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PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION

MEMORANDUM

TO: **CIAB**

FROM: **Scott Sinder**
John Fielding
Rhonda Bolton

SUBJECT: **House Health Reform Bill – "Affordable Health Care for Americans Act"**

Tonight, the House of Representatives passed the "Affordable Health Care for Americans Act." The focus now shifts to the Senate where Majority Leader Harry Reid (D-NV) is leading the effort to cobble together the bills passed by the Finance and Health, Education, Labor & Pensions Committees in a way that – he hopes – will allow him to secure the 60 votes necessary to allow that bill to move forward. Speculation already has begun that final passage of this legislation will be delayed until 2010.

This memorandum provides an overview of the House-passed bill, with a focus on provisions that affect CIAB members and their clients. The bill, which weighs in at a stout 1990 pages plus the amendments that were incorporated during the floor consideration of the bill, includes all of the most onerous components of the reform proposals that were considered during the extended House process. There were also a few new surprises, including – new authority is granted to the FTC to conduct insurance-related investigations and to issue reports related to insurance products and practices; the insurance industry exemption from the federal antitrust laws established under the McCarran-Ferguson Act generally would be repealed for "the business of health insurance" and "the business of medical malpractice insurance"; current and future COBRA participants would be afforded an extended participation period that

would be in effect until they are eligible for employer-provided coverage or Health Insurance Exchange provided options become available.

The subsidies provided to individuals and small businesses under the legislation would be paid for through the imposition of tax penalties on individuals who fail to purchase "acceptable coverage" and on employers who fail to offer it, as well as an income tax surcharge of 5.4 percent to the extent an individual's adjusted gross income exceeds $500,000 or a joint filing couple's joint adjusted gross income exceeds $1,000,000.

With respect to the core substantive provisions included under the legislation, key provisions include –

- Creation of a public health insurance plan;

- Extensive individual and group market reforms, all of which extend to self-insured plans. (We note, however, that there is no limit on the ability of groups to self-insure, as there had been in earlier versions of the bill);

- Creation of a national Health Insurance Exchange, through which individuals and employers can purchase a "qualified health benefits plan" ("QHBP"). A new federal Health Choices Administration would be created to set up the Exchange and also impose and administer a broad range of market reforms. States and regions may set up their own exchanges but only with federal approval. A new grant program would fund qualifying health cooperatives. There appears to be no preclusion of agents' and brokers' ability to provide their services in connection with the Exchanges and no explicit restriction on commissions, although it appears the Health Choices Administration may have sufficiently broad authority to impose such restrictions if it decided to do so;

- Individual purchase mandates (enforced through the payment of a 2.5% tax) for any individual that does not hold "acceptable coverage" for any period of time in a year;

- Employer mandates that impose various taxes on any employer that does not provide "acceptable coverage" and that does not pay for a specified percentage of the premium for a base policy (a minimum of 72.5% of individual coverage for each full time employee, and 65% for family coverage). This requirement is prorated for part time employees. The bill provides an exemption for small employers. An employer can satisfy the coverage mandate by certifying to HHS that it will maintain its own plan, but that plan must meet the requirements for qualified health benefits plans after 2018;

- Premium and co-pay subsidies for those with income below 400% of the federal poverty level, and a tax credit of 50% to help small businesses (those with fewer than 25 employees, with phase outs starting for those with more than 10 employees and that pay average annual salaries greater than $20,000) pay for health insurance for their employees;
- A new wellness grant program for small employers;
- The public plan will only be available through the national Exchange, will have geographically adjusted premiums set by HHS, and will pay providers based on negotiated rates that must be at least as rich as current Medicare rates. There is lip service to creating a level playing field between the public and private plans but there are provisions that likely will result in state mandate relief for the public plan as well as those participating in the Exchanges.

Following are comments on some of the more relevant details of the House bill from the perspective of CIAB members and their clients.

Analysis of Key Provisions

1. Market Reforms

Like all of the earlier bills considered in both chambers, the final House bill contains group and individual market reform provisions that would greatly extend the federal government's authority over the health insurance sector. As a general matter, these reforms become effective on January 1, 2013.

