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January 20, 2010

MEMORANDUM

TO: Trion

**FROM: Scott Sinder
Rhonda Bolton
Elizabeth Glidden**

RE: Final Version of Senate Health Reform Bill – “Patient Protection & Affordable Care Act” (H.R. 3590)

On Dec. 24, 2009, the Senate passed, 60-40, the “Patient Protection & Affordable Care Act” (H.R. 3590). The measure, formally introduced by Senate Majority Leader Harry Reid (D-NV), included key provisions that differed significantly from the House passed version, the “Affordable Health Care for America Act” (H.R. 3962).

On balance, the changes made by the Senate measure have a mixed set of implications for employers and insurance plans. The headline news was the elimination of a public insurance option, but, more parochially, self-insured plans and large group plans (101 employees or more) would escape the bulk of the reform initiatives under the Senate approach.

There is an employer mandate and penalty for failure to provide coverage; there are new taxes on insurers that provide so-called “Cadillac” employer-sponsored health plans and an excise tax on health insurance companies; and there is a carrier rebate provision that would require large group plans (but not self-insured plans) that spend less than 85% of premium revenue on clinical services and quality to provide a rebate to enrollees (the benchmark is 80% for small group and individual plans).

This memorandum provides a very high level overview of the Senate measure, with more extensive analysis of some of the provisions of central concern to employers and plans.

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

- Employer Mandates. Employer mandates that impose tax penalties on any employer that has over 50 employees and that does not provide a requisite level of coverage. The penalty is \$750 per employee (substantially less than the 8% payroll tax penalty that would be imposed under the House bill), and up to four times that amount on employers that do offer coverage but have an employee that nevertheless, enrolls in a health exchange plan and receives federal subsidies for their health coverage purchase. Note that construction industry employers with 5-50 full-time employees and annual payroll in excess of \$250,000 will be subject to a penalty of \$750 per employee if they fail to offer health care to their employees. (§1511-1515)
- Individual Mandates. The broad outlines of the individual mandate remain unchanged from earlier versions of the Senate bill. Individuals who do not purchase coverage will pay the greater of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to two percent of income by 2016, up to a cap equivalent to the national average bronze plan premium. Families will pay half these amounts for children, up to a cap of \$2,250 for the entire family. The House required a 2.5% tax on income for any individual that does not hold at least a requisite base level of coverage at any period of time during a year. (§1501)
- Subsidies. 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. (§1421)
- Vouchers. As part of a compromise with Senator Ron Wyden (D-OR), workers who qualify for an “affordability exemption” to the individual mandate but do not qualify for tax credits can take their employer contribution in lieu of coverage through the employer’s group plan and join an exchange plan. Employees qualify if their required contribution under the employer’s plan would be between 8 and 9.8 percent of their income, and the employee does not earn more than 400% above the federal poverty level. The vouchers are excluded from taxation to the extent they are used to purchase health coverage through an exchange and must be equal to the contribution that the employer would have made to its own plan on behalf of the employee. The voucher must be used to purchase coverage through the exchange but any excess funds are paid to the employee. (§10108)

- Carrier Rebates. Requires insurers offering coverage in the group and individual markets (including grandfathered plans, but excluding self-insured plans) to report all “non-claims costs,” including premium revenues spent on clinical services and activities to improve health care quality. Beginning in 2011, large group plans which spend less than 85% of premium revenue and small group and individual market plans which spend less than 80% of premium revenue on clinical services and quality (thresholds known as “medical loss ratios”) must provide a rebate to enrollees. Under certain conditions, states may increase small group or individual percentages, or the Department of Health & Human Services (“HHS”) may decrease these threshold percentages. Non-profit and mutual carriers that spend less than 8% of their premium revenue on administrative costs across all of their markets also will be exempt from the health insurer excise tax that would be imposed under this legislation. (§1001)
- Market Reforms. Extensive individual and group market reforms that primarily are concentrated in the individual and small group (defined primarily as being less than 101 employees) markets. Significantly, and in contrast with the House bill, there is no rate reform or community rating that would apply in the self-insured space or to groups of 101 employees or more, except to the extent large group plans are offered through an exchange. The other market reforms (guaranteed issue; no lifetime or, after 2014, annual coverage limits; bar on pre-existing conditions limitations and rescissions; guaranteed renewals; non-discrimination standards; network provider standards; and mandatory extension of family coverage to older dependents (to age 26 in the Senate bill versus 27 in the House bill)) all largely parallel the House proposals. (§1323, §2701)
- Health Insurance Exchanges. State-by-state creation of state-based Health Insurance Exchanges, through which individuals and small employers could purchase “qualified health benefits plans” (“QHBP”). This is in contrast to the single national exchange that would be established under the House bill and – largely because of that – no new federal agency would be created under the Senate bill to oversee this process. HHS would be charged with establishing and operating a state-based exchange in any State that failed to establish such an exchange on or before January 1, 2014. The exchanges initially would be limited to employers of fewer than 101 employees. States would have the option to reduce this to employers with less than 51 employees; starting in 2017, a State also would have the option of expanding its exchange to accommodate larger employers.
- CO-OPs. Like the House bill, a new grant program that would fund qualifying health insurance cooperatives. (§1322)

