



AMERICAN BENEFITS COUNCIL

January 7, 2010

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	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Individual Mandate	<ul style="list-style-type: none"> ○ Includes an individual mandate to obtain qualified health coverage, subject to a penalty for failure to obtain coverage that is the <i>greater</i> of a per-person fixed dollar amount or a percent of income amount. The fixed dollar amount is determined by using the <i>lesser</i> of an "applicable dollar amount" for the year the failure occurred times the number of individuals who failed to obtain coverage, or 300 percent of the applicable amount in that year. These amounts are applied on a monthly basis (1/12 of the annual amounts for each month an individual fails to obtain coverage.) The "applicable annual amounts" are \$95 in 2014, \$495 in 2015, \$750 in 2016, and indexed thereafter. The percent of income penalty starts at 0.5 percent in 2014 and phases in to a maximum of 2.0 percent. The penalty is capped at the national average premium for "bronze" level health coverage in a health insurance exchange. ○ No penalty for lapses in coverage less than 3 months. 	<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. 	<ul style="list-style-type: none"> ○ Include a blend of the assessment provisions to enforce the individual mandate from both bills; i.e., include the House 2.5 percent of income penalty capped at the national average premium for a basic health plan in a health insurance exchange <i>and</i> the Senate provision establishing a minimum fixed dollar penalty amount, if it is greater than the percent of income penalty. ○ Include the Senate provision to permit those who are unable to obtain affordable coverage within a health insurance exchange to purchase lower-cost catastrophic plans (which are otherwise only available to young adults), regardless of age. Obtaining a catastrophic plan in these cases should be permitted to satisfy the individual mandate requirement.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Individual Mandate (continued)	<ul style="list-style-type: none"> ○ 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. ○ 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 an annual dollar limit on overall coverage. However, specific covered benefits that are not “essential benefits” may still be subject to individual limits. 		<ul style="list-style-type: none"> ○ Include the Senate provision that permits eligible individuals to enroll in an employer plan to satisfy their individual mandate, without the House bill requirements to apply the essential benefits package requirements on the employer plan.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
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 or overall annual dollar limits on benefits. Specific benefits that are not part of the essential benefits package may be subject to individual limits. Restrictions apply as of 2014 and prior to that date any plan lifetime or annual limits would be subject to regulations issued by the Secretary of Health and Human Services. ○ No waiting periods longer than 90 days and penalties would apply to waiting periods over 60 days. ○ Directs the Secretary of HHS to determine the scope of essential benefits “equal to the scope of benefits provided under a typical employer plan.” 	<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. 	<ul style="list-style-type: none"> ○ Include Senate approach that limits the application of the essential benefits package to the individual and small group insurance market, and does not apply these requirements to large groups offered outside of a health insurance exchange. ○ Include Senate provisions that permit plans to establish limits on specific benefits and allow overall plan limits to be established subject to regulations rather than prohibited entirely. ○ Include Senate premium and cost-sharing discount provisions to encourage participation in employee wellness programs.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Minimum Benefit Requirements and Wellness Program Incentives (continued)	<ul style="list-style-type: none"> ○ 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 percent of the cost of employee-only coverage.) Current law privacy and non-discriminatory provisions of the HIPAA regulations would continue to apply. 		
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, determined on a monthly basis) does <i>not</i> provide health coverage, the employer would be subject to an assessment for each full-time employee. Employers that <i>do</i> provide health coverage are only subject to assessments for those full-time employees who opt-out of the employer plan because it is deemed to be unaffordable 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 <i>not</i> 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 <i>do</i> 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 	<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 	<ul style="list-style-type: none"> ○ Include the Senate employer responsibility provisions, but allow minimum waiting periods up to 90-days without penalties (this is particularly important for employers with a high turnover workforce) and define full-time employment as at least 390 hours of work per quarter (this is important for employers with temporary or seasonal workers without a long term connection to the workforce). ○ Delete the Senate voucher provisions and instead expand the availability of lower-cost catastrophic plan coverage in a health insurance exchange to those without affordable coverage through an employer plan.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Employer Mandate (continued)	<p>employer plan does not have at least a 60 percent actuarial value <i>and</i> 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.</p> <ul style="list-style-type: none"> ○ 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 60 days would be subject to a penalty. ○ Employers would be required to provide a voucher to certain employees equal to the "largest portion" of the premium contribution the employer makes to a health plan. Qualified employees are those who are eligible for coverage under an employer plan whose required premium contribution is between 8 and 9.8 percent of their income <i>and</i> 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 (in lieu of the employer plan) and would not be taxable to the employee. Any amounts in excess of the portion used to obtain coverage in the exchange could be retained by the employee. 	<p>affirmatively elects another coverage option or opts-out of the employer's plan within 30 days.</p> <ul style="list-style-type: none"> ○ 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. 	

