GROOM LAW GROUP

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UPDATE ON HEALTH CARE REFORM LEGISLATION:

HOUSE TRI-COMMITTEE DISCUSSION DRAFT

On June 19th, the three committees within the House of Representatives that have jurisdiction over health care reform – the Ways and Means Committee, the Education and Labor Committee, and the Energy and Commerce Committee released a "discussion draft" of health care reform legislation in the form of an 852-page bill ("House bill"). The House bill includes many provisions that are similar to the provisions that are found in the Senate HELP Committee bill,[1] including insurance market reforms that would affect individual and group insurance policies and, in some cases, would apply to self-funded plans, a new "Health Insurance Exchange" program through which individuals could obtain coverage from private insurers, a new requirement for individuals to obtain coverage, and new employer responsibility mandates.

Unlike the Senate HELP Committee bill, which did not describe the public plan option or the employer "pay or play" mandate in detail, the House bill does contain details regarding both of those issues. The House bill also goes into much more detail as to what is required for a "qualified" health plan for both employer-provided coverage and under the Government-provided Health Insurance Exchange (the "Exchange") and contains a number of new provisions that will impact Medicare, including changes to the Medicare Part D rules. Notably, the House bill also includes new "consumer protection" provisions that were not found in the Senate HELP Committee bill, such as a required external review process, a prompt pay requirement, and an advance notice requirement for plan changes. These requirements go beyond simply providing access to coverage, as the Senate HELP Committee bill does, and insert new mandates that are similar to those found in the Patients' Bill of Rights legislation that Congress failed to pass a few years ago. In addition, the House bill amends ERISA to significantly expand private remedies under state law for employer plans that utilize the new Exchange program to provide coverage. The summary below highlights the major provisions that would impact employer health plans.

Like the Senate HELP Committee bill, this bill is also unprecedented in scope and a massive undertaking that would affect public and private markets, employers, individuals, insurers, and providers. The Congressional Budget Office has yet to release a formal estimate of the cost of the House proposal. Similar to the Senate HELP Committee bill, there are no real revenue offsets yet proposed for the bill.

The three House committees have been holding a series of hearings on the House bill since it was released. These three committees will start to mark up their respective portions of the bill in July. Then all three parts will be melded together by the Rules Committee, and the full House will vote on the legislation. Initially, it was expected that the full House would act on the legislation prior to the August recess, but that seems unlikely at this point.

On the Senate side, the HELP Committee has begun to mark up its legislation, and, as anticipated, there are a large number of amendments to the draft that was released on June 9,

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[1] We provided a summary of the Senate HELP Committee Bill on June 16, 2009. It is available at http://www.groom.com/resources-401.html.

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2009 (nearly 500!). We are expecting the HELP Committee to continue its work after the July 4th weekend. In addition, we are expecting legislation from the Senate Finance Committee later in July, which will describe the financing options for the HELP Committee bill, which could include a limitation on the employer exclusion – watch your email for future updates.

I. Qualified Health Benefit Plan Requirements

The House bill creates a new executive agency, the Health Choices Administration. The agency will be led by the Health Choices Commissioner, a new position appointed by the President, with advice and consent of the Senate. The Health Choices Commissioner has responsibility for much of the future rulemaking and guidance required under the bill, including setting standards for "qualified health benefits plans" ("QHBPs"). While the Senate HELP Committee Bill also had a qualifying plan requirement, the House bill goes into much greater detail as to what these requirements will be (the Senate bill left many of these details for future rulemaking). The QHBP standards would apply to plans under the new Exchange program established by the government, but also to group health plans, including fully insured and self-funded ERISA plans, governmental plans, multiemployer plans, multiple employer plans, and church plans.

The QHBP requirements are grouped into three areas – Access to Coverage, Access to Essential Benefits, and Consumer Protections.

A. Access to Coverage (Insurance Market Reforms)

Similar to the Senate HELP Committee Bill, the House bill includes insurance market reforms that apply in the individual, small, and large group markets, and, where relevant, to self-funded plans.

- No Pre-Existing Condition Exclusion – A QHBP may not impose a pre-existing condition exclusion.

- Guaranteed Issue & Renewal – Individual and group insurers in the small or large group market, or issuing coverage under the Exchange, must comply with the guaranteed issue and renewability requirements currently applicable under HIPAA's small group market rules.

