



SENATE PASSES THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (H.R. 3590)

January 2010

*ON THURSDAY DECEMBER 24, 2009 THE SENATE PASSED H.R.3590, **THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE SENATE ACT)**, BY A VOTE OF 60 – 39. WITH THIS VOTE, THE STAGE IS SET FOR THE HOUSE AND SENATE TO RECONCILE THE DIFFERENCES BETWEEN THE HEALTHCARE REFORM BILLS PASSED IN EACH CHAMBER AND PRESENT A FINAL BILL FOR PRESIDENT OBAMA TO SIGN INTO LAW. THIS **INSIGHTS** WILL HIGHLIGHT THE KEY PORTIONS OF THE SENATE ACT AND WILL FOCUS ON THOSE ISSUES THAT WILL HAVE THE MOST IMPACT ON INDIVIDUAL EMPLOYEES AND EMPLOYER-SPONSORED PLANS.*

A summary of the House of Representatives healthcare reform bill (H.R. 3962) can be found in our November 2009 *Insights* at http://www.chernoffdiamond.com/insights_news_alerts_list_GHW/. For easy reference and comparison, where possible, this Senate Act *Insights* will follow the same format as our summary of the House bill.

CURRENT STATUS

As of this writing, there is speculation that a final bill will be crafted to more closely resemble the Senate's version of healthcare reform. In order to move the reconciliation process along, Democratic leaders have opted to hold high-level negotiations among themselves rather than iron out the differences between the House and Senate bills in a bipartisan conference committee.

There has been some buzz that implementation of the coverage requirements, generally slated for **January 1, 2014** in the Senate Act, should be accelerated to help expand coverage to those in need as quickly as possible.

To further complicate the process, several groups are considering the possibility of filing lawsuits to challenge the constitutionality of certain Senate Act provisions, the most notable being:

- ◆ Requiring individuals to purchase a product (health

insurance) from a private source or pay a tax penalty, and

- ◆ Exempting Nebraska (Senator Bob Nelson's state) from certain Medicaid obligations which other states are required to adhere.

EXPANDING COVERAGE

The Senate Act includes the following provisions to help assure that individuals have access to healthcare coverage:

- ◆ Require most U.S. citizens and legal residents to have health insurance,
- ◆ Create state-based **American Health Benefit Exchanges** through which certain qualifying individuals can purchase coverage,
- ◆ Establish separate Exchanges where small businesses can purchase coverage,
- ◆ Mandate employers (except certain small employers) to provide coverage or pay penalties for employees who receive tax credits for Exchange-based coverage,
- ◆ Impose cost and design regulations, and
- ◆ Expand Medicaid eligibility.

INDIVIDUAL MANDATE

As of January 1, 2014, most U.S. citizens and legal residents will be required to have "qualifying health coverage" or be subject to a phased-in tax penalty equal to the greater of:

- ◆ A flat dollar penalty of \$95 in 2014, \$495 in 2015, and \$750 in 2016 (3-times this amount for family coverage), or
- ◆ A percentage of household income starting at .5% in 2014, 1% in 2015 and 2% in 2016.

The penalty will be adjusted each year for cost-of-living beginning in 2017. Certain exemptions will apply for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals and those with incomes below stipulated levels.

HEALTH INSURANCE EXCHANGES

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In order to purchase qualified health coverage beginning January 1, 2014, the Senate Act establishes state-based **American Health Benefit Exchanges** for individuals and **Small Business Health Options (SHOP) Exchanges** for employers with up to 100 employees. The Exchanges would be administered by a government agency or non-profit organization. Beginning in 2017, each state would have the authority to allow employers with more than 100 employees the ability to purchase coverage in the SHOP Exchange. States would also have the ability to create regional, multi-state Exchanges.

The Senate Act creates four benefit categories to be offered through the Exchange (and in the individual and small group market) as well as a separate catastrophic plan for young adults up to age 30. The benefit design categories are as follows:

- ◆ The *Bronze Plan* covers the essential health benefits which must be offered. The plan's comprehensive services must cover at least 60% of the actuarial value of the benefits. Annual cost sharing is set at the current HSA limits (\$5,950 for an individual in 2010). The Secretary of Health and Human services would be responsible to review and update the essential benefits package each year.
- ◆ The *Silver, Gold and Platinum Plans* would cover at least 70%, 80% and 90% of the actuarial value of the benefits, respectively, with out-of-pocket costs set at the current HSA limits.
- ◆ The *Catastrophic Plan*, available to individuals up to age 30 and those who are exempt from the individual mandate, provides catastrophic coverage as well as some basic preventive services. This plan is only available in the individual market.

