

Towers Watson Legislative Tracking Chart

-- Health and Group Benefits --

Updated February 25, 2010

What's New:

A bill (H.R. 4563) was introduced that would require group health plans and health insurers to provide coverage for breast, prostate, and colorectal cancer screenings.

The House approved a bill (H.R. 2847) that would further extend the federal government's 65% subsidy for COBRA premiums paid on behalf of certain involuntarily terminated workers.

The House approved a bill (H.R. 4626) that would repeal the antitrust exemption provisions regarding price-fixing, bid-rigging and market allocations for health insurance issuers under the McCarran-Ferguson Act

Issues:

[Health Care Reform](#)

[Public Health Plans](#)

[Health Benefit Mandates](#)

[Other Health & Welfare Bills](#)

Thousands of bills are introduced in Congress but only a select few are summarized on this chart. This selection represents our best judgment on the likelihood of enactment and the relevance of the issue for employers.

Health Care Reform

Bill	Summary	Status
<p>Affordable Health Care for America Act</p> <p>H.R. 3962 Dingell (D-MI)</p>	<p><i>Health care reform.</i> Summary of key provisions that have greatest potential impact for large employers and employees.</p> <p><u>Individual Mandate</u> – Requires all U.S. adult residents to obtain and maintain “acceptable coverage” for themselves and their tax dependent qualifying children. Acceptable coverage includes grandfathered individual and employer-provided coverage, certain government plans (e.g., Medicare, Medicaid, VA coverage, and TRICARE), and coverage obtained through the Exchanges (see below) or an employer offer of coverage. Individuals who do not obtain “acceptable coverage” are required to pay a tax based on 2.5% of their modified adjusted gross income (AGI) 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 are available.</p> <p><u>Individual and Small Group Market Reform</u> – Requires all private health insurers to offer basic plan(s) that are guaranteed issue 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 based on age of 2:1; other rating factors (e.g., geographic area, family size) subject to regulation by State or Exchange.</p> <p><u>Employer “Pay or Play” Mandate</u> – Includes an employer “pay or play” mandate. An employer can “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 applicable premium 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 during the period of enrollment (determined by taking into account all employees of the employer). The minimum required employer contributions are prorated for part-timers (to be defined by a government commission). Employers are 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 an 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, has 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 are required to automatically enroll employees for individual coverage under the employer plan option with the lowest premium; employees are allowed to opt-out of such coverage.</p>	<p>On November 7, 2009, the House approved H.R. 3962 by a vote of 220-215.</p> <p>H.R. 3962 is the result of the merger of three separate health care reform bills (H.R. 3200) approved earlier this year by the House Ways and Means, Energy and Commerce, and Education and Labor Committees.</p> <p>On February 25, 2010, the President held a bipartisan meeting to discuss health care reform. In advance of that meeting, the President released his own proposal for health care reform which incorporates concepts from both the House and Senate passed bills. The President’s Proposal can be located at: http://www.whitehouse.gov/health-care-meeting/proposal</p>

Health Care Reform

Bill	Summary	Status
<p>Affordable Health Care for America Act (cont'd.)</p> <p>H.R. 3962</p> <p>Dingell (D-MI)</p>	<p><u>Health Insurance Exchanges/Low- and Middle-Income Subsidies</u> – Creates Health Insurance Exchanges which 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 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 are allowed to waive an employer's offer of health coverage and go to Exchange, but such employees may not be eligible for low- and middle-income premium and cost-sharing "affordability credits". The annual increase in premiums charged under Exchanged-based plan is limited. The bill provides premium and cost-sharing "affordability credits" on a sliding-scale basis to individuals and families up to 400% of the federal poverty level (FPL) (\$43,320 individual / \$58,280 couple / \$88,200 family of four in 2009). Employees who were <i>offered</i> employer coverage are ineligible to receive Exchange-based affordability credits. However beginning in Year 2, full-time employees are 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 12% of their modified AGI.</p> <p><u>Standard Benefit Packages</u> – Requires "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 limits annual out-of-pocket spending to \$5,000 self-only/\$10,000 family coverage (indexed to CPI). The initial essential benefits package has an actuarial value of 70% of the package if there were no cost-sharing imposed.</p> <p><u>Public Plan</u> – Creates a new public health insurance option which will be available through the Exchanges, and must meet the same benefit requirements, and comply with the same insurance market reforms as private plans. Public plan must be financially self-sustaining, and must build contingency funds into its rates and adjust premiums annually in order to assure it financial viability. Requires the government to negotiate provider reimbursement rates, using Medicare rates as a floor. In addition, authorizes \$5B 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. Also raises national uniform Medicaid eligibility to 150% of FPL.</p> <p><u>Reinsurance for Employer-Provided Retiree Health Coverage</u> – Establishes a temporary \$10 billion federal reinsurance program to provide reimbursement to employers and insurers for part of the cost of providing health benefits to retirees (and their families) older than age 55 but not yet eligible for Medicare. The program reimburses eligible employers or insurers for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000 (indexed for medical CPI). Amounts paid to an employer plan sponsor must be used to lower costs for the plan. Such payments may be used to reduce premium costs for an employer plan sponsor or to reduce premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. However, such payments may not be used as general revenues for an employer. The federal government must develop a mechanism to monitor the appropriate use of such payments by employers.</p>	

Health Care Reform

Bill	Summary	Status
<p>Affordable Health Care for America Act (cont'd.)</p> <p>H.R. 3962 Dingell (D-MI)</p>	<p><u>Modify HSA/FSA/HRA Rules</u> – Limits employee pre-tax contributions to a health FSA to \$2,500 per year (indexed for inflation). Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%. Makes 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), unless prescribed by a doctor.</p> <p><u>Vested Retiree Health Benefits</u> – Prohibits employers from reducing retiree health benefits after those individuals have retired, unless such reduction is also made with respect to active employee participants. With respect to premiums, a reduction in benefits occurs when a participant's share of the total premium (or, in the case of a self-insured plan, the costs of coverage) of the plan substantially increases. With respect to other cost-sharing and benefits, a reduction in benefits occurs when there is a substantial decrease in the actuarial value of the benefit package under the plan. The term "substantial" means an increase in the total premium share or a decrease in the actuarial value of the benefit package that is greater than 5 percent.</p> <p><u>Preexisting Condition Exclusions</u> – Provides additional limitations on preexisting condition exclusions for group health plans in advance of applicability of general prohibition against all preexisting condition exclusions. Reduces 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 reduces 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>Dependent Child Coverage Through Age 26</u> – Amends ERISA, the PHSA and the IRC to require that group health plans, and issuers of group and individual health insurance, that provide coverage for dependent children permit dependent children, at the parents' option, to remain on the parent's plan through age 26.</p> <p><u>Mandated Coverage for Reconstructive Surgery of Child Deformities</u> – Amends ERISA, the PHSA and the IRC to require that group health plans, and issuers of group and individual health insurance, provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's (i.e., under age 22) congenital or developmental deformity, disease or injury. The term "treatment" includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, including procedures that do not materially affect the function of the body part being treated, and procedures for secondary conditions and follow-up treatment. Excludes cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.</p> <p><u>Extension of COBRA Coverage</u> – Temporarily waives 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 are entitled to retain COBRA coverage until the earlier of the date on which such QB becomes <i>eligible</i> for "acceptable coverage" (including qualified employer-provided coverage) or Exchange-based coverage (which is expected to begin 2013).</p>	

