February 26, 2010

Comparison of the Coverage and Revenue Provisions in the America's Affordable Health Choices Act (H.R. 3962), as Approved by the House of Representatives, the Patient Protection and Affordable Care Act (H.R. 3590), as Approved by the Senate, and President Obama's Health Care Reform Proposal*

Note: The President's proposal is a set of changes to the Senate-approved bill. Where a change is not included in the President's proposal, the provisions of the Senate bill are assumed to be unaltered.

Provision	House-passed America's Affordable Health Choices Act (H.R. 3962)	Senate-passed Patient Protection and Affordable Care Act (H.R. 3590)	President Obama's Health Care Proposal (Released February 22, 2010)
Individual Mandate	o 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. o Requirement also applies to dependents of an individual subject to the coverage mandate. o 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". o Provides a federal premium subsidy to individuals or families with incomes up to 400 percent of the federal poverty level who obtain coverage from a qualified plan in a health insurance exchange so	o Includes an individual mandate to obtain qualified health coverage, subject to a penalty for failure to obtain coverage that is the *greater* of a per-person fixed dollar amount or a percent of income amount. The fixed dollar amount is determined by using the *lesser* 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	o Modifies the Senate bill to lower the fixed dollar penalty amount and increase the percent of income amount. Fixed dollar penalty would be $325 in 2015, $695 in 2016, and indexed thereafter. The percent of income penalty amount would be 1.0 percent in 2014, 2.0 percent in 2015, 2.5 percent in 2016 and thereafter. o Includes Senate hardship exemptions. o No assessment for individuals with incomes below the tax filing threshold ($9,350 for single, $18,700 for married). o Increases tax credits for individuals or families with incomes up to 400 percent of the federal poverty level relative to both the Senate bill and the House bill in certain income brackets to make required health coverage more affordable.

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Individual Mandate (continued)	that they are able to obtain affordable coverage and meet the individual mandate.	for "bronze" level health coverage in a health insurance exchange. o No penalty for lapses in coverage less than 3 months. o 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. o 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. o 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. o 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	

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		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.	
Minimum Benefit Requirements and Wellness Program Incentives	o Service categories required to be covered as "essential benefits" would be: • 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. o Establishes a Health Benefits Advisory Committee with a broad group of	o 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: • 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 o No cost-sharing permitted for preventive services, except to value-based insurance designs. o 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	o No changes proposed to the Senate benefit provisions.

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Minimum Benefit Requirements and Wellness Program Incentives (continued)	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. o No wellness incentive provisions comparable to those in the Senate bills.	the Secretary of Health and Human Services. o No waiting periods longer than 90 days and penalties would apply to waiting periods over 60 days. o Directs the Secretary of HHS to determine the scope of essential benefits "equal to the scope of benefits provided under a typical employer plan." o 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	o 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). o 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	o 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 *not* provide health coverage, the employer would be subject to an assessment for each full-time employee. Employers that *do* 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	o Increases the penalty from $750 to $2,000 for the total number of full-time employees in the workforce if an employer does not provide health coverage, if at least one full-time employee obtains an income-based tax credit for coverage in a health insurance exchange. o Exempts the first 30 employees in calculating the penalty when an employer does not provide health coverage. o No penalties apply if employees must wait up to 90 days for coverage. o As with Senate bill, employers would not be required to offer a minimum benefit

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Employer Mandate (continued)	offer coverage and pay the 8 percent penalty. o 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. o 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.	an income-based tax credit for coverage in a health insurance exchange. o For employers that do *not* 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. o For employers that *do* 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 *and* 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. o These assessments would not be deductible by the employer. o 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. o Employers would be required to provide a voucher to certain employees equal to the largest portion" of the premium	plan or make a minimum contribution to premiums. o No proposed changes to the Senate "free-rider" penalty provisions ($3,000 for each full-time employee who obtains an income-based tax credit for coverage in a health insurance exchange if the coverage available from their employer is not affordable or does not meet a minimum actuarial value standard.)

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		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 *and* 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.	
Insurance Exchanges	o 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. o Plans offered through the health insurance exchanges are available to individuals who are *not enrolled in* coverage under Medicare, Medicaid, TRICARE, Veterans Administration coverage, a state high risk pool, or a qualified employer-sponsored plan. o 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	o 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). o 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	o No proposed changes to Senate bill.

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	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.	or if the employer plan has an actuarial value of less than 60 percent). o 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 *may* 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).	
Additional Requirements on Group Health Plans	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 Applies insurance rating rules to insured coverage, subject to 2 to 1 age rating limits. o Requires first-dollar coverage of preventive services as determined by the U.S. Preventive Services Task Force. o Prohibits application of pre-existing condition exclusions. o Requires coverage of child dependents up to age 27. o Establishes network adequacy standards.	o 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. o Requires first-dollar coverage of preventive services as determined by the U.S. Preventive Services Task Force. o Prohibits application of pre-existing condition exclusions. o Requires coverage of child dependents up to age 26. o Requires plans to provide internal and external review procedures. Insured plans would generally be required to follow appeals standards established	o See proposed changes below under "ERISA".

