

House and Senate Health Reform Legislation Comparison

The chart below serves to highlight the major components of the leading health reform proposals that have been put forward thus far by Congress. It is based upon materials that have been made available to the public, and is subject to change as the process moves forward. The information below is up to date as of December 28, 2009.

	<p style="text-align: center;">House Bill H.R. 3962</p> <p style="text-align: center;">(Affordable Health Care for America Act)</p> <p>* <u>Energy & Commerce</u> marked up and passed their portion of the bill on July 31 by a 31-28 vote</p> <p>* <u>Ways & Means</u> marked up and passed their portion of the bill on July 17 by a 23-18 vote</p> <p>* <u>Education & Labor</u> also completed marking up and pass their portion of the bill on July 17 by a 26-22 vote.</p> <p>*The various committee drafts were merged into H.R. 3200, which has since been reintroduced as H.R. 3962, the Affordable Health Care for America Act, which passed the House by a vote of 220-215 on November 7, 2009.</p>	<p style="text-align: center;">Senate Bill H.R. 3590</p> <p style="text-align: center;">(Patient Protection and Affordable Care Act)</p> <p>* <u>HELP Committee</u> completed mark up of their bill and passed it July 15 by a party line vote of 13-11. This language was officially introduced on September 17, 2009, by HELP Committee Chairman Senator Tom Harkin (D-IA). As The Affordable Health Choices Act (S. 1679)</p> <p>* <u>Finance Committee</u> completed marking up its draft on October 2, 2009. The Finance Committee passed their draft by a vote of 14-9 (1 Republican, Senator Olympia Snowe of Maine joining with the Democrats) on October 13, 2009.</p> <p>*The various committee drafts were merged into a single package, which will be considered on the Senate floor as H.R. 3950. On Thursday, December 24, 2009, the Senate passed the Patient Protection and Affordable Care Act by a party line vote, 60-39.</p>
<p>Medicare</p>	<p><u>Program Solvency/Delivery of Care</u></p> <p>-Requires the Institute of Medicine to conduct a study on geographic variation in health care spending across all providers and recommend changes to Medicare payments that promote high-value care; require the Secretary to develop an</p>	<p><u>Program Solvency/Delivery of Care</u></p> <p>- Creates an independent, 15-member Medicare Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. In years when Medicare costs are</p>

