



NATIONAL ASSOCIATION OF INSURANCE AND FINANCIAL ADVISORS

## HEALTH CARE REFORM January 2010

	<b>SENATE</b> <b>Patient Protection &amp; Affordable Care Act HR 3590</b> <b>Passed 12/24/2009</b>	<b>HOUSE</b> <b>The Affordable Health Care for America Act HR 3962</b> <b>Passed 11/7/2009</b>	<b>NAIFA Principles</b>
<b>Insurance Market Reforms</b>	<p>Require guarantee issue and renewability. No preexisting condition exclusions</p> <p>Rating variation based only on age (3:1), tobacco use (1.5:1), family composition, and geography defined by the states in the individual and small group (up to 100 employees) markets</p> <p>All state-licensed insurers in the non-group and small group markets required to participate in the Health Insurance Exchange</p> <p>Require all insurers to issue policies in each of the four new benefit categories</p> <p>Allow states the option of merging the non-group and small group markets</p>	<p>Require guarantee issue and renewability. No preexisting condition exclusions</p> <p>Community rating for all health plans</p> <p>Limits rate variances to those based on area, family structure, and age (age variance is limited to 2 to 1)</p> <p>Unlimited COBRA access until exchange is available</p> <p>Established medical loss ratio of 85% (2010)</p>	<p>No preexisting condition underwriting and guaranteed-issue coverage if balanced with maintained coverage</p> <p>Modified community rating provides the opportunity for those who take the initiative to improve their lifestyle and health status to be rewarded in a premium cost variance</p> <p>Rating based upon individuals who present the same class characteristics should not vary more than +/- 30 percent from the modified community rate set because of health status, claim</p>

	<p>Cost-sharing limits (generally, deductibles cannot exceed \$2000 for individual coverage or \$4000 for family coverage (indexed))</p> <p>No waiting periods in excess of 90 days (and in most cases, only a 30-day waiting period will avoid fines and fees)</p> <p>Dependent coverage is extended to unmarried children up to age 26</p> <p>Established medical loss ratio of 85% for groups and 80% for individual and small group (reporting 2010; rebating 2011)</p>		<p>experience or any other factor</p>
<p><b>Connector Mechanism</b></p>	<p>HHS &amp; States to develop standardized format for presenting insurance options (private, Medicaid, CHIP, high-risk pools) including internet site</p> <p>States required to create Exchanges for individuals and small employers by Jan. 1, 2014</p> <p>Can be one for both or separate exchanges</p> <p>Federal funding to states to create</p> <p>Must be self-sustaining by Jan. 1, 2015</p> <p>Stand-alone child- only and dental plans would also be allowed to be offered through the state-based exchanges.</p> <p>Members of Congress and Congressional staff must purchase through a state-based exchange beginning July 1, 2014</p> <p>After 2017, states may allow large groups (over 100) to purchase coverage through the exchanges</p>	<p>Creates a new “National Health Insurance Exchange” administered by new federal agency “Health Choices Administration”</p> <p>Only “qualified health benefits plans” that meet all market reform requirements will be offered through the Exchange</p> <p>No explicit prohibition on insurance agents and brokers providing services in connection with Exchange plans (although Exchange administration has sufficiently broad authority to adopt limits)</p> <p>Phased-in eligibility for Exchange plans, starting with small employers (up to 100 employees) and uninsured individuals</p> <p>Allows option of developing a state or regional exchange in lieu of the national exchange, but only with federal approval</p> <p>Establishes an advisory council to make recommendations concerning the components of minimum benefits packages and maximum out of pocket costs</p>	<p>If government-organized exchanges or gateways are created as an alternative method for distributing coverage, consumers will need reliable information from which to make informed decisions</p> <p>It would be a significant mistake to assume that a federal government call center, website or unlicensed “navigators” could perform the many services currently offered by the professional advisor</p>