- Premium Rating – Insurers only may vary premium rates based on age (subject to a maximum ratio difference of 2 to 1), premium rating area (as determined by state insurance regulators and the Health Choices Commissioner), and family structure.

- Nondiscrimination – A QHBP must comply with new nondiscrimination standards set by the Health Choices Commissioner (the language does not indicate whether these would be health or income nondiscrimination standards – the Senate HELP Committee bill includes both).

- Network Adequacy - A QHBP must comply with new standards set by the Health Choices Commissioner related to network adequacy. The standards are to ensure

enrollee access to services and transparency in the cost-sharing differentials between network and out-of-network coverage.

- Minimum Medical Loss Ratio - For any year that a QHBP has a medical loss ratio (as defined by the Health Choices Commissioner) that is less than 85%, the QHBP must provide rebates to enrollees. A medical loss ratio generally refers to the ratio of non-claims related costs over actual claims costs.

- Grandfathered Insurance Plans -

  Individual Coverage – The new requirements do not apply to individual coverage offered and in force prior to Year 1, where no individual is enrolled after Year 1 begins (except for dependents), and the issuer does not change plan terms or premiums after the first day of Year 1 except with respect to a change in premiums due to geographic area. Individual coverage must be either grandfathered or offered through Exchange (no new private individual policies will be permitted).

  Group Coverage – Group coverage in effect prior to Year 1 will have 5 years to come into compliance with new QHBP requirements. In addition, the new requirements will not be applicable to HIPAA excepted benefits or health FSAs.

B. Access to Essential Benefits

The House bill requires QHBPs to provide an "essential benefits package." The Senate HELP Committee bill had a similar provision, but it directed a new Medical Advisory Council to determine the minimum requirements for "essential benefits." The House bill specifies these requirements in the bill language.

- Minimum Services – An essential benefits package must provide services for:

  - Hospitalization;
  - Outpatient hospital and outpatient clinic services, including emergency department services;
  - Professional services of physicians and other health professionals;
  - Services, equipment, and supplies that are incident to a physician's or health professional's delivery of care in institutional settings, offices, patients' homes, or other settings of care;
  - Prescription drugs;
  - Rehabilitative and habilitative services;
  - Mental health and substance use disorder services;
  - Preventive services and vaccines (with no cost-sharing);

- Maternity benefits;
- Well baby and well child care (with no cost sharing); and
- Oral, vision, health, and hearing services, equipment, and supplies for children under 21 years of age.

- Out-of-Pocket Limit – Annual cost-sharing under an "essential benefits package" is limited to $5,000 for individuals, $10,000 for families (indexed to CPI).

- No Coinsurance – In establishing cost-sharing for Exchange plans, the Health Choices Commissioner must use copayments, rather than coinsurance, to the extent possible.

- Actuarial Value – Cost sharing under the essential benefits package must be the limited to 30% of the actuarial value of the full benefits provided.

- Health Benefits Advisory Committee – A new Health Benefits Advisory Committee, made up of the Surgeon General and representatives of providers, consumers, employers, labor, health insurance issuers, and health experts will have responsibility to recommend and update benefits standards for the "essential benefits package."

C. Consumer Protections

QHBPs also are required to provide certain "consumer protections." As we note above, many of these provisions originally appeared the Patients' Bill of Rights legislation considered (and not passed) a few years ago. These requirements do not appear in the Senate HELP Committee bill, which focuses more on access to health coverage.

All of these provisions, except the last two, apply to Exchange plans and, if determined by the Health Choices Commissioner, to employer plans offered outside of the Exchange. The last two requirements, related to prompt pay and coordination of benefits / subrogation, expressly apply to both Exchange plans and employer plans.

- Marketing – The Health Choices Commissioner will establish uniform marketing standards for QHBPs.

- Appeals & External Review - A QHBP must provide claims and appeals procedures that meet the DOL claims procedure regulations, along with external review for an impartial, independent, and de novo review of denied claims, as established by the Health Choices Commissioner (who may utilize existing state external review procedures).

- Transparency – A QHBP must provide plan-related documents, as determined by the Health Choices Commissioner, such as the plan terms, claims payment policies, claims payment amounts, financial disclosures, and reimbursement arrangements between the plan and providers.

