

## Provisions of the Federal Health Care Measures<sup>1</sup>

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### Senate Patient Protection and Affordable Health Care Act (H.R. 3590) as amended by the Health Care & Education Affordability Reconciliation Bill of 2010 (H.R. 4872)

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#### **OVERVIEW OF PROPOSED FEDERAL HEALTHCARE REFORM LEGISLATION**

The measure would require most U.S. citizens and legal residents to have health insurance. It creates state-based American Health Benefit Exchanges through which individuals can purchase coverage. Premium and cost-sharing credits would be available to individuals and families with income between 100-400% of the federal poverty level (the poverty level is \$18,310 for a family of three in 2009). The bill would create separate Exchanges through which small businesses can purchase coverage. Employers would be required to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for most small employers. Health plans in the Exchanges, as well as individual and small group markets, would be subject to new regulations. Medicaid eligibility would be expanded to those with incomes up to 133% of the federal poverty level.

#### **AGENT/ BROKER ISSUES<sup>2</sup>**

##### **Broker Role Exchanges:**

- HHS Secretary is required to “establish procedures under which a State *may allow*” (but is not required to permit) “agents and brokers to enroll individuals” in Exchange plans;
- HHS would be required to establish an advisory board to assist with helping to clarify the requirements for the state exchanges. The Advisory Board must include “individuals and entities with experience in facilitating

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<sup>1</sup> All citations refer to the section numbers in the applicable bill. “PHSA” section numbers refer to sections of the Public Health Service Act that would be amended or added by the corresponding bill provision. “IRC” section numbers refer to sections of the Internal Revenue Code of 1986 that would be amended or added by the corresponding bill provision.

<sup>2</sup> Note that the provision in a prior version of the Senate bill that would have authorized the Department of Health and Human Services to set agent/broker commission rates for exchange-provided plans has been eliminated.

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enrollment in qualified health plans.” (§1311(d)(6)(B));

- Any state exchange can enter into contracts with private entities to carry out any exchange responsibility; although health insurance issuers are precluded from entering into such contracts, there is no agent/broker prohibition. (§1311(f)(3))
- Exchanges will contract with outside parties to engage in exchange-related education, marketing and enrollment-related activities (“Navigators”). Insurance agents and brokers are expressly included in the list of individuals/entities contemplated as Navigators. Note, however, there is a restriction prohibiting anyone from serving as a Navigator who is paid in any way “directly or indirectly” in connection with the “enrollment of any individuals or employees” in an Exchange-provided plan. HHS will be required to promulgate regulations that would apply to the state exchanges to ensure that any Navigator “is qualified, and licensed if appropriate.”

CO-OPs:

- The broker role is not completely clear with regards to setting up and running a CO-OP, but nothing in the legislation prevents brokers from selling CO-OP plans. For a CO-OP to be eligible for federal start-up assistance, its “governing documents [must] incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.” Additionally, the federal advisory board that would be established to oversee the funding program for CO-OPs specifically bars any insurance industry involvement. (§1322(b)(3)(B)).

<b>Reporting Non-Claim Costs</b>	Plans offering coverage in the group and individual markets (including grandfathered plans, but excluding self-insured plans) are required to report all “non-claims costs,” including premium revenues spent on clinical services and activities to improve health care quality. (§1001)
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<b>Carrier Rebates</b>	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 (i.e., the minimum medical loss ratio) must provide a rebate to enrollees. The rebate amount will be equal to the difference between the issuer’s medical loss ratio and the minimum set by the statute. States may increase the minimum medical loss ratio percentages, while the Department of Health & Human Services (“HHS”) may decrease the small group or individual percentages under certain conditions. (§1001; PHSA § 2718)
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These minimum medical loss ratio requirements could put downward pressure on the agent/broker component of the cost calculation over time.

