



**SELF-INSURANCE INSTITUTE
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Protecting and Promoting Self-Insurance and Alternative Risk Transfer Since 1981.

Summary of the Senate Healthcare Reform Proposal As Passed By the Senate

Sections Applying to the Employer-Based Healthcare System

As of 12/24/09

The following is a summary compiled by SIIA's Government Relations Staff of the "Patient Protection and Affordable Care Act" as passed by the Senate:

Italics = Not directly applicable to self-insured health plans

Insurance Market Reforms:

- Individual and Group Market Reforms:
 - Prohibition of lifetime limits - Prohibits all plans from establishing lifetime limits. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Prohibition of annual limits - Prohibits all plans from establishing annual limits on the dollar value of benefits starting in 2014. Prohibits plans from setting limits that would "impair essential health benefits" in subsequent years. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Prohibition on rescissions - Prohibits all plans from rescinding coverage except in instances of fraud or misrepresentation. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Coverage of preventive health services - Requires all plans to cover preventive services and immunizations, recommended by various Federal agencies, also specifically includes certain child preventive services and women's preventive care. Plans are prohibited from imposing any cost-sharing requirements. **Only applicable to self-insured plans established after 6 months from date of enactment**

- Dependent coverage - Requires all plans offering dependent coverage to make coverage available to dependents that are under the age of 26 and unmarried. Plans are not required to cover dependents of dependents. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Prohibition of discrimination based on salary – Prohibits plans from limiting eligibility for coverage based on the salaries of full-time employees.
 - Minimum Loss Ratio – Group plans required to spend a minimum of 85% on claims payment. Through 2013, plans required to rebate beneficiaries the amount of premium revenue spent on non-claims costs which exceed 20% in the group market and 25% in the individual market. Plans are required to report compliance.
- Insurance Market Reforms:
 - Rating rules – Premiums in the individual and small group markets may vary only by family structure, geography, the actuarial value of the benefit, age (limited to a ratio of 3 to 1) and tobacco use (limited to a ratio of 1.5 to 1).
 - Guaranteed availability of coverage - Each health insurance issuer must accept every employer and individual in the State that applies for coverage, permitting annual and special open enrollment periods for those with qualifying lifetime events.
 - Guaranteed renewability of coverage - Requires guaranteed renewability of coverage; regardless of health status, utilization of health services or any other related factor.
 - Prohibition of preexisting conditions - No group health plan or insurer offering group or individual coverage may impose any pre-existing condition exclusion or discriminate against those who have been sick in the past. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Prohibiting discrimination based on health status - No group health plan may set eligibility rules based on health status, medical condition, claims-experience, receipt of healthcare, medical history, genetic information or evidence of insurability – including acts of domestic violence or disability. Permits employers to vary insurance premiums by as much as 30 % for employee participation in certain health promotion and disease prevention programs. **Only applicable to self-insured plans established after 6 months from date of enactment**
 - Prohibition on waiting periods - Prohibits any waiting periods for group or individual coverage that exceed 60 days. Employers are penalized \$600 per full-time employee for each employee required to wait beyond 60 days. **Only applicable to self-insured plans established after 6 months from date of enactment**

Uniform Explanations and Standardized Definitions:

- Requires plans to issue a summary of benefits and explanation of coverage to beneficiaries with the following criteria:
 - In uniform format
 - In “easily understood” language
 - Inclusion of uniform definitions of standard insurance and medical terms
 - Explanation of cost-sharing exceptions, reductions and limitations on coverage
 - Provide common benefits scenarios

Required Appeals Process Implementation:

- Requires plans to implement a process for external appeals of coverage determinations and claims
- Requires self-insured plans to comply with minimum standards to be established by the Secretary of DOL
- **Only applicable to self-insured plans established after 6 months from date of enactment**

Premium Increase Review and Restrictions:

- *Requires States to perform annual review of increases in premiums by exchange participating plans*
- *States recommend to their exchanges whether issuers should be excluded from exchange*

Health Information Technology:

- Adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under HIPAA (such as benefit eligibility verification, prior authorization and electronic funds transfer payments)
- Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary

“Young Invincibles” Plan:

- Allows health insurers to offer a catastrophic, high-deductible plan as an exchange option
- To be eligible for plan, individuals must be either:
 - Under the age of 30
 - Exempt from the individual responsibility requirement because coverage is unaffordable to them
 - Individuals with access to employer-sponsored plans who meet criteria may join
 - Plan must:
 - Cover essential health benefits
 - Cover at least 3 primary care visits
 - Require cost-sharing up to the HSA out-of-pocket limits

Allowable Prevention and Wellness Incentives:

