National Healthcare Reform Proposals

Employer and Employee Considerations

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Introduction

This report is based on the two major healthcare reform bills that have been passed by Congress. The Senate Bill, the Patient Protection and Affordable Care Act (H.R. 3590[1]) was passed on December 24, 2009. The House Bill, the Affordable Health Care for America Act (H.R. 3962) was passed on November 7, 2009. Additionally, a Manager's Amendment to the Senate Bill was introduced on December 19, 2009 and passed on December 21, 2009. (A Manager's Amendment is a package of numerous individual amendments agreed to by both sides in advance. The managers are the majority and the minority member who manage the debate on a bill for their side.) This Manager's Amendment made significant changes to the Senate Bill and the employer and employee impact of these changes is included. This report focuses on the major aspects of the bills that will have a significant impact on employers and their employees. It is not intended to be an exhaustive comparison of all of the House and Senate bills' provisions, nor provide any direct guidance or solutions until a final bill is passed.

Traditionally, when two bills are passed that are not exactly the same, a bipartisan Conference Committee is formed to work out the differences and then the final bill is presented to both houses of Congress for final passage, and then sent to the President for his signature-it can not be further amended or changed during these final votes.

Due to the controversial nature of health care reform, and the desire for the Obama administration to have a final bill passed prior to the President's 2010 State of the Union Address, which is traditionally given in mid to late January, there has been speculation that House and Senate leadership will work out the differences themselves, rather than the public, and lengthy Conference Committee forum.

It appears very likely that a national healthcare reform bill will pass in 2010, and although some of the key provisions have staggered or delayed effective dates, employers need to understand now how the final bill may impact them and their employees – both directly and indirectly in order to develop a comprehensive employee benefits strategy.

[1] The Senate Bill has a House number for technical and parliamentary reasons.

Background and Overview

The national healthcare reform bills, like their Massachusetts predecessor, were originally introduced to reduce the number of uninsured Americans. In order to accomplish this goal, both bills will expand access to free or subsidized insurance, require all individuals to be covered (if "affordable"), and regulate the provision of health insurance benefits by employers. Additionally, the bills also provide for some changes in Medicare, Medicaid, and the methodology used to pay providers, which may also indirectly impact employers in terms of costs and administrative requirements.

Massachusetts' success to date has been measured in the reduction of the number of uninsured residents pre and post-healthcare reform. As employers evaluate the two bills, (and later the final bill), understanding that each provision has an overarching goal of more individuals eligible for insurance and more people covered, is important, as the final regulations may interpret the bill with a bias toward this goal.

Analyzing the Massachusetts experience, penalties from individuals not having coverage and employer fines for not providing/complying with the law will not provide all of the financing necessary to cover the uninsured. Additional taxes, fees, and appropriations will be necessary to pay for the subsidized premiums and the other costs of the final bill.

Massachusetts has also taught us that the regulations related to the final bill's provisions will be key to understanding and compliance. Both bills give great latitude and power to the Secretary of Health and Human services to promulgate regulations relative to the bill's sections. The Secretary's interpretation and applicability of the regulations could have a dramatically different result than other readers [authors] of the bill(s). The delayed implementation dates of some sections of the bills is used to draft these regulations, and give the tax, advocacy, and employee benefit community time to comment and/or testify relative to their applicability.

The two bills reference the Federal Poverty Levels (FPL) and various percentages above in determining individual eligibility and/or employer responsibility. A table of the various current (2009) Federal Poverty Levels is provided in the appendix.

We have utilized the Kaiser Family Foundation's side-by-side format and language[2] for comparison of some of the bills key sections.

[2] www.kff.org

Individual Requirements

Both the House and Senate bills contain a requirement that individuals have insurance coverage. The insurance coverage would have to meet certain criteria, and cover a minimum level of benefits. The Senate bill would be effective on January 1, 2014, the House bill on January 1, 2013.

