FACTS ABOUT THE PROPOSED HEALTH CARE REFORM LEGISLATION

Health care reform is President Obama's top legislative priority as he continues to invest much of his political capital in the issue. Early deadlines have come and gone but the Democratic leadership is confident they can pass a bill with or without bipartisan support.

Currently there are five legislative proposals, all with the goal of providing universal coverage while lowering health care costs. Both the House and the Senate have committees that are tasked with the responsibility of drafting proposed language to be considered in the final bill. In the Senate, the two committees of jurisdiction are the Committee on Finance and the Committee on Health Education, Labor and Pensions (HELP). In the House, the three committees of jurisdiction are the Committee on Ways and Means, the Committee on Energy and Commerce and the Committee on Education and Labor. Currently, all three committees in the House have approved H.R. 3200, known as America's Affordable Health Choices Act of 2009, and in September the Energy and Commerce Committee will review pending amendments to determine which of them will be added into the bill before it is merged with the bills from the other two committees. After the final version of H.R. 3200 is fully merged together, it will be presented to the House floor for a vote. If it passes, it will be sent to the Senate. The Senate HELP Committee has passed its own version of health care reform legislation and the Senate Finance Committee has yet to release a bill. The debate is expected to last through September.

HIGHLIGHTED ISSUES OF H.R. 3200

- All individuals would be required to purchase "qualified health benefits" and all employers would be required to offer it, exempting businesses with an annual payroll of $500,000. Employees of exempted firms would still be required to purchase benefits on their own.

- H.R. 3200 would create state-run health insurance exchanges that would allow shoppers, including eligible employers, to purchase health insurance from a variety of different health insurance providers, which will in turn mandate a minimum set of essential insurance benefits that each health insurance plan must offer.

- By eliminating the use of risk pools, insurance companies will have to use a community rating system, which would charge individuals a uniform rate regardless of conditions that may influence their risk of illness, such as age or lifestyle choices.

- The bill would provide health care credits to low income families and also expand Medicaid coverage.

- Finally, the most controversial and expensive portion of H.R. 3200 is the public option, the government's own insurance, which in theory would compete with private insurance companies to help drive down prices.

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DETAILED INFORMATION FOR EMPLOYERS ON H.R. 3200

1. **Employers Mandated to Provide Health Care Benefits.** Employers will be required to provide "Qualified Health Benefits" for all employees and their dependents. It is important to note that the current bill does not exclude part-time or temporary employees and fails to define part-time or temporary employees. Rules that would apply to the employers who choose to offer benefits include:

    - Employers could offer employment-based coverage, like many employers currently offer or they could offer coverage through an exchange plan if the employer is eligible to participate in the exchange. Eligibility requirements are defined later.

    - Current employment-based health plans would be grandfathered for five years, at which time any plan offered by the employer would then have to meet or exceed the minimum requirements of the essential benefits package, as defined later.

    - Employers would have to contribute at least 72.5 percent of the lowest cost, qualified benefits plan offered to single employees and 65 percent for those electing family coverage. This contribution would be prorated for part-time employees.

    - Employee contributions used to offset required employer contributions would not count as amounts paid by the employer.

    - Employers would be required to provide individual coverage by automatically enrolling their employees into the plan with the lowest associated employee premium. Employees could, however, select a different plan offered by the employer or choose not to accept the employer-based coverage at all.

2. **Penalties for Employers who do not Offer Health Care.** Employers would face penalties for not providing "Qualified Health Benefits" to their employees. The penalties would be in the form of taxes:

    - Two percent for businesses with annual payrolls of between $500,000 and $585,000;

    - Increase to four percent for businesses with annual payrolls of between $585,000 and $670,000;

    - Increase to six percent for firms with annual payrolls of between $670,000 and $750,000; and

    - Eight percent for businesses with payrolls over $750,000.

3. **Exemptions to Employer Mandate.** Employers with annual payrolls that do not exceed $500,000 would be exempt from the requirement to provide health insurance to their workers. Employees of these firms would be mandated to purchase "Qualified Health Benefits" through the exchange or pay an individual income tax penalty.

