HEFFERNAN INSURANCE BROKERS

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DATE: November 16, 2009

TO: Our Valued Client Partners & Friends

FROM: HIB Account Team

RE: **LEGISLATIVE UPDATE 2009-18**
The House Reform Bill: Another Tree Falls

We are pleased to bring you our **Legislative Update 2009-18: The House Reform Bill: Another Tree Falls.** In the following Legislative Update, we have recapped some of the major points of the House version of the Health Reform Bill, H.R. 3962

We will continue to keep you informed of progress on this matter as it occurs, and please, if you have any questions, contact your HIB Account Team for assistance.

The House Reform Bill
Another Tree Falls

Between the length of the House version of the Health Reform Bill (H.R. 3962) and the focus of both print and electronic media on the topic, we are all on overload. We all struggle with the concept of keeping things simple when it comes to health reform proposed legislation. The purpose of this update is to provide an outline of the key elements of H.R. 3962, "Affordable Healthcare for America Act" (House Bill), in an easy to read format, albeit lengthy.

THE PROCESS

As we all know, the U.S. Senate will now join the fray. If it passes its version of Health Reform (and some say the Senate may not be able to do so), then a Conference Committee composed of members of both Houses must merge the two bills and present a unified version to both Houses for a final vote. Few anticipate that this will happen before January, just ahead of the beginning of the mid-term election season.

LAST SATURDAY

Representative Bart Stupak introduced an amendment to prohibit federal funding of abortion in health coverage available through the "Exchange" or through the "Public Option" program. The House adopted this amendment by a vote of 240-194, setting the table for passage of the final bill, late Saturday evening. Some salad spinners believe this amendment will be a flash point in the Senate debate. Most believe it will survive.

THE KEY PROVISIONS

1. **Individuals (Effective 2013):**

   - **Coverage Mandate**. All citizens and documented residents must obtain health insurance if it is not provided through employment. This would leave approximately 10 million undocumented aliens without insurance (down from an estimated 50 million currently). Individuals with existing health plan coverage can keep their current policies. All would have access through the Exchange (discussed below) or directly through the individual insurance market.
   - **Subsidy**. For individuals with incomes under 400% of the federal poverty level (in 2009: single, $43,420; family, $88,000) the federal government would provide financial assistance. Employers with annual payrolls in excess of $500,000 would be required to pay a payroll tax to help fund the subsidy.
   - **Penalty**. The penalty to the individual for not having qualifying health coverage will be 2.5% of adjusted gross income above a statutory threshold. It would be collected on individual tax returns.

2. **Employers (Effective 2013):**

   - **Coverage Mandate**. Employers with $500,000 or more of annual payroll must offer acceptable health care coverage or make an insurance contribution on behalf of eligible employees set at 8% of payroll for employers with annual payrolls in excess of $750,000. The penalty would be graduated for annual payrolls between $500,000 and $750,000.
   - **Employer Premium Contributions**. Employers providing coverage must contribute at least 72.5% of the cost of single coverage and 65% of the cost of family coverage for full-time employees and a lesser amount for part-time employees.
   - **Automatic Enrollment**. Employers must enroll all eligible employees with the lowest applicable premium in the absence of an employee election or an employee's affirmative opt-out of coverage. Election periods must be at least 30 days.
   - **Eligible Employee**. This term is not defined in the House Bill, but most expect that it will include part-time employees.
   - **Eligible Dependents**. The House Bill would require dependent coverage to age 27 (i.e. birthday), regardless of student status, as long as they are dependents. (This provision would take effect as of 2010). We discuss this in the Insurance Market Reforms.
   - **Excise Tax**. The House Bill would impose an excise tax of $100/day/employee on employers who elect to provide coverage to their employees but fail to do so.

3. Health Insurers (Effective 2013):

- **Qualified Health Benefit Plan**. To be considered a "Qualified Health Benefit Plan" an insurance plan must meet certain criteria including affordability, inclusion of essential benefits, and compliance with consumer protection requirements.

  a. *Affordability* includes the following elements:
  - Absolute bar on exclusion for pre-existing conditions;
  - Guarantee issue and renewal;
  - Out of pocket limits not exceeding $5,000 per individual ($10,000 per family);
  - Premium variations on gender health status or occupation prohibited;
  - Age rating limited to a 2 to 1 ratio for elderly versus youth;
  - Must be non-discriminatory;
  - Must provide for mental health parity;
  - Adequate provider networks, if offered, with transparent cost-sharing provisions and permitting of out network options; and,
  - 90 days notice requirement in the event of a reduction in coverage or increase in contributions.

  b. *Essential Benefits Package* is defined to be a package offering inpatient and outpatient hospital services, professional services, equipment and supplies, drug coverage, rehabilitative services, preventive services, maternity, well baby and child care, and coverage for durable medical equipment.

  c. Health Benefits Advisory Committee for adoption of standards (by 2011); Health and Human Services (HHS) would have 45 days to say yes or no.

  d. Minimum benefits package could not require inclusion for abortion services.

