

A Primer on Employer and Employee Issues in the House Health Care Reform Legislation

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Foreword

The U.S. Chamber of Commerce commissioned this analysis by Nandan Kenkeremath, President of Leading Edge Policy and Strategy LLC, in order to enlighten the often confusing debate surrounding pending health care legislation on Capitol Hill. While the focus of this analysis is on H.R. 3200, “America’s Affordable Health Choices Act of 2009,” we believe that this review will help readers better understand both that bill and those pending in the Senate.

While much has been written about pending legislation, we believe that this analysis is one of the few that really digs down into the many nuances involved in how they affect the employer community. We hope that you will find it helpful, and look forward to continuing to foster informed, critical debate about this important policy issue and the legislative process leading toward comprehensive health reform.

A handwritten signature in black ink, appearing to read "Randel K. Johnson", with a stylized flourish at the end.

Randel K. Johnson
Senior Vice President, Labor, Immigration, & Employee Benefits
U.S. Chamber of Commerce

I. Overview

The health care reform efforts of the Obama Administration and Congress have been moving quickly. The House bill contains many provisions with substantial consequences for employers and employees. The proposed legislation would launch over a trillion dollars in new spending and launch a massive new bureaucracy that will impose dozens of new rules on employer-sponsored health plans. A review of the bill raises numerous questions and concerns. Moreover, it seems that many public statements of both protagonists of the legislation and those with concerns do not seem to reflect the content of the bill.

This primer lays out some basics regarding H.R. 3200, America's Affordable Health Choices Act of 2009, as introduced. Some of these points will change during the legislative process. However, the input of the employer and employee community is essential at this time.

The broad observations are as follows. The current House bill will:

- Reduce the number of uninsured
- Increase the federal debt and deficits
- Launch a massive federal bureaucracy for employer-sponsored insurance
- Force changes to current employer plans, regardless of whether employees liked the original plans
- Deny individual affordability credits to low and moderate income workers whose employers provide health insurance
- Tie up substantial resources of employers, insurers, and providers to adjust to a wide variety of new rules and changes
- Limit the marketing of individual policies to a new health insurance exchange (Exchange) with rules that will guarantee access and limit costs for some, but increase costs for others
- Reduce spending under Medicare, but not direct those savings to address the problem of unfunded obligations under Medicare
- Expand the Medicaid entitlement
- Fail to reduce the rise in national health care costs

This primer will try to help the employer and employee community review these issues.

II. Current Coverage and Regulation of Plans and Individual Market

Today, employers choosing to offer health coverage may either purchase insurance or choose to self-fund health benefits for their employees. This distinction is very important for regulatory purposes.

A. Breakdown of Current Coverage

According to the Congressional Research Service, employment-based insurance has several strengths, including risk pools that are not formed on the basis of health status, ease of acquisition by workers, and tax subsidies that exceed those for individual market insurance.ⁱ

According to the Employee Benefit Research Instituteⁱⁱ (EBRI), over 216 million nonelderly individuals had insurance coverage in 2007, while 45 million were uninsured. The percentage of nonelderly individuals without health insurance coverage was 17.2% in 2007. Employment-based health benefits are still by far the dominant source of health coverage in the United States for the population under age 65, providing coverage for over 162 million people. While the majority of individuals insured in 2007 received coverage through an employment-based health plan, 47.7 million, or 18.2 percent of the nonelderly population, were covered by public programs. An additional 17.9 million, or 6.8%, were covered by policies purchased directly from an insurer. More than 36 million nonelderly individuals participated in the Medicaid or State Children's Health Insurance Program (S-CHIP), and 7.5 million received their health insurance through the military.

In 2007, there were 36.8 million Americans ages 65 and over that were eligible for Medicare. Such parties may also have had employment-based insurance or insurance on the individual or non-group market. In 2007, approximately 177 million persons (elderly and nonelderly) had employment-based health insurance, which accounts for nearly 60% of the total population.ⁱⁱⁱ

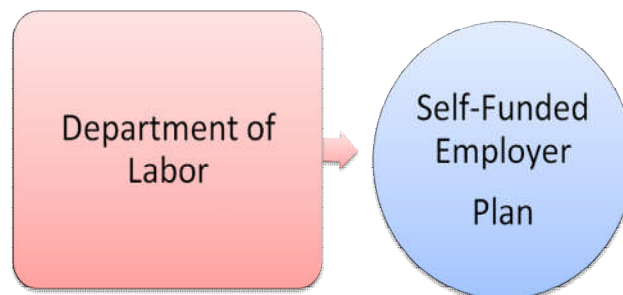
B. Health Benefits Offer Rates

According to the Kaiser Family Foundation's 2008 Employer Health Benefits Annual Survey, the likelihood that a firm offers health benefits to its workers varies considerably with the firm's characteristics, such as firm size, the proportion of lower-wage workers, the proportion of part-time workers in the firm, and whether workers are unionized.^{iv}

- Ninety-nine percent of large firms (200 or more workers) offered health benefits in 2008. In contrast, only 62% of small firms (3–199 workers) offered health benefits in 2008.
- The smallest firms are least likely to offer health insurance. Only 49% of firms with 3 to 9 workers offer coverage compared with 78% of firms with 10 to 24 workers, and 90% of firms with 25 to 49 workers. Over 95% of firms with 50 or more employees offer health insurance coverage.
- Firms with fewer lower-wage workers (where less than 35% of workers earn \$22,000 or less annually) are significantly more likely to offer health insurance than firms with many lower-wage workers (where 35% or more of workers earn \$22,000 or less annually).
- Ninety-nine percent of firms with union workers offer health benefits, whereas 60% of firms that do not have union employees offer health coverage.
- Among firms offering health benefits, relatively few offer benefits to their part-time and temporary workers.

