

Health care reform state of play — Comparison of emerging legislation



	Senate Finance Committee "America's Healthy Future Act of 2009" (as introduced on 9/16)	Senate Health, Education, Labor and Pensions Committee (HELP) "Affordable Health Choices Act" (as passed on 7/15)	HR 3200 "America's Affordable Health Choices Act" (as approved by the Ways and Means, Education and Labor, and Energy and Commerce Committees)
Individual mandate	<p>Yes. Would require all U.S. citizens and legal residents to obtain and maintain qualified health coverage for themselves and their tax dependents through the individual market, a public program (e.g., Medicare, Medicaid, CHIP, VA coverage, and TRICARE), or an employer plan. An individual enrolled in a grandfathered plan would be deemed to have met this requirement. Individuals would be required to report on their Federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependents under age 18. In addition, insurers and self-insured employer plan sponsors would be required to report information on health insurance coverage information to both the covered individual and to the IRS. Individuals who do not maintain qualified health insurance would be subject to an excise tax penalty. For individuals with modified adjusted gross income (MAGI) between 100-300% of the federal poverty level (FPL) the penalty would be up to \$750 per year, with a maximum penalty per family of \$1,500. For individuals with MAGI above 300% of FPL the penalty would be up to \$950 year, with a maximum penalty per family of \$3,800. The penalty would be prorated for partial years of noncompliance. Exemptions from the penalty would apply to individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds 10% of their AGI. Other limited exemptions would be available.</p>	<p>Yes. Would require all adults to obtain and maintain "qualifying coverage" for themselves and their tax dependents. "Qualifying coverage" would include grandfathered individual and employer-provided coverage, certain government plans (e.g., Medicare, Medicaid, VA coverage, and TRICARE), and coverage obtained through the Gateway or an employer offer of coverage that meets or exceeds the criteria for "minimum qualifying coverage". Individuals who do not obtain "qualifying coverage" would be required to pay a minimum penalty of no more than \$750 per year. Limited exemptions would be available.</p>	<p>Yes. Would require all U.S. adult residents to obtain and maintain "acceptable coverage" for themselves and their tax dependent children. "Acceptable coverage" would include grandfathered individual and employer-provided coverage, certain government plans (e.g., Medicare, Medicaid, VA coverage, and TRICARE), and coverage obtained through Exchanges or an employer offer of coverage. Individuals who do not obtain "acceptable coverage" would be required to pay a tax based on 2.5% of their modified adjusted gross income above a specified threshold, but in no case more than the "applicable national average premium" for self-only (or family) coverage under an Exchange-based basic plan. Limited exemptions would be available.</p>



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Individual and small group market reform	Yes. Would require all private health insurers to offer basic plan(s) that are guaranteed issue (subject to a plan’s capacity limit) and guaranteed renewable, with no health status underwriting, no pre-existing condition exclusions, no annual limits on any benefits or lifetime limits on coverage, and maximum rating bands (7.5:1) which would be permissible only for certain factors (i.e., age, tobacco use, family size, geographic area, etc.).	Yes. Generally the same as Senate Finance Committee, except maximum rating bands of 2:1. Health insurers would not be permitted to limit eligibility based on employees’ salaries or wages. Dependents would be permitted to stay on parents’ policies (individual and group) until age 26.	Yes. Generally the same as Senate Finance Committee, except maximum rating bands based on age of 2:1; other rating factors subject to regulation by State or Exchange.
Low- and middle- income premium subsidies	Yes. Would provide refundable, advanceable premium tax credits on a sliding-scale basis to individuals and families with modified adjusted gross income (MAGI) of up to 300% of federal poverty level (FPL) (\$32,490 individual / \$43,710 couple / \$66,150 family of four in 2009). In addition, individuals between 300-400% of FPL would be eligible for a premium credit at a flat percent of income, capped at 13% of income for the purchase of a silver plan. No illegal immigrants would be eligible for health care tax credits. In addition, a cost-sharing subsidy may be provided to individuals up to 200% of the FPL. Employees who were <i>offered</i> employer coverage would be ineligible to receive Exchange-based tax credits unless either their employer’s plan does not have an actuarial value of at least 65%, or their employer’s plan is “unaffordable” because it costs the employee over 13% of the employee’s income.	Yes. Would provide premium credits on a sliding-scale basis to individuals and families up to 400% of federal poverty level (FPL) (\$43,320 individual / \$58,280 couple / \$88,200 family of four in 2009). Employees who were <i>offered</i> employer qualifying coverage would be ineligible to receive Gateway-based premium credits unless their employer’s plan is “unaffordable” because it costs the employee over 12.5% of their adjusted gross income.	Yes. Would provide premium and cost-sharing “affordability credits” on a sliding-scale basis to individuals and families up to 400% of federal poverty level (FPL) (\$43,320 individual / \$58,280 couple / \$88,200 family of four in 2009). Employees who were <i>offered</i> a “qualified health benefits plan” would be ineligible to receive Exchange-based affordability credits. However beginning in Year 2, <i>full-time employees</i> would be eligible for Exchange-based affordability credits if they opt out of employer plan, but only if their employer’s plan is “unaffordable” because it costs the employee over 11% of their modified adjusted gross income. [Energy and Commerce Committee version increases affordability threshold to 12% of modified adjusted gross.]

