

# Senate Finance Committee Readies Health Care Reform Vote

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The Senate Finance Committee is preparing to vote this week on its long-awaited, long-debated health care reform plan, which would restructure the nation's health care system while insuring millions of Americans. The bill, sponsored by Senate Finance Chairman Max Baucus (D-MT) (the "Baucus Bill"), has not been endorsed by any Senate Republicans, but is expected to garner the support of all Democrats on the Senate Finance Committee.

The Senate Finance Committee adopted a provision stating that, before the Senate Finance Committee can vote on final passage of the Baucus Bill (officially titled "America's Healthy Future Act of 2009"), the "conceptual language in plain English" and a complete cost analysis by the Congressional Budget Office must be publicly available on the Senate Finance Committee's Web site ahead of the vote. The Congressional Budget Office scoring of the Baucus Bill is expected this week.

The Baucus Bill provides for the following changes in the United States' health care system.

## **Health Insurance Reforms**

### **Health Insurance Exchanges**

States would set up health insurance exchanges to provide easier, more efficient comparison of health insurance plan benefits and premium costs. Information about coverage and cost sharing would be available in a standard format. National plans that meet the federal standards in the bill could offer uniform benefits through the different exchanges without being subject to state law benefit mandates.

In 2010, 2011, and 2012, plans with annual and lifetime limits and so-called "mini-medical" plans with limited benefits and low annual caps would be prohibited from being offered in the state exchanges. All other policies would be offered in the state exchange. Beginning July 1, 2013, all plans offered in the individual and small group market—whether through the exchange or outside of the exchange—would have to comply with the rating reforms and benefit options detailed in the Baucus Bill.

Beginning in 2015, states must allow small businesses with up to 100 employees to purchase coverage through the health insurance exchange. Beginning in 2017, states may allow employers with more than 100 employees into the state exchange. Businesses that grow beyond the upper employee limit may continue to purchase health insurance through the exchange.

### **Insurance Reforms in the Individual and Small Group Market**

For individual and small group insurance reform, the Baucus Bill includes guaranteed issue and a prohibition against exclusions for preexisting health conditions. Limited benefit plans would be prohibited, and health insurers would be prohibited from rescinding health coverage. The Baucus Bill would preclude midsize and large employers with group health plans from imposing "unreasonable" annual or lifetime limits on coverage.

Health insurance premiums would be allowed to vary based only on tobacco use, age, family composition, and geographic location. A "small group" is defined as up to 50 employees (or up to 100 depending on state

law). To protect newly reformed markets against adverse risk selection and facilitate market entry of new plans, the Baucus Bill includes three mechanisms to share risk: risk adjustment, reinsurance, and risk corridors. The exchanges would offer health plans at four different levels of actuarial value, as well as a lower cost “young invincibles” plan that provides catastrophic coverage with preventive benefits.

### **Reinsurance Program for Early Retirees**

All health insurance issuers would be required to contribute to a reinsurance program for individual policies that would be administered by a non-profit reinsurance entity (the “Non-Profit”). The purpose of the Non-Profit would be to help stabilize premiums for individual coverage during the first few years of operation of the state exchanges, when the risk of adverse selection related to new rating rules and market changes would be greatest. The Non-Profit would coordinate the funding and operation of a risk spreading mechanism that would take the form of reinsurance.

Under the Baucus Bill, the reinsurance program would include early retirees. The program would reimburse any eligible employers or insurers 80% of claims between \$15,000 and \$90,000. The thresholds would rise annually based on the Medical Care Component of the Consumer Price Index for All Urban Consumers (CPI-U), rounded to the nearest multiple of \$1,000. It would reinsure only the claims for individuals age 55 to 64 who are not active workers or dependents of active workers and who are not Medicare-eligible. Eligible employers are those offering coverage that is appropriate for a mature population between 55 and 64, offering preventive benefits, that have demonstrated programs to generate cost savings for those with chronic and high-cost conditions, and that can show actual cost of medical claims.

### **State Opt-Out**

Beginning in 2015, the Baucus Bill provides states with an opportunity to apply for a waiver to opt out of certain aspects of the Baucus Bill. A state may be granted a waiver if the state applies to the Secretary of the Department of Health and Human Services (HHS) and agrees to provide health care coverage that is at least as comprehensive as required under the Baucus Bill. The Secretary’s waiver authority would only relate to laws under the Secretary’s authority and would not apply to laws such as the Civil Rights Act, ERISA, the Americans with Disabilities Act (ADA), and any other federal law or regulation which is not under the Secretary’s jurisdiction.

