA § 121] See above, Insurance Market Reforms, Minimum Required Coverage.	Gateways may only offer qualified health plans, and must offer a public option known as a community health insurance option. (New PHSA §§ 3101(c)(2)(C); 3116) [AHCA § 142(b)] To offer a qualified health plan, a health insurer must be licensed in good standing in the state, offer at least one qualifying health plan in each two specific cost sharing levels, comply with HHS regulations, and agree to pay a surcharge (New PHSA 3101(c)(4). (i.e., one in tier § 3111(a)(1)(A) and one in tier § 3111(a)(1)(B)) (New PHSA § 3116) [AHCA § 142(b)] Qualified health plans must be certified by the Gateway and	All policies (with the exception of mini-medical policies) would be offered. For minimum requirements, see above, Insurance Market Reforms, Minimum Required Coverage. Beginning July 1, 2013, all plans offered in the individual and small group market, whether through an exchange or outside of an exchange, would have to comply with the rating reforms and benefit options in the Act. In 2010, 2011 and 2012, plans with annual and lifetime limits and "mini-medical" plans with limited benefits and low annual caps would not be offered in an exchange. Beginning in July 2010, state insurance commissioners would determine whether certain health benefit plans may

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III. EXCHANGE / GATEWAY			
Provision	House (Tri-Committee)[‡]	Senate HELP	Senate Finance
		provide at least the essential benefits, see above, Insurance Market Reforms, Minimum Required Coverage. Coverage limited to a single condition, or "an unreasonably limited set of diseases or conditions" do not meet the conditions of a qualified health plan. (New PHSA § 3103(c)(2)(A)) [AHCA § 142(b)] States may require additional benefits, if state assumes additional costs. (New PHSA § 3101(c)(2)(F)) [AHCA § 142(b)] Mental health parity (§ 2716) applies to qualified health plans offered through Gateways. (New PHSA § 3101(q)) [AHCA § 142(b)]	be available in an exchange. Child-only health plans and pediatric dental-only plans would be available through the exchange. [AFHA, Chairman's Mark, Redline, 18] Plans offered through the exchange must cover emergency room services without regard to prior authorization or the ER doctor's contractual relationship to the health plan. Plans may not charge higher co-payments or cost-sharing for emergency room furnished out-of-network than those services provided in-network. [AFHA, Chairman's Mark, Redline, 18] A separate "young invincible" policy (catastrophic coverage with levels set at the current HSA limits) would be available for those 25 years or younger and individuals (including employees) whose full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight percent of their income. [AFHA, Chairman's Mark, Redline, 23, 35]
b. Coverage Outside of the Exchange/Gateway	New individual health insurance coverage offered on or after January 1, 2013 must be offered through the Exchange. [AAHCA § 102(c)(1)]	Licensed health insurers may continue to offer health insurance coverage outside the Gateway; such coverage is not required to meet the standards of qualified plans. Individuals are not required to purchase insurance through a Gateway. State law may impose requirements regarding ability of non-qualified plans to offer benefits. (New PHSA § 3101(l)) [AHCA § 142(b)]	Insurers may offer coverage outside of the exchange. [AFHA, Chairman's Mark, Redline, 33]
c. Surcharges	No analogous provision.	Gateways may assess surcharges on all health insurance issuers offering qualified health plans through the Gateway to pay the expenses of the Gateway (surcharge may not exceed 4% of premiums collected). (New PHSA	No analogous provision.

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
		§ 3101(c)(4)) [AHCA § 142(b)]	
d. Risk Adjustment Payments	No analogous provision.	States shall assess charges on low actuarial risk plans if the risk is less than the average actuarial risk of all enrollees in all plans in such state for the year (excluding self-insured plans). States shall make a payment to certain high actuarial risk plans if the risk is greater than the average for all enrollees in the state (excluding self-insured plans) and the issuer/plan meets size requirements. (New PHSA § 3101(c)(5)) [AHCA § 142(b)]	No analogous provision.
e. Risk Pools	HCA will adjust the premium amounts payable to qualified health benefit offering entities to minimize the impact of adverse selection of individuals enrolled in Exchange-participating health benefits plans. [AAHCA § 206(b)] Qualified health benefit offering entities must participate in the risk pooling mechanism established by the HCA in order to participate in the Exchange. [AAHCA § 204(b)(5)]	A health insurance issuer shall consider all enrollees in an individual plan, including individuals who do not purchase a plan through the Gateway, to be members of a single risk pool. All enrollees in a small group health plan, other than a self-insured group health plan, including individuals who do not purchase through the Gateway, shall be considered members of a single risk pool. (New PHSA § 3101(k)) [AHCA § 142(b)]	State entering into health care choice compacts would be eligible to form multi-state risk pools. [AFHA, Chairman's Mark, Redline, 17]
f. Federal HHS/HCA and/or State Duties	In coordination with the appropriate state and federal officials, HCA shall: • contract with Exchange providers, [AAHCA § 204] • conduct outreach to inform and educate individuals and employers about the Exchange and Exchange plan options, [AAHCA § 205(a)(1)] • determine whether individuals and employers are eligible, [AAHCA § 205(a)(2)] • establish and carry out an enrollment process, including automatic enrollment for certain individuals who lose acceptable coverage, [AAHCA §§ 205(a)(3); 205(b)]	HHS shall also establish policies to facilitate enrollment and provide grants to enhance community-based enrollment and public education campaigns, and policies for the certification of qualified health plans. (New PHSA § 3101(c)) [AHCA § 142(b)] HHS conducts annual audits, requiring financial reporting, and establishing protections against fraud and abuse for Gateways. (New PHSA § 3102) [AHCA § 142(b)] A temporary advisory commission shall be established to advise HHS on the development of the essential benefits	HHS and/or the States shall: • consult with state insurance commissioners to develop a standard enrollment application, • provide a standard format for presenting insurance options within the exchange, • develop standard marketing requirements, • develop a rating system for plans entering the exchange based on relative quality and price, • maintain call center support for customer service (including multilingual assistance), • enable enrollment in local hospitals, schools, DMVs,