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
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 and small group markets. States would be required to have exchanges established and operational by January 1, 2014, or the Secretary of Health and Human Services 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 <i>may</i> 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 a national health insurance exchange to facilitate the offering of qualified health insurance plans with different levels of coverage. States would have the option to operate the exchanges, subject to federal rules. 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. 	<ul style="list-style-type: none"> ○ Include the Senate provisions on insurance exchanges, but permit employers of any size to obtain coverage for their employees through a health insurance exchange if the total number of employees in a state is fewer than the applicable number of employees for a small employer group (e.g., 50 or 100, depending on the state standard).

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Additional Requirements on Group Health 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. ○ Requires first-dollar coverage of preventive services as determined by the U.S. Preventive Services Task Force. ○ Prohibits application of pre-existing condition exclusions. ○ Requires coverage of child dependents up to age 26. ○ Requires plans to provide internal and external review procedures. Insured plans would generally be required to follow appeals standards established by the states and self-insured plans would follow federal standards. ○ Prohibits waiting periods longer than 90 days (and penalties apply after 60 days). ○ Requires coverage for clinical trials for life-threatening conditions (provided the condition would otherwise be covered and subject to plan rules on out-of-network providers). ○ Prohibits prior authorization or referral rules for OB-GYNs. ○ Prohibits prior authorization or limits cost sharing for emergency services, in or out of networks. ○ Allows plan participants to select a primary care provider (or pediatrician for a child) from any available participating primary care provider. 	<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. ○ Applies insurance rating rules to insured coverage, subject to 2 to 1 age rating limits. ○ Requires first-dollar coverage of preventive services as determined by the U.S. Preventive Services Task Force. ○ Prohibits application of pre-existing condition exclusions. ○ Requires coverage of child dependents up to age 27. ○ 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. 	<ul style="list-style-type: none"> ○ Include the Senate provision limiting the insurance rating limits to insured health plans (not self-insured plans). ○ Do not require coverage of adult children up to the age of 26. (Or limit the application of this provision until such time as coverage in a health insurance exchange is available for these individuals.) ○ Apply consistent appeals standards to both insured and self-insured employer-sponsored health plans. ○ Do not include House provision permitting individuals who become eligible for COBRA continuation coverage after the date of enactment to remain on COBRA coverage through the establishment of health insurance exchanges.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Public Health Insurance Plan Option	<ul style="list-style-type: none"> ○ Does not include a public health insurance plan option, but does include multi-state private health plan options (both non-profit and for-profit), subject to oversight by the Office of Personnel Management. ○ 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. 	<ul style="list-style-type: none"> ○ Include the Senate provisions establishing multi-state private plan options and health plans offered by voluntary, non-profit cooperatives, not the House provisions establishing a public health plan option.
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" below.]</p>	<ul style="list-style-type: none"> ○ Include the retiree reinsurance program (comparable provisions in both bills) at the higher funding level available under the House. ○ Include greater flexibility in the use of reinsurance funds, particularly for retiree health plans with minimal premium or cost-sharing provisions.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
ERISA	<ul style="list-style-type: none"> ○ 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, including state-specific “employer responsibility” provisions. 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 <i>not</i> apply to waivers of ERISA (which is under the jurisdiction of the Secretary of Labor), but could still lead to considerable variation in state rules under waivers granted by HHS or Treasury. ○ Allows for the grandfathering of plans in effect as of the date of enactment so that individuals would be able to maintain current coverage. Later enrollment of family members and new hires would be permitted to grandfathered plans. Free-rider penalties under the employer responsibility provisions would still apply to grandfathered plans. Transition rules apply to collectively bargained plans as of the termination date of the last collective bargaining agreement in effect as of date of enactment. Unclear what actions might end grandfathering status for non-collectively bargained plans. 	<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. 	<ul style="list-style-type: none"> ○ Do not include the Senate provisions allowing the Secretary of Health and Human Services and the Secretary of Treasury to grant waivers to states for certain provisions, including those related to “employer responsibilities”. Although these waivers do not extend to provisions governed by ERISA, they could nonetheless undermine the uniformity of new federal rules that employers will be required to comply with when they offer benefits to employees. ○ Do not include House provision restricting changes in retiree health benefits. ○ Do not include House provision applying state law rights and remedies to employer-sponsored health coverage when obtained through a health insurance exchange. ○ Include Senate grandfathering provisions that continue without time limits, not the House five-year “grace” period.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
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. Employers may combine pre-65 and post-65 retirees when determining coverage value subject to the tax thresholds. 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. 	<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 2013. This amount is indexed to CPI starting in 2014. ○ 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, 	<ul style="list-style-type: none"> ○ Eliminate or reduce the Senate 40 percent high-cost plan excise tax to make it fairer and less disruptive by: <ul style="list-style-type: none"> ● Increasing the tax thresholds so that fewer plans will face immediate taxation. ● Provide a multi-year transition rule for plans already above the thresholds in tax year 2010. ● Index the tax thresholds to the medical component of CPI, or at a minimum, by a blend of the CPI and the medical component. ● Include adjustments to reflect cost differences related to the average age of the workforce. ● Establish a “safe harbor” for plans that would not be subject to the excise tax, such as plans that do not exceed the actuarial value of plans available in the health insurance exchanges. ● Exempt employee contributions to health plans and retiree health plans from the calculations toward the tax thresholds. ● Do not count contributions to flexible spending accounts, health savings accounts or supplemental benefits such as vision care, dental care plans or wellness programs.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Tax Provisions Relating to Health Benefits (continued)	<ul style="list-style-type: none"> ○ Health Industry Fees – Annual fees would be assessed on insurance companies, pharmaceutical companies and medical device companies for certain amounts received starting in 2009. ○ Limit on FSA Contributions – Annual contributions to health FSAs would be limited to \$2,500, starting in 2011. This amount is indexed to CPI starting in 2012. ○ 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 2011. ○ 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 0.9 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 in 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 	<p>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.</p> <ul style="list-style-type: none"> ○ 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. 	<ul style="list-style-type: none"> ● Maintain the initial year increase in the tax thresholds for benefits provided in high-cost states on a permanent basis. ● Exempt plans from the excise tax if multiple plan options are offered and their aggregate average value is below the tax thresholds. ○ Delete House and Senate provision requiring employers to reduce their tax deductions by the amount they receive as subsidies for maintaining prescription drug coverage for Medicare-eligible retirees. Deleting this provision would help to avoid significant losses of employer-sponsored retiree drug coverage and higher Medicare costs if retirees obtain drug coverage under the Part D program. ○ Eliminate or reduce the annual “fees” included in both the House and Senate bills on health insurers and other health industry stakeholders (e.g., medical devices and pharmaceuticals manufacturers) since the Congressional Budget Office has correctly advised that these fees will be passed along in the form of higher prices paid by employers, employees and other purchasers and consumers