### **Individual Mandate**

Beginning in 2013, all U.S. citizens and legal residents would be required to carry health insurance that meets certain minimum benefit standards, either from an employer, through a public program (e.g., Medicare or Medicaid), or through some other source (such as the exchanges). The consequence for not maintaining insurance would be an excise tax of \$750 per adult in the household. This per-adult penalty would be phased in at \$0 for 2013, \$200 for 2014, \$400 for 2015, \$600 in 2016, and \$750 in 2017. Exemptions from the individual mandate would apply for a variety of situations, including religious beliefs and being unable to afford coverage. Individuals earning below 133% of the federal poverty level (FPL) would not be subject to the excise tax penalty and would not be eligible for health care affordability tax credits in the exchanges.

### **Health Care Affordability Tax Credits for Premiums**

The Baucus Bill would provide a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit would subsidize the purchase of certain health insurance plans through the state exchanges and would be refundable and payable in advance directly to the insurer.

Beginning in 2013, the tax credits would be available on a sliding scale basis for individuals and families earning between 134%–300% of FPL to help offset the cost of private health insurance premiums. Beginning in 2014, the credits would also be available to individuals and families earning between 100%–133% of FPL. The credits would be based on the percentage of income the cost of premiums

represents, rising from 2% of income for those at 100% of FPL to 12% of income for those at 300% of FPL. Individuals between 300%–400% of FPL would be eligible for a premium credit based on capping an individual's share of the premium at a flat 12% of income.

### **Auto Enrollment**

Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source (e.g., through a public program or as a dependent in a spouse or other family member's health benefits). Though the Baucus Bill is not explicit on the following point, based on other similar proposals, we believe the default for employees who do not actively enroll would be to single coverage for the lowest cost plan option available to the employee.

### **Employer "Free Rider" Penalty**

Unlike the other health care bills in Congress, the Baucus Bill would not require employers to offer health insurance coverage. Instead, the Baucus Bill provides that employers with more than 50 full-time employees ("full-time" meaning 30 hours or more per week) that do not offer health care coverage must pay a "free rider" penalty for each employee who receives the premium tax credit for health insurance through an exchange.

For each such full-time employee receiving a tax credit through the exchanges, the employer would be required to pay the lesser of: 1) a flat dollar amount, set by the Secretary of HHS, equal to the average tax credit in the state exchanges; or 2) an amount equal to \$400 multiplied by the total number of full-time employees at the firm (regardless of how many employees are receiving the state exchange credit). (No free rider penalty is assessed if employees are eligible and enroll in Medicaid.) Fees would not be deductible.

If an employee is offered employer-provided health insurance coverage, the individual is not eligible for the tax credit for health insurance purchased through an exchange, with two exceptions. First, if the employer-provided health insurance does not have an actuarial value of at least 65% (i.e., the plan pays at least 65% of covered medical expenses), the employee can be eligible for the tax credits and the employer would be liable for the free rider penalty. Second, the employee will also be eligible for the tax credit—and the employer will be liable for the free rider penalty—if the employer health insurance is "unaffordable," which is defined as 10% or more of the employee's income. If employer-sponsored coverage would cost an individual more than 10% of his or her income, that person would be eligible to receive a Health Care Affordability Tax Credit in an exchange and the employer would be assessed a free-rider penalty for such employees. For purposes of determining if employer coverage is unaffordable, as described in the Baucus Bill, salary reduction contributions would be treated as payments by the employee, not the employer.

Health care coverage offered outside the exchanges by an employer of any size, including fully insured and self insured plans, is not required to comply with the list of benefits required of plans in the non-group and small group markets. However, in order for employees who elect employer coverage to satisfy the individual mandate, the employer plan in which they are enrolled must provide first dollar coverage for prevention services (except where value-based insurance design is used), and the plan cannot have a maximum out-of-pocket (OOP) limit greater than that provided by the standards established for health savings accounts (HSAs).

### **Employer-Sponsored Wellness Programs**

The Baucus Bill would codify the HIPAA regulations on employer-sponsored wellness programs, which allow for rewards to be provided to employees for wellness program participation or for meeting certain health status targets related to a wellness program. In practice, this means that HIPAA rules, such as the monetary limit on wellness incentives (which would now be 30% of the cost of coverage, rather than 20%)

and the rules regarding availability of a reasonable alternative to satisfying a health status factor, would become statutory in nature and would not be susceptible to change by regulatory agencies.

