



MARLOWE & COMPANY

GOVERNMENT AFFAIRS CONSULTANTS

Memo

To: Marlowe & Company Clients
From: Toby Hicks, Legislative Intern
Re: Comparison of Major Healthcare Reform Proposals
Date: November 9, 2009

Background

The current U.S. healthcare system ranks 37th out of 191 according to a World Health Organization study nine years ago, and accounts for 17% or more of the nation's GDP – 7% more than Germany's or France's universal healthcare costs. Achieving comprehensive health reform is a leading priority for both President Obama and the 111th Congress. As of this writing, there are two prominent bills that should warrant the interest of your community: the House bill is H.R. 3962 "Affordable Health Care for America Act" and the Senate bill is S. 1796 "America's Healthy Future Act of 2009." H.R. 3962 passed in the House on November 7th by a narrow margin of 220-215. It is unlikely that the Senate will pass this same bill because of the extreme differences compared with its own S. 1796. If H.R. 3962 passes, it will be referred to the President for approval. If H.R. 3962 does not pass, and S. 1796 does, then the differences will be worked out in a Conference Committee.

The most important issues that Marlowe & Company clients should be aware of are the bills' overall approaches, employer requirements, insurance premium subsidies for employers, state role, changes to public programs, and prevention wellness provisions which will be explained below. The first four will be of most use to you while the latter two will be likely be of interest to your employees. Of moderate importance are the bills' individual mandate, premium subsidies to individuals, and financing which will be touched on briefly. There have been at least five healthcare bills proposed but the scope of this memo is restricted to the two which we deem are closest to what the end result may be.

Comparison of Overall Approach

Both of the leading bills were proposed by Democrats. They both set up "exchanges" which will act as forums where U.S. citizens can purchase government health insurance. Establishing exchanges is considered by many to be an efficient and intelligent alternative to the current disorganized insurance policy market. A close analogy would be the establishment of stock exchanges rather than purchasing stock directly from individual companies. Though the mechanics of the exchanges vary, they are similar in

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function. The House bill is estimated by the Congressional Budget Office to provide coverage to about 96% of legal residents under the age of 65, while the Senate bill would provide coverage for about 94%. Of the 18 to 22 million Americans left uninsured by these bills, around one third of that number are illegal immigrants. In principle, both bills should meet President Obama's goal of costing less than \$900 billion. The cost of H.R. 3962 would largely be borne by new taxes on wealthy individuals and couples, cuts to Medicare and Medicaid, taxes on certain medical devices, and the "pay-or-play" penalty system of high taxes for employers who do not provide health insurance as detailed in the employer requirements section. The cost of S. 1796 would largely be borne by taxes on insurance companies, cuts to Medicare and Medicaid, employer fees, and fines on individuals who fail to purchase insurance plans. Finally, H.R. 3962 mandates that individuals have acceptable coverage or pay a penalty of 2.5% adjusted income while not having an insurance policy. Under S. 1796 having no policy would result in a flat penalty of \$750 per person. Exceptions are made for individuals who demonstrate extreme hardship, religious objections, or are American Indians.

Employer Requirements

The two bills differ drastically in the employer responsibilities they stipulate. The House bill has a lesser minimum percentage contribution of an employee's insurance premium for an employer, but the penalty for not providing health insurance under can be much higher than that of the Senate bill. This is the "pay-or-play" system, where employers will either "play" and offer healthcare, or "pay" by having a fine assessed. The fine that H.R. 3962 imposes is equal to 8% of total payroll on large employers who don't "play" by offering health insurance and contributing to the employee's premium cost. S. 1796, on the other hand, imposes a flat penalty of only \$400 per employee.

Here is a quick example to illustrate the difference: Firm X has a payroll of \$2,000,000 and 50 employees and does not offer health insurance. Under H.R. 3962 firm X would pay \$160,000 in penalties while under S. 1796 firm X would pay only \$20,000. As mentioned earlier, the discrepancy in these numbers is because H.R. 3962 is funded partly by the revenue that these fines would generate. However the Democrats state that approximately 86% of businesses would be immediately exempted from the fine by not having a payroll of \$500,000. A full description of the requirements and penalties for the bills H.R. 3962 and S. 1796 is included in Table 1.