	<p>implementation plan and issue regulations to implement the Medicare payment changes unless Congress acts to stop implementation.</p> <p>-Establishes within the Centers for Medicaid and Medicare Services a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Successful models can be expanded within both programs.</p> <p>-Conducts Medicare and Medicaid pilot programs to test payment incentive models for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes.</p> <p><u><i>Provider Reimbursement Reform</i></u></p> <p>-Does not include SGR Reform – long term fix was separated from H.R. 3962 and is now a stand-alone bill, H.R. 3961. H.R. 3961 passed the House on November 19, 2009, by a vote of 243 – 183.</p> <p>-Directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare, including services that have experienced high growth rates. Strengthens the Secretary’s authority to adjust fees schedule rates that are found</p>	<p>projected to be unsustainable, the Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards.</p> <p>- Establishes Center for Medicare and Medicaid Innovation within CMS. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Successful models can be expanded nationally.</p> <p>-Directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The Secretary will phase-in the new payment system over a 2-year period beginning in 2015.</p> <p>-Authorizes funding for the development of quality measures and to support the use of quality measures in Medicare, reporting performance information to the public and in health care programs.</p> <p>-Establishes a national pilot program on Medicare payment bundling between providers and hospitals.</p>
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	<p>to be misvalued or inaccurate.</p> <ul style="list-style-type: none"> - Modifies equipment utilization rates for advanced imaging services from 50% to 75%. <p><u>PQRI Modifications</u></p> <ul style="list-style-type: none"> -Extends through 2012 payments under the PQRI program, which provide incentives to physicians who report quality data to Medicare. <p><u>Fraud & Abuse</u></p> <ul style="list-style-type: none"> -Reduces the period for Medicare claims submission to no later than 12 months. -Requires overpayments to be reported and returned within 60 days from the date the overpayment was identified or the date a corresponding cost report was due. - Seeks to reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. -Enhanced penalties for false statements on provider or supplier enrollment applications. Also outlines 	<p><u>Provider Reimbursement Reform</u></p> <ul style="list-style-type: none"> -Does not include SGR reform provision. A separate piece of legislation, the FY2010 Defense Appropriations Bill, signed into law by the President on December 19, 2009, included a 60 day fix to prevent a 21% cut on January 1, 2010. -Beginning in 2011, allots primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 % Medicare payment bonus for five years. Half of the cost of the bonuses would be offset through an across-the-board reduction in all other services. -Directs Secretary to regularly review fee schedule rates for provider services paid for by Medicare, including services that have experienced high growth rates; strengthens Secretary’s authority to adjust fee schedule rates that are found to be misvalued or inaccurate. -Modifies equipment utilization rates for advanced imaging services from 50% to 75% by 2014. This rate is gradually increased starting at 65% in 2010-2012, and 70% in 2013. <p><u>PQRI Modifications</u></p> <ul style="list-style-type: none"> -Extends through 2014 payments under PQRI. Beginning in 2014, physicians who do not submit
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	<p>enhanced penalties for submission of false statements material to a false claim</p> <p>-Allows the Secretary to establish screening procedures for new providers, which may include: licensing board checks, screening lists of those excluded from other federal or state health programs, background checks, unannounced pre-enrollment or other site visits.</p> <p>-Requires new suppliers or providers of services to disclose affiliations within the past 10 years with any provider or supplier that has uncollected debt or has been suspended from Medicare, Medicaid, or CHIP.</p>	<p>measures to PQRI will have their Medicare payments reduced.</p> <p>-Adds an additional requirement to the Medicare for in-office ancillary services to the prohibition on physician self-referral for certain imaging services.</p> <p><u>Fraud & Abuse</u></p> <p>-Reduces the period for Medicare claims submission to no later than 12 months.</p> <p>-Requires overpayments to be reported and returned within 1 year from the date the overpayment was identified or the date a corresponding cost report was due.</p> <p>-Requires that HHS establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and CHIP. At a minimum, all providers and suppliers would be subject to licensure checks. The Secretary would have the authority to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State data base inquiries, and random or unannounced site visits. An application fee of \$200 for individual practitioners and \$500 for institutional providers and suppliers would be imposed to cover the costs of screening each time they re-verify their enrollment (every five years).</p>
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Medicaid	-Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 150% FPL.	- Expands Medicaid to all non-elderly individuals with incomes up to 133% of the federal poverty level. States have the option to provide coverage to such individuals above 133% FPL through a state plan amendment.

<p>Quality Initiatives</p>	<p><u>Comparative Effectiveness</u></p> <ul style="list-style-type: none"> - Establishes a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. -Independent CER Commission will oversee the activities of the Center. - Provides that comparative effectiveness research findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. <p><u>Quality Measure</u></p> <ul style="list-style-type: none"> - Establishes the Center for Quality Improvement to identify, develop, evaluate, disseminate, and implement best practices in the delivery of health care services. Develop national priorities for performance improvement and quality measures for the delivery of health care services. 	<p><u>Comparative Effectiveness</u></p> <ul style="list-style-type: none"> - Establishes the Patient-Centered Outcomes Research Institute private/non-profit) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research. Prohibits any findings to be construed as mandates on “practice guidelines, coverage recommendations, payment, or policy recommendations.”.” <p><u>Quality Measures</u></p> <ul style="list-style-type: none"> -Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.
<p>Shared Responsibility</p>	<p><u>Individual Mandate</u></p> <ul style="list-style-type: none"> - Requires all individuals to have “acceptable health coverage” (hardship exemptions made). Those without coverage pay a penalty of 	<p><u>Individual Mandate</u></p> <ul style="list-style-type: none"> - All U.S. citizens and legal residents will be required to have ‘qualifying’ health coverage (hardship exemptions made) by 2014. Those that do