- **Compliance**. The House Bill would give "non-exchange" insurers five years (up to 2018) to comply with these standards.

- **Direct Primary Care Medical Home Plans**. Direct Primary care medical homes (DPM) practices offer patients comprehensive primary care coverage outside of traditional insurance and include preventive and primary care as well as chronic disease management. Care is coordinated with specialists and hospitals. Beneficiaries in a DPM program pay a flat monthly fee in lieu of a premium to cover primary care and preventive services. It is specified that enrollees in a DPM must also obtain wrap-around insurance to cover non-DPM provided services.

4. Insurance Market Reforms (Effective 2010):

- **National High Risk Pool Program.** Health and Human Services (HHS) is to establish a high risk insurance pool to provide health benefits for individuals not eligible for Medicare or an employer based program and who have been denied coverage within the last six months

because of a pre-existing condition or other health status or whose coverage is limited because of their pre-existing condition. HHS could contract with the state HIPAA Guarantee Issue programs or launch its own. This program will also be available to participants in an employment-based retiree health plan if the annual premium increases exceeds "an excessive percentage" as determined by HHS. The High Risk Pool will cease to exist on the date the Health Insurance Exchange is established. The House Bill contains numerous additional provisions limiting how insurers set their premiums and benefit designs. It also prohibits illegal immigrants from participation in the High Risk Pool.

- **Requirements for Health Insurers:**

a. Premiums. Insurers in both small and large group markets must provide rebates to enrollees if claims loss ratios are below 85% (adjustable by HHS). This provision ceases to apply once the Health Insurance Exchange is established.

b. Review of Premium Increases. Each insurer will be required to submit actuarial justification for any premium increase to (HHS or state?) prior to implementing a rate increase. The justification must be placed prominently on the insurer's website and available for public disclosure! This review process will continue beyond the implementation of the Health Insurance Exchange.

c. Rescissions. Insurers will be permitted to rescind group or individual coverage only in the event of "clear and convincing" evidence of fraud as determined by a third party reviewer.

d. Coverage for Young Adults. Insurers must allow parents to continue coverage to age 27 for dependent children who would otherwise have no health coverage.

e. Pre-existing Conditions. As of January 2010, insurers may only use a 30 day look back rule. Currently the law allows insurers to look back six months for any treatment or diagnosis of an illness. As of January 2010, the maximum period for exclusion due to a pre-existing condition will be three (3) months rather than the current twelve (12) months. Also, late entrants will have a maximum exclusionary period of nine (9) months instead of eighteen (18) months.

f. Domestic Violence. Insurers may not limit or deny coverage as a pre-existing condition based on evidence of domestic violence.

g. Children with Deformities. Both individual and group plans must cover outpatient and inpatient diagnosis and treatment of a child's congenital or developmental deformity disease or injury. It also requires plans to cover necessary reconstructive surgeries to children age 21 or younger (other than those for cosmetic reasons.)

h. Elimination of Lifetime Benefit Limits. This bill bars both individual and group plans from imposing aggregate dollar lifetime benefits. Note this provision would take effect in January 2010.

i. Retiree Coverage. This bill also bars employer based group health plans from reducing benefits for retirees unless the same reduction is made for active employee in the same plan. It can, however, have a total aggregate cap on retiree health benefits, an apparent exception to the provision prohibiting lifetime benefit maximums.

j. COBRA Continuation. Upon the enactment of H.R. 3962, the maximum COBRA benefit period will be extended from its current 18 or 36 months to include the period between enactment and the establishment of the Health Insurance Exchange in 2013.

5. Retirees Reinsurance (Within 90 days of Enactment):

- The House Bill also requires HHS to establish a temporary reinsurance program that would provide reimbursement to employment-based plans to assist with the costs of providing health benefits to retirees and their spouses, surviving spouses, and dependents of retirees. The provision covers retirees who are 55 or older but ineligible for Medicare coverage. Plans would apply to HHS in order to participate in the program. HHS would reimburse plans for 80% of costs of a claim that exceeds $15,000, but less than $90,000, and provides for annual inflationary increases to those amounts. The House Bill establishes a Retiree Reserve Trust Fund with an appropriation of $10 billion to fund it.

6. The Health Insurance Exchange (Effective 2013):

- **Management**. Exchanges would be managed by the Healthy Choices Administration (new). Individual states or groups of states could apply to operate and manage their own exchanges.
- **Coverage**. The Exchange would market private plans electing to be offered through the Exchange, a Public Option, and Health Plan Cooperatives.
- **State Exchanges**. To qualify to operate its own exchange, the state (or states) must demonstrate the ability to do so and must operate without exceeding to relative cost of the federal government's Exchange.
- **Cooperatives**. Within six months of enactment, Healthy Choices Administration must establish a "Consumer Operated and Oriented Plan" program (CO-OP), through which grants and loans would be provided for the establishment and initial operation for a not-for-profit, member-run health insurance cooperative to provide insurance through the National Health Insurance Exchange or state based exchange. Existing co-ops will not qualify for grants or loans.

