

## THIS WEEK IN HEALTH CARE REFORM

THE STAGE IS NOW SET FOR A JOINT HOUSE-SENATE  
CONFERENCE COMMITTEE

12/28/09

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The U.S. Senate passed the Patient Protection and Affordable Care Act (H.R. 3590) on December 24 by a vote of 60-39. With the House of Representatives having passed its health care reform bill, the Affordable Health Care for America Act (H.R. 3962), back on November 7, the stage is now set for a joint House-Senate Conference Committee to reconcile the differences in the two bills and negotiate a final compromise version of health care reform legislation. The compromise version will have to be approved by each chamber in order for President Obama to sign a bill into law in January or February 2010.

**The Week Past**

**Recapping the final version of the Senate bill.** The Senate-approved version of H.R. 3590 incorporated a 383-page Managers Amendment introduced by Senator Harry Reid (D-NV) that modified the existing 2,074-page Senate bill. Key revenue raisers and employer- and employee-facing provisions include:

- **Excise tax on high-cost health coverage.** Beginning in 2013, a 40% excise tax (nondeductible) would be imposed on insurers (for insured health coverages) and employers/plan administrators (for self-insured health coverages) if the aggregate value of employer-sponsored health coverage for an employee generally exceeds \$8,500 for individual coverage and \$23,000 for family coverage. These thresholds are indexed to CPI-U plus 1%, beginning in 2014.
- The amount subject to the 40% excise tax would be calculated by subtracting the \$8,500/\$23,000 threshold amount from the sum of:
  - the aggregate premiums for health coverage, including active and retiree medical, dental, vision and any other supplementary health insurance coverage
  - the amount of any pretax contributions to a health flexible spending arrangement (health FSA)
  - any employer contributions to a health savings account (HSA) (which likely include employee pretax HSA contributions made through a cafeteria plan)
  - the applicable premium for a health reimbursement arrangement (HRA).

- A transition rule would raise the threshold by 20%, 10% and 5% for the 17 highest-cost states (not identified in the bill) for the first three years.
  - Higher threshold amounts would also apply for retirees age 55 to 64 and certain high-risk professions or individuals employed to repair or install electrical or telecommunication lines — i.e., an additional \$1,350 for individual coverage or \$3,000 for family coverage. In determining the coverage value for retirees, employers would be allowed to elect to treat pre-65 retirees together with post-65 retirees. The value of employer-sponsored health coverage generally would be calculated in the same manner as the premiums for COBRA.
  - The excise tax would be imposed pro rata across insurance companies. For self-insured group health plans (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 Department.
- **Employer pay-or-play mandate.** Beginning in 2014, employers with more than 50 full-time employees would be required to either:
- “play” by offering their full-time employees (working 30-plus hours per week) and their dependents the opportunity to enroll in “minimum essential coverage,” or
  - “pay” an annual assessment equal to \$750 per full-time employee, if at least one full-time employee received government-subsidized Exchange-based coverage.

In addition, even if an employer plays by offering minimum essential coverage to full-time employees, such an employer would still have to pay an annual assessment equal to the *lesser* of:

- \$3,000 multiplied by the number of full-time employees who decline the employer's plan and who are certified to receive subsidized health coverage in a health plan offered through the Exchanges, or
- \$750 multiplied by the total number of full-time employees, if at least one full-time employee received government-subsidized Exchange-based coverage.

All assessment amounts noted above would be indexed annually.

Generally, if an employee is *offered* employer-provided health coverage, the employee would be ineligible for the Exchange-based premium subsidy. However, an employee would be eligible for the premium subsidy if offered health coverage that either does not have an actuarial value of at least 60% or costs the employee more than 9.8% of his or her household income.

- **Employer free-choice vouchers.** Beginning in 2014, employers that offer and subsidize minimum essential coverage for their employees would be required to offer certain employees the option of either enrolling in the employer's plan or receiving a tax-free voucher from the employer for use in purchasing an Exchange-based health plan. An employee would be eligible for a voucher if:
  - the employee's premium share for the employer plan was between 8% and 9.8% of the employee's household income (above which the employee would be eligible for federal subsidies), and
  - the employee's household income did not exceed 400% of the federal poverty level (FPL).

The 8% and 9.8% levels would be indexed after 2014 to reflect the rate of premium growth over the rate of income growth. The amount of the voucher would be equal to the employer's largest cost-sharing contribution to any of the options under the employer's health plan. In addition, the amount of the voucher would be adjusted for age and would be based on the amount the employer would pay for an employee with self-only coverage unless the employee elects family coverage (in which case the voucher amount would be the amount the employer would pay for family coverage).