4. **When Employees Decline Employer-Provided Coverage.** If the employer offers coverage, but the employee declines and chooses to obtain coverage through the exchange, then the employer must pay

the payroll tax penalty of up to eight percent, unless otherwise exempt. The penalty would not be required for an employee who was covered under a spouse or dependent plan.

5. **"Qualified Health Benefit Plans" Standards.** The new federal health insurance standards would do the following:

   - Prohibit coverage exclusions of pre-existing health conditions;
   - Require premiums to be determined using adjusted community rating rules, which prohibit issuers from pricing health insurance policies based on health factors;
   - Require coverage to be offered on both a guaranteed issue and guaranteed renewal basis;
   - Impose new, non-discrimination rules; and
   - Comply with a medical loss ratio; the portion of health plan revenue that does not cover administrative or marketing expenses, taxes and profits.

   If an employer offers coverage other than the "qualified" plan, they can be assessed a penalty of up to $100 per day/per employee.

   A newly created Health Choices Commissioner would set many of the standards. Health plans that are subject to collective bargaining agreements are exempted from the additional requirements through the expiration of the agreement or one year after enactment of the legislation, whichever is later.

6. **"Essential Benefits Package" Requirements for "Qualified Health Benefit Plans."** Cost-sharing under the essential benefits package would be designed so that the plan covers approximately 70 percent of the full value of benefits in the essential benefits package; "Qualified Health Benefit Plans" could cover a higher percentage. The essential benefits package would be required to cover the following items and services:

   - hospitalization;
   - outpatient hospital and clinic services, including emergency department services;
   - services of physicians and other health professionals;
   - services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;
   - prescription drugs;
   - rehabilitative and "habilitative" services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
   - mental health and substance use disorder services;

- certain preventive services (with no cost-sharing permitted) and vaccines;
- maternity care;
- well-baby, well-childcare, oral health, vision, hearing services, equipment, and supplies for those under age 21.

7. **"Health Insurance Exchange" to Facilitate Purchase of "Qualified Health Benefit Plans."** The state-based exchanges would provide eligible individuals and small businesses with access to insurers' plans in a comparable way, but would not act as insurers themselves. The Exchange would be funded by (1) taxes on certain individuals who did not obtain acceptable coverage, (2) penalties for employers whose coverage failed to meet the minimum requirements for coverage, (3) payments made by employers who opt not to provide insurance coverage, (4) payments by employers whose employees opt for exchange coverage instead of employment-based coverage.

8. **"Health Insurance Exchange" Eligibility.** Eligibility for the exchange is limited to individuals and small employers (<10 employees: 2013); (<20 employees: 2014). Eligibility for the exchange may be expanded in later years. Once employers are exchange-eligible and enroll their employees through the exchange, they would continue to be exchange-eligible, unless they decided later to offer their own "Qualified Health Benefit Plan." As for individuals who are not enrolled in an employer-provided plan or Medicare, they would automatically be eligible to purchase insurance individually through the exchange.

9. **Government-Run Public Option.** This option creates an essential benefits package that provides a comprehensive set of services and covers 70 percent of the actuarial value of the covered benefits. The Health Benefits Advisory Council will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. The essential benefits must include well-baby, well-child, oral health, vision, hearing, equipment and supplies for children under the age of 21, along with preventive services with no cost-sharing. These essential benefits will be included in the basic plan, plus there may be optional benefits offered, such as adult oral health and vision care, to create an enhanced plan, premium plan or premium plus plan. The Health Choices Commissioner will also be able to specify that plans contract with essential community providers.

10. **Small Employer Tax Credits.** Certain small businesses would be eligible for a 50 percent credit toward the cost of coverage. This credit would be phased out as average employee compensation increased from $20,000 to $40,000, and then as the number of employees increased from 10 to 25. Employees would be counted if they received at least $5,000 in compensation, but the credit would not apply toward insurance for employees whose compensation exceeded $80,000. This credit would be treated as part of the general business credit and would not be refundable and it would be available only to a business with a tax liability. The credit would be available even if the small business has previously been determined to be exempt from sharing in the responsibility of contributing to or offering coverage. However, few employers would qualify for the full credit due to the structure of the credit.