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Health Insurance Exchanges/ Gateways	<p>Yes. Would create state-based (or regional) Health Insurance Exchanges to provide easier, more efficient comparison of health insurance plan benefits and premium costs, and would facilitate enrollment for legal U.S. residents, and separately for small groups. Information about coverage, cost-sharing and enrollment would be available in a standardized format. In time, large employers (50+ employees) would be allowed to purchase Exchange-based coverage for employees. For employed individuals who purchase Exchange-based health insurance, the premium payments would be made through payroll deductions. The Exchanges would make available four benefit categories (i.e., bronze, silver, gold, platinum), each of which must include a core set of covered benefits. So-called "mini-medical" plans with limited benefits and low annual caps would not be offered in the Exchanges. Employees would be allowed to waive an employer's offer of health coverage and go to Exchange, but see 'Subsidies' above.</p>	<p>Yes. Would create state-based Affordable Health Benefit Gateways which would give individuals (e.g., those without access to an "affordable" employer plan) and small employers the ability to choose from a variety of private plans or a new public health insurance option. Employees who were <i>offered</i> employer qualifying coverage would be ineligible to purchase Gateway-based health insurance (with or without premium credits) unless their employer's plan is "unaffordable" because it costs the employee over 12.5% of their adjusted gross income.</p>	<p>Yes. Would create Health Insurance Exchanges which would give individuals who are not enrolled in other acceptable coverage, small employers, and, in time, larger employers, the ability to choose from a variety of private plans or a new public health insurance option. The Exchanges would make available four tiers of standard benefit plans (i.e., basic, enhanced, premium, premium plus), each of which must include a core set of covered benefits. Employees would be allowed to waive an employer's offer of health coverage and go to Exchange, but see 'Subsidies' above. The annual increase in premiums charged under Exchanged-based plan would be limited.</p>