Senate	House
Those without coverage pay a tax penalty of the greater of $750 per year up to a maximum of three times that amount ($2,250) per family or 2% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $495 in 2015, and $750 in 2016 for the flat fee or .5% of taxable income in 2014, 1.0% of taxable income in 2015, and 2% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, if the lowest cost plan option exceeds 8% of an individual's income, and if the individual has income below 100% of the poverty level.	Those without coverage pay a penalty of 2.5% of their adjusted income above the filing threshold up to the cost of the average national premium for self-only or family coverage under a basic plan in the Health Insurance Exchange. Exceptions granted for those with incomes below the filing threshold (in 2009 the threshold for taxpayers under age 65 is $9,350 for singles and $18,700 for couples), religious objections and financial hardship.

Longfellow Comment: The individual mandate will change employee behavior in terms of enrolling in health insurance coverage or enrolling in a different [more expensive] coverage tier. As the amount of the penalty increases relative to the cost of purchasing employer sponsored coverage, more individuals will choose to be covered rather than be subject to the penalty. Additionally, with the proposed expansion of the "dependent" definition [see insurance market reforms later in this report], the number of covered lives under an employer sponsored plan will likely increase [the final regulations will indicate the extent the various provisions will apply to self-insured plans]. Additionally, since the individual mandate requires individuals to have a certain level of coverage (e.g., "acceptable" or "qualifying") employers will want to ensure their plans meet these minimum levels of coverage so as to not unknowingly penalize employees for not meeting the mandate, although providing them with coverage.

The Massachusetts Law utilizes the individual's state tax return (separate schedule - HC) as the mechanism for certifying an individual (and/or their dependents) has health insurance coverage. The insurance carrier or plan sends [to the individual and the Department of Revenue] a Form 1099 HC indicating the months covered by an approved plan during the year.

Educating employees (and their dependents) about their responsibilities under the law will most likely fall on the human resources and employee benefits departments of employers. Similar to the Massachusetts requirements, employers may also be responsible for collecting standardized waiver forms annually, indicating that an employee was offered coverage, the cost of coverage, and declined.

Some of the issues to be settled in the final bill or in the related regulations will be:

- Definition of "individual" (e.g., age, citizenship status, etc.)
- Definition of "acceptable or qualifying insurance coverage"
- Affordability schedule
- Penalty amount and calculation methodology
- Effective date

Individual Premium Credits and Subsidies

Both the House and Senate bills contain provisions that provide for premium credits and/or subsidies. The Senate bill would be effective on January 1, 2014, the House bill on January 1, 2013.

Senate	House
Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee share of the premium exceeds 9.8% of income. Provide refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest-cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to: 2.8% of income for those at 100% FPL to 9.8% of income for those between 300-400% FPL, except that for those with incomes between 100 and 133% FPL, the premium contribution is limited to 2% of income.	Individuals with access to employer-based coverage are eligible for the premium and cost sharing credits if the cost of the employee premium exceeds 12% of the individuals' income. Provide affordability premium credits to eligible individuals and families with incomes up to 400% FPL to purchase insurance through the Health Insurance Exchange. The premium credits will be based on the average cost of the three lowest cost basic health plans in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income tiers: 133-150% FPL: 1.5 - 3% of income 150-200% FPL: 3 – 5.5% of income 200-250% FPL: 5.5 - 8% of income 250-300% FPL: 8 - 10% of income 300-350% FPL: 10 - 11% of income 350-400% FPL: 11 - 12% of income