**MARKET REFORMS**

**Guaranteed Issue** Require guarantee issue  
(Effective 1/1/2014) (§1201: PHSA §2702, §2703)

**Guaranteed Renewals** Guaranteed renewal required  
(Effective 1/1/2014) (§1201: PHSA §2702, §2703)

**Rate Reform** No rate reform or community rating would apply in the self-insured space or to groups of 101 employees or less. In the individual and the small group markets, and in the Exchanges, allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio). Require risk adjustment in the individual and small group markets and in the Exchange. The use of information related to gun ownership for purposes of determining premium rates is expressly prohibited.  
(Effective 1/1/2014) (§1323: PHSA §2701, §1333)

**Lifetime or Annual Coverage Limits** Individual and group health plans (including all grandfathered plans) would be prohibited from placing lifetime limits on the dollar value of coverage. (Effective six months following enactment). Beginning in January 2014, individual and group health plans (including grandfathered group health plans) would be prohibited from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary. (§1001; Recon § 2301: PHSA §2711)

**Pre-Existing Conditions Limits** Group health plans (including grandfathered group health plans) and issuers in the individual and group markets will be prohibited from excluding coverage for pre-existing health conditions (§1201; Recon § 2301: PHSA § 2704).

Not later than 90 days after enactment, the Secretary would establish a temporary high-risk pool program to provide health insurance coverage for eligible individuals. Individuals would be eligible if they are U.S. citizens and legal immigrants with a pre-existing medical condition and have not had credible medical coverage for at least six months. The program would begin on the date the program is established and end on January 1, 2014. (§1101)

Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit (\$5,950/individual and \$11,900/family in 2010).

The Secretary would establish criteria for determining whether health insurance issuers and employment based health plans discouraged an individual from remaining enrolled in prior coverage based on that individual's health

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status. (§1101)

\$5 billion would be appropriated from the period of the program implementation to January 1, 2014 to pay claims and the administrative costs of the high-risk pool. (§1101)

**Rescissions** Prohibit insurers (including grandfathered plans) from rescinding coverage except in cases of fraud. (§ 1001; Recon § 2301; PHSA § 2712)

**Requirements for New Policies** All new policies (except stand-alone dental, vision, and long term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, would be required to comply with one of the four benefit categories. Existing individual and employer sponsored plans do not have to meet the new benefit standards. (Effective 1/1/2014)

**Non-Discrimination Standards**

- Beginning in 2011, no discrimination permitted based on the wages of employees
- Beginning in 2014, insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS

(§1201: PHSA §2706)

**Extension of Family Coverage to Older Dependents** Insurers (including grandfathered group plans) that offer dependant coverage would be required to allow uninsured children to remain on their parents’ health insurance up 26 years of age. Up until 1/1/ 2014, grandfathered group health plans need only cover dependents who are not eligible for other employer-sponsored coverage.  
(Effective 1/1/2011). (§1001; Recon § 2301: PHSA §2714)

**Medical Loss Ratio (MLR)**

- Individual plans and Small Group Markets (1-100 employees) must have a minimum MLR of 80%
- Large employers (101 or more employees) must have a minimum MLR of 85%
- Beginning in 2011, if minimums are not met, the issuer must provide a rebate to enrollees; the rebate will be equal to the difference between the carrier’s MLR and the minimum MLR specified in the statute
- Health plans would be required to report the proportion of premium dollars that are spent on items other than medical care
- It appears that the MLR requirement does not apply to Administrative Services Only (“ASO”) or ancillary coverage.

(§1331, §1001, §10101: PHSA §2718)

**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

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premium increases. States may receive grants to support efforts to review and approve premium increases. (Effective beginning plan year 2010) (§1001: PHSA §2794)

**Merger of Individual and  
Small Group Markets**

Allow states the option of merging the individual and small group markets. (Effective 1/1/2014)

**Reinsurance**

Each state required to establish a temporary reinsurance program for individual and small group markets, by January 1, 2014. (§1341) Thereafter, reinsurance program for early retirees (see discussion below in “Subsidies to Employers – Reinsurance” section) would sunset.