However, the Baucus Bill gives authority to the Department of Labor (DOL), the Internal Revenue Service (IRS), and HHS to conduct a study of wellness programs. The study must include a determination of the Secretaries as to whether there is a threshold level of increase in the permissible HIPAA incentive above which any additional increase will be punitive in nature as to other enrollees and employees, discourage non-participating employees from accepting employer coverage, or lack any marginal benefit in encouraging employees to participate in the wellness program. Upon completion of that study, the agencies could then raise the permissible wellness incentive to 50% of the cost of coverage if the agencies determine that adequate safeguards could be put in place to assure that the rewards would accomplish the wellness program goals and not be punitive in nature.

### **Interstate Sale of Insurance**

Starting in 2015, states may form “health care choice compacts” to allow for the purchase of non-group health insurance across state lines, based on model rules developed by the National Association of Insurance Commissioners (NAIC). Such compacts may exist between two or more states. Once compacts have been formed, insurers would be allowed to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued. However, the state where the consumer resides would retain the authority to regulate market conduct, unfair trade practices, network adequacy, and consumer protection standards. The effective date of this provision would be January 1, 2013.

The Baucus Bill would allow national plans, with uniform benefit packages that are offered across state lines. Such national plans must be compliant with the benefit levels and categories detailed in the Baucus Bill, but would preempt state benefit mandates—thereby allowing these national plans to offer a single, uniform benefit package. States are permitted to opt out of the national plan.

### **Health Care Cooperatives**

Instead of a federally administered public health care plan option, the Baucus Bill would authorize \$6 billion of federal funding to create non-profit, member-run health insurance companies that serve individuals in one or more states. Co-ops would compete in the individual and small group insurance markets and be subject to the same rules as other health plans. Co-op participants could enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, including claims administration, health information technology, and actuarial services. A purchasing council could be established to execute the collective purchasing agreements. Grants to meet state solvency requirements and loans to assist with start-up costs would be made by HHS in consultation with an advisory board made up of the HHS Secretary and appointed members of Congress. If a co-op is not formed in every state, HHS could use planning grants to encourage formation of new organizations or expand organizations currently participating in the co-op program.

## **Medicare**

### **Medicare Part D Drug Program**

Beginning in July 2010, in order to have their drugs covered under Medicare Part D, pharmaceutical manufacturers must provide a 50% discount off the negotiated price (minus dispensing fees) for brand-name drugs covered on plan formularies when beneficiaries enter the Part D coverage gap or “doughnut hole.” The full negotiated price would count toward a beneficiary’s true out-of-pocket (TROOP) costs to ensure that the coverage gap is not expanded. Beneficiaries are eligible provided they do not qualify for low-income subsidies, do not have employer-sponsored coverage, or do not pay higher, income-related Medicare premiums under Part B or Part D. Pharmaceutical manufacturers that do not comply with the discount program would be subject to fines.

Under current law, beneficiary premiums under Medicare Part D are not subject to income thresholds, though they are under Part B. Currently, beneficiary premiums account for 25.5% of Part D premium costs for standard coverage, with Medicare paying the remaining 74.5%. The Medicare portion or subsidy amount of average Part D premiums is determined annually and paid directly to plans on a monthly basis for each beneficiary they enroll. However, beneficiaries pay different monthly premiums depending on the plan they select and whether or not they are entitled to low-income premium subsidies. As a result, if a beneficiary chooses a plan with lower than average premiums, then the beneficiary's share of the plan's premium will be lower than the 25.5% set nationally.

Beginning in 2011, the Baucus Bill would reduce the Medicare premium subsidy amount for high-income beneficiaries enrolled in Part D, similar to the reductions made for high-income Medicare Part B enrollees. As a result, Part D beneficiaries whose modified adjusted gross income (AGI) exceeds the thresholds used for Part B premiums—in 2009, \$85,000 for an individual and \$170,000 per couple in 2009—would be required to pay higher Part D premiums. Income thresholds would be indexed to the CPI beginning in 2020.

### **Efforts to Improve Efficiency of Medicare**

In a lengthy series of proposals, the Baucus Bill includes provisions intended to reduce future Medicare cost growth, including value-based purchasing and an enhanced Medicare Commission, the recommendations of which would become law if Congress fails to act. The Baucus Bill also includes significant changes to Medicare Advantage plans.