At a minimum, beginning January 1, 2014, the essential health benefits package must be offered through the Exchanges as well as in the individual and small group markets outside the Exchange (except grandfathered individual and employer-sponsored plans). All new policies would also be required to comply with one of the four benefit category designs. Existing employer-sponsored plans would be exempt from having to meet the new benefit design standards.

EMPLOYER REQUIREMENTS

Employers with more than 50 employees would be required to offer coverage or pay a penalty of \$750 per full-time employee if at least one full-time employee receives a federal premium tax credit. Employers with 50 or more employees who offer coverage and have at

least one full-time employee receiving a federal premium tax credit, would be responsible to pay the lesser of (i) \$3,000 for each employee receiving the credit or (ii) \$750 for each full-time employee.

Employers that offer coverage would be required to provide a "free choice voucher" to any employee who enrolls in an Exchange Plan and meets the following criteria:

- ◆ Has income less than 400% of the Federal Poverty Level, and
- ◆ The employee's contribution for healthcare coverage is greater than 8% but less than 9.8% of income.

The voucher would be equal to the employer's share of the healthcare premium and would be used to offset the premium under the Exchange plan. Employers providing vouchers would not be subject to the penalties for any employee who receives premium credits in the Exchange.

Employers with 200 or more employees would be required to automatically enroll employees into health plans. Employees would still have the ability to opt out of coverage.

Large employers with more than 100 employees would not be allowed to have a health plan with a waiting period in excess of 90 days. Those who impose a waiting period would be subject to a tax of \$400 for any full-time employee in a 30 – 60 day waiting period and \$600 for any full-time employee in a 60 – 90 day waiting period.

The employer requirements under the Senate Act would become effective January 1, 2014.

EMPLOYER AND INDIVIDUAL PREMIUM SUBSIDIES

The Senate Act provides a phased-in tax credit for small employers with no more than 25 employees and annual average wages of less than \$50,000 who offer coverage to their employees as follows:

- ◆ **Phase I** would be effective for tax years 2010 – 2013 and provide a tax credit up to 35% of the employer's contribution toward employees' healthcare coverage if the employer contributes at least 50% of the total cost or 50% of a benchmark premium.

Employers with 10 or fewer employees and average annual wages of less than \$25,000 would be eligible for a full tax credit.

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Phase II would take effect beginning in 2014 and would allow small businesses who purchase coverage through the Exchange to receive a tax credit of up to 50% of the employer's contribution toward employees' healthcare coverage as long as the employer contributes at least 50% of the cost. This credit is available for two years. Similar Phase I credit amounts are also available to small employers and tax-exempt employers who satisfy the same Phase I criteria.

Premium credits and cost-sharing subsidies, similar to those created under the House bill, would also be available for lower income individuals and families (up to 400% of the Federal Poverty Level) who purchase coverage through the Exchanges. The **Premium Credit** would help defray the cost of coverage and would limit an individual's healthcare contribution to a range of 2.8% to 9.8% of income. The **Cost-Sharing** subsidies would further limit the out-of-pocket costs under the plan and basically increase the value of the benefits provided under the Exchange plans.

Employees who are offered coverage by an employer are not eligible for Premium Credits unless the employer's plan:

- ◆ Has an actuarial value less than 60%, or
- ◆ The employee's contribution for healthcare coverage is greater than 9.8% of income.

The individual subsidies are scheduled to become effective on January 1, 2014.

THE PUBLIC OPTION

The Senate Act does not establish a federal-style, public plan option. However, the **Office of Personnel Management** would be required to contract with insurers to offer at least two multi-state plans in each Exchange with at least one plan offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond what is permitted by federal law.

MISCELLANEOUS REQUIREMENTS

Additional provisions contained in the Senate Act include:

- ◆ The Secretary of Health and Human Services will establish the guidelines for imposing Annual Benefit Limits in health plan designs. The limits will be reviewed each year until January 1, 2014, at which time annual limits will no longer be allowed.
- ◆ Establish a temporary reinsurance fund (effective 90

days after enactment through January 1, 2014) of \$5 billion to help employers defray the cost of benefits provided to retirees over age 55 who are not eligible for Medicare. The fund will pay 80% of claims between \$15,000 and \$90,000.