Health Care Reform

Bill	Summary	Status
<p>Affordable Health Care for America Act (cont'd.)</p> <p>H.R. 3962 Dingell (D-MI)</p>	<p><u>Other ERISA Changes</u> – Changes ERISA remedies to allow employees to sue in state court if state law permits, and requires a study whether self-insurance should still be permitted.</p> <p><u>Generic Biological Drugs</u> – Authorizes the 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 get 12 years of market exclusivity. The first interchangeable follow-on biologic to be approved for any given brand name biologic gets 1 year of market exclusivity.</p> <p><u>Modify Business Deduction for Employer Part D Retiree Drug Subsidy</u> – Amends the IRC so that the amount otherwise allowable as an employer business deduction for retiree prescription drug expenses is reduced by the amount of the 28% Medicare Part D retiree drug subsidy (RDS) employers receive from the federal government.</p> <p><u>Part D Prescription Drug Discount Program and Elimination of Donut Hole</u> – Provides Medicare Part D eligible beneficiaries a 50% discount off the negotiated price for brand-name prescription drugs and biologics that are covered under Part D. The discount is available for drug costs incurred during an eligible beneficiary’s coverage gap (i.e., donut hole). In addition, the size of the Part D donut hole decreases by \$500 in 2010, and continues to narrow over the coming years until it is fully eliminated by 2019.</p> <p><u>Government Negotiation of Part D Prescription Drug Costs</u> – Requires the 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. Prohibits HHS from establishing a particular formulary and allows PDPs and MA-PDs to negotiate prices that are lower than those obtained by HHS.</p> <p><u>Tax-Free Employer Health Coverage for an Employee’s Non-Spouse, Non-Tax Dependent</u> – Extends 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.). Permits a VEBA to provide payment for sick and accident benefits to such eligible beneficiaries. Additionally, the Treasury Department must 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>Comparative Effectiveness Fund Tax on Insured and Self-Insured Health Plans</u> – Establishes the Health Care Comparative Effectiveness Research Trust Fund, which is 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 FY 2013. The assessment is 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> <p><u>Voluntary, public, long-term care insurance program</u> – “CLASS Act” creates 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 receive a daily or weekly cash benefit to help purchase the services and supports needed to maintain personal and financial independence. Employees are default-enrolled by employers at 100% employee contribution, unless employees decline.</p>	

Health Care Reform

Bill	Summary	Status
<p>Affordable Health Care for America Act (cont'd.)</p> <p>H.R. 3962 Dingell (D-MI)</p>	<p><u>Excise Tax on Medical Devices</u> – Establishes a 2.5% excise tax on medical devices sold for use in the U.S. The excise tax does not apply to exported devices and does not apply to retail sales of devices.</p> <p><u>Income Tax Surcharge on High-Income Taxpayers</u> – Imposes a 5.4% income tax surcharge on higher income taxpayers on the their AGI in excess of \$500,000 single filers/\$1 million married individuals filing jointly (NOT indexed for inflation).</p>	
<p>Patient Protection and Affordable Care Act</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p><i>Health care reform.</i> Summary of key provisions that have greatest potential impact for large employers and employees.</p> <p><u>Individual Mandate</u> – Requires all U.S. citizens, nationals, and legal residents to maintain “minimum essential coverage” for themselves and their tax dependents through: (i) a government sponsored program (i.e., Medicare, Medicaid, CHIP, VA coverage, TRICARE, or a Peace Corps plan), (ii) an eligible employer-sponsored plan, (iii) a plan in the individual market, (iv) a grandfathered health plan, and (v) any other plan approved by HHS. Insurers and self-insured employer plan sponsors are required to report information on health insurance coverage information to both the covered individual and to the IRS. Individuals who do not maintain minimum essential coverage for themselves and/or their tax dependents are required to pay an annual penalty. The penalty is the greater of a flat dollar amount or a percent of household income. The flat dollar amount starts at \$95 per year per adult in 2014, increases to \$495 in 2015, and reaches \$750 per year per adult in 2016 and indexed thereafter. The percent of household income starts at 0.5% in 2014, then 1.0% in 2015 and 2.0% thereafter. The penalty for uninsured individuals under age 18 is equal to ½ of the penalty amounts for adults. The amount of the annual penalty imposed on any taxpayer with respect to all individuals for whom the taxpayer is liable is capped at 300% of the penalty amount for adults (e.g., \$2,250 in 2016). The amount of the penalty is calculated on a monthly basis. Exemptions from the penalty apply to individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds 8% of the individual’s household modified AGI. Other limited exemptions are available (e.g., religious exemptions).</p> <p><u>Individual and Small Group Market Reform</u> – Requires all private health insurers to offer a “qualified health plan” that covers an “essential health benefits package”, are guaranteed issue and guaranteed renewable, with no health status underwriting, no pre-existing condition exclusions, no lifetime limits or “unreasonable” annual limits on the dollar value of benefits, no waiting periods in excess of 90 days, and have maximum rating bands which are permissible only for certain factors (i.e., age (capped at 3:1), tobacco use (capped at 1.5:1), family size, and geographic area). Health insurers are not be permitted to limit eligibility based on employees’ salaries or wages.</p>	<p>On December 24, 2009, the Senate approved H.R. 3590 by a vote of 60-39.</p> <p>H.R. 3590 is the result of the merger of two separate health care reform bills (S. 1796 and S. 1679) approved earlier this year by the Senate Finance and Senate Health, Education, Labor and Pensions (HELP) Committees.</p> <p>On February 25, 2010, the President held a bipartisan meeting to discuss health care reform. In advance of that meeting, the President released his own proposal for health care reform which incorporates concepts from both the House and Senate passed bills. The President’s Proposal can be located at: http://www.whitehouse.gov/health-care-meeting/proposal</p>

Health Care Reform

Bill	Summary	Status
<p>Patient Protection and Affordable Care Act (cont'd.)</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p><u>Employer “Pay or Play” Mandate</u> – Includes an employer “pay or play” mandate. An employer with more than 50 employees can either: (i) “play” by offering their <i>full-time employees</i> (working on average 30+ hours per week) and their dependents the opportunity to enroll in “minimum essential coverage”, or (ii) “pay” an annual assessment (nondeductible) 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 offers minimum essential coverage to full-time employees, that employer still has to pay an annual assessment equal to the <u>lesser</u> of: (i) \$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 an Exchange, or (ii) \$750 multiplied by the total number of full-time employees, if at least one full-time employee received government-subsidized Exchange-based coverage. Additional assessments apply to employer plans that include waiting periods greater than 60 days (i.e., \$600 per full-time employee in the waiting period). All assessment amounts noted above are indexed annually. Generally, if an employee is <i>offered</i> employer-provided health coverage, the employee is 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 60% or costs the employee more than 9.8% of his or her household income is eligible for the premium tax credit in an Exchange. If compliant employer coverage costs an employee a premium between 8% and 9.8% of the employee’s household income, and the employee’s household income is at or below 400% of the FPL, the employee must be offered an employer voucher to purchase coverage in an Exchange. Such a “free choice voucher” must equal the value of the employer’s greatest health plan subsidy, single or family. An employee would be allowed to 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. Employers with 200+ employees are required to automatically enroll new full-time employees in the employer’s health plan, and continue the health plan enrollment of current employees; employees are allowed to opt out of such coverage.</p> <p><u>Health Insurance Exchanges/Low- and Middle-Income Subsidies</u> – Creates state-based American Health Benefit Exchanges to provide easier, more efficient comparison of health insurance plan benefits and premium costs, and facilitate enrollment for legal U.S. residents, and separately for small groups. Information about coverage, cost-sharing and enrollment is available in a standardized format. Beginning in 2017, states may allow large employers (100+ employees) to purchase Exchange-based coverage for employees. The Exchanges make available four benefit categories (i.e., bronze, silver, gold, platinum), each of which must include a core set of covered benefits. Employees are allowed to waive an employer’s offer of health coverage and go to Exchange. Provides refundable, advanceable premium assistance tax credits to individuals and families with household modified adjusted gross income (MAGI) of up to 400% of federal poverty level (FPL) (\$43,320 individual / \$58,280 couple / \$88,200 family of four in 2009). The premium assistance tax credits, which could only be used to purchase Exchange-based plans, are based on the percentage of income the cost of premiums for the purchase of the second lowest cost silver plan represents, rising on a sliding-scale from 2% of income for those at 100% of FPL to 9.8% of income for those at 400% of FPL. No illegal immigrants are eligible for health care tax credits. In addition, reduced cost sharing is provided to eligible individuals up to 400% of the FPL who enroll in a silver plan. Employees who are <i>offered</i></p>	