- Multi-State Option Replaces Government-Run Plan. Elimination of the government-run health insurance plan and replacement with a multi-state option. The Office of Personnel Management (OPM) would be required to contract with health insurance carriers to offer at least two multi-state qualified health plans through each state exchange. At least one of the plans must be offered by a non-profit entity and groups of insurers that are commonly owned/controlled or that operate under a common network name may join together to collectively offer a multi-state plan. The multi-state plans must cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multi-state plans to offer additional benefits, but must pay for the additional cost. It is important to note that the federal government will not bear any risk or provide any direct subsidies under these contracts but it will negotiate medical loss ratios, profit margins, premiums and other terms and conditions with the providers of the multi-state options; the offerors of the multi-state options would be entitled to brand their plans as such. It also is important to note that the multi-state option plans must maintain risk pools separate and apart from the federal employee plans if they offer both. (§1334)
- Retiree Insurance: Retiree health care reinsurance and new federal long-term care insurance provisions both on par with the House proposal. (§1102)
- Premium Rate Review: For plans other than employer-sponsored plans, the bill would establish a process for reviewing increases in health plan premiums and require plans to justify increases. States would be required to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. (§1001)
- New Disclosures. Requires all plans to disclose information such as claims payment policies and rating practices. Plans that are not offered through an Exchange must submit this information to the Secretary of HHS and the State insurance commissioner and make such information available to the public. (§1303) Additionally, the bill prohibits the collection and disclosure of information related to gun ownership or use of such information for purposes of determining premium rates. (§2716)
- Reports and Studies. Requires the Secretary of Labor to prepare an annual report on various aspects of self-insured group health plans. Requires the Secretary of HHS to conduct a study of the fully-insured and self-insured group health plan markets to compare characteristics and determine the extent to which new insurance market reforms are likely to cause adverse selection in the large group market. Requires GAO to study the cost and affordability of qualified health plans offered

through Exchanges. Directs the GAO to study the rate of denial of coverage and enrollment by health insurance issuers and group health plans. (§1253-4)

- Tax Changes:

- Under the Senate measure, a 0.9% increase in the Medicare wage tax would be imposed for single taxpayers with income in excess of \$200,000 and couples filing jointly with incomes in excess of \$250,000 (this is an increase from 0.5% in the original Senate bill). (§3308)
- The final Senate bill eliminates the annual excise tax on third party administrators (“TPAs”) that had been included in an earlier version of the Senate bill. Excise taxes would still be imposed on health insurance companies, pharmaceutical companies and medical device companies. (§9001-8)
- TPAs and health insurers must bear a pro rata portion of a 3 year aggregate industry fee to fund a transitional reinsurance program for the individual and small group markets, that will total \$12 billion in 2014, \$8 billion in 2015 and \$5 billion in 2016. (§1341(b))
- Creates an exemption from the health insurance company excise tax for certain non-profit insurers with a medical loss ratios of at least 90% in every market segment it serves and that average 92% across all market segments, including individual, small group and large group plans. (§9010) The same exception applies to mutual companies with at least 40% of the market share in any state. (§9010, §10905)
- The measure passed by the Senate eliminates the tax on cosmetic surgery, which was in earlier versions of the legislation, and replaces it with a 10% sales-type tax on indoor tanning services. (§10907)
- The floor for itemized expense deductions for health care expenditures will be increased from 7.5% of adjusted gross income to 10%. (§9013) Importantly, the legislation does not change the basic tax treatment afforded to health insurance coverage under current law, except to the extent that an employee uses a voucher to purchase individual coverage through an exchange – premium payments made by an employee (and the employer contribution) for an employer-provided plan remain tax exempt while individual purchases of

health insurance outside of the employer context are afforded no special tax treatment. (§10108)

- The tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses would be increased to 20% (from 10% for HSAs and from 15% for Archer MSAs) of disbursed amount. (§9004)

Following are comments on some of the more relevant details of the Senate bill from the perspective of employers and plans.