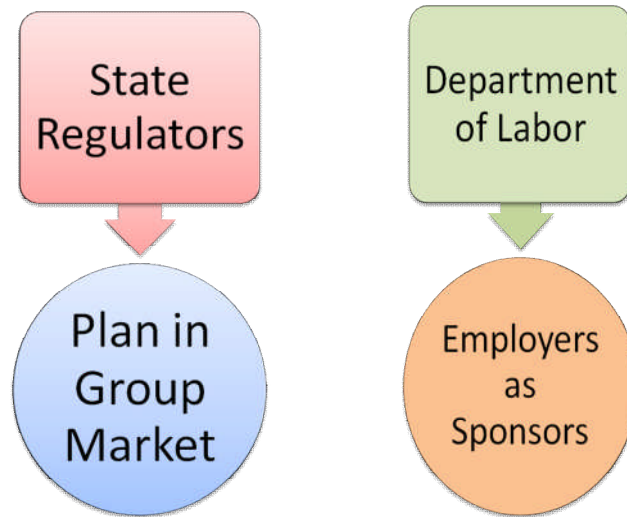
C. Self-Funded ERISA Plans

A self-funded plan is one where the employer is directly covering the risk of insurance. The plan itself may still be administered by a third party. Because self-funded plans are not sold on the market and because of provisions in the Employee Retirement Income Security Act of 1974 (ERISA), self-funded plans are not subject to many state regulations. Such plans are regulated by the Department of Labor under ERISA. As one might expect many large companies have self-funded plans. Smaller groups do not.



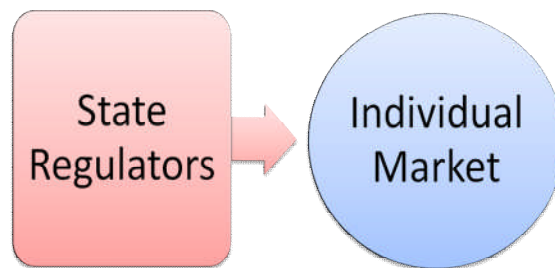
D. Employer Plans in the Group Market

Plans that are provided by health insurers to employers are regulated by state agencies for a variety of purposes. The Department of Labor still governs a number of features of the employer's sponsorship of such plans under ERISA.



E. Individual or Non-Group Market

The individual or non-group market is primarily regulated by the states.



The regulatory distinctions are important because many of the issues discussed in the current debate do not apply outside of the individual or non-group markets. For example, as a general matter, an employee's health status is not a legally applicable consideration in employer group plans. Thus, issues such as insurance companies imposing pre-existing condition requirements

or taking steps for rescission are relevant to the individual or non-group market, but not generally to employer plans. The effort to regulate direct sales from insurance companies to individuals does not require changes to the regulation of the employer-sponsored market or self-insured plans.

F. Current Primary Regulatory Authorities

States

States have long played a significant role in health care.^v They are the principal regulators for insurance sold in the private market, particularly the individual and small group markets. While their authority to regulate self-insured employer plans has been preempted by ERISA, they remain largely responsible for regulating business practices associated with the insurance that employers purchase. States are also responsible for licensing of health care providers and investigating certain complaints about them, approval of health care facilities, and much of the law governing contracts, employment, and other matters.

Department of Labor

ERISA provides a comprehensive federal scheme for the regulation of private-sector employee benefit plans.^{vi} While ERISA does not require an employer to offer employee benefits, it does mandate compliance with its provisions if such benefits are offered. Besides the regulation of pension plans, ERISA also regulates welfare benefit plans offered by an employer to provide medical, surgical and other health benefits. ERISA applies to health benefit coverage offered through health insurance or other arrangements (e.g., self-funded plans). Health plans, like other welfare benefit plans governed by ERISA, must comply with certain standards, including plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing a denied claim for benefits. However, these health plans must also meet additional requirements under ERISA.

In 1986, Congress added to ERISA a number of requirements on the nature and content of health plans, including rules governing health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, parity between medical/surgical benefits and mental health benefits, and minimum hospital stay requirements for mothers following the birth of a child.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added new provisions to ERISA, which requires the sponsor of a group health plan to provide an option of temporarily continuing health care coverage for plan participants and beneficiaries under

certain circumstances. Employers must typically provide this continuation coverage for 18 months. The health plan may charge a premium to COBRA participants, but it cannot exceed 102% of the plan's group rate.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added additional health plan coverage requirements under ERISA. Other federal legislation amended Part 7 of ERISA to require plans to offer specific health benefits. HIPAA amended ERISA to limit the circumstances under which a health plan may exclude a participant or beneficiary with a preexisting condition from coverage. HIPAA also created ERISA section 702, which provides that a group health plan or health insurance issuer may not base coverage eligibility rules on certain health-related factors, such as medical history or disability. In addition, a health plan may not require an individual to pay a higher premium or contribution than another "similarly situated" participant, based on these health-related factors.

For a number of requirements, Congress has added potential penalties from the Internal Revenue Service.

The following figures indicate existing regulatory authorities applicable to employer plans.

Current Regulatory Authorities for Employer Plans

State Insurance Regulators Licensure, Accreditation

EXISTING REQUIREMENTS

- Guaranteed renewal
- Rating
- Preexisting conditions
- Non-discrimination
- Quality improvement and reporting
- Benefit mandates
- Solvency and financial requirements
- Market conduct
- Prompt pay
- Appeals and grievances
- Privacy/Confidentiality
- Licensure/Accreditation
- Antitrust

Department of Labor

EXISTING PROGRAMS

- ERISA
- COBRA
- Health care portability
- Privacy, Mental Health Parity, Genetic Non Discrimination
- Benefit Requirements

Internal Revenue Service

EXISTING AUTHORITIES

- Enforcement for HIPAA, Mental Health Parity, Genetic nondiscrimination
- Tax provisions

