



**AMERICAN BENEFITS
COUNCIL**

December 3, 2009

**COMPARISON OF THE COVERAGE AND REVENUE PROVISIONS
IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3590),
AND THE AMERICA’S AFFORDABLE HEALTH CHOICES ACT (H.R. 3962), AS APPROVED BY THE HOUSE OF REPRESENTATIVES**

Provision	Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)
Individual Mandate	<ul style="list-style-type: none"> ○ Includes an individual mandate to obtain qualified health coverage, subject to an excise tax penalty on adults of \$95 in 2014, \$350 in 2015, \$750 in 2016, and indexed thereafter. ○ No penalty for lapses in coverage less than 3 months. ○ No penalty if the lowest cost available plan would exceed 8 percent of adjusted gross income, however these individuals would be permitted to purchase a low-cost catastrophic coverage policy (which otherwise would only be available to young adults) regardless of age. ○ Provides for federal premium subsidies (in the form of tax credits) for 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. ○ Participants in the individual and small group markets who obtain coverage from a qualified health plan offered inside a health insurance exchange will satisfy their individual mandate by enrolling in a plan with at least a 60 percent actuarial value (a bronze level plan) that includes coverage for “essential health benefits” required under the legislation, or for those below age 30 at the beginning of the plan year, a policy providing catastrophic coverage and at least three primary care visits. 	<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, effective in 2013. 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 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.

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Individual Mandate (continued)	<ul style="list-style-type: none"> ○ Individuals eligible to participate in an employer plan would satisfy their individual mandate requirement by enrolling in an employer plan. Note, large group plans are not required to meet the “essential benefits package” standards applicable to plans inside the exchange, but must provide first dollar coverage for preventive services and may not have a lifetime dollar limit or “unreasonable” annual limit on coverage. 	
Minimum Benefit Requirements and Wellness Program Incentives	<ul style="list-style-type: none"> ○ Service categories required to be covered in an “essential benefits” package by health plans in the individual and small group markets offered inside and outside of the insurance exchanges would be: <ul style="list-style-type: none"> ● Ambulatory patient services ● Emergency services ● Hospitalization ● Maternity and newborn 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 ○ No cost-sharing permitted for preventive services, except to value-based insurance designs. ○ No lifetime limits on coverage and no “unreasonable” annual dollar limits on benefits. ○ 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 ● Durable medical equipment, prosthetics, orthotics and related supplies. ○ 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 wellness incentive provisions comparable to those in the Senate bills.

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Employer Mandate	<ul style="list-style-type: none"> ○ Employers are not required to offer coverage or make a minimum contribution to the cost of coverage. However, if an employer with 50 or more full-time employees (an individual who works at least 30 hours per week) does <u>not</u> provide health coverage, the employer would be subject to an assessment for each full-time employee. Employers that <u>do</u> provide health coverage are only subject to assessments for those full-time employees who opt-out of the employer plan because it is not affordable or fails to meet a minimum value standard and the employee obtains an income-based tax credit for coverage in a health insurance exchange. ○ For employers that do <u>not</u> offer coverage, and even one full-time employee obtains a tax credit for coverage in an insurance exchange, the employer assessment would equal \$750 x the total number of full-time employees in the workforce. ○ For employers that <u>do</u> offer coverage and an employee opts-out of the employer plan either because the employee's share of the premium would exceed 9.8 percent of the employee's income, or if the coverage provided by the employer plan does not have at least a 60 percent actuarial value <u>and</u> the employee obtains a tax credit for coverage in a health insurance exchange, the employer assessment would equal \$3,000 x the total number of full-time employees who obtain an income-based tax credit. This assessment is capped at an amount not to exceed \$750 x the total number of full-time employees in the workforce. ○ These assessments would not be deductible by the employer. ○ Employers with 200 or more employees would be required to auto-enroll employees into health plans offered by the employer, with an employee opt-out opportunity if they demonstrate that they have coverage from another source. Waiting periods longer than 30 days would be subject to a penalty. ○ Note: Senator Ron Wyden (D-OR) is expected to offer an amendment to the bill, or may have already reached agreement with Senate Majority Leader Harry Reid (D-NV) to add to the bill, as it will be formally introduced. It would require employers to provide a voucher to certain employees equal to the largest portion" of any premium contribution the employer makes to a health plan. Qualified employees are those who opt out of an employer plan when their share of the premium is between 8 and 9.8 percent of their income <u>and</u> their total household income does not exceed 400 percent of the federal poverty level. The employer voucher would be applied by these individuals for the purchase of coverage in a health insurance exchange and would not be taxable to the employee, including any amounts in excess of the portion they would use to obtain coverage in the exchange. 	<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 12 percent of adjusted gross income.