Provide cost-sharing subsidies to eligible individuals and families with incomes between 100-200% FPL. For those with incomes between 100-150% FPL, the cost-sharing subsidies will result in coverage for 90% of the benefit costs of the plan. For those with incomes between 150-200%, the cost-sharing subsidies will result in coverage for 80% of the benefit costs of the plan. American Indians with income less than 300% FPL will not be subject to any cost-sharing requirements.	Provide affordability cost-sharing credits to eligible individuals and families with incomes up to 400% FPL. The cost-sharing credits reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income tier: 133-150% FPL: 97% 150-200% FPL: 93% 200-250% FPL: 85% 250-300% FPL: 78% 300-350% FPL: 72% 350-400% FPL: 70% Lowers the out-of-pocket spending limits established in the essential benefits package ($5,000/individual and $10,000/family) for eligible individuals and families with incomes up to 400% FPL to the following amounts: 133-150% FPL: $500/individual; $1,000/family 150-200% FPL: $1,000/individual; $2,000/family 200-250% FPL: $2,000/individual; $4,000/family 250-300% FPL: $4,000/individual; $8,000/family 300-350% FPL: $4,500/individual; $9,000/family 350-400% FPL: $5,000/individual; $10,000/family

Longfellow Comment: Employers, as part of their employee benefits strategy, will now need to evaluate the cost (employee contributions) of health insurance relative to their employee incomes. Employers can be penalized [see Employer Requirements later in this report] if any of their employees are receiving a premium credit.

Creditable Coverage

Both the House and Senate bills create minimum levels of coverage that would meet the standard for individuals to meet their mandate. The Senate bill would be effective on January 1, 2014, the House bill January 1, 2013.

Senate	House
Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package.	Create an essential benefits package that provides a comprehensive set of services, covers 70% of the actuarial value of the covered benefits, limits annual cost-sharing to $5,000/individual and $10,000/family, does not require cost sharing for preventive services, and does not impose annual or lifetime limits on coverage. The Health Benefits Advisory Council, chaired by the Surgeon General, will make recommendations on specific services to be covered by the essential benefits package as well as cost-sharing levels. All qualified health benefits plans, including those offered through the Exchange and those offered outside of the Exchange (except certain grandfathered individual and employer-sponsored plans) must provide at least the essential benefits package. Require a report on including oral health benefits in the essential benefits package.

Longfellow Comment: The details of an "essential health benefits package" will be determined in the final regulations, however they will include comprehensive services (i.e., not Mini-Med plans), and have limits on member out of pocket costs [see Insurance Market Reforms section of this report]. Employers will need to evaluate their benefit designs annually as the list of covered services and limits change to ensure compliance.

Employer Requirements

Both the House and Senate bills contain a requirement that employers offer insurance coverage. The Senate bill would be effective on January 1, 2014, the House bill on January 1, 2013.

Senate	House
Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit, a fee of $750 per full-time employee. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $750 for each full-time employee. For employers that impose a waiting period before employees can enroll in coverage, require payment of $400 for any full-time employee in a 30-60 day waiting period and $600 for any employee in a 60-90 day waiting period. Exempt employers with 50 or fewer employees from any of the above penalties. Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange.	Require employers to offer coverage to their employees and contribute at least 72.5% of the premium cost for single coverage and 65% of the premium cost for family coverage of the lowest cost plan that meets the essential benefits package requirements or pay 8% of payroll into the Health Insurance Exchange Trust Fund. Eliminate or reduce the pay or play assessment for small employers with annual payroll of less than $750,000: Annual payroll less than $500,000: exempt Annual payroll between $500,000 and $585,000: 2% of payroll; Annual payroll between $585,000 and $670,000: 4% of payroll; Annual payroll between $670,000 and $750,000: 6% of payroll.
Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	Require employers that offer coverage to automatically enroll into the employer's lowest cost premium plan any individual who does not elect coverage under the employer plan or does not opt out of such coverage.

Longfellow Comment: One of the keys in the final regulation will be the definition of “full time employee”, as this definition is critical to the application of this section. This section will regulate who is offered coverage (full time employee definition), when coverage is offered (waiting period), and how much an employer will contribute (either specifying a percentage, or a % of an employees income).

Employers will need to evaluate the impact of its employer contribution strategy on each employee, to determine who is eligible for a voucher, and if any employees are eligible for a premium tax credit. An employer contribution strategy based on salary level may make more sense given these proposals.

