# National Association of Health Underwriters

## Comparison of the Employer-Related Issues in the Comprehensive Health Reform Measures Under Consideration in the Senate and U.S. House of Representatives

## January 12, 2010

| | **Senate Democratic Legislation, the Patient Protection and Affordable Care Act, H.R. 3590**<br><br>**Status: Passed by the United States Senate (60-39) on December 24, 2009** | **House Democratic Legislation, The Affordable Health Care for America Act, H.R. 3962**<br><br>**Status: Passed by the House of Representatives (220-215) on November 7, 2009** |
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| **Effective Dates** | The majority of the provisions in the bill especially those relative to health insurance coverage, take effect on January 1, 2014. Effective dates by provision do vary, and different effective dates are noted in each section of the chart. | The majority of the provisions in the legislation would take effect on January 1, 2013, but effective dates do vary by provision and are noted when possible. |
| **Employer Mandate** | Employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of $750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate.<br><br>For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than $250,000.<br><br>An employer with more than 50 full-time employees that requires a waiting period before an employee can enroll in health care coverage will pay $600 for any full-time employee subject to more than a 60- day waiting period.<br><br>An employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of $3,000 for each of those employees receiving a tax credit or $750 for each of their full-time employees total. | All employers must offer coverage through either Qualified Health Benefit Plans (QHBPs) or grandfathered plans as permitted. Employers would be required to pay 72.5% of the cost of acceptable coverage for individuals and 65% for family coverage, and part-time employees must be covered on a pro-rated basis based on average hours worked.<br><br>In lieu of paying for coverage, the measure creates a "pay or play" option allowing the employer to pay instead 8% of wages to the Commissioner.<br><br>Small employers with annual payroll up to $500,000 will be exempt from the requirement. Employers with $500,001-$585,000 in annual payroll would pay a fee of 2%, employers with annual payroll of $585,001-$670,000 would pay a fee of 4%, and employers with annual payroll of $670,001-$750,000 would pay a fee of 6% for non-compliance. |

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| **Individual Mandate** | Requires that effective after December 31, 2013, all American citizens and legal residents purchase qualified health insurance coverage. Qualified coverage includes public program coverage, coverage purchased through the individual market, and qualified employer-sponsored coverage, and Individuals in grandfathered plans meet the terms of the mandate. Exceptions are provided for religious objectors, individuals not lawfully present and incarcerated individuals.<br><br>Exemptions from the penalty will be made for those who cannot afford coverage, taxpayers with income under 100 percent of poverty, members of Indian tribes, those who have received a hardship waiver and those who were not covered for a period of less than three months during the year.<br><br>Individuals would be required to report on their federal income tax returns the months of the year for which they had qualified health insurance coverage. Health plans, including self-funded employer plans and public programs, must also provide coverage documentation to both covered individuals and the IRS.<br><br>The penalty for not maintaining coverage is an excise tax penalty of a flat dollar amount per person or a percentage of the individual's income equal to the higher of: (1) 2% of taxable (gross) household income capped at the average bronze-level insurance premium (60% actuarial) rate for the person's family; beginning in 2016, or (b) a fixed dollar amount that phases in beginning with $95 per person in 2015 to $750 in 2016, with a 50% penalty for children up to an annual maximum of $2250 in 2017. | The legislation creates an individual mandate to maintain acceptable coverage with a federal income tax penalty equal to 2.5% of the excess of the taxpayer's adjusted gross income over the threshold amount or the average premium in the exchange.<br><br>Hardship waivers are included.<br><br>The tax shall not exceed the applicable national average premium for individual or family coverage (tax is pro-rated for partial year failures).<br><br>Acceptable coverage includes qualified health benefit plans, grandfathered plans, Medicare, Medicaid, tribal coverage TRICARE and VA coverage.<br><br>Any entity providing acceptable coverage to individuals must provide them with annual documentation of coverage. |
| **Essential Benefits** | The bill requires the Secretary of DHHS to establish a standard of essential benefits that would be used to determine four types of coverage packages (bronze, silver, gold and platinum) of varying actuarial values. All individual and fully insured group insurers would have to offer, at minimum, plans in the silver and gold values.<br><br>The essential benefits determined by the Secretary must include | A new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General, will recommend a benefit package based on standards set in the law. This new essential benefit package will serve as the basic benefit package for coverage in the exchange and over time will become the minimum quality standard for employer plans. |

