



**Executive Summary of Key Provisions of the Senate Health Reform Legislation Impacted
by the House Reconciliation Legislation,
“The Health Care and Education Affordability Reconciliation Act”**
[as released on March 18, 2010]

Overview

On March 18, 2010, the House leadership released its budget reconciliation legislation that is intended to amend the Senate-passed “Patient Protection and Affordable Care Act.” House leaders simultaneously released the Congressional Budget Office score of the reconciliation measure, which estimated that the measure in conjunction with the Senate bill would devote \$940 billion to coverage expansion, while proposing budget offsets that would reduce the deficit by \$130 billion over ten years. The reconciliation bill contained many of the key provisions outlined in the proposal released by President Obama on February 22, 2010, including: an increase in subsidies for individuals and families to purchase coverage, changes to the personal coverage requirement, additional cuts to the Medicare Advantage program, and a delay in the application of both the excise tax (or “Cadillac tax”) on high cost plans and the premium tax (or “fee”) on health plans.

The information below includes highlights of the major provisions of the budget reconciliation measure as released on March 18, 2010.

Changes to Impact on Grandfathered Plans

The Senate bill exempts “grandfathered” individual and group health insurance coverage from the insurance provisions, with these plans continuing to be exempted from these requirements even if renewed. The reconciliation bill, however, requires grandfathered plans to comply with certain insurance reform provisions including, by six months after enactment, a prohibition on lifetime benefit limits, a prohibition on rescissions, extending dependant coverage to age 26 (except where other employer coverage is available), and prohibiting “unreasonable” limits on benefits (group coverage only). For renewals and new plan years beginning in 2014, the reconciliation bill prohibits pre-existing condition limits (group coverage only), as well as annual benefit limits.

Increase in Tax Credits for Health Insurance Premiums

Adjustments to Tax Credit Subsidies: Similar to the Senate bill, the reconciliation bill creates refundable tax credits for individuals with incomes between 133 percent and 400 percent of the federal poverty level (FPL). However, the reconciliation bill alters the value of tax credit subsidies for health plan premiums, increasing premium subsidies relative to the Senate bill for individuals between 133 and 150 percent FPL, 250 to 300 percent FPL, and 300 to 400 percent FPL. In addition, the reconciliation measure increases cost-sharing subsidies for families with incomes below 250 percent FPL.

Individual Responsibility

Mandate to Purchase Coverage and Excise Tax: The reconciliation measure does not alter the timing of the Senate bill's provision that requires all U.S. citizens and legal residents, beginning in 2014, to purchase coverage or face a penalty. However, the penalty one would face for failing to maintain coverage is changed to the greater of a flat fee of \$695 per year (\$750 in the Senate bill) or 2.5 percent of income (2 percent in the Senate bill). This would be phased in over time in the following manner:

| Year | Senate Bill Penalty | Reconciliation Bill Penalty |
|----------------|---|---|
| 2014 | The greater of \$95 or 0.5 percent of income | The greater of \$95 or 1 percent of income |
| 2015 | The greater of \$495 or 1 percent of income | The greater of \$325 or 2 percent of income |
| 2016 | The greater of \$750 or 2 percent of income | The greater of \$695 or 2.5 percent of income |
| 2017 and after | The greater of \$750 (plus a COLA) or 2 percent of income | The greater of \$695 (plus a COLA) or 2.5 percent of income |

Individuals below the filing threshold are exempt from these provisions.

Employer-Based Coverage

The Senate bill requires employers with more than 50 full-time workers that do not offer coverage and have at least one worker who receives the premium assistance tax credit to pay a fee of \$750 for each full-time employee. The reconciliation bill exempts the first 30 employees, for employers with 50 or more workers, from the payment calculation for firms that do not offer coverage. It increases the fee for such firms from \$750 to \$2,000 for each full-time employee who receives the premium assistance tax credit. Moreover, for larger employers offering coverage that have at least one employee receiving a premium tax credit, the amount that must be paid to offset those subsidies has been changed from the product of the number of full-time employees for that month and 400 percent of the applicable payment amount, to the product of the number of full-time employees for that month and 1/12 of \$3,000. In addition, the reconciliation bill eliminates the Senate provision requiring large employers that institute a waiting period to enroll in coverage that is more than 60 days to pay a fine of \$600 per full time employee. It also allows employers to count part-time workers' time as "full-time equivalents," calculated by dividing the aggregate number of hours of service of these employees for the month by 120.

Long-term Care Public Plan: The CLASS Program

The Secretary of Health and Human Services would establish a national voluntary insurance program, the CLASS Independence Benefit Plan, to provide community living assistance services and supports. The Secretary would also set criteria for participation in the program that does not restrict eligibility based on underwriting, establish criteria for eligibility for benefits and benefit levels, and establish mechanisms for collecting and distributing payments and assisting beneficiaries in the use of benefits. The Secretary would promulgate rules as necessary and take actions, including adjusting benefits or premiums, to maintain program solvency and ensure the program remains deficit neutral. The reconciliation bill delays the start of the Program from 2011 to 2012.

