National Association of Health Underwriters

Comparison of the Coverage Provisions in the American Health Choices Act and the House Democratic Tri-Committee Health Reform Legislation

August 3, 2009

	Senate HELP Committee Bill American Health Choices Act Passed by Committee July 15, 2009	House Democratic Tri-Committee Health Reform Bill, H.R. 3200, as Reported From the Three Committees of Jurisdiction
ERISA	This legislation would create a minimum standard for benefit plans that would apply to all sized groups (regardless of whether insured or self-funded). Additionally the rating reforms would apply to all-sized insured groups (not self-funded), limiting an area where ERISA currently permits pricing flexibility above small group reform standards. Claims experience rating for fully insured groups of any size would be prohibited.	This legislation would have a significant impact on self-funded group health plans in that it (1) would end ERISA's preemption by exposing self-funded groups to potential state criminal and civil actions; (2) would permit states to adopt single-payer models that would preempt ERISA and mandate participation by self-funded groups (under a Dennis Kucinich sponsored amendment which passed the Education and Labor Committee); (3) would create new tax on self-funded groups to fund comparative effective research; and (4) would require federal approval of ERISA health plans (similar to the requirement for retirement plans under ERISA)
Employer Mandate	Employers must pay 60% of the premiums for employee coverage or 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. The fee for part time employees is $375.	All employers must offer coverage through either 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-rata basis based on average hours worked. In lieu of paying for coverage, the measure creates a "pay

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	Employers with 25 or fewer employees are exempt.	or play" option allowing the employer to pay instead 8% of wages to the Commissioner. 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.
Individual Mandate	The legislation creates a requirement that all individuals have health insurance coverage with a federal income tax penalty on any individual who does not have in effect qualifying coverage for any month during the year. Health plans must provide a return to individuals as documentation of coverage. Exemptions will also be made for individuals for whom affordable health care coverage is not available or for those for whom purchasing coverage creates an exceptional financial hardship. The new tax penalty imposed for those who do not comply with the mandate would be 50% of the unsubsidized premium of a qualifying health plan providing the lowest level of acceptable coverage. The mandate is not applicable in states where Gateways are not yet operating.	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. The tax shall not exceed the applicable national average premium for individual or family coverage pro-rated for partial year failures. Acceptable coverage includes QHBPs, a grandfathered plan, Medicare, Medicaid, TRICARE and VA coverage. Any entity providing acceptable coverage to individuals must provide them with annual documentation of coverage, and regulations will be promulgated relative to hardship waivers and waivers for people with minimal lapses in coverage.

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Ability to Keep Your Current Coverage	Existing policies would only be able to be retained if the only change to the policy was to add or delete a dependent. Changes to deductibles, coinsurance, copays, and other cost-sharing would also be allowed if they were not deemed significant under rules to be developed by the Secretary.	Existing individual policies would only be able to be retained if the only change to the policy was to add or delete a dependent. 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.
Market Reforms	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. For all fully insured plans, **regardless of size**, it would impose strict modified community rating standards consisting of variances only by family structure, community rating area (defined by the HHS Secretary based on the recommendation of the NAIC), actuarial value of the benefit, and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of 2:1. 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. These rating rules do not apply to self-funded plans. An amendment was accepted during the mark-up that expanded the possible rating parameters slightly to allow	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. Would apply the HIPAA guarantee renewability and guarantee issue small group market rules to all health insurance markets. For all qualified health benefit plans, **regardless of size**, it would impose strict modified community rating standards consisting of variances only by family enrollment, geographic, and age bands that would limit premium differences for the oldest insured individuals to differ from the youngest insureds by a ratio of 2:1. 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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	for participation in wellness programs.	
Essential Benefits	The Secretary will determine (1) the schedule of items and services that constitute the essential health care benefits eligible for credits including the amount, duration, and scope of such items and services; (2) the coverage that should be considered minimum qualifying coverage and (3) the conditions under which coverage shall be considered affordable and available coverage for individuals and families at different income levels. At a minimum, these benefits must include: Ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, pediatric services, including oral and vision care. The maximum out of pocket limit will be roughly equivalent to the out of pocket maximum for an HSA qualified high deductible health plan for the year involved. The secretary will establish a standard under which coverage is deemed to be unaffordable only if the premium is greater than 12.5% of the AGI of the individual involved. In this case the individual would be eligible for affordability credits. The bill language currently requires such credits to be provided through the exchange rather than flowing through the employer sponsored plan. Regarding the level of benefits that must be provided for	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. The basic 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 and habilitative services, mental health and substance use services, maternity care, well baby and well child care and oral health, vision, and hearing services, equipment and supplies up to 21 years of age. The out of pocket maximum will be $5,000 for individuals and $10,000 for families, indexed to the CPI. Copayments are preferred over coinsurance. 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,

