National Association of Health Underwriters

Analysis of Key Provisions in The Senate-Passed Comprehensive Health Reform Bill and the Reconciliation Package

March 19, 2010

	Senate Democratic Legislation, the Patient Protection and Affordable Care Act, H.R. 3590 **Status: Passed by the Unites States Senate (60-39) on December 24, 2009**	**The Reconciliation Package** **The Health Care and Education Affordability Reconciliation Act of 2010** **Status: Released on March 18, 2010**
Market Reforms	Would require all individual health insurance policies and all fully insured group policies to abide by strict modified community rating standards with premium variations only allowed for age (3:1), tobacco use (1.5:1), family composition and geographic regions to be defined by the states and experience rating would be prohibited. Wellness discounts are allowed for group plans under specific circumstances. Requires the Secretary of DHHS, within a year of enactment of this bill, to conduct a study on the impact the market reforms in the bill will have on the large group market, if they increase adverse selection and if they will increase the incentive to self-fund. Requires the Secretary of Labor, within a year of the enactment of this bill, to begin annual studies on self-funded plans.	The reconciliation package does not change many of market reform provisions contained in H.R. 3590. However, it does extend certain market reform provisions of H.R. 3590 to "grandfathered" plans" relative to lifetime and annual dollar limits, rescissions, employer plan waiting periods and coverage of dependent children to age 26 within six months of enactment. For grandfathered group health plans, preexisting condition waiting periods are banned beginning with plan years starting in 2014. In addition, for grandfathered group plans until 2014, the coverage to age 26 provisions only apply to those dependents that do not have another source of employer-sponsored health insurance. The bill also eliminates the requirement in H.R. 3590 that dependents up to age 26 be unmarried and clarifies that the group health insurance income tax exclusion is extended to dependents up to age 26.

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	Coverage must be offered on a guarantee issue basis in all markets and be guarantee renewable. Exclusions based on preexisting conditions and policy rescissions would be prohibited in all markets. Small group coverage is defined as up to 100 employees. States may also elect to reduce this number to 50 for plan years prior to January 1, 2016. Prohibits any annual limits or lifetime limits in group or individual plans after 2014. Between now and then, the only limits allowed are for nonessential benefits. All group plans, except self-funded, would also be subject to cost-sharing limitations and preventive care would have be covered first-dollar. Group and individual plans will have to have an external appeals process that meets or exceeds state law on the subject, meets or exceeds the NAIC external review model act requirements or complies with a regulation the Secretary of DHHS will promulgate on the topic. Grants the Secretary of DHHS authority over the external review process and certification of plans.	
Exchanges/ Information Portals	Beginning no later than July 1, 2010, requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk	The reconciliation package would not change the Exchange provisions of H.R. 3590 other than to allow U.S. territories to create Exchanges and clarify for funding purposes a U.S. territory that establishes an Exchange will be treated like a state for funding purposes.

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	pool options. Beginning January 1, 2014 each state must create an Exchange so as to facilitate the sale of qualified benefit plans to individuals. In addition the states must create "SHOP Exchanges" to help small employers purchase such coverage. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange. Beginning in 2014 would require employers to give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount. The bill allows for grants to the states to create the exchanges, but they must be self-sustaining by January 1, 2015. Stand-alone child- only and dental plans would also be allowed to be offered through the state-based exchanges.	

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	States would have to consult with stakeholders in exchange development, including agents and brokers. Plans offering coverage through the exchange would have to submit premium increase justification through the exchange prior to implementation and the exchange could use this information and premium increase patterns to deny a carrier the ability to sell exchange-based policies. States could create multiple exchanges under specified circumstances. The individual low-income tax credits created would only apply to U.S. citizens or legal residents who purchase individual coverage through the exchange or do not have access to affordable employer-sponsored coverage and purchase policies through the exchange. Creates specific requirements for the Secretary of DHHS in establishing the exchanges, including standardized applications, quality information, formats for presenting insurance options available through the exchange, and marketing requirements. States could require additional mandated benefits on exchange-based policies, but would have to assume the additional cost of the subsidized coverage relative to the mandates they impose.	

