

Health care reform state of play — Comparison of emerging legislation

	Senate Finance Committee Chair is Sen. Max Baucus (D-MT) Based on Committee May 2009 Options Papers	Senate Health, Education, Labor and Pensions Committee (HELP) Chair is Sen. Ted Kennedy (D-MA) "Affordable Health Choices Act" (passed on 7/15)	H.R. 3200 "America's Affordable Health Choices Act" As approved by Ways and Means, Education and Labor, and Energy and Commerce Committees
Individual mandate	Yes. Would require all individuals to obtain and maintain health coverage purchased through: (a) the individual market, meeting requirements of at least a lowest cost option; (b) any grandfathered plan or (c) in the group market, a plan that has an actuarial value equal to the lowest coverage option, with no annual or lifetime limits allowed. Individuals who do not obtain basic health coverage would be required to pay an excise tax (phased-in over three years) eventually equaling 75% of premium for lowest-cost plan available through Exchanges. Limited exemptions would be available.	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.	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.
Individual/ small group market reform	Yes. Would require all private health insurers to offer basic plan(s) that are guaranteed issue, with no health status underwriting, no pre-existing condition exclusions, no annual or lifetime maximums, and maximum rating bands (7.5:1) which would be permissible only for certain factors (e.g., age, place of residence, etc.).	Yes, 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, 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. Would also allow variations based on geographic area and family size.

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Subsidies to low-income individuals	Yes, 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).	Yes, same as Senate Finance Committee. Employees who were <i>offered</i> employer qualifying coverage would be ineligible to "opt out" of an employer plan and receive low-income subsidies to purchase health insurance through a Gateway unless their employer's plan is "unaffordable" because it costs the employee over 12.5% of their adjusted gross income.	Yes, same as Senate Finance Committee, except would generally make employees <i>offered</i> employer coverage ineligible for premium and cost-sharing "affordability credits" for those who choose to "opt out" of an employer plan to purchase Exchange-based coverage. However beginning in Year 2, full-time employees would be eligible for affordability credits for Exchange-based coverage if they "opt out" of employer plan, but only if their employer's plan is "unaffordable" because it costs the employee over 11% (for those at 400% of the FPL) of their modified adjusted gross income. [Energy & Commerce Committee version increases affordability threshold to 12% of modified adjusted gross for those at 400% of FPL.]
Health Insurance Exchanges/ Gateways	Yes. Would create single, regional or 50 different state-based Health Insurance Exchanges.	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 "opt out" of an employer plan to purchase health insurance through a Gateway unless their employer's plan is "unaffordable" because it costs the employee over 12.5% of their adjusted gross income.	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 "opt out" of an employer plan and go to Exchange, but see 'Subsidies', above. The annual increase in premiums charged under Exchanged-based plan would be limited.

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Standard benefit packages	Yes, four standard value plans at actuarial values of 93%, 87%, 82% and 76%, respectively. Employer must offer at least 76% plan.	Yes, but benefit design delegated to 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	Yes. Would also raise Medicaid eligibility to 150% of FPL for pregnant women, children and parents. <i>Rumors</i> have the public plan option being replaced in the forthcoming Finance Committee bill with member-owned nonprofit health insurance cooperatives to compete against private health insurers in the Exchange.	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 & 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>Yes. Would require employers to "play" by offering a 76% actuarial value plan with 50% employer subsidy to all employees working ≥ 30 hours/week. Otherwise, employer "pays" by remitting to the government \$6,000/year per ineligible employee (Committee considering alternative of 6% of employees' payroll instead). Employer must send its normal subsidy to Exchanges if employee declines employer coverage.</p> <p><i>Rumors</i> indicate that there may be no pay or play mandate in the forthcoming Senate Finance Committee bill.</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 "opt out" of an employer plan to purchase health insurance through a Gateway 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. The minimum required employer contributions would be prorated for part-timers (to be defined by a government commission). Would require employers offering health coverage 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. 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. Alternatively, an employer could "pay" by making a contribution to the Exchanges in an amount equal to 8% of the employer's "average wages" paid. 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. Hardship exemption available based on potential job losses.</p>

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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.
Tax cap on employee exclusion for employer coverage	Yes. Considering tax cap based on plan cost or, on actuarial value. Considering cap on all taxpayers or, a cap based on income level; e.g., individuals with AGI of \$200,000 and \$400,000 joint filers. Cap could count all employer-paid "accident and health plan" coverage, including dental, vision, FSA/HRA/HSA, on-site clinic offering more than first-aid. <i>Rumors</i> indicate that the tax cap described above may be replaced with a tax imposed instead on self-insured employers (and insurers on insured plans) on the value of all forms of health coverage provided to an employee and family in excess of a yet-to-be determined amount (e.g., \$25,000/year for family coverage)	N/A. Committee does not have jurisdiction to originate tax changes.	No tax cap in bill. 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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Change HSA/FSA/HRA rules	Yes. Would limit HSA contributions to lesser of statutory cap or individual's deductible under the HDHP (i.e., reinstates original HSA law). Would double penalty tax to 20% on non-medical distributions. Would require claim substantiation for HSA withdrawals. Would count employer (incl. employee pre-tax) HSA contributions against tax cap.	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).
ERISA changes	No, other than imposing new federal employer mandate to offer and subsidize basic health coverage or make a payment to the government.	No, same as Senate Finance Committee.	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.



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ERISA changes (cont'd.)			<p><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.</p> <p><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.</p>

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Miscellaneous changes that directly (or indirectly) impact employers	TBD	<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; also permits 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>