- Allows employers to discount up to 30% of the premium or cost-sharing requirements for participants in a workplace wellness program
- Provides discretion to HHS to permit discounts up to 50%

Temporary Early-Retiree Reinsurance Program:

- Establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to early retirees (age 55-64) and their families
- The program reimburses participating employment-based plans for 80 % of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000

Out-of-Pocket Limits:

- *Prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts*
- *For the small group market, prohibits deductibles that are greater than \$2,000 for individuals and \$4,000 for families*

Health Insurance Exchanges:

- *Each State to establish and operate an “American Health Benefit Exchange”*
- *State exchange to include sub-exchange for small businesses*
- *Private and non-profit COOP plan options*
- *Participating plan requirements:*
 - *Offer TBD “essential health benefits”*
 - *Limit cost-sharing*
 - *Has a specified actuarial value (pays for a specified % of costs)*
- *Allows States to require benefits in addition to “essential benefits”, but States must subsidize additional costs*
- *After initial startup, exchanges required to be self-sustaining and are allowed to charge user fees*
- *Interstate, or regional exchanges allowed for States who agree to do so*
- *Within three years of enactment, businesses of all sizes may be allowed to purchase coverage through an exchange*

OPM Administered Plans:

- *Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through Exchanges in each State*
- *Requires OPM to negotiate contracts in a manner similar to the manner in which it negotiates contracts for the Federal Employees Health Benefits Program (FEHBP)*
- *Allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins and premiums*

Temporary Reinsurance Fund:

- *Enacts a temporary reinsurance program with financial assistance for those who have been uninsured for several months and have a pre-existing condition*
- *Designed to ensure premium rate limits for the newly-insured population*
- *Only insurers in the small and group markets to make and receive payments*

Temporary Risk Corridors:

- *Established temporary risk corridors for insurers in the small and group market*
- *If a plan's costs (other than administrative costs) exceed 103 percent of total premiums, the Secretary makes payments to the plan to defray the excess*
- *If a plan's costs (other than administrative costs) are less than 97 percent of total premiums, the plan makes payments to the Secretary*

Risk Adjustment:

- *Requires States to assess charges on health plans with enrollees of lower-than-average risk, and to provide payments to health plans with enrollees of higher-than-average risk*
- *Risk adjustment applies to plans in the individual and small group markets*

Healthcare Cooperatives:

- *Allows for a member-run, health insurance plan as an exchange option*
- *Required to operate as a non-profit*
- *Federal grants to meet solvency standards*
- *Federal loans for start-up costs*
- *Exempts participants from taxation*

Temporary Exchange Reinsurance Program:

- *Temporary program to be available during the first three years of the operation of the exchanges*
- *Designed for individual and small group markets*
- *Collects payments from all insurers in the individual and group markets*
- *Makes payments to insurers who cover high-risk individuals*

Risk Corridors:

- *Risk corridors established for first three years after the enactment of the exchanges*
- *Plans whose costs (other than ad-min costs) exceed 103% of total premiums would receive a Federal payment*
- *Plans whose costs (other than ad-min costs) are less than 97% of total premiums would make a payment to the Federal government*

Low-Income Tax Credits:

- *“Premium assistance” credits available to low-income workers (w/o access to employer-sponsored plan) to subsidize the cost of coverage*
- *Credit amount is calculated on sliding scale:*
 - *starting at two % of income for those at or above 100% of poverty*
 - *phasing out to 9.8 % of income for those at 400% of poverty*
- *Employees with access to employer-sponsored coverage are eligible for credit (for use in an Exchange only), if:*
 - *Plan covers less than 60% of total coverage cost*
 - *The premium exceeds 9.8 of total income*

Reduced Cost-Sharing:

- *Sets out-of-pocket maximums (indexed yearly upon enactment) of:*
 - *\$5,950 for individuals*
 - *\$11,9000 for families*
- *Maximums reduced by:*
 - *one-third for those between 100-200% of poverty*
 - *one-half for those between 200-300% of poverty*
 - *two-thirds for those between 300-400% of poverty*
- *The plan’s share of total allowed costs of benefits would be increased to:*
 - *90 % for those between 100-150% of poverty*
 - *80 % for those between 150-200% of poverty*

Small Business Tax Credits:

- *Provides a tax credit to small employers starting in 2010 who purchase coverage:*
 - *The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000*
 - *Sliding scale credit available for employers with 11-25 employees with average annual wages below \$50,000*
- *To be eligible for a tax credit, the employer must contribute at least 50% of the total premium cost*
- *Eligible employers who purchase coverage through the State Exchange can receive a tax credit for two years of up to 50% of their contribution*