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)‡**	**Senate HELP**	**Senate Finance**
	• provide information and assistance to consumers regarding Exchange plans, [AAHCA § 205(c)] • coordinate the distribution of affordability credits, and [AAHCA § 206] • adjust premium amounts (risk pooling). [AAHCA § 206(b)] [AAHCA § 201] **EL Amendment**: HCA shall also establish a program to assist small employers (those employers with fewer than 100 employees) with counseling, information and technical assistance regarding providing health insurance through the Exchange. [EL AAHCA § 206(d)] HCA is also authorized to enter into contracts with Small Employer Benefit Arrangements to provide information, outreach and assistance regarding enrolling small employers under Exchange plans. [EL AAHCA § 209]	package. (New PHSA § 3103) [AHCA § 142(b)] HHS shall establish an internet portal through which residents may identify the Gateway(s) operating in their state. (New PHSA § 3101(h)) [AHCA § 142(b)] HHS shall establish standards and protocols to facilitate the enrollment of individuals in federal and state health and human services programs. (New PHSA § 3101(c)(8)) [AHCA § 142(b)]	Social Security offices, and any other office designated by the state, • develop a model web portal that directs individuals to insurance options, provides tax credit calculators, and presents standardized information related to the options, including quality ratings, • conduct eligibility determinations for tax credits and subsidies and enable enrollment of individuals and small businesses, • establish unaffordability certification procedures, • establish procedures to appeal subsidy eligibility determinations, and • establish a plan to publicize the exchanges and open-enrollment periods [AFHA, Chairman's Mark, Redline, 19-20]
g. State Participation in Exchange/Gateway	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. [AAHCA § 208] **EC Amendment** would require a state to enact medical liability reforms in order for a state Exchange to be approved by the HCA. Incentive payments will also be provided to states that enact alternative medical liability laws that comply with the requirements as outlined in the section. HHS is given rulemaking authority to carry out the requirements of the section. [EC AAHCA § 208(g) Gordon (Gordon9_001)]	Gateways may be regional (operate in more than one state) and states may establish subsidiary Gateways. (New PHSA § 3101(f)) [AHCA § 142(b)] During a four year period following enactment, states have three options regarding participation in the Gateway: • an "establishing state" if it launches its Gateway that meets the requirements of the Act, • a "participating state" if it requests that the Secretary establish an initial Gateway once all necessary insurance market reforms have been enacted by the state into law, and other requirements have been met, or • a state that does not act to conform to the new requirements within 4 years from the date of enactment, in which case, the Secretary shall establish and operate	States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from HHS in 2010. A single exchange with resources for individuals and small employers may be created instead. States would assist small employers that opt to use the SHOP exchange as the enrollment option for their employees. Small firms offering through the exchange could not self-insure. Small employers that made age-adjusted contributions on behalf of their employees would be granted a safe harbor from non-discrimination rules. After states adopt federal rating rules and the exchange is

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
		a Gateway in the state, the Insurance market reforms will become effective, and the state will be deemed a "participating state." (New PHSA § 3104) [AHCA § 142(b)] Until 60 days after HHS determines that a state is an establishing or participating state, the residents of that state will not be eligible for premium credits, expanded Medicaid match, or small business credits. (New PHSA § 3104(b)(1) and (c)(4)) [AHCA § 142(b)] Gateways must facilitate enrollment and help individuals find affordable coverage that is available to them. (New PHSA § 3101(b)(6), (10)) [AHCA § 142(b)] States may only certify a health plan as qualified if it: • meets criteria for certification, (New PHSA § 3101(m)) • the availability of the plan is in the interest of the individuals and employers in the state (with limitations), and • the plan has not engaged in a pattern or practice of discrimination based on age, disability, medical dependency or quality of life. (New PHSA § 3101(d)) [AHCA § 142(b)] Gateways must give HHS an annual financial report. (New PHSA § 3102(a)) [AHCA § 142(b)]	functional for at least three years, states could permit other entities to operate an exchange if it met specified requirements, and subject to approval by HHS. States may form regional exchanges, subject to approval by HHS. [AFHA, Chairman's Mark, Redline, 20]
h. Criteria for Certification	Entities must be: • licensed under the law in each state that service is provided, • provide data to the HCA as required, • implement affordability credits, • accept all enrollments (subject to limited exceptions,	HHS shall establish criteria for certification requiring that a plan: • not employ marketing practices that discourage individuals with significant health needs from enrolling, • employ methods to ensure products are simple and comparable for consumers, • ensure a wide choice of providers (including essential	State insurance commissioners would establish procedures for reviewing plans to be offered through the state exchanges and would develop criteria for determining whether certain health benefit plans can be available for sale in the market. [AFHA, Chairman's Mark, Redline, 20]

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
	such as capacity), • participate in the HCA's risk pooling arrangement, • use essential community providers (as established under the PHSA § 340(B)(a)(4)) for outpatient services under the basic plan, • provide culturally and linguistically appropriate services, and • any other additional requirements as specified by the HCA. [AAHCA § 204(b)(1)-(8)]	community providers that serve low-income, medically underserved individuals), • provide the essential benefits package, • be accredited, • implement a quality improvement strategy, (§ 3101(n)(1)) • not establish a benefits design that substantially discourages enrollment, and • report required plan quality performance data. (New PHSA § 3101(m)) [AHCA § 142(b)]	
i. 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 and activities to prevent hospital readmission. (New PHSA § 3101(n)) [AHCA § 142(b)]	No analogous provision.
j. Summary of Benefits	See Insurance Market Reforms: Consumer Protections above.	HHS shall develop standards for benefits and coverage disclosures for plans offered through a Gateway. These standards shall preempt any state standards that provide less information. Failure to provide the standard summary will be subject to a fine. HHS shall evaluate whether these standards should be applied to plans outside of the Gateway. (New PHSA § 3101(r)) [AHCA § 142(b)]	In implementing state exchanges, HHS is required to: • develop standard definitions for common insurance and medical terms, • develop several scenarios (for example, Breast Cancer) which include information that must be provided by every insurance carrier offering coverage in the individual and small group markets in describing their plans to consumers. This label should include information regarding at minimum estimated out-of-pocket cost-sharing and significant exclusions or benefit limits for such scenarios, and • develop standards of an annual personalized statement that summarizes an individuals' use of health care services and claims paid in the previous year,[AFHA, Chairman's Mark, Redline, 47]