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Tax Provisions Relating to Health Benefits (continued)	<p>information reporting on payment for goods and services similar to Form 1099 rules that currently apply for services of non-corporate providers; and starting in 2010, limits deductions for “excessive remuneration” above \$500,000 by individuals employed by health insurance providers.</p>		<p>of health care services and make health care less affordable.</p> <ul style="list-style-type: none"> ○ Do not apply annual tax on insurers to third-party administrators or self-insured plans. ○ Eliminate the premium taxes included in the House and Senate bills on insured and self-insured plans to fund the comparative effectiveness program and a reinsurance program for individuals in the non-group insurance market. While employers strongly support the objectives of the comparative effectiveness program and the need for reinsurance in the non-group market, premium taxes are a highly inappropriate financing solution for these programs. ○ Increase the limits for contributions to flexible spending arrangements in both the House and Senate bills so that individuals with high unreimbursed health care expenses (including high-cost chronically or seriously ill individuals with costly prescription drug or medical equipment needs) do not experience sudden increased costs. Also index the limits to the medical component of CPI in future years.

Provision	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	House-passed America's Affordable Health Choices Act (H.R. 3962)	Council Recommendation
Tax Equity for Domestic Partners	No provision.	Extends the same tax treatment to domestic partners (and other persons who do not qualify as spouses or dependents) who are eligible for coverage under plan as the tax treatment under current law provided to qualified spouses and dependents.	Include the House provision.