Health and Human Services

EXISTING REQUIREMENTS/PROVISIONS

- HIPAA Benefit Mandates
- HIPAA Privacy/ARRA Privacy
- Mental Health Parity
- Genetic Information Nondiscrimination Act
- Medicaid/CHIP
- Medicare

III. Summary of Provisions Directly Relevant to Employers

The following summary points are from a Congressional Research Service document^{vii}:

- Division A of H.R. 3200 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, providing financial assistance to certain individuals, and, in some cases, small employers.
- Individuals would be required to maintain health insurance and employers would be required to either provide insurance or pay into a fund, with penalties/taxes for noncompliance.
- Several market reforms would be made, such as modified community rating and guaranteed issue and renewal.
- Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include:
 - coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created health insurance exchange (Exchange) or outside the Exchange through new employer plans;
 - grandfathered employment based plans;
 - grandfathered non-group plans; and
 - other coverage, such as Medicare and Medicaid.
- The Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a commissioner. The Exchange would offer private plans alongside a public option.
- The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurer's plans in a comparable way.
- The public option would be established by the Secretary of Health and Human Services (HHS), would offer three different cost-sharing options, would vary premiums geographically, and would have payments to health care providers set by the Secretary based on Medicare payment rates, with adjustments.
- Individuals wanting to purchase the public option or a private health insurance not through an employer or a grandfathered non-group plan could only obtain such coverage through the Exchange. They would only be eligible to enroll in an Exchange plan if they were not enrolled in other acceptable coverage (e.g., from an employer, Medicare, and generally Medicaid).

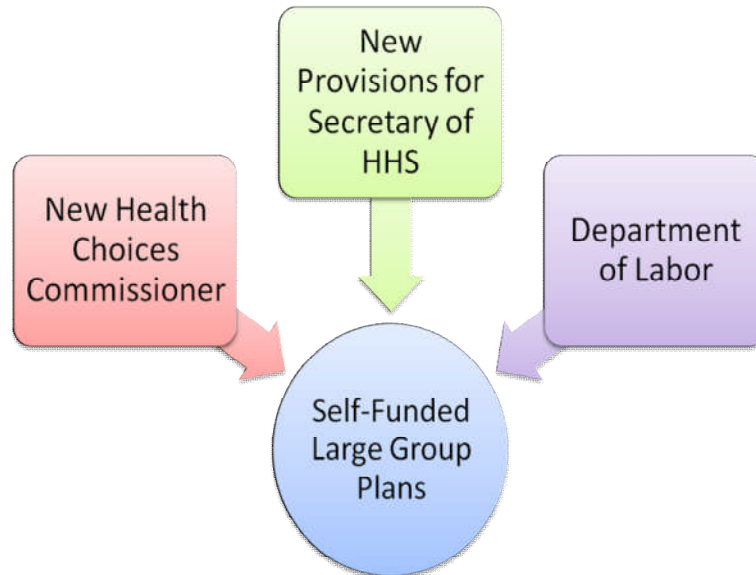
- Certain individuals with incomes below 400% of the federal poverty level could qualify for subsidies toward their premium costs and cost-sharing; these subsidies would be available only through the Exchange.
- Only within the Exchange, credits would be available to limit the amount of money individuals would pay for premiums. For example, a family of three at 133% of the federal poverty line (\$24,352 in 2009 annual income) would be required to only pay annual premiums of \$365 toward a Basic plan in the Exchange. A family of three at 400% of poverty (\$73,240), where the premium subsidies end, would be required to pay no more than \$8,056 in annual premiums for a basic Exchange plan. Individuals eligible for premium credits would also be eligible for cost-sharing credits.
- In the individual market (the non-group market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of the plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute.
- This bill would not affect plans covering specific services, such as dental or vision care.
- Most of these provisions would be effective beginning in 2013.
- H.R. 3200 would extend Medicaid coverage for most individuals under 133% of poverty; individuals would generally be ineligible for Exchange coverage if they were eligible for Medicaid.

IV. Basic Long-Term Changes in Regulation and Markets

There are provisions regarding grandfathered plans in the individual market, but as a practical matter, such plans would no longer be sold on the individual market after a period of time. After the grace period (section 102), plans marketed on the Exchange, those employer plans marketed outside of the Exchange, and self-funded employer plans must, as a practical matter, be qualified health benefit plans that meet a raft of new statutory and regulatory requirements. To avoid penalties, employers (other than certain small employers) must either offer insurance obtained in the group market, self-fund a plan, or become an Exchange participating employer by providing premium support for employees on the Exchange. Below is basically what happens to the above categories after the grace period.

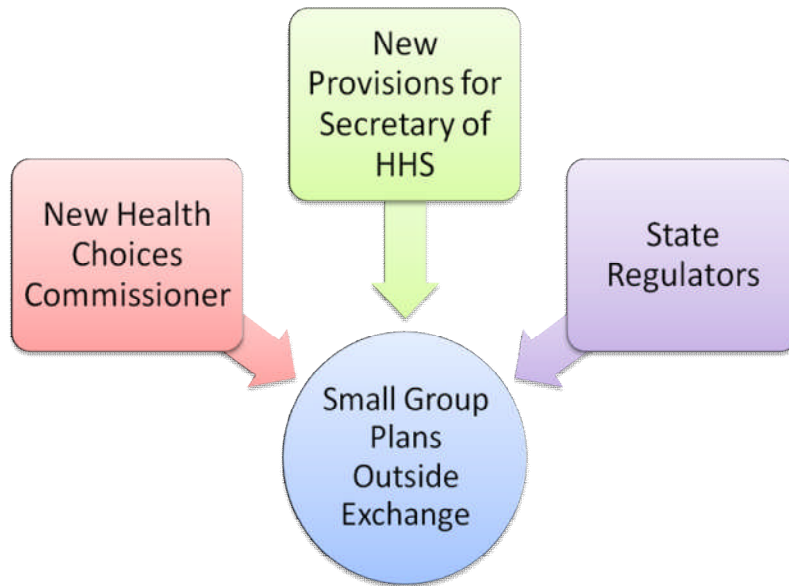
A. Self-Funded ERISA Plans

Self-funded plans are obviously not available in the Exchange. After a grace period, employers that do not provide premium support for a qualified health benefit plan would face substantial penalties.