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
k. Presumption that State Exchanges Meet Act's Requirements	**EC Amendment**: 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 HCA 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. [EC AAHCA § 208(b)(2) Ross (BlueDog3_002) & (BlueDogOmnibus)]	No analogous provision.	No analogous provision.
l. CO-OPs	**EC Amendment** would provide that the HCA may make grants and loans for the operation of "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 new entity requirement, no insurance industry involvement, not-for-profit status, licensing and conflict of interest and governance standards) to be eligible for grants and participation in an Exchange. [EC AAHCA §§ 251, 252 Ross (BlueDog3_002) & (BlueDogOmnibus)] Also includes cooperatives in the definition of a health benefits plan, a qualified health benefit plan offering entity, and a qualified health benefits plan. [EC AAHCA § 253 Ross (BlueDog3_002) &(BlueDogOmnibus)]	No analogous provision.	The Consumer Operated and Oriented Plan (CO-OP) program would foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states. CO-OPs would operate in the individual and small group markets on a level-playing field with other plans. In order to receive federal funds (grants and loans administered by HHS) under the CO-OP program, an organization must: • be organized as a non-profit, member corporation under State law, • 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, • incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference in its governing documents, • not be sponsored by a State, county, or local government, or any government instrumentality, • limit substantially all of its activities to the issuance of

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
			qualified health benefit plans in the individual and small group markets in each State in which it is licensed to issue such plans, • 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. Effective the date of enactment but no CO-OP can operate until a state has implemented individual and small group insurance market reforms required under this Act. [AFHA, Chairman's Mark, Redline, 43-45]
m. State Single Payer System	**EL Amendment**: A state may establish a single payer system that is structured and operates in a manner consistent with the Act, including providing benefits that meet or exceed the Act's standards. [EL AAHCA §§ 251, 252] The state may request that the Secretary of Labor waive the application of ERISA § 514 (the provision of ERISA that preempts state laws that relate to ERISA plans) and such a waiver shall be granted absent extraordinary circumstances. [EL AAHCA § 251(a)] During such a waiver period, the state single payer option shall operate in lieu of the Exchange or the public plan. [EL AAHCA § 251(b)(2)]	No analogous provision.	No analogous provision.
n. Navigators	No analogous provision.	States will receive federal grants to contract with private and public entities (e.g., trade associations) to act as health coverage "navigators" to assist employers, workers, and	No analogous provision.

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
		self-employed individuals to obtain coverage through Gateways. Navigators will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance. 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 an employer or individual. (New PHSA § 3105) [ACHA § 142(b)]	
o. Role of Brokers	**EC Amendment**: Adds subsection to end of § 205 to preserve the role of enrollment agents and brokers under state law including with regard to the enrollment of individuals and employers in qualified health benefit plans, including the public health insurance option. [EC AAHCA § 205(g) Ross (BlueDog3_002) & (BlueDogOmnibus)]	No analogous provision.	Agents and brokers are permitted to enroll individuals and employers in any health insurance option available in the state exchanges. [AFHA, Chairman's Mark, Redline, 19]
p. Automatic Enrollment	HCA will provide a process for certain Exchange-eligible individuals to be automatically enrolled in Exchange coverage. [AAHCA § 205(b)(3)]	No analogous provision.	States will have the option to auto-enroll individuals and families into policies offered in the individual and small group markets. State programs for auto enrollment must be approved by HHS. [AFHA, Chairman's Mark, Redline, 36]
B. ELIGIBILITY			
a. Individual Eligibility	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. Acceptable coverage includes grandfathered health insurance	Individuals residing in a participating or establishing State are eligible ("qualified") to obtain coverage through a Gateway, so long as they are not incarcerated, entitled to or enrolled in coverage under Medicare or Medicaid, TRICARE, FEHBP, or employer-sponsored coverage.	Legal U.S. residents will be able to obtain insurance through the state exchanges. Parents who are in the country illegally will not be able to buy personal insurance coverage through the state exchange but will be able to buy insurance for their U.S. citizen or lawfully present children.

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)‡**	**Senate HELP**	**Senate Finance**
	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, [AAHCA §§ 202(a); 202(d)(2)] (Note that certain Medicaid-eligible individuals are also eligible. [AAHCA §§ 202(c)(1)-(3)]) 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 (minimum contribution is 72.5% of the premium for individual coverage and 65% for family) of § 312 (employer responsibilities to contribute to coverage). [AAHCA § 202(d)(1)(B)] **EC Amendment** provides that despite having acceptable coverage, veterans and members of the armed forces would also be eligible to obtain enrollment in an Exchange plan. [EC AAHCA § 202 Buyer (AMDT_002)]	(New PHSA § 3116(a)(4)) [AHCA § 163] Employees are eligible if the employer-sponsored coverage does not meet criteria for minimum qualifying coverage or is not affordable for the employee. (New PHSA § 3116(a)(4)(B)) [AHCA § 163] Individuals are not required to buy insurance through the Gateway. (New PHSA § 3101(c)(2)) [AHCA § 142(b)] Qualified individuals may enroll in any available plan. (New PHSA § 3101(i)) [AHCA § 142(b)]	Effective July 1, 2010 [AFHA, Chairman's Mark, Redline, 19]
b. Continuation of Individual Eligibility	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, the individual enrolls in a qualified health benefits plan outside of the Exchange, or other circumstances as the HCA may provide. [AAHCA § 202(d)(4)]	No analogous provision.	No analogous provision.
c. Employer Eligibility	Employers are eligible to participate in the Exchange on a transition schedule, as follows: • 2013: employers with 10 or fewer employees [AAHCA §§ 202(c)(1)(B); 202(e)(1)] • 2014: employers with 20 or fewer employees [AAHCA §§ 202 (c)(2)(B); 202(e)(2)]	Initially, only small employers that meet certain state and federal criteria are qualified to participate in the Gateways. In general, a State may establish the number of employees (not less than 50) used for determining whether employer is a "qualified employer."(New PHSA § 3116) [AHCA § 163] Qualified employers may choose to provide premium subsidies at any benefit tier offered. (New PHSA § 3101(i))	Beginning in 2015, states must allow small businesses with up to 100 employees purchase coverage through the SHOP health insurance exchange and states may allow employers with more than 100 employees into the state exchange beginning in 2017. [AFHA, Chairman's Mark, Redline, 20]