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	The exchanges will be based on a model web-based portal to direct individuals to insurance options and provide a tax credit calculator and determine public program eligibility. Carriers must pool all risks in the individual market (inside and outside the exchange) in a single risk pool, excluding grandfathered plans. Carriers must pool all risks in the small group market (inside and outside the exchange) in a single risk pool, excluding grandfathered plans. States can elect to merge the two pools of risk. Individual and small group markets outside of the exchange are specifically permitted. Beginning July 1, 2014, all members of Congress and Congressional employees must purchase their employer-sponsored health insurance coverage through a state-based exchange rather than using the traditional Federal Employees Health Benefits Plan. However, there is no penalty to transfer to a minimum benefit plan offered outside the exchange if you are eligible. Initially the exchanges would be limited to individual and small group purchasers, but after January 1, 2017 states may allow large groups (over 100) to purchase coverage through the exchanges.	

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	Provides for some flexibility and NAIC interaction for state-based exchange creation. Calls for federal fall-back enforcement with the Secretary of DHHS to create an exchange for a state if a state does not create an exchange by January 1, 2014. Includes grandfathering provisions for existing state-based exchanges that meet specified criteria and were in existence before January 1, 2010. There are also limitations on public funding in exchange policies relative to abortion services.	
Essential Benefits	The bill requires the Secretary of DHHS to establish a standard of essential benefits that would be used to determine four types of coverage packages (bronze, silver, gold and platinum) of varying actuarial values. All individual and small group insurers would have to offer, at minimum, plans in the silver and gold values. The essential benefits determined by the Secretary must include coverage of the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.	The reconciliation package would not change the essential benefit provisions of H.R. 3590.

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	In addition to the benefits that must be included, there can be no cost-sharing for preventive care and there are specified cost-sharing limits for plans, with separate limits for self-only coverage and indexed deductible limitations for employer-sponsored plans. Each level of coverage must meet its own actuarial value of the mandatory covered services as determined by the Secretary of DHHS. Bronze level policies must equal 60% of the value of the benefits, silver 70%, gold 80% and platinum 90%. A separate catastrophic-only policy would be available for those 30 and younger. Plans can offer child-only coverage through the exchanges to meet the child-specific benefit provisions. Requires group and individual plans to cover emergency care services even if the provider is not a participating provider at in-network rates, using a reasonable layperson definition of emergency services. Requires plans that make beneficiaries establish a primary care provider to allow the beneficiary to set any available participating provider their primary care physician. Requires that pediatricians be allowed to be set as primary care providers. Prohibits the requirement of authorizations or referrals for OB/GYN services.	

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	Requires coverage of clinical trial participation.	
Government-Run Public Plan Option	The government-run public plan option was eliminated from the Senate bill by the Manager's amendment, but it creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM). At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards. States can require that multistate plans offer additional benefits that are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules. Insurers who contract to be multistate plans must offer qualified coverage in 60% of states the first year of participation, working up to 100% of states by year four of participation. Although OPM also operates Federal Employees Health Benefits Plan (FEHBP), the two programs must	The reconcilliation package does not address the creation of a government-run plan option, nor does it make any changes to the multistate or national plan provisions contained in H.R. 3590.

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	have completely separate risk pools. Also OPM cannot divert funds or resources away from FEHBP to operate the multistate plan program. Also give states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer-sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars. Requires the Secretary to certify that participating individuals do not have to pay more in premiums and cost-sharing than they would have paid under qualified health plans, and that the plans cover essential health benefits. If a state elects this option, the basic health plan choices will be the only subsidized coverage options available to qualified state residents in this income bracket. Upper income individuals would still have access to subsidized private coverage options through the state-based exchange. States that do not create a basic health care plan would still have subsidized coverage available to residents in this income level and upper income levels through coverage purchased in the state exchange. Also establishes a HRSA grant 10-state demonstration	

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	project to create state-based non-profit/private partnerships to provide coverage to the uninsured at reduced fees.	
Cooperatives	Authorizes $6 billion in federal funding to be distributed before July 1, 2013 for states to create Consumer Operated and Oriented Plan (Co-op) programs for non-profit member-run health insurance companies. The Co-op plans would compete on a level playing field (including by negotiating provider rates, meeting state solvency standards and complying with all applicable state laws for health insurers) with other private plan options in a reformed individual and small group health insurance market. In order to receive Co-op funding loans or grants, which will be distributed by the Secretary of DHHS, an organization must meet a number of specified criteria. Co-op start-up loans and grants must be repaid within 5-15 years.	The reconciliation package would not change the Consumer Operate and Oriented Plan (Co-op) provisions of H.R. 3590.
State-Level Opt Out Provisions	Beginning in 2014, allows states to apply for a waiver for up to 5 years of requirements relating to qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual responsibility requirement, and shared responsibility for employers. The state would receive the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the state in the absence of a waiver. The state would be required by the DHHS Secretary to provide coverage that is at least as comprehensive and affordable, to at least a comparable number of	The reconciliation package would not change the state-level opt-out provisions contained in H.R. 3590.

