



## House of Representatives Passes The Affordable Health Care For America Act (H. R. 3962)

### November 2009

*ON SATURDAY NOVEMBER 7, 2009, THE HOUSE OF REPRESENTATIVES PASSED H.R. 3962, **THE AFFORDABLE HEALTH CARE FOR AMERICA ACT (THE ACT)**, BY A VOTE OF 220 TO 215. THE THREE PANELS WITH JURISDICTION OVER HEALTH POLICY IN THE HOUSE HAVE CRAFTED THIS BILL IN HOPES OF ACHIEVING PRESIDENT OBAMA'S OBJECTIVES WHICH INCLUDE PROTECTING AND INCREASING CONSUMERS' CHOICES, GUARANTEEING ACCESS TO QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS AND REDUCING OVERALL HEALTH CARE COSTS. THIS **INSIGHTS** WILL BRIEFLY REVIEW THE HEALTH CARE REFORM PROCESS AS WELL AS SUMMARIZE KEY ELEMENTS OF THE ACT, WITH PARTICULAR FOCUS ON THOSE PROVISIONS THAT WILL MOST DIRECTLY IMPACT EMPLOYER-SPONSORED HEALTH CARE PLANS.*

#### CURRENT STATUS

With the House of Representatives passing **The Affordable Health Care for America Act**, the next phase in the process focuses on the Senate. On September 18, 2009, Senate Majority Leader, Harry Reid, released H.R. 3590, **The Patient Protection and Affordable Care Act**, which merges the two Senate committee healthcare bills previously drafted by the Senate H.E.L.P. and Finance committees. The Senate has begun the review and deliberation of the merged Senate bills. Any healthcare legislation passed from the Senate would then have to be merged with the House healthcare reform legislation by a joint congressional committee, be voted upon and pass in each chamber, before being sent to President Obama for his signature.

#### EXPANDING COVERAGE

H.R. 3962 is a sweeping piece of legislation that would impact everyone in the healthcare equation including individual consumers, healthcare providers, insurance companies, employer plan sponsors, and government entities. Addressing the objective to expand access to

coverage for all eligible individuals, the Act will:

- ◆ Require all individuals to have health insurance,
- ◆ Create a **Health Insurance Exchange** through which qualifying individuals and certain employers can purchase coverage,
- ◆ Require employers to provide coverage to employees or pay into a **Health Insurance Exchange Trust Fund** (certain exemptions for small employers),
- ◆ Impose cost and design regulations, and
- ◆ Broaden Medicaid eligibility.

Many of the Act's provisions are not scheduled to take effect until January 1, 2013; however, certain features including revenue and financing mechanisms have accelerated implementation dates.

#### INDIVIDUAL MANDATE

Beginning January 1, 2013 all individuals would be required to have "acceptable health coverage" or pay a penalty of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self or family coverage as listed under the **Health Insurance Exchange**. Certain exceptions will apply for financial hardships, religious objections or those with incomes below a certain level.

#### HEALTH INSURANCE EXCHANGE

The Act would create a **National Health Insurance Exchange** where individuals and certain employers could purchase "acceptable health coverage" from either a choice of private plans or a newly created **Public Insurance Option** beginning January 1, 2013. The Exchange would initially be open to individuals not enrolled in other coverage (i.e. an employer-sponsored plan, Medicare, Medicaid, etc.) and to small employers with 25 or fewer employees. Employers with 50 or fewer employees will be eligible to participate in the Exchange in the second year. Thereafter, the **Health Choices Commissioner** will determine the process to expand participation to all employers.

# Insights

The Act creates four benefit categories and delegates responsibility to the **Health Choices Commissioner** to specify the benefits that must be made available in each benefit category each year and to determine a permissible range of cost-sharing variation between each benefit category. Each participating Exchange plan must offer at least one Basic plan in all areas they service with the option to offer one Enhanced and one Premium level plan. The benefit design categories are as follows:

- ◆ The *Basic Plan* (“essential benefits package”) would cover preventive care, limit annual cost-sharing, not impose a lifetime limit and is designed to cover approximately 70% of plan costs.
- ◆ The *Enhanced Plan* would include the essential benefits package, have lower cost-sharing requirements and cover approximately 85% of plan costs.
- ◆ The *Premium Plan* would include the essential benefits package, have lower cost-sharing requirements and cover approximately 95% of plan costs.
- ◆ The *Premium Plus Plan* would provide additional services such as dental and vision care.

Effective January 1, 2013 all qualified health plans offered through the Exchange or outside the Exchange must provide at least the essential benefits package. The Act does provide a five-year grace period for current group health plans (“grandfathered plans”) to meet specified insurance and benefit design standards.