Section 202 establishes grandfathering rights. Under those provisions, plans that enroll individuals are not required to adopt the new reforms provided they do not enroll any new individuals (other than dependents of currently participating individuals) after January 1, 2013, and provided the issuer does not change any of the terms and conditions of the coverage (except for approved rate increases) after that date. This means that all new enrollees in individual coverage would have to be covered under plans in compliance with the new mandates. Therefore, from a practical perspective, the effectiveness of this grandfather provision will be severely limited.

Any group plan in existence as of January 1, 2013 is completely exempt from the reforms until January 1, 2018.

For new plans that are created after January 1, 2013 and for all group plans after January 1, 2018, the plans must satisfy the new "qualified health benefits plans" requirements to satisfy the new individual and employer mandates (both discussed below). For individual coverage, a core requirement is that new plans (or plans to cover new enrollees) must be offered exclusively through the new Health Insurance

Exchange. Both individual plans and group plans also must satisfy the following requirements –

- A bar on pre-existing condition exclusions (§ 211);

- A guaranteed issue/renewability requirement coupled with a prohibition on rescissions (§ 212);

- Rate reform that limits rate variances to those based on:

    - family structure (with uniformity limits on the ratio of family enrollment premiums to individual premiums as specified by state law or the federal Health Choices Commissioner);

    - premium rating area (as allowed by states or a the Health Choices Commissioner); and

    - age (but this variance is limited to 2 to 1).

  (§ 213). Premiums for plans that include more benefits than the "essential benefits package" may include extra premium charges based on the actuarial value of these optional services. It is important to note that these rating rules apply to all plans; they thus seriously undermine wellness program incentives that are based on premium reductions as those do not appear to be permitted under this structure.

- Non-discrimination standards, which will be specified by the Health Choices Commissioner (§ 214);

- Network provider standards with regard to access and transparency in cost sharing differentials between in-network and out-of-network services, to be specified by the Health Choices Commissioner (§ 215);

- Providing the option to extend dependent coverage for uninsured young adults to the age of 27 (§ 216) (NOTE: This requirement goes into effect immediately. See § 105)

- A minimum "essential benefit package" which must be provided (§ 222). More "enhanced" and "premium" plans may be provided if and only if the issuer or plan sponsor also is providing a separate "essential benefit package" plan.[1]

[1] "Enhanced" and "premium" plans offer the same benefits as the "essential benefits package" but with higher premiums and lower levels of cost-sharing and out-of-pocket maximums; "premium-plus" plans are "premium" plans that may also include

A new "Health Benefits Advisory Committee" will make recommendations as to the specific "essential benefit package" which must be provided and that guidance is intended to evolve over time (§§ 223-24). The bill nevertheless spells out minimum criteria that must be satisfied, including, for example, coverage for hospitalization, prescriptions, preventative care, and rehabilitative services; and subjects this coverage to limits on cost sharing (for example, co-pays for preventative services and lifetime payment limits both will be prohibited and annual total cost-sharing for an individual cannot exceed $5,000 and for a family cannot exceed $10,000) and a minimum actuarial value, all of which will be set by HHS in consultation with the new public-private Health Benefits Advisory Committee. The minimum benefits package must be offered regardless of whether the plan participates in the national Exchange; and the minimum benefits package serves as the standard against which compliance with the individual and employer mandates will be evaluated; and

- "Consumer protection" standards which will include uniform marketing standards, grievance, appeals, and transparency standards, and will be further specified by the Health Choices Commission (§§ 331-34), as well as standards for claims payment, and benefits coordination and subrogation (§§ 235-40).