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)‡**	**Senate HELP**	**Senate Finance**
	• 2015: larger employers on timetable determined by HCA (based on number of full-time employees). [AAHCA §§ 202(c)(3)(B); 202(e)(3)] [AAHCA § 202(e)(1)-(3)] **EL Amendment**: Employers are eligible to participate in the Exchange on a transition schedule, as follows: • 2013: employers with 15 or fewer employees [EL AAHCA §§ 202(c)(1)(B); 202(e)(1)] • 2014: employers with 25 or fewer employees [EL AAHCA §§ 202 (c)(2)(B); 202(e)(2)] • 2015: employers with 50 or fewer employees and other, larger employers as permitted by HCA [EL AAHCA §§ 202 (c)(3)(B) and (C); 202(e)(3)] • 2016:larger employers on timetable determined by HCA (based on number of full-time employees). [AAHCA §§ 202(c)(4)(B); 202(e)(4)] [EL AAHCA § 202(e)(1)-(4)]	[AHCA § 142(b)]	
d. Continuation of Employer Eligibility	Once eligible an employer remains eligible regardless of the number of employees employed unless the employer offers an employer-based group health plan, instead of an Exchange health plan, in meeting the Act's employer participation requirements. [AAHCA § 202(e)(4)]	Participating employers with up to 50 employees may continue participation in the Gateway if they subsequently grow to more than 50 employees. (New PHSA § 3116) [AHCA § 163]	Businesses that grow beyond the upper employee limit in the SHOP exchange may continue to purchase health insurance through the SHOP exchange. [AFHA, Chairman's Mark, Redline, 20]

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)‡**	**Senate HELP**	**Senate Finance**
C. CONDITIONS ON PARTICIPATION			
i. Employers			
a. General	Employers may meet their health coverage participation requirements under § 312 through Exchange plans. [AHCA § 202(e)(5)(A)]	A qualified employer may enroll employees in coverage through a Gateway. (New PHSA § 3116) [AHCA § 163]	Small firms may opt to use the SHOP exchange as the enrollment option for their employees. Small firms offering through the exchange could not self-insure. Small employers that made age-adjusted contributions on behalf of their employees would be granted a safe harbor from non-discrimination rules. Effective July 1, 2010 [AFHA, Chairman's Mark, Redline, 20] Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible that does not exceed $2,000 for individuals and $4,000 for families, unless offering contributions through a health reimbursement account or some other mechanism that would offset a deductible above these limits. This deductible limit would not affect the actuarial value of the plan, including Bronze plans, and does not apply to "young invincible" plans. [AFHA, Chairman's Mark, Redline, 23]
b. Employee Choice	Participating employers must allow employees to choose any plan in the Exchange, including dependent coverage. [AAHCA § 202(e)(5)(B)]	Employees are free to select any coverage within the benefit tier selected by the employer. (New PHSA § 3101(i)) [AHCA § 142(b)]	No analogous provision.
ii. Plans / Providers			
a. Benefit Levels Established	The HCA shall establish standards for 3 levels of benefits plans (basic, enhanced, premium) to be offered through the Exchange. [AAHCA § 203(c)]	Qualified health plans must be certified and provide at least the essential benefits. HHS is required to establish the complete list of essential benefits. (New PHSA § 3103(a)(1)(A)) [AHCA § 142(b)]	Exchanges may offer five levels of benefits plans (Bronze, Silver, Gold, Platinum, and Young Invincible). [AFHA, Chairman's Mark, Redline, 22]

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)‡**	**Senate HELP**	**Senate Finance**
b. Benefit Levels Offered	To participate in the Exchange, a provider must offer the following: • only one basic plan may be offered in each service area in which the provider operates. [AAHCA § 203(b)(1)] A provider may then offer: • one enhanced coverage plan for said service area if a basic plan is offered, [AAHCA § 203(b)(2)] • one premium coverage plan for said service area may be offered if an enhanced plan is offered, [AAHCA § 203(b)(3)] • additional benefits (vision, dental, etc) may be offered in a premium-plus plan with no limit on the number of premium-plus plans but extra costs must be detailed separately. [AAHCA § 203(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. [AAHCA § 203(d)]	Providers must offer at least the essential benefits package. (New PHSA § 3101(m)(1)(F)) [AHCA § 142(b)]	All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories. [AFHA, Chairman's Mark, Redline, 22] No policies could be issued in the individual or small group market that did not meet the actuarial standards of the four benefit categories. [AFHA, Chairman's Mark, Redline, 22]
c. Cost-Sharing Levels	Permissible cost-sharing will be established by the HCA and may not vary by more than 10% with respect to each benefit category. [AAHCA § 203(c)(6)] **EC Amendment**: Premiums charged under any Exchange plan may not exceed 150% of the annual percentage increase in medical inflation for the 12-month period ending in June of the prior year, except in the case of qualified health benefit plans that provide additional benefits, and where the qualified health benefit plan demonstrates to the HCA (or state insurance commissioner, if applicable) that	No analogous provision.	Plans in the state exchanges would be required to apply parity for cost-sharing for treatment of conditions for: • inpatient hospital, • outpatient hospital, • physician services, and • other items and services, except in cases where value-based insurance design is used. A value-based insurance design is one that identifies clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and efficacious treatments for which cost-

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III. EXCHANGE / GATEWAY			
Provision	**House (Tri-Committee)[‡]**	**Senate HELP**	**Senate Finance**
	complying with the limitation would threaten the plan's viability or its ability to provide timely benefits to plan participants. [EC AAHCA § 209 (PremiumsandDrugs003)]		sharing (co-payments or coinsurance and deductibles) should be eliminated or reduced due to their high value and effectiveness. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. (Generally, Part D plans must offer two drugs in each class or category.) States may permit some flexibility in plan design to encourage widely agreed upon cost and quality effective services. Insurers participating in the state exchanges would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased inside or outside the state exchange from the carrier or an agent). [AFHA, Chairman's Mark, Redline, 23]
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. [AAHCA § 204(c)(3)]	No analogous provision.	No analogous provision.
e. Limitations on Contracting with Hospitals	No analogous provision.	After January 1, 2012, a qualified health plan must only contract with hospitals that meet the requirements of the Act. (New PHSA § 3101(p)) [AHCA § 142(b)]	No analogous provision.

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IV. PUBLIC PLAN OPTION			
Provision	**House (Tri-Committee)**[§]	**Senate HELP**	**Senate Finance**
a. Establishment	The Secretary of HHS will develop a public health insurance option to be offered only in the Exchange beginning in 2013. [AAHCA § 221(a), (b)] 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. [AAHCA § 221(b)(2)] **EC Amendment** would provide that enrollment in the public plan is voluntary. [EC AAHCA § 229 Ross (BlueDog3_002)]	HHS will establish a voluntary community health insurance option that provides only the essential health benefits (§ 3103), except in States that offer additional benefits.	No analogous provision.
b. "Level Playing Field" (Requiring Public Option to Comply with Requirements with which Private Plans Must Comply)	**EC Amendment**: The public option must also comply with the Act's: • rating provisions (§ 113), • nondiscrimination provisions (§ 114), • network adequacy provisions (§ 115), • disclosure provisions (§ 133), and • contingency margin provisions (§ 222(a)(2)) [EC AAHCA § 221(b)(2) Ross (BlueDog3_002) & (BlueDog Omnibus)] HIPAA requirements would also apply. [EC AAHCA § 227 Ross (BlueDog3_002) & (BlueDog Omnibus)] Sections of the Social Security Act related to health information privacy, security and electronic transactions would apply to the public plan. [EC AAHCA § 228 Ross	No private health insurer shall be subject to any federal or state law (listed in (b)) if a community health insurance option 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	No analogous provision.