<p><b>Benefit Design</b></p>	<p>HHS to establish a standard of essential benefits and must include 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</p> <p>Four benefit categories would be created with the following actuarial values: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%)</p> <p>A separate catastrophic policy would be available for those under age 30</p>	<p>Create an essential benefits package that provides a comprehensive set of services as recommended by the Health Benefits Advisory Council and must 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</p> <p>All policies, including those offered through the Exchange and those offered outside of the Exchange must provide at least the essential benefits package</p> <p>Out-of-pocket maximum \$5,000 for individuals and \$10,000 for families, indexed to the CPI</p> <p>There will be three levels (actuarially equivalent) of coverage. Basic (70%), Enhanced (75%) and Premium (95%)</p>	<p>Allow insurers to offer low-cost, basic benefit packages which are exempt from costly benefit mandates. Basic benefit policies should be structured to keep premiums low. A basic benefit package can be designed with specific benefits or specific cost coverage</p> <p>Develop consumer choice health plans which encompass a variety of approaches to health care financing designed to improve consumer awareness of the costs and quality of their care</p>
<p><b>Individual Subsidies</b></p>	<p>Refundable tax credits to individuals and families with incomes between 100 and 400% FPL to purchase insurance through the Health Insurance Exchange.</p> <p>Employees with employer plan coverage that meets the standards of the coverage may not opt for subsidized Exchange unless employer coverage is deemed unaffordable (9.8% of income) or is not valued at 60% of the actuarial value of the essential benefits package (2014)</p>	<p>Provide affordability premium credits to individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange</p> <p>Available to individuals without employer coverage or employer cover that is more than 12% of their family income</p>	<p>Subsidies should be provided inside and outside the Gateway/Exchange</p> <p>Tax credits, full deductibility of premiums and other incentives should be adopted to encourage more businesses and individuals to purchase coverage.</p> <p>Make refundable, tax credits available for low-income individuals and families for the purchase of</p>

			health coverage. The credits would be used to purchase employer-sponsored insurance when an employer offers coverage
<b>Employer Subsidies</b>	<p>Provide small employers with fewer than 25 employees and average wages of less than \$50,000 with a health coverage tax credit</p> <p>Full credit of 50% of premium cost paid by employers is available to employers with 10 or fewer employees and average annual wages of less than \$20,000 for up to 2 years</p> <p>Credit phases-out as firm size and average wage increases</p>	<p>Provide small employers with fewer than 25 employees and average wages of less than \$40,000 with a health coverage tax credit</p> <p>Full credit of 50% of premium costs paid by employers is available to employers with 10 or fewer employees and average annual wages of \$20,000 or less for up to 2 years</p> <p>Credit phases-out as firm size and average wage increases</p>	Tax credits, full deductibility of premiums and other incentives should be adopted to encourage more businesses and individuals to purchase coverage
<b>Public Program Expansions</b>	<p>Expands Medicaid coverage to all individuals with incomes up to 133% of the FPL (2014)</p> <p>Creates a new State option to provide Medicaid coverage through a State plan amendment beginning on January 1, 2011.</p> <p>States required to offer premium assistance and Medicaid wrap-around benefits to beneficiaries who are offered employer-sponsored coverage if cost-effective</p> <p>States to maintain CHIP until 2019 and extend funding thru 2015</p>	<p>Expands Medicaid coverage to all individuals with incomes up to 150% of the FPL</p> <p>Eliminates the asset test for all groups except those receiving long-term care</p> <p>Prohibits the upper income Medicaid beneficiaries from obtaining other private coverage though the exchange</p> <p>Repeals CHIP (2014)</p>	<p>Support initiatives to expand access to health care to the 3 million adults and 6 million children who are eligible for, but not enrolled in, the Medicaid or Children's Health Insurance (CHIP) programs.</p> <p>Support adequately funding state Medicaid programs. Fully funding Medicaid will ensure that the important safety net that state programs provide will remain viable, and those with low incomes will be able to continue to receive necessary health care services</p>
<b>Individual Mandates</b>	<p>Individuals required to purchase qualified health insurance</p> <p>Non-compliance excise tax penalty of \$95 in 2014, \$495 in 2015, \$750 or 2% of income in 2016 and indexed thereafter for individuals age 18 and older</p> <p>Penalty for individuals under the age of 18 is half</p>	<p>Individuals required to purchase qualified health insurance (2013)</p> <p>Individuals who fail to obtain health coverage will be subject to 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</p>	A voluntary approach to coverage is preferred. However, a given proposal will not be automatically opposed simply because such proposal includes an individual or employer mandate, so long as it includes appropriate safe-guards designed to protect the vitality of choice, quality and competition, with