2. The National Health Insurance Exchange & The Health Choices Administration

The House bill establishes a new Health Choices Administration that will set up and run the national Exchange, administer the market reforms required by the bill, and generally oversee the health insurance industry, in consultation with the states, and other federal agencies. Significantly, the new HCA will have the power to conduct random audits as well as targeted compliance audits in response to complaints to ensure full compliance by "qualified health benefits plans" with the new federal requirements. HCA also will have the power to impose the cost of such audits on the auditees as well as to impose sanctions for non-compliance. (See §§ 241-44)

The Exchange itself essentially will serve as a mechanism through which "qualified health benefits plans" ("QHBPs") can be offered to individuals and employers. In 2013, employers that may participate will be limited to those with 25 or fewer employees; in 2014, 50 or fewer employees; and in 2015, 100 or fewer employees. In 2015 and after, HCA also may permit larger employers to participate. (See §§ 301-302.)

As a general matter, enrollment in Exchange offered plans shall be limited to "open enrollment periods" that will be established by HCA. There are exceptions to this for

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additional benefits provided that they are approved by the HCA and that the plan sponsor or issuer also offers "enhanced" and "premium" plan options. See § 303.

individuals that lose access to acceptable coverage or that experience a change that would permit enrollment in a new plan in the normal course (change in marital or dependent status, or moving outside the service area of an Exchange-participating insurer, for example). (See § 305.)

The Exchange will take bids and enter into contracts with entities to serve as providers of QHBPs that will be made available through the Exchange (§ 304), and the QHBPs must offer at least one "basic" plan for each service area, with the option to offer an "enhanced," "premium," and "premium plus" plan for each service area as described above (§ 303).

States and regions can set up exchanges and interstate health insurance compacts upon approval by the HCA (§§ 308 & 309). A new grant program to be administered by HCA to make grants and loans for the establishment and operation of not-for-profit, member-run "Consumer Operated and Oriented Plans" or "CO-Ops" is established under Section 310. Significantly, one of the requirements for such a CO-OP to receive federal support under this section is that its governing documents "incorporate ethical and conflict of interest standards designed to ***protect against insurance industry involvement and interference in the governance of the cooperative***."

The Broker Role. Section 305 outlines procedures for marketing the Exchange plans and for enrolling participants in those plans. Section 305(g) explicitly states that nothing in the Act may be construed to "affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefits plans including the public insurance option." Although we would prefer to see clarification that no one may engage in any marketing or enrollment service without being appropriately licensed as required under applicable State law, this provision does go a long way to articulate the clear intent that that be so. We note, however, that – given the plenary nature of the authority the HCA will have over QHBPs, which is broad enough to include the authority to approve costs – room potentially remains under the House bill for the federal government to limit agent or broker commissions in connection with QHBPs offered through the Exchange and in connection with the Public Plan discussed below.

3. The Public Plan

Title III, Subtitle B of the legislation would create the public plan. The general outlines of the public plan set forth in the bill are that the public option will only be available through the national Exchange; the premiums will be set by HHS and are to be geographically adjusted and established in accordance with the premium rules for QHBPs participating in the Exchange, but set at a level to allow the program to fully finance itself plus a contingency margin; and provider payments will be negotiated but are not permitted to be lower, in the aggregate, than Medicare rates.

The bill states that the public plan must comply with all requirements applicable to QHBPs in the Exchanges, to "level the playing field." And although the bill purports to require the public plan (and QHBPs in the Exchanges) to comply with state mandates,

we note that this requirement is significantly weakened by the fact that states imposing mandates on the public and Exchange plans will be required to pay for the increased premium costs associated with such mandates (*see* §§ 303(d) & 321). Given the unlikelihood that states would make up these costs, the public and Exchange plans can be expected to enjoy state insurance mandate relief under the House bill.

4. Individual and Employer Mandates

The House bill includes individual and employer mandates. Individual purchase mandates will be enforced through the payment of a 2.5% tax for any individual that is not enrolled in "acceptable coverage" (including exempted group plans, "qualified health benefits plans," and any form of government provided comprehensive health coverage plan) for any period of time in a year (§ 501).[2] The House bill would provide premium and co-pay subsidies for those with income below 400% of the federal poverty level, which would apply only to basic coverage (see §§ 343).