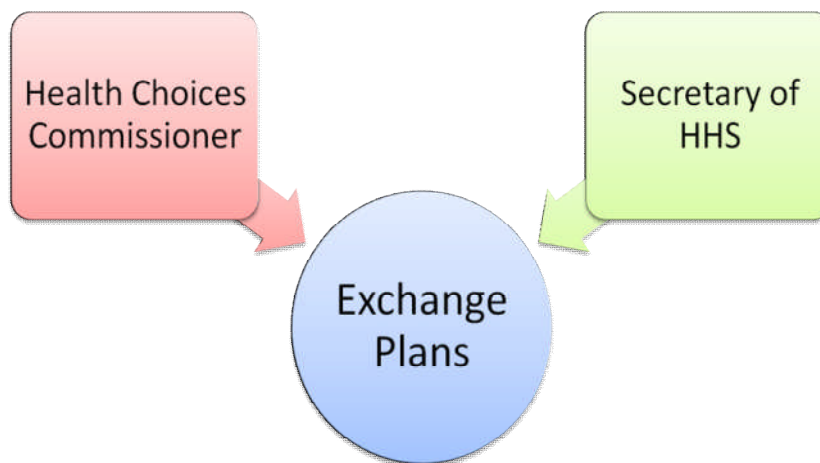
B. Employer Plans in the Group Market

Employer plans may still be marketed outside of the Exchange. However, an employer may also become an Exchange eligible employer and pay premium support for plans in the Exchange. After a grace period, employers that do not provide premium support for a qualified health benefit plan would face substantial penalties. Current plans would not qualify. Providing Flexible Spending Accounts (FSAs), Health Spending Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) will not save an employer from the substantial penalties. Furthermore, employers will be required to pay 72.5% of premiums for their employees. There are also requirement to provide dependent coverage and pay 65% of premiums.



C. Individual or Non-Group Market/Exchange

Individual and non-group plans may no longer be sold. Qualified Health Benefit Plans may be marketed to individuals in the new health information exchange. Also, in the Exchange itself, state mandates may or may not apply. Moreover, there are extensive new requirements for qualified plans in the Exchange. This is one of the more dramatic changes in the bill. Individuals who cannot get group coverage must get insurance through the Exchange or a government program.



V. The Bill Reduces the Number of Uninsured

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have completed a preliminary analysis of H.R. 3200 as introduced on July 14, 2009.^{viii} This analysis does not reflect any modifications or amendments made after that date. Among other things, the legislation would establish a mandate for legal residents to obtain health insurance; set up insurance “exchanges” through which some individuals and families could receive subsidies to substantially reduce the cost of purchasing insurance; and significantly expand eligibility for Medicaid.

Collectively, those provisions would yield a significant increase in the number of Americans with health insurance. By 2019, CBO and the staff of JCT estimate, the number of nonelderly people without health insurance would be reduced by about 37 million in the year 2019, leaving about 17 million nonelderly residents uninsured (nearly half of whom would be unauthorized immigrants).

To be clear on these points, the program plays out over time. The new health insurance exchanges begin in 2013, but more robust funding does not begin until about 2015. At that time, and beyond, according to CBO the number of uninsured would reduce significantly. The subsidies associated with the programs also begin later, so the cost of the program really begins in earnest after a number of years.

VI. The Bill Increases Deficits and the National Debt

A. The President Correctly Points to the Rising Costs of Health Care and Unfunded Health Care Obligations

President Obama has made some important statements on the rising costs of health care and unfunded financial obligations under Medicare, Medicaid and the CHIP program. At a June 15th speech before the American Medical Association he stated, in part:

Make no mistake: the cost of our health care is a threat to our economy. It is an escalating burden on our families and businesses. It is a ticking time-bomb for the federal budget. And it is unsustainable for the United States of America....

This is a test of whether we - Democrats and Republicans alike - are serious about holding the line on new spending and restoring fiscal discipline.

If we fail to act, one out of every five dollars we earn will be spent on health care within a decade. In thirty years, it will be about one out of every three - a trend that will mean lost jobs, lower take-home pay, shuttered businesses, and a lower standard of living for all Americans.

And if we fail to act, federal spending on Medicaid and Medicare will grow over the coming decades by an amount almost equal to the amount our government currently spends on our nation's defense. In fact, it will eventually grow larger than what our government spends on anything else today. It's a scenario that will swamp our federal and state budgets, and impose a vicious choice of either unprecedented tax hikes, overwhelming deficits, or drastic cuts in our federal and state budgets.

Many of these statements are backed up by the Congressional Budget Office, the Medicare Trustees and actuaries and HHS. As stated by the Congressional Budget Office, the federal budget is on an unsustainable path, primarily because of rapidly rising spending on health care.^{ix} Federal outlays for Medicare and Medicaid have increased from 1% of gross domestic product (GDP) in 1970 to more than 5% in 2009; and the Congressional Budget Office (CBO) projects that under current policy, they will exceed 6% of GDP in 2019 and about 8% in 2029. Most of that increase will result from rising costs per capita, rather than from the aging of the population. As a result, the country faces difficult and fundamental trade-offs between limiting the growth of Medicare and Medicaid relative to GDP, accepting a continuing increase in taxes relative to GDP, and reducing other spending relative to GDP, possibly to levels not experienced in this country in more than 40 years.

Moreover, serious fiscal imbalances are not a far-off problem. Under current law, CBO projects, Medicare's Part A trust fund—which pays for inpatient services, post-acute care, and hospice services and receives revenues principally from the payroll tax—will have insufficient funds to pay for all covered services starting in 2017.