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Insurance Exchanges	<ul style="list-style-type: none"> ○ Establishes health insurance exchanges to facilitate the offering of qualified health insurance plans at four different levels of coverage (bronze, silver, gold and platinum) with actuarial values of 60, 70, 80 and 90 percent to individuals in the non-group small group markets. States would be required to have exchanges established and operational by January 1, 2014, or the Secretary is required to establish and operate an exchange in a non-compliant state (directly or through a not-for-profit entity). ○ All legal U.S. residents may obtain insurance coverage through the health insurance exchanges (although those with employer coverage are not eligible for an income-based tax credit for coverage obtained in an exchange unless their share of the premium for the employer plan would exceed 9.8 percent of income or if the employer plan has an actuarial value of less than 60 percent). ○ Employers in small groups (with 100 employees or fewer) may elect to offer coverage through an insurance exchange. (States have the option to define small employer groups as those with 50 employees or fewer.) Starting in 2017, states <u>may</u> allow employers with more than 100 employees to purchase coverage in the exchanges (or more than 50 employees for states that use the alternate definition of small employers). 	<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</i> coverage under Medicare, Medicaid, TRICARE, Veterans Administration coverage, 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 Health Choices Commissioner, a new federal position to be established.

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Additional Requirements on Group Health Plans (both insured and self-insured plans)	<ul style="list-style-type: none"> ○ Market reform rules apply to the individual and small group insurance markets and include rating limits for variations in premiums related to individual or family coverage, rating areas, age (subject to a 3 to 1 limit) and tobacco use (subject to a 1.5 to 1 limit). Also requires guaranteed issue, guaranteed renewability of coverage, prohibits rescissions of coverage and imposes minimum loss ratios of 80 percent for group coverage and 75 percent for individual coverage. ○ Within 90 days after enactment, high risk pool coverage would be available to any uninsured individual who has been denied health coverage due to a pre-existing condition. This would be available until 2014 when coverage in the new health insurance exchanges is available to all enrollees. ○ Requires first-dollar coverage of preventive services as determined by the U.S. Preventive Services Task Force. ○ Requires coverage of child dependents up to age 26. ○ Requires plans to provide internal and external review procedures. ○ Prohibits establishment of eligibility rules for coverage based on health status or other health related factors. 	<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 that 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) that would be available alongside qualified private health insurance plans offered through the new health insurance exchanges. States would have the option not to offer the public plan option. ○ A 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 that apply to private plans (e.g., benefits standards, solvency requirements, and consumer protection standards). ○ Also allows for non-profit, member-run health cooperatives (Co-ops) to be offered in the health insurance exchanges. 	<ul style="list-style-type: none"> ○ Establishes a Public Health Insurance Plan that 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 providers. ○ Rates paid by public plan may not be lower than those paid by Medicare or higher than average rates by private plans offered in the insurance exchange.

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Retiree Health Reinsurance	<ul style="list-style-type: none"> ○ Within 90 days after enactment, a temporary \$5 billion retiree health reinsurance program for employer-sponsored coverage would be established for claims from retirees between the ages of 55 and 64. The program would reimburse eligible employers or insurers for 80 percent of the claims between \$15,000 and \$90,000 (adjusted annually by the medical component of the CPI). Eligible employers must implement programs and procedures to generate cost-savings for those with chronic and high-cost conditions, provide documentation on actual costs of medical claims and be certified by the Secretary of Health and Human Services. ○ Requires that all reinsurance payments be used to lower costs of the plan and may be used to reduce retiree health insurance premiums or lower cost-sharing by retirees and “shall not be used as general revenues by the employer...or for any other purposes.” ○ Program terminates on January 1, 2014 when coverage is available through health insurance exchanges. 	<ul style="list-style-type: none"> ○ Establishes a temporary reinsurance program for qualified employers with retirees between ages 55 and 64. 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 as general revenues by the employer...or for any other purposes.” <p>[Note: See also the provisions restricting 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 exclusive federal regulation of self-insured plans. ○ Includes broad authority for states to obtain waivers of federal health-related laws and regulations in order for states to pursue their own health reform initiatives, but the waiver authority is limited to laws under the jurisdiction of the Secretary of Health and Human Services and the Secretary of Treasury and therefore does <u>not</u> apply to waivers of ERISA (which is under the jurisdiction of the Secretary of Labor). 	<ul style="list-style-type: none"> ○ Prohibits reductions in employer-sponsored retiree health benefits after an individual retires that would reduce the plan’s actuarial value by more than 5 percent or increase the retiree’s share of the premium by more than 5 percent, unless the same change is made in benefits for active employees. ○ Applies state law rights and remedies to employer-sponsored health coverage when obtained through a health insurance exchange, though state law remedies would not apply to “requirements applicable to employers and other plan sponsors” in connection with group health plans. ○ 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 choices commissioner to determine whether employers are in compliance.

