

Senate Passes Health Reform Bill

On December 24th, with a vote of 60 to 39, the Senate passed the "Patient Protection and Affordable Care Act" after nearly one month of floor debate. A 383-page manager's amendment was added to the original bill containing a variety of provisions to secure the support of 60 Senators, thus allowing a final vote on the bill. The CBO estimates that this bill will cost \$871 billion over ten years and cover 31 million of the 54 million uninsured. To offset the cost of the legislation, the bill places a 40% excise tax on "high value" employer-based plans (insured and self funded) valued at over \$8,500 for individuals and \$23,000 for families, places annual fees on pharmaceutical companies, medical device manufacturers, and health insurers (excluding some non-profit plans), increases the Medicare FICA tax by 0.9% on income over \$200,000 for singles and \$250,000 for couples, changes HSA and FSA rules, increases the threshold for individual tax deductibility of medical expenses to 10%, sets a 10% tax on tanning bed services, reduces spending for the Medicare Advantage program, reduces provider payment rates under Medicare, and secures rebates for Medicaid and discounts for Medicare Part D from pharmaceutical companies. Details of the Senate bill include:

- **Insurance Market Rules Effective Within Six Months of Enactment:** Several insurance market rules take effect within six months of enactment, including review of health plan premiums by state departments of insurance and HHS, prohibition of lifetime benefit limits and "restricted" annual limits, a requirement that plans that cover dependents cover children through the age of 25, prohibition of waiting periods exceeding 90 days, a requirement that all individual and group plans cover preventive services without cost-sharing, prohibition of pre-existing condition exclusions for children under 19, and prohibition of coverage cancellation or rescission except in cases of fraud. Prior to the implementation of new market rules in 2014, the bill also establishes high risk pool provisions for individuals who can not obtain coverage due to health status and creates a reinsurance program for employer coverage of early retirees. Provisions related to lifetime and annual limits, dependent coverage, waiting periods, preventive services, and retiree reinsurance apply to insured and self funded plans.

- **Insurance Market Rules Effective in 2011:** The bill sets up a 80% medical loss ratio (MLR) for individual and small group plans and a 85% MLR for large group plans. Certain non-profit plans must meet higher MLR standards to be exempt from the annual fee on health insurers. The definition of small group follows current state law until 2014, when small group is defined as 100 employees unless a state limits the definition to 50 employees before 2017. These requirements apply to health plans inside and outside of Exchanges, including “grandfathered plans.”
- **Insurance Market Rules Effective Starting in 2014:** Reforms that require guarantee issue and renewal during an open enrollment period, establish risk sharing mechanisms (partly funded by insured and self funded health plans), prohibit annual limits (insured and self funded), prohibit pre-existing condition exclusions as well as premium variations based on health status, and limit premium variation to tobacco use, age (3:1 band), geography, and family composition apply to individuals and small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 with expanded Exchange eligibility starting in 2017). States can pass legislation to form “Health Care Choice Compacts” to allow the purchase of individual insurance across state lines.
- **Multi-State Plans and CO-OPs:** The Senate bill establishes “Multi-State Plans” in 2014 to compete with private insurers in state Exchanges. The Office of Personnel Management (OPM) will enter into contracts and negotiate premiums and other conditions with at least two private health plans (health plans may voluntarily participate and at least one must be non-profit) to create Multi-State individual and small group plans to be offered in every state by 2017. The bill also provides start-up funding to establish non-profit member-governed health plans (CO-OPs) not currently in existence to compete with private insurers and Multi-State Plans in Exchanges. CO-OPs and Multi-State Plans must comply with the same rules as other plans in Exchanges. States are not required to establish CO-OPs.
- **State Exchanges:** The Senate bill establishes state-based “Exchanges” in 2014 for individuals without access to affordable group coverage (and not eligible for Medicare or Medicaid), small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 starting in 2017), and CHIP eligibles if benefit plans are

similar. State Exchanges are designed to facilitate comparison shopping, enrollment, and subsidy administration and certify plans for participation that meet established standards and rules, including reasonable rate increases. Participation is voluntary.