	<p>2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange.</p> <p>-Premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level (or \$73,240 for a family of three in 2009)</p> <p><u>Employer Responsibility</u></p> <p>- Requires employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund.</p> <p>- Annual payroll less than \$500,000 are exempt from the mandate. Those between \$500,000 - \$750,000 receive reduced “pay or play” penalties.</p> <p>- Provide employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit for up to two years. The full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit phases-out as firm size and average wage</p>	<p>not comply will face a tax maximum penalty of \$750 per adult per year (phased in by 2016).</p> <p>- Provides refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the health insurance exchanges.</p> <p>-Provides reduced cost-sharing for individuals and families with incomes between 100-200% FPL enrolled in qualified health plans.</p> <p><u>Employer Responsibility</u></p> <p>- Does not include a comprehensive employer mandate.</p> <p>- Assesses employers with more than 50 employees and not offering employee health coverage a \$750/employee fee (for all employees) if just one of their employees receives a tax credit for health insurance through an exchange.</p> <p>-Employers who offer coverage but either institute a waiting period or offer unaffordable coverage such that at least one employee qualifies for federal premium assistance are subject to pay certain fees.</p> <p>- Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages of less than \$50,000 that</p>
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	<p>increases and is not permitted for employees earning more than \$80,000 per year.</p> <ul style="list-style-type: none"> • Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers for 80% of retiree claims between \$15,000 and \$90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. 	<p>purchase health insurance for their employees. The full credit is available to employers with 10 or less employees and average annual wages less than \$20K and who contribute 50 percent of total premium costs or 50 percent of a benchmark premium. The tax credit covers up to 50% of their contribution for two years by 2014.</p>
<p>Health Insurance Exchange or Gateway</p>	<ul style="list-style-type: none"> -Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. -Creates a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. -Create four benefit categories of plans to be offered through the Exchange: <ul style="list-style-type: none"> *<i>Basic plan</i> includes essential benefits package and covers 70% of the benefit costs of the plan; * <i>Enhanced plan</i> includes essential benefits package, reduced cost-sharing compared to the basic plan and covers 85% of benefit costs of the plan; 	<ul style="list-style-type: none"> - Creates state-based exchanges for the individual market and small business health options program (SHOP) exchanges for the small group market to be operational by 2014. - Allow small businesses with up to 100 employees to purchase coverage through the SHOP exchanges beginning in 2014 (states may limit this market to businesses with 50 employees until 2016) and permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP exchange beginning in 2017. - Creates the Consumer Operated and Oriented Plan (CO-OP) program and appropriates money to qualified insurance issuers to create non-profit, member-run health insurance companies in all 50 states and District of Columbia. - Creates four benefit categories of plans plus a separate “young invincible plan”(aka catastrophic

	<p>*<i>Premium plan</i> includes essential benefits package with reduced cost-sharing compared to the enhanced plan and covers 95% of the benefit costs of the plan; * <i>Premium plus plan</i> is a premium plan that provides additional benefits, such as oral health and vision care.</p> <p>-Restricts access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage.</p>	<p>plan) to be offered through the exchange, and in the individual and small group markets. Allows states flexibility to establish basic health programs by contracting with 1 or more standard health plans for low-income individuals (below 200%FPL) not eligible for Medicaid.</p> <p>-Four benefit categories under which the plan pays for the specified percentage of costs: *Bronze: 60 percent *Silver: 70 percent *Gold: 80 percent *Platinum: 90 percent</p> <p>- Requires the Secretary to establish a system for residents of each State to utilize when applying for their respective State health subsidy programs. The system will ensure that if any individual applying to an Exchange is found to be eligible for Medicaid or a State children’s health insurance program (CHIP), the individual is enrolled for assistance under such plan or program.</p>
Public Option	<p>-Exchange includes a public option, required to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out.</p> <p>- Public option must meet the same requirements as</p>	<p>-No public plan provision.</p> <p>-Would require the Office of Personnel Management (OPM) to contract with insurers to offer at least two multi-state plans in each Exchange. OPM currently operates the Federal Employees Health Benefit Program, but these new multi-state plans will be offered separately from the FEHB plans and have a separate risk pool.</p>