[§] Notable amendments from the committees are noted in the text.

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IV. PUBLIC PLAN OPTION			
Provision	**House (Tri-Committee)[§]**	**Senate HELP**	**Senate Finance**
	(BlueDog3_002) & (BlueDog Omnibus)]	• benefit plan material or information. (New PHSA § 3107) [AHCA § 142(b)]	
c. Benefits Offered	The public health plan option shall offer the same benefits and levels (basic, enhanced, premium) as private plans and may offer premium-plus plans. [[AAHCA § 221(b)(3)]	The Community health insurance option will provide only essential benefits (§ 3103), except in states where additional benefits are offered. (New PHSA § 3106(b)(3)) [AHCA § 142(b)]	No analogous provision.
d. Premiums	Premiums shall be set by the Secretary to will comply with the medical loss ratio rules (§ 113), to fully cover the cost plus administrative expenses and include a contingency margin. [AAHCA § 222(a)]	Premiums shall be sufficient to cover the plan's cost (including claims and administrative costs). (New PHSA § 3106(b)(5)) [AHCA § 142(b)]	No analogous provision.
e. Remedies	Public plan participants shall have the same access to federal court as Medicare beneficiaries. [AAHCA § 221(g)]	No analogous provision.	No analogous provision.
A. ADMINISTRATION			
a. Administrative Contracts	The Secretary may enter into administrative contracts in the same way and to the same extent as under Medicare. [AAHCA § 221(c)] **EC Amendment** would require HHS to establish a prescription drug formulary and negotiate payment rates (including discounts, rebates and other price concessions) with pharmaceutical manufacturers. [EC AAHCA § 223 Baldwin (Progressive_004)] **EC Amendment** would require HHS to establish a prescription drug formulary but omits the negotiation of payment rates. [EC AAHCA § 223 Baldwin (Progressive_005)]	HHS shall contract with qualified nonprofit entities to administer the community health insurance plan in the same manner as Medicare. (New PHSA § 3106(e)) [AHCA § 142(b)] To be qualified to offer a community health insurance option, a entity must: • meet the requirements of SSA § 1874A(a)(2), • be a nonprofit entity for purposes of offering the option, • meet solvency standards, • be legible to offer health insurance or benefits coverage, • meet quality standards, • have fraud and abuse control standards, and	No analogous provision.

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IV. PUBLIC PLAN OPTION			
Provision	**House (Tri-Committee)[§]**	**Senate HELP**	**Senate Finance**
		• meet any other requirements HHS shall impose. (New PHSA § 3106(e)(2)) [AHCA § 142(b)] Contracts will last between 5 and 10 year-terms, at the end of which there will be a competitive bidding process for new and renewed contracts. (New PHSA § 3106) [ACHA § 142(b)] HHS may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions. (New PHSA § 3106(c)(4)) [AHCA § 142(b)]	
b. Provider Reimbursement Rates	Secretary of HHS will set provider reimbursement rates. For the first 3 years, reimbursement rates are based on Medicare rates, with adjustments and incentives. After first 3 years, Secretary may change rates, but overall spending should be consistent with first 3 years. Administrative and judicial review of provider rates is prohibited. [AACHA § 223] **EC Amendment** would provide reimbursement rates for the public plan for the first three years would be negotiated by the Secretary but should be rates that are not lower than Medicare rates and not higher than qualified health benefit plans. Amendment would not offer incentives, but provides procedure for providers to opt-in and out of participating in the public plan. [EC AAHCA § 223 Ross (BlueDog3_002) & (BlueDogOmnibus)]	HHS shall negotiate provider reimbursement rates. Physicians may continue to negotiate with health plans in states that permit such negotiation. (New PHSA § 3106(b)(6)) [AHCA § 142(b)]	No analogous provision.
c. Provider Payment Initiatives	Secretary may use incentive payments to encourage providers to provide greater quality and efficiency in the use	No analogous provision.	No analogous provision.

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IV. PUBLIC PLAN OPTION			
Provision	**House (Tri-Committee)[§]**	**Senate HELP**	**Senate Finance**
	of medical care. [AAHCA § 224]		
d. Ombudsman	The Secretary shall establish an Ombudsman that has the same duties as the Medicare Beneficiary Ombudsman. [AAHCA § 221(d)]	HHS shall establish an ombudsman. (New PHSA § 3106(b)(9)) [AHCA § 142(b)]	No analogous provision.
e. Fraud and Abuse	Medicare's fraud and abuse provisions apply to the public health insurance option. [AAHCA § 226]	State consumer protection laws shall apply. (New PHSA § 3106(b)(7)(C)) [AHCA § 142(b)]	No analogous provision.
f. Funding	A start-up fund will be established for the public health insurance option. Costs shall be repaid within 10 years. [AAHCA § 222(b)(2)]	A "Health Benefit Plan Start-up Trust Fund" will be created to provide for the initial operations of the community health insurance plan, which the plan will be required to pay back no later than 10 years after the payment is made. (New PHSA § 3106(c)) [AHCA § 142(b)]	No analogous provision.
B. PROVIDER PARTICIPATION			
a. Conditions on Participation	Secretary will develop conditions of participation, to include state licensing. [AAHCA § 225] **EC Amendment** would provide that health care providers participating in Medicare are participating providers in the public health insurance option unless they opt-out. [EC AAHCA § 223(b) Ross (BlueDog3_002) & (BlueDog Omnibus)]	Each state will establish a State Advisory Council to provide recommendations to the Secretary on the policies and procedures of the community health insurance plan. (New PHSA § 3106(c)(7)(D)) [AHCA § 142(b)]	No analogous provision.
b. Classes of Provider-Participants	Two classes of physician providers shall participate – preferred and non-preferred. The Secretary shall establish the rates for preferred and non-preferred providers. Other providers may participate if the provider agrees to accept public option rates; [AAHCA § 225(c)] **EC Amendment** would strike. [EC AAHCA § 225(c) Ross (BlueDog03_002)]	No analogous provision.	No analogous provision.