These are important points because under the bill, savings under the Medicare or Medicaid program do not appear to go toward addressing the unfunded obligations under these programs but, instead, to an additional entitlement.

B. Unfortunately, the House Bill Substantially Increases Deficits and the National Debt over the Long Term

According to CBO's and JCT's assessment, H.R. 3200 would result in a net increase in the federal budget deficit of \$239 billion over the 2010-2019 timeframe.^x That estimate reflects a projected 10-year cost of the bill's insurance coverage provisions of \$1,042 billion, partly offset by net spending changes that CBO estimates would save \$219 billion over the same period, and by revenue provisions that JCT estimates would increase federal revenues by about \$583 billion over those 10 years.

These points need to be understood in context. For example, in the year 2019 the estimate is \$84 billion in new Medicaid and CHIP outlay, \$160 billion in Exchange subsidies, and \$10 billion in small business credits. This is \$254 billion in new spending for one year. In that year, the estimated reduction in uninsured is 37 million. This is new federal outlays of about \$6,800 per newly insured person. Employers and individuals will pay additional sums for the insurance, so the total cost per newly insured person is higher. A ten year outlay at this rate is over \$2.5 trillion. And after 2019, the costs will be higher because medical inflation is higher than increases in any revenue streams. In 2019, the net deficit for that year alone is \$65 billion. Again, ten years of this level would be \$650 billion in additional deficit and not merely \$239 billion.

If one is concerned about long term debt, deficit, and the problem of unfunded obligations, it is important to ask whether the new revenue streams and savings in the bill are sufficient to keep up with the likely cost of spending for the new outlays and expenses in the bill. The answer according to the CBO is no.

The net cost of the coverage provisions would be growing at a rate of more than 8 percent per year in nominal terms between 2017 and 2019; we would anticipate a similar trend in the subsequent decade. The reductions in direct spending would also be larger in the second decade than in the first, and they would represent an increasing share of spending on Medicare over that period; however, they would be much smaller at the end of the 10-year budget window than the cost of the coverage provisions, so they would not be likely to keep pace in dollar terms with the rising cost of the coverage expansion.

Again, according to CBO, the proposal limits the share of income that eligible people would have to pay when they purchased coverage in the insurance exchanges, and that share of income would not change over time.^{xi} In addition, insurance plans offered through the Exchange would be required to pay a specified share of costs for covered services (on average),

and that share also would not change over time. Combining those provisions, increases in health care spending in excess of the rate of growth in income would be borne entirely by the federal government in the form of higher subsidy payments—because those payments would have to cover the entire difference between the total premium for insurance coverage and the capped amount that enrollees would pay. Those factors help explain why the costs of the coverage provisions would continue to grow rapidly in the decade after 2019.

In sum, relative to current law, the proposal would probably generate substantial increases in federal budget deficits during the decade beyond the current 10-year budget window.^{xii}

For many observers and policymakers, that grim outlook for the federal budget during the next decade and beyond is an important motivation for crafting health care reform and making other policy choices in a manner that significantly reduces future deficits.^{xiii}

Note that the CBO preliminary estimate explicitly does not include additional administrative costs. There seem to be a number of new Federal government administrative costs. There is a new Health Choices Administration with numerous rulemaking responsibilities, implantation responsibilities of the Exchange, and administration of the individual affordability credit. HHS has new rulemakings and new areas to enforce. IRS and the Department of Labor have new areas to administer and enforce. Many of these rules now seem to duplicate prior roles which may maintain regulation such as under ERISA or state programs. We would assume there are a number of start-up costs and then regular operating costs.

VII. The Bill Guarantees Access for Some Type of Insurance for Americans Outside of Employer-Sponsored Insurance

The health care reform proposal would be the latest in a long list of laws and programs. Medicaid provides a safety net of medical coverage below certain income and asset levels. The Children’s Health Insurance Program also provides such a net for a broader range of income and asset categories. Many currently uninsured are eligible for these programs. For employer programs, the law already provides that premiums or coverage cannot vary by individual medical conditions. COBRA coverage provides a window of 18 months where access to the former employer’s coverage is available. However, currently, in the individual market, consideration of health status allows insurers to make sure their products are not sold at a knowing loss to an individual that will clearly cost more than the insurance amount. Some

states have limited consideration of certain conditions. Some states have established high risk pools to help fund individuals whose medical condition created higher insurance premiums.

H.R. 3200 essentially eliminates the individual market, creates a broader pool through the Exchange, and sets out rules that were otherwise not required in the individual market. These include rules like prohibitions on consideration of pre-existing conditions, guaranteed renewal rules, rules against rescission, and ratings band that do not allow wide variance in premiums. These rules will guarantee access. They will likely increase costs for some. This may reduce incentives to get insurance for the healthy. Higher costs of coverage for the healthy combined with guaranteed access may mean some will wait until they have higher utilization before getting such insurance.

As discussed below, much of the new bureaucracy for employer-sponsored insurance is not necessary for such reforms. In addition, one should note that access to coverage and access to health care are related but different. Many have argued that certain systems make doctors less inclined to participate under a given payment structure.

VIII. The Bill Needlessly Launches a Massive Federal Bureaucracy for Employer-Sponsored Insurance

Under H.R. 3200, among the new entrants to regulate employer plans are:

- Congress through numerous specific mandates
- The new and powerful Health Choices Commissioner
- The Health Choices Administration
- Health Benefits Advisors
- Qualified Health Plan Ombudsmen
- The Health Insurance Exchange
- State Exchanges

These new players would be added to the same or substantially expanded power for:

- The Secretary of Health and Human Services
- The Secretary of the Department of Labor
- State Insurance Regulators
- Department of Justice
- Internal Revenue Services
- State Medicaid Agencies

The figures below illustrate new entities and authorities that will regulate or directly affect employers under H.R. 3200.