Premium Subsidies to Employers

Both bills provide tax credits for small businesses which differ more in implementation than magnitude, and temporary reinsurance programs for older employees which are near-identical. Small businesses receive tax credits under both bills, but their extent differs and modulates by both firm size and average salary amount.

For H.R. 3962 the full tax credit of 50% premium costs can only be achieved by businesses of 10 or fewer employees with average salaries of only \$20,000. The tax credit decreases as the employee amount rises to 25 and average salary rises to \$40,000. No tax credit is allowed for an employee earning more than \$80,000 annually.

The Senate bill is similarly structured and also designed to provide firms with fewer than 25 employees earning an average of \$40,000 with tax credits. But S. 1796 provides two "phases" during which there are

different tax credit structures. In the first phase (tax years 2011 and 2012), a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium is allowed if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. In the second phase (tax years 2013 and later), a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium is allowed if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. In both phases the full tax credit will be available to businesses of 10 or fewer employees with an average salary of under \$20,000.

Ensuring that older retirees are covered immediately is an important aspect of both the Senate and House bills. Temporary reinsurance programs are provided for and would be up and running within 90 days of enactment. These programs are designed to cover those over age 55 who are not yet eligible for Medicare. Both bills reimburse employers or insurers 80% of cost for claims falling in the range of \$15,000 and \$90,000. S. 1796 and H.R. 3962 propose \$5 and \$10 billion appropriations for these programs respectively.

Comparison of State Role

In general the Senate bill provides states with more control over healthcare exchanges, but this also gives them the burden of oversight. Both plans require the states to coordinate with and enroll the new Medicaid beneficiaries. Under the House bill the Children's Health Insurance Program (CHIP) would be dismantled, while under S. 1796 it would not. S. 1796 requires states to not only create the health care exchanges, but also requires that state insurance commissioners provide oversight of health plans along the dimensions of regulation, consumer protection, solvency, reserve fund requirements, and premium taxes. In addition, states would be required to appoint an ombudsman to assist the people who retain insurance coverage in private programs better deal with their insurance companies. Finally, any state would have the ability to waive some new health insurance requirements if they can certify that current coverage is at least as good as that of an exchange plan and budget neutral to the federal government over ten years.

Changes to Public Programs

Both bills plan to expand Medicaid drastically by placing many citizens at or near poverty level into the program. The House bill would eliminate CHIP, while the Senate bill will keep and enhance it as an accompaniment to the new Medicaid.

The changes to Medicaid under H.R. 3962 would become effective on January 1, 2013 and expand enrollment to all individuals under age 65 with incomes up to 150% of the Federal Poverty Level (FPL). Insurance would also be extended to newborns who lack sufficient coverage, low-income HIV-infected individuals, and certain low income women for family planning services. Medicaid payment rates to primary care providers would also be increased by up to 100% by 2012. If the bill becomes law, every state would submit a plan specifying that state's proposed Medicaid payment rate. The federal government will finance 100% of the required program coverage expansions through 2014 (the first year only) and reduce this to 91% beginning in 2015. Depending on their FPL status, CHIP enrollees would either be covered by Medicaid immediately or be required to purchase healthcare as soon as 2014 through the new Health Insurance Exchange.

The changes to Medicaid under S. 1796 would become effective in 2014 and expand coverage to all individuals under age 65 with incomes up to 133% FPL. Those with incomes between 100% and 133% of FPL will be allowed the option of being subsidized to purchase into the exchange. To help the states pay for the newly eligible, states will receive elevated federal medical assistance percentage (FMAP) bonuses. Initially the FMAP bonus will be 27.3 for states that already cover adults with incomes above 100% FPL and 37.3 for other states. By 2019, however, all states will receive an FMAP increase of 32.3 percentage points for the newly eligible. "High need states," defined as those with total Medicaid enrollment that is below the national average for enrollment as a percentage of the state population and unemployment rates of 12% or higher for August 2009, will receive full federal funding for the newly eligible for five years. Additionally under S. 1796, CHIP will maintain its current income eligibility levels but beginning in 2014, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100% and a 0.15% point increase in the Medicaid match rate.