An employee could keep the amount of the voucher in excess of the cost of any Exchange-based coverage the employee obtains and would be taxed on such excess. An employee would not be taxed on the portion of a voucher used to pay premiums in an Exchange. The amount of the voucher would reduce the pay-or-play penalty that the employer otherwise would have to pay for an employee receiving subsidized coverage through the Exchange.

- **Individual health coverage mandate.** Beginning in 2014, all individuals, with limited exceptions, would be required to enroll in minimum essential coverage or pay an annual penalty. The penalty would be the greater of a flat dollar amount per person or a percentage of the individual's household income — set at .5% in 2014, 1% in 2015, and 2% in 2016 and beyond.
- **Insurance market reforms.** Beginning in 2014, insurers in the individual and small group markets would be required to offer coverage on a guaranteed-available and renewable basis, with no health status underwriting, no preexisting condition exclusions and limits on permissible premium rating bands.
- **American Health Benefit Exchange.** States would be required to establish an insurance Exchange to facilitate the offering and purchase of approved, qualified health plans for legal U.S. residents, and separately for small groups. Information about coverage, cost sharing and enrollment would be available in a standardized format. Beginning in 2017, states may allow large employers (100-plus employees) to purchase Exchange-based coverage for employees. The Exchanges would make available four benefit categories — bronze, silver, gold and platinum — each of which must include a core set of covered benefits.

- **Public plan “lite.”** There would be no public plan option per se, but a new national or multistate option under which at least two private plans (one of which must be nonprofit) would be included in the Exchanges and supervised by the U.S. Office of Personnel Management.
- **Low- and middle-income subsidies.** Beginning in 2013, federal premium subsidy credits and reduced cost sharing would be provided on a sliding scale to individuals earning up to 400% of the FPL who enroll in health plans offered through the Exchanges. Employees offered employer-provided health coverage would be eligible for the government’s premium subsidies only if the employer’s group health plan had an actuarial value of less than 60% or the employee’s required contribution for the plan exceeded 9.8% of the employee’s household income.
- **Medicaid eligibility expansion.** Medicaid eligibility would be expanded, beginning in 2014, to those with incomes up to 133% of the FPL.
- **Account-based plan provisions.** Beginning in 2011, employee pretax contributions to a health FSA would be capped at \$2,500 per year (indexed annually). In addition, the costs of over-the-counter drugs would not be reimbursable from a health FSA, HSA or HRA unless obtained with a prescription. Finally, the penalty on HSA distributions prior to age 65 that are not used for qualified medical expenses would be increased from 10% to 20%.
- **Form W-2 reporting.** Beginning in tax-year 2011, employers would be required to disclose the value of each employee’s health coverage on the employee’s annual Form W-2.
- **Employer health coverage reporting.** Employers would be required to report to the government:
  - confirmation that they offer (or do not offer) minimum essential coverage to their full-time employees and their dependents
  - the length of any applicable waiting period
  - the lowest-cost option in each enrollment category under the plan
  - the employer’s share of the total allowed costs of benefits provided under the plan
  - the total number and names of full-time employees receiving health coverage.
- **Dependent coverage to age 26.** Beginning in 2010, group health plans (insured and self-insured) would be required to extend eligibility to unmarried dependent children until age 26.
- **Benefit limits and exclusions.** Group health plans would be prohibited from establishing lifetime limits or “unreasonable” annual limits on benefits, and would be prohibited from imposing preexisting condition exclusions. In addition, the plan’s out-of-pocket limits could not exceed the limits prescribed for HSAs.
- **Salary-based health plan eligibility.** Employers would be prohibited from limiting eligibility for insured group health plan coverage based on the wages or salaries of full-time employees, if the effect of such eligibility provision would favor higher-wage employees.