	<p>of the amounts above</p> <p>Exemptions allowed if the premium exceeds 8 percent of a person's income</p>	Exemptions allowed	<p>such safe-guards to include but not be limited to:</p> <ul style="list-style-type: none"> <li>• Appropriate cost sharing between employers and employees</li> <li>• Establishment of affordable basic benefits packages exempt from mandated benefit laws</li> <li>• Appropriate government subsidies for low-income individuals</li> <li>• Availability of pooling mechanisms to which high risks may be ceded</li> <li>• Real consequences for those that ignore the coverage mandate</li> </ul>
<b>Employer Mandates</b>	<p>Employers that do not offer health insurance to 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 (2014)</p> <p>The fine is \$750 (indexed) per full-time employee</p> <p>Employers with 50 or fewer full-time employees are exempt from this “free rider” rule</p> <p>Seasonal workers (less than 120 days per year) and part-time employees are not counted in calculating how the rules apply to a given employer</p>	<p>Employers must pay 72.5% of the cost of acceptable coverage for individuals and 65% for family coverage or pay 8% of wages (2013)</p> <p>Part-time employees must be covered on a pro-rated basis</p> <p>Employers with payroll up to \$500,000 are exempt from the requirement</p> <p>\$500,001 - \$585,000 = 2%</p> <p>\$585,001 - \$670,000 = 4%</p> <p>\$670,001 - \$750,000 = 6%</p>	<p>A voluntary approach to coverage is preferred. However, a given proposal will not be automatically opposed simply because such proposal includes an individual or employer mandate, so long as it includes appropriate safe-guards designed to protect the vitality of choice, quality and competition, with such safe-guards to include but not be limited to:</p> <ul style="list-style-type: none"> <li>• Appropriate cost sharing between employers and employees</li> <li>• Establishment of affordable basic benefits packages exempt from mandated benefit laws</li> <li>• Appropriate government subsidies for low-income individuals</li> <li>• Availability of pooling mechanisms to which high risks may be ceded</li> <li>• Real consequences for those that ignore the coverage mandate</li> </ul>
<b>New Public Plan</b>	Requires OPM to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions	<p>Creates a new public insurance plan option within the Exchange that will “compete on a level playing field” with private insurers</p> <p>Premiums will be set by HHS in accordance with the premium rules for plans participating in the</p>	A new government plan should not be created to contend with private insurance. In order to compete on a level playing field, the new government plan would need to comply with the numerous private

	Multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool	Exchange but set at a level to allow the program to fully finance itself plus a contingency margin  States will be allowed to impose mandates on public and Exchange plans, but only if states pay for any excess premium cost associated with their mandates	plan requirements including: state licensure, capital requirements, financial solvency, provider network adequacy standards, rate approval, federal and state taxes and assessments, state privacy protections and marketing requirements. If a government plan met the same requirements as private plans, there would be no reason to justify the enormous cost of creating a new federal government establishment to administer the government plan. Preservation of the private health insurance delivery system is necessary in order to ensure choice, quality and competition.
<b>Cooperatives</b>	\$6 billion in federal funding for a CO-OP Program to create nonprofit, member-run health insurance companies (2013)  Must meet state solvency and consumer protection standards	Start-up loans available to establish not-for-profit or cooperative plans (6 months after enactment)	
<b>Interstate Compacts</b>	States permitted (2016) to form "compacts" to allow for the purchase of non-group health insurance across state lines  HHS Secretary, working in consultation with the NAIC to issue regulations for the creation of such compacts	Allows for the creation of interstate compacts	Supports efforts to make health insurance more available and more affordable. However, there are issues of concern regarding policy pricing, as well as licensing (and oversight) of agents and advisors selling primary state individual health insurance in secondary states. Close financial oversight by each state's office or commissioner of insurance has helped protect the consumer purchasing financial protection from catastrophic health care expenses. This type of oversight would be compromised under proposals to allow the sale of health insurance across state lines