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IV. PUBLIC PLAN OPTION			
Provision	**House (Tri-Committee)[§]**	**Senate HELP**	**Senate Finance**
c. Excluded Providers	Providers that are excluded from participation in other federal health programs may be excluded from the public health option. [AAHCA § 225(d)]	No analogous provision.	No analogous provision.

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V. INDIVIDUAL RESPONSIBILITY			
Provision	**House (Tri-Committee)[**]**	**Senate HELP**	**Senate Finance**
A. INDIVIDUAL MANDATE			
a. Tax for Failure to Obtain Acceptable/Qualifying Coverage	A tax of 2.5% is imposed on the modified adjusted gross income of individuals who fail to obtain acceptable coverage at any time during the tax year is imposed. The tax is limited to not more than the average national premium (for an individual or family, as applicable) under a basic plan. The tax may be prorated for any periods during which the individual had acceptable coverage. The tax does not apply to individuals who may be claimed as a dependent on another taxpayer's return. [AAHCA §§ 301; 401]	All individuals will be required to obtain health insurance coverage. The minimum penalty will be no more than $750 per year (adjusted for inflation.) Provisions apply to tax years after December 31, 2011. (New IRC § 59B) [AHCA §161]	The consequence for not maintaining insurance would be an excise tax of $750 per adult per household. This per adult penalty would be phased in as follows: For 2013, $0; $200 for 2014; $400 for 2015; $600 in 2016 and $750 in 2017. Non-compliance with the individual responsibility to have health coverage shall incur no criminal penalty; and neither civil penalty nor interest shall accrue for failure to pay such assessment in a timely manner. Collection shall be limited to withholding of federal payments due. [AFHA, Chairman's Mark, Redline, 35]
b. Acceptable/Qualifying Coverage Defined	Acceptable coverage includes 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. [AAHCA §§ 202(a); 202(d)(2)] (Note that certain Medicaid-eligible individuals are also eligible. [AAHCA §§ 202(c)(1)-(3)]) **EL Amendment**: High deductible health plans (as defined in IRC § 233(c)(2)) would be treated as acceptable coverage. [EL AAHCA § 102(b)(3)]	Qualifying coverage means a group health plan or health insurance coverage that an individual is enrolled in on the date of enactment or coverage (including renewal of such coverage), or group health plan or health insurance coverage that meets or exceeds the criteria for minimum qualifying coverage (§ 3103), Medicare, Medicaid (with exceptions), CHIP, TRICARE, veteran's health coverage (if coverage meets the minimum qualifying coverage criteria, as determined by HHS), FEHB, state health benefits high risk pool, health care provided to Peace Corps members, or coverage under a qualified health plan. Individuals who are enrolled in a group health plan or health insurance coverage on the date of enactment may renew such coverage, may enroll family members in such coverage and employers may enroll new employees (and families) in such coverage. This coverage will not be	Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through: • the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or • in the large group market, in a plan with first dollar coverage for preventative care (except in cases where value-based insurance design is used) and cannot have an reasonable annual or lifetime limit coverage or maximum out-of-pocket limit greater than that provided by the standards established for HSA current law limit.

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V. INDIVIDUAL RESPONSIBILITY			
Provision	**House (Tri-Committee)****	**Senate HELP**	**Senate Finance**
		subject to the requirements of this subtitle as long as the group health plan or health insurance coverage has not been modified to a "significant extent." HHS will issue regulations to determine when coverage has been modified to a significant extent. [AHCA § 131]	An individual enrolled in a grandfathered plan would be considered to have met the responsibility requirement. [AFHA, Chairman's Mark, Redline, 34]
c. Exceptions	The tax does not apply to: • individuals who may be claimed as a dependent on another taxpayer's return. [AAHCA § 401(a)(1)] • nonresident aliens [AAHCA § (a)(2)], • qualified individuals and qualifying children (as defined in IRC § 911(d)) residing outside the United States. [AAHCA § 401(a)(3)], • bona fide residents of United States possessions (as defined in IRC § 937(a)) will be treated as having acceptable coverage. [AAHCA § 401(a)(4)], or • individuals who have an exemption that certifies that they belong to 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 Secretary. [AAHCA § 401(a)(5)]	Exemptions will be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. Certain individuals, including individuals living in states without Gateways, and individuals without coverage for fewer than 90 days operating are exempt from the mandate and penalty. (New IRC § 59B) [AHCA § 161]	Exemptions would be allowed for religious objections that are consistent with those allowed under Medicare and for undocumented aliens. Exemptions from the tax will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds eight percent of their income. These individuals may purchase a young invincibles policy regardless of age. Exemptions from the excise tax will also be made for individuals below 100 percent of FPL, any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs, those experiencing hardship situations (as determined by HHS) and an individual who is an Indian as defined in Sec. 4 of the Indian Health Care Improvement Act. In 2013, individuals at or below 133 percent of FPL will be exempt from the excise tax. [AFHA, Chairman's Mark, Redline, 34]

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V. INDIVIDUAL RESPONSIBILITY			
Provision	**House (Tri-Committee)****	**Senate HELP**	**Senate Finance**
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. [AAHCA § 241(b)] 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 § 312 is not eligible for affordability credits. [AAHCA § 242(b)(1)]	Gateways will determine eligibility, using HHS guidelines and income verification. (New PHSA § 3111) [AHCA § 151]	The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. The program is established and administered by the Treasury Department, which pays insurers directly. An eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return. [AFHA, Chairman's Mark, Redline, 24] States are permitted to enter into contracts with state Medicaid agencies to make eligibility determinations for the credit. [AFHA, Chairman's Mark, Redline, 26]
b. Use of Credits	Credit 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 credit against enhanced and premium plans, but individual must pay difference between premium of enhanced or premium plan and the basic plan. [AAHCA § 241(c)] No cash rebate is available. [AAHCA § 241(e)]	Premium credits available for Gateway plans. Credits may only be used for essential benefits, but states may make additional payments for services beyond the essential benefits. (New PHSA§ 3111) [AHCA § 151]	The health coverage tax credit is available for qualified health insurance, which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market. A refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges would be provided. The premium tax credit will be available to purchase certain health insurance plans through the state exchanges. The credit is payable in advance directly to the insurer. The individual pays the plan the difference between the premium credit amount and the premium charged for the plan. Individuals who fail to pay all or part of the remaining premium amount would be given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. [AFHA, Chairman's Mark, Redline, 26]
c. Affordability Credit Eligibility	Generally, individuals with incomes up to 400% of FPL are eligible for affordability credits, except that full-time employees of employers that offer group health coverage	The credits would be on a sliding scale up to 400% of the poverty line and will be adjusted geographically. (New PHSA § 3111) [AHCA § 151]	The tax credit would be available for individuals with incomes up to 300 percent of FPL.