Additionally, employers will be required to auto enroll employees who do not waive coverage, this will create both additional administration and employee education given the strict rules regarding Section 125 plans, and dropping coverage.

Insurance Market Reforms

Both the House and Senate bills contain “insurance market reforms”. The effective dates of these provisions vary [are noted below], but some would take effect immediately.

Senate	House
Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)	Provide dependent coverage for children up to age 27 for all individual and group policies. (January 1, 2010)
Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.	Prohibit individual and group health plans from placing aggregate dollar lifetime limits on coverage. Prohibit insurers from rescinding coverage except in cases of fraud. (Effective six months following enactment) Limit pre-existing condition exclusions for group policies prior to implementation of the insurance market reforms by shortening the period plans can look back for pre-existing conditions from six months to 30 days and shortening the period plans can exclude coverage of certain benefits from 12 months to three months. (January 1, 2010) Prohibit reductions to retiree benefits unless reductions also apply to current employees. (Effective upon enactment)
Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011) Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases. Provide grants to states to support efforts to review and approve premium increases. (Effective beginning plan year 2010)	Limit health plans’ medical loss ratio to not less than 85% to be enforced through a rebate back to consumers and prohibit plans from imposing aggregate dollar lifetime limits on coverage. (January 1, 2010) Prohibit insurers from rescinding coverage except in cases of fraud. (July 1, 2010) Require review of increases in health insurance premiums prior to implementation of the increases. (Effective upon enactment)

Require all new policies (except stand-alone dental, vision, and long term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four standardized benefit categories. Existing individual and employer sponsored plans do not have to meet the new benefit standards. (January 1, 2014) Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (January 1, 2014) Penalize employers that require a waiting period for coverage of more than 60 days by requiring a payment of $600 for each full-time employee subject to the waiting period. (January 1, 2014) Allow states the option of merging the individual and small group markets. (January 1, 2014)	Prohibit coverage purchased through the individual market from qualifying as acceptable coverage for purposes of the individual mandate unless it is grandfathered coverage. Individuals can purchase a qualifying health benefit plan through the Health Insurance Exchange. (January 1, 2013) Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on pre-existing condition exclusions in the insured group market and in the Exchange. (January 1, 2013) Individuals eligible for COBRA continuation coverage may retain COBRA coverage until the Exchange is established or they obtain acceptable coverage. (Effective upon enactment)

Longfellow Comment: These market reforms apply to insurance companies and their offering of a fully insured plan, however, employers who are self insured may want to review their benefit designs as these market reforms will be tied to the creditable coverage and the “essential benefit plan” definition. Most states have already expanded their definition of dependent similar to these proposals, imputed income calculations and education will be necessary for those employees with non-IRS dependent “dependents”.

The House bill increases the time period that individuals can stay on COBRA. Although employees pay for this coverage, the claims for these COBRA members are part of an employer’s experience in the renewal calculation, or part of an employer’s self insured claims costs. This provision is effective immediately, if enacted.

Alternative Insurance Purchasing

Both the House and Senate bills create an insurance "exchange" and "CO-OP" Plans. The Senate bill would be effective on January 1, 2015, the House bill on January 1, 2013.

Senate	House
Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.	Create a National Health Insurance Exchange, through which individuals and employers (phasing-in eligibility for employers starting with smallest employers) can purchase qualified insurance, including from private health plans and the public health insurance option. Allow states to operate state-based exchanges if they demonstrate the capacity to meet the requirements for administering the exchange. Restrict access to coverage through the Exchange to individuals who are not enrolled in qualified or grandfathered employer or individual coverage, Medicare, Medicaid, TRICARE, or VA coverage.
Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (July 1, 2013)	Create a Consumer Operated and Oriented Program (CO-OP) to facilitate the establishment of non-profit, member-run health insurance cooperatives to provide insurance through the Exchange. (Effective six months following enactment)

Longfellow Comment: Massachusetts currently has such an exchange, without the "public health insurance option". It has not been successful in attracting small employers to utilize it as a substitute for an employee benefits offering. It has however, been effective as an aggregator for individuals and part time (ineligible for an employer sponsored plan) employees to purchase coverage.