			unless multiple state regulatory issues are addressed.
<b>Risk Pool</b>	Creates temporary high-risk health insurance pool program to provide coverage to uninsured individuals with preexisting conditions (90 days after enactment)	Creates temporary high-risk health insurance pool program to provide coverage to uninsured individuals with preexisting conditions (2010)	Supports federal grants to states in order to provide health coverage for high-risk populations. States should establish high risk pools to meet the needs of the medically uninsurable. Funding of losses from such pools should be broad-based and not impose undue hardship on any single group.
<b>Antitrust and FTC Exemptions</b>	No provision.	Federal Trade Commission (FTC) to prepare studies and reports on the entire insurance industry and to repeal the limited antitrust exemption in the McCarran-Ferguson Act as it applies to health and medical malpractice insurance (upon enactment)	Opposes the naked repeal of the McCarran federal antitrust and FTC unfair trade practices exemptions. All that such repeals would accomplish would be to undermine the only insurance regulatory authorities – the states – to the detriment of both policyholders and small carriers. Ultimately, consumers will be faced with fewer insurance carriers willing to operate in certain regions of the country or offer appropriate products.
<b>Medical Malpractice</b>	States should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives  Five year demo grants to states for alternatives to tort litigations (2011)	Limited incentive to States to set up alternatives to litigation in cases of medical malpractice (upon enactment)	Supports reduction in defensive medicine by adopting a system of peer approved practice protocols, which would establish guidelines for providers to follow for specific procedures and impose limits on a provider's liability if such guidelines were followed in a non-negligent manner.  Medical malpractice and tort reforms should be enacted.
<b>Reporting and Disclosure Obligations</b>	Requires all employers provide notice to their employees informing them of the existence of an Exchange	Those who provide health insurance coverage will be required to provide covered individuals with tax returns describing the coverage and the time	Additional documentation requirements should not be overly burdensome and/or costly for

	<p>Requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan</p> <p>Employers will be required to list on employees' W-2 forms the value of the health insurance they provide to their workers (2011)</p>	<p>periods of coverage;</p> <p>Insurers and employers will be subject to random audits by the federal government to assess compliance with employer mandates</p> <p>"Corporate reporting" requires all business to report transactions of more than \$600</p>	<p>insurers and employers.</p>
<b>Long Term Care Insurance</b>	<p>Establishes a national voluntary long-term care insurance program</p> <p>Employers to automatically enroll workers (subject to employee opt-out) and payroll deduct premiums</p> <p>Workers 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)</p> <p>Premium collection begins in 2011 and benefits begin in 2016 under a five-year vesting requirement</p>	<p>Establishes a national voluntary long-term care insurance program</p> <p>Employers to automatically enroll workers (subject to employee opt-out) and payroll deduct premiums</p> <p>Workers 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)</p> <p>Premium collection begins in 2011 and benefits begin in 2016 under a five-year vesting requirement</p>	<p>Provide tax incentives for the purchase of long-term care insurance coverage including an above-the-line deduction for long term care insurance</p> <p>Permit long term care insurance in cafeteria plans</p>
<b>Disease Prevention &amp; Wellness</b>	<p>Provide grants for up to five years to small employers that establish wellness programs. (2011)</p> <p>Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs (two years following enactment)</p> <p>Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness</p>	<p>Provides wellness grants for up to three years to small employers for up to 50% of costs incurred for a qualified wellness program. (July 2010)</p> <p>Creates national task forces on evidence-based prevention and wellness</p> <p>Increases Medicare and Medicaid beneficiary access to proven preventive care services</p>	<p>Expand cost-effective wellness programs and preventive medicine</p> <p>Tax incentives for employers who offer long term wellness and disease prevention programs should be considered</p> <p>Create cost transparency by providing consumers with information about payment rates, the quality of care and services allowing them to make wise decisions about health care</p>

