



**AMERICAN BENEFITS
COUNCIL**

October 16, 2009

**COMPARISON OF THE COVERAGE AND REVENUE PROVISIONS IN
AMERICA’S HEALTHY FUTURE ACT (AS APPROVED BY THE SENATE FINANCE COMMITTEE)
THE AFFORDABLE HEALTH CHOICES ACT (S. 1979, AS APPROVED BY THE SENATE HELP COMMITTEE)
AND THE AMERICA’S AFFORDABLE HEALTH CHOICES ACT (H.R. 3200, THE HOUSE “TRI-COMMITTEE” BILL)**

Provision	Senate Finance Committee Bill (The America’s Healthy Future Act)	Senate HELP Committee Bill (The Affordable Health Choices Act, S. 1679)	House Tri-Committee Bill (The America’s Affordable Health Choices Act, H.R. 3200)
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-only of \$0 in 2013, \$200 in 2014, \$400 in 2015, \$600 in 2016 and \$750 in 2017, 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 would be required to obtain coverage that at least meets the requirements of the lowest level plan offered in a health insurance exchange, or for those age 25 or younger, a “young invincible” policy providing catastrophic coverage and preventive benefits. ○ Participants in the large group market would be required to obtain coverage that provides first dollar coverage for preventive services, a maximum out-of-pocket limit that does not exceed the standards for coverage offered in connection with an HSA, and may not have an “unreasonable annual or lifetime limit on coverage”. 	<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 above the minimum taxable income level. 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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Minimum Benefit Requirements and Wellness Program Incentives	<ul style="list-style-type: none"> ○ For coverage in the individual and small group markets, required benefits would be: <ul style="list-style-type: none"> ● Preventive and primary care ● Emergency services ● Hospitalization ● Physician services ● Outpatient services ● Day surgery and related anesthesia ● Diagnostic imaging and screening ● Maternity and newborn care ● Pediatric services (including dental and vision) ● Medical/surgical care ● Prescription drugs ● Radiation and chemotherapy ● Mental health and substance abuse services ○ No cost-sharing permitted for preventive services, except for value-based insurance designs. ○ No lifetime limits on coverage and no annual limits on benefits. ○ The Secretary of HHS would be required to define and update the categories of covered treatments, items and services with benefit classes annually through a "transparent and public process" that allows for a public comment period. The Secretary may not define a benefit category that is more extensive than the 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"> ● 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 are not required to offer coverage or make a minimum contribution to the cost of coverage. However, they would be subject to an assessment for each full-time employee (an individual who works at least 30 hours per week) who obtains a tax credit for coverage in a health insurance exchange. ○ Employees are eligible to obtain an income-based tax credit in an insurance exchange only if their employer does not provide health coverage, or if the coverage provided by an employer would exceed 10 percent of the employee's income, or if the coverage provided by their employer does not have an actuarial value of at least 65 percent. ○ The assessment to the employer would be the lesser of a flat dollar amount (equal to the national average tax credit) multiplied by the number of employees who obtain a tax credit in an exchange or \$400 multiplied by the total of the employer's full-time employees. 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. 	<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 to facilitate the offering of qualified health insurance plans at four different levels of coverage (bronze, silver, gold and platinum) with actuarial values of 65, 70, 80 and 90 percent, respectively. States would be required to establish exchanges and beginning in 2013, all private insured plans that operate nationally, regionally, statewide or locally must be available in the state exchanges and must meet the insurance market reforms in the legislation. ○ 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 10 percent of income or if the employer plan has an actuarial value of less than 65 percent). ○ Employers in small groups (with up to 50 employees) may elect to offer coverage through an insurance exchange. Starting in 2015, states <u>must</u> allow employers with up to 100 employees to purchase coverage in the exchanges and states <u>may</u> allow employers with more than 100 employees to purchase coverage through the exchanges starting in 2017. ○ National insurance plans are also authorized that could be offered in all states and would be subject to federal, but not state, benefit requirements. 	<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 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</i> coverage 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"> o Market reform rules apply to the individual and small group insurance markets and include rating limits for variations in premiums related to tobacco use, age and family composition. Also requires guaranteed issue and guaranteed renewability of coverage. o Within the first year 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 2013 until coverage in the new health insurance exchanges is available to all enrollees. o State insurance commissioners would continue to provide oversight of insurance plans with regard to consumer protections (e.g., grievance procedures, external review, agent training and practices and market conduct) and rate review, solvency, reserve requirements, premium taxes, and enforcement of all new requirements imposed by the legislation. o Insurers would be required to contribute to a new \$20 billion individual market reinsurance program with contribution amounts reflecting the entity's insured book of business for major medical coverage <u>and</u> its fees for third party administration of self-insured plans (based on percent of revenues or a flat, per enrollee amount). 	