September 18, 2009

Health Reform Update and Summary of Key Provisions of the September 15, 2009, Health Care Reform Legislative Proposal from Senate Finance Committee Chairman Max Baucus, The "America's Healthy Future Act"

After an unusually contentious month of August when many members of Congress faced often hostile groups of constituents on health care reform, Congress returned to Washington, D.C. after Labor Day and heard from President Obama that he is still intent on enacting health reform legislation by the end of the year. Importantly, the President stated that he was flexible on many of the details of health reform legislation while attempting to encourage further efforts to achieve bipartisan support for the legislation, without ruling out the possibility that it may need to proceed with support only from members of his party if a bipartisan approach is not possible.

To date, three committees in the House of Representatives and one Senate committee have all approved health reform legislation, thus far without a single Republican vote in favor of any of the proposals which have been considered. On September 15, 2009, Senate Finance Committee Max Baucus (D-MT) released a detailed description of the proposal that he intends to have members of his panel begin considering on September 22 in a committee “mark-up” session that is likely to be one of the most important tests that health reform legislation will face in the legislative process.

The Baucus proposal, known as the Chairman’s Mark, is the product of months of closed door negotiations among three Democratic members of the Senate Finance Committee -- Chairman Baucus, Senator Kent Conrad (D-ND) and Senator Jeff Bingaman (D-NM) – and three Republicans – Ranking Republican Member Chuck Grassley (R-IA), Senator Mike Enzi (R-WY) and Senator Olympia Snowe (R-ME). While no other member of the “Gang of Six” Senate Finance Committee negotiators has indicated support for the Chairman’s Mark, Senator Baucus has expressed continued optimism that it can attract bipartisan support as the proposal moves through the committee consideration and amendment process. However, the proposal also faces significant criticism from more liberal members of the Senate panel, including Senator
Jay Rockefeller (D-WV), Senator Charles Schumer (D-NY) and Senator Ron Wyden (D-OR) who have all indicated that they intend to offer amendments to the Chairman’s Mark which could increase its cost by expanding the new tax credits for low-income individuals to purchase health insurance, strengthen requirements on employers to either offer health coverage for employees or face a penalty or include a public plan health insurance option. Any of these amendments, if successful, would make it more difficult for the Chairman’s Mark to serve as the basis for bipartisan agreement.

Following the Finance Committee’s consideration of health reform, several other key steps are then likely to take place. First, the panel’s proposal will need to be merged with the proposal previously approved by the Senate Committee on Health, Education, Labor and Pensions (HELP) so that a consolidated measure can then be considered on the Senate floor where it would then be open to further amendment. This process could take a considerable amount of time and is likely to mean that final Senate action on health reform will not begin any sooner than October. After Senate action on a reform measure, the House of Representatives is expected to follow a similar procedure by consolidating the work of the three different committee that have approved legislation into a single bill to be considered on the House floor. Finally, following House and Senate approval of a health reform bill, a conference committee with members from all five of the committees of jurisdiction will need to meet to develop a single bill that could be approved by both bodies and presented to the President to sign.

Because of the many difficult substantive and political issues involved in the health reform debate, it is likely that the legislation will not be completed until late 2009. If it encounters additional obstacles it could be delayed even further. Despite the uncertainty over the timing for completion of the legislation, it still appears more likely than not that a health reform measure will be signed into law by the President as many of the core elements of a reform proposal are quite similar among the measures that have been considered to date.