Health Care Reform

Bill	Summary	Status
<p>Patient Protection and Affordable Care Act (cont'd.)</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p>employer-sponsored minimum essential coverage are ineligible to receive Exchange-based premium tax credits unless either their employer's plan does not have an actuarial value of at least 60%, or their employer's plan is unaffordable because it costs the employee over 9.8% of the employee's household income.</p> <p><u>Standard Benefit Packages</u> – Creates four “essential health benefit packages” with actuarial values of 90% (platinum), 80% (gold), 70% (silver) and 60% (bronze). A separate “catastrophic” policy is available for those 29 years of age or younger and for those who are exempt from the individual mandate because coverage is “unaffordable”. Plans' out-of-pocket (OOP) limits for in-network benefits are tied to HSA standards (e.g., \$5,950 for self-only/ \$11,900 family coverage in 2010). Cost-sharing (e.g., deductibles, copayments) are eliminated for preventive services. ERISA-covered self-insured group health plans and multiple employer welfare arrangements (MEWAs) do not have to meet the “essential health benefits package” requirements; however, such employer plans must still have an actuarial value of at least 60% and be “affordable”.</p> <p><u>Public Plan</u> – No public plan option <i>per se</i>, but creates a new national or multi-state plan 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. In addition, authorizes \$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. Also raises Medicaid eligibility to 133% of FPL.</p> <p><u>Tax Insurers / Self-Insured Employers on ‘High-Cost’ Plans</u> – Imposes a 40% excise tax (nondeductible) on the insurer, or plan administrator (e.g., employers) of self-insured group health plans, if aggregate value of employer-sponsored health coverage for an employee generally exceeded \$8,500 for individual coverage and \$23,000 for family coverage for 2013 (indexed to CPI-U plus 1%). The amount subject to 40% excise tax is the sum of: (i) the aggregate premiums for health coverage (including active and retiree 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 \$8,500/\$23,000 threshold amount. Higher amounts apply for retirees 55-64 and certain high-risk professions (i.e., an additional \$1,350 for individual coverage/\$3,000 for family coverage). The value of employer-sponsored health coverage generally is calculated in same manner as the premiums for COBRA. In determining the coverage value for retirees, employers are allowed to elect to treat pre-65 retirees together with post-65 retirees. The excise tax is imposed pro rata across insurance companies. For self-insured group health plans (including a health FSA or HRA), the excise tax is paid by the plan administrator/employer. The employer is 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 raises the threshold by 20%, 10%, and 5% for the 17 highest cost states for the first three years.</p>	

Health Care Reform

Bill	Summary	Status
<p>Patient Protection and Affordable Care Act (cont'd.)</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p><u>Reinsurance for Employer-Provided Retiree Health Coverage</u> – Establishes a temporary \$5 billion federal reinsurance program to provide reimbursement to employers and insurers for part of the cost of providing health benefits to retirees (and their families) older than age 55 but not yet eligible for Medicare. The program reimburses eligible employers or insurers for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000 (indexed for medical CPI). Amounts paid to an employer plan sponsor must be used to lower costs for the plan. Such payments may be used to reduce premium costs for an employer plan sponsor or to reduce premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. However, such payments may not be used as general revenues for an employer. The federal government must develop a mechanism to monitor the appropriate use of such payments by employers.</p> <p><u>Modify HSA/FSA/HRA Rules</u> – Limits employee pre-tax contributions to a health FSA to \$2,500 per year (indexed for inflation). Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%. Makes 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), unless prescribed by a doctor.</p> <p><u>Dependent Child Coverage Through Age 25</u> – Requires group health plans, and issuers of group and individual health insurance, that provide coverage for dependent children permit unmarried dependent children to remain on their parent’s plan through age 25. Exemption may apply to grandfathered plans.</p> <p><u>HIPAA Wellness Programs</u> – Increases the HIPAA limit on financial incentives for participation in a wellness program from 20% to 30% of total plan cost, and permits the federal government to increase this limit to 50% if deemed appropriate.</p> <p><u>State Waivers from Federal Regulation</u> – Allows States to apply for a waiver from the Secretary of HHS for up to 5 years from the requirements related to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual mandate, and employers pay-or-play mandate. States are required to enact a law and to comply with regulations that ensure transparency. Requires the Secretary of HHS to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Also requires the Secretary of HHS to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this Act provides, and that it will not increase the Federal deficit. Secretary of HHS may not waive any Federal law or requirement that is not within the authority of the HHS Secretary. Since HHS does not administer or enforce ERISA, it is unclear whether the HHS Secretary could issue a waiver of ERISA.</p>	

Health Care Reform

Bill	Summary	Status
<p>Patient Protection and Affordable Care Act (cont'd.)</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p><u>Modify Deduction for Employer Part D Retiree Drug Subsidy</u> – Amends the IRC so that the amount otherwise allowable as an employer business deduction for retiree prescription drug expenses is reduced by the amount of the 28% Medicare Part D retiree drug subsidy (RDS) employers receive from the federal government.</p> <p><u>Part D Prescription Drug Discount Program and Temporary Reduction of Donut Hole</u> – Provides Medicare Part D eligible beneficiaries a 50% discount off the negotiated price for brand-name prescription drugs and biologics that are covered under Part D. The discount is available for drug costs incurred during an eligible beneficiary's coverage gap (i.e., donut hole). In addition, for 2010 only, immediately shrinks the size of the Part D donut hole by \$500.</p> <p><u>Part D Prescription Drug Premiums</u> – Makes the Medicare Part D premium income-related by requiring that higher-income beneficiaries pay a greater share of their premiums under the Medicare prescription drug program.</p> <p><u>Generic Biological Drugs</u> – Authorizes 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 get 12 years of market exclusivity. The first interchangeable follow-on biologic to be approved for any given brand name biologic gets 1 year of market exclusivity.</p> <p><u>Employer W-2 Reporting of Value of Health Benefits</u> – Requires employers to disclose the aggregate value of employer-provided health coverage (excluding health FSA coverage) on employees' annual Form W-2.</p> <p><u>Comparative Effectiveness Fund Tax on Insured and Self-Insured Health Plans</u> – Establishes the Patient-Centered Outcomes Research Trust Fund, which is 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 is equal to \$1 in FY2013, and \$2 in FY2014 – FY 2019 multiplied by the number of covered lives under the plan (indexed for medical CPI).</p> <p><u>Health Care Industry Annual Fees</u> – Imposes annual fees of approximately \$6B on pharmaceutical and medical device manufacturers and health insurers in 2011, growing to \$14B annually in 2019. These assessments potentially could be passed through to consumers and employer plan sponsors.</p> <p><u>Voluntary, Public Long-Term Care Insurance Program</u> – "CLASS Act" creates 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 receive a daily or weekly cash benefit to help purchase the services and supports needed to maintain personal and financial independence. Employees are default-enrolled by employers at 100% employee contribution, unless employees decline.</p> <p><u>Modify Itemized Deductions for Medical Expenses</u> – Increases the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses from 7.5% of AGI to 10% of AGI. Individuals age 65+ are exempt from the 10% threshold, permitting them to continue to be subject to the 7.5% AGI threshold until 2017.</p>	

Health Care Reform

Bill	Summary	Status
<p>Patient Protection and Affordable Care Act (cont'd.)</p> <p>H.R. 3590 Rangel (D-NY)</p>	<p><u>Tanning Salon Tax</u> – Imposes a 10% tax on customers on amounts paid for indoor tanning services. This tanning salon tax replaces a 5% tax on elective cosmetic surgery that was included in a prior version of the Senate bill.</p> <p><u>Additional Medicare Tax on High-Income Taxpayers</u> – Increases the Medicare hospital insurance tax rate from 1.45% to 2.35% on the amount of an individual taxpayer's earned wages in excess of \$200,000 single filers / \$250,000 for married individuals filing jointly.</p>	
<p>American Recovery and Reinvestment Act of 2009</p> <p>H.R. 1 Obey (D-WI)</p> <p>P.L. 111-5</p>	<p><i>Health coverage tax credit (HCTC) – IRC § 35.</i> Temporarily increase the amount of the Health Coverage Tax Credit (HCTC) established under the Trade Adjustment Assistance Act of 2002 (TAA) from 65% to 80% of the premium for qualified health coverage. This incremental increase to an 80% tax credit is effective beginning May 1, 2009, and continues through December 31, 2010. The HCTC, under IRC § 35, may be assigned to pay for qualified health coverage by certain individuals whose jobs have been lost to foreign competition as well as certain pension recipients whose plans have been taken over by the Pension Benefit Guaranty Corporation. Extends the HCTC to family members for up to 24 months if the former employee entitled to the HCTC becomes entitled to coverage under Medicare or in the case of the death or divorce of the eligible individual.</p>	<p>President Obama signed H.R. 1 into law on February 17, 2009.</p>