<ul style="list-style-type: none"> o Prohibits application of pre-existing condition exclusions. o Applies insurance rating rules to insured coverage, with exceptions for large plans. o Requires guaranteed issue and guaranteed renewability of coverage. o Prohibits establishment of eligibility rules for coverage based on health status or other health related factors. o 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. o Prohibits cost sharing for preventive health services (except for minimal cost sharing as defined by the Secretary of HHS). o Requires coverage of child dependents up to age 26. o Prohibits annual or lifetime dollar limits on coverage. o 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"> o 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. o Prohibits application of pre-existing condition exclusions. o Applies insurance rating rules to insured coverage. o Establishes network adequacy standards. o Requires plans to meet any new grievance and appeals procedures established by the federal health commissioner. o 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. o Applies federal timely claims payment standards to all health plans.
Public Health Insurance Plan Option	<ul style="list-style-type: none"> o Establishes non-profit, member-run health cooperatives (Co-ops) that would compete with private insured health plans in the individual and small group markets. o The Co-ops 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., benefit standards, solvency requirements, consumer protection standards). 	<ul style="list-style-type: none"> o 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. o 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). 	<ul style="list-style-type: none"> o Establishes a Public Health Insurance Plan that would be available alongside qualified private health insurance plans offered through the new health insurance exchanges. o 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"> ○ A temporary \$5 billion retiree health reinsurance program for employer-sponsored coverage would be established for claims from retirees between 55 and 64 years old. 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 offer coverage that is "appropriate for a mature population" offer preventive benefits, has demonstrated programs for generating cost-savings for those with chronic and high-cost conditions, and can show actual costs of medical claims. The reinsurance payments would apply to claims insured through 2015. The \$5 billion program would be financed by assessments that appear to operate in the same fashion as the assessment on insurers for the individual market reinsurance program [see Additional Requirements on Group Health Plans]. 	<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 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 explicitly 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"> ○ Retains state regulation of insured health plans and exclusive federal regulation of self-insured plans. ○ Adds numerous new federal requirements under ERISA on employer-sponsored coverage, whether insured or self insured plans. [See requirements discussed under Minimum Benefit Requirement and Additional Requirements on Group Health Plans.] 	<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 that 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 rights and remedies to employer-sponsored health coverage when 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"> ○ High Cost Plan Excise Tax – Beginning in 2013, 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 \$8,000 for singles and \$21,000 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 – Currently, employers exclude from income the amount they receive in federal subsidies 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, employers would be required to reduce corporate deductions by the amount they received as a federal subsidy. ○ Premium Taxes – Starting in 2013, a new federal premium tax of \$1.00 on each covered life in an insured or self-insured health plan would be assessed to finance a comparative effectiveness research program. The tax would increase to \$2.00 in 2014 and be indexed to the medical component of CPI in subsequent years and would sunset after 2019. (See also discussion under Additional Requirements on Group Health Plans for similar premium assessments to finance a reinsurance program for the individual insurance market.) ○ Health Industry Fees – Annual fees would be assessed on insurance companies, pharmaceutical companies and medical device companies. Total assessments on the three industries would be \$13 billion per year and would begin in 2010. ○ 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. ○ 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 2010, 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 2011, requires new corporate information reporting on payment of more than \$600 for goods and services similar to Form 1099 rules that currently apply to for services of non-corporate providers; and new requirements for non-profit hospitals starting in 2010. 	<ul style="list-style-type: none"> ○ Generally no changes in tax policy because the Senate HELP Committee does not have jurisdiction over the tax code. 	<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. ○ Note: Most of the revenue for the House bill would come from a new surcharge on high income taxpayers rather than health sources as under the bill approved by the Senate Finance Committee.