- **Benefit Plans:** Individuals and small groups to size 100 (states may limit small groups to 50 and may increase beyond 100 with expanded Exchange eligibility starting in 2017) have a choice of up to five plan types including “Bronze” (60% actuarial value), “Silver” (70% actuarial value), “Gold” (80% actuarial value), “Platinum” (90% actuarial value) and “Young Invincible” (catastrophic plan available for adults under 30 and for those whom a Bronze premium would exceed 8% of income). Individuals between 133% and 200% of the federal poverty level without access to employer coverage would be enrolled in a state-negotiated “Basic Plan” where available. HHS establishes and updates benefit plan definitions through a public process, but states may establish additional benefit rules as long as additional subsidy costs are state paid. Out-of-pocket spending is limited to HSA limits for individual and group plans (insured and self funded). **Wellness incentives up to 30-50% of the cost of coverage are allowed for group plans (insured and self funded).**
- **Coverage Mandates, Penalties, and Subsidies:** In 2014, individuals are required to have coverage through a “grandfathered plan,” a large group plan, a government program (Medicaid, Medicare, and the like), or through an individual or small group plan that meets minimum requirements (“Bronze” plan or “Young Invincible” plan for those under age 30), or pay a penalty. The penalty is the greater of a flat dollar amount (\$95 in 2014 phased-in to \$750 by 2016) or a percent of income (0.5% in 2014 phased-in to 2.0% by 2016). Waivers of the penalty are allowed for Native Americans, those with religious objections, and individuals with a financial hardship defined as premiums exceeding 8% of income. Individuals up to 400% of the federal poverty level (\$88,000 for a family of four) are eligible for premium and cost-sharing subsidies. Employers are not required to offer coverage, but those with 50 or more employees not offering coverage are required to pay a \$750 fee for employees obtaining a subsidized plan through an Exchange. Employers offering coverage must pay up to a \$3,000 fee for employees obtaining subsidized coverage through an Exchange. Those

employers offering coverage must also provide tax-exempt “free choice vouchers” to qualifying employees (whose premium contribution would be between 8% and 9.8% of their income) to purchase coverage through an Exchange that is equal to the contribution the employer would have made to its own plan. Employers are also assessed a \$600 fee per employee for imposing a waiting period exceeding 60 days. Low wage employers (average salary less than \$50,000) with 25 or less employees are eligible for up to a 50% premium credit for two years if they pay for at least 50% of the premium.

- **State Waivers:** States can seek a waiver from HHS starting in 2017 to adopt their own rules in lieu of the new federal standards related to benefit requirements, Exchanges, and coverage mandates as long as the state standards would result in similar outcomes and not increase the federal deficit.
- **Medicaid and the Children’s Health Insurance Program (CHIP):** Medicaid eligibility is expanded to 133% of the federal poverty level for all individuals in 2014 with full federal funding of the expansion until 2017 (up to 95% federal funding thereafter that varies by state). States are required to maintain existing Medicaid and CHIP eligibility. Funding for CHIP is extended to 2015 when states can enroll CHIP eligible children into private coverage through an Exchange if the benefits are similar to those under CHIP.
- **Medicare:** The Senate bill changes the payment structure for Medicare Advantage by reducing payments, creating a competitive bidding process, and providing financial incentives for care coordination programs and quality achievement. Pharmaceutical manufacturers provide a 50% discount for brand name drugs purchased in the “donut hole” or coverage gap under Part D and the income subsidy exclusion for employers who maintain prescription drug plans for Part D eligible retirees is eliminated. The bill also links provider payments to quality outcomes, creates pilot programs for coordinated care delivery models, establishes a new “Innovation Center” to test and implement new provider payment methods, and changes payment incentives to reduce hospital acquired infections and preventable readmissions. Annual provider payment updates are reduced for Medicare Part A and B and an independent “Payment Advisory Board” is established to report on system-wide health care costs, access, and quality and recommend policy changes to slow

the rate of national health care spending growth and limit the rate of growth in Medicare spending.