Analysis of Key Provisions

1. *Employer Impact.*

Most of the key employer-related provisions are described at the top of this memorandum, but include –

- The new voucher requirement for employees who pay between 8 and 9.5% of their income in premiums under an employee-provided plan and whose family incomes are less than 400% of the poverty line (requires employers to offer employees the choice to have their employer-provide health plan contributions directed to an exchange provided plan option; to the extent the contribution is used to pay for the exchange provided coverage, it is tax exempt for the employee; any overage is paid directly to the employee) (§10108)
- New annual Form 5500 reporting requirements will be imposed to enable the Department of Labor to satisfy its reporting obligations under the Act (enrollment benefits, number of participants, funding arrangements, and – for self-insured plans – assets, liabilities, expenses and investments) (§1253)
- New W-2 reporting obligations with respect to the cost of employer provided health care to satisfy the new “Cadillac” plan tax burdens described below (Section 9002) (§9001)
- Elimination of the employer tax deduction for expenses allocatable Medicare Part D subsidies (§9012)
- Imposition of a new fee on both health insurers and self-insured plans of \$2 per covered beneficiary to fund comparative research initiatives (§6301)
- The new, temporary fee on TPAs and health insurers who must bear a pro rata portion of an 3 year aggregate industry fee to fund a

transitional reinsurance program for the individual and small group markets, that will total \$12 billion in 2014, \$8 billion in 2015 and \$5 billion in 2016 (§1341).

The key component of the employer-related provisions remains the new mandate-penalty regime. These provisions impose tax penalties on any employer that has over 50 employees and that does not provide a requisite level of coverage. The penalty is \$750 per employee (substantially less than the 8% payroll tax penalty that would be imposed under the House bill), and up to four times that amount on employers that do offer coverage but have employees that still end up enrolling in a plan through a health exchange plan and who receive federal subsidies for their coverage (§1513). A few elements of these provisions bear noting:

- Only full-time employees (defined as those who work 30 or more hours per week) are included in these calculations (§1513);
- The requisite level of coverage is defined to be “minimum essential coverage,” which in turn, is defined as employer-sponsored coverage, government-sponsored coverage, and grandfathered plans (§1513). Although employer-sponsored plans have avoided many of the mandates imposed by the Senate bill, the bill does require that group health plans, including employer-sponsored plans, cover several preventive services and screenings identified in government guidelines (§ 2713);
- For employers that offer qualifying coverage, the cap on the penalty for an employee that chooses to enroll in an exchange-provided plan is the amount of the subsidy received by that employee under that plan (§1513)
- Employers who impose waiting periods for access to coverage for new employees also will be subject to penalties of \$600 per employee for waiting periods that exceed 60 days to whom the waiting period applies (the original Senate bill imposed this penalty for waiting periods longer than 30 days) (§1513)
- There is an exclusion for employers that employ seasonal workers that permits those employers to exclude from the calculation of their number of employees anyone who is employed more than 30 hours per week but for less than 120 days in a calendar year (§1513)
- Insurers that offer dependant coverage would be required to allow uninsured children to remain on their parents’ health insurance up to 26 years of age. (§1001) The House measure required comparable coverage up to 27 years of age.

Large employers (with over 200 employees) also must automatically enroll new employees in one of their coverage options if they provide group coverage (§1511).

In addition, self-insured plans will be required to implement new mandated appeals processes (with both internal and external appeal rights for the denial of coverage claims) and to notify participants of these new rights. The rights include allowing participants to review their files, present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the proceedings. HHS will establish minimum standards that will apply to the external appeals process component for self-insured plans; the States will set such rules for insured plans and HHS will have the authority to do so only to the extent a State does not do so. (See §1001)

2. Funding.

To pay for the premium subsidies and the costs of establishing the exchanges, the bill would impose several new funding mechanisms. Like the House bill, the Senate proposal would impose direct payment obligations on medical device manufacturers, health insurers and pharmaceutical companies. (See §9001-8) The Senate bill also would adopt a variation of the House “millionaire” tax by imposing a 0.9% hike in the Medicare wage tax on individuals earning more than \$200,000 and joint filers earning more than \$250,000, starting in 2013. (See §3308)

Perhaps most significantly, the bill includes a variation on the “Cadillac plan” tax initially adopted by the Senate Finance Committee. (See §9001) Under the current version, beginning in 2013, carriers and other benefits providers would be required to pay a tax on any plan benefits in excess of \$8,500 for individuals and \$23,000 for families. Employees who work for companies that primarily employ those in “high risk” occupations (defined broadly to include longshoreman, police, fire, emergency medical services, construction, mining, agriculture, forestry and fisheries) would qualify for higher bases (\$1500 higher for individuals and \$3000 for families). These thresholds are subject to annual cost of living adjustments and the tax would commence in 2013.