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	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.	by the states and self-insured plans would follow federal standards. o Prohibits waiting periods longer than 90 days (and penalties apply after 60 days). o 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). o Prohibits prior authorization or referral rules for OB-GYNs. o Prohibits prior authorization or limits cost sharing for emergency services, in or out of networks. o Allows plan participants to select a primary care provider (or pediatrician for a child) from any available participating primary care provider.	
Public Health Insurance Plan Option	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 be required to negotiate reimbursement rates with health providers. o 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.	o 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. o Also allows for non-profit, member-run health cooperatives (Co-ops) to be offered in the health insurance exchanges.	o No proposed changes to Senate bill.
Retiree Health Reinsurance	o Establishes a temporary reinsurance program for qualified employers with retirees between ages 55 and 64. Reinsurance payments for 80 percent of	o Within 90 days after enactment, a temporary $5 billion retiree health reinsurance program for employer-sponsored coverage would be established	o No proposed changes to Senate bill.

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	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. o 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." o [Note: See also the provisions restricting reductions in retiree health benefits described under "ERISA" below.]	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. o 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.	
ERISA	o 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. o 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	o 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 secretaries of Health and Human Services and of the Treasury and therefore does *not* apply to waivers of ERISA (which is under the Secretary of Labor's jurisdiction), but could still lead to considerable variation in state rules under waivers granted by HHS or Treasury.	o No proposed changes to Senate state waiver provisions. o "Within months" after enactment plans would be required to cover adult dependents up to age 26. The proposal would prohibit rescissions, apply new appeals procedures, and require states to conduct annual rate review. In 2014 when insurance exchanges are established, annual and lifetime limits and pre-existing condition exclusions would be prohibited, and plans could not discriminate in favor of highly compensated individuals. Starting in 2018, "grandfathered" plans

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	plan sponsors" in connection with group health plans. o 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.	o 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.	would be required to cover preventive services with no cost sharing.
Tax Provisions Relating to Health Benefits	o 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. o 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. o 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	o 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. o Taxation of Employer Subsidy for Retiree Prescription Drugs – Employers would not	o High-Cost Plan Excise Tax -- President's proposal would change the Senate bill's high-cost plan excise tax effective date for all plans to 2018 as it was for union plans under the previous White House agreement with organized labor. In addition, it raises the tax thresholds from $8,500 to $10,200 for singles and $23,000 to $27,500 for family coverage. Retains indexing of the threshold to the Consumer Price Index plus 1 percent for future years. o Includes an automatic adjustment in the tax thresholds if health care costs increase more quickly than projected until 2018. o Excludes dental and vision benefits from the calculation of costs subject to the tax. o Includes cost adjustments for age and gender of workers. o Taxation of Employer Subsidy for Retiree Prescription Drugs – Retains the Senate provision but delays the effective date to 2012. (Note: The President's proposal

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Tax Provisions Relating to Health Benefits (continued)	maintaining retiree prescription drug coverage that is at least the same actuarial value as coverage offered under Medicare Part D. Effective starting in 2013. o 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. o Establishes a 2.5 percent excise tax on medical devices sold in the U.S. o 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. o 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. o 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.	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. o Premium Taxes – A new federal premium tax of $2.00 on each covered life in an insured or 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. o Health Industry Fees – Annual fees would be assessed on insurance companies, pharmaceutical companies and medical device companies for certain amounts received starting in 2009. o 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. o 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. o Penalties for Non-qualified Use of HSA Funds – The penalty for non-qualified withdrawals from HSAs by individuals	also would close the Medicare "donut hole" that has the effect of increasing the actuarial value of Medicare Part D benefits that employers would be required to at least meet in order to qualify for participation in the retiree drug subsidy program.) o Health Industry Fees – Increases by $10 billion the annual fees on the pharmaceutical industry from $23 billion over 10 years. Delays effective date until 2011. Delays until 2014 the fees on health insurers, which remain at $67 billion over 10 years. Imposes an excise tax on medical device manufacturers to raise $20 billion over 10 years, starting in 2013. o FICA Tax for High Income Individuals – Includes the Senate increase of 0.9 percent for high income households for a total of 2.35 percent (applies to earned income above $200,000 for singles and $250,000 for joint filers). Adds a 2.9 percent tax on unearned income (e.g., interest, dividends, annuities, royalties, rents), applicable to income above the same thresholds as the 0.9 percent increase on earned income. o Other Provisions – Retains all other revenue provisions in the Senate bill.

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Tax Provisions Relating to Health Benefits (continued)		prior to age 65 would increase from 10 to 20 percent, starting in 2011. o 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. o 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 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.	
Tax Equity for Domestic Partners	o 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.	o No provision.	Clarifies the tax treatment of employer contributions for coverage of adult dependents up to age 26, but does not include other broader tax equity provisions as included in the House bill.