Prevention & Wellness Mandates

Each of the two bills provides for very different prevention and wellness strategies. Of special interest to employers is that both bills provide grants to establish prevention and wellness programs. The House bill provides grants for up to 50% of costs for up to three years while the Senate bill neither specifies the percent reimbursement nor the time period. S. 1796 additionally offers employers rewards (in the form of premium discounts, waivers of cost-sharing requirements, or other benefits) of up to 50% of the cost average of participating in an existing wellness program. Furthermore, under S. 1796, ten state pilot programs would be established to permit participating states to offer similar rewards for participating in wellness programs in the individual market.

Beyond the changes in the wellness mandates which directly affect employers, there are specific differences of importance between the two bills. S. 1796, for example, allows insurers to vary premium rates based on tobacco use but stipulates that if this is done, insurers must provide coverage for tobacco cessation programs. Notably, S. 1796 also 1) disallows insurance plans from charging cost sharing for preventative services, 2) creates a new Medicaid state plan option to allow enrollees with at least two chronic health conditions to designate a provider as a "health home" and receive in-home health services (90% FMAP), 3) provides coverage for and removes cost-sharing for preventive services recommended by the U.S. Preventive Services Task Force and recommends immunizations (1% FMAP), 4) requires Medicaid coverage for tobacco cessation services for pregnant women (1% FMAP), 5) provides incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs, and 6) provides Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan.

H.R. 3962 lays out less specific items initially, but calls for a national strategy to be developed and task forces on Clinical Preventive Services and Community Preventive Services to provide guidance on future wellness mandates. H.R. 3962 also has less emphasis on tobacco, supports grants for community based health and wellness programs, and eliminates cost sharing for preventative services in Medicare and Medicaid while increasing Medicare payments for some preventative service up to 100%.

If you have questions or would like more information, please contact your Marlowe & Company team leader or email legislation@marloweco.com.

Common acronyms used

H.R. 3962	Leading House Bill: “Affordable Health Care for America Act”
S. 1796	Leading Senate Bill: “America’s Healthy Future Act of 2009”
CHIP	Children’s Health Insurance Program
FMAP	federal medical assistance percentage
FPL	Federal Poverty Level

Table 1. Comparison of leading House and Senate healthcare reform bills’ requirements for employers.

H.R. 3962	S. 1796		
<p>1. Requires employers to offer coverage to their employees and pay at least 72.5% premium for individuals and/or 65% premium for families.</p> <p style="text-align: center;"><i>Penalties for not providing health coverage</i></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p style="text-align: center;">Large Employers (Payroll > \$750,000)</p> <ul style="list-style-type: none"> • Assessment of 8% of employer payroll. </td> <td style="width: 50%; vertical-align: top;"> <p style="text-align: center;">Small Employers (Payroll < \$750,000)</p> <ul style="list-style-type: none"> • Exempt if payroll is < \$500,000. • Assessment of 2% [of payroll] if \$500,000 < payroll < \$585,000. • Assessment of 4% if \$585,000 < payroll < \$670,000. • Assessment of 6% if \$670,000 < payroll < \$750,000. </td> </tr> </table> <p>2. Requires employers who offer coverage to enroll employees into the lowest cost premium plan if they have not selected or opted out of the plan.</p> <p>3. Requires a government study to see if an employer hardship exemption is appropriate.</p>	<p style="text-align: center;">Large Employers (Payroll > \$750,000)</p> <ul style="list-style-type: none"> • Assessment of 8% of employer payroll. 	<p style="text-align: center;">Small Employers (Payroll < \$750,000)</p> <ul style="list-style-type: none"> • Exempt if payroll is < \$500,000. • Assessment of 2% [of payroll] if \$500,000 < payroll < \$585,000. • Assessment of 4% if \$585,000 < payroll < \$670,000. • Assessment of 6% if \$670,000 < payroll < \$750,000. 	<p>1. Exempt employers with 50 or fewer employees.</p> <p>2. Requires employers with 200 or more employees to enroll employees into health insurance plans offered by the employer. Employees may opt out if they have insurance from another source.</p> <p>3. Assesses employers with more than 50 employees that do not offer coverage a fee for each employee who receives a tax credit for health insurance through an exchange. The penalty is the lesser of a flat dollar amount equal to the average national tax credit for each full-time employee receiving a tax credit or \$400 per employee.</p>
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