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UPDATE ON HEALTH CARE REFORM LEGISLATION:

SENATE HELP COMMITTEE BILL

Last week, the Senate Health, Education, Labor, and Pension Committee ("HELP Committee") released its draft of health care reform legislation in the form of a 615-page bill. The HELP Committee bill includes insurance market reforms that would affect individual and group insurance policies, some provisions that apply to self-funded plans, a new state "Gateway" program through which individuals could obtain coverage from private insurers (and potentially a public plan option), a new requirement for individuals to obtain coverage, and new employer mandates. The summary below highlights the major provisions that would impact employer health plans (the bill also includes provisions more directly applicable to health care providers).

The bill is unprecedented in scope and is a massive undertaking that would affect public and private markets, employers, individuals, insurers and providers. Unsurprisingly, the bill is expensive. Yesterday, the Congressional Budget Office ("CBO") provided a preliminary estimate to the HELP Committee Chairman that the bill would cost \$1.3 trillion dollars over 10 years. In addition, CBO estimated that 39 million individuals would obtain coverage through these state Gateways, but that the number of people with employer-provided coverage would decline by 15 million (roughly 10 percent).

The Senate HELP Committee will be taking up this legislation this week. The Committee will review and discuss the bill in Executive Session tomorrow, and soon thereafter, the Committee should begin to mark-up the legislation. It is expected that there will be many amendments offered to the bill during the mark-up. This could slow down the process and we may not see a bill reported out of the HELP Committee before Congress takes off for its July 4th recess.

Importantly, the HELP Committee bill does not address financing issues, which are likely to be controversial and could include changes to the Medicare program and the imposition of limits on the income tax exclusion for employer-provided health insurance, to pay for the bill's provisions. These financing issues should be addressed in legislation from the Senate Finance Committee, which we are expecting this week – watch your email for future updates!

I. Insurance Market Reforms (Applies to Self-Funded, Too)

The HELP Committee bill has a number of changes that apply to individual and group policies under the Public Health Service Act. The bill also extends certain of these changes to self-funded benefits by applying the provisions to group health plans and incorporating these provisions into ERISA. Importantly, the insurance reforms apply to the entire group market (i.e., the large group market as well as the small group market). The changes would not apply to "excepted benefits" under HIPAA. These changes include:

- Pre-Existing Condition Exclusions - Group and individual coverage, including self-insured group health plans, may no longer impose a preexisting condition exclusion.

- Premium Rating – For group and individual coverage, an insurer may not take in account health-related factors, gender, class of business, or claims experience when setting premiums. The insurer only may vary the premium rate based on family structure, the actuarial value of the benefit, age (subject to a maximum rate difference ratio of 2 to 1), and the community rating area (which will be established by the Secretary of Health and Human Services by regulation). This rule applies to the small and large group insurance market. It does not appear to apply to self-insured plans.
- Guaranteed Availability / Renewability – Insurers in the large group, small group, and individual markets must accept every individual and employer that applies for coverage.
- "Medical Loss Ratios" – Insurers must submit a report to the Secretary that lists the percentage of premium revenue that the insurer spent on: (1) reimbursement of clinical services; (2) activities that improve health care quality; and (3) all other non-claims costs. Insurers must provide a rebate to enrollees based on the percentage of premium revenue spent on non-claims or health-related costs, as set by Secretary.
- Preventive Care / Immunizations – Group and individual coverage, including self-insured group health plans, must cover preventive care and immunizations without cost sharing, based on specified recommendations and guidelines.
- Dependent Coverage to Age 26 – Group and individual coverage, including self-insured group health plans, must cover dependent children to age 26. No conforming amendment is made to section 152 of the Internal Revenue Code.
- No Annual or Lifetime Caps – Group and individual coverage, including self-insured group health plans, may no longer impose annual or lifetime maximums.
- Nondiscrimination Based on Salary – Group coverage, including self-insured group health plans, may not have an eligibility rule based on salary (but may allow greater employer contributions for lower paid employees).
- Grandfathered Plans – The new requirements would not apply to group or individual coverage in effect as of enactment with respect to current enrollees (or later enrolled family members). This provision has significant limits. For example, it appears that an employer plan would lose its grandfathered status if new employees are enrolled in the plan and insurance policies could lose the grandfathered status if amended to conform with new state law mandates.

II. Governmental/ Gateway

Under the HELP Committee bill, states will receive money from the federal government to either establish "American Health Benefit Gateways" ("Gateways"), or participate in a Gateway that the federal government establishes. Although a state has the right to decline establishing or participating in a Gateway for four years from the date the legislation is enacted, at the expiration of four years, Gateway will become mandatory under a "federal fallback"

provision. A Gateway can be in one state, or if states coordinate, in multiple states. A state can have more than one Gateway if it establishes that there is a need.