**Waiting Periods**

No group health plan (including grandfathered group plans) or issuer offering group or individual coverage may apply a waiting period that exceeds 90 days. (§1201; Recon § 2301: PHSA § 2708) (eff. 1/1/2014)

**EMPLOYER  
MANDATES**

**Large Employers**

Employers with more than 50 Employees:

Employers with more than 50 employees must offer coverage to their employees.

Employers that *do not offer coverage* and have at least one full-time employee (defined as one working 30 or more hours/week) who receives a premium tax credit will be assessed a fee of \$2,000 per full-time employee.

Employers that *offer coverage* but have at least one full-time employee receiving a premium tax credit will pay the lesser of up to \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee.

The penalties will be calculated by subtracting the first 30 full-time employees from the payment calculation.

For purposes of determining employer size under this provision, the hours worked by part-time employees are to be converted into full time equivalents and must be added to the number of full time employees.

(Effective 1/1/2014) (Section amended: §1511-1515; Recon § 1003; Laws amended: IRC and the Fair Labor Standards Act)

**Small Employers**

Employers with less than 50 Employees:

Employers with 50 or fewer employees are exempt from any of the above penalties. Therefore, participation in the

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	Exchanges is optional for such employers. (§1513)
	Exception: Construction Industry Employers with 5-50 full-time employees and whose annual payroll is in excess of \$250,000 will be subject to the above penalties if they fail to offer health care to their employees.
<b>Mandated Coverage Levels</b>	The requisite level of coverage is “minimum essential coverage,” (§1513 (a) creating new 43 USC §4980H), which is defined as an “eligible employer sponsored plan,” (§1501 (b) creating new Internal Revenue Code sec. 5000A (f)(2)). An “eligible employer sponsored plan” is government-sponsored coverage, employer-sponsored coverage, and grandfathered health plans. (§1501 (b):IRC § 5000A (f)(2); see also §1304 (a)(3)).
<b>Automatic Enrollment Mandate</b>	Employers with more than 200 employees would be required to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. (Effective 1/1/2014) ( §1511: FLSA §18A)
<b>Employer Responsibility Study</b>	No such provision.
<b>Voucher</b>	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 a 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 make more than 400% above the federal poverty level. Voucher amounts are excluded from taxation to the extent used to pay for insurance coverage, and must be equal to the contribution that the employer would have made to its own plan.  The voucher can only be used to purchase coverage through the exchange, but any excess funds are paid to the employee. (§10108: IRC §139D)
<b>Waiting Periods</b>	No employer may impose a waiting period that exceeds 90 days. (§1201: PHSA §2708)
<b>Mandated Appeals Process</b>	Self-insured plans will be required to implement new mandated appeals processes (with both internal and external appeal rights) 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. (§1001: PHSA §2719)

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## **SUBSIDIES TO EMPLOYERS**

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| <b>Small Businesses<br/>Tax Credit</b> | <p>Provide small employers with no more than 25 employees and average annual wages of less than \$40,000 that purchase health insurance for employees with a tax credit.</p> <ul style="list-style-type: none"><li>• <u>Phase I:</u><ul style="list-style-type: none"><li>• For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium.</li><li>• The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.</li><li>• The credit phases-out as firm size and average wage increases.<sup>3</sup></li><li>• Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.</li></ul></li><li>• <u>Phase II:</u><ul style="list-style-type: none"><li>• For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost.</li><li>• The credit will be available for two years.</li></ul></li></ul> |
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<sup>3</sup> For Phase I and II: For employers with 10-25 employees, the tax credit amount is reduced by multiplying the sum of the following two fractions:  
(1) the number of full-time employees (more than 10) / 15, PLUS  
(2) the average annual wages of the employer in excess of \$25,000 / \$25,000

- The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000.
- The credit phases-out as firm size and average wage increases.<sup>4</sup>
- Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

(§1421: IRC §45Q)

**Reinsurance Program for Early Retirees**

A temporary reinsurance program would be created for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. The program would reimburse employers or insurers for 80% of retiree claims between \$15,000 and \$90,000. The payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Congress would appropriate \$5 billion to finance the program.