Public Health Plans

Bill	Summary	Status
<p>Medicare Early Access Act of 2009</p> <p>S. 960 Rockefeller (D-WV)</p>	<p><i>Early Medicare access.</i> Amends Medicare (creates a new Part E) to provide early retirees and other individuals aged 55 to 64 who are not eligible for coverage under a federal health insurance program or under a group health plan (other than eligibility for COBRA coverage or employment-based retiree health coverage), early access to Medicare in return for a full premium payment. Additionally, the bill amends the IRC to allow a 75% refundable, advanceable tax credit for payment of such premiums.</p>	<p>Introduced on May 1, 2009, and referred to the Senate Finance Committee.</p>
<p>Medicare Premium Fairness Act</p> <p>H.R. 3631 Titus (D-NV)</p>	<p><i>Part B premium freeze.</i> Amends Part B of Medicare with respect to the Part B premium and the related monthly actuarial rate for 2010, keeping them the same as those for 2009. Part B premiums are scheduled to rise from \$96.40 per month in 2009 to \$110.50 per month in 2010.</p> <p>The bill was introduced in response to estimates that there would be no cost-of-living adjustments (COLA) in 2010 for Social Security payments. Under current law, most Medicare enrollees are protected from any Medicare Part B premium increases beyond the COLA by a "hold harmless" provision; however, that protection does not include new Medicare enrollees, those outside the Social Security system or those individuals who do not have their Medicare premiums deducted from their Social Security payments.</p>	<p>On September 24, 2009, the House approved H.R. 3631 by a vote of 406-18. The bill now heads to the Senate for consideration.</p>
<p>[untitled]</p> <p>H.R. 2235 Frank (D-MA)</p>	<p><i>Part B late enrollment penalty.</i> Amends Part B of Medicare to: (i) limit the penalty for late enrollment under Part B to 10% and twice the period of no enrollment; and (ii) exclude periods of COBRA and retiree coverage from such late enrollment penalty. The bill provides for a special enrollment period for individuals whose COBRA or retiree coverage terminates.</p>	<p>Introduced on May 4, 2009, and referred to the House Energy and Commerce, and the House Ways and Means Committees.</p>
<p>Reforming an Entitlement through Premium Adjustments based on Income Resources (REPAIR) Act of 2009</p> <p>S. 677 Ensign (R-NV)</p>	<p><i>Part D prescription drug premiums.</i> Makes the Medicare Part D premium income-related by requiring that higher-income beneficiaries pay a greater share of their premiums under the Medicare prescription drug program.</p>	<p>S. 677 was introduced on March 24, 2009, and referred to the Senate Finance Committee.</p>

Public Health Plans

Bill	Summary	Status
<p>Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA")</p> <p>H.R. 2 Pallone (D-NJ)</p> <p>P.L. 111-3</p>	<p><i>SCHIP reauthorization.</i> Reauthorizes the state Children's Health Insurance Program (CHIP) through September 2013 and extends CHIP to 4.1 million additional uninsured low-income children by expanding CHIP eligibility to families with incomes up to 300% of the federal poverty level (e.g., approximately \$66,000 in 2009 for a family of four). Adds dental coverage to all children enrolled in CHIP, and requires that children receive mental health services which are in parity with CHIP-covered medical and surgical benefits. Gives states the option of providing coverage under CHIP or Medicaid to legal immigrant children and pregnant women who have been in the U.S. less than 5 years (waiving that waiting period under prior law), but retaining the requirements that limit benefits to only legal residents. To offset the cost of the \$32.8 billion CHIP reauthorization and expansion over 5 years, the law increases the federal excise tax on cigarettes by 62 cents a pack to \$1.01, and also increases taxes on other tobacco products.</p> <p><i>Low-income premium assistance subsidy for employer-sponsored coverage.</i> Allows states that opt to do so to offer a premium assistance subsidy for "qualified employer-sponsored coverage" to all targeted low-income children eligible for CHIP who have access to such coverage, if the child (or the child's parent) voluntarily elects to receive such a subsidy. Amends Title XIX (Medicaid) of the SSA to allow a state to elect to offer a similar voluntary premium assistance subsidy for qualified employer-sponsored coverage to all individuals under age 19 entitled to Medicaid. Amends ERISA, the PHSA, and the IRC to require a group health plan, and health insurance issuer offering group health insurance coverage, to permit an employee who is eligible, but not enrolled, for coverage under the plan to enroll outside of open enrollment if either of the following conditions are met: (i) the employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, and the employee requests coverage under the group health plan within 60 days after such termination; or (ii) the employee or dependent becomes eligible for Medicaid or CHIP premium assistance if the employee requests coverage within 60 days after the eligibility determination date. Employers are required to provide employees with a notice regarding potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. Employers are required to provide the initial notice to employees beginning with the first plan year that begins after the date on which such model notice is first issued by the DOL/HHS. The DOL/HHS are required to develop such model notice by February 4, 2010. In addition, plan administrators are required to disclose to the State, upon request, information about the benefits available under the group health plan to permit the State to make a determination concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan. Once a delegated Working Group develops the "model coverage coordination disclosure form", employers will be required to use this model form to reply to a State's request for information about the benefits available under the group health plan for all requests beginning with the first plan year that begins after the date on which such model form is first issued. The Working Group is required to develop such model form by August 4, 2010.</p>	<p>President Obama signed H.R. 2 into law on February 4, 2009.</p>

Health Benefit Mandates

Bill	Summary	Status
<p>Autism Treatment Acceleration Act of 2009</p> <p>S. 819 Durbin (D-IL)</p> <p>H.R. 2413 Doyle (D-PA)</p>	<p><i>Autism.</i> Amends ERISA and the PHSa to require that group health plans, and issuers of group and individual health insurance, provide coverage for the diagnosis and treatment of autism spectrum disorders (ASDs). A group health plan may impose financial requirements or limits in relation to benefits for the diagnosis and treatment of ASDs, except that such financial requirements or limits for any such benefits may not be less favorable to the individual than such financial requirements or limits for substantially all other medical and surgical benefits covered by the plan. In addition, a plan may not contain separate financial requirements or limits that are applicable only with respect to benefits for the diagnosis or treatment of ASDs.</p>	<p>S. 819 was introduced on April 2, 2009, and referred to the Senate Health, Education, Labor and Pensions Committee.</p> <p>H.R. 2413 was introduced on May 14, 2009, and referred to the House Armed Services, the House Education and Labor, the House Energy and Commerce, and the House Oversight and Government Reform Committees.</p>
<p>Breast Cancer Patient Protection Act of 2009</p> <p>S. 688 Snowe (R-ME)</p> <p>H.R. 1691 DeLauro (D-CT)</p>	<p><i>Breast cancer treatment.</i> Amends ERISA, the PHSa and the IRC to require that group health plans, and issuers of group and individual health insurance, that provide medical and surgical benefits to ensure that inpatient (and in the case of a lumpectomy, outpatient) coverage and radiation therapy are provided for breast cancer treatment. The bill prohibits group health plans and issuers from: (i) restricting benefits for any hospital length of stay to less than 48 hours in connection with a mastectomy or breast conserving surgery or 24 hours in connection with a lymph node dissection; or (ii) requiring that a provider obtain authorization from the plan or issuer for prescribing any such length of stay. In addition, the bill requires group health plans and issuers to: (i) provide an initial and annual notice to each participant and beneficiary regarding the coverage required under this bill; and (ii) ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields to confirm or refute a diagnosis of cancer.</p>	<p>S. 688 was introduced on March 24, 2009, and referred to the Senate Health, Education, Labor and Pensions Committee.</p> <p>H.R. 1691 was introduced on March 24, 2009, and referred to the House Education and Labor, the House Energy and Commerce and the House Ways and Means Committees.</p> <p>On October 7, 2009, the House Energy and Commerce Committee, Subcommittee on Health held a hearing on the bill.</p>
<p>Access to Cancer Clinical Trials Act of 2009</p> <p>S. 488 Brown (D-OH)</p> <p>H.R. 716 Israel (D-NY)</p>	<p><i>Cancer clinical trials.</i> Amends ERISA, the PHSa and the IRC to require that group health plans, and issuers of group and individual health insurance, provide coverage for qualified individuals participating in approved cancer clinical trials. Specifically, the bill prohibits group health plans and issuers from: (i) denying an eligible participant or beneficiary participation in clinical trials related to the treatment of cancer that are federally funded or conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); (ii) denying (or limiting or imposing additional conditions on) the coverage of routine patient costs for items and services furnished in connection with such participation; or (iii) discriminating against an individual on the basis of such participation. The bill includes as "routine patient costs" all items and services provided in the clinical trial that are otherwise generally available to a qualified individual, with certain exceptions.</p>	<p>S. 488 was introduced on February 26, 2009, and referred to the Senate Health, Education, Labor and Pensions Committee.</p> <p>H.R. 716 was introduced on January 27, 2009, and referred to the House Education and Labor, the House Energy and Commerce, and the House Ways and Means Committees.</p>

