



AMERICAN BENEFITS
COUNCIL

August 7, 2009

COMPARISON OF THE COVERAGE PROVISIONS IN THE AFFORDABLE HEALTH CHOICES ACT
AS APPROVED BY THE SENATE HELP COMMITTEE
AND THE HOUSE "TRI-COMMITTEE" BILL, H.R. 3200, AMERICA'S AFFORDABLE HEALTH CHOICES ACT

| Provision | Senate HELP Committee Bill (Affordable Health Choices Act) | House Tri-Committee Bill, H.R. 3200 |
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| Individual Mandate | <ul style="list-style-type: none">○ Includes an individual mandate to obtain qualified health coverage or pay a \$750 annual penalty.○ Requirement also applies to dependents of an individual subject to the coverage mandate.○ Penalty does not apply to lapses of coverage of less than 90 days or unless "affordable health care coverage is not available" (subject to terms determined by the Secretary of Health and Human Services) and other limited exceptions.○ Provides a federal premium subsidy to individuals or families with incomes below 400 percent of the federal poverty level who obtain coverage from a qualified plan in a health insurance exchange so that they are able to obtain affordable coverage and meet the individual mandate. | <ul style="list-style-type: none">○ Includes an individual mandate to obtain qualified health coverage or pay a 2.5 percent tax on income in excess of an individual's modified adjusted gross income. Penalty could not exceed the national average premium for a "basic" health plan offered in a health insurance exchange.○ Requirement also applies to dependents of an individual subject to the coverage mandate.○ Directs the Secretary of Treasury to develop regulations to not apply the penalty in cases of "de minimis" lapses of coverage or in cases of "hardship".○ Provides a federal premium subsidy to individuals or families with incomes up to 400% of the federal poverty line who obtain coverage from a qualified plan in a health insurance exchange so that they are able to obtain affordable coverage and meet the individual mandate. |

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| <p>Minimum Benefit Requirements and Wellness Program Incentives</p> | <ul style="list-style-type: none"> ○ Service categories required to be covered as “essential benefits” would be: <ul style="list-style-type: none"> ● Ambulatory patient services ● Emergency services ● Hospitalization ● Maternity and newborn care ● Medical and surgical care ● Mental health and substance abuse ● Prescription drugs ● Rehabilitative, habilitative and devices ● Laboratory services ● Preventive and wellness services ● Pediatric services, including oral and vision care ○ The Secretary of HHS would also determine the criteria that coverage must meet to be considered “minimum qualifying coverage” for the purposes of the coverage mandate and the conditions under which coverage would be considered “affordable and available” for individuals and families at different income levels. ○ Directs the Secretary of HHS to determine the scope of essential benefits “equal to the scope of benefits provided under a typical employer plan.” ○ Permits employers to establish premium discounts or rebates, or modify co-pays or deductibles up to 30 percent to encourage participation in health promotion or disease prevention program. The Secretary would have authority to issue regulations to allow financial incentives up to 50 percent. (Existing regulations limit these rewards or incentives up to 20 % of the cost of employee-only coverage.) Current law privacy and non-discriminatory provisions of the HIPAA regulations would continue to apply. | <ul style="list-style-type: none"> ○ Service categories required to be covered as “essential benefits” would be: <ul style="list-style-type: none"> ● Hospitalization ● Outpatient hospital and outpatient clinic services, including emergency services ● Professional services of physicians and other health professionals ● Services, equipment supplies incident to a physician or other health professional’s delivery of care ● Prescription drugs ● Rehabilitative and habilitative services ● Mental health and substance abuse ● Preventive services (as recommended by the Task Force on Clinical Preventive Services) ● Maternity care ● Well baby and well child care, including oral, vision and hearing services for children up to age 21. ○ Establishes a Health Benefits Advisory Committee with a broad group of stakeholders (including employers and insurers) to make recommendations on other covered benefits, terms and conditions applied to covered benefits and cost sharing levels for plans offered in the insurance exchanges. Secretary is authorized to approve the recommendations of the Committee to apply to all health plans as conditions for qualified coverage. ○ No comparable wellness incentive provision, although it is possible incentives to encourage wellness program participation could still be considered when the bill is considered by the full House of Representatives. |