Public Option

Both the House and Senate bills have government run programs. The Senate bill would be effective on January 1, 2015, the House bill on January 1, 2013. The House bill contains the so-called "public-option".

Senate	House
Require the Office of Personnel Management 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 beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has a lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.	Create a new public health insurance option to be offered through the Health Insurance Exchange that must meet the same requirements as private plans regarding benefit levels, provider networks, consumer protections, and cost sharing. Require the public plan to offer basic, enhanced, and premium plans, and permit it to offer premium plus plans. Prohibit the public plan from providing coverage for abortions beyond those permitted by federal law (to save the life of the woman and in cases of rape and incest). Finance the costs of the public plan through revenues from premiums. Require the public health insurance option to negotiate rates with providers so that the rates are not lower than Medicare rates and not higher than the average rates paid by other qualified health benefit plan offering entities. Health care providers participating in Medicare are considered participating providers in the public plan unless they opt out. Permit the public plan to develop innovative payment mechanisms, including medical home and other care management payments, value-based purchasing, bundling of services, differential payment rates, performance based payments, or partial capitation and modify cost-sharing and payment rates to encourage use of high-value services.

Longfellow Comment: Conventional wisdom indicates the "public option" in the house bill will not survive into the final bill. A public option would compete with traditional insurers, and would have an advantage in terms of financing and rate setting.

Tax Reforms

Both the House and Senate bills change tax laws as part of healthcare reform. Some of the key provisions are detailed below and their proposed effective dates.

Senate	House
Exclude over the counter (OTC) drugs from eligibility for reimbursement in an FSA, HSA, or HRA (January 1, 2011)	Exclude over the counter (OTC) drugs from eligibility for reimbursement in an FSA, HSA, or HRA. (January 1, 2011)
Limit Medical FSA contributions to $2,500. (increased annually by COLA) (January 1, 2011)	Limit Medical FSA contributions to $2,500. (January 1, 2013)
Increase excise tax on HSA distributions (from 10%-20%) not used for eligible medical expenses. (January 1, 2011)	Increase excise tax on HSA distributions (from 10%-20%) not used for eligible medical expenses. (January 1, 2011)
Increase the medical expense itemized deduction . 7.5% to 10% of adjusted gross income for individuals under age 65. (January 1, 2013)	Impose a tax of 5.4% on individuals with modified adjusted gross income exceeding $500,000 and families with modified adjusted gross income exceeding $1,000,000. (January 1, 2011)
Increase Medicare Part A tax rate from 1.45% to 2.35% for individuals earning $200,000or more and married couples filing jointly earning over $250,000. (January 1, 2013)	Impose a tax of 2.5% of the price on the first taxable sale of any medical device. (January 1, 2013)
Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $8,500 for individual coverage and $23,000 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) plus one percentage point). The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,350 for individual coverage and $3,000 for family coverage. In the 17 states [Massachusetts] with the highest health care costs, the threshold amount is increased by 20% initially; this increase is subsequently reduced by half each year until it is phased out in 2015.	

The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for dental, vision, and other supplementary health insurance coverage. (Effective January 1, 2013)	

Longfellow Comment: The tax aspects of the reform proposals will have a direct and measureable impact on employers and employees. The elimination of the tax exemption for over the counter medicines will both reduce the amounts employees save in their FSAs (notwithstanding the proposed $2,500 limit) and may lead to a higher prescription drug cost for the companion medical plan [the theory is that members will opt for a prescription medication covered by the medical plan if it is less expensive, (e.g. copay)].

This, combined with the limit of $2,500 will reduce the employer tax savings associated with the FSA, as well as reduce the amount of forfeitures, that may have been used to offset the expense of operating the plan.