Brief Comparison of Senate and House Health Reform Bills

Issues	Senate	House
10 Year Cost	\$871 Billion	\$1.052 Trillion
Coverage by 2019	31 of 54 Million uninsured covered	36 of 54 Million uninsured covered
Financing	<ul style="list-style-type: none"> ▪ 40% tax on “high value” plans* ▪ Fees on insurers & drug & medical device makers ▪ Changes in HSA & FSA rules <ul style="list-style-type: none"> ▪ 10% tanning bed service tax ▪ 0.9% increase in Medicare FICA tax ▪ 10% individual tax deductibility for medical expenses ▪ Medicare provider & Medicare Advantage cuts ▪ Medicaid rebates & Part D discounts from drug makers 	<ul style="list-style-type: none"> ▪ 5.4% income surcharge ▪ 2.5% medical device tax ▪ Changes in HSA & FSA rules ▪ Medicare provider & Medicare Advantage cuts ▪ Medicaid & Part D rebates/discounts from drug makers
Insurance Market Rules	<ul style="list-style-type: none"> ▪ 2010: rate review, no lifetime limits*, “restricted” annual limits*, dependents to 26*, no waiting periods*, no cost-sharing for prevention*, no rescissions, no pre-ex for kids to 19, interim high risk pool & retiree reinsurance* ▪ 2011: 80% & 85% MLR provisions ▪ 2014: guarantee issue & renewal, risk sharing*, no annual limits*, no health status rating or pre-ex, rating only for tobacco, age (3:1), family size, & geography (rating FI to size 100, states may limit to 50, maybe 100+ starting 2017) ▪ Allows health plans to sell individual market plans across state lines 	<ul style="list-style-type: none"> ▪ 2010: rate review, 85% MLR, no lifetime limits*, dependents to 27*, no cost-sharing for prevention*, no rescissions, interim pre-ex limitations, COBRA eligibility extension*, high risk pool, & retiree reinsurance* ▪ 2013: guarantee issue & renewal, no annual limits*, no health status rating or pre-ex, rating only for age (2:1), family size, & geography (rating all FI, groups phased-in by 2018), ▪ Allows health plans to sell individual market plans across state lines
Public Plan/CO-OPs	<ul style="list-style-type: none"> ▪ No public plan; Federal OPM agency negotiates national Multi-State Plans & premiums w/private plans ▪ State non-profit CO-OPs 	<ul style="list-style-type: none"> ▪ National public plan with provider rates negotiated within a corridor & provider opt out ▪ State non-profit CO-OPs
Exchange	<ul style="list-style-type: none"> ▪ State/regional based, run by states ▪ Individuals, CHIP, & small groups to size 100 (states may limit to 50 & increase to 100+ in 2017) eligible ▪ Facilitates comparisons, enrollment, & subsidies ▪ Regulates Exchange rules ▪ Certifies plans meeting standards for participation 	<ul style="list-style-type: none"> ▪ National with state/regional option, run by new HCA federal agency separate from HHS and DOL ▪ Individuals, CHIP, & groups to size 100 phased-in by 2015 (possibly all groups starting 2015) eligible ▪ Facilitates comparisons, enrollment, & subsidies ▪ Regulates Exchange rules ▪ Decides plan participation & negotiates premiums
Benefit Plans	<ul style="list-style-type: none"> ▪ 60% minimum actuarial value ▪ “Young Invincible” catastrophic plan ▪ State “Basic Plan” option for 133%-200% FPL ▪ Applies to individuals & small groups to size 100 (states may limit to 50 & increase to 100+ in 2017) ▪ Individuals & groups can “grandfather” plan* ▪ 30-50% wellness incentives* 	<ul style="list-style-type: none"> ▪ 70% minimum actuarial value ▪ Applies to individuals & all groups (phased-in by 2018) ▪ Individuals may “grandfather” plan; employers must offer at least minimum plan by 2018*
Mandates, Subsidies, & Penalties	<ul style="list-style-type: none"> ▪ Individual mandate in 2014, penalty phased-in from 2014 to 2016 to greater of \$750 or 2% of income ▪ Waiver from penalty for Native Americans, religious objection, & hardship (8% of income) ▪ Subsidies up to 400% FPL in state Exchanges ▪ No employer mandate, but employers 50+ must pay for employees getting subsidies, “free choice vouchers”, & waiting periods* ▪ 2 year subsidy for low wage small employers 	<ul style="list-style-type: none"> ▪ Individual mandate in 2013, penalty is 2.5% of income ▪ Waiver from penalty for Native Americans, religious objection, & hardship (12% of income) ▪ Subsidies up to 400% FPL in Exchange ▪ Employer mandate to pay 72.5% individual/65% family, penalty is 8% of wages* ▪ 2 year subsidy for low wage small employers
Medicaid & CHIP	<ul style="list-style-type: none"> ▪ Eligibility expanded to 133%, more fed funding ▪ States must maintain eligibility ▪ CHIP may go in Exchange if benefits similar 	<ul style="list-style-type: none"> ▪ Eligibility expanded to 150%, more fed funding ▪ States must maintain eligibility ▪ CHIP in Exchange ▪ ARRA funding to June 2011
Medicare & Medicare Advantage (MA)	<ul style="list-style-type: none"> ▪ MA competitive bidding; quality & coordination bonus ▪ Employer Part D income subsidy exclusion eliminated* ▪ Payment “ Innovation Center” ▪ “Payment Advisory Board” to limit spending growth ▪ Care coordination pilots ▪ Hospital payment tied to quality ▪ Payment penalties to reduce hospital readmits 	<ul style="list-style-type: none"> ▪ MA payments 100% FFS; quality bonus some markets ▪ Employer Part D income subsidy exclusion eliminated* ▪ Payment “ Innovation Center” ▪ Care coordination pilots ▪ Payment penalties to reduce hospital readmits ▪ Government negotiation of drug prices for Part D

* Denotes impact to insured & self funded plans.