(Effective 90 days following enactment through 1/1/2014) (§1102)

**Wellness Subsidies for Employers**

Small employers that establish wellness programs would be eligible for grants for up to five years. (Funds appropriated for five years beginning in FY 2011) (§10408)

Technical assistance and other resources would be available to evaluate employer based wellness programs. Funds would be available to conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)

(§4303: PSHA §4102)

Employers would be permitted to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. The rewards may take the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. (§1201: PSHA §2701)

Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective 1/1/2014) A state pilot program will be created by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. The program would be expanded in 2017 if it is effective. Reporting on effectiveness and impact of wellness programs would be required. (Report due

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<sup>4</sup> For Phase I and II: For employers with 10-25 employees, the tax credit amount is reduced by multiplying the sum of the following two fractions:

(1) the number of full-time employees (more than 10) / 15, PLUS

(2) the average annual wages of the employer in excess of \$25,000 / \$25,000

three years following enactment) (§1201: PHSA §2705)

**REVENUE**  
**GENERATING**  
**PROVISIONS**

**Excise Tax on “Cadillac Plans”**

A 40% excise tax would be imposed on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage, indexed to the consumer price index for urban consumers (CPI-U). The index may increase starting in 2020 depending on the accuracy of CBO forecasts of the premium inflation rate between now and 2018. (Effective 1/1/2018).

Threshold amounts would be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by \$1,650 for individual coverage and \$3,450 for family coverage.

Standalone dental and vision plans will be excluded from the tax.

Employers may reduce the cost of coverage when applying the tax if the employer’s age and gender demographics are not representative of the age and gender demographics of a national risk pool.

(Effective 1/1/2018). (§9001; Recon § 1401: IRC §4980I)

The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market, except for coverage eligible for the deduction for self-employed individuals. (Effective 1/1/2013). (§9001: IRC §4980I)

Health insurance coverage subject to the excise tax is broadly defined to include the employer and employee premium payments for health insurance (including self-insured plans), but not premiums paid by the employee and the employer for dental and vision. In addition, tax advantaged accounts such as flexible spending accounts (FSAs), health savings accounts (HSAs) and health reimbursement accounts (HRAs) are also specified as health insurance coverage and subject to the excise tax. (§9001: IRC §4980I). Note, however, that the tax is calculated based on the aggregate premium amount for each employee for all relevant coverage they have.

It is the employer’s responsibility to calculate the amount of benefits that are subject to the tax and calculate the tax, except in the case of multi-employer plans, in which case the bill imposes the responsibility on the plan sponsor.

(§ 9001: IRC § 4980I (c)(4)) .

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	Voluntary products that provide economic benefits - disability, indemnity, and policies that trigger payment based on the condition and not the filing of health claims are all explicitly exempt. (§9001: IRC §4980I)
	The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. (§9001: IRC §4980I)
<b>Tax on High Income Individuals</b>	Imposes a 0.9% increase to the Medicare tax on wages for single taxpayers with income in excess of \$200,000 and couples filing jointly with incomes in excess of \$250,000. Applies the Medicare tax (a total of 3.8%) to net investment income for individuals or couples meeting these thresholds. (§3308; Recon § 1402: SSA §1860D-13(a))
<b>Executive Compensation</b>	The deductibility of executive and employee compensation would be limited to \$500,000 per applicable individual for health insurance providers. (Effective 1/1/2010) (§9014: IRC §162(m))
<b>Treatment of HSAs and MSAs</b>	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. (Effective 1/1/2011) (§9004: IRC §223(f)(4)(A))
	Only prescribed drugs would be permitted to be reimbursable through a health savings account, Archer medical savings account, health reimbursement arrangement, or flexible spending arrangement for medical expenses. (Effective 1/2011) (§9003)
<b>FSA Contributions</b>	The amount of contributions to a flexible spending account (FSA) for medical expenses would be limited to \$2,500 per year, adjusted for inflation. (Effective 1/1/2013) (§9005; Recon § 1403: IRC §125)
<b>Medical Expense Deductions</b>	The threshold for the itemized deduction for unreimbursed medical expenses would be increased from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes. The increase for individuals age 65 and older would be waived for tax years 2013 through 2016. (Effective 1/1/2013) (§9013: IRC §213)
<b>New Taxes and Fees for Various Sectors of the Health Care Industry including Insurers</b>	<ul style="list-style-type: none"><li>• Third-party administrators and health insurers must bear a pro rata share of a three year aggregate industry fee to fund a transitional reinsurance program that will total \$12 billion in 2014, \$8 billion in 2015, and \$5 billion in 2016; (§1341(b))</li><li>• 10% sales-type tax on indoor tanning services; (§10907: IRC §5000B)</li><li>• A new fee on both health insurers and self-insured plans of \$2 per covered beneficiary to fund comparative research initiatives (§6301);</li><li>• A new annual fee on the pharmaceutical manufacturing sector (effective for sales after 12/31/2008); fee</li></ul>