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Standard benefit packages	Yes. Would create four benefit categories with actuarial values of 90% (platinum), 80% (gold), 70% (silver) and 65% (bronze – "minimum creditable coverage"). A separate "young invincible" policy would be available for those 25 years or younger. Plans would be prohibited from applying lifetime limits on coverage or annual limits on any benefits, and out-of-pocket limits for all benefit categories would be tied to current HSA standards (e.g., \$5,950 for self-only/ \$11,900 family coverage in 2010). Cost-sharing (e.g., deductibles, copayments) would be eliminated for preventive services except where value-based insurance design is used.	Yes. Would delegate benefit design to an advisory panel.	Yes. Would require "qualified health benefit plans" to provide coverage that at least meets the benefit standards adopted for the "essential benefits package", as recommended by a newly created Health Benefits Advisory Committee. An essential benefits package would limit annual out-of-pocket spending to \$5,000 self-only/\$10,000 family coverage (indexed to CPI). The initial essential benefits package would have an actuarial value of 70% of the package if there were no cost-sharing imposed.
Create new public plan	No. Instead, would authorize \$6B in funding for a "Consumer Operated and Oriented Plan" (CO-OP) program to foster the creation of private, nonprofit, member-run health insurance companies that serve individuals in one or more states. CO-OPs grantees would compete in the reformed non-group and small group insurance markets. Federal loans would be provided to assist with start-up costs, and federal grants would be provided to meet state solvency requirements. Grants and loans will be awarded by the Secretary of HHS based on recommendations made by a newly-created advisory board. Would also raise Medicaid eligibility to 133% of FPL.	Yes. Would be available through the state-based Gateways. Provider participation would be voluntary. Public plan would follow same rules as private plans for defining benefits, protecting consumers, and setting premiums. Government would be required to negotiate premiums and provider reimbursement rates, which may not exceed local average private rates. Would also raise national uniform Medicaid eligibility to 150% of FPL.	Yes. Would be available through the Exchanges, and must meet the same benefit requirements, comply with the same insurance market reforms as private plans. Public plan would have to be financially self-sustaining and would have to build contingency funds into its rates and adjust premiums annually in order to assure its financial viability. For the first 3 years, would pay participating providers Medicare rates, plus 5% for Medicare participating providers, and those providers who don't typically participate in Medicare (e.g., pediatricians). After 3 years, HHS would have flexibility in setting provider reimbursement rates. [Energy and Commerce version requires the government to negotiate provider reimbursement rates, using Medicare rates as a floor.] Would also raise national uniform Medicaid eligibility to 133% of FPL.



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Employer pay or play mandate	<p>Modified. Would require employers with more than 50 employees to "play" by offering employees health coverage with a 65% actuarial value, or else "pay" a fee for each full-time employee (defined as working 30+ hours each week) who receives an Exchange-based premium tax credit. This so-called "free rider" assessment would be a flat dollar amount equal to the average tax credit in the Exchanges, and would set by HHS and published in a schedule each year. The employer would pay the <u>lesser</u> of: (i) the flat dollar amount multiplied by the number of full-time employees receiving a premium tax credit, or (ii) \$400 per employee paid on its total number of employees (regardless of how many are receiving the premium tax credit). Generally, if an employee is <i>offered</i> employer-provided health coverage, the employee would be ineligible for the Exchange-based premium tax credit. However, an employee who is offered health coverage that either does not have an actuarial value of at least 65%, or is "unaffordable" would be eligible for the premium tax credit. Unaffordable is defined as 13% of the employee's income. Employers with 200+ employees would be required to automatically enroll employees in the employer's health plan; employees would be allowed to opt out of such coverage if they are able to demonstrate that they have coverage from another source (e.g., Medicare, Medicaid, CHIP, or as a dependent in a spouse or other family member's plan).</p>	<p>Yes. Would require employers with more than 25 employees to "play" by offering and subsidizing at least 60% of the cost of "qualifying coverage" (based on the scope of a "typical employer plan" with precise design to be determined by regulation), or else "pay" an annual fee of \$750 for each full-time employee and \$375 for each part-time employee who is not offered such employer coverage (indexed to the CPI for urban consumers). For employers subject to the assessment, the first 25 workers would be exempted. Employees who were <i>offered</i> employer qualifying coverage would be ineligible to purchase Gateway-based health insurance (with or without Gateway-based premium credits) unless their employer's plan is "unaffordable" because it costs the employee over 12.5% of their adjusted gross income.</p>	<p>Yes. Would require employers to "play" by offering all full-time and part-time employees self-only and family coverage under a "qualified health benefits plan" (or under a current group health plan), and making a contribution on behalf of full-time employees of at least 72.5% for self-only coverage and 65% for family coverage of the lowest cost plan offered by the employer, or else "pay" a fee to the Exchanges in an amount equal to 8% of the employer's "average wages" paid the during the period of enrollment (determined by taking into account all employees of the employer). The minimum required employer contributions would be prorated for part-timers (to be defined by a government commission). Employers would be allowed to make separate elections to play with respect to employers' "separate lines of business", as well as for full-time and part-time employees. Beginning in Year 2, if an employee "opts out" of employer's offer of coverage, and instead obtains coverage in an Exchange-based health benefits plan (other than by reason of being covered as a spouse or dependent), the employer is required to make a contribution to the Exchange, even if such employer coverage was affordable. In Year 5 after the Exchange begins, an employer that offers group health plan coverage through a plan that was in existence prior to Year 1, would have to meet minimum coverage standards like those required of Exchange-based plans. Employer hardship exemption available based on potential job losses. Employers offering health coverage would be required to automatically enroll employees for individual coverage under the employer plan option with the lowest premium; employees would be allowed to opt-out of such coverage.</p>