	<p>private plans regarding benefit levels, provider networks, consumer protections, and cost-sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Finance the costs of the public plan through revenues from premiums.</p>	
<p>Insurance/ Essential Benefits</p>	<p>-Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusion for pre-existing conditions and rescinding coverage except in instances of fraud and requires independent review of any rescission determination.</p> <p>-Requires all health plans participating in the exchange to include the following defined minimum benefits: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.</p> <p>-Requires within one year of enactment the Secretary submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package.</p> <p>- Includes provision allowing a qualified health</p>	<p>-Private insurance must guarantee issue/renewability may not be based on gender. Prohibits exclusion for pre-existing conditions or other discrimination based on health status. Also prohibits rescissions except in instances of fraud or misrepresentation.</p> <p>-Prohibits plans from establishing lifetime or unreasonable annual limits on the dollar value of benefits.</p> <p>-Requires coverage of preventative health services recommended by the Health Resources and Services Administration without cost sharing.</p> <p>-All plans in the individual and group markets are required to provide coverage for children up to age 26.</p> <p>-Permits employers to vary insurance premiums by as much as 30% for employee participation in certain health promotion and disease prevention programs.</p> <p>-Prohibits insurers from discriminating against health providers acting within the scope of their professional licensure and applicable state laws.</p>

	<p>benefits plan to subcontract with stand-alone health insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services,</p>	<p>- Requires all health plans operating in the exchange to cover the following defined minimum benefits: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws.</p> <p>- Stand-alone dental plans would be permitted to offer pediatric dental benefits directly and to offer coverage through the exchange. These plans must comply with all consumer protection requirements in order to participate in the exchange.</p>
<p>Public Health/Workforce Development</p>	<p>- Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy.</p> <p><u>Dental Training Program</u></p> <p>- Provides funding to support training programs for general, pediatric, and public health dentists and dental hygienists, including faculty loan repayment benefits.</p>	<p>- Establishes National Health Care Workforce Commission, with purpose of advising Congress with on the health care workforce and projected workforce needs.</p> <p><u>Dental Training Program</u></p> <p>-Allows dental schools and education programs to use grants for pre-doctoral training, faculty development, dental faculty loan repayment, and academic administrative units.</p> <p><u>“Alternative Dental Health Care Providers”</u></p>

		<p>-Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. The term ‘alternative dental health care providers’ includes “community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.”</p> <p>-Incorporated Indian Health Care Improvement Act (IHCA), which includes provision to allow tribes in states that license dental therapists to establish a Dental Health Aide Therapist (DHAT) program.</p>
<p>Misc.</p>	<p><u>Liability Reform</u></p> <p>-Establishes an incentive program for States to adopt and implement alternatives to traditional medical malpractice litigation. Such alternatives may not include provisions that limit attorneys’ fees or impose caps on damages.</p> <p><u>Oral Health Provisions</u></p> <p>-HHS will make grants to, or enter into contracts with, eligible entities to plan, develop, operate, or participate in an accredited professional training program for oral health professionals. Will also</p>	<p><u>Liability Reform</u></p> <p>-“Expresses the sense of the Senate” that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.</p> <p>- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in</p>