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amount starts at \$2.5 billion for 2011 (§9008; Recon § 1404)

- A new 2.9% excise tax on the medical device manufacturing sector (effective for sales after 12/31/2012); (§9009; Recon § 1405)
- Annual fee imposed on all health insurers (excluding self-insured plans), based on their market share. The fee will be assessed based on net premiums written (but not TPA fees), starting in 2014. The total amount of the fee levied across all health insurers will be \$8 billion in 2014, \$11.3 billion in 2015, \$11.3 billion in 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. After 2018 the fee will increase by a rate equal to the rate of premium growth for the preceding year. There is an exemption from the annual fee for voluntary employee benefit associations and nonprofit providers more than 80% of whose revenues are received from Social Security Act programs that target low income, elderly, or disabled populations. In the case of tax exempt providers, only 50% of their net premiums that relate to their tax exempt status are taken into account when calculating the fee. (§9010; Recon § 1406.)

**Taxation of Retiree Drug Subsidies**

Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees, starting in 2013. (§9012; Recon § 1407)

**Comparative Effectiveness Research**

A private, nonprofit entity, the Patient-Centered Outcomes Research Institute, would be established. The bill would prohibit the Institute or HHS from mandating coverage or reimbursement policies based on the Institute's research. The comparative effectiveness program will be funded by appropriations and an annual fee imposed on all health insurance policies (§6301)  
Upon date of enactment, the bill would sunset the Federal Coordinating Council created in the American Recovery and Reinvestment Act of 2010 (P.L. 111-5). (§6302)

**INDIVIDUAL MANDATES**

Mandate:

- Require U.S. citizens and legal residents to have qualifying health coverage. (§1501)

Penalty:

- For individuals without coverage, a tax penalty of the greater of \$750 per year up to a maximum of three times that amount (\$2,250) per family or 2% of household income would apply.
- The penalty will be phased-in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 or the flat fee of 1% of taxable income in 2014, 2% of taxable income in 2015, and 2.5% of taxable income in 2016. (§1501)
- After 2016, the penalty will be increased annually by the cost-of-living adjustment. (§1501)

Exemptions:

- Exempted individuals would include those whose income is below the filing threshold, nonresident aliens, individuals who live and work outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax filing purposes, and others granted an exemption by the Secretary. (§1501; Recon § 1002)

## **SUBSIDIES TO INDIVIDUALS**

Individuals and families with incomes between 100-400% FPL would be eligible for refundable and advanceable premium credits to purchase insurance through the Exchanges. The premium credits would be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to 2.0% of income for those at 100% FPL to 9.5% of income for those between 300-400% FPL, except that for those with incomes between 100-133% FPL, the premium contribution is limited to 2% of income. (Individuals with incomes less than 133% FPL are intended to get their coverage through Medicaid.) (Recon §1001(a): IRC §36B)

Premium contributions for those receiving subsidies would be increased annually by an amount equal to the excess of rate of premium growth over the rate of income growth, from the preceding year. (Recon §1001(a): IRC §36B)