- ◆ Effective within 90 days of enactment, establish a temporary high-risk pool to provide subsidized coverage to those individuals who have pre-existing conditions and have been without insurance for at least 6 months.
- ◆ Effective 6 months after enactment, require qualified health plans to provide preventive services (as defined by the U.S. Preventive Services Task Force) without cost-sharing.
- ◆ Dependent coverage would be extended for children up to age 26 beginning 6 months after enactment.
- ◆ Prohibit plans from placing lifetime limits on benefits beginning 6 months after enactment.
- ◆ For plan years beginning in 2010, states must establish a process to review health insurance premium increases.
- ◆ Beginning January 1, 2010, health plans would be required to report the proportion of premium dollars spent on providing healthcare services, and one year later must begin to provide rebates to consumers if the amount of premium dollars spent on providing services fails to meet certain criteria.
- ◆ Increase the Medicare Part D coverage limit to reduce the coverage gap beginning January 1, 2010.
- ◆ Higher income retirees would be required to pay larger premiums for Medicare prescription drug coverage under Part D beginning in 2011.
- ◆ Only allow prescribed drugs to be reimbursable through healthcare savings arrangements (FSA, HSA, and HRA,) beginning January 1, 2011.
- ◆ Implement new W-2 and other reporting requirements beginning with tax year 2011.
- ◆ Establish a voluntary long-term care insurance program which pays \$50 per day for certain services (CLASS program) financed through payroll deduction, with automatic enrollment beginning January 1, 2011. Employees would be eligible to opt-out of the program.
- ◆ Beginning January 1, 2014, limit the annual deductible in the small group market for single coverage to \$2,000 and \$4,000 for families, unless contributions are offered to help offset the deductible.
- ◆ Additional insurance market reforms such as elimination of pre-existing condition limitations become effective January 1, 2014.

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- ◆ Enhance wellness program rewards beginning January 1, 2014.
- ◆ Require certain nondiscrimination testing for all self-funded as well as fully insured plans.

COST AND FINANCING

The Congressional Budget Office (CBO) has put the price tag for the Senate Act at **\$871 billion** over 10 years. The CBO estimates that funding for the Senate Act will come from a combination of new fees, taxes and other savings, most notably from changes to Medicare.

The Senate Act imposes new fees on various healthcare industries and incorporates new taxes to fund the legislation which include the following:

- ◆ Impose a 40% excise tax (“Cadillac Tax”) on plans (insured and self-insured) based on the aggregate value in excess of \$8,500 for individuals and \$23,000 for families beginning January 1, 2013. Certain adjustments apply for retired participants, high-risk professions and for 17 states with the highest health-care cost. The determination of “aggregate value” includes dental, vision, and other supplementary premiums, FSA and HRA reimbursements, and employer contributions to HSAs.
- ◆ Increase the HSA tax from 10% to 20% for distributions not used to pay for qualified medical expenses beginning January 1, 2011.
- ◆ Impose a maximum annual contribution limit of \$2,500 (adjusted annually by cost-of-living) on Flexible Spending Accounts beginning January 1, 2011.
- ◆ Increase the Medicare Part A tax from 1.45% to 2.35% on earnings over \$200,000 for individuals and \$250,000 for married couples beginning January 1, 2013.
- ◆ Increase the itemized deductions for unreimbursed medical expenses from 7% of adjusted gross income to 10% beginning January 1, 2013.
- ◆ Assess annual fees of \$2.3 billion on drug manufacturers beginning December 31, 2008; \$2 billion on medical device manufacturers beginning January 1, 2010; and \$2 billion on insurers and third-party payers beginning in 2011 increasing to \$10 billion in 2017.
- ◆ Impose a 10% tax on indoor tanning services beginning January 1, 2010.

COST CONTAINMENT

Supporters of the Senate Act believe the following

measures, many of which are similar to the House bill, will help control the growth of healthcare spending:

- ◆ Modify the Medicare provider reimbursement structure.
- ◆ Restructure payments to Medicare Advantage plans.
- ◆ Beginning July 1, 2010, provide Medicare Part D enrollees a 50% discount on brand-name prescriptions filled in the coverage gap, other than those who receive subsidies or those with income above \$85,000 for individuals or \$170,000 for joint filers.
- ◆ Reduce Medicare payments to hospitals for preventable readmissions beginning October 1, 2012.
- ◆ Freeze the threshold for income-related Part B premiums from 2011- 2019 and reduce the Medicare Part D subsidy for higher earning retirees beginning January 1, 2011.
- ◆ Restructure the Medicaid reimbursement allotment to the States.
- ◆ Simplify health insurance administration by adopting standards for financial and administrative transactions.

NEXT STEPS

The House and Senate leadership are in the final stages of completing a reconciled bill with the goal to present legislation to President Obama prior to the 2010 State of the Union address (expected by early February). As of this writing, the Democratic House and Senate negotiations have produced certain compromises, including a higher “Cadillac Tax” premium threshold, and a delayed implementation of the tax for collectively bargained plans. The CBO will prepare updated cost estimates as new developments unfold.

ADDITIONAL INFORMATION

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

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