New Authorities and Requirements

Health Choices Administration and Commissioner

Health Insurance Exchange

ACTIVITIES/ REQUIREMENTS

- Administration of employer contribution or 8% wage fee
- Bids, negotiations, contracts
- Outreach and enrollment
- Benefit package levels
- Culturally/ linguistically appropriate
- Medicaid/CHIP/Medicare interface
- Coordination of risk pooling
- Essential community providers

INDIVIDUAL AFFORDABILITY

- Applications and forms
- Income determinations
- Establish income tiers
- Administer credits

NEW REQUIREMENTS FOR QUALIFIED HEALTH BENEFIT PLANS

- Defines service & premium ratings areas
- Establishes grace period for existing plans
- Preexisting conditions*
- Guaranteed issue and renewal *
- Insurance ratings rules
- Limited age variation categories
- Variation by family enrollment rules
- Standards for nondiscrimination in benefits
- Standards for network adequacy
- Minimum medical loss ratio
- No limits on coverage unrelated to clinical appropriateness*
- Marketing standards
- Standards for internal claims and appeals
- Standards for transparency and disclosure

Internal Revenue Service

NEW INDIVIDUAL MANDATES

- Tax on individuals
- Reporting and disclosure to other agencies
- Tax penalties & enforcement

NEW EMPLOYER MANDATE

- Election Process
- Penalty of 8% of wages for non-election
- New penalties for noncompliance
- Tax & enforcement

Health and Human Services

NEW REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLANS

- Essential benefits & services
- Limits on cost-sharing
- Cost-sharing and copayments
- Actuarial value
- Basic, enhanced, premium and plus plans

NEW REQUIREMENTS/PROVISIONS FOR HEALTH PLANS

- Prohibition on use of personal characteristics
- Prohibits preexisting conditions
- Guaranteed issue and renewal

Department of Labor

NEW REQUIREMENTS

- Election process or 8% of wages penalty
- New enforcement provisions

HHS Run Exchange Plan

- Administrative contracting
- Data collection
- Premiums and financing
- Provider participation
- Medicare or other rates
- New payment initiative
- Fraud and abuse

A significant part of this new regulatory apparatus is directed at employers that are already providing insurance. Plans that are already regulated by the Department of Labor or state agencies would be subject to extensive new rules and new regulatory bodies. This will create needless confusion over the next decade. New liabilities, new rulemakings and new ambiguities will make providing health insurance more and more difficult for employers. The new bureaucracy will raise administrative costs and force a new round of negotiation with providers. Moreover, many of the restrictions will create barriers to innovative programs and insurance better tailored for younger workers.

IX. The Bill is Not Consistent with the President's Promise to Allow Americans to Keep Their Current Employer Plans if They Like Them

The President has repeatedly stated that under reform you can keep your current health insurance plan if you like it. Here is an example from his speech before the American Medical Association on June 15, 2009:

So let me begin by saying this: I know that there are millions of Americans who are content with their health care coverage - they like their plan and they value their relationship with their doctor. And that means that no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what. My view is that health care reform should be guided by a simple principle: fix what's broken and build on what works.

Despite this promise, the current House bills force employers to substantially change the plans that they are allowed to provide in substantial ways. Under the House bill, it is not true that Americans can keep their current employer plans if they like them. After a grace period, employer-sponsored plans must meet the requirements of a "Qualified Health Benefit Plan" (QHBP) or face substantial penalties. For employers with annual payrolls over \$400,000, there is a penalty of 8% of payroll. For employers with annual payrolls between \$250,000 and \$400,000, the penalty is between 2% to 6 % of payroll.

The House reform bill will launch new regulatory schemes that will burden the ability of employers and insurers to innovate and provide value to beneficiaries. Today, large group health plans are largely regulated under the Federal law ERISA, administered by the Department of Labor. States are the primary regulators of the individual and small group market of health insurance products. The bill cast an additional burdensome regulatory net over all of this.

To be a QHBP, employers must rewrite such plans based on dozens of new requirements which are spread out over numerous pages of the bill. Many of these requirements are not easy to understand. Some will be based on the actions of a health benefits advisory committee. Others will be based on decisions of an entirely new bureaucracy called the Health Choices Administration. Without question, new government rules and

bureaucracy will have the key roles in the revisions to these plans – not employers or employees.

Mr. Stearns, a member of the House Committee on Energy and Commerce Committee, offered this simple amendment to force the House legislation to be consistent with the President’s promise. It states:

SEC. 102. PROTECTING THE RIGHT TO KEEP CURRENT COVERAGE.

Nothing in this division shall prevent or limit individuals from keeping their current health benefit plan.

The Committee voted this amendment down. It appears that the current House bill imposes a vast new bureaucracy with dozens of new rules that force major changes to all health plans. This means individuals and employees will not be able to keep their current health care plans, even if they like them.

X. The Proposal Unfairly Denies Individual Affordability Credits to Low and Moderate Income Workers Whose Employers Offer Qualified Health Coverage

Individual affordability credits are available on the Exchange for people at certain lower income levels. Under H.R. 3200, workers at the same level of income are divided into two classes. A worker who does not work for an employer who offers qualified health care can get most of his or her health insurance paid for by the Federal Government. However, such credits are not available where an employer offers qualified health insurance. This rule creates a basic inequity among low and middle income workers who would otherwise qualify for the credit. When a worker gets health insurance through an employer that worker is paying for it.

Quite simply, the bill provides a financial advantage to those who work for an employer that does not offer qualified health insurance, or to those who contract out their services, or to those who work part time. This is not fair or rational.

Our private sector is defined by enterprises that create value for others. This compensation for this value is generally determined in a free market with open competition. Consumers of goods, products, and services generally have choices as to how to spend their money. This spending rewards those who create value, provides accountability, and allows for innovation and improvement. For many private sector enterprises, value comes from a

collaboration of employers, employees, and investors. Each employee receives compensation which represents a portion of the value that comes from his or her work. Today that compensation often includes health insurance coverage.