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	residents, as this title would provide; and that it will not increase the Federal deficit.	
Risk Adjustment	Within 90 days of enactment, any individual who has been uninsured for at least 6 months and has a preexisting medical condition can receive coverage through a high risk pool, which may be a national high risk pool created by DHHS or another arrangement made with a state by DHHS (state high risk pool) that will exist until January 1, 2014 and be funded through a $5 billion federal appropriation. Premiums will be capped. As the market reforms take effect in January 2014, the temporary high-risk pool coverage will end and covered individuals will be transitioned to the exchanges. Within 90 days of enactment also creates a temporary reinsurance program to provide assistance to qualified employer-sponsored retiree health plans for early retirees (age 55-64). This program would reimburse employers retrospectively 80% of claims between $15,000-90,000, which will be indexed for inflation. It will end on January 1, 2014 and be financed by a $5 billion appropriation. **Reinsurance** From 2014-2016 a reinsurance program would be in effect for the individual and group markets and all carriers would be required to contribute $25 billion total to a non-profit reinsurance entity over the two year period to finance the program.	The reconciliation package would not change the risk-adjustment provisions contained in H.R. 3590.

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	Reinsurance payments would be transparent to the individual and be made based on a list of 50-100 high-risk medical conditions to be developed by the American Academy of Actuaries. The reinsurance program would operate at the state level based on a model to be developed by the NAIC, with federal fallback enforcement through DHHS. State high risk pools can be converted for this purpose. **Risk Corridors** After reinsurance is applied, mandatory risk corridors in 2014-2016 modeled those used for PPO organizations in Medicare Part D will be provided to plans that choose to participate. These risk corridors would provide relief on staggered basis to plans with allowable cost that exceed 103% and require payment on a staggered basis from those with costs less than 97 percent. Risk adjustment applies to plans in the individual and group markets, but not to grandfathered health plans.	
Employer Mandate	Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of $750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. For the construction industry only, the responsibility requirement to provide affordable	The reconciliation bill increases the annual fine specified in H.R. 3590 from $750 to $2000, but exempts the first 30 employees from the fine (i.e., if you employ 51 employees and don't provide coverage, you would pay the fine for 21 employees). For employers that use a benefits waiting period of up to 90

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	coverage applies to employers of more than 5 people with annual payrolls of more than $250,000. An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay $600 for any full-time employee subject to more than a 60- day waiting period. An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit or $750 for each of their full-time employees total. The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the assessable payments.	days, as per the specification in H.R. 3590, the fine will not apply to any employee in the waiting period.
Individual Mandate	Requires that effective after December 31, 2013, all American citizens and legal residents purchase qualified health insurance coverage. Qualified coverage includes the multistate plans, coverage purchased through the individual market, and qualified employer-sponsored coverage, and Individuals in grandfathered plans meet the terms of the mandate. Exceptions are provided for religious objectors, individuals not lawfully present and incarcerated individuals. Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those	The reconcilliation package changes the excise tax penalty for non compliance. The penalty structure is now either a flat dollar amount per person or a percentage of the individual's income, whichever is higher. In 2014 the percentage of income determining the fine amount will be 1%, then 2% in 2015, with the maximum fine of 2.5% of taxable (gross) household income capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family beginning in 2016. The alternative is a fixed dollar amount that phases in beginning with $325 per person in 2015 to $695 in 2016. The reconcilliation package also exempts those with incomes below the federal tax filing threshold from the tax.