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Tax insurers/self-insured employers on 'high-cost' plans	Yes. Would impose a 35% excise tax (not a deductible business expenses) on health insurers and/or plan administrators (e.g., employers) of self-insured group health plans if the aggregate value of employer-sponsored health coverage for an employee exceeded \$8,000 for individual coverage and \$21,000 for family coverage for 2013 (indexed to the CPI for urban consumers beginning in 2014). The amount subject to 35% excise tax would be the sum of: (i) the aggregate premiums for health coverage (including medical, dental, vision and any other supplementary health insurance coverage), (ii) the amount of any pre-tax contributions to a health FSA, (iii) any employer contributions to an HSA, and (iv) the applicable premium for an HRA, minus the \$8,000/\$21,000 threshold amount. The value of employer-sponsored health coverage would generally be calculated in the same manner as the applicable premiums for purposes of COBRA. The excise tax would be imposed pro rata on insurance companies. In the case of a self-insured group health plan (including a health FSA or HRA), the excise tax would be paid by the plan administrator/employer. The employer would be responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and the Treasury. A transition rule would raise the threshold by 20%, 10%, and 5% for the 17 highest cost states for the first three years.	N/A. Committee does not have jurisdiction to originate tax changes.	No. Would instead raise about half the 10-year cost of health care reform by imposing a progressive income tax surcharge of 1% to 5.4% on higher income individuals (i.e., beginning with an additional 1% at modified adjusted gross income of over \$280,000/single, \$350,000/married filing jointly).

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Reinsurance for employer- provided retiree health coverage	No.	Yes. Would establish a temporary federal reinsurance program to provide reimbursement to employers for part of the cost of providing health benefits to retirees (and their families) older than age 55 but not yet eligible for Medicare and who live in states that have not established Gateways. Employment-based plans would be required to apply to participate and be approved by the Secretary. The program would reimburse participating employers for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000. The plans would be required to use the funds to lower costs borne directly by participants and beneficiaries.	Yes, same as Senate HELP Committee bill, except that program will not end once a State establishes an Exchange.
Modify health FSA, HRA and HSA rules	Yes. Would limit employee pre-tax contributions to a health FSA to \$2,000 per year. Would increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%. Would make the costs of non-prescription over-the-counter medicines ineligible for reimbursement under a health FSA, HRA, or HSA, unless prescribed by a doctor.	N/A. Committee does not have jurisdiction to originate tax changes.	Yes. Would make the costs of non-prescription over-the-counter medicines ineligible for reimbursement under a health FSA, health reimbursement arrangement (HRA) or health savings account (HSA).



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ERISA changes	No, other than imposing new federal employer mandate to offer health coverage or pay a "free-rider" assessment to the government.	No, other than imposing new federal employer mandate to offer and subsidize basic health coverage or make a payment to the government.	Yes. <u>ERISA preemption waivers</u> – Would require the DOL, in consultation with HHS, to grant (except under extraordinary circumstances) any requesting state a waiver from ERISA's broad preemption provision, to allow such a state to implement a "State single payer system". <u>Vested retiree health benefits</u> – Would prohibit a group health plan from reducing the benefits provided to a retired participant (or his or her beneficiary) if such reduction of benefits occurs after the date the participant retired for purposes of the plan, and doing so would reduce benefits that were provided to the participant as of the date of retirement, unless such reduction is also made with respect to active employee participants. <u>Preexisting condition exclusions</u> – Would provide additional limitations on preexisting condition exclusions for group health plans in advance of applicability of general prohibition against all preexisting condition exclusions. Would reduce from 12 months to 3 months (or from 18 months to 9 months for late enrollees) the maximum "look-forward" period during which a plan may subject an individual to a preexisting condition exclusion, and would reduce from 6 months to 30 days, the maximum "look-back" period during which a plan may treat a condition for which an individual received medical advice, diagnosis, care, or treatment as a preexisting condition. <u>Other</u> – Would: (a) change ERISA remedies to allow employees to sue in state court if state law permits, and (b) require a study whether self-insurance should still be permitted.