The Medicare Part A tax increase appears to be on the excess compensation over $200,000 for individual filers and $250,000 for married filing jointly filers. The regulations would need to provide guidance on the operation of this provision since the employer will not know the compensation or filing status of the spouse, even if they know the employee is married.

Employers may have to annually value (e.g., actuarial certification?) their plans to determine if the fall within the limits, or be subject to the excise tax. Including the value of other benefits – dental, vision, etc. may lead to them no longer being offered if they push the value of the benefits package over the limits.

Other Provisions

Expansion of Medicaid

Both bills expand Medicaid to cover all individuals under age 65 with modified adjusted gross incomes of less than 133% FPL in the Senate bill, 150% FPL in the House bill.

Small Business Tax Credits

Both bills provide tax credit for small businesses (less than 25 employees and average annual wages of less than $50k – Senate, $40k House) to assist them in purchasing health insurance for their employees.

Anti-Trust Exemption

The House bill contains a provision that removes the anti-trust exemption for health and medical malpractice insurers.

Reinsurance Program

Both bills create a temporary reinsurance program for employers that provide health insurance coverage to retirees over age 55 who are not Medicare eligible. Program would reimburse employers 80% of the retiree claims between $15,000 - $90,000. (Effective 90 days after enactment through December 31, 2013)

Health Care Industry

The Senate bill contains fees ($ billions) charged to the pharmaceutical manufacturing, medical device manufacturing, and health insurance companies. Additionally, the bill would limit the deductibility of executive compensation to $500,000 per year per executive. Also includes a 10% tax on indoor tanning services.

Wellness Initiatives

Both bills would provide grants for 3-5 years to small employers to establish wellness programs. The Senate bill would permit employers to discount premiums up to 30%-50% to wellness participants.

Medicare Part D

Both bills would reduce the Medicare "coverage gap" by $500 beginning in January 1, 2010. Additionally, the bills would eliminate the tax exemption for the retiree drug subsidy for those employers that are subject to taxation (January 1, 2011).

Longfellow Comment: These changes will make the retiree drug subsidy harder to get (achieve actuarial equivalence) and will make it less attractive for employers, which could mean elimination or changes to retiree health insurance plans.

Appendices

2009 Federal Poverty Guidelines

2009 Federal Poverty Guidelines

2009 Federal Poverty Guidelines				
Household size	**100% FPL**		**150% FPL**	
	Month	Year	Month	Year
1	$903	$10,836	$1,355	$16,254
2	$1,215	$14,580	$1,823	$21,870
3	$1,526	$18,312	$2,289	$27,468
4	$1,838	$22,056	$2,757	$33,084
5	$2,150	$25,800	$3,225	$38,700
6	$2,461	$29,532	$3,692	$44,298
7	$2,773	$33,276	$4,160	$49,914
8	$3,085	$37,020	$4,628	$55,530
each extra person	$312	$3,744	$468	$5,616
Household size	**200% FPL**		**250% FPL**	
	Month	Year	Month	Year
1	$1,806	$21,672	$2,258	$27,090
2	$2,430	$29,160	$3,038	$36,450
3	$3,052	$36,624	$3,815	$45,780
4	$3,676	$44,112	$4,595	$55,140
5	$4,300	$51,600	$5,375	$64,500
6	$4,922	$59,064	$6,153	$73,830
7	$5,546	$66,552	$6,933	$83,190
8	$6,170	$74,040	$7,713	$92,550
each extra person	$624	$7,488	$780	$9,360
Household size	**300% FPL**		**400% FPL**	
	Month	Year	Month	Year
1	$2,709	$32,508	$3,612	$43,344
2	$3,645	$43,740	$4,860	$58,320
3	$4,578	$54,936	$6,104	$73,248
4	$5,514	$66,168	$7,352	$88,224
5	$6,450	$77,400	$8,600	$103,200
6	$7,383	$88,596	$9,844	$118,128
7	$8,319	$99,828	$11,092	$133,104
8	$9,255	$111,060	$12,340	$148,080
each extra person	$936	$11,232	$1,248	$14,976