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| | coverage of the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.<br><br>A separate catastrophic-only policy would be available for those 30 and younger. | The basic essential benefits package will include preventive services and well child care with no cost-sharing, hospitalization, outpatient hospital and outpatient clinic services, including emergency department services, physician and other health professional services, prescription drugs, rehabilitative services, mental health, behavioral health and substance use services, durable medical equipment, prosthetics and orthotics, maternity care, well baby and well child care and oral health, vision, and hearing services, equipment and supplies up to 21 years of age.<br><br>The out-of-pocket maximum will be $5,000 for individuals and $10,000 for families, indexed to the CPI. Copayments are preferred over co-insurance.<br><br>There will be three levels (actuarially equivalent) of coverage. The basic package will look at the benefits above, as modified by the Health Benefits Advisory Committee, and be required to provide the required benefits, with no more than 30% cost-sharing (not counting premiums).The enhanced package will consist of the same benefits, but with 15% cost-sharing. The premium plan will be designed so that benefits are actuarially equivalent to 95% of the value of the reference benefits. |
| **Market Reforms** | Coverage must be offered on a guarantee issue basis in all markets and be guaranteed renewable. Exclusions based on preexisting conditions and policy rescissions would be **prohibited in all markets.**<br><br>All group plans (small and large), except grandfathered plans and self-funded plans, would be prohibited from offering unreasonable lifetime limits.<br><br>Would require all individual health insurance policies and all fully insured group policies to abide by strict modified community rating standards with premium variations only allowed for age (3:1, difference from oldest insured individual to youngest), tobacco use (1.5:1), family composition and geographic regions to be defined by | Would require all health plans, whether fully insured or self-funded, to issue coverage regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. Dependents would have to be covered to age 26.<br><br>For all qualified health benefit plans, **regardless of size**, it would impose strict modified community rating with premium variations only allowed for family enrollment, geographic regions, and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insured by a ratio of 2:1.<br><br>No premium variations would be permitted for health status, gender, class of business, **claims experience** or any other factor not specifically described in the legislation. |

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| | the states. Experience rating would be prohibited.<br><br>Prohibits any annual limits or lifetime limits in group or individual plans after 2014. Between now and then, the only limits allowed are for nonessential benefits.<br><br>Small group coverage is defined as 1 to up to 100 employees. States may elect to reduce this number to 50 for plan years prior to January 1, 2016. | |
| **Financing the Reforms** | Excise tax of 40% would apply to insurance premiums in excess of $8,500 for individuals and $23,000 for families. For qualified retirees and individuals in high-risk professions, the thresholds would still be $9,850, and $26,000 for families.<br>• HSAs, HRAs and FSAs included in calculation<br>• Amounts indexed annually for inflation<br>• 17 highest cost states allowed transitional higher amounts for 2013 (120%); 2014 (110%) and 2015 105%)<br><br>Increases the Medicare payroll tax from 2.9 percent to 3.8 percent for wages and self-employment income above $200,000 ($250,000 married). Current 2.9 percent rate retained for wages and self-employment income below this amount<br><br>Increases penalty for “taxable distributions” for non-qualified medical expenses from HSAs (from 10% to 20%)<br><br>Over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs.<br><br>Limits FSA contributions for medical expenses to $2,500 per year indexed for inflation.<br><br>Requires employers to report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy | Surtax on the adjusted gross income of upper-income Americans of 5.4% for joint filers making $1 million/single filers making $500,000 or more beginning in 2011 and thereafter. .<br><br>Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).<br><br>Pay or play payments from employers (see employer mandate)<br><br>Eliminates the tax deduction for retiree prescription drug coverage.<br><br>2.5 percent excise tax on medical devices.<br><br>Payments by employers to Exchanges<br><br>Payments from uninsured individuals.<br><br>Cuts to Medicare Advantage Program. |