Health Benefit Mandates

Bill	Summary	Status
<p>Cancer Screening Coverage Act of 2009</p> <p>H.R. 4563 Maloney (D-NY)</p>	<p><i>Cancer screening.</i> Amends ERISA, the PHS Act and the IRC to require that group health plans, and issuers of group health insurance, provide coverage for certain types of cancer screening. Required coverage includes mammograms, clinical breast examinations, pap tests and pelvic examinations, colorectal screening procedures, and prostate screening tests, at specified intervals and through specified procedures for certain age groups in appropriate genders. In addition, the bill prohibits related eligibility discrimination, monetary incentives to individuals, and penalties or incentives to providers. The bill also requires such group health plans and issuers to provide certain disclosures to participants and beneficiaries, including information regarding covered benefits, cost sharing, and participating providers.</p>	<p>Introduced on February 2, 2010, and referred to the House Education and Labor, the House Energy and Commerce, the House Oversight and Government Reform, and the House Ways and Means Committees.</p>
<p>Jobs for Main Street Act</p> <p>H.R. 2847 Mollohan (D-WV)</p>	<p><i>COBRA subsidy.</i> Extends the federal government's 65% COBRA subsidy (initially created by ARRA, and as amended by the DOD Appropriations Act of 2010, see H.R. 3326 and H.R. 1 below) from 9 months to 15 months, and extends the deadline for qualifying for the COBRA subsidy through June 30, 2010. Also prescribes rules allowing eligible individuals to pay premiums retroactively by a certain deadline in order to maintain COBRA coverage. Additionally, the bill specifies a new COBRA coverage election period, under involuntary termination of employment, for individuals who did not make (or who made and discontinued) an election of COBRA coverage on the basis of a reduction of hours of employment.</p>	<p>On December 16, 2009, the House approved H.R. 2847 by a vote of 217-212.</p>
<p>Department of Defense Appropriations Act, 2010</p> <p>H.R. 3326 Murtha (D-PA)</p> <p>P.L. 111-118</p>	<p><i>COBRA subsidy.</i> Extends the federal government's 65% COBRA subsidy (initially created by the American Recovery and Reinvestment Act of 2009, see below) from 9 months to 15 months, and extends the deadline for qualifying for the COBRA subsidy from December 31, 2009 to February 28, 2010. The new law did not, however, change the amount of the federal subsidy, which remains at 65% of the COBRA premium that an "assistance eligible individual" (AEI) would otherwise pay. The law also imposes new notice requirements on group health plan administrators. Specifically, a plan administrator must provide information regarding the COBRA subsidy extension to any individual who:</p> <ul style="list-style-type: none"> (i) qualified as AEI at any time on or after October 31, 2009, or (ii) experiences a qualifying event consisting of termination of employment on or after October 31, 2009. Such notice must be provided within 60 days after December 19, 2009 (i.e., by February 17, 2010), or in the case of a qualifying event occurring after December 19, within the general timeframe for distributing COBRA subsidy-related notices. In addition, a plan administrator must provide notice to an AEI who did not timely pay the COBRA premium, or who paid the premium at the unsubsidized rate, for any period of coverage during such individual's "transition period." An AEI's transition period is the period that begins immediately after the end of the maximum number of months (generally 9 months) of COBRA subsidy available under ARRA prior to its extension. An AEI is in a transition period only if the COBRA subsidy would continue to apply due to the extension from 9 to 15 months and the AEI otherwise remains eligible for the subsidy. Such notice must be provided within the first 60 days of the first day of the individual's transition period, and must include information regarding the ability to make retroactive premium payments in order to maintain COBRA coverage. 	<p>President Obama signed H.R. 3326 into law on December 19, 2009.</p>

Health Benefit Mandates

Bill	Summary	Status
<p>American Recovery and Reinvestment Act of 2009 (“ARRA”)</p> <p>H.R. 1 Obey (D-WI)</p> <p>P.L. 111-5</p>	<p><i>COBRA subsidy.</i> Provides a federal tax-free subsidy for 65% of the cost actually charged to “assistance eligible individuals” for COBRA continuation coverage for up to 9 months. The subsidy is available to employees who have been involuntarily terminated (and their families) between September 1, 2008 and December 31, 2009, and who lost group health plan coverage due to such involuntary termination of employment. The subsidy is effective for periods of coverage beginning on or after the date of enactment (e.g., March 1, 2009). The subsidy may be applied to any group health plan coverage that the assistance eligible individual had at the time of the qualifying event (e.g., medical, dental, vision, but <i>not</i> a health FSA). The subsidy phases-out for high-income individuals (i.e., those with modified adjusted gross income above \$125,000 for individual; \$250,000 for joint filers). The subsidy terminates after 9 months or, if earlier, upon <i>eligibility</i> for coverage under Medicare or any new employer-sponsored group health plan (other than coverage that consists only of dental, vision, counseling, referral services, a health FSA, or an employer’s on-site medical facility that consists primarily of first-aid services, prevention and wellness). Employees who were involuntarily terminated between September 1, 2008 and February 16, 2009, but failed to initially elect COBRA within 60 days as required by law (or initially elected, and then subsequently dropped COBRA coverage), are given an additional 60 days to elect COBRA and receive the subsidy. In these instances, benefits are prospective only, and do not extend the period of COBRA coverage beyond the original maximum required period (generally 18-months after the date of the qualifying event). Employers are required to provide all qualified beneficiaries with notice of the availability of this subsidy in their COBRA election notice. Assistance eligible individuals are allowed to change medical coverage options (if such an option is provided by their employer) upon the election of COBRA, but only to a medical option that provides the same or lower premiums than the individual’s previous coverage option. Employers are reimbursed by the government for the 65% subsidy via a payroll tax credit, in which employers reduce the amount of income tax wage withholding and FICA taxes they are required to periodically deposit by the amount of the COBRA premiums not paid by assistance eligible individuals.</p>	<p>President Obama signed H.R. 1 into law on February 17, 2009.</p>
<p>Colorectal Cancer Screening and Detection Coverage Act of 2009</p> <p>H.R. 1330 Boren (D-OK)</p>	<p><i>Colorectal cancer screening.</i> Amends ERISA, the PHSA, the IRC, and the U.S. Code to require that group health plans, issuers of group and individual health insurance, and the Federal Employees Health Benefits Program (FEHBP), provide coverage for colorectal cancer screening for any participant or beneficiary who is 50 years of age or older, or is an individual who is at high risk for colorectal cancer, under terms and conditions that are no less favorable than the terms and conditions applicable to other screening benefits otherwise provided under the plan. The amount of any coinsurance applicable to such screening may not be more than 5 percent of the payment amount for such screening, and coverage for such screening may not be subject to any deductible. The bill also requires group health plans and issuers to provide initial and annual disclosure notices to participants and beneficiaries, including information regarding covered benefits, cost sharing, and participating providers.</p>	<p>Introduced on March 5, 2009, and referred to the House Education and Labor, the House Energy and Commerce, the House Oversight and Government Reform, and the House Ways and Means Committees.</p>