The Council has been quite critical of the health reform proposals approved the Senate HELP Committee and the three House committees. All these measures include highly restrictive and costly employer “pay or play” mandates, public health plan options that are likely to disrupt private health plan competition in a reformed health insurance marketplace, and, in the case of the House bills, unacceptable changes in the essential ERISA regulatory framework which employers rely on when they offer coverage to their employees. In addition, none of these measures has succeeded in achieving bipartisan support which the Council has repeatedly called for as a path toward achieving pragmatic reforms that are most likely to be sustained in future years rather than being subject to significant changes depending on shifts in the partisan control of Congress.
The proposal soon to be considered by the Senate Finance Committee is the last measure that could still meet many of the Council’s standards for health reform, depending on how it is altered in the committee amendment process in the “mark-up” session beginning on September 22. Key features of the proposal introduced by Chairman Baucus include:

**Individual Coverage Requirement:** Starting in 2013, all U.S. citizens and legal residents would be required to purchase health coverage through the individual insurance market, an employer plan, or, if eligible, through existing government health insurance programs such as Medicare, Medicaid, the Children’s Health Insurance Program, veteran’s health program, or TRICARE.

Individuals who obtain coverage in the small employer market (generally groups with 50 or fewer employees, or at a state’s option, up to 100 employees) would be required to obtain coverage that at least meets the standards for “bronze” level coverage, the lowest level of health coverage for plans offered to individuals and small groups in the newly established state-based health insurance exchanges.

Individuals in the large group market (generally groups with 50 or more employees, unless a state has defined the small group market to include groups with up to 100 employees) would be required to obtain coverage that provides first-dollar coverage for preventive health care services. These would be defined by the U.S. Preventive Services Task Force and may not have out-of-pocket limits greater than those established for high-deductible plans offered in conjunction with a Health Savings Account (HSA).

Individuals would be required to report that they had satisfied the minimum coverage requirement for themselves and all dependents under age 18 when filing their federal income tax return. An excise tax would be assessed for individuals or dependents who fail to obtain minimal coverage. The excise tax would vary by income and for lower income individuals would be $750 per person, subject to a family cap of $1,500, and for individuals whose income is more than 300 percent of the federal poverty limit, it would be $950 per person, capped at $3,800 per family. Financial hardship exceptions would apply if the lowest cost available coverage would exceed 10 percent of adjusted gross income for whose income is below 133 percent of the federal poverty line. The Secretary of Health and Human Services would also be permitted to establish standards for additional hardship waivers and waivers would be available for religious purposes.

**Employer Coverage Requirement:** Employers would generally not be required to offer coverage to employees, meet minimum coverage requirements or make minimum contributions to premiums for health coverage. However, employers would be required to pay a new “free-rider” assessment for any full-time employees (those working 30 or more hours per week) who qualify for and receive income-based
subsidized health coverage in a health insurance exchange. For example, if the employer did not provide health coverage, the employer would be subject to an assessment for each low-wage employee who received a subsidy for the purchase of health insurance in an insurance exchange.

Employers would also be assessed for these amounts for employees who opt-out of a plan in which the employer covers less than 65 percent of the actuarial value of the plan’s overall cost (which is equal to the actuarial value of the lowest level “bronze” health plans offered in an insurance exchange), or if the employee’s share of the premium would exceed 13 percent of the employee’s income. Finally, as discussed previously, employees in the large group market would be required to obtain coverage that provides first-dollar coverage for preventive health care services and meets out-of-pocket limit standards that are no greater than those for plans offered in conjunction with HSAs. As a result, employers will also have a strong incentive to ensure that their health coverage also meets these standards so that their employees are not subject to year end excise taxes for failing to be enrolled in qualified health coverage.

Free-rider assessments would be the lesser of a fixed dollar amount determined by the Secretary of HHS or $400 per employee based on the employer’s total workforce (calculated on a full-time equivalent basis where employees working 30 or more hours per week are considered full-time). For example, if an employer has 100 workers and 30 receive a subsidy for health insurance coverage obtained in an insurance exchange and the Secretary defines the flat-dollar assessment as $3,000 per person, the employer should owe $90,000. However, the maximum that the employer would be required to pay in this example would be $40,000 because the employer’s initial liability would exceed the cap of $400 per employee multiplied by its total number of 100 employees.

Employers with more than 200 employees would also be required to auto-enroll employees into health coverage if they do not otherwise elect a plan. Employees would be allowed to opt-out of coverage if they can demonstrate that they are enrolled in coverage from another source.