It is useful to remember a few attributes of this system. First, employees who receive health insurance coverage from their employers pay for it by virtue of their own work. Such employees are not passing on the cost of their health coverage to other families. Second, such employers and employees are not contributing to the problem of the uninsured. Third, private sector health insurance is solvent. By law, such insurance has to have enough money to cover potential expenses. This is not going to be the case for Medicare and Medicaid which are projected to cost more than we have previously set aside for such coverage.

XI. The Proposal Will Create Pressure for Outsourcing and Reduction in Lower Wage Positions in Certain Companies

This set of rules also creates a variety of new incentives including pressure to outsource certain types of work rather than maintain in-house employees. Smaller employers would not face the potential penalties or would face lesser penalties. Employers of lower income employees—perhaps contractors that provide facilities maintenance, drivers, dining services, day care, cleaning, or gardening—may choose not to offer coverage since their employees are generally eligible for individual affordability credits. Such service contractors may gain a competitive advantage in terms of per employee costs versus in-house positions.

Accordingly, larger companies may increase outsourcing to firms that do not carry health insurance. This might apply to federal, state, and local government employees as well. It may be important to assess whether there would be a movement of the workforce from such in-house positions to outsourcing under the House bills.

XII. New Requirements for Qualified Employer Plans Are Confusing and Counterproductive

A. New and Needless Restrictions and Health Status May Adversely Impact Health Plan Operations

There are numerous confusing new regulations in H.R. 3200. ERISA, HIPAA, and state laws already determine whether the use of individual health information or health status is acceptable. Under HIPAA, health status factors may not be taken into consideration when determining whether a person is eligible for group or guaranteed-issue individual insurance.

These provisions allow some flexibility for claims processing, helpful communications, employer-sponsored wellness programs and for addressing disabilities. The new restrictions on use of health information or health status are of substantial concern because they have not addressed these existing areas of flexibility. Such new provisions may have adverse impacts on employer wellness programs, insurance design in general, and claims processing.

In section 152, the draft bill would require that all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality care or related services. The Secretary of HHS must issue new regulations which would presumably apply in addition to ERISA or state laws. This requirement may be enforceable against health care providers, health plans, employers, and federal programs. The term “personal characteristics” could be read to include genetic characteristics.

This provision raises the question of the relationship of this provision to Title I of the Genetic Information Nondiscrimination Act. Could this regulation further constrain what is allowable for the actions of health insurers and plans with respect to medical information such as genetic information? “Personal characteristics” could be read to include health status or medical information. Could new rules restrict what is allowable for purposes of claims processing? If an insurer or health care provider believes consideration of a personal characteristic is relevant to the provision of high quality health care, could this regulation prohibit such consideration under penalty of law?

Proposed section 114 provides:

A qualified health benefits plan shall comply with standards established by the Commissioner to prohibit discrimination in health benefits or benefit structures for qualifying health benefits plans, building from sections 702 of Employee Retirement Income Security Act of 1974, 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.

In this case there are new regulations issued by the new Health Care Commissioner on essentially the same topic as existing law.

In subsection 121 (c) the bill states that a qualified health benefits plan may not impose any limit (other than cost-sharing) unrelated to clinical appropriateness on the coverage of health care items or services. How would this provision relate to co-pays, coinsurance, or tiers

in formularies? What aspects of health insurance today could change under this requirement? Again, this set of rules would appear to require changes to insurance design and raise questions about wellness programs and other efforts to control costs.

Providing Flexible Spending Accounts (FSAs), Health Spending Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) will not save an employer from the substantial penalties under the bill. Thus, employer efforts would likely focus benefits on what qualifies to avoid penalties and not on providing innovative forms of health insurance, accounts or arrangements.

B. The New Requirements Interfere with the Ability of Employers to Provide Wellness Programs and Financial Incentives for Healthy Behaviors

The HIPAA nondiscrimination rules generally prohibit group health plans from establishing rules for eligibility that discriminate against similarly-situated individuals based on a health factor. “Health factors” include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

HIPAA’s nondiscrimination provisions allow plans to establish rewards for adherence to a wellness program, which is defined as “any program designed to promote health or prevent disease.” A wellness program may condition a reward on satisfying a standard that is based on a health-related factor, as long as the program satisfies five conditions including that the total amount of the reward for all wellness programs offered under the plan is limited to 20% of the cost of employee-only coverage under the plan.

There are numerous other tailored exceptions to the general prohibition. Sections 114, 121(c) and 152 appear to call these exceptions into question. Without further clarification, H.R. 3200 may constrain even existing authority for behavioral incentives. Many in the employer community have asked for more flexibility to promote health, harness programs that work, and reduce health care costs. The President has numerous times lauded the Safeway incentives program as the right direction. However, H.R. 3200 throws roadblocks in front of such programs.

C. New Restrictions May Reduce the Ability to Control Costs or Incentivize Value

Employers have been in the lead on wellness and value-based insurance design. These require flexibility and creative uses of incentives. Sections 114, 121, and 152 along with numerous other burdensome provisions restrict the capacity of employer plans to provide for innovative health plans. Each rule would need explicit exceptions for such innovation and there are none. The statutory problems are just the start. It is difficult to predict what the extensive new rulemaking will require with respect to restrictions and changes. This will all stop the momentum toward value-based insurance design and various cost control efforts.

Interestingly, under section 224, under the government run option in the Exchange the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, Accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers. This provision essentially acts as an exception to the many other restrictions in the bill for health plans. This is a double standard which leaves employer plans without the necessary flexibility to innovate, maintain wellness programs, and pursue or maintain value-based insurance designs.