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	who have received a hardship waiver and those who were not covered for a period of less than three months during the year. Individuals must report on their federal income tax returns the months of the year for which they had qualified health insurance coverage. Health plans, including self-funded employer plans and public programs, must also provide documentation to individuals and the IRS. The penalty for not maintaining coverage is an excise tax penalty of a flat dollar amount per person or a percentage of the individual's income equal to the higher of: (1) 2% of taxable (gross) household income capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family; beginning in 2016, or (b) a fixed dollar amount that phases in beginning with $495 per person in 2015 to $750 in 2016, with a 50% penalty for children up to an annual maximum of $2250 in 2017.	
ERISA	Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage. Requires all employers provide notice to their employees informing them of the existence of an Exchange.	The reconcilliation package makes changes to the structure and amount of the employer responsibility provisions that would also apply to self-funded plans government by ERISA. The reconciliation bill increases the annual fine for large employers that do not provide adequate and affordable coverage to their employees specified in H.R. 3590 from $750 to $2000, but exempts the first 30 employees from the fine (i.e., if you employ 51 employees and don't provide coverage, you would pay the fine for 21 employees).

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	Self-funded plans would be required to report coverage status data on all plan participants to the IRS annually as part of the individual mandate. Coverage plans must comply with the terms of the employer mandate (minimum standard for benefit plans) that would apply to all size groups (regardless of whether insured or self-funded) or pay a penalty. Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill.	For employers that use a benefits waiting period of up to 90 days, as per the specification in H.R. 3590, the fine will not apply to any employee in the waiting period.
Ability to Keep Your Current Coverage	Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement.	The reconciliation package would require plans that were grandfathered under H.R. 3590 to abide by the market reform requirements specified in H.R. 3590 relative to lifetime and annual dollar limits, rescissions, employer plan waiting periods and coverage of dependent children to age 26 within six months of enactment. For grandfathered group health plans, preexisting condition waiting periods are banned beginning with plan years starting in 2014. In addition, for grandfathered group plans until 2014, the coverage to age 26 provisions only apply to those dependents that do not have another source of employer-sponsored health insurance.

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HSAs, HRAs, FSAs	The bill assumes inclusion of consumer directed and account-based products like HSAs, HRAs and FSAs and clearly includes them in the outlines of minimal creditable coverage. The 60% minimum actuarial value for Bronze level plans should be sufficient to cover many account-based consumer directed high-deductible plans. The definition of medical expenses for purposes of employer provided health coverage (including HRAs, HSAs and FSAs) to the definition for purposes of the itemized deduction for medical expenses. This change means that over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs. The bill also increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%). The bill limits FSA contributions for medical expenses to $2,500 per year with the limit indexed for inflation.	The reconcilliation package delays implementation on the H.R. 3590 provisions that limit FSA contributions for medical expenses to $2,500 per year with the limit indexed for inflation from 2011 to 2013.
Minimum Loss Ratios	Starting on January 1, 2011, creates a minimum loss ratio requirement that applies to all fully insured plans including grandfathered plans. The MLR is 85% for large group plans and 80% for individual and small group plans (100 and below). Allows the Secretary of DHHS to make adjustments to the percentage if it proves to be destabilizing to the individual or small	The reconciliation package would not change the minimum loss ratio requirements in H.R. 3590 for individual, small group or large group health plans. However, it does require Medicare Advantage plans to maintain an 85% MLR or face termination from the program.

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	group markets. The amendment creates a premium rebate to individuals for plans that fail to meet the minimum MLR. The calculation is independent of federal or state taxes and any payments as a result of the risk adjustment or reinsurance provisions. Requires the National Association of Insurance Commissioners (NAIC) to establish uniform definitions regarding the MLR and how the rebate is calculated by December 31, 2010. The legislation also gives the Secretary of DHHS, in conjunction with the states, new authority to monitor health insurance carrier premium increases beginning in 2010 to prevent unreasonable increases and publicly disclose such information. Carriers that have a pattern of unreasonable increases may be barred from participating in the exchange. In addition, $250,000,000 is appropriated for state grants to increase their review and approval process of health insurance carrier premium rate increases.	
New Regulatory Entities	The legislation provides $30 million in federal funds to help states establish health insurance ombudsman offices or consumer assistance offices. These offices will provide assistance with claims, appeals, provide uniform enrollment information and assist with questions about subsidies. The bill also requires or encourages the creation of a	The reconcilliation package does not substantially change the structure of new federal regulatory entities created by H.R. 3590.