- Advance Notice of Plan Changes – QHBPs may not make changes without providing reasonable and timely advance notice to enrollees (currently, under ERISA's summary of

material modification rules, notice does not have to be provided until after the plan amendment date).

- Prompt Pay – A QHBP must comply with the prompt pay requirements generally applicable to Medicare Advantage plans.

- Coordination of Benefits (COB) & Subrogation – The Health Choices Commissioner will establish uniform COB and subrogation standards for QHBPs.

D. New State Remedies for Employer-Provided Exchange Coverage

As described in more detail below, employers generally are required to offer coverage that meets the QHBP requirements. The employer may offer its own QHBP coverage or, on a phased-in basis, offer coverage through the Exchange, which would be similar to the employer purchasing a group insurance policy. Currently, ERISA provides no private right of action under state law with respect to ERISA plans (generally, plan participants only may bring a claim in federal court for the actual benefit to be covered and may not bring state law claims for other types of damages). The House bill amends ERISA so that if an employer chooses to offer coverage through the Exchange, participants would appear to have a private right of action under state law with respect to Exchange coverage.

II. Governmental Plan Options

A. Health Insurance Exchange

The House Bill requires the Health Choices Commissioner to establish a "Health Insurance Exchange" ("Exchange"). The stated purpose of the Exchange is "*to facilitate access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option.*"

In order for an entity to offer a health benefit plan through the Exchange, the entity must meet several requirements, including:

- being licensed to offer health insurance coverage under applicable State law;

- complying with reporting requirements established by the Health Choices Commissioner;

- implementing "affordability credits" (i.e., premium and cost-sharing credits provided to certain enrollees);

- accepting all enrollments, with certain limited exceptions;

- offering "wrap around services" to Medicaid-eligible individuals who participate in the Exchange (beginning in Year 5); and

- participating in a "pooling mechanism" under which premium payments to the entity are adjusted based upon group risk.

The bill identifies four levels of coverage that will be available through the Exchange—basic, enhanced, premium, and premium-plus, and specifies that each level will provide specific services at cost-sharing levels that do not exceed specific dollar amounts, as determined by the Health Choices Commissioner. In order to offer coverage through the Exchange, an entity must agree to offer at least the basic level of coverage, and must bid and be selected by the Health Choices Commissioner.

An "Exchange Eligible Individual" who is permitted to purchase coverage through the Exchange is defined as a individual who does not have coverage under Medicare Part A, Medicaid, the Armed Forces (e.g., TRICARE), or the Veteran's Administration. In addition, an individual can only be an Exchange Eligible Individual if he or she is not eligible for employer-sponsored coverage that satisfies the requirements for minimum qualifying coverage and affordability. However, within 3 years of enactment, all employers can choose to cover employees through the Exchange (this right is phased in over 3 years based on employer size). Exchange Eligible Individuals may enroll in the Exchange during annual open enrollment or during special enrollment periods established by the Health Choices Commissioner.

Individuals who are lawfully present in the United States, who earn up to 400% of the federal poverty level, and who enroll in a health benefit plan offered through the Exchange are eligible for federal "affordability credits" to reduce the cost of the premiums and to reduce cost-sharing that otherwise would apply (the amount of the credit is higher for individuals who earn lower amounts). The credit is not available with respect to coverage offered outside the Exchange and generally is not available for coverage offered through an employer's plan. The credits will be paid by the Health Choices Commissioner to the entity offering coverage through the Exchange.

B. Public Plan

The House bill contains rules surrounding the formation of a "public health insurance option" that only will be available through the Health Insurance Exchange. The public option will be required to comply with the requirements that are applicable to all Exchange–participating health benefit plans, and will be required to offer at least three levels of coverage (basic, enhanced, and premium). Premium-plus coverage also may be offered. Premium rates will be established by the Secretary of Health and Human Services ("HHS").