Cost-sharing subsidies would be provided to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 94% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 87% of the benefit costs of the plan; for those with incomes between 200-250% the subsidies will result in coverage for 73% of the benefits costs of the plan; and for those with incomes between 250-400% FPL the subsidies will result in coverage for 70% of the benefits costs of the plan. American Indians with income less than 300% FPL will not be subject to any cost-sharing requirements. (Recon §1001(b))

### **Premium and Cost-Sharing Credits**

The availability of premium credits and cost-sharing subsidies through the Exchanges would be limited to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employees share of the premium exceeds 9.8% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits. Provisions related to the premium and cost-sharing subsidies are effective 1/1/2014. (§1401-1415)

### **Verification of Citizenship**

Both income and citizenship status must be verified in determining eligibility for the federal premium credits. (§1411)

### **Abortion Coverage**

Federal premium or cost-sharing subsidies may not be used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or in cases of rape or incest. If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds. (§1303, §4101, §10401)

**Voucher Program**

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 a 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 make more than 400% above the federal poverty level. The vouchers are excluded from taxation and must be equal to the contribution that the employer would have made to its own plan. The voucher can only be used to purchase coverage through the exchange but excess funds are paid to the employee. (§10108)

**EXCHANGES**

**Creation**

A state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges would be created for individuals and small businesses with up to 100 employees can purchase qualified coverage. The program would be administered by a governmental agency or non-profit organization, through which Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until 1/1 2015) (§1311)

**Eligibility**

Access to coverage through the Exchanges would be restricted to U.S. citizens and legal immigrants who are not incarcerated. (§1311)

**Benefit Tiers**

Four benefit categories of plans plus a separate catastrophic plan would be offered through the Exchange, and in the individual and small group markets:

- Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010);
- Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;
- Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;
- Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits; (§1311)

Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market. (§1311)

Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:

- 100-200% FPL: one-third of the HSA limits (\$1,983/individual and \$3,967/family);
- 200-300% FPL: one-half of the HSA limits (\$2,975/individual and \$5,950/family);
- 300-400% FPL: two-thirds of the HSA limits (\$3,987/individual and \$7,973/family).

These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan. (§1402)

**Community Rating with  
the Exchange**

A variation in rating would be allowed based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the Exchange. (§1201: PHSA §2701)

**Licensure, Marketing, and  
Other Requirements for  
Exchange Plans**

Qualified health plans participating in the Exchange would be required to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information. (§1311)

Qualified health plans would be required to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost sharing requirements, out-of-network policies, and enrollee rights in plain language. (§1303 (f))

The Exchanges must maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. (§4303) States must develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. (§1413)

The states would have the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage would contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 85% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges. (§1331)

Exchanges would be required to consider the reasonableness of premium rate increases when determining whether to certify and offer plans (§1003: PHSA §2794)

Exchanges must submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges. (§1313)

**Abortion Coverage** States would be permitted to prohibit plans participating in the Exchange from providing coverage for abortions. Plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage are required to create allocation accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium or cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than \$1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Plans participating in the Exchanges are prohibited from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions. (§1303, §10104)

**Effective Date** Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective 1/1/2014.

**PUBLIC OPTION**

The public option has been eliminated, and is replaced with a Multi-State Option as described below.

**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. 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. The multi-state option plans must also maintain risk pools separate and apart from the federal employee plans if they offer both. (§1334)

**CO-OP PROGRAM**

A CO-OP initiative would be established to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans.

A grant or loan would not be awarded unless the following conditions are met to be a qualified health insurance issuer: an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members.

Any profits made would be used to lower premiums, improve benefits, or to otherwise improve the quality of health care delivered to its members.

The cooperative would coordinate with the implementation of state insurance reforms required by this bill.