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V. INDIVIDUAL RESPONSIBILITY			
Provision	**House (Tri-Committee)[**]**	**Senate HELP**	**Senate Finance**
	that meets the requirements of § 312 are not eligible. Beginning in 2014, if employer-provided coverage would cost more than 11% of an employee's income, that employee would be eligible to obtain credits. [AAHCA §242(a),(b); § 243(d)] Certain Medicaid-eligible individuals are eligible for affordability credits. [AAHCA § 242(a)(1)(C)] Undocumented aliens are ineligible for credits. [AAHCA §§ 242(a)(1); 246] 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. [AAHCA § 243] 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. [AAHCA § 244] **EC Amendment** would treat employees of employers with annual payroll of less than $750,000 as if the employer made a qualifying contribution in lieu of coverage under certain circumstances. [EC AAHCA § 242(a) Ross (BlueDog3-002) & (BlueDogOmnibus)] **EC Amendment** would raise the exception for employees with employer-provider coverage to require that the employer-provided coverage must cost more than 12% of an employee's income before that employee would be		Beginning in 2013, tax credits would be available on a sliding scale basis for individuals and families between 134-300 percent of federal poverty level to help offset the cost of private health insurance premiums. Beginning in 2014, the credits are also available to individuals and families between 100-133 percent of federal poverty level. Individuals subject to a five-year waiting period under Medicaid or CHIP are eligible for the tax credit beginning in 2013. The credits would be based on the percentage of income the cost of premiums represents, rising from three percent of income for those at 100 percent of poverty to 13 percent of income for those at 300 percent of poverty. Liability for premiums would be capped at 13 percent of income for the purchase of a silver plan. The share of premium enrollees pay would be held constant over time. The premium credit amount would be tied to the second lowest-cost silver plan in the area where the individual resides (by age according to standard age factors defined by HHS) plan. An employee that is offered employer-provided health insurance coverage is ineligible for a low income premium tax credit. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer (defined as 10 percent of income), however, can be eligible for the tax credit. [AFHA, Chairman's Mark, Redline, 26]

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V. INDIVIDUAL RESPONSIBILITY			
Provision	**House (Tri-Committee)**[**]	**Senate HELP**	**Senate Finance**
	eligible to obtain credits. [EC AAHCA § 242(a) Ross (BlueDog3-002)] **EC Amendment** would provide for a contingency adjustment to the affordable premium credits by the HCA based on savings realized as a result of certain other amendments. [EC AAHCA §243 (PremiumsandDrugs003) & Baldwin (Progressive_004)] **EC Amendment** would raise the initial premium percentage that an affordability credit eligible individual with a family incomes of 200% to 400% of FPL and requires HCA to adjust the percentages to maintain the ratio of governmental to enrollee shares over time. [EC AAHCA § 242(a) Ross (BlueDog3-002) & (BlueDog Omnibus)]		

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VI. REVENUE RAISERS		
Provision	**House (Tri-Committee)[††]**	**Senate Finance**
a. Tax on High Income Individuals/Health Care Surcharge	The amount that an individual taxpayer earns that is more than $280,000 (modified adjusted gross) is taxed on a progressive basis. A tax of 1% is imposed on the modified adjusted gross income of more than $280,000 but does not exceed $400,000; 1.5% on the modified adjust gross income of more than $400,000 but does not exceed $800,000; 5.4% on the modified adjusted gross income that exceeds $800,000. (IRC § 59C) [AAHCA § 441(a)]	No analogous provision.
b. Adjustments on Rates	The rates on modified adjusted gross income of more than $280,000 to $400,000 and the modified adjust gross income of more than $500,000 to $1,000,00,000 will be increased to 2% and 3% respectively. If the federal health reform savings is in excess of certain base amounts, the tax on the first two groups will not apply. (IRC § 59C(c)) [AAHCA § 441]	No analogous provision.
c. 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 allow reimbursement for drugs and medicine only if such drug or medicine is a prescribed drug or is insulin. The effective date for these provisions is for expenses incurred after December 31, 2009. [AAHCA § 441]	The definition of medical expense for purposes of employer provided health coverage (including HRAs and Health FSAs), HSAs, and Archer MSAs, generally is conformed to the definition for purposes of the itemized deduction for medical expenses. Under the provision, the cost of over-the-counter medicine (other than doctor prescribed) may not be reimbursed through a Health FSA or HRA. In addition, the cost of over-the-counter medicines (other than doctor prescribed) may not be reimbursed on a tax-free basis through a HSA or Archer MSA. [AFHA, Chairman's Mark, Redline, 240]
d. Excise Tax on High Cost Insurance	No analogous provision.	An excise tax would be imposed on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds $8,000 for individual coverage and $21,000 for family coverage for 2013. The tax is equal to 40 percent of the aggregate value that exceeds $8,000 for individual coverage and $21,000 for family coverage for 2013. The threshold amounts are indexed to the Consumer Price Index for Urban Consumers (CPI-U) plus one percent as determined by the Department of Labor beginning in 2014. The excise tax is imposed pro rata on the issuers of the insurance. In the case of a self-insured group health plan, a Health FSA, an HRA, the excise tax is paid by the plan administrator. Where the employer acts as plan administrator to a self-insured group health

[††] Notable amendments from the committees are noted in the text.