Health Benefit Mandates

Bill	Summary	Status
<p>Routine HIV Screening Coverage Act of 2009</p> <p>H.R. 2137 Waters (D-CA)</p>	<p><i>HIV screening coverage.</i> Amends ERISA, the PHSa, the IRC, and the U.S. Code to require that group health plans, issuers of group and individual health insurance, and the Federal Employees Health Benefits Program (FEHBP), provide coverage for routine HIV screening under the same terms and conditions that are applicable to other routine health screenings. Deductibles, coinsurance, and other cost-sharing or other limitations for HIV screenings may not be imposed to the extent they exceed the deductibles, coinsurance, and limitations that are applied to other routine health screenings under the group health plan or health insurance coverage. Also requires a group health plan to provide notice to each participant and beneficiary under the plan about the HIV screening coverage.</p>	<p>Introduced on April 28, 2009, and referred to the House Education and Labor, the House Energy and Commerce, the House Oversight and Government Reform, and the House Ways and Means Committees.</p>
<p>Family Building Act of 2009</p> <p>Weiner (D-NY) H.R. 697</p>	<p><i>Infertility treatment.</i> Amends ERISA, the PHSa, and the U.S. Code to require that group health plans, and issuers of group and individual health insurance, provide coverage for infertility treatment if such plan provides coverage for obstetrical services. Specifically, the bill requires coverage for treatment of infertility deemed appropriate by a participant or beneficiary and the treating physician. Such treatment shall include ovulation induction, artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), and any other treatment provided it has been deemed as "non-experimental" by the Secretary of HHS after consultation with appropriate professional and patient organizations. The bill requires coverage for "assisted reproductive technology", provided certain conditions are met. Deductibles, coinsurance, and other cost-sharing or other limitations for infertility therapy may not be imposed to the extent they exceed the deductibles, coinsurance, and limitations that are applied to similar services under the group health plan or health insurance coverage. The bill applies such requirements to health insurance coverage offered through Federal Employees Health Benefit (FEHB) plans. The bill also requires group health plans and issuers to provide initial and annual disclosure notices to participants and beneficiaries regarding coverage for infertility treatment.</p>	<p>Introduced on January 26, 2009, and referred to the House Education and Labor, the House Energy and Commerce, and the House Oversight and Government Reform Committees.</p>
<p>Mammogram and MRI Availability Act of 2009</p> <p>H.R. 995 Nadler (D-NY)</p>	<p><i>Mammography screenings.</i> Amends ERISA and the PHSa to require that group health plans, and issuers of group and individual health insurance, which provide coverage for diagnostic mammography for any woman who is 40 years of age or older to also provide coverage for annual screening mammography for such a woman and diagnostic mammography, annual screening mammography, and annual magnetic resonance imaging for any high risk woman under terms and conditions that are not less favorable than the terms and conditions for coverage of diagnostic mammography for a woman who is 40 years of age or older.</p>	<p>Introduced on February 11, 2009, and referred to the House Education and Labor, and the House Energy and Commerce Committees.</p> <p>On October 7, 2009, the House Energy and Commerce Committee, Subcommittee on Health held a hearing on the bill.</p>
<p>Preexisting Condition Patient Protection Act of 2009</p> <p>S. 623 Rockefeller (D-WV)</p> <p>H.R. 1558 Courtney (D-CT)</p>	<p><i>Preexisting condition exclusions.</i> Amends ERISA, the PHSa and the IRC to prohibit group health plans, and issuers of group and individual health insurance, from imposing preexisting condition exclusions against any plan participants or beneficiaries. In addition, the bill prohibits group health plans that offer medical care through health insurance coverage offered by a health maintenance organization from imposing an affiliation period with respect to coverage through the organization.</p>	<p>These bills were introduced on March 17, 2009. S. 623 was referred to the Senate Health, Education, Labor and Pensions Committee. H.R. 1558 was referred to the House Education and Labor, the House Energy and Commerce, and the House Ways and Means Committees.</p>

Health Benefit Mandates

Bill	Summary	Status
<p>Children's Health Protection Act of 2009</p> <p>S. 643 Lautenberg (D-NJ)</p> <p>H.R. 1619 Schwartz (D-PA)</p>	<p><i>Preexisting condition exclusions.</i> Amends ERISA, the PHSA and the IRC to prohibit group health plans, and issuers of group and individual health insurance, from imposing preexisting condition exclusions against individuals under age 25.</p>	<p>These bills were introduced on March 19, 2009. S. 643 was referred to the Senate Health, Education, Labor and Pensions Committee. H.R. 1619 was referred to the House Education and Labor, the House Energy and Commerce, and the House Ways and Means Committees.</p>
<p>Prosthetic and Custom Orthotic Parity Act of 2009</p> <p>H.R. 2575 Andrews (D-NJ)</p>	<p><i>Prosthetic limb parity.</i> Amends ERISA to provide parity under group health plans and group health insurance coverage in the provision of benefits for prosthetic devices and components and custom orthotic devices and related services with substantially all medical and surgical benefits. Specifically, the bill provides parity with respect to: (i) "financial requirements" (e.g., deductibles, co-payments, co-insurance, other cost sharing, out-of-pocket expenses, application of annual and lifetime limits) as applied to prosthetic devices and components and custom orthotic devices and related services and medical/surgical benefits; and (ii) "treatment limitations" (e.g., limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope of duration of treatment) as applied to prosthetic devices and components and custom orthotic devices and related services and medical/surgical benefits.</p>	<p>Introduced on May 21, 2009, and referred to the House Education and Labor Committee.</p>
<p>Right to a Second Medical Opinion Act of 2009</p> <p>H.R. 2457 Davis (D-CA)</p>	<p><i>Second opinions.</i> Amends ERISA, the PHSA, and the IRC to require that group health plans, and issuers of group and individual health insurance, provide coverage for second opinions, if the second opinion is requested by either a participant or beneficiary, or a health care practitioner who, with respect to a medical condition, is treating or has proposed a treatment plan for the participant or beneficiary, and who has the consent of the participant or beneficiary to make the request. Coverage of second opinion is required if: (i) the participant or beneficiary questions a diagnosis, treatment plan, surgical procedure, or therapeutic procedure for a medical condition that threatens loss of life, quality of life, loss of limb, loss of bodily function, loss of cognitive function, or substantial impairment of the mind or body (including a serious chronic condition or infection); (ii) the clinical indications with respect to a medical condition are not conclusive; (iii) a diagnosis for a medical condition is in doubt due to conflicting test results; (iv) the health care practitioner treating the participant or beneficiary for a medical condition is unable to diagnose the condition; (v) the treatment plan being used by the participant or beneficiary for a medical condition is not causing improvement in the condition within an appropriate period of time given the diagnosis and plan of care as expected for such condition; or (vi) the medical condition under treatment accelerates or continues.</p>	<p>Introduced on May 18, 2009, and referred to the House Education and Labor, the House Energy and Commerce, and the House Ways and Means Committees.</p>