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| Employer Mandate | <ul style="list-style-type: none"> ○ Employers would be subject to an annual “pay or play” penalty of \$750 for each full-time employee and \$375 for each part-time employee if they fail to offer qualifying coverage or do not contribute at least 60 percent of the cost of qualifying coverage. ○ Employees who are offered qualifying coverage under an employer plan are not eligible to receive premium subsidies for coverage obtained in a health insurance exchange unless the employee’s share of the premium for their employer coverage exceeds 12.5 percent of adjusted gross income. | <ul style="list-style-type: none"> ○ Employers would be subject to an annual “pay or play” penalty equal to 8 percent of average total wages paid by the employer if they fail to offer qualifying coverage or do not contribute at least 72.5 percent for self-only coverage or 65 percent for family coverage (based on the lowest cost plan option offered by the employer). ○ Employers may make separate elections under regulations to be developed by the Secretary of Treasury with respect to separate lines of business and full-time vs. part-time workers about whether to provide qualifying coverage (and make the minimum contribution to coverage) or not offer coverage and pay the 8 percent penalty. ○ Beginning in Year 2 after insurance exchanges are established, the employer would also be required to pay the 8 percent penalty for each employee who opts-out of the employer’s plan and obtains coverage from a plan in the health insurance exchange. ○ Employers would be required to automatically enroll an employee in its lowest cost self-only coverage plan unless an employee affirmatively elects another coverage option or opts-out of the employer’s plan within 30 days. ○ Employees who are offered qualifying coverage under an employer plan are not eligible to receive premium subsidies for coverage obtained in a health insurance exchange unless the employee’s share of the premium for their employer coverage exceeds 11 percent of adjusted gross income. |

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| Insurance Exchanges | <ul style="list-style-type: none"> ○ Establishes health insurance exchanges (referred to as a Gateway in the Senate HELP bill) to facilitate the offering of qualified health insurance plans with different levels of coverage. Generally, exchanges are expected to be established by states, but will be maintained by the federal government if a state fails to establish an exchange. Exchanges are to be effective in 2013. ○ Plans offered through the health insurance exchange are available to individuals who are <i>not entitled to coverage</i> under Medicare or eligible for coverage under Medicaid, TRICARE, the federal employee health benefits program, or an employer plan (unless the coverage under the plan does not meet qualifying coverage standards under this Act or is not affordable because the employee's share of the premium exceeds 12.5 percent of adjusted gross income.) ○ Employers may offer coverage by allowing employees to elect plans offered through the exchange, but only if eligible based on group size as determined by the state. In a state where no exchange has been established, the Secretary of Health and Human Services will determine the group size that may participate in the exchange, or if the Secretary fails to establish a group size, the employers with up to 10 employees may participate in the exchange. [Note: Generally, exchanges are expected to only be available to those in the individual market and for very small employers, although eventually larger employers may be eligible to participate in insurance exchanges based on subsequent State or federal determinations.] | <ul style="list-style-type: none"> ○ Establishes health insurance exchanges to facilitate the offering of qualified health insurance plans with different levels of coverage. Generally, exchanges are expected to be established by states, but will be maintained by the federal government if a state fails to establish an exchange. Exchanges are to be effective in 2013. ○ Plans offered through the health insurance exchanges are available to individuals who are <i>not enrolled in coverage</i> under Medicare, Medicaid, TRICARE, the Veterans Administration, a state high risk pool, or a qualified employer-sponsored plan. ○ Beginning the first year that exchanges are available (2013), employers with 10 or fewer employees may offer coverage by allowing employees to elect plans offered through the exchange. In the second year, employers with 20 or fewer employees would be eligible to participate. In the third and subsequent years, larger employers would be eligible to participate up to group sizes to be determined by the new federal health commissioner. |

