SENATE FINANCE COMMITTEE HEALTH CARE REFORM BILL
BRIEF OVERVIEW

- **Health Insurance Exchanges**: States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers or two separate exchanges. Four benefit categories would be available in both the individual and small group markets: bronze, silver, gold and platinum. Qualified private plans as well as co-ops would be available in the exchanges.

- **No Public Plan**

- **CO-OPs**: The bill authorizes $6 billion in funding for the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies that serve individuals in one or more states. CO-OP grantees would compete in the reformed individual and small group insurance markets. Federal funds would be distributed as loans and grants. Loans would be provided to assist with start-up costs, and grants would be provided to meet state solvency requirements. Organizations participating in the CO-OP program would be permitted to enter into collective purchasing arrangements for services and items that increase administrative and other cost efficiencies, especially to facilitate start-up of the entities, including claims administration, administrative services, health information technology, and actuarial services. Grant and loan awards will be made by the Secretary of HHS. Recommendations to the Secretary of HHS will be made by an advisory board chaired by the Secretary of HHS or his or her delegate and the other members appointed by the Majority Leader of the Senate (four members), the Minority Leader of the Senate (three members), the Speaker of the House of Representatives (three members) and the Minority Leader of the House of Representatives (three members).

- **Agent Commissions**: State insurance commissioners would continue to provide oversight of insurance plans with regard to consumer protections (e.g., grievance procedures, external review, agent practices and training, market conduct), rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans as specified in this bill. They would provide oversight of plans with regards to Federal rating rules and any additional state rating rules, facilitate risk-adjustment within service areas, and establish rate schedules for broker commissions in the state exchanges.

- **Agent Marketing Regulations**: The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new Federal law with regards to Federal health insurance rating, issuance and marketing requirements. This model becomes the new Federal minimum standard without any further Congressional action. The new model should be developed by the NAIC with input from all NAIC members, health insurance issuers, consumer groups and other qualified individuals. Representatives shall be selected in a manner so as to assure balanced representation among the interested parties. Once completed, the NAIC Model Regulation is considered a Federal regulation. If the NAIC does not act with the 12 month time period, the Secretary of HHS

promulgates regulations within six months in a manner consistent with the new Federal law. Once the Model is completed, states must adopt the new NAIC Model (or adopt the HHS Model if the NAIC did not act in the specified time period) through changes in state regulation and/or legislation. States may also, with approval from the Secretary of HHS, implement a rule or provision differently as long as it is still consistent with the intent of the new Federal law and provides the same level of consumer protections. If a state fails to adopt the changes in conformance with the new Federal minimum standards either by adopting the NAIC Model or through Secretarial approval, conflicting state laws would be preempted. In such a case, insurers would then offer coverage under Federal law and be overseen by HHS until the state adopts the necessary changes.

- **Individual Mandate**: Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through (1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or (2) in the large group market, in a plan with first dollar coverage for prevention-related services as recommended by the U.S. Preventive Services Task Force – except in cases where value-based insurance design is used and cannot have a maximum out-of-pocket limit greater than that provided by the standards established for HSA current law limit. Exemptions from the requirement to have health coverage would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. An individual enrolled in a grandfathered plan would be deemed to have met the responsibility requirement. The consequence for not maintaining insurance would be an excise tax. If a taxpayer's modified adjusted gross income (MAGI) is between 100-300 percent of the federal poverty line (FPL), the excise tax for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or an individual claimed as a dependent) is **$750 per year**. However, the maximum penalty for the taxpayer unit is **$1,500**. If a taxpayer's MAGI is above 300 percent of FPL the penalty for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or as an individual claimed as a dependent) is **$950 year**. However, the maximum penalty amount a family above 300 percent of FPL would pay is **$3,800**.

- **Guaranteed Issue**: Issuers in the individual market would be required to offer coverage on a guaranteed issue basis. Under guaranteed issue, if a plan has a capacity limit and the Secretary determines that the number of individuals who elect that plan would exceed the limit, the issuer would be allowed to limit the number of enrollees according to specified rules. Also, issuers would be required to offer coverage on a guaranteed renewability basis, and rate those policies on the same factors used when initially issuing such policies. Issuers would be prohibited from excluding coverage for pre-existing health conditions and from rescinding health coverage.

  The rules for the small group market would be the same as those for the individual market, except that they would be phased in over a period of up to five years beginning January 1, 2013, as determined by each state with approval from the Secretary.

- **Limited Premium Variance**: The bill would establish Federal rating, issue, renewability, and pre-existing condition rules for the individual market. Issuers in the individual market could vary premiums based only on the following characteristics: tobacco use, age, and family composition. Premiums could also vary among, but not within, rating areas to reflect geographic differences.

States would define geographic rating areas. Taking together all permissible risk factors, premiums within a family category could not vary by more than a 7.5:1 composite ratio.

- **Employers**: An employer would **not** be required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the exclusion from gross income would apply to the employer provided portion of the coverage. The tax treatment would be the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange. As a general matter, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 13 percent of the employee's income. All **employers with more than 50 employees** that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. The flat dollar amount would be equal to the average tax credit in the state exchanges. These payments would not be linked to the individual, but would be contributed to a general fund. The assessment is capped for all employers at an amount equal to $400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange credit).

- **Refundable Tax Credits**: The bill would provide a refundable tax credit for eligible individuals and families who purchase health insurance through the state exchanges. The premium tax credit will subsidize the purchase of certain health insurance plans through the state exchanges and will be refundable and payable in advance directly to the insurer. The tax credit would be available for individuals (single or joint filers) with MAGI up to 300 percent of the FPL.

- **Medicaid Expansion**: Medicaid would be expanded to 133% of FPL.

- **Small Business Tax Credit**: The bill would provide a tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small employer for this purpose generally would be an employer with no more than 25 fulltime equivalent employees (FTEs) employed during the employer's taxable year, and whose employees have annual fulltime equivalent wages that average no more than $40,000. However, the full amount of the credit would be available only to an employer with ten or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $20,000. The credit would initially be available for a maximum of two taxable years for any qualified small business offering health insurance. Beginning with taxable years ending after December 31, 2012, the credit would only be available for a small employer that purchases health insurance coverage for its employees through the state exchange.

- **Cadillac Tax:** Imposes an excise tax on insurers if the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount. The tax is equal to 35 percent of the aggregate value that exceeds a threshold amount. The threshold amount is $8,000 for individual coverage and $21,000 for family coverage for 2013. The threshold amounts are indexed to the Consumer Price Index for Urban Consumers (CPI-U) as determined by the Department of Labor beginning in 2014.

- **Other New Taxes:** Annual fees would be levied on insurance providers, drug makers, medical device manufacturers and clinical laboratories.

- **Cost**: In total, the bill would cost an estimated **$856 billion** over ten years.