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| | payments from their gross income under the bill.<br><br>Eliminates Medicare Part D deduction.<br><br>Creates a new 10 percent excise tax on indoor tanning.<br><br>Annual $2 billion fee/tax on Rx manufacturers.<br><br>Annual $2 billion fee/tax on medical device manufactures.<br>Beginning in 2011, imposes an annual $6 billion fee/tax on health insurance companies with $50 million in profits and assess the tax on a pro-rated basis to insurance companies based on profits. Carves out certain non-profit insurers from the insurer assessment<br><br>Raises 7.5% AGI floor on medical expense deduction to 10%; AGI floor for 65+ remains at 7.5%.<br><br>Prohibits health insurance companies from deducting any executive pay in excess of $500,000 if at least 25 percent of its gross premium income is derived from health insurance plans that meet specified minimum requirements. Under current law, businesses can deduct up to $1 million annually per executive. | |
| **Ability to Keep Your Current Coverage** | Individuals and employer group plans that wish to keep their current policy on a grandfathered basis would only be able to do so if the only plan changes made were to add or delete new employees and any new dependents. In addition, an exception is made for employers that have scheduled plan changes as a result of a collective bargaining agreement. | Existing individual policies would only be able to be retained if the only change to the policy was to add or delete a dependent.<br><br>Group plans would be allowed to phase in reform requirements over 5 years, eventually these plans would have to change to meet the terms of the proposed individual and employer mandates. |
| **HSAs, HRAs & FSAs** | The bill assumes inclusion of consumer directed and account-based products like HSAs, HRAs and FSAs and clearly includes them in the outlines of minimal creditable coverage. The 60% minimum actuarial value for Bronze level plans should be sufficient to cover many account-based consumer directed high-deductible plans.<br><br>Over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs. | The bill does not directly restrict HSAs, but 70 percent minimum actuarial value equivalents are insufficient to meet HSA qualified high deductible health plan requirements.<br><br>Prohibition of over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs.<br><br>Increases the tax on distributions from a health savings account that |

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| | Increases the tax on distributions from a health savings account that are not used for qualified medical expenses to 20% (from 10%).<br><br>The bill limits FSA contributions for medical expenses to $2,500 per year and indexes the limit for inflation. | are not used for qualified medical expenses to 20% (from 10%).<br><br>The bill limits FSA contributions for medical expenses to $2,500 per year and does not index the limit for inflation. |
| **Small Business Assistance** | Beginning in 2010, provides tax credits for qualified small employer contributions to purchase coverage for employees. Would apply to small employers with fewer than 25 employees and average annual wages of less than $40,000 that purchase health insurance for their employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. Small employers could receive a maximum credit of up to 50% of premiums for up to 2 years if the employer contributes at least 50% of the total premium cost. The credit would phase out entirely for employers of more than 25 employees whose average annual salaries exceeded $40,000.<br><br>The credit is provided in two phases. In phase one the maximum credit amount is 35% of the employee's premium costs if employer contributes at least 50% of the premium costs or 50% of the benchmark premium. In phase two, the credit only applies if the small employer purchases coverage through the exchange and only applies for two years. | The bill provides a health insurance tax credit for small businesses, equal to 50% of the cost of coverage for firms where the average employee compensation is less than $20,000 for the first two years the employer provides coverage.<br><br>Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers.<br><br>Individuals with incomes of over $80,000 do not count for purposes of determining the credit amount. |
| **Government Run Public Option** | The government-run public plan option was eliminated from the Senate bill by the Manager's amendment, but it creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM).<br><br>At least two multistate plans must be offered through each state exchange and offer individual and small group coverage, and one must be offered by a non-profit entity. Multistate plans must operate under specified standards.<br><br>States can require that multistate plans offer additional benefits that | The measure would create a government-run public plan option that would be made available to consumers purchasing coverage through the Exchange. The bill states the plan shall comply with requirements related to other Exchange plans, and offer basic, enhanced, and premium plan options.<br><br>Premiums will be established according to exchange rules for other plans. The Secretary will negotiate rates for providers that are not higher than the average reimbursement rates paid by private plans offered through the Exchange.<br><br>The public plan will be initially financed by unlimited start-up funding |