As an alternative and in addition to the National Health Insurance Exchange, each state would be allowed to establish its own exchange if they are able to demonstrate the capacity to meet the administration requirements.

## EMPLOYER REQUIREMENTS

As of the **date of enactment**, employers who sponsor retiree medical plans would be prohibited from reducing retiree health benefits below what was offered to retirees at the time of their retirement unless reductions are also made to active worker’s health benefits. The Act would establish a temporary reinsurance fund of \$10 billion to reimburse employer-based plans 80% of the cost of benefits in excess of \$15,000 and below \$90,000 for early retirees (age 55 – 64) and their families. This subsidy will cease when the allotted funds are exhausted.

Under the Act, beginning January 1, 2013, employers

would be required to:

- ◆ Offer coverage to employees and provide automatic enrollment (unless they opt out with other coverage) into the plan with the lowest employee premium that must be at least of equal value to the essential benefits coverage under the Basic Plan, and
- ◆ Contribute at least 72.5% of the cost for single coverage and 65% of the cost of family coverage (or a proportional amount for non-full-time employees), or
- ◆ Pay a penalty of 8% of payroll to the Health Insurance Exchange Trust Fund.

Small employers with annual payrolls less than \$500,000 would be exempt from this mandate. A graded penalty (2% of payroll increasing to 8% of payroll), would be assessed for employers with annual payrolls between \$500,000 and \$750,000 who fail to offer coverage to their employees.

Employers who offer coverage would be required to pay the appropriate penalty to the Exchange for each employee who declines the Employer’s coverage and enters the Exchange under an **Affordability Test** outlined in the Act. The Act authorizes the creation of rules that would prohibit employers from engaging in practices that steer employees away from employer-offered coverage and into coverage offered under the Exchange.

Employers who offer coverage through the Exchange are also required to pay the appropriate portion of the single and family premium and must also allow employees the freedom to choose any plan within the Exchange.

The Act seems to permit employers some latitude to offer different benefit options to full-time and non-full-time-time employees as well as for separate lines of business. However, The Act establishes rules that would apply to employers offering coverage and violations of these rules would result in the further imposition of excise taxes.

## EMPLOYER AND INDIVIDUAL PREMIUM SUBSIDIES

The Act creates a **Health Coverage Tax Credit** up to two years for small employers. The full tax credit is equal to 50% of the employer’s premium cost and is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less. The credit will be phased out based on employer size and average wages. The credit will be eliminated for employers with 25 or

# Insights

more employees, or if average wages are \$40,000 or more.

The Act creates **Premium and Cost-Sharing Affordability Credits** to help lower income individuals and families (annual income up to 400% of the Federal Poverty Level) purchase insurance through the Exchange. Individuals with access to employer-sponsored coverage will be eligible for the **Affordability Credits** under the Exchange in year two, if the cost of the employee premium exceeds 12% of the individual's income. The **Premium Credit** helps to offset the cost of the coverage while the **Cost-Sharing Credit** is designed to reduce the required cost-sharing amounts under the plan, thus providing an enriched level of benefits.

## THE PUBLIC OPTION

The Secretary of Health and Human Services is directed to create a public health insurance option to be offered under the Exchange beginning January 1, 2013. The premiums will be geographically-adjusted and are required to be set to fully cover the cost of coverage and associated administrative expenses. The public plan must offer the same benefits, follow the provider network requirements and other consumer protection mechanisms imposed upon private plans in the Exchange. It should be noted that the **Health Choices Commissioner**, appointed by the President, would be responsible for developing the rules and regulations that govern the Exchange plans. Other features of the public option include:

- ◆ Rates will be set through direct negotiation with providers and will not be lower than Medicare rates or higher than the average rates paid by other qualified health plans.
- ◆ Health care providers who participate in Medicare will automatically be assumed to participate in the public plan, unless they elect to opt-out. No penalty will be imposed on providers who choose not to participate in the public option.
- ◆ Encourage the development of innovative payment mechanisms to influence the use of high-value services.

## MISCELLANEOUS REQUIREMENTS

Additional provisions in the Act include:

- ◆ As of the date of enactment, individuals eligible for COBRA would be able to continue coverage until the Exchange is established or other coverage becomes available.
- ◆ As of the date of enactment, new federal

underwriting requirements will be imposed and an annual process will be established to review increases in health insurance premiums by the Secretary of Health and Human Services in conjunction with State Insurance Departments.