No automatic enrollment will be made to the public plan. Rather, the public plan will be an equal participant in the Health Exchange. The Secretary of HHS is authorized under the bill to enter into contracts for the purpose of performing administrative functions with respect to the public health insurance option. However, such contracts may not involve the transfer of insurance risk to such entity. The public plan option will be similar to Medicare in the following respects:

- The Secretary of HHS will establish an "office of the ombudsman for the public health insurance option," similar to the duties of the Medicare Beneficiary Ombudsman;

- Payment rates for services and health care providers for the first three years following enactment will be the same as those provided under Medicare (after that, rates will be established by the Secretary of HHS);

- The provisions of Medicare relating to access of Medicare beneficiaries to federal courts for enforcement of rights under Medicare will apply; and

- Providers who participate in both Medicare and the public plan option will receive payment rates that are 5% greater than the rates that otherwise apply.

III. Individual Responsibility

The House bill creates a new section of the Internal Revenue Code - section 59B - which requires individuals who do not have "acceptable coverage" to pay an additional tax in an amount equal to 2% of the excess of the taxpayer's adjusted gross income over the "threshold amount" determined under Code section 6012(a)(1) (which sets forth income thresholds over which a taxpayer is required to file of a return) that will be determined annually by the IRS, in consultation with HHS. There are limitations to this provision, including that the tax shall not exceed the applicable national average premium. In addition, the tax is prorated if an individual had acceptable coverage for part of the year. There also are exemptions for dependents, nonresident aliens, and individuals residing outside the United States, as well as a religious conscience exemption.

"Acceptable Coverage" is defined as coverage that an individual is enrolled in on the date of enactment, or that meets or exceeds the criteria for minimum qualifying coverage. Acceptable coverage specifically includes coverage under Medicare, CHIP, TRICARE, and the veteran's health care program.

Issuers of qualified coverage are required to submit a report to the IRS with the name, address, and taxpayer identification number of each individual with acceptable coverage provided by such issuer and the period during the calendar year during which each individual was covered.

IV. Employer Responsibility

The House bill includes an employer "pay or play" structure with three components: a requirement to offer coverage, a requirement to contribute to coverage, and a "penalty" if an employee opts for the government-provided Exchange program instead. The House bill also requires insured and self-funded plans to pay a fee to the Health Care Comparative Effectiveness Research Trust Fund, beginning in 2013.

- Requirement to Elect to Offer Coverage – An employer must make an election with the Department of Labor ("DOL"), HHS, or Treasury as to whether it will offer QHBP coverage that meets requirements below. Different elections can be made for different lines of business and full time versus part-time employees.

- Requirement to Offer QHBP Coverage – Employers are required to offer individual and family coverage that meets the QHBP requirements (unless the employer's plan qualifies for the 5-year "grandfathered" status, as described above). The employer may offer its own QHBP coverage or, on a phased-in basis, offer coverage through the Exchange. In Year 1, only employers with 10 or fewer employees may offer coverage through the Exchange. In Year 2, employees with 20 or fewer employees may offer Exchange

coverage. In Year 3 and later, any employer may offer Exchange coverage. (However, as discussed above, coverage offered through the Exchange will be subject to additional state law causes of action not applicable to non-Exchange ERISA plans.)

- Requirement to Contribute to Premiums – For full-time employees, employers must contribute at least 72.5% of the contributions that would be payable under the employer's lowest cost plan that meets the essential benefits package requirements for individual coverage, and 65% of contributions for family coverage. If coverage is through the Exchange, the applicable premium is based on an average premium of three basic plans in the coverage area. For part-time employees, employers are required to contribute a proportionate amount, to be determined by the Health Choices Commissioner and Secretaries of Labor, HHS, and Treasury.

- If Employee Declines Coverage in Favor of Exchange - Beginning in Year 5, if an employee declines employer coverage in favor of coverage through the Exchange, the employer must contribute to 8% of that employee's wages to the Exchange as long as the employee is enrolled. The Health Choices Commissioner will have authority to set standards to determine whether employers are intentionally affecting the Exchange risk pool by inducing individuals to decline employer coverage in favor or Exchange coverage (similar to the anti-inducement provisions of the Medicare Secondary Payer rules).

- Penalty for Not Meeting Above Requirements - If an employer that elects to offer QHBP coverage fails to satisfy the QHBP and minimum premium requirements with respect to any participant, the Secretaries of Labor and HHS may assess a civil penalty, and the Secretary of Treasury may assess an excise tax, of $100 per day from the date of the failure to the date the failure is corrected (arguably, this could be $100 per person per day). No penalty will be assessed if the employer demonstrates it did not know, or exercising reasonable diligence would not have known, of the failure or if the failure was due to reasonable cause and corrected within 30 days. Where the failure is due to reasonable cause and not willful neglect, the maximum penalty will be limited to the lesser of: (1) 10% of the aggregate amount paid by the employer for its group health plans, or (2) $500,000.

