

PRELIMINARY SUMMARY OF SENATE HEALTH BILL:

- **Government Plan Option:** The bill includes a government plan option (from which States may opt out). It also authorizes state-based exchanges and non-profit co-op plans.
- **Agent role:** The legislation specifically allows agents to participate in selling insurance in the private market, or through the state-based exchanges. It also calls for marketing practice rules to be promulgated by regulation, and directs the Department of Health and Human Services (HHS) to set up a website to explain the insurance available through the exchanges. It also requires provision of clear explanatory documents to individuals explaining the insurance available through the exchanges.
- **Insurance Reforms:** The bill includes extensive insurance reforms, including:
 - Prohibition against use of preexisting conditions and health history in deciding to accept an insurance application, and in pricing it
 - Prohibition against all rescissions except in cases of fraud or intentional misrepresentation of material facts.
 - Community rating.
 - Limits on cost-sharing.
 - Elimination of lifetime benefit caps.
 - Prohibition against “unreasonable” annual benefit caps.
 - Prohibition against discrimination as to salary by employers offering health insurance (i.e., employers could condition employer-provided insurance on the level of a worker’s salary, or contribute more to the cost of health insurance on behalf of highly-paid workers than on behalf of rank-and-file workers).
 - The federal government, in conjunction with the NAIC, would establish allowable age-based rating bands.
 - Guaranteed issue and renewability.
 - Cost-sharing limits (generally, deductibles could not exceed \$2000 for individual coverage or \$4000 for family coverage. Those amounts are indexed. Flexible spending account (FSAs) amounts would be in addition to the allowable deductibles.
 - No waiting periods in excess of 90 days (and in most cases, only a 30-day waiting period will avoid fines and fees).
 - Employer-provided health insurance generally must be “qualified.” To be qualified, it must include one of four specified “essential benefits packages.”
 - Preventive services must be included in a qualified health plan, and may not be subject to cost-sharing requirements.
 - Dependent coverage is extended to unmarried children up to age 26, with regulatory authority granted for working out rules for older dependents.
- **Individual Mandate:** The bill also includes an individual mandate (a rule that generally requires all individuals to carry health insurance). There are exceptions to the individual mandate for hardship, religious objection or an exemption due to lack of access to affordable coverage—all of which are

specifically defined in the statute. The rule is imposed on a monthly basis (i.e., violations will occur for each month of no coverage). The penalty for failure to comply becomes fully effective in 2016, and is \$750/year (1/12 of that amount for each month of noncompliance). In 2014 the penalty is \$95/year and in 2015 it is \$350.

- **Employer “Shared Responsibility/Free Rider Provision:** Employers would not be subject to a mandate, as they would be under the House-passed health reform bill, H.R.3962. Rather, employers that do not offer health insurance to their workers would be subject to an assessment based on the number of workers who qualify for federal premium subsidies who must buy their insurance through the exchange. The fine is \$750 (indexed) per full-time employee. Employers with 50 or fewer full-time employees are exempt from this “free rider” rule. Seasonal workers (those who work less than 120 days per year) and part-time employees are not counted in calculating how the rules apply to a given employer.
- **Premium Increases:** Insurers’ rate increases will be subject, annually, to state review.
- **State Based Exchanges:** Each State will set up an exchange, open to individuals without access to affordable employer provided health insurance and small employers. Private insurance, insurance offered by non-profit co-ops, and the government plan can be offered through the exchange. All insurance, including co-op and government plans, are subject to all the insurance reforms, reporting requirements and other rules promulgated by the legislation and its implementing regulations. Exchanges will be initially funded by the federal government, must become self-sustaining (i.e., operated by income received from premiums for insurance sold within them), and will be operational by January 1, 2014.
- **Federal Long Term Care Program:** The bill includes the CLASS Act—a program offered by the late Sen. Edward Kennedy (D-MA) that would require employers to automatically enroll (subject to employee opt-out) workers in a program under which they would pay actuarially sound premiums (estimated at about \$65/month) for a daily cash benefit (also required to be actuarially sound, and projected to be about \$50/day) if, after at least five years of participation in the program, a participant were to become unable to perform at least two activities of daily living (ADLs).
- **Temporary High Risk Pool:** The bill authorizes \$5 billion for a high risk pool to insure people with preexisting conditions (or who are otherwise uninsurable) during the time it takes to set up exchanges (2014).
- **Wellness and Prevention:** The legislation provides for employer-established wellness and prevention programs.
- **Health Information Technology:** The legislation provides for electronic medical recordkeeping, claims processing, payments, etc.
- **Cost of Coverage:** Insurers are required to report annually on how much of their premium income they spend on claims, wellness programs, and all other non-claims costs (excluding State taxes, licensing and regulatory fees).

- ***Interstate Compacts:*** As of 2016, States can band together into interstate compacts under which residents of the participating states can purchase insurance sold in other participating states. The law of the state issuing the insurance will govern.
- ***Antitrust Laws:*** The only reference to antitrust laws found in the initial review of the legislation was with respect to co-ops and nonprofit insurance provided through co-ops. That section specifies that application of antitrust laws will not be limited with respect to co-op insurance. This bill does not appear to contain the House-passed bill's authority for Federal Trade Commission study of all lines of insurance, or its imposition of antitrust rules relative to health and medical malpractice rate-making, market share planning, etc.
- ***Medical Malpractice:*** There also does not appear to be inclusion of even limited medical malpractice reforms in this bill.