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| | are more expensive than what is required federally, but then the states are responsible for the increased cost of exchange subsidies for the provision of those benefits. In addition, if a state imposes stricter age bands than what are imposed nationally (3:1) then the multistate plan has to comply with the state rules.<br><br>Gives states the option of establishing a federally-funded non-Medicaid state plan for people between 133-200% FPL who do not have access to affordable employer-sponsored coverage and would otherwise be eligible for subsidized coverage through a state-based exchange. The funding for this program will come from the subsidy dollars.<br><br>Also establishes a HRSA grant 10-state demonstration project to create state-based non-profit/private partnerships to provide coverage to the uninsured at reduced fees. | provided by Secretary of DHHS, but eventually it must be self-sustaining.<br><br>The public option will establish a formulary for prescription drugs and PBMS operating with the plan will be subject to new transparency requirements. |
| **Exchanges/ Information Portals** | Beginning no later than July 1, 2010, requires the states and the Secretary of DHHS to develop information portal options for state residents to obtain uniform information on sources of affordable coverage, including an Internet site. Information must be provided on private health coverage options, Medicaid, CHIP, the new high-risk pool coverage and existing state high-risk pool options.<br><br>Beginning January 1, 2014 each state must create an Exchange so as to facilitate the sale of qualified benefit plans to individuals. In addition the states must create "SHOP Exchanges" to help small employers purchase such coverage. The state can either create one exchange to serve both the individual and group market or they can create a separate individual market exchange and group SHOP exchange.<br><br>Beginning in 2014 would require employers to give a voucher to use in the individual market or exchange to their lower-income employees who would normally be ineligible to purchase subsidized coverage through the exchange instead of participating in the employer-provided plan. The value of vouchers would be adjusted | The bill would create a national Health Insurance Exchange to purchase coverage to be administered by a new federal Agency, the "Health Choices Administration," governed by a Commissioner to be appointed by the President.<br><br>The categories of people and businesses qualified to purchase coverage through the Exchange would be phased in over three year's time To up to 100 employees and the Commissioner has the authority to expand the exchange to larger groups after that.<br><br>Once someone is deemed eligible to participate in the Exchange, they will remain eligible until they qualify for Medicare, regardless of their other coverage options.<br><br>Also, states could establish their own Exchanges, provided that no more than one Exchange operates in any State. However, the new federal Commissioner would retain enforcement authority and could terminate the state Exchange at any time.<br><br>Allows people to stay on COBRA without time limits until the |

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| | for age, and the vouchers would be used in the exchanges to purchase coverage that would otherwise be unsubsidized. The employee can also keep amounts of the voucher in excess of the cost of coverage elected in an exchange without being taxed on the excess amount.<br><br>The bill allows for grants to the states to create the exchanges, but they must be self-sustaining by January 1, 2015.<br><br>Stand-alone child- only and dental plans would also be allowed to be offered through the state-based exchanges.<br><br>The individual low-income tax credits created would only apply to U.S. citizens or legal residents who purchase individual coverage through the exchange or do not have access to affordable employer-sponsored coverage and purchase policies through the exchange.<br><br>Individual and small group markets outside of the exchange are specifically permitted.<br><br>Beginning July 1, 2014, all members of Congress and Congressional employees must purchase their employer-sponsored health insurance coverage through a state-based exchange rather than using the traditional Federal Employees Health Benefits Plan. However, there is no penalty to transfer to a minimum benefit plan offered outside the exchange if you are eligible.<br><br>Initially the exchanges would be limited to individual and small group purchasers, but after January 1, 2017 states may allow large groups (over 100) to purchase coverage through the exchanges. | exchange is up and running. |
| **Retiree Medical Benefit Plans** | Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for those retirees eligible for Medicare Part D, effective for tax years beginning after Dec. 31, 2010.<br>Creates a temporary reinsurance program for employer health plans providing coverage for non-Medicare eligible retirees aged 55-64 and their families. It would reimburse plans for 80 percent of the cost | Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for those retirees eligible for Medicare Part D, effective for tax years beginning after Dec. 31, 2012.<br><br>Creates a temporary reinsurance program for employer health plans providing coverage for non-Medicare eligible retirees aged 55-64 |

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| | of benefits provided per enrollee above $15,000 and below $90,000. It would authorize $5 billion for the fund until the money is expended. Plan sponsors would have to submit an application to participate. Program is scheduled to sunset on January 1, 2014 and would take effect within 90 days of enactment. | and their families. It would reimburse plans for 80 percent of the cost of benefits provided per enrollee above $15,000 and below $90,000. The allocation of payments would be subject to collective bargaining if the benefits were provided to members of a represented bargaining unit. Participating plans would be subject to audit to ensure proper use of payments. Plan sponsors would have to submit an application to participate. $10 billion in funding is appropriated for use until expended.<br><br>Amends ERISA to require all group health plans to add a provision that expressly bars post-retirement reductions in benefits that may be provided to retirees or their beneficiaries unless the reduction is also made with respect to active participants. This prohibition would override any plan provision that reserves the right to amend or terminate the plan or specifically authorizes the plan to make post-retirement reductions in retiree medical benefits. A group health plan would not be prohibited from enforcing a total aggregate cap on amounts paid for retiree health coverage, provided the cap is part of the plan when the participant retires.<br>A "reduction in benefits" means:<br>• Changes in premiums: a participant's or beneficiary's share of the total premium (or for self-insured plans, costs of coverage) for the plan increases by more than 5%, or<br>• Changes in other cost-sharing and benefits: the actuarial value of the benefit package decreases by more than 5%.<br>The Secretary of Labor can grant a waiver if the employer can reasonably demonstrate that the requirements would impose an "undue hardship." |

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