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VI. REVENUE RAISERS		
Provision	**House (Tri-Committee)[††]**	**Senate Finance**
		plan, a Health FSA, or an HRA and with respect to employer contributions to an HSA, the excise tax is paid by the employer. The amount subject to the excise tax on high cost employer-sponsored coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health coverage including coverage for major medical, dental, vision and other supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount. This amount subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by the employee with after-tax dollars. Fixed indemnity coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, provided that the coverage is not coordinated with other health coverage. Certain transition relief is provided for individuals with coverage within the 17 most expensive states in 2012. [AFHA, Chairman's Mark, Redline, 231]
e. Additional Tax on HSA Distributions Not Used for Medical Purposes	No analogous provision.	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. [AFHA, Chairman's Mark, Redline, 242]
f. Limiting FSAs	No analogous provision.	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. Dependent Care FSA and HRA limits are not changed. Effective after December 31, 2010. [AFHA, Chairman's Mark, Redline, 244]
g. Additional Requirements for 501(c)(3) Hospitals	No analogous provision.	501(c)(3) hospitals 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 be generally required to

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VI. REVENUE RAISERS		
Provision	**House (Tri-Committee)[††]**	**Senate Finance**
		follow Medicare law and regulations regarding collections of debts; and the IRS would be required to review hospital's community benefit activities in the same way the Securities and Exchange Commission currently reviews registered companies. These requirements are in addition to current requirements. Effective for taxable years beginning after the date of enactment. [AFHA, Chairman's Mark, Redline, 248]
h. Annual Fee on Manufacturers and Importers of Branded Drugs	No analogous provision.	A fee would be imposed on any person that manufactures or imports prescription drugs for sale in the United States. Fees collected would be credited to the Medicare SMI trust fund. The Secretary of the Treasury would establish individual assessments by determining the relative market share for each covered entity. A covered entity's relative market share would be the entity's total covered domestic sales from all specified government programs as a percentage of the total covered domestic sales from all specified government programs for all covered entities. In determining each covered entity's relative market share, covered domestic sales will be taken into account as follows: 0 percent of sales up to $5 million; ten percent of sales over $5 million and up to $125 million; 40 percent of sales over $125 million and up to $225 million; 75 percent of sales over $225 million and up to $400 million; and 100 percent of sales over $400 million. The fee assessed is determined by the covered entity's market share in the preceding calendar year. Effective calendar year 2010 for sales in 2009 and thereafter. [AFHA, Chairman's Mark, Redline, 250-251]
i. Annual Fee on Manufacturers of Medical Devices	No analogous provision.	A fee would be imposed on any person that manufactures or imports medical devices offered for sale in the United States. The Secretary of the Treasury would require any covered entity to file an annual report of its covered domestic sales for the prior calendar year. The Secretary would establish individual assessments by determining the relative market share for each covered entity. A covered entity's relative market share would be the entity's covered domestic sales as a percentage of the total reported covered domestic sales for all covered entities. In determining each covered entity's relative market share, covered domestic sales will be taken into account as follows: 0 percent of sales up to $5 million; 50 percent of sales over $5 million and up to $25 million; and 100 percent of sales over $25 million. The fee assessed is determined by the covered entity's market share in the preceding calendar year. Effective calendar year 2010 for sales in calendar year 2009 and thereafter. [AFHA, Chairman's Mark, Redline, 251-252]
j. Annual Fee on Health Insurance	No analogous provision.	An annual fee would be applied to any U.S. health insurance provider with respect to health insurance. A U.S. health insurance provider includes any company subject to Federal

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VI. REVENUE RAISERS		
Provision	**House (Tri-Committee)[††]**	**Senate Finance**
Providers		income tax as an insurance company and includes (1) any insurer that sells employer-sponsored group health care coverage to employees that are either U.S. citizens or are employed in the United States, and (2) any insurer that sells health care insurance to individuals or groups of individuals (whether or not U.S. citizens) in the United States. A company or organization that underwrites policies for government-funded insurance is also a U.S. health insurance provider for purposes of the Mark. A Federal, state, or other governmental entity is not a U.S. health insurance provider, nor is an self-insured employer. The fee assessed is determined by the provider's market share in the preceding calendar year. Effective calendar year 2010 with respect to insurance premiums in 2009 and thereafter. [AFHA, Chairman's Mark, Redline, 253-254]
k. Repeal Deduction for Certain Retiree Prescription Drug Plans	No analogous provision.	Would eliminate the rule that the exclusion for prescription drug subsidy payments for retiree prescription drug coverage is not taken into account for purposes of determining whether a deduction is allowable with respect to retiree prescription drug expenses and thus reduces the deduction by the amount of the excludible subsidy payments received. Effective after December 31, 2010. [AFHA, Chairman's Mark, Redline, 257]
l. Amend Itemized Deduction for Medical Expenses	No analogous provision.	This provision increases the threshold for the deduction from the current 7.5 percent of AGI to 10 percent of AGI for regular income tax purposes. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim the Section 213 deduction if their medical expenses exceed 7.5 percent of AGI. The proposal does not change the AMT treatment of the itemized deduction for medical expenses. [AFHA, Chairman's Mark, Redline, 257]
m. Health Insurance Executive Compensation Limits	No analogous provision.	In the case of a covered health insurance provider (an insurance provider that receives at least 25 percent of its gross premium income from health insurance plans that meet the minimum creditable coverage requirements), no tax deduction shall be allowed for remuneration which is attributable to services performed by an officer, employee, director, and other worker or service provider (such as consultants) performing services for or on behalf of a covered health insurance provider for such covered health insurance provider during a taxable year to the extent that such remuneration exceeds $500,000. This special rule applies without regard to whether such remuneration is paid during the taxable year or a subsequent taxable year (in applying this rule, rules similar to those in section 162(m)(5)(A)(ii) will be applied). Further, in determining whether the remuneration of an applicable individual for a year exceeds $500,000, all remuneration from all members of

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VI. REVENUE RAISERS		
Provision	**House (Tri-Committee)[††]**	**Senate Finance**
		any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of section 414(m) and (o)) is aggregated. The amendment would be effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009. [AFHA, Chairman's Mark, Redline, 258-259]
n. Worldwide Allocation of Interest	Effective date delayed from December 31, 2010 to December 31, 2019. [AAHCA § 443]	No analogous provision.
o. Limit on Treaty Benefits	§ 451	No analogous provision.
p. Economic Substance Doctrine	§ 452	No analogous provision.
q. Penalties for Underpayment	§ 453	No analogous provision.
r. Corporate Information Reporting	No analogous provision.	Informational returns (*e.g.*, 1099s) will be required for payments made to corporations (currently not required). Effective after December 31, 2011. [AFHA, Chairman's Mark, Redline, 245]

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VII. SOURCES OF INFORMATION			
Provision	**House (Tri-Committee)**	**Senate HELP**	**Senate Finance**
Internet Locations	Ways and Means Committee: http://waysandmeans.house.gov/MoreInfo.asp?section=52 Energy and Commerce Committee: http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1687&catid=156&Itemid=55 Education and Labor Committee: http://edlabor.house.gov/newsroom/2009/07/ed-labor-approves-historic-hea.shtml	http://help.senate.gov/	http://finance.senate.gov/sitepages/baucus.htm

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