The employer mandate provisions impose various penalties and taxes on any employer that does not offer each employee individual and family coverage under an "acceptable plan" (including exempted group plans and other "qualified health benefits plans") (§ 411) and that does not make a contribution on behalf of those who accept such coverage for a specified percentage of each employee's (and dependent's) premium (a minimum of 72.5% of individual coverage for each full time employee, and 65% for family coverage, and prorated amounts for part-time employees) (§ 412).

Alternatively, employers may make a "contribution" to the Exchange Trust Fund essentially equal to 8 percent of the average wages paid by the employer during its tax year (or the component of the year for which qualifying coverage was not offered) (§ 413) The bill provides a sliding scale exemption for small employers with annual payrolls of less than $750,000 under which, for example, employers with payrolls under $500,000 are completely exempt from this requirement while employers with payrolls of between $670,00 and $750,000 are subject to a 6 percent "contribution" (§ 413(b)). There are also tax credits available for employers with less than 25 employees with average employee compensation of less than $40,000 (§ 521).

An employer that fails to demonstrate that it has satisfied one of the mandate requirements will be subject to tax and excise tax penalties (§§ 422 & 511). The tax penalty would be $100 per employee for each day the employer is not in compliance with the mandate requirements. There are tax penalty exemptions

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[2] The tax is the excess of the taxpayer's modified adjusted gross income for the taxable year over a gross income threshold but it is subject to a maximum that is equivalent to the "applicable national average premium" for that year as determined by HHS for self-only coverage under a basic Exchange-provided benefits plan.

for unknowing violations and if the violations are corrected within 30 days of discovery (§ 511). If the failures are "due to reasonable cause and not to willful neglect," the penalties are limited to 10 percent of the amount the employer paid the prior year for benefits coverage or $500,000, whichever is less.

An employer or insurer that attempts to "steer" potential higher risk plan participants to the public plan or an Exchange plan shall be treated as not satisfying the employer mandate requirements (§ 414).

5. New Reporting Obligations For Insurers & Employers

The House bill would impose several new disclosure and reporting obligations on insurers and employers, for example –

- Employers would be required to provide the federal government with such information as it may require to determine whether the employer is meeting employer mandate obligations, and the government will conduct random periodic audits of employers and group plans to assess compliance (§§ 241-44, 412);

- Employers sponsoring group plans will be required to submit an election form indicating that they intend to use their plans to satisfy the mandate requirements. Section 421 establishes the procedures for this and also gives the Department of Labor the authority to issue new recordkeeping requirements to help with the enforcement of these requirements and provides the DoL with separate audit authority to ensure compliance with these requirements. If a plan is found to be out of compliance, the employer could be subject to the tax and excise tax penalties discussed above as well as separate civil penalties of up to $500,000. There is a provision exempting any employer from the civil penalties if the compliance failure was not discovered exercising "reasonable diligence" or if the non-compliance issue was corrected within 30 days of the discovery of the non-compliance issue.

- "Every person who provides acceptable coverage" (i.e. insurers and self-insured plans) will be required to provide a tax form to the covered individual containing information about the coverage (to be specified by HHS) and when it was in place during the prior year, and also to submit that information to the IRS (§ 501).

6. Wellness

Section 112 establishes a new HHS wellness grant program for "small employers" (to be defined by HHS by regulation) in an amount equal to one-half of the costs paid or incurred by a small employer in connection with a "qualified wellness program." The grants can be for up to 3 years but may not be more than $150 per employee per plan year or more than $50,000 in total. As a general matter, a wellness program is

"qualified" for grants under this Section if it has been certified by both HHS and the Department of Labor as satisfying the standards established under the Act. Those standards require demonstration that the wellness program is "consistent with evidence-based research and best practices" and "includes strategies which focus on prevention and support for employee populations at risk of poor health outcomes." To be "qualified," a wellness program also has to include three of the following four "components"

1. Health awareness;
2. Employee engagement;
3. Behavioral change; and
4. Supportive environment.

HHS is authorized under the Act to begin making these grants as of July 1, 2010.