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	number of new state-level entities including the state-based exchanges, the Co-ops and their related purchasing council, among others.	
Medicaid Expansion	Expands Medicaid coverage to all individuals with incomes up to 133% of the FPL effective January 1, 2014. Creates a new state option to provide Medicaid coverage through a state plan amendment beginning on January 1, 2011. States would be required to maintain current Medicaid income eligibility levels and funding for all populations upon enactment of this measure would be phased out beginning in January 2014 for the adult population and in 2019 for children. Requires that the federal government pay for the entire share of the Medicaid expansion for all states until 2017, then phases out the increased federal match over time. Provides that the federal government will always pay for entire the Medicaid expansion population in perpetuity for the state of Nebraska. Expands Medicaid funding for the states of Vermont and Massachusetts. States would be required to offer premium assistance and Medicaid wrap-around benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost-effective to do so, under terms outlined	Modifies the provisions of H.R. 3590 relative to Medicaid by establishes that the federal government will pay 100% of the cost of the new expansion population until 2016, not 2017. Starting in 2017, all states except for the expansion states (including Nebraska), will then have to begin to have to pay a phased in amount of the cost of covering the expansion population, so that the federal government's match is 90% in 2020 and the out-years. For expansion states (where the state is already covering these adults through their Medicaid programs), reduces the amount they are currently paying to cover this population by 50% in 2014 and gradually increases the amount of the federal share, so that by 2019, all states are paying the same amount for the non-pregnant adult Medicaid population. Makes changes to lower the disproportionate share hospitable (DSH) payment structure and moves up the reduction in payments 2014. Prevents states from lowering the amount they pay Medicaid primary care providers to less than 100% of Medicare rates in 2013 and 2014, and provides additional federal funds to states to ensure compliance.

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	already in current law. Retains the current CHIP program structure under an enhanced federal cost match rate and requires reauthorization of CHIP by September 30, 2015.	
Individual Subsidies	Creates a complex system of sliding-scale tax credits for people with incomes between 100% and 400% of the FPL. The subsidies would only be available to legal U.S. residents and U.S. citizens who purchase individual coverage through the exchanges or do not have access to affordable employer-sponsored coverage and purchase policies through the Exchange. An employee with employer plan coverage that meets the standards of the coverage may not opt out of that coverage for subsidized coverage in the Exchange unless their income is 400% of FPL or below and their employer plan coverage is deemed unaffordable (exceed 9.8% of their family income) or is not valued at 60% of the actuarial value of the essential benefits package (bronze level coverage). However, beginning in 2014, employers must give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted for age, and the vouchers would be used in	The reconcilliation makes slight changes to the sliding-scale tax credit formula for people with incomes between 100% and 400% of the FPL purchasing coverage through the Exchange. It provides slight increases to the subsidy amounts for all subsidy-eligible individuals and increases the cost-sharing subsidies for those making 250% FPL or less. However, beginning in 2019, a failsafe mechanism is applied that reduces overall premium subsidies if the aggregate amount exceeds 0.504 percent of GDP.

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	the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.	
Small Business Assistance	Beginning in 2010, provides tax credits for qualified small employer contributions to purchase coverage for employees. Would apply to small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. Small employers could receive a maximum credit of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost. The credit would phase out entirely for employers of more than 25 employees whose average annual salaries exceeded $40,000. The credit is provided in two phases. In phase one the maximum credit amount is 35% of the employee's premium costs if employer contributes at least 50% of the premium costs or 50% of the benchmark premium. In phase two, the credit only applies if the small employer purchases coverage through the exchange and only applies for two years.	The reconciliation package would not change the structure of the small business tax credits provided in H.R. 3590.
Wellness Provisions	Codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums. Establishes a 10-state pilot program to apply the rules	The reconciliation package would not change the wellness provisions contained in H.R. 3590. The package does appropriate $11 billion in additional funding for community health centers over 5 years.

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	to the individual market in 2014-2017 with potential expansion to all states after 2017. It also calls for a new federal study on wellness program effectiveness and cost savings. Creates grants for small employer-based wellness programs. Appropriates $200 million in funding from 2011-2015. Establishes a Prevention and Public Health Investment Fund. The goal of the Investment Fund is to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. For Medicare beneficiaries, allows for coverage of an annual health risk assessment and expanded preventive care coverage. Provides at-risk populations who utilize community health centers with a comprehensive risk-factor assessment and an individualized wellness plan designed to reduce risk factors for preventable conditions. Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers.	