Other Health & Welfare Bills

Bill	Summary	Status
<p>[untitled] H.R. 1025 Becerra (D-CA)</p>	<p><i>Cafeteria plans.</i> Amends the IRC to exempt from employment (i.e., FICA) and unemployment insurance (i.e., FUTA) taxes, any payments made on behalf of Puerto Rican residents participating in tax-exempt employee benefit cafeteria plans established under Puerto Rico IRC §1022(1).</p>	<p>Introduced on February 12, 2009, and referred to the House Ways and Means Committee.</p>
<p>Expanding Dependent and Child Care Act of 2009 H.R. 2298 Yarmuth (D-KY)</p>	<p><i>Dependent care assistance.</i> Amends IRC §129 to increase the gross income exclusion for employer-provided dependent care assistance, which includes employee pre-tax contributions to a dependent care FSA, from \$5,000 (\$2,500 for a married employee who files separately), to \$7,500 (\$3,750), and indexes that amount for inflation.</p>	<p>Introduced on May 7, 2009, and referred to the House Ways and Means Committee.</p>
<p>Health Insurance Restrictions and Limitations Clarification Act of 2009 H.R. 1253 Burgess (R-TX)</p>	<p><i>Disclosure of group health plan benefit restrictions and limitations.</i> Amends ERISA, the PHSA and the IRC to require that if a group health plan, and/or issuer of group health insurance, wants to impose limitations and restrictions on the amount, level, extent, or nature of the benefits of coverage for similarly situated individuals enrolled in such a plan as is currently permitted under HIPAA (e.g., "source-of-injury exclusions" which permit a group health plan to deny benefits for injuries that are the result of participation in risky but legal recreational activities), such a plan may continue to do so only if: (i) such limitations and restrictions are explicit and clear; (ii) in the case of such limitations and restrictions in health insurance coverage offered in connection with the group health plan, such limitations and restrictions have been disclosed to the plan sponsor in writing in advance of the point of sale; (iii) the plan sponsor of the health insurance coverage provides a description of such limitations and restrictions to participants and beneficiaries in a form that is easily understandable before enrollment; and (iv) the plan sponsor and the issuer of the coverage provide such description to the participants and beneficiaries upon their enrollment under the plan at the earliest opportunity that other materials are provided.</p>	<p>On March 31, 2009, the House approved H.R. 1253 by a vote of 422-3.</p> <p>Last Congress the House approved the same bill but it was never taken up by the Senate.</p>
<p>[untitled] H.R. 3490 Johnson (R-IL)</p>	<p><i>Employer tax credit for qualified wellness programs.</i> Amends the IRC to provide employers with a tax credit worth 30% of the costs they pay or incur in connection with a "qualified wellness program." Employers receive a tax credit of up to \$400 per employee. The bill also provides a \$400 credit for employees who participate in the programs.</p>	<p>Introduced on July 31, 2009, and referred to the House Ways and Means Committee.</p>

Other Health & Welfare Bills

Bill	Summary	Status
<p>The Healthy Workforce Act of 2009</p> <p>S. 803 Harkin (D-IA)</p> <p>H.R. 1897 Blumenauer (D-OR)</p>	<p><i>Employer tax credit for qualified wellness programs.</i> Amends the IRC to provide employers with a tax credit worth 50% of the costs they pay or incur in connection with a “qualified wellness program.” Employers receive a tax credit of up to \$200 for the first 200 employees and up to \$100 per employee thereafter. To qualify for the tax credit, a qualified wellness program must be certified by the HHS and include three of the following four elements: (i) health awareness programs that include health education and health screening programs; (ii) behavioral change programs that encourage employees to lead a healthy lifestyle through counseling, seminars or on-line programs, including classes on nutrition, stress management, obesity, substance abuse and smoking cessation; (iii) a supportive environment to encourage employee participation in the workplace wellness program, which could include offering an HHS-approved “qualified incentive benefit” to participating employees; and (iv) an employee engagement committee, which would tailor the wellness program to the needs of the workforce at a particular company. Employers that implement new qualified wellness programs are eligible for the tax credit for up to 10 years. Employers with existing qualified wellness programs are eligible for the tax credit for up to 3 years.</p>	<p>S. 803 was introduced on April 2, 2009, and referred to the Senate Finance Committee.</p> <p>H.R. 1897 was introduced on April 2, 2009, and referred to the House Ways and Means Committee.</p>
<p>Legal Services Benefit Act of 2009</p> <p>S. 825 Lincoln (D-AK)</p>	<p><i>Group legal services plans.</i> Amends the IRC to restore and make permanent the lapsed provision of IRC §120, and make the gross income exclusion unlimited for amounts received under employer-provided qualified group legal services plans.</p>	<p>Introduced on April 2, 2009, and referred to the Senate Finance Committee.</p>
<p>American Recovery and Reinvestment Act of 2009</p> <p>H.R. 1 Obey (D-WI)</p> <p>P.L. 111-5</p>	<p><i>Health information technology.</i> Calls for the federal government to spend approximately \$19 billion to accelerate the adoption of health information technology (IT) systems by doctors and hospitals, aimed at modernizing the health care system, reducing medical errors and improving quality. The Department of Health and Human Services is instructed to develop health IT standards by 2010 that allow for secure nationwide electronic exchange of health information. Authorizes bonus payments ranging from \$44,000 to \$64,000 for a physician, and up to \$11 million for a hospital, that takes steps to “meaningfully use” electronic health records. Medicare payment penalties for those physicians and hospitals not using electronic health records will be phased in starting in 2014. Seeks to reach a 90% electronic health record adoption-rate by physicians and 70% for hospitals.</p> <p><i>HIPAA privacy and security.</i> Amends current federal health information privacy laws to extend directly to “business associates” the HIPAA privacy and security rules and the civil and criminal penalties for violating those standards, in the same manner as those rules apply to “covered entities” (e.g., health care providers and health plans). This change takes effect on February 17, 2010. The law also clarifies and expands the reporting required following unauthorized access or disclosure of protected health information, and makes other amendments to the HIPAA privacy and security laws.</p> <p><i>Transportation fringe benefit.</i> Amends IRC §132(f) qualified transportation fringe benefit to temporarily increase the monthly amount of pre-tax income that employees can set aside for transit passes/vanpooling to the same level as the monthly amount for qualified parking expenses. Before the change, the 2009 monthly amount for transit passes/vanpooling was set at \$120 and for qualified parking at \$230 (indexed annually). This change is effective beginning on March 1, 2009 through December 31, 2010.</p>	<p>President Obama signed H.R. 1 into law on February 17, 2009.</p>

Other Health & Welfare Bills

Bill	Summary	Status
<p>Long-Term Care Affordability and Security Act of 2009</p> <p>S. 702 Grassley (R-IA)</p> <p>H.R. 2096 Pomeroy (D-ND)</p>	<p><i>Long-term care.</i> Amends the IRC to permit an employer-sponsored cafeteria plan under IRC §125 to: (i) offer qualified long-term care insurance with premiums paid on a pretax basis; and (ii) reimburse qualified long-term care services under a health FSA.</p>	<p>S. 702 was introduced on March 25, 2009, and referred to the Senate Finance Committee.</p> <p>H.R. 2096 was introduced on April 23, 2009, and referred to the House Ways and Means Committee.</p>
<p>Health Insurance Industry Fair Competition Act</p> <p>H.R. 4626 Perriello (D-VA)</p>	<p><i>McCarran-Ferguson Act.</i> Amends the McCarran-Ferguson Act to repeal the antitrust exemptions currently in place for health insurance issuers. The repeal of this exemption would prevent anti-competitive health insurance issuer practices like price-fixing, bid-rigging and market allocations that drive up costs. The bill does repeal the exemption as it applies to medical malpractice insurers</p>	<p>On February 24, 2010, the House approved H.R. 4626 by a vote of 406-19. The bill now heads to the Senate for consideration.</p> <p>The White House issued a Statement of Administration Policy supporting H.R. 4626.</p>
<p>Health Insurance Industry Antitrust Enforcement Act of 2009</p> <p>S. 1681 Leahy (D-VT)</p> <p>H.R. 3596 Conyers (D-MI)</p>	<p><i>McCarran-Ferguson Act.</i> Amends the McCarran-Ferguson Act to repeal the antitrust exemptions currently in place for health insurance issuers. The repeal of this exemption would prevent anti-competitive health insurance and medical malpractice insurance issuer practices like price-fixing, bid-rigging and market allocations that drive up costs. Clarifies that nothing in the bill affects the ability of states to gather information or set insurance rates. As amended by the House Judiciary Committee, the bill makes clear that insurers are allowed to gather historical loss data.</p>	<p>S. 1681 was introduced on September 17, 2009, and referred to the Senate Judiciary Committee. On October 14, 2009 the committee held a hearing on the bill.</p> <p>On October 21, 2009, the House Judiciary Committee approved H.R. 3596 by a vote of 20-9. H.R. 3569 was referred to the full House.</p> <p>A similar provision is included in the House approved comprehensive health care reform legislation, the Affordable Health Care for America Act (H.R. 3962).</p>
<p>Personal Health Investment Today (PHIT) Act of 2009</p> <p>H.R. 2105 Kind (D-WI)</p>	<p><i>Medical care expenses under IRC § 213.</i> Amends IRC §213(d) to treat up to \$1,000 per year (\$2,000 per year for a head of household or joint filer) paid for membership at a fitness center, for participation or instruction in a program of physical exercise or activity, or for exercise equipment as expenses for medical care. However, health savings accounts (HSAs) are not allowed to reimburse such exercise expenses on a tax-favored basis.</p>	<p>Introduced on April 27, 2009, and referred to the House Ways and Means Committee.</p>