These provisions now take into account the reality that an individual’s overall health benefits package may be composed of products from multiple providers. Accordingly, the bill places the obligation on employers to: calculate the value of each individual’s benefits package and determine whether it is subject to the tax; allocate any tax burden to the benefits providers on a pro rata basis; and inform the benefits providers of their findings.

Starting in 2011, the bill also would impose a direct excise tax on health insurers that would total \$2 billion in 2011, \$4 billion in 2012, \$7 billion in 2013, \$9 billion in 2014-2016, and \$10 billion in 2017 and thereafter. (See §9010) This excise tax would not be imposed on self-insured plans. The Senate bill also includes an exemption outlined above that would exempt any non-profit health insurer from bearing any portion of this industry excise tax if its medical loss ratio (including expenditures for anything designed

to increase the value of health care, such as wellness programs) is at least 90% in every market it serves and is at least 92% in the aggregate. (See §9010) Any mutual company health insurer that has a market share of between 40 and 60% in any State also may qualify for this exemption for its premium volume in any such State, provided it satisfies these medical loss ratio requirements. (See §10905). HHS is specifically directed to prescribe regulations to prevent inappropriate avoidance of the excise tax through abuse of these exemption provisions.

The bill also would –

- Impose a sales type tax of 10% on indoor tanning services (§10907)
- Limit FSA contributions to \$2,500 annually (adjusted for inflation) (§9005)
- Bar expense deductions for health insurers to the extent any executive compensation packages exceed \$500,000 per year (including both cash compensation and long-term and deferred benefits) (§9014)
- Impose a tax on medical device manufacturers that would be an industry aggregate tax of \$2 billion per year starting in 2011 and would increase to \$3 billion per year beginning in 2017 (§9009)
- Impose a tax on pharmaceutical companies branded products that would be an industry aggregate of \$2.3 billion per year starting in 2010 (§9008)

3. Wellness.

Unlike the House bill, the Senate bill includes a relatively extensive set of provisions designed to encourage employer wellness programs. (See §1201, §4303, and §10408) The provisions would establish a regime clarifying that the benefits that can be offered to wellness program participants can include premium incentives that can be as high as 30% of the cost of the provided coverage. (See §1201) There are rules prohibiting the programs from being based in any way on a medical condition, but the overall structure would help to clarify what can and cannot be done in the name of “wellness” and the range of acceptable rewards that can be offered to program participants. Any wellness and disease management programs currently in operation would be exempt from the new requirements. Additionally, the Senate bill authorizes an appropriation of \$200 million to give employees of small businesses access to comprehensive workplace wellness programs. (See §10408)

With respect to the carrier rebates, the Senate bill also clarifies that wellness program costs are included on the claims side of the ledger and will not be treated as administrative costs subject to the rebating requirements if those administrative costs exceed the prescribed thresholds.

4. Carrier Rebates.

As noted above, the legislation requires insurers offering coverage in the group and individual markets (including grandfathered plans, but excluding self-insured plans) to

report all “non-claims costs,” including premium revenues spent on clinical services and activities to improve health care quality. Beginning in 2011, large group plans which spend less than 85% of premium revenue and small group and individual market plans which spend less than 80% of premium revenue on clinical services and activities to improve health care quality must provide a rebate to enrollees. Under certain conditions, states may increase small group or individual percentages, or the Department of Health & Human Services (“HHS”) may decrease these threshold percentages. (§1001)

Non-profit and mutual carriers that spend less than 8% of their premium revenue on administrative costs across all of their markets also will be exempt from the health insurer excise tax that would be imposed under this legislation. (§9010)

The rebate provisions in general and the availability of the exemption may generate downward pressure on administrative costs. It is important to note that premium taxes are excluded from all calculations so do not count toward the administrative cost component for purposes of these provisions.

5. *What Is Not Here.*

One of the positive elements of the Senate measure is that some of the provisions included in the House bill and other earlier committee efforts have not been included in the Senate bill. A few of the most significant –

- A government-run health insurance plan that would compete with private insurers as proposed in the House measure;
- The House provisions related to repealing the McCarran antitrust exemption for health and medical malpractice carriers;
- The House provision providing the Federal Trade Commission with new and broad investigatory authority over any insurance-related activities and entities;
- The self-insured plan audit and reporting requirements imposed under the House bill (employers do have reporting obligations under the Senate bill to verify mandate compliance and a new W-2 reporting obligation with respect to covered health benefits but these requirements are less onerous than the House proposal); and
- The House COBRA extension provisions under which any current or future COBRA beneficiary would be afforded the right to continue COBRA coverage until Exchange-provided plans are available.

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