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	the services above, the Secretary will establish tiers of cost sharing. The first tier has coverage not less than 76% of the total allowed costs of the benefit and the out of pocket limit can't be greater than the HSA qualified high deductible health plan that year. Tier two cost sharing would be 84% of the benefit level and out of pocket limits equal to half of the amount for tier one. The third tier is 94% of the benefit level and out of pocket amounts equal to 20% of tier 1.	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.
HSAs, HRAs, FSAs	The bill does not impact any of these provisions. The essential benefits package clearly creates in its first tier a tier that would accommodate the benefit requirements of HSAs. HRAs would not be prohibited as long as the underlying insurance package met at least the requirements of HSA qualified coverage. FSAs are not addressed in this bill.	The bill does not directly impact these provisions, but there is some question about whether the actuarial equivalents are sufficient to meet HSA qualified high deductible health plan requirements. An amendment is pending in the House Energy and Commerce Committee that would ensure that this would not be a problem. There was one change mentioned below relative to over the counter prescription drugs which would no longer be an allowed expense in any of these plans.
Government-Run Public Plan Option	The bill creates a new Community Health Insurance Option to be offered through the Gateway. It does not require health care providers to participate. The benefits offered may include state mandates but if they do, the state will be required to pay the difference in cost for individuals who are eligible for subsidies. The Community Health Insurance option must set premiums that are sufficient to cover costs. The Secretary will negotiate rates for providers that are	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. Premiums will be established according to exchange rules for other plans. The Exchange will be initially financed by unlimited

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	not higher than the average reimbursement rates paid by private plans offered through the Gateway. The Secretary will establish a federal solvency standard. The minimum reserve fund will be equal at least to incurred but not reported claims. The plan will also be subject to the solvency standard of each state in which it is offered. An Ombudsman will be established to provide assistance to consumers. A fund will be established in Treasury to provide loans for initial operations that will include start up costs and claims for 90 days after the plan has begun and risk corridor payments. Plans have 10 years to repay the fund. States are required to establish a public or non-profit entity to serve as a State Advisory Council to provide recommendations to the Secretary on the operations and policies of the community health insurance option in the State.	start-up funding provided by Secretary, but eventually it must be self-sustaining including establishment of reserves. The Secretary will negotiate rates for providers that are not lower than Medicare rates or higher than the average reimbursement rates paid by private plans offered through the Exchange. The public option will establish a formulary for prescription drugs and PBMS operating with the plan will be subject to new transparency requirements.
Cooperatives		The Commissioner is authorized to provide grants for the establishment of non-profit member-based health insurance cooperatives that can be offered either through the national exchange or through state based exchanges.
Exchange	The measure requires each state to establish a variation of a health insurance exchange that is termed a Gateway.	The bill would create a national Health Insurance Exchange to purchase coverage to be administered by a