Section 2301 establishes a new wellness trust fund to be administered by HHS to research and support various wellness and preventative care initiatives. Section 2301 also includes provisions requiring HHS to issue a report outlining a national wellness and preventative care strategy on at least a bi-annual basis and authorizes grants for conducting wellness and preventative care-related research.

7. New Reinsurance Program For Retiree Healthcare

Section 111 of the House bill also establishes a new temporary program to assist employers with the cost of covering retiree healthcare. Under the program, HHS will reimburse group health plans for 80 percent of the portion of any individual's claims that have been paid by the health plan to the extent such claims exceed $15,000 and are less than $90,000. Group plans will be required to apply to participate in this program and there will be limitations on the manner in which the reimbursed funds can be used by the plans going forward.

8. Extension of COBRA Continuation Coverage

Section 113 of the House bill extends the COBRA coverage period to the earlier of the date on which a participating individual (or family) becomes eligible for acceptable coverage or the date on which the individual becomes eligible for coverage under the Health Insurance Exchange (or a state-based exchange). This extension right is subject to any termination event that normally would terminate COBRA eligibility except for the expiration of the coverage period. It is not retroactive so any employee whose COBRA eligibility has lapsed would not get a right to come back into COBRA coverage. There also are new notice requirements that must be satisfied informing current COBRA participants of the new extension right; notices to individuals who become eligible for COBRA coverage after the date of enactment must receive notices that conform to this new requirement.

9. Long Term Care

This is the first health care bill in the House to include the “Community Living Assistance Services & Supports” (or “CLASS Act”) provisions initially produced in the Senate HELP Committee. Under these provisions – set forth in Section 2581 –

- A voluntary nationwide insurance program for long term care would be established;

- That would be self-funded, financed through voluntary payroll deductions;

- And would provide for cash benefits that would be payable to those unable to perform two or more activities of daily living. The benefit under the House bill is potentially much richer than the Senate HELP benefit as – here – it is a minimum of $50 per day but subject to various escalations as determined by HHS while under the Senate bill benefits would be designed to cover half the current average cost of long term care in order to retain a role for private insurance; and

- Employers would be required to participate in an automatic employee enrollment process under the House bill (the Senate HELP bill, in contrast, would provide a tax credit for automatically enrolling employees in this long term care program and withholding premiums from wages).

10. Miscellaneous Provisions

Several extraneous provisions included in the bill do not affect any of the substantive coverage requirements in any way but are noteworthy for the havoc they may cause more broadly. Section 257, for example, gives State Attorneys General the power to bring actions on behalf of citizens of their states based on alleged violations of any of the requirements included in the legislation.

Section 260 would give the Federal Trade Commission new power to conduct investigations and issue reports regarding anything related to insurance. This new FTC right is not limited to health insurance but applies more broadly to anything “relating to insurance.” This power had been taken away from the FTC in the 1980s and it is the only general investigatory power the FTC would have over any regulated industry; other regulated industries are not subject to this authority.

Section 262 would “restore the application of the antitrust laws to health sector insurers” by generally repealing the McCarran antitrust exclusions with respect to “the business of health insurance” and “the business of medical malpractice insurance,” but it would exempt the collection of historical loss data and determining loss development factors applicable to that historical loss data from this repeal.

The bill also includes provisions –

- Limiting HSA, MSA, and flexible spending account reimbursements for medications solely to medicines or drugs that are prescribed or are insulin (§ 531);

- Capping flexible spending accounts at a maximum of $2,500 per year (§ 532);

- Doubling the penalties for non-qualified HSA distributions (§ 533);

- Establishing a Comparative Effectiveness Commission to oversee expenditures on comparative effectiveness research (§ 1401) and a Comparative Effectiveness Trust Fund to be managed by the Department of Treasury and funded by fees imposed on health insurers and self-insured health benefit plans (§ 1802);

- Imposing a tax surcharge of 5.4 percent on individuals to the extent their modified adjusted income exceeds $500,000 and on couples filing jointly to the extent their joint modified adjusted gross income exceeds $1,000,000 (§ 551).

Finally, the legislation would order 27 separate studies