Medicare

Medicare Advantage (MA) Payments: The Reconciliation bill freezes 2011 MA payment rates at 2010 levels. Starting in 2012, MA plan county rates would phase down to benchmark targets based upon local fee-for-service (FFS) costs. County rates in areas in the highest quartile of FFS costs would be phased down to 95 percent of FFS; county rates in the second highest quartile would be phased down to 100 percent of FFS costs; county rates in the second lowest quartile would be phased down to 107.5 percent of FFS costs; and county rates in the lowest quartile would be phased down to 115 percent of FFS costs.

Organizations scoring four stars or more on the Centers for Medicare & Medicaid Services' (CMS) five-star rating scale would be eligible for a five percent county rate bonus phased in over three years. An additional five percent benchmark bonus would be available to four-star and above plans participating in specified areas. The phase-in period for the county rate changes would vary from two to six years, with plans that are estimated to experience larger reductions in their benchmarks subject to the longer phase-in period. The percentage of the savings that MA plans that bid below the benchmark may keep to provide additional benefits and reduce beneficiary cost-sharing would be reduced from 75 percent currently to 50 percent to 70 percent, phased in over three years. Plans that perform higher on CMS's star rating scale would be permitted to keep a higher percentage of these savings.

The reconciliation bill would extend federal authority for the MA coding intensity adjustment and establish a minimum adjustment of 5.7 percent starting in 2019. Starting in 2014, organizations with a medical loss ratio below 85 percent would be subject to penalties. All non-payment related MA provisions in the Senate-passed bill would continue to apply including the Special Needs Plan extension, changes to the annual and open enrollment periods, and new requirements for MA benefit packages.

Improving Coverage in the Part D Coverage Gap: The reconciliation bill provides a \$250 bonus to Part D enrollees entering the Part D coverage gap in 2010. The bill also gradually closes the Part D coverage gap from 2011-2020.

Independent Payment Advisory Board: The Senate legislation establishes a 15-member Independent Payment Advisory Board to make recommendations to Congress to reduce Medicare spending and improve quality. The Board's recommendations would become law in years that Medicare spending is determined to be unsustainable unless Congress enacts alternative measures to achieve similar savings. The Board would be prohibited from making recommendations that increase beneficiary cost-sharing or eligibility standards, raise taxes, or reduce payments to certain groups of providers including hospitals and physicians.

CMS Innovation Center: The Senate bill directs the Secretary to establish, prior to January 1, 2011, an Innovation Center within CMS authorized to test, evaluate, and expand different payment structures and methodologies that aim to improve quality and slow the rate of Medicare, Medicaid, and CHIP cost growth. The Center would be funded by a transfer of \$10 billion from the Part A and Part B Trust Funds over ten years.

Additional Hospital Insurance Tax on High-income Taxpayers: The Senate bill increases the Medicare hospital insurance payroll tax rate by 0.9 percentage points, beginning in 2013, on taxpayers above certain thresholds (\$200,000, singles/\$250,000, couples). The reconciliation bill retains this increase and adds a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents for taxpayers above certain thresholds (\$200,000, singles/\$250,000, couples).

Medicaid and CHIP

Medicaid: The Senate bill creates a new mandatory eligibility category of all non-elderly, non-pregnant individuals at or below 133 percent FPL effective January 1, 2014, and provides states the option of covering such populations beginning April 1, 2010. The reconciliation bill modifies the enhanced federal match rates for costs of services provided to the newly eligible. From 2014 through 2016, the federal government will pay 100 percent of the costs of covering the newly eligible for states that have not previously expanded Medicaid coverage to non-pregnant, non-elderly adults. Starting in 2017, the reconciliation bill incrementally decreases the federal medical assistance percentage (FMAP) for those states resulting in a rate of 90 percent for 2020 and each year thereafter. For states that have previously made such coverage expansions, the state receives a 50 percent reduction in its 2014 state match requirement, with the federal match incrementally increasing to a 90 percent FMAP rate in 2019.

A “maintenance of effort” is established in the Senate bill, under which states are required to maintain existing income eligibility levels for adults in Medicaid through September 30, 2013, and for all children in Medicaid and CHIP through September 30, 2019. Beginning in 2014, all states would have to use modified gross income for determining Medicaid eligibility. Income disregards and asset tests would no longer apply in Medicaid except for long-term services and supports, and for certain populations, such as individuals eligible for Medicaid through another program.

States would be required to offer premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered employer sponsored insurance if it is cost-effective as determined under current law requirements. In addition, the Senate bill facilitates enrollment coordination with state exchanges, and requires states to establish a state enrollment Web site to promote seamless enrollment in Medicaid, CHIP or the exchange should a Medicaid or CHIP-eligible individual apply for tax credits through a state exchange Web site or vice versa.

The reconciliation bill mandates that state Medicaid payments to primary care physicians in 2013 and 2014 shall be no less than 100 percent of Medicare payment rates, and provides 100 percent federal match for the incremental costs for meeting the mandate. Payments to primary care physicians under a capitated or partially-capitated arrangement must be consistent with the mandate.