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	If a state does not establish a Gateway within four years, the Secretary must establish one for them. The legislation provides for grants to states to establish their Gateways. The Gateways will use risk-adjustment mechanisms to remove incentives for plans to avoid offering coverage to those with serious health needs.	new federal Agency, the "Health Choices Administration," governed by a Commissioner to be appointed by the President. The categories of people and businesses qualified to purchase coverage through the Exchange would be phased in over five year's time. Individuals and groups up to 10 would be allowed the first year, groups up to 20 would be allowed the second year, and any size group if allowed by the commissioner would be allowed in the 3rd and later years. 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. States would be allowed to transition their Medicaid populations to the Exchange—with appropriate supplemental wrap-around coverage—after five years. 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.
Risk Adjustment	States are required to set up a system for risk adjustment across state markets. If states have a higher risk profile than the average risk in the state, they will be eligible for additional funding from the state to offset their excess costs.	The bill requires the Commissioner to establish for the exchange "a mechanism whereby there is an adjustment made of the premium amounts payable" to plans to reflect differing risk profiles in a manner that minimizes adverse selection—and leaves to the Commissioner to

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	If a state has a lower than average risk profile, they will be required to pay an assessment to the state. This will be administered similar to Part D. Payments will be calculated on a retrospective basis. The risk adjustment applies across markets in a state, and is not limited to the Gateway. It does not apply to self-funded plans. Carriers are directed to pool their individual market risks in the Gateway and outside the Gateway together, and their group market risks together but are not required to co-mingle individual and group market risks.	determine all of the details of this mechanism.
Minimum Loss Ratios	For all fully insured health plans, the measure requires insurers to track reimbursements for clinical services, activities that improve health care quality and all other non-claims costs. This provision does not apply to self-funded plans.	All qualified health benefits plans will have to operate with a minimum loss ratio of 85%. If non-claims costs exceed 15%, beneficiaries must be rebated on a pro-rata basis for the excess.
New Regulatory Entities	The Gateways are the only new federal coverage entity in the second draft of the bill. States are required to establish State Advisory Councils to monitor the community health insurance option.	The measure provides for the creation of several new government entities to regulate the purchase of health insurance coverage including a new government agency, the "Health Choices Administration," governed by a Commissioner who would be appointed by the President and charged with governing the Exchange, enforcing plan standards, and distributing taxpayer-funded subsidies. There would also be a Health Insurance Ombudsman appointed by the new Commissioner to receive and

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		provides assistance with complaints, grievances, and requests for information; handle disenrollment problems; provide assistance to individuals selecting plans, and give assistance to individuals with affordability credits. Finally the bill would establish a new government health board called the "Health Benefits Advisory Committee," chaired by the Surgeon General, to make recommendations on minimum federal benefit standards and cost-sharing levels.
Medicaid Expansion	This provision was removed and referred to the Finance committee.	Would expand Medicaid coverage to all individuals with incomes up to 133% of the FPL. This expansion would be shared by states and the federal government.
Individual Subsidies	The legislation creates a complicated system of sliding-scale subsides for people purchasing coverage through the Gateway with incomes between 100% and 400% of the Federal Poverty Level (FPL). Funding will not be provided for individuals who are not lawfully present in the United States.	The legislation creates a system of sliding-scale tax for people with incomes between 100% and 400% of the FPL. The subsidies would only be available through the Exchange. Funding will not be provided for individuals who are not lawfully present in the United States. An employee with employer plan coverage that meets the standards of the coverage may not opt out of that coverage for subsidized coverage in the Exchange unless their income is 400% of FPL or below and their employer plan coverage is deemed unaffordable. Such employer coverage is deemed unaffordable for these individuals under the following circumstances: Coverage for employees with incomes between 133%