Individual Insurance Mandate:

- *Requires all individuals to have healthcare coverage either through an exchange certified “qualified health plan” or through an employer plan that meets the minimum standards*
- *Individuals required to report coverage to the IRS*
- *Penalty levels for non-compliance:*
 - *In 2014, the higher of \$95 or 2% of income*
 - *In 2015, the higher of \$495 or 2% of income*
 - *In 2016, the higher of \$750 or 2% of income*
- *For those under the age of 18, the penalty will be one-half the imposed yearly penalty amount up to cap of \$2,250 for the entire family*
- *After 2016, all penalty amounts are indexed by the annual cost-of-living adjustment*

Employer Mandate:

- Requires an employer with more than 50 full-time (over 30 hours) employees, that does not offer coverage and who has at least one full-time employee receiving a “premium assistance” tax credit, to pay \$750 per full-time employee – adjusted annually and non-deductible
- Requires an employer with more than 50 full-time employees that offers coverage, but has employees receiving the “premium assistance” tax credit, to pay the lesser of \$3,000 for each employee receiving the credit, or \$750 for each full-time employee - adjusted annually and non-deductible
- An employer with more than 50 full-time employees that maintains an enrollment waiting period would be required to pay:
\$600 for any full-time employee subjected to longer than a 60 day waiting period - adjusted annually and non-deductible

Employee “Free Choice” Voucher:

- Allows employees with access to an employer-sponsored plan, under certain income eligibility, to receive a voucher from their employer, equal to their employer’s contribution (“free choice” voucher), to purchase coverage through an Exchange participating plan
- To be eligible for a voucher, an employee would have to meet both of the following criteria:
 - The cost of the employee’s coverage needs to be between 8% and 9.8 percent of the employee’s household income
 - Employee has a household income below 400% FPL
- The contribution amount to the voucher must be equal to the amount the employer contributes to their own health plan
- If the employee chooses coverage that costs less than the voucher, the employee keeps the remainder amount
- Vouchers cannot be taxed as income

Automatic Enrollment:

- Requires employers with more than 200 employees to automatically enroll new full-time employees in coverage
- Requires employers to provide adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in

Reporting Requirements for Employer-Plan Sponsors:

- Requires large employers (over 200 employees) to report the following:
 - Whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan
 - The length of any applicable waiting period
 - The lowest cost option in each of the enrollment categories under the plan
 - The employer’s share of the total allowed costs of benefits provided under the plan
 - The number and names of full-time employees receiving coverage
 - Disclose the value of the benefit provided by the employer for each employee’s health insurance coverage on the employee’s annual Form W-2

Requirement to Disclose Coverage Options:

- Requires that an employer provide notice to their employees informing them of the existence of an exchange

Excise Tax on Generous Plans:

- Levies an excise tax of 40% on insurance companies and plan administrators for any health coverage plan that is above the threshold of:
 - \$8,500 for single coverage
 - \$23,000 for family coverage

Fees on Self-Insured Plans:

- In 2013, the plan sponsor of a self-insured plan is required to pay \$2 multiplied by the average number of covered lives
- From 2013-2019 the previous year's fee is multiplied by projected per-capita amount of National Health Expenditures
- Plans are not required to pay fees beyond 2019

Fees on Health Insurance Providers:

- *Imposes an annual flat fee of \$6.7 billion on the health insurance sector allocated across the industry according to market share*
- *Does not apply to companies whose net premiums written are \$25 million or less*

Fees on Pharmaceuticals:

- *Imposes an annual flat fee of \$2.3 billion on the pharmaceutical manufacturing sector beginning in 2010*

Fee on Medical Devices:

- *Imposes an annual flat fee of \$2 billion on the medical device manufacturing sector in years 2011 – 2017*
- *Imposes an annual flat fee of \$3 billion on the medical device manufacturing sector in years after 2017*

Increase in Tax on HSAs Used For Non-Qualified Medical Expenses:

- Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20

Termination of Deductibility of Medicare Prescription Drug Subsidies:

- Elimination of the deductibility of Federal subsidies for Medicare Rx programs

Limitation on Health Flexible Spending Arrangements:

- Limits the amount of contributions to health FSAs to \$2,500 per year indexed by CPI

Annual Report on Self-Insured Plans:

- Requires the Secretary of DOL to prepare an annual report, using information obtained from submitted Form 5500, on various aspects of self-insured, group health plans
- Report will include:
 - Plan type
 - Number of participants
 - Benefits offered
 - Funding arrangements
 - Benefit arrangements
 - Data from the financial filings including:
 - Information on assets
 - Liabilities
 - Contributions
 - Investments
 - Expenses