Other Health & Welfare Bills

Bill	Summary	Status
<p>Promoting Innovation and Access to Life-Saving Medicine Act</p> <p>H.R. 1427 Waxman (D-CA)</p>	<p><i>Prescription drug costs – follow-on biologics.</i> Amends the PHSA to 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. The FDA is allowed to approve “biosimilar” and “biogeneric” (interchangeable) follow-on biologics through an abbreviated process. An application for a biosimilar version of a biological drug must demonstrate to the FDA that there are no clinically meaningful differences between the two products, and that the two products are highly similar in molecular structure and share the same mechanism(s) of action, if known. An applicant for a biosimilar may also try to establish that the product is “biogeneric” (i.e., “interchangeable”) with the original product. A product found by the FDA to be interchangeable can be safely substituted for the original product without increased risk of side effects, including immunogenicity, or diminished effectiveness, if state law permits. The bill grants 6 months of market exclusivity to the first applicant to demonstrate interchangeability to the FDA. The FDA must approve or disapprove an application for a follow-on biologic ten months after submission, or 180 days after the application is accepted for filing by the FDA, whichever is earlier, unless the final action date is extended by joint agreement of the applicant and the FDA. Consistent with the current law’s exclusivity periods (i.e., periods without generic competition) for traditional drugs, an original product with a novel molecular structure is entitled to 5 years of market exclusivity. A modification of a previously approved product is entitled to 3 years of market exclusivity in some instances. These periods could be extended by up to 1 year if the applicant establishes that the product can be used for a new disease indication or conducts pediatric studies. The bill establishes a procedure for resolution of patent disputes before a biosimilar is approved, and establishes penalties for failure to litigate patents in a timely fashion.</p>	<p>Introduced on March 11, 2009, and referred to the House Energy and Commerce, and the House Judiciary Committees.</p>
<p>Pharmaceutical Market Access and Drug Safety Act of 2009</p> <p>S. 1232 Dorgan (D-ND)</p> <p>S. 525 Dorgan (D-ND)</p> <p>H.R. 1298 Berry (D-AR)</p>	<p><i>Prescription drug importation.</i> Amends the Federal Food, Drugs and Cosmetics Act to allow pharmacies and wholesalers to import drugs only from countries with comparable regulation to that of the FDA, including Canada, within one year of the bill's enactment. Anti-counterfeiting measures are adopted, along with the requirement to have licensed pharmacists track, examine, and label the imported drugs. The bill also gives the FTC the authority to take action against companies that try to cut off drug supplies to wholesalers in participating countries and provides for treble damages for violations.</p>	<p>S. 1232 was introduced on June 10, 2009, and placed on the Senate Legislative Calendar.</p> <p>S. 525 was introduced on March 4, 2009, and referred to the Senate Health, Education, Labor and Pensions Committee.</p> <p>H.R. 1298 was introduced on March 4, 2009, and referred to the House Energy and Commerce Committee.</p>
<p>Pharmaceutical Market Access Act of 2009</p> <p>S. 80 Vitter (R-LA)</p>	<p><i>Prescription drug importation.</i> Amends the Federal Food, Drugs and Cosmetics Act to allow pharmacists and wholesalers to import FDA-approved prescription drugs manufactured in FDA-approved facilities in a number of industrialized nations including Canada. Requires that imported prescription drugs be packaged and shipped using counterfeit-resistant technologies. Enables Americans to purchase through the mail or internet, FDA-approved prescription medicines from facilities from Canada and other highly industrialized nations with pharmaceutical infrastructures comparable to the United States. Qualifying internet pharmacies have to register with the HHS before being allowed to sell drugs from out of the United States.</p>	<p>Introduced on January 6, 2009, and referred to the Senate HELP Committee.</p>

Other Health & Welfare Bills

Bill	Summary	Status
<p>Emergency Retiree Health Benefits Protection Act of 2009</p> <p>H.R. 1322 Tierney (D-MA)</p>	<p><i>Retiree health benefits.</i> Amends ERISA to: (i) prohibit group health plans from making post-retirement reductions in retiree benefits (i.e., the plan could not: (a) cancel, decrease or limit the amount, type, level, or form of any benefit or option; (b) impose or increase the out-of-pocket costs; or (c) modify the manner by which medical services are delivered under the plan so that a retired participant, or his or her beneficiary, has less ready access to the delivery of any such medical services); (ii) require plans to adopt provisions barring post-retirement cuts in retiree health benefits; (iii) require employers to restore benefits reduced after retirement (i.e., retroactive enforcement on employers who reduced retiree benefits prior to the bill's enactment); (iv) provide an exemption for employers from restoring retiree health benefits if such restoration, as determined by the Secretary, would: (a) be adverse to the interests of plan participants in the aggregate; (b) not be administratively feasible; and (c) cause substantial business hardship to the plan sponsor; and (v) create a loan guarantee program to assist employers in restoring retiree health benefits.</p>	<p>Introduced on March 5, 2009, and referred to the House Education and Labor Committee.</p> <p>Similar provisions are included in the House approved comprehensive health care reform legislation, the Affordable Health Care for America Act (H.R. 3962).</p>
<p>Respect for Marriage Act of 2009</p> <p>H.R. 3567 Nadler (D-NY)</p>	<p><i>Same-sex marriage.</i> Repeals the Defense of Marriage Act (under which marriage is defined as the union of one man and one woman for purposes of all federal laws) and would instead provide that if a marriage is valid under state law, it must be recognized for purposes of federal law (e.g., ERISA and the Internal Revenue Code). However, states that have not previously recognized same-sex marriage would not be required under the bill to do so.</p>	<p>Introduced on September 15, 2009, and referred to the House Judiciary Committee.</p> <p>The Administration has expressed support for the repeal of DOMA.</p> <p>If enacted, the bill would have significant implications for employer provided health and welfare plans (e.g. employees would no longer be taxed on the imputed value of the same-sex spouse's coverage).</p>
<p>Forewarn Act</p> <p>S. 1374 Brown (D-OH)</p> <p>H.R. 3042 Miller (D-CA)</p>	<p><i>WARN expansion.</i> Amends the Worker Adjustment and Retraining Notification Act (WARN) to: (i) increase the required advance notification period of plant closings and mass layoffs from 60 to 90 days; (ii) require employers to also provide written notification to the DOL and the relevant State's Governor; (iii) reduce the threshold employer size for WARN Act coverage from 100 to 75 employees; (iv) amend the definition of a covered plant closing to apply to employment losses at a single site for 25 or more employees (reduced from the current threshold of 50 or more employees); (v) amend the definition of a covered mass layoff to apply to employment losses at a single site of at least 25 employees (reduced from the current threshold of at least 500 employees); (vi) permit employees to recover double back-pay damages for WARN Act violations; and (vii) authorize the DOL to file civil actions to enforce the WARN Act.</p>	<p>S. 1374 was introduced on June 25, 2009, and referred to the Senate HELP Committee.</p> <p>H.R. 3042 was introduced on June 25, 2009, and referred to the House Education and Labor Committee.</p>