A Gateway is defined as a *mechanism that facilitates the purchase of health insurance coverage and related insurance products at an affordable price by qualified individuals and qualified employer groups*. The legislation also states that the Gateway shall include a public plan option, but that the details of such option are still under discussion. In order to be offered through the Gateway, insurance coverage/products be certified as "qualified health plans." One of the criteria necessary for certification as a qualified health plan is providing coverage for "essential health care benefits." A new advisory committee called the "Medical Advisory Council" is charged with determining what benefits should be considered essential health benefits for purposes of the qualified health plan definition.¹ Other criteria that a plan must satisfy to be certified as a qualified health plan include:

- Not having marketing practices or benefit designs that discourage enrollment by individuals with significant health needs;
- Having insurance products that are simple, comparable, and structured for ease of consumer choice;
- Ensuring a wide choice of providers;
- Making available a detailed description of benefits, cost-sharing limitations, exclusions, maximums, the service area, required premiums, the manner in which providers can be accessed, and grievance/appeals procedures and having adequate procedures in place for appeals determinations;
- Being accredited by the National Committee for Quality Assurance or other similar entity recognized by HHS and implementing quality improvement strategies described in the legislation.

The legislation requires HHS to ensure that there are three tiers of qualified health plan options available for eligible individuals with premiums that do not exceed a specified percentage of total allowed costs of the benefits provided, and that have maximum out of pocket limitations that do not exceed the amount under section 223 of the Internal Revenue Code (i.e., for 2010, \$5,950 self-only and \$11,900 family). Qualified health plans are required to offer options that satisfy the lowest cost-sharing tier and the second cost-sharing tier. A Gateway is permitted to charge a qualified health plan a surcharge of 3% of the premiums collected by the qualified health plan. In addition, a qualified health plan is subject to a "risk adjustment" whereby the state may assess a charge against an insurer where the actuarial risk of enrollees under the qualified health plan is less than the actuarial risk of all health plans in the state, other than self-insured plans. If the actuarial risk of enrollees under the qualified health plan is greater

¹ The Council is made up of members that are appointed by HHS and is required to submit an annual report to HHS with recommendations on issues related to the Gateway. These recommendations will be considered to be "applicable" (i.e., legal requirements) unless Congress overturns the report through a joint resolution within 90 calendar days.

than the actuarial risk of all health plans in the state, other than self-insured plans, the health insurance issuer will receive a refund from the state.

A "Qualified Individual" who is permitted to purchase coverage through the Gateway is defined as a individual who is a citizen or legal immigrant residing in a participating or establishing state, not incarcerated, not entitled to coverage under Medicare part A or B, and not eligible for coverage under Medicaid, TRICARE, or the FEHB. In addition, it appears that an individual can only be a qualifying individual if he or she is not eligible for employer-sponsored coverage that satisfies the requirements for minimum qualifying coverage and affordability as determined by the Medical Advisory Council. Note, however, that the bill also contains a provision indicating that employees of qualified employers can choose whether to enroll in Gateway coverage. This provision arguably conflicts with the above definition of Qualifying Individual, making it unclear which employees are eligible for coverage through the Gateway.

Individuals who earn up to 500% of the federal poverty level and enroll in a qualified health plan are eligible for federal "credits" to reduce the cost of the premiums (the amount of the credit is higher for individuals who earn lower amounts). The credit is not available for coverage offered outside the Gateway (either through an employer plan or individual insurance bought from an insurer outside the Gateway). The credit is paid by HHS to the Gateway, and in turn, to the health coverage provider.

A "Qualified Employer Group" permitted to offer coverage through the Gateway is defined as an employer who elects to make all full-time employees eligible for a qualified health plan, and who meets the criteria established by a state or HHS, including employer size.

III. Individual Responsibility

The HELP Committee bill creates a new section of the Internal Revenue Code- section 59B, which requires individuals who do not participate in "qualifying coverage" to pay additional taxes in an amount that will be determined annually by the IRS, in consultation with HHS. There are exceptions to this provision, including for individuals who are without coverage for a period of less than 90 days, who would suffer an "exceptional financial hardship" as a result of the additional taxes, or who do not have affordable coverage available. Moreover, it is not clear how the mandates will be enforced on the many uninsured Americans who pay no income tax.

Qualifying coverage is defined as coverage that an individual is enrolled in on the date of enactment, or that meets or exceeds the criteria for minimum qualifying coverage. Qualifying coverage specifically includes coverage under Medicare, CHIP, TRICARE, the veteran's health care program, the FEHBP, a state health benefits high risk pool, a Peace Corps Program, or a qualified health plan.

Issuers of qualified coverage are required to submit a report to the IRS with the name, address and taxpayer identification number of each individual with qualifying coverage provided by such issuer, and the number of months during the calendar year during which each individual was covered.