7. Eligibility for the Exchange:

- **Individual Eligibility**. To participate, an individual must not be enrolled in another health plan (including employer sponsored plans, TRICARE, Medicaid, or Medicare, and the like). Individuals eligible for CHIP would also not be eligible to participate in the Exchange.

- **Business Eligibility**. In 2013, business with less than 25 employees may join. In 2014, the limit is raised to 50 employees. In 2015, the limit will be 100 employees. Healthy Choices Administration may allow larger businesses to join after 2015.
- **Benefit Levels in the Exchange**. Once again, Health Choices Administration will specify the types of packages to be available. The House Bill requires four different offerings:

Title	Coverage
Basic Plan	70% of benefits costs
Enhanced Plan	85% of benefits costs and lower co-pays
Premium Plan	95% of benefits costs with yet even lower co-pays
Premium Plus Plan	Premium Plan plus dental and vision

- **Participating Entities**. Healthy Choices Administration would contract with insurers who meet certain standards such as affordable premiums, willingness to participate in risk pools, and no coverage for abortions.

8. The Public Option:

Under the House Bill, states may not opt out of the Public Option. The Senate Bill, at present, would allow it. As we all know, this element has raised controversy. Through the din, the House attempted to create an option to compete on a level playing field with private insurers, especially in geographic locations where one or two insurers dominate the market. The Congressional Budget Office estimates that 6 million people would be enrolled in the Public Plan by 2019 out of the 30 million participating in the Exchange.

- **Benefit Levels**. The Public Option must meet the same standard designs as available through other insurers inside the Exchange.
- **Contracting**. Health and Human Services (HHS) would do the contracting with providers and suppliers, much as it does now for Medicare.
- **Reimbursement**. Although the House Speaker preferred reimbursements to be the same as Medicare plus 5%, the House voted to require rates to be negotiated but never at an aggregated rate lower than the Medicare rate for the same services.
- **Networks**. The House Bill stipulates that participating Medicare providers would automatically be named participating providers in the Public Option plans, unless they opt out by 2013. There would be two classes of providers: Preferred (accepted negotiated rate as payment in full), and Non-preferred (agree not to impose patient responsibility amounts unless the total cost exceeds 115% of the negotiated rate).
- **Funding the Public Option**. The House Bill provides a $2 billion start up fund. The House intends to have the Public Option sustain itself through premium revenue. The Bill prohibits a "TARP" type bailout of the Public Option. Additionally, the House Bill appropriates whatever sums are necessary to cover 90 days worth of claims reserves based on projected

enrollment. The Public Option plan must repay this appropriation amortized over a 10 year period.

- **The Health Insurance Portability and Accountability Act (HIPAA)**. The House Bill also requires the Public Option to meet all standards set by HIPAA. It does not mention the Employee Retirement Income Security Act.

9. Funding

- **Taxes**:
  a. 5.4% surcharge on incomes exceeding $500,000 for single filers and $1,000,000 for joint filers. No indexing.
  b. 2.5% excise tax on the sale or lease of medical devices.
  c. Other taxes on fuels.
- **Reduction in Allowable Tax Free Benefits:**
  a. IRC Section 125 Flexible Spending Account (Health): $2,500 pre-tax limit for tax years beginning 2013.
  b. IRC Section 125, IRC Section 105 (Health Reimbursement Accounts), IRC Section 223 (Health Savings Accounts), and Archer MSAs: No deductions allowed for over the counter medicine for tax years **beginning 2011**.
- **Health Savings Account Penalty**. In the event HSA monies are used for a non-qualifying expense, the penalty is increased from 10% to 20% for tax years beginning in 2011.
- **Medicare Part-D**. Federal subsidies amounts for Part-D plans will no longer be shielded from plan sponsor income, effective for tax years beginning 2013.

ADDITIONAL PROVISIONS

In the over 2,000-page House Bill there are many other provisions relating to changes to Medicare, Medicaid, CHIP, Public Health, Prevent Care and Indian Health Care. It also provides for grants to states for covering the uninsured, and grants to small employers toward the cost of wellness programs.

RELATED MATTERS

1. **Applicability to Self-funded Plans**. At the present time, the House Bill occasionally uses the term “Plan” rather than the term “insurer” in its mandates. We are studying the House Bill’s provisions and public commentary to determine the applicability of such mandates as “no lifetime limits” to self-funded plans. We will keep you informed of developments here.

2. **Domestic Partner Coverage**. The House Bill would amend current law to allow coverage (not mandate) for domestic partners, either same sex or opposite sex, as well as the dependent children of any domestic partner, for tax years beginning 2010.

3. **Medical Malpractice**. The House Bill also clarifies that certain provisions (such as "Essential Benefit Package" requirements) cannot be used to set a standard of care in malpractice actions. Similarly, the Bill does not restrict state law in setting its own legal standard of care. In brief, each state can continue to create law governing medical malpractice.

Before we are through with Health Reform, whether achieved or not, whether overreaching or incremental, both Congress and ourselves will have vetted the issues confronting us. We will continue to report all significant developments as they emerge. For more information on this topic please visit our website at http://www.abferisa.com.

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