\$6 billion would be appropriated to finance the program and award loans and grants to establish CO-OPs by 7/1/2013. (§1322)

### **EXPANSION OF PUBLIC PROGRAMS**

Medicaid would be available to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) (to be implemented in 2014). All newly eligible adults would be guaranteed a benchmark benefit package that at least provides the essential health benefits. States would be required to provide premium assistance to any Medicaid beneficiary with access to employer-sponsored insurance if it is cost-effective for the state. The program would be cover financing for the newly eligible individuals (those who were not eligible for a full benchmark benefit package or who were eligible for a capped program but were not enrolled), states will receive 100% federal funding for 2014 through 2016. Beginning in 2017, financing for the newly eligible will be shared between the states and the federal government through an increase in the federal medical assistance percentage (FMAP). For states that already cover adults with incomes above 100% FPL, the percentage point increase in the FMAP will be 30.3 in 2017 and 31.3 in 2018. For all other states, the percentage point increase in the FMAP will be 34.3 in 2017 and 33.3 in 2018. Beginning in 2019, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. (§1331)

### **BENEFITS MANDATES**

Group health plans (including employer-sponsored plans) and issuers in the individual and group markets would be required to provide coverage for preventive health services, including items or services rated “A” or “B” by the US Preventive Services Task Force, immunizations, and preventive care and screenings in Health Resources and Services Administration guidelines. (Effective for plan years beginning 6 months after date of enactment) (§1001: PHSA § 2713)

An essential health benefits package would be created that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective 1/1/2014) (§1301, §1311)

#### **Scope of Benefits Mandate**

All qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, would be required to offer at least the essential health benefits package. This requirement does not apply to employer-sponsored plans, and grandfathered individual

plans. (Effective 1/1/2014)

## **REPORTS AND STUDIES**

Requires the Secretary of Labor to prepare an annual report on various aspects of self-insured group health plans. (§1253)

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. (§1254)

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. (§1254)

## **DISCLOSURES**

All plans must 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)

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 (§9002)

Prohibits the collection and disclosure of information related to gun ownership or use for purposes of determining premium rates. (§2716)

## **PREVENTION AND WELLNESS**

### **National Strategy**

The National Prevention, Health Promotion and Public Health Council would be created to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation’s health. A Prevention and Public Health Fund would be established to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment) (§1201: ERISA §702, PHSA §2702,

	IRC §9802)
	A grant program would be created to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. Funds would be appropriated for five years beginning in FY 2010. (§1201: ERISA §702, PHS §2702, IRC §9802)
<b>Wellness Grants for Small Employers</b>	Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in FY 2011) (§10408)
<b>Wellness Assistance for all Employers</b>	Technical assistance and other resources would be provided to evaluate employer based wellness programs. HHS would conduct a national worksite health policies and programs survey, within two years following enactment, to assess employer-based health policies and programs. (§4303: PSHA §4102)
<b>Wellness Subsidies for all Employers</b>	Employers would be permitted to offer employees rewards of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. The rewards may take the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective 1/1/2014)
	A state pilot program will be created by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. The program would be expanded in 2017 if it is effective. Reporting on effectiveness and impact of wellness programs would be required. (Report due three years following enactment) (§4202)
	Qualified health plans would be required to provide coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, and preventive care for infants, children, and adolescents. (Effective six months following enactment)

**OTHER SELECTED TOPICS**

<b>Nutritional Information Labeling</b>	Chain restaurants and food sold from vending machines would be required to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment) ( §4205)
<b>Medical Tort Reform</b>	HHS would be authorized to award demonstration grants to states to test alternatives to civil tort litigation. Models would be required to emphasize patient safety, disclosure of health care errors and early resolution of disputes. Patients would be allowed to opt out at any time. HHS would be required to study effectiveness of the alternatives. ( §6801)
<b>Long Term Care</b>	Includes the Community Living Assistance Services and Supports (CLASS) Act, which would require HHS to create a

national, voluntary long term care insurance program that would provide a cash benefit to participants if they become unable to perform at least two activities of daily life, such as dressing and bathing. Workers would pay a monthly premium to buy coverage, most likely through their employer. They would have to pay into the program for at least five years before qualifying for benefits. The benefit would be at least \$50 a day. The program is intended to be self-supporting. HHS would determine premium amounts. (§8002)