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		and 150% of FPL is deemed unaffordable if premiums are more than 3% of annual income, 150% -200% of FPL at 5.5% of annual income, 200% - 250% of FPL at 8% of annual income, 250% - 300% of FPL at 10% of annual income, 300% -350% of FPL at 11% of annual income, and 350% - 400% of FPL at 12% of annual income.
Small Business Assistance	Provides small employers with a health options tax credit. Eligible employers must pay an average wage of less than $50,000 and must pay at least 60% of employee health expenses. Credit is $1,000 for each employee and $2,000 for an employee with family coverage. It is adjusted for group size and # of months covered. Bonuses are paid for larger employer payments.	The bill provides a health insurance tax credit for small businesses, equal to 50 percent of the cost of coverage for firms where the average employee compensation is less than $20,000. Firms with 10 or fewer employees are eligible for the full credit, which phases out entirely for firms with more than 25 workers. Individuals with incomes of over $80,000 do not count for purposes of determining the credit amount.
Medicare Advantage	Not addressed.	This legislation would reduce Medicare Advantage payment benchmarks to traditional Medicare fee-for-service levels over a three-year period. The bill also imposes requirements on Medicare Advantage plans to offer cost-sharing no greater than that provided in government-run Medicare, and imposes price controls on MA plans, limiting their ability to offer innovative benefit packages. Specifically, the bill requires MA plans to report their ratio of total medical expenses to overall costs (i.e. a medical loss ratio), requires plans with a medical loss

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		ratio of less than 85 percent to offer rebates to beneficiaries, prohibits plans with a medical loss ratio below 85 percent for three consecutive years from enrolling new beneficiaries, and exclude plans with a medical loss ratio below 85 percent for five consecutive years.
Long-term Care	The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. There would be a five year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at $65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period. Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at $50 per day. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living. EMPLOYERS ARE REQUIRED TO PAYROLL DEDUCT THIS BENEFIT ON AN OPT-OUT BASIS. To promote the purchase of private long-term care insurance, the bill allows LTC insurance premiums to be	Although not included in the proposed legislation, an amendment has passed in the House Energy and Commerce Committee that would implement reforms similar to those approved in the HELP legislation. The bill creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. There would be a five year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at $65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period. Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at $50 per day. Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living.

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	included in Section 125 plans.	EMPLOYERS ARE REQUIRED TO PAYROLL DEDUCT THIS BENEFIT ON AN OPT-OUT BASIS.
How the new reforms are paid for	Although the HELP committee is not required to specify the exact methods of paying for its bill (this will be done by the Finance Committee), some new costs are clear. The new proposal does impose new tax penalties as described above for those who do not comply with an individual mandate. The new proposal also proposes new penalties for employers who do not provide approved coverage for their employees, as described above.	Surtax on the AGI of upper-income Americans, beginning with a 1% surtax on joint filers with incomes from $350,000-$500,000 for 2011 through 2012, and increasing to 2% in 2013 and thereafter; 1.5% for joint filers with incomes from $500,000-$2,000 in 2011 and 2012, increasing to 3% in 2013 and thereafter; and a top rate of 5.4% for joint filers making $1 million or more beginning in 2011 and thereafter (raises $544 billion). Prohibition of over-the-counter drugs as an eligible expense in HSAs, HRAs, and FSAs (raises $8 billion) Pay or play payments from employers, as described above (raises $163 billion) Tax on employer plans to fund Comparative Effective Research (raises $2 billion) Payments by employers to Exchanges (raises $45 billion) Delaying Worldwide Interest Allocation until 2020 (raises $26 billion) Limiting eligibility for reduced treaty withholding rates based on residency of foreign parent (raises 7.5 billion) Codification of Economic Substance Doctrine and

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		penalties for underpayments (raises $3.6 billion) Payments from uninsured individuals (raises $29 billion) Permanent reductions in the annual updates to Medicare's payment rates for most services (other than physician services (yields ($196 billion over 10 years) Setting payment rates in Medicare Advantage based on per capita Medicare spending in the fee for service sector (yields $156 billion) Changes to Medicare Part D that would establish a new rebate program for dual eligibles while expanding coverage in gap (yields $30 billion)

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