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Miscellaneous changes that directly (or indirectly) impact employers	<p><u>Employer W-2 reporting of value of health benefits</u> – Would require employers to disclose the aggregate value of employer-provided health coverage (excluding health FSA coverage) on employees’ annual Form W-2.</p> <p><u>Repeal business deduction for employer Part D retiree drug subsidy.</u> Would amend the IRC so that the amount otherwise allowable as an employer business deduction for retiree prescription drug expenses would be reduced by the amount of the 28% Medicare Part D retiree drug subsidy employers receive from the federal government.</p> <p><u>Health care industry annual fees</u> – Would impose annual fees of approximately \$13B on pharmaceutical and medical device manufacturers, health insurers, and clinical laboratories.</p> <p><u>Long-term care insurance</u> – Would amend the IRC to permit an employer-sponsored cafeteria plan to (i) offer qualified long-term care insurance with premiums paid on a pretax basis, and (ii) reimburse employee-paid premiums for qualified long-term care insurance through a health FSA.</p>	<p><u>HIPAA wellness programs</u> – Would increase the HIPAA limit on financial incentives for participation in a wellness program from 20% to 30% of total plan cost, and would permit the federal government to increase this limit to 50% if deemed appropriate.</p> <p><u>Prescription drug costs – follow-on biologics.</u> – Would authorize the Food and Drug Administration (FDA) to approve generic versions of biological or biotech drugs (“follow-on biologics”) that have been determined to be both safe and effective. Brand-name manufacturers of biotechnology products would get 12 years of market exclusivity. The first interchangeable follow-on biologic to be approved for any given brand name biologic would get 1 year of market exclusivity.</p>	<p><u>Extension of COBRA coverage</u> – Would temporarily waive the 18, 29, and 36-month durational time limits for COBRA coverage for any qualified beneficiary (QB) who is or becomes covered under COBRA on or after the date of the bill’s enactment. Instead, such QBs would be entitled to retain COBRA coverage until the earlier of the date on which such QB becomes <i>eligible</i> for either employer-provided group health plan coverage or Exchange-based coverage (which is expected to begin 2013). Other events which result in early termination of COBRA coverage (e.g., Medicare entitlement, failure to timely pay premiums) would continue to apply.</p> <p><u>Prescription drug costs – follow-on biologics.</u> – Yes, essentially the same as Senate HELP Committee bill.</p> <p><u>Part D prescription drug costs.</u> Would <i>require</i> the Secretary of HHS to negotiate with pharmaceutical manufactures for lower prices of covered Part D drugs on behalf of Medicare beneficiaries enrolled in PDPs and MA-PDs. The bill would prohibit the Secretary from establishing a particular formulary and would allow PDPs and MA-PDs to negotiate prices that are lower than those obtained by the Secretary.</p>

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Miscellaneous changes that directly (or indirectly) impact employers (cont'd.)			<p><u>Tax-free employer health coverage for an employee's non-spouse, non-tax dependent</u> – Would extend the exclusion from an employee's gross income (and from payroll tax withholding) for employer-provided health coverage and reimbursements to include individuals designated as "eligible beneficiaries" under an employer's plan who are not the spouse or tax dependent of the employee (e.g., domestic partner, same-sex spouse, older children, etc.). Would also permit a VEBA to provide payment for sick and accident benefits to such eligible beneficiaries. Additionally, the Secretary of Treasury would be required to issue guidance specifying that a health FSA and/or HRA may reimburse qualifying medical expenses of an employee's non-spouse, non-dependent eligible beneficiary.</p> <p><u>Tax on insured and self-insured health plans</u> – Would establish the Health Care Comparative Effectiveness Research Trust Fund, which would be funded, in part, by an annual assessment on private health insurers and plan sponsors (e.g., employers, unions) of self-insured health plans beginning in FY2013. The assessment would be equal to a "fair share per capita amount" (e.g., \$2) multiplied by the average number of covered lives under the plan (indexed for medical CPI).</p>