Sponsors of prescription drug plans and Medicare Advantage prescription drug plans under Medicare Part D would be allowed to waive copayments for first fills of generic drugs as an incentive for beneficiaries to try a generic formulation of a drug. This provision would be effective January 1, 2011.

### **Medicare Sustainable Growth Rate Formula**

Medicare payments for services of physicians and certain non-physician practitioners are made on the basis of a fee schedule that assigns relative values to their services. The relative values are adjusted for geographic variation in costs and then converted into dollar payment amounts by a conversion factor. Medicare specifies a formula, commonly referred to as the sustainable growth rate formula (SGR), for calculating the annual update to the conversion factors and the resultant fees. Unless further legislation is passed, the update formula will require a 21% reduction in physician fees beginning January 1, 2010 and by additional annual amounts for at least several years thereafter.

The Baucus Bill provides for an increase rather than a decrease in physician fees for 2010. The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5% increase in 2010 instead of a 21% reduction.

### **Medicare Advantage**

The Baucus Bill would base the calculation of Medicare Advantage benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates. Using plan bids to set Medicare Advantage benchmarks would encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. It would also provide cost savings to Medicare because in nearly all areas of the country plan bids are lower than the current benchmark rates. The Baucus Bill would allow Medicare Advantage plans to grandfather the extra benefits for their current enrollees in certain areas of the country where average plan bids are at or below 75% of local fee-for-service costs. Plans would be able to grandfather enrollees beginning in 2012.

## **Revenue Provisions**

### **Excise Tax on High-Cost Insurance**

Beginning in 2013, the Baucus Bill would impose a non-deductible excise tax of 40% on insurance companies and plan administrators if the aggregate value of employer-sponsored health insurance

coverage for an employee exceeds a certain threshold amount. For 2013, the threshold amount would be \$8,000 for single coverage and \$21,000 for family coverage. The excise tax would apply to self-insured plans and fully insured plans in the group market, but not to plans sold in the individual market. After 2013, the threshold amounts would be indexed to the CPI-U. The excise tax would apply only to the portion of the cost that exceeds the threshold amount.

The cost of health insurance coverage for excise tax purposes is calculated by including the premiums for medical, dental, and vision coverage (even if dental and vision coverage is provided under a separate fully insured policy); any employer contribution to an HSA or health reimbursement arrangement (HRA); and the entire amount of any health flexible spending account (FSA) contributions.

For plans located in the 17 states (not yet named) in which health costs are highest, the Baucus Bill would phase in the tax at higher thresholds over three years beginning in 2013. Under the transition rule, the threshold amount would be raised by 20% in 2013. That increase would be reduced by half in 2014, reduced by half again in 2015, and would then be set at the otherwise applicable threshold in 2016.

For retired individuals over the age of 55, the threshold amounts would be \$9,850 for individual coverage and \$26,000 for family coverage. The additional amounts are indexed to the CPI-U, as determined by the DOL beginning in 2014, plus 1%.

For plans that cover employees engaged in high risk professions, the threshold amounts would be \$9,850 for individual coverage and \$26,000 for family coverage and would be indexed as described above. Employees considered to be engaged in a high risk profession are law enforcement officers; firefighters; members of a rescue squad or ambulance crew; and individuals engaged in the construction, mining, agriculture (but not food processing), forestry, or fishing industries.

An individual's threshold would not exceed these increased amounts, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

The amount subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by the employee with after-tax dollars. Fixed indemnity coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury, or a hospitalization, provided that the coverage is not coordinated with other health coverage

In determining the coverage value for retirees, employers would be able to elect to treat pre-65 retirees together with post-65 retirees.

The employer is responsible for calculating the amount of each employee's coverage that is subject to the excise tax and reporting these amounts to the insurer/plan administrator and the IRS. If an employer underreports the cost of health coverage, the employer will be assessed penalties plus interest from the due date of the excise tax. The penalty (but not the excise taxes due or interest on the taxes due) may be waived if the employer can show that the failure was due to reasonable cause and not willful neglect.

### **Employer Reporting of Value of Health Insurance Benefits**

Beginning in 2010, the Baucus Bill would require employers to disclose the value of employer-provided health insurance coverage on the employee's annual Form W-2. Employers would not be required to provide a breakdown of costs for the employees' health, dental, and vision coverage. Instead, they would be permitted to report the total cost for all medical coverage. Contributions to a health FSA are excluded for

this purpose. For employees that generally receive the same type of coverage (single or family), employers would be permitted to report the same cost amount for all of them as they would be considered “similarly situated.”