IV. Employer Pay or Play

The HELP Committee bill includes a placeholder for an “Employer Responsibility” section, which apparently is intended to include a “pay or play” mandate. This language was left out of the Committee bill, presumably to be discussed in mark-up. However, just prior to the HELP Committee bill’s release, a draft that had been prepared by Senator Kennedy’s office was leaked and did include “pay or play” language. Senator Kennedy’s draft includes:

- Pay or Play – The Kennedy draft requires employers to make a quarterly payment to the Secretary for each full-time employee not offered qualifying coverage or for whom the employer does not contribute a specified percentage of monthly premiums, which the language indicates is to be determined. Employers must pay a prorated amount with respect to part-time employees not offered coverage or for whom the employer does not contribute the required premium. There is an exemption for small employers ("small employer" is not defined).
- Free Rider Penalty – Where employees are not offered qualifying employer coverage, the Kennedy draft also requires employers to pay a monthly “Free Rider Penalty.” The penalty amount would be a percentage of the amount paid on behalf of these employees by the federal government for health care coverage.
- Employees Who Do Not Enroll in Employer Coverage – Where employees are offered qualifying employer coverage but choose to enroll in a state Gateway program instead, the Kennedy draft requires employers to pay an amount equal to the amount the employer otherwise would have paid for coverage on behalf of the employee had the employee enrolled in employer coverage.

The HELP Committee did issue a section-by-section summary of the HELP Committee bill, which outlined additional options that were being considered. With respect to employer responsibility, other options included dropping the employer mandate altogether or allowing employers to incentivize health behaviors, such as increasing the 20% limit on wellness program rewards under the HIPAA wellness rules or removing the tax that would apply to some prizes and rewards under wellness programs.

V. Other Employer Provisions

In addition to the placeholder for future “pay or play” provisions, the HELP Committee bill includes the following provisions that also would impact employers:

- Notice about Gateway Programs – The bill requires employers to provide written notice to employees within 90 days of enactment (and at time of hiring thereafter) of the existence of the state Gateway programs, their services, and how the employee may request assistance.
- Retiree Reinsurance – The bill requires the Secretary to establish a retiree reinsurance program for employers in states where a Gateway program has not yet been established. The reinsurance program would reimburse employers for a claim by a retiree between

ages 55 to 64 that is between \$15,000 - \$90,000. The program could apply to coverage offered through insurance, a Taft-Hartley plan, a multiemployer plan, self-funded plan, or a VEBA. Amounts paid to participating employers only may be used to lower premium costs and may not be used for administrative costs or profit increases.

- Small Employer Credit – Small employers who pay at least 60% of health insurance premiums would be eligible for a tax credit based on the number of employees who have single, married, or family coverage (the credit would be \$1,000, \$1,500, and \$2,000 per employee, respectively). This amount would be adjusted based on the size of the employer (the larger the employer the lower the credit), the portion of premiums over 60% the employer pays (the employer receives extra credit if it pays a greater portion of the premiums), and the percentage of the year for which premiums are paid. A small employer generally is defined as an employer with 50 or fewer employees who earn an average wage of less than \$50,000. A small employer only may qualify for the credit for 3 consecutive years.
- Class (Community Living Assistance Services and Supports) - The bill creates a structure that is similar to the Gateway for long-term care insurance. The stated goal of the "Class" provisions is to establish a national voluntary insurance program for purchasing community living assistance services and supports that can be accessed by individuals with "functional limitations." The legislation establishes an advisory council, referred to as the "Class Independence Advisory Council," to make design decisions regarding the structure of the voluntary long-term care plan. Individuals who are age 18 or over are automatically enrolled in the plan through their employer with premium payments made through salary reduction, but any individual may opt out of the coverage. Premiums for the coverage are reduced for individuals with incomes below the federal poverty level. Employers are to claim a tax credit in the amount of 25% of costs incurred to automatically enroll employees and withhold monthly premiums on their behalf. The bill also amends section 125 of the Internal Revenue Code to allow long-term care insurance premiums to be purchased on a pre-tax basis through a cafeteria plan.
- Promotion of Wellness Programs – The bill requires the CDC to conduct a targeted campaign to educate employers as to the benefits of employer-based wellness programs and to provide employers with technical assistance and resources to evaluate employer-based wellness programs, including participation rate, impact on health outcomes and expenditures, and productivity. The bill requires the CDC to institute a workplace demonstration project across small, medium, and large employers to create strong, sustainable, coordinated, and integrated workplace health promotion and wellness programs. Interestingly, the section-by-section analysis from the HELP Committee notes that additional wellness options being considered are to increase the reward allowed under the HIPAA wellness rules from 20% to 50% of the cost of coverage and to clarify that voluntary health risk assessments are “legal.”
- New HIPAA Standard Transactions - Under HIPAA’s current rules, if health plans and providers exchange certain information electronically, they must use specific standards and formats established by the Secretary. The bill requires the Secretary to adopt new standards to enable real time determination of a patient’s financial responsibility at the

point of service, including whether the patient is eligible for a specific service with a specific physician or facility. The bill says this may include a machine-readable health plan identification card. The Secretary also is required to update existing standards.

- National Health Plan Identifier - The bill requires the Secretary to issue a final rule to establish a National Health Plan Identifier system within 1 year of enactment. This means that plans and providers must use a health plan's National Health Plan Identifier when conducting standard transactions.

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We will provide updates on further developments. In the meantime, if you have any questions, please contact your regular Groom attorney or any of the Health and Welfare Practice Group attorneys listed below:

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