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	Expresses the sense of the Senate that the Congress should work with the Congressional Budget Office to develop better methodologies for scoring prevention and wellness programs given that results may occur outside the 5 and 10 year budget windows. Requires the DHHS Secretary to evaluate the effectiveness of existing Federal health and wellness initiatives. The Secretary will consider whether such programs are effective in achieving their stated goals and evaluate their effect on the health and productivity of the Federal workforce.	
Agent Provisions	The bill assumes the use of health insurance agents and brokers and includes specific language to ensure that agents and brokers may sell coverage, enroll individuals and assist with subsidy implementation in the Exchanges. The measure also gives grants to states to contract with health coverage navigators could be private and public entities that could act as facilitators for those looking for health insurance coverage to provide information about Gateways. Entities eligible to become navigators may be licensed, although the licensing provisions are not explicit enough. Navigators include trade, industry and professional organizations, unions and chambers of commerce, small business development centers, licensed agents and brokers, and others, but there is also language in the bill that states that Navigators can't be employed by health insurance carriers and language that may impact the navigator's ability to be paid a	The reconciliation package would not change the agent provisions contained in H.R. 3590.

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	commission by the carriers.	
Coverage Across State Lines	Allows for the creation of interstate compacts and national plans for the sale of similar insurance products in different states. Creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM). At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards. States can require that multistate plans offer additional benefits that are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules. Insurers who contract to be multistate plans must offer qualified coverage in 60% of states the first year of	The reconciliation package would not change the interstate compact and national plan provisions contained in H.R. 3590.

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	participation, working up to 100% of states by year four of participation.	
Medical Liability Reform	Includes a sense of the Senate resolution supporting state demonstration projects. Provides $50 million over five years in grant funding for state-based demonstration projects relative to medical liability alternatives.	The reconciliation package would not change the grant funding for state-based demonstration projects relative to medical liability alternatives provisions contained in H.R. 3590.
Medicare Advantage	Sets Medicare Advantage payments based on the average of the bids from Medicare Advantage plans in each market. Creates performance bonus payments based on a plan's level of care coordination and care management and achievement on quality rankings. Provides a four-year transition to new benchmarks beginning in 2011. Provides a longer transition of the amount of extra benefits available from plans to beneficiaries in certain areas where the level of extra benefits available is highest relative to other areas. New bidding process is expected to cut $120 billion in funding to the MA program. Prohibits Medicare Advantage plans from charging beneficiaries cost sharing for covered services that is greater than what is charged under the traditional fee-for-service program. Requires plans that provide extra benefits to give priority to cost sharing reductions, wellness and preventive care, and then benefits not covered under Medicare.	The reconcilliation package increases the total amount of cuts to the Medicare Advantage program from approximately $120 billion in H.R. 3590 to $202 billion. The cuts represent $130 billion in direct reductions in payment for Medicare Advantage payments and $70 billion due to other cuts to traditional Medicare. The legislation would freeze benchmark payments in 2011 and then reduces benchmark payments over 3-7 years by different percentages of fee-for-service Medicare spending by service area, but includes bonus payments for quality and enrollee satisfaction. The bill also increases CMS's regulatory authority and ability to reduce payments because of plan coding practices. Medicare advantage plans will also be required to maintain at least an 85% minimum loss ration, or be terminated from the program. Closes the Medicare Part D "donut hole" by initially providing a

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	Slightly extends the Medicare annual election period for Medicare Advantage and Part D enrollees by seven days and also moves it up to slightly earlier in the year, so that it will be October 15- December 7, rather than November 15-December 31. Eliminates the traditional MA OEP, but allows Medicare beneficiaries enrolled in MA or MA-PD plans to return to original Medicare in the first 45 days of the Calendar Year. Enhances penalties for those who do not comply with the Medicare Advantage rules, including the marketing requirements. Provides protections against Medicare Advantage benefit cuts to residents of New York, Pennsylvania and Florida.	$250 rebate to Seniors who hit the “donut hole” in 2010 and phases it out entirely to just a 25% coinsurance payment by 2020.
Long-Term Care	The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. There would be a five-year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at $65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period. Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at $50 per day.	The reconciliation package would not change the long-term care provisions contained in H.R. 3590.