	<p>program and meeting certain health-related Standards</p> <p>The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (2014)</p> <p>Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)</p>		
<b>Costs</b>	<p>The Congressional Budget Office estimates the bill to cost \$848 billion over 10 years</p>	<p>The CBO says the bill's cost is \$1.05 trillion over 10 years</p> <p>After adding up a variety of new costs in the bill, including increased prescription drug coverage for seniors under Medicare, the cost is around \$1.2 trillion</p>	
<b>Financing</b>	<p>Imposes tax on individuals without coverage (see individual mandate)</p> <p>Imposes 40% excise tax on employer-sponsored coverage for any health insurance plan with a premium exceeding \$8,500/single coverage and \$23,000/family coverage (2013)</p> <p>FSA, HSA, HRA, MSA amounts included in calculation</p> <p>Higher thresholds would be established for retirees and for plans covering workers in high-risk professions</p> <p>Increases Medicare payroll tax from 1.45% to 2.35% on individual income in excess of \$200,000 and married filing jointly income of \$250,000 or more (2013)</p>	<p>Imposes tax on individuals without coverage (see individual mandate)</p> <p>Indexes annual cap of \$2,500 on contributions to FSA (2013)</p> <p>Increases from 10% to 20% in the penalty tax for early (prior to age 65) withdrawals (for nonmedical expenses) from HSAs (2011)</p> <p>Restricts tax-free use of FSA and HSA funds for medicine – only prescription medications will qualify for tax-free use of FSA and HSA funds (2011)</p> <p>5.4% surcharge on modified adjusted gross income in excess of \$500,000 for individuals and \$1 million for married couples filing joint tax returns (2011)</p> <p>Elimination of the tax deduction for employers receiving government subsidies for providing retiree</p>	<p>Preservation of the current federal employer deduction and employee exclusion is critical to the success of any health reform effort.</p> <p>It's not fair or responsible to finance comprehensive health reform on the backs of people who already have coverage.</p> <p>Financing efforts for health reform must begin by addressing the true underlying problem with our existing system: the cost of medical care. Bending the growth curve of health delivery costs and creating and synthesizing greater efficiencies in the delivery of medical care is the most important step toward making</p>

	<p>Increases from 10 percent to 20 percent penalty tax for non-medical early withdrawals from HSAs (2011)</p> <p>Restricts tax-free use of FSA and HSA funds for medicine – only prescription medications will qualify for tax-free use of FSA and HSA funds</p> <p>Limits annual FSA contributions to \$2,500 (2011)</p> <p>The FSA contribution limit is not indexed</p> <p>Medical expenses would be deductible to the extent they exceed 10 percent, up from 7.5 percent, of adjusted gross income (2013)</p> <p>Limits the deductibility of health insurance company executives' compensation (2009)</p> <p>10% tax on indoor tanning services (2010)</p> <p>Annual premium tax beginning at \$2 billion in 2010 and ramping up to \$10 billion annually by 2017</p> <p>New annual fees on pharmaceuticals (\$2 billion), and medical device manufacturers (\$2 billion)</p> <p>\$117 billion in cuts to Medicare Advantage (2012)</p> <p>Restructured Medicare &amp; Medicaid payment rates (varies)</p>	<p>prescription drug coverage</p> <p>Tax parity for employer-provided health coverage for domestic partners and other non-dependents</p> <p>Information reporting for payments made to corporations</p> <p>2.5% excise tax on the sale of medical devices (2013)</p> <p>Cuts to Medicare Advantage (2011)</p> <p>Restructured Medicare &amp; Medicaid payment rates (varies)</p>	<p>insurance coverage more affordable and our health system sustainable in the long term.</p>
<p><b>Additional Information</b></p>	<p>Final <a href="#">Bill Text</a> (2,409 pages) CBO <a href="#">analyses</a></p>	<p><a href="#">H.R. 3692 Bill Text</a> (1,990 pages) <a href="#">Section by Section Analysis</a> <a href="#">Major Changes</a> <a href="#">Implementation Timeline</a></p>	<p><a href="http://www.ahia.net/advocacy/documents/RXForHealthcare_0609.pdf">http://www.ahia.net/advocacy/documents/RXForHealthcare_0609.pdf</a></p>