- ◆ Dependent coverage would be extended for children up to age 27 beginning January 1, 2010.
- ◆ Limit the annual deductible for single coverage to \$1,500; maximum out-of-pocket expenses to \$5,000 for an individual and \$10,000 for a family; and remove the aggregate lifetime limits, beginning January 1, 2010.
- ◆ Only allow prescribed drugs to be reimbursable through healthcare savings arrangements (FSA, HSA, and HRA,) beginning January 1, 2011.
- ◆ The pre-existing condition limitation criteria will be phased out by January 1, 2013.
- ◆ Coverage purchased through the Exchange may not be purchased on a pre-tax salary-reduction basis unless the purchaser's employer is eligible to offer employer coverage through the Exchange.
- ◆ Repeal the Children's Health Insurance Program (CHIP) and transition those affected to Medicaid. Medicaid eligibility would be expanded to cover additional individuals.
- ◆ Phase-out the Medicare Part D Prescription Drug "coverage gap" by 2019.

## COST AND FINANCING

On November 6, 2009 the Congressional Budget Office released an updated estimate of the cost of H.R. 3962 to reflect last-minute amendments and other legislation. The estimate includes a projected net cost of **\$891 billion** over 10 years for the proposed expansions in insurance coverage. The CBO estimate breaks out the cost as follows:

- ◆ **\$1,052 billion** in subsidies provided through the Exchange (and related spending), increased net outlays for Medicaid and the current CHIP program, and tax credits for small employers, plus
- ◆ **\$6 billion** associated with outlays for other coverage provisions, offset by
- ◆ **\$167 billion** in the collection of penalties paid by individuals and employers.

The House has proposed new taxes and revenue raising mechanisms to fund the healthcare reform legislation as follows:

- ◆ Impose a 5.4% tax on individuals with modified adjusted gross income exceeding \$500,000 and families with modified adjusted gross income of

# Insights

\$1,000,000 beginning January 1, 2011.

- ◆ Increase the tax from 10% to 20% on distributions from health savings accounts not used for qualified medical expenses beginning January 1, 2011.
- ◆ Repeal the 28% subsidy credit for employer-sponsored retiree medical prescription drug coverage beginning January 1, 2011.
- ◆ Impose a maximum contribution limit of \$2,500 to Flexible Spending Arrangements (FSA and HRA) beginning January 1, 2013.
- ◆ Impose a tax of 2.5% of the price on the first taxable sale of any medical device beginning January 1, 2013.
- ◆ Impose a penalty on individuals without acceptable health coverage of 2.5% of adjusted income above the filing threshold up to the cost of the average national premium for self or family coverage as listed under the **Health Insurance Exchange** beginning January 1, 2013.

## COST CONTAINMENT

The Act identifies a variety of measures congressional representatives believe will help stabilize and better control the escalation of healthcare costs. Some of these measures, many of which impact Medicare, include:

- ◆ Modify the Medicare provider reimbursement structure.
- ◆ Reduce Medicare payments for potentially preventable hospital readmissions beginning October 1, 2011.
- ◆ Revise the payment structure for Medicare Advantage plans beginning in 2011 and impose new underwriting requirements on these plans beginning in 2014.
- ◆ Incorporate the voluntary PhRMA agreement to discount brand-name drugs, used by Part D enrollees in the coverage gap, by 50% beginning in 2010.
- ◆ Negotiate the cost of drugs for Medicare D plans directly between the Secretary of Health & Human Services and the pharmaceutical manufacturers.
- ◆ Restructure the Medicaid reimbursement allotment to the states.
- ◆ Reduce fraud, waste and abuse through various new programs and increase penalties for violations.
- ◆ Simplify health insurance administration by adopting standards for financial and administrative transactions.

## NEXT STEPS

Employers and plan sponsors should continue to monitor

the progress of healthcare reform as it winds through the legislative process. Much work will need to be done to actually implement a final version of any enacted legislation. In the meantime, employers and plan sponsors should focus on the tasks at hand and address benefit plan issues and challenges in today's environment.

## ADDITIONAL INFORMATION

For specific questions concerning information contained in this *Insights*, please contact your Chernoff Diamond consultant.

Information contained in this *Insights* is not intended to render tax or legal advice. Employers should consult with qualified legal and/or tax counsel for guidance in respect of matters of law, tax and related regulation.

Chernoff Diamond provides comprehensive consulting and administrative services with respect to all forms of employee benefits, risk management and qualified and non-qualified retirement plans.

For additional information about our services please contact us at (516) 683-6100 or via e-mail at [mail@chernoffdiamond.com](mailto:mail@chernoffdiamond.com).