When determining the value of employer-provided health insurance coverage for Form W-2 reporting purposes, the Baucus Bill directs employers to use the same calculation method used to calculate the employer’s portion of premiums for COBRA continuation coverage. However, if a plan charges the same amount for single and family coverage under a COBRA continuation policy, then it will have to separately calculate single and family premiums for Form W-2 reporting purposes.

### **\$2,500 Limit on Contributions to Health Care Flexible Spending Accounts (FSAs)**

Beginning in 2011, the Baucus Bill would place an annual limit of \$2,500 on contributions to health care FSAs. At the same time, the cost of over-the-counter medication (unless prescribed) would not be reimbursable through an FSA (or an HRA, HSA, or Archer MSA).

### **Eliminate Income Tax Exclusion for Employer Part D Subsidy**

Beginning in 2011, the Baucus Bill would eliminate the exclusion from gross income for the federal subsidy paid to employers that maintain prescription drug plans for their Medicare Part D-eligible retirees. For fiscal years 2011 through 2019, the JCT estimates that this provision will generate revenue of \$4 billion.

### **Standardize the Definition of Qualified Medical Expenses**

The Baucus Bill would standardize the definition of qualified medical expenses. The definition of medical expense used for individual itemized medical deductions would apply to employer-provided health coverage, including HSAs, FSAs, and HRAs. This provision would be effective beginning in 2010.

### **Increase the Threshold for Claiming the Itemized Deduction for Medical Expenses**

The Baucus Bill would increase the AGI threshold for claiming the itemized deduction for medical expenses to 10% from 7.5%, effective in 2013. Individuals age 65 and older (and their spouses) are exempt from the increased threshold and would continue to be eligible to claim the Section 213 deduction if their medical expenses exceed 7.5% of AGI. The proposal does not change the AMT treatment of the itemized deduction for medical expenses.

### **Increase the Penalty for Use of HSA Funds for Non-Qualified Medical Expenses**

Beginning in 2011, the Baucus Bill would double the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses to 20% from 10%.

### **Corporate Information Reporting**

Beginning in 2012, the Baucus Bill would require businesses that pay more than \$600 annually to corporate providers of property and services to file an information report with each provider and with the IRS. Information reporting is already required on payments to non-corporate providers for services.

### **Fees on Health Care Manufacturers and Service Providers**

The Baucus Bill includes several non-deductible fees on health care manufacturers and service providers, beginning in 2010:

- **Annual Fee of \$2.3 Billion on Pharmaceutical Manufacturers**—Any manufacturer or importer (domestic or foreign) of certain drugs and biologics would be subject to this fee. Each manufacturers’ and/or importers’ share of the \$2.3 billion fee would be based on their market share of domestic covered sales for the prior year. The Treasury Department would be responsible for determining the market share of each manufacturer and importer. Covered domestic sales would be defined as sales of branded prescription drugs made to or funded by Medicare, Medicaid, the Veterans Administration, and TRICARE. Single source or innovator multiple source drugs (excluding orphan drugs) would be considered branded

prescription drugs. Although this provision would not be effective until 2010, this fee would apply to domestic covered sales in 2009.

- **Annual Fee of \$4 Billion on Medical Devices Manufacturers**—Any manufacturer or importer (domestic or foreign) of medical devices would be subject to this fee. Each manufacturers' and or importers' share of the \$4 billion fee would be based on their market share of domestic covered sales for the prior year. Domestic covered sales include U.S. sales of medical devices regulated by the FDA and subject to pre-marketing and post-marketing regulatory controls. Sales of Class I products and products intended for use on animals would be excluded. The term would also not include sales of Class II products that are sold at retail for up to \$100 per unit from the definition of covered domestic sales. Manufacturers and importers would have to file annual reports of their domestic covered sales for the prior year with the Treasury Department. Although this provision would not be effective until 2010, this fee would apply to domestic covered sales in 2009.
  
- **An Annual Fee of \$6.7 Billion on the Health Insurance Sector**—Each health insurance provider's share of the \$6 billion fee would be based on their market share in the prior year. Market share would be determined by comparing the net premiums written by each health insurance provider to the total reported net premiums written by all providers. Health insurance providers would be required to file annual reports of net premiums written for the prior calendar year with the Treasury Department. Employers with self-insured plans would not be considered health insurance providers under the Baucus Bill. Although this provision would not be effective until 2010, this fee would apply to health insurance premiums written in 2009.