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	Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living. EMPLOYERS ARE REQUIRED TO PAYROLL DEDUCT THIS BENEFIT ON AN OPT-OUT BASIS.	
Financing the Reforms	Excise tax of 40% would apply to insurance premiums in excess of $8,500 for individuals and $23,000 for families. For qualified retirees and individuals in high-risk professions, the thresholds would still be $9,850, and $26,000 for families. • HSAs, HRAs and FSAs included in calculation • Amounts indexed annually for inflation • 17 highest cost states allowed transitional higher amounts for 2013 (120%); 2014 (110%) and 2015 105%) Increases the Medicare payroll tax from 2.9 percent to 3.8 percent for wages and self-employment income above $200,000 ($250,000 married). Current 2.9 percent rate retained for wages and self-employment income below this amount Increases penalty for “taxable distributions” for non-qualified medical expenses from HSAs (from 10% to 20%) Over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs.	The reconciliation package makes significant changes to the tax on health insurers included in H.R. 3590. While it delays the tax until l 2014 and eliminates existing exemptions for certain insurers from the Senate-passed bill, it increases the amount of fees once they become effective. The fees start at $8 billion in 2014, going up to $11.3 billion in 2015 and 2016, $13.9billion in 2017, and $14.3 billion in 2018. After 2018 the fee is indexed to the annual amount of premium growth in subsequent years At the same time, it reduces the fee for certain tax exempt health plans by allowing them to calculate the fee based on only 50 percent of their premiums. The bill's insurer tax provisions also exempt: (1) nonprofit insurers that receive over 80 percent of their gross revenues from government programs like Medicare, Medicaid, and CHIP; and (2) voluntary employee benefit associations that are established by non-employers. Delays implementation of the limit on FSA contributions for medical expenses to $2,500 per year with the limit indexed for inflation from 2011 to 2013. Changes the effective date of the Senate's tax on "Cadillac" plans from 2013 to 2018. It also raises the threshold for

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	Limits FSA contributions for medical expenses to $2,500 per year indexed for inflation. Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill. Eliminates Medicare Part D deduction. Creates a new 10 percent excise tax on indoor tanning. Annual $2 billion fee/tax on Rx manufacturers. Annual $2 billion fee/tax on medical device manufactures. Beginning in 2011, imposes an annual $6 billion fee/tax on health insurance companies with $50 million in profits and assess the tax on a pro-rated basis to insurance companies based on profits. Carves out certain non-profit insurers from the insurer assessment Raises 7.5% AGI floor on medical expense deduction to 10%; AGI floor for 65+ remains at 7.5%. Prohibits health insurance companies from deducting any executive pay in excess of $500,000 if at least 25 percent of its gross premium income is derived from	premiums that are exempt from the assessment from $8,500 for individual coverage to $10,200 and from $23,000 for families to $27,500. The bill also reduces the formula for indexing the thresholds even further (to just inflation, not inflation plus 1%) so that more plans will fall under the tax faster, but also allows plans to take into account age, gender and certain other factors that impact premium costs. Stand-alone vision and dental plans are also excluded from the tax. Clarifies that the group health insurance income tax exclusion is extended to dependents up to age 26. Delays implementation of the elimination of the corporate deduction for Medicare Part D payments by two years to 2013. Increases the Medicare payroll tax from 2.9% on unearned income to 3.8 percent for individuals with incomes over $200,000 and families with incomes over $250,000, beginning on January 1, 2013. The legislation would also increase the 1.45 percent Medicare payroll tax on workers' wages to 2.35 percent on earnings that exceed $200,000 for an individual and $250,000 for a couple. The portion of the Medicare payroll tax paid by the employer would remain at 1.45 percent. Delays the excise tax on brand-name pharmaceuticals by one year to 2011 but increases the overall amount. Modifies and delays the tax on medical devices to 2013.

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	health insurance plans that meet specified minimum requirements. Under current law, businesses can deduct up to $1 million annually per executive.	Eliminates a tax provision that allows certain byproducts of paper production to be eligible for the cellulosic biofuels producer credit. Reduces tax shelters by clarifying the definition of when activities have true "economic substance" beyond evading taxes. Makes an adjustment to corporate estimated tax payments in 2014.
Effective Dates	The majority of the provisions in the bill especially those relative to health insurance coverage, take effect on January 1, 2014. Effective dates by provision do vary, and different effective dates are noted in each section of the chart.	As with H.R. 3590, the majority of the provisions in the bill take effect on January 1, 2014. Effective dates by provision do vary, and different effective dates are noted in each section of the chart. The reconcilliation package also appropriates $1 billion to DHHS for the administrative costs of implementing these reforms.

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