

# 2009 Health Reform Update



November 11, 2009

## HEALTH REFORM UPDATE – November 11, 2009

This Update summarizes the House bill provisions and what they may mean to your employer-sponsored plans, and offers some political perspective being shared by many reform observers.

### House Approves Its Health Reform Bill – What’s In It and What’s Next

Last Saturday, November 7, the House approved its Health Reform Bill with much fanfare but also with much political capital spent by the House leadership and the President to gain passage by a very slim margin. This Bill likely represents the more liberal or aggressive reform provisions that Congress might include in final legislation. From the employer’s perspective, there aren’t many positives – the Bill includes stringent employer mandate provisions, enhances employees’ ability to select against employer plans, limits the opportunity for creative plan design and incentive contribution strategies, increases the risk of provider/supplier cost-shifting to employer plans, and does little to reduce future health care market cost increases.

#### Summary of House Bill Provisions

- *Employer Mandate* – effective January 1, 2013 and phased in over a 5-year period, employers are required to subsidize at least 72.5% of full-time employee premium and 65% of family premium for an “essential benefits package” (discussed later) or pay an 8% federal payroll tax. “Other than full-time” employees’ coverage must be subsidized on a proportionate basis – it appears full-time may be 35+ hours/week and “other” employee eligibility may go down to 15 or 20 hours/week. Employees can opt-out of their employer-sponsored plan if the plan is considered unaffordable for them (> 12.5% adjusted gross income). Reducing employee compensation by the health plan subsidy isn’t allowed, so the primary employer mandate considerations include:
  - Employer \$\$ subsidy of medical/Rx plan vs. 8% of payroll + any employee compensation increase required to offset employees’ cost to now buy health insurance in the individual marketplace (recruiting & retention issue);
  - Basic benefits package improvement or modification to initially meet “minimum” and eventually “essential” benefits requirements;
  - Eligibility and waiting period provisions aligned with individual mandate rules, and
  - Definition and eligibility of full-time and “other than full-time” employees.

- *Benefits Plan Tax Treatment* – no change, except gross income tax exclusion extended to domestic partner, same-sex spouse and others not a dependent under federal tax laws
- *Essential and Minimum Benefits Packages* – the “essential” package will be defined by a new federal advisory committee and evolve over time, but the bill describes some minimum coverage requirements effective 1 year after enactment for hospital services, physicians, prescriptions, preventive care and rehabilitation services and sets a minimum plan benefit reimbursement level of 70% of the actuarial value of covered services (i.e., cost-sharing provisions can’t be greater than 30% of total medical costs); preventive services must be covered @ 100%. These provisions appear to threaten limited medical reimbursement plans and even some CDHP/HDHP models.
- *Other Employer Coverage Requirements* – all of which will increase employer plan costs:
  - automatic employee enrollment default in the lowest premium plan;
  - extended COBRA coverage until eligible for other employer coverage or health exchange coverage available;
  - can’t reduce retiree health coverage unless active coverage similarly reduced, but temporary federal reinsurance program available for pre-65 retiree claims between \$15,000 - \$90,000;
  - automatic enrollment unless employee opt-out in national disability/long-term care plan;
  - prohibit lifetime maximums, pre-existing condition exclusion, and non-renewal by insurers or self-funded plans;
  - dependent coverage to age 27.
- *Individual Health Accounts* – effective 2011, covered services in all accounts will be consistent with tax code’s definition of itemized deductions and OTC drugs no longer will be covered; in 2013, FSA contribution limit capped at \$2,500.
- *Individual Mandate and Subsidies* – requires most legal residents to enroll in a “qualified” health plan or pay a penalty tax of 2.5% on modified adjusted gross income, with premium and cost-sharing subsidies offered to help low- and middle-income individuals (2009 income levels up to \$43,320/individual and \$88,200/family of four) afford health care; these subsidies and the employee opt-out provision enable a sizable group of employees to select between the employer plan and health exchange plans based on benefit levels and employee costs after subsidies.

- *Public Plan and Health Exchanges* – as soon as possible after enactment, the Bill encourages Health Exchanges exist to drive price and product transparency and competition, and one of the plans available within the exchange will be a government-run health plan that’s operating no later than 2013; the public plan is described as primarily a competitive solution for individual and small employer groups with less than 100 employees.
- *Wellness Plan Support* – 100% benefits required for preventive care in “minimum” and “essential” benefits packages; subsidies/tax credits only for “small employer” (to be defined) wellness programs; government support for this long-term employer cost containment strategy may fall victim to the need for immediate savings programs.
- *Quality Care & Patient Safety* – requires pay-for-performance reimbursement arrangements and evidence-based medicine review programs in private plans available through exchanges, which may be the catalyst for value-based benefits programs to be a significant future plan design and funding consideration for most employer-sponsored plans.
- *Medicare Benefit & Cost Containment Changes* – phased-in elimination of Part D “donut hole” benefit gap, 50% discount on manufacturers’ brand drug pricing, reduction of employer RDS deduction (2013), and federal government directly negotiates Part D reimbursable drug prices; significant changes in provider payment and accountability methods; substantial Medicare Advantage plan cutbacks; eliminates 2010 20% physician payment cut, which lessens this immediate cost shifting risk to employer plans.
- *Health Care Legal Reform* – states maintain their medical malpractice laws and have greater authority to litigate on behalf of their citizens for broad violations of federal legislation and to control local health insurance practices, which will increase legal and administration concerns for multi-state employers
- *Paying for Reform* – 5.4% excise tax on “wealthy” individuals, Medicare payment reform and cost containment, individual and employer mandate taxes, premium tax on insured and self-funded employer plans to directly fund comparative effectiveness research/implementation, and limited surcharges on health care marketplace suppliers

## What's Next

The House now can watch the political drama in the Senate as they work to find an acceptable reform bill. Senate leadership appears to have its work cut out to secure the 60 votes needed to pass a reform bill, so predictions on critical provisions and bill passage date are premature – with the holidays approaching, end of the year or into January are expected. And then, a compromise bill must be negotiated by the House-Senate conference committee and passed by both entities before it goes to the President for approval and signature.

As mentioned on the first page, in general the House bill is at the more liberal/aggressive end of the health reform spectrum and the Senate version is expected to be more moderate – less stringent employer mandate provisions, less emphasis on government-run plans and programs, and fewer requirements around benefits levels and plan provisions. The compromise positions of key provisions in the final legislation remain uncertain at this point, so we'll continue to update you at key events along the way.

Unfortunately, what does appear certain is only 2 of the 3 fundamental reform objectives – greater access and quality improvement – may be achieved, and health care market cost and affordability improvements will continue to be led by creative employer initiatives.