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| Additional Requirements on Group Health Plans (both insured and self-insured plans) | <ul style="list-style-type: none"> ○ Prohibits application of pre-existing condition exclusions. ○ Applies insurance rating rules to insured coverage, with exceptions for large plans. ○ Requires guaranteed issue and guaranteed renewability of coverage. ○ Prohibits establishment of eligibility rules for coverage based on health status or other health related factors. ○ Requires reimbursement policies for services of health care providers that provide incentives for high quality care and implements case management, care management, chronic disease management, medication and care compliance and the use of a “medical home” model. ○ Prohibits cost sharing for preventive health services (except for minimal cost sharing as defined by the Secretary of HHS). ○ Requires coverage of child dependents up to age 26. ○ Prohibits annual or lifetime dollar limits on coverage. ○ Prohibits eligibility rules for any full-time employee that are based on the total hourly or annual salary of the employee. | <ul style="list-style-type: none"> ○ Extends COBRA coverage until the earlier of the date on which a COBRA-eligible individual becomes eligible for coverage under an employer plan or is eligible for coverage under a plan offered in an insurance exchange (expected to be 2013). Other current law provisions apply which also terminate COBRA coverage (e.g., Medicare eligibility, failure to pay claims, etc.) Provision does <u>not</u> extend the 65 percent COBRA subsidy program enacted earlier this year. ○ Prohibits application of pre-existing condition exclusions. ○ Applies insurance rating rules to insured coverage. ○ Establishes network adequacy standards. ○ Requires plans to meet any new grievance and appeals procedures established by the federal health commissioner. ○ Requires plans to meet new standards for information “transparency” relating to plan documents, terms and conditions, payment policies and practices, enrollment, claims denials, rating practices and other matters determined by the new federal health commissioner. ○ Applies federal timely claims payment standards to all health plans. |
| Public Health Insurance Plan Option | <ul style="list-style-type: none"> ○ Establishes a Community Health Insurance Plan option (i.e., public health insurance plan) which would be available alongside qualified private health insurance plans offered through the new health insurance exchanges. ○ Public health insurance plan would be required to negotiate reimbursement rates with health care providers for covered services and meet other federal and state insurance rules which apply to private plans (e.g., benefits standards, solvency requirements, and consumer protection standards). | <ul style="list-style-type: none"> ○ Establishes a Public Health Insurance Plan which would be available alongside qualified private health insurance plans offered through the new health insurance exchanges. ○ Public health insurance plan would use Medicare reimbursement rates for payments to health care providers for three years (plus a bonus payment of 5 percent for providers who participate in both the public plan and Medicare) and then provides broad discretion to the Secretary of HHS establishing payment rates for future years. (Note: House Energy and Commerce Committee approved an amendment to require public plan to negotiate reimbursement rates with health providers.) |

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| Retiree Health Reinsurance | <ul style="list-style-type: none"> ○ Establishes a temporary reinsurance program for qualified employers with retirees between ages 55 and 64 until such time as the state in which the retiree resides establishes a health insurance exchange. Reinsurance payments for 80 percent of valid retiree claims costs that exceed \$15,000 and are not greater than \$90,000 (i.e., a maximum reinsurance amount of \$60,000 per retiree). Total funding for the program is capped at \$10 billion. ○ Requires that all reinsurance payments be used to reduce retiree health insurance premiums or lower cost-sharing and “shall not be used to reduce the costs of an employer maintaining the participating employment-based plan.” | <p>Same retiree health reinsurance provisions as in the Senate HELP bill.</p> <p>[Note: See also the provisions prohibiting reductions in retiree health benefits described under ERISA provisions.]</p> |
| ERISA | <ul style="list-style-type: none"> ○ Retains state regulation of insured health plans and federal regulation of self-insured plans. ○ Adds numerous new federal requirements under ERISA on employer-sponsored health coverage, whether insured or self-insured, to implement the provisions of the Affordable Health Choices Act . (See requirements discussed under Minimum Benefit Requirements and Additional Requirements.) | <ul style="list-style-type: none"> ○ Requires the Secretary of Labor (except in extraordinary circumstances) to waive ERISA’s preemption rules to permit a state which has enacted a “single payer system” to require employer participation in the state program. ○ Prohibits any reductions in employer-sponsored retiree health benefits after an individual retires, unless the same change is made in benefits for active employees. ○ Applies State law individual rights and remedies to employer-sponsored coverage obtained through a health insurance exchange. ○ Applies numerous new federal requirements under ERISA on employer-sponsored health coverage, whether insured or self-insured, after an initial 5-year “grace period”, and requires employers to provide such information as may be required by the new federal health Commissioner to determine whether employers are in compliance. |

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| Tax Provisions Relating to Health Benefits | <ul style="list-style-type: none"> ○ Generally no changes in tax policy because Senate HELP Committee does not have jurisdiction over the tax code. ○ Note: The Senate Finance Committee is considering a provision to tax “high cost” health benefits above a specified level, indexed in future years by CPI. Tax would reportedly apply to all health related benefits offered to an employee including benefits such as dental, vision services, and “executive physicals”. Tax threshold may also include medical FSAs, although a separate cap on annual FSA deferrals for qualified medical expenses is also reportedly under consideration. | <ul style="list-style-type: none"> ○ Includes a federal premium tax on insured and self-insured plans to finance a comparative effectiveness research program. Tax would initially be \$2.00 per average number of covered lives under the plan and would be indexed to the medical component of CPI. ○ Extends the current law income and payroll tax exclusion for the cost of health insurance provided by an employer to individuals who, under the terms of the plan, are eligible for coverage. This includes domestic partners, other relatives, older children or any other individual who is an eligible beneficiary under the terms of the plan. Directs the Secretary of Treasury to issue guidance to permit reimbursements from FSAs and HRAs for such eligible beneficiaries. |