**Public Plan Option:** Another central issue in the health reform debate is whether there will be a public health insurance plan option for individuals to choose in the small group and individual insurance markets, and would be available to individuals who opt-out of employer coverage and purchase coverage on their own through the health insurance exchanges. One of the most important aspects of this issue is whether any public plan option could be structured so that any governmental plan would compete on a level playing field basis with private insurance plan options. Another key issue is whether any public option plan would pay health care providers using competitively negotiated reimbursement schedules rather than using payment rates set by the government (e.g., Medicare rates) which could exacerbate cost-shifting to employers and other private purchasers and give the public plan an unfair cost advantage over private health plan options offered in the insurance exchanges.
The Baucus proposal does not include a public plan option. Instead, it would establish non-profit, member-operated health insurance cooperative plans to be offered along with private health plan options in the insurance exchanges. While the cooperative would be exempt from taxation and would receive federal grants and loans for its initial capital needs, it would generally otherwise be required to meet the same insurance standards as other private plan competitors and would not be permitted to set payment rates for health care providers except through negotiations. The proposal calls for the establishment of at least one cooperative in all 50 states and the District of Columbia.

**ERISA:** The Baucus proposal maintains the current law ERISA framework for employer-sponsored health coverage and therefore does not expand state jurisdiction over the regulation of group health plans. Importantly, this was a conscious design element of the Chairman’s Mark in recognition of the importance that employers place on the ERISA framework, especially large employers who have employees in multiple states and would be significantly burdened if they had to meet separate state regulatory requirements.

**Taxation of High Cost Health Coverage:** One of the most potentially disruptive provisions in the Chairman’s Mark is the provision to impose a 35 percent excise tax on total health-related coverage that exceeds $8,000 for single coverage or $21,000 for family coverage. The excise tax would apply to amounts above these thresholds and would be indexed by the general Consumer Price Index (CPI) while health care costs tend to increase three or four times faster than CPI. Plans would be subject to the excise tax starting in 2013. Plan costs would be determined using the methodology for determining COBRA continuation coverage premiums. Coverage subject to the thresholds would include major medical plans, reimbursement from health FSAs or HRAs, employer contributions to HSAs, coverage for dental and vision services and other supplementary health insurance coverage. Disability and long-term care coverage under an accident or health plan would not be taken into account for purposes of the new tax thresholds.

While many employers may initially not be subject to the excise tax because their total health-related coverage is below the thresholds, that is likely to change over time because of the higher rate of increase in health care costs compared to the increase in the thresholds which would be indexed to the CPI. As employers approach the tax thresholds, they would have a strong incentive to remain below them, for example, by seeking further efficiencies, reducing benefits, or increasing cost-sharing. As the overall value of the employer plan declines over time, it may contribute to more employers re-evaluating whether to continue offering health coverage or instead pay a penalty for not sponsoring a plan and allowing their employees to obtain coverage from a plan in a health insurance exchange. This could contribute to a decline in employer sponsorship of health coverage, not immediately, but rather as more and more of the health-related
benefits exceed the tax thresholds and employers find it increasingly difficult to achieve further reductions to avoid being subject to the excise tax.

**Additional Revenue Measures:** The Baucus proposal would also subject to corporate income taxation the subsidy payments that employers now receive for maintaining qualified retiree prescription drug coverage that provides at least the same actuarial value as the Medicare prescription drug benefit. In addition, health insurers, pharmaceutical and medical devise manufacturers and clinical laboratories would all be subject to new federal fees, which are likely to be passed along in the costs of these goods and services to employers and employees. Finally, the Chairman’s Mark proposes to: require annual reporting to employees of the value of their health coverage on the Form W-2, limit FSA contributions to $2,000 per year, increase the penalty for non-qualified uses of HSA funds from 10 percent to 20 percent, require Form 1099 reporting for payments to corporations, and modify the definition of qualified medical expenses to preclude tax-favored payment of over-the-counter medications from vehicles such as HSAs, FSAs, or HRAs, except when they are ordered by a physician.