- **Automatic enrollment.** Employers with more than 200 employees would be required to automatically enroll new full-time employees in the employer's health plan and continue the health plan enrollment of current employees; employees would be allowed to opt out of such coverage.
- **Waiting periods.** Employers would pay a \$600 penalty (indexed annually) for each full-time employee (working 30-plus hours per week) subject to a waiting period longer than 60 days before enrollment in a health plan.
- **Claim appeals.** Group health plans would face requirements for expanded internal claim and appeal processes beyond those currently required under ERISA, including providing assistance to participants making an appeal, as well as adding an external appeal process.
- **HIPAA wellness programs.** The HIPAA limit on financial incentives for participation in a wellness program would increase, beginning in 2014, from 20% to 30% of total plan cost, and the government would have the authority to increase the limit to 50% if such an increase were deemed appropriate.
- **Early retiree reinsurance program.** Beginning in 2010, a temporary reinsurance program would reimburse employer plans for 80% of the cost of benefits provided to retirees age 55 to 64 in excess of \$15,000 and below \$90,000 (indexed annually for medical CPI). Amounts paid to an employer plan sponsor would have to be used to lower costs for the plan. Such payments could be used to reduce premium costs for an employer plan sponsor or to reduce premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs for plan participants. However, such payments could not be used as general revenues for an employer.
- **Reduced employer tax deduction for retiree drug costs.** Beginning in 2011, an employer's income-tax deduction for its retiree drug costs would be reduced by the amount of any Medicare Part D retiree drug subsidy received by the employer.
- **Medicare payroll tax increase for employees.** Beginning in 2013, the employee's share of the Medicare hospital insurance tax rate would increase from 1.45% to 2.35% on the amount of a taxpayer's earned wages in excess of \$200,000 for single filers or \$250,000 for married individuals filing jointly. Employers would not be subject to the additional .9% Medicare hospital insurance tax.
- **Change in itemized deductions for medical expenses.** The adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses would increase from 7.5% of AGI to 10% of AGI. Individuals age 65 and over would be exempt from the 10% threshold, permitting them to continue to claim deductions using the 7.5% AGI threshold until 2017.

- ***Income-based Part D premiums.*** Higher-income Medicare beneficiaries would pay higher premiums for Part D prescription drug coverage beginning in 2011, similar to the income-based premiums currently in place for Medicare Part B coverage.
- ***Part D drug discounts and the donut hole.*** Drug manufacturers would be required to provide a 50% discount on brand-name drugs and biologics to Medicare Part D beneficiaries beginning in July 2010. In addition, for 2010 only, the donut hole in the standard Part D plan would be reduced by \$500.
- ***Indoor-tanning tax.*** A new 10% tax would be imposed on customers on amounts paid for indoor-tanning services. This social policy tax essentially replaces the so-called “bo-tax” included in a prior version of the Senate bill, which would have imposed a 5% tax on patients receiving elective cosmetic surgery.
- ***Health industry assessments.*** Medical device manufacturers would be subject to an annual assessment of \$2 billion per year from 2011 through 2017, and \$3 billion per year in 2018 and beyond. Health insurers would be subject to an annual assessment, based on their net written premiums, of \$2 billion per year beginning in 2011 and increasing gradually to \$10 billion per year in 2017 and beyond. Nonprofit health insurers meeting certain loss-ratio targets would be exempt from this assessment. Pharmaceutical manufacturers would be subject to an annual assessment of \$2.2 billion per year beginning in 2010.
- ***Comparative effectiveness fund tax on insured and self-insured health plans.*** A Patient-Centered Outcomes Research Trust Fund would be established and funded, in part, by an annual assessment on private health insurers and plan sponsors of self-insured health plans (e.g., employers and unions) beginning in 2013. The assessment would be equal to \$1 in 2013, and \$2 in 2014 through 2019, multiplied by the number of covered lives under the plan (indexed for medical CPI).
- ***Voluntary public long-term-care insurance program.*** The CLASS Act provisions of the bill would create a new voluntary public long-term care insurance program to help purchase services and support for individuals with functional limitations not covered by private long-term-care insurance or Medicaid. Individuals would receive a daily or weekly cash benefit to help purchase the services and supports needed to maintain personal and financial independence. Employees would be default-enrolled by employers at a 100% employee contribution, unless employees decline.

### The Weeks (and Months) Ahead

***And down the stretch they come.*** When Congress reconvenes in January 2010 (House on January 12 and Senate on January 19), a House-Senate Conference Committee will begin work to delicately assemble a final piece of health care reform legislation that is palatable to both the House and Senate — no easy task in its own right. While only a simple majority vote is required in each chamber to adopt the final Conference Committee bill, Senators opposed to

the legislation are permitted to filibuster to prevent the legislation from reaching a vote in the Senate. Consequently, Democrats will once again need 60 votes to prevent a filibuster and proceed to a vote on the final health care reform bill.

Reportedly, Democratic leadership is aiming to have legislation on the President's desk prior to the State of the Union address, which will be delivered in late January or early February. However, White House officials have expressed doubt about whether meeting this artificial deadline is possible considering the differences (e.g., abortion language and revenue raisers) that still need to be reconciled in the two bills.

***Final weekly edition — This Week in Health Care Reform, December 28, 2009.*** Since June 2009, we have distributed a weekly bulletin and podcast each Monday, summarizing the key developments in Congress on health care reform. This week's edition, dated December 28, 2009, will be the final *weekly* edition of this bulletin. Analysis of health care reform will, of course, continue but with bulletins issued as events dictate, such as when the Conference Committee report emerges, rather than each Monday. We hope that *This Week in Health Care Reform* was useful to readers seeking to efficiently follow this important legislation as it made its way through Congress.