The Senate bill increases the brand-name drug and generic drug rebate amounts and extends the Medicaid drug rebate to include drugs dispensed to enrollees of Medicaid health plans. It includes several provisions that provide incentives for states to increase their coverage of home and community-based services and supports. The Secretary is directed to develop a set of quality measures for Medicaid-eligible adults that is similar to the quality measurement program for children enacted in the Children’s Health Insurance Program Reauthorization Act of 2009. States are prohibited from making Medicaid payments for services related to a health care acquired condition. The scope of topics that the Medicaid and CHIP Program Advisory Commission (MACPAC) is to address is expanded to include federal Medicaid and CHIP regulations, and an assessment of adult services in Medicaid.

CHIP: The Senate bill maintains the current CHIP structure, requiring states to maintain income eligibility levels for currently eligible children in Medicaid (up to the CHIP eligibility level) and CHIP. Reauthorizes CHIP through 2015. It allows states to expand their current income eligibility levels at any time. CHIP-eligible children who cannot enroll in CHIP due to federal allotment caps are eligible for tax

credits in the state exchange. It provides additional federal allocations of \$17.4 billion in FY 2013, \$19.1 billion in FY 2014, and \$5.7 billion in FY 2015. Beginning in 2014, the legislation provides a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent, through federal FY 2019. Beginning in 2015, states that experience CHIP shortfalls may enroll targeted low-income children into qualified health plans that participate in exchanges. The qualified health plans must be certified by the Secretary as providing CHIP-comparable coverage.

Select Revenue-Raising Provisions

Excise Tax on High-Cost Insurance: The Senate bill imposes an excise tax, effective in 2013, on insurers equal to 40 percent of the aggregate value of employer-sponsored health coverage that exceeds the threshold amount of \$8,500 for an individual policy and \$23,000 for a family policy for 2013, indexed to CPI-U plus one percent. The reconciliation bill delays the tax to 2018 and increases the thresholds to \$10,200 for individuals and \$27,500 for families. The Senate bill allows for threshold adjustments for retired persons over age 55 and employees engaged in “high risk professions;” the reconciliation bill grants further flexibility to adjust thresholds to account for instances in which firms have higher health costs due to the age or gender of the workforce. The reconciliation bill adds dental and vision benefits to the list of products that are exempt from this tax, as outlined in the Senate bill (accident only, disability, long-term care, and employee-pay-all with after tax dollars for specified disease or illness, and hospital or other fixed indemnity coverage).

Annual Fee on Health Insurance Providers: The Senate health reform bill imposes a national premium tax (or “fee”), in the aggregate amount of \$70 billion over ten years, on the health insurance sector beginning in 2011, allocated by market share. The reconciliation measure delays the start date to 2014, and increases the industry’s total liability for annual fees as follows:

| Year | Senate Bill Fee Level | Reconciliation Bill Fee Level |
|--|-----------------------|-------------------------------|
| 2011 | \$2 billion | N/A |
| 2012 | \$4 billion | N/A |
| 2013 | \$7 billion | N/A |
| 2014 | \$9 billion | \$8 billion |
| 2015 | \$9 billion | \$11.3 billion |
| 2016 | \$9 billion | \$11.3 billion |
| 2017 (and, in Senate bill, each year thereafter) | \$10 billion | \$13.9 billion |
| 2018 | See above | \$14.3 billion |

In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.

The reconciliation bill eliminates the exemptions for certain non-profit insurers that meet minimum medical loss ratios and other requirements with a reduction in the fee that would otherwise apply to certain non-profit insurers that receive more than 80 percent of income from government programs targeting certain populations and voluntary employee benefit associations (VEBAs) that are not established by employers. In the case of tax-exempt entities, only 50 percent of premiums are considered in calculating the tax.

The reconciliation bill retains the same list of exempted products that was included in the Senate bill (long-term care, disability, accident only, specified disease or illness, hospital or other fixed indemnity, and Medigap). In addition, the reconciliation bill continues to make the tax non-deductible and applies only to fully-insured net premiums written. It makes no changes to the Senate bill's reinsurance provisions.

Delay of Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans: The reconciliation bill delays the imposition of the \$2,500 cap on FSA contributions from 2011 to 2013.

Annual Fee on Pharmaceutical Manufacturers and Importers: The reconciliation bill increases the fee from \$23 billion over ten years to \$28 billion, phased in between 2011 and 2019 and with the applicable amount holding steady at \$2.8 billion after 2019. The bill also delays the implementation of the tax from 2010 to 2011.

Conversion of Fee on Medical Device Manufacturers to an Excise Tax: The reconciliation bill removes the annual fee on medical device manufacturers established in the Senate bill, instead establishing in 2013 an excise tax on medical device sales equal to 2.9 percent of the price of the device. Exemptions apply to certain devices.

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America's Health Insurance Plans
601 Pennsylvania Ave., NW
South Building, Suite 500
Washington, DC 20004
202.778.3200
www.ahip.org