	<p>provide financial assistance to oral health professionals who are participants in any such program, and plan to work in general, pediatric, or public health dentistry, or dental hygiene.</p> <p><u>CARES Act</u></p> <p>-Includes the text of H.R. 1339, the CARES Act, which would require insurance companies, to cover corrective procedures to address congenital craniofacial anomalies for children age 21 and under. This language would also clarify the purpose of these procedures as reconstructive, rather than cosmetic.</p> <p><u>Antitrust Reform</u></p> <p>-Repeals the antitrust exemption that was established in the 1945 McCarran-Ferguson Act for health insurance companies.</p> <p><u>Residency Issues (GME)</u></p> <p>- Provides incentives for the training of primary care physicians and encourages medical residency training in non-hospital settings</p> <p><u>Dental Emergency Responders</u></p> <p>-Amends the Homeland Security Act to include dentistry as part of the national preparedness system.</p>	<p>consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance.</p> <p><u>Oral Health Provisions</u></p> <p>-Establishes an oral healthcare prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women.</p> <p><u>Trauma Care</u></p> <p>-Provides grants to states and trauma centers to strengthen the nation’s trauma system.</p> <p>-Reauthorizes the Wakefield Emergency Medical Services for Children Act which provides grants to states and medical schools to support emergency medical services for children.</p> <p><u>Diagnostic Equipment Standards</u></p> <p>-Within two years of enactment the FDA will set forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician’s offices, clinics, emergency rooms, hospitals, and other medical settings to ensure they are handicapped accessible. Includes examination chairs and x-ray machines.</p>
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<p>Financing</p>	<p>-CBO cost - \$894 billion over 10 years.</p> <p><u>Medicare/Medicaid Savings</u></p> <p>-Partially financed through savings from Medicare and Medicaid are estimated to be \$426 billion over ten years and the primary sources of these savings include incorporating productivity improvements into Medicare market basket updates, reducing payments to Medicare Advantage plans, changing the Medicaid drug rebate provisions, and cutting Medicaid and Medicare DSH payments.</p> <p><u>Income Tax Surcharge</u></p> <p>- The largest source of new revenue will come from a 5.4% surcharge imposed on families with incomes above \$1,000,000 and individuals with incomes above \$500,000.</p> <p><u>Flexible Spending Accounts(FSA) & Health Savings Accounts (HSA)</u></p>	<p>-CBO Cost - \$871 billion over 10 years</p> <p><u>Medicare/Medicaid Savings</u></p> <p>-Primarily financed through reducing payments to Medicare Advantage plans, expected savings via newly created Medicare Commission, changing Medicaid drug rebate provisions and cutting Medicaid and Medicare DSH payments.</p> <p>- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly.</p> <p><u>Excise Tax on High-Cost Health Plans</u></p> <p>-Revenue from a new excise tax of 40 % on insurance companies and plan administrators for any health coverage plan that is above the threshold of \$8,500 for single coverage and \$23,000 for family coverage.</p>

	<ul style="list-style-type: none"> - Limit the amount of contributions to a FSA for medical expenses to \$2,500 per year. - Increase the tax on distributions from a HSA that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. <p><u>Medical Device Tax</u></p> <p>-Includes a 2.5% annual tax on medical device to be assessed at point of sale. Does not exempt any category of medical supplies so the tax would be applicable to FDA Class I - III medical devices.</p>	<p><u>Flexible Spending Accounts(FSA) & Health Savings Accounts (HSA)</u></p> <ul style="list-style-type: none"> - Limits the amount of contributions to a FSA for medical expenses to \$2,500 per year, indexed for inflation. - Increases the tax on distributions from a HSA (prior to age 65) that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. <p><u>Tanning Tax</u></p> <p>- Imposes a tax of 10% on the amount paid for indoor tanning services.</p> <p><u>Medical Device Tax</u></p> <p>-Imposes an annual flat fee of \$2 billion on the medical device manufacturing sector beginning in 2010. Shall be increased to \$3 billion after 2017. This non-deductible fee would be allocated across the industry according to market share and would not apply to companies with sales of medical devices in the U.S. of \$5 million or less. The fee does not apply to any sale of a Class I product or any sale of a Class II product that is primarily sold to consumers at retail for not more than \$100 per unit.</p> <p><u>Pharmaceutical Manufacturer Tax</u></p>
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		-Imposes a \$2.3 billion annual fee on the pharmaceutical manufacturing sector (effective for sales after December 31, 2008).
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