- If Employer Makes No Election - Every nonelecting employer must pay an excise tax of 8% of wages for all employees for whom an election should have been made. The bill language indicates that there will be an exemption for small employers, but specific language is not yet included.

- Applicability to Multiemployer Plans – For multiemployer plans, the House bill provides that the health coverage participation requirement will apply to the plan sponsor and contributing sponsors of such plans.

- Disclosures to Government - The employer must report to the Health Choices Commissioner and the Secretaries of Labor, HHS, and Treasury such information as may be required to ascertain compliance with these provisions.

- Small Employer Tax Credit – Small employers with less than 25 employees are eligible for a tax credit equal to a 50% of qualified employee health coverage expenses for the taxable year. The credit will be phased out for employers with more than 10 employees or whose average annual employee compensation for the tax year exceeds $20,000. The credit will not be available with respect to employees who earn over $125,000.

- Contribution to Comparative Effectiveness Fund – The House bill establishes a Health Care Comparative Research Trust Fund to facilitate new provisions related to health research and delivery systems and requires insurers and self-funded plans to contribute to the Fund, beginning in 2013. Insurers and self-funded plans will be required to contribute a fee equal to the "fair share per capita amount" determined by the Secretary of HHS, multiplied by the number of lives under each policy or plan. If the Secretary fails to set an amount, the default amount for 2013 will be $2 per person.

V. Medicare Part D Reforms (Prescription Drug Coverage)

The House bill includes several reforms to Medicare, including the Medicare Part D program. Since 2006, Medicare Part D plans have covered eligible individuals (at least age 65 or disabled) who enroll for prescription drug coverage through Medicare. The bill would make reforms in three important areas – first, it would reduce, then eliminate, the "doughnut hole"; second, it would make reforms regarding the drug rebates that are paid to Medicare; and third, it would permit mid-year changes to enrollment where a participant is adversely impacted by a formulary change.

- Elimination of the Doughnut Hole - Under Medicare Part D plans, an individual who incurs prescription drug expenses (paid in part by Medicare) up to an initial coverage limit ($2,700 for 2009) falls into a "doughnut hole" and becomes entirely responsible for the total cost of all prescription drugs. The initial coverage limit is reached by taking into consideration the full cost of the drugs, not just the amount paid by the individual through cost-sharing (e.g., co-insurance or co-payments). Once the individual incurs a certain level of out-of-pocket expenses ($4,350 for 2009), he or she is out of the doughnut hole and is covered for catastrophic prescription drug coverage with Medicare paying 95% of the expenses. The out-of-pocket expenses counted toward the upper limit of the doughnut hole, however, include only the deductible, co-payments and co-insurance, and not amounts paid by Medicare, insurance, or employer plans.

  The bill would reduce the size of the doughnut hole by $500, effective for 2011, then eliminate the doughnut hole completely within 15 years.

- Drug Rebates - The drug rebates available under the Medicare Part D program currently are limited to rebates on brand drugs. However, Medicaid and the Veterans Administration, along with many employer and union-sponsored plans, obtain rebates or discounts from manufacturers of brand and generic drugs. The House bill would establish specific rules requiring drug manufacturers to provide rebates for Medicare beneficiaries, require that rebates for drugs used by "dual eligible" beneficiaries (i.e., those covered by both Medicare and Medicaid) be as large as the drug rebates that would have been received under Medicaid, and restore drug rebate levels in effect for dual

eligible beneficiaries prior to the effective date of Medicare Part D (2006). These additional rebates then would be used to help fund health care reform efforts.

- Mid-Year Changes in Enrollment – The House bill would permit mid-year changes in enrollment for formulary changes that adversely impact a Medicare Part D participant. A participant would be allowed to change Part D plans to the most appropriate coverage when the formulary is materially changed mid-year so as to reduce the coverage (or increase the cost-sharing) of a drug prescribed for that participant under the plan.

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We will provide updates on further developments. In the meantime, if you have any questions, please contact your regular Groom attorney or any of the Health and Welfare Practice Group attorneys listed below:

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