11. **Impact on FSA, HSAs and HRAs.** Individuals using Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), or Health Reimbursement Arrangements (HRAs) would be prohibited from using

the plans to purchase medicine or drugs other than prescription drugs or insulin. Over-the-counter purchases would no longer qualify for reimbursement.

12. **Health Care Surtax.** A one percentage point income tax surtax would be imposed, starting at $280,000 ($350,000 for couples), plus another percentage point at $400,000 ($500,000 for couples), will then rise to three points on more than $800,000 ($1 million for couples) in 2011. The surcharge could rise by two more percentage points in 2013 if health-care costs are larger than projected. Almost half of the income taxed at this highest rate is small business income from sole proprietorships and subchapter S corporations whose owners pay the individual rate. If the Bush tax rates expire after 2010, this would raise the top personal income tax rate to 39.6 percent from 35 percent, and the next rate to 36 percent from 33 percent. The Bush expiration would also phase out various tax deductions and exemptions, bringing the top marginal rate to as high as 41 percent.

13. **Impact on ERISA.** After 5 years, all plans will be required to meet the "qualified health plan" definition and ERISA plans will no longer have design flexibility. Among the changes to ERISA: automatic federal waivers to ERISA for states that enact a single-payer health care system; unlimited state law remedies for employer-sponsored health coverage obtained through health insurance exchanges; and, prohibition on modifications to retiree health plans.

14. **Expansion of COBRA Coverage.** Employers would be obligated to extend COBRA health care continuation coverage to former employees and dependents until they become eligible under a new employer's health care plan or through a federal-based or state-based health insurance exchange. A federal exchange may not be available until 2013.

15. **Labor Union Provisions.**

    - **Benefits of any "qualified health benefits plan" must be equivalent to average prevailing employer coverage.** Businesses will not be free to vary the mix of benefits available to see which ones best attract employees. Instead, they will have to offer a certain minimum level of health benefits regardless of the demonstrated preferences of their employees (for, say, higher salaries in lieu of pricier health benefits.)

    - **Rights to collective bargaining over health care maintained.** The bill ensures that the new federal health care program will set a floor (but not a ceiling) for health care negotiations for unionized employers. Furthermore, the bill will not permit unionized employers to unilaterally drop health coverage of its employees in favor of shunting them into the federal plan or simply paying the penalty associated with not offering health care benefits to workers.

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HR 3200 PROPOSED TIMELINE

The timeline for the proposed bill would be 2010 – 2018. Although the bill is far from becoming law, HR 3200 is comprehensive and has the support House Democrat leaders.

2010

- Health Benefits Advisory Committee established to provide recommendations on the essential benefits package. Insurance companies must end rescissions, cancelling existing policies. Creates reinsurance for early retires. Averts a 20 percent cut from payments for physician services under Medicare. Reduces paperwork requirements.

2011

- Surtax on high income individuals effective. Health Benefits Advisory Committee recommends essential benefits package. Health plans must meet minimum medical loss ration standards. Medicare relief for prescription drug coverage for individuals. Expands Medicare enrollment to low-income beneficiaries.

2012

- Improves low-income protection in Medicare.

2013

- Surtax on high income individuals could be raised. Insurance companies barred from discriminating against individuals for pre-existing health conditions or charging higher rates to individuals. Health Insurance Exchange opened to individuals without coverage and to small employers under 10. New public health insurance plan created in Health Insurance Exchange to compete on level playing field with private insurance. Low income individuals available for credits in the exchange. Requires individuals to obtain health insurance or pay a penalty of 2.5 percent of their income. Employers required to offer coverage to their employees and families. Plans must meet standards for coverage or pay up to an 8 percent payroll tax to offset cost of their workers receiving coverage in exchange. Employers have a grace period and are not require to meet the benefit standards until 2018. Exempts small businesses with payroll under $500,000 from the requirement of coverage. Provides lower wage small business tax credits to provide coverage. Medicaid eligibility expanded.

2014

- Individuals unable to afford employer-sponsored coverage could enter the exchange. The exchange is expanded to employers with up to 20 employees.

2015

- Health Choices Commissioners has authority to expand eligibility to the exchange to larger employers.

2018

- Employers outside the exchange are required to meet essential benefits package and minimum contribution levels.