Provision	Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)
Tax Provisions Relating to Health Benefits	<ul style="list-style-type: none"> ○ High Cost Plan Excise Tax –A 40 percent excise tax would be assessed on the aggregate cost of insured and self-insured group health coverage that is above a threshold of \$8,500 for singles and \$23,000 for family plans. For retirees age 55 and older and those in certain high risk occupations, the thresholds would be \$9,850 for singles and \$26,000 for families. The tax would apply to the amounts above the thresholds. Thresholds would be indexed each year by CPI plus 1 percent. A three year transition rule would also increase the thresholds for the 17 highest health care cost states. Fixed indemnity coverage purchased on an after-tax basis would not be subject to the excise tax. Effective starting in 2013. ○ Taxation of Employer Subsidy for Retiree Prescription Drugs – Employers would not be permitted to deduct an amount equal to the federal subsidy they receive for maintaining retiree prescription drug coverage that is at least the same actuarial value as coverage offered under Medicare Part D. Effective starting in 2011. ○ Premium Taxes – A new federal premium tax of \$2.00 on each covered life in an insured <u>or</u> self-insured health plan would be assessed to finance a comparative effectiveness research program. This provision is effective for policies and plans ending after September 30, 2012. The tax would increase to \$2.00 in 2014 and be indexed by the percentage increase in the national health expenditures component of CPI in subsequent years and would sunset after 2019. ○ Health Industry Fees – Annual fees would be assessed on insurance companies, pharmaceutical companies and medical device companies for certain amounts received starting in 2009. Insurance company assessments would also apply to the amounts they receive in fees as third-party administrators. ○ Limit on FSA Contributions – Annual contributions to health FSAs would be limited to \$2,500, starting in 2011. This amount is not indexed. ○ W-2 Reporting of the Value of Health Benefits – Employers would be required to report the value of health benefits provided by the employer on the employee's annual W-2 form. Effective beginning in 2010. 	<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. ○ Taxation of Employer Subsidy for Retiree Prescription Drugs – Employers would not be permitted to deduct an amount equal to the federal subsidy they receive for maintaining retiree prescription drug coverage that is at least the same actuarial value as coverage offered under Medicare Part D. Effective starting in 2013. ○ Limit on FSA Contributions – Annual contributions to health FSAs would be limited to \$2,500, starting in 2011. This amount <u>is</u> indexed to CPI. ○ Establishes a 2.5 percent excise tax on medical devices sold in the U.S. ○ Penalties for Non-qualified Use of HSA Funds – The penalty for non-qualified withdrawals from HSAs by individuals prior to age 65 would increase from 10 to 20 percent, starting in 2011. ○ Other Provisions – Beginning in 2011, standardizes the definition of qualified medical expenses for purposes of an HSA, FSA or HRA to prohibit use of funds for over-the-counter drugs (unless prescribed or insulin); starting in 2012, requires new corporate information reporting on payment for goods and services similar to Form 1099 rules that currently apply for services of non-corporate providers. ○ Note: Most of the revenue for the House bill would come from a new surcharge on high income taxpayers rather than health-related revenue sources as under the bill approved by the Senate Finance Committee.

Provision	Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)
Tax Provisions Relating to Health Benefits (continued)	<ul style="list-style-type: none"> ○ Penalties for Non-qualified Use of HSA Funds – The penalty for non-qualified withdrawals from HSAs by individuals prior to age 65 would increase from 10 to 20 percent, starting in 2011. ○ Starting 2013, imposes an increase of 0.5 percent in the FICA tax paid on wages above \$200,000 (\$250,000 in the case of joint returns). Increase is only applicable to amounts paid by the employee. ○ Other Provisions – Beginning in 2011, standardizes the definition of qualified medical expenses for purposes of an HSA, FSA or HRA to prohibit use of funds for over-the-counter drugs (unless prescribed); starting 2013, increases the threshold for claiming a deduction for medical expenses from 7.5 percent to 10 percent of adjusted gross income (except those over age 65 would continue to be eligible for the 7.5 percent deduction through 2016); starting in 2012, requires new corporate information reporting on payment for goods and services similar to Form 1099 rules that currently apply for services of non-corporate providers; and starting 2010, limits deductions for “excessive remuneration” above \$500,000 by individuals employed by health insurance providers. ○ Starting in 2010, imposes a 5 percent tax on elective cosmetic medical procedures. 	