D. Small Businesses Will Become Subject to Complicated Parity Requirements

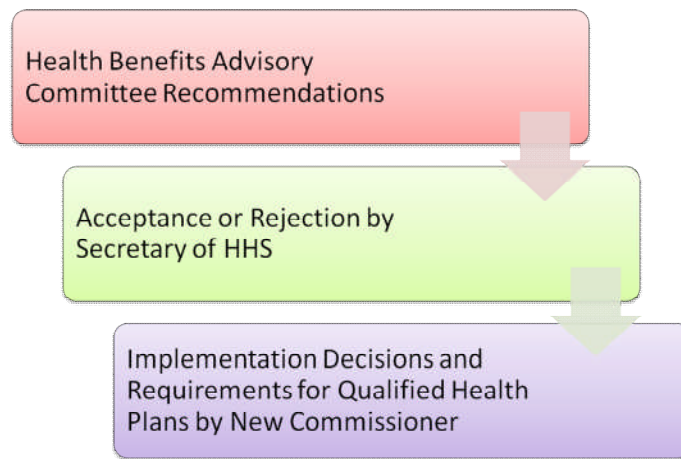
Just last year, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 became law. It was a careful agreement which did not impose the complex requirements on small businesses below 50 employees. Section 114 of the House bill explicitly changes this and would impose these requirements on small businesses, adding to costs and possibly reducing incentives for small businesses to provide basic insurance.

E. New Requirements Will Raise Uncertainty, Force Changes, and Raise Rates for Some Plans

It is difficult to gauge the full impact of H.R. 3200 on employer plans because so many new rulemakings and interpretations are necessary. Section 113 does not allow the ordinary market to vary their premiums by geographic area. This provision is confusing in its application to the employer market. This would appear to mean that whichever zip codes get combined with New York City must pay New York City rates. How these geographic areas are determined will create winners and losers and force new negotiations between plans and providers. The

family rules under section 113 also appear to assume a single rule for attributing premiums between single coverage and family coverage. The section 116 medical loss ratio provision appears to remove incentives for plans to find and share in savings through improvements in incentives.

The whole process of establishing new minimum benefit requirements above those under ERISA and state laws creates a great new set of uncertainties for employers. For plans not in the Exchange, state benefit mandates continue to apply, creating a disadvantage for employers providing insurance outside of the Exchange and making it difficult for the minimum standards panel to use definitions that dovetail with state requirements.



It also appears under section 136 that the Commissioner could apply numerous new requirements to plan outside of the Exchange.

F. The Proposal Forces Certain Employers to Become an Exchange Participating Employer Even Though They Offer Qualified Health Insurance

Under H.R. 3200, subsidies are available on the Exchange for people at certain lower income levels. In addition, employees appear to have a right to choose an Exchange plan. If an employee chooses an Exchange plan, it appears that under section 301 and related provisions that an employer must pay an 8% fee if an employee chooses an Exchange plan over the employer's plan. This would not happen frequently since the 8% payment does not seem to help subsidize the employee in question. That being the case, one wonders why it is necessary to have this provision at all. It is an odd requirement. A highly paid professional making \$200,000 could force an employer to pay a \$16,000 fee. To avoid this outcome, an employer could choose to become an Exchange participating employer. Under that scenario, the

payments would at least constitute premium support for the employee. This is, however, all paperwork and uncertainty.

XIII. Numerous New Authorities Require Employers and Others to Provide Extensive Information to the Government

Section 142 provides broad new data collection authority to the new Health Choices Commissioner. That section also provides that the new Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements, regardless of whether such accountability is with respect to qualified health benefits plans offered through the Exchange or outside of the Exchange. This includes compliance examination and audits. Such audits may include random compliance audits and targeted audits in response to complaints or other suspected non-compliance. The Commissioner is further authorized to recoup from qualified health benefits plans reimbursement for the costs of such examinations and audit of such QHBP offering entities.

Section 221 provides that the Secretary of HHS shall collect such data as may be required to establish premiums and payment rates for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care.

Section 133 provides that a qualified health benefits plan shall comply with standards established by the Commissioner for the accurate and timely disclosure of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on enrollment, data on disenrollment, data on the number of claims denials, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner. The Commissioner shall require that such disclosure be provided in plain language. Under section 134 the Commissioner can determine whether these provisions apply outside of Exchange plans.

Section 2402 creates a new Assistant Secretary for Health Information who will have authorities to ensure the collection, collation, reporting, and publishing of information (including full and complete statistics) on key health indicators. This would also ensure appropriate specificity and standardization for data collection at the national, regional, state, and local levels and standards, as appropriate, for the collection of accurate data on health and health care by race, ethnicity, primary language, sex, sexual orientation, gender identity,

disability, socioeconomic status, rural, urban, or other geographic setting, and any other population or subpopulation determined appropriate by the Secretary;

There are dozens of new requirements and through simple rulemaking authority both the new Health Choices Commissioner and the Secretary of HHS will have authority above the current authorities of the Department of Labor and state agencies to require new paperwork and reporting burdens. This will cost money and complicate the ability to provide and administer health plans.

XIV. The Bill Authorizes Powerful and Complicated Sanctions

Under H.R. 3200, employers and health plans face new and complicated sanctions. The general sanction under the “play or pay” mandate is 8% of payroll. However, this may be triggered for many circumstances. It is unclear whether an agency could go back to a prior calendar year and declare that, despite the employer’s intentions, a given plan did not meet the status of being a qualified health benefits plan.

Under section 142, the new Commissioner for Health Choices has authority to issue civil penalties, suspend enrollment of individuals, and terminate plans. There are also new enforcement authorities for the Department of Labor and the Internal Revenue Service. Each agency can issue civil penalties of up to \$500,000 per year for unintentional failures. Without the cap the penalty can be up to \$100 per day per employee. So anything not satisfying the unintentional clause can escalate to very high sums. Assume an employer with 9,000 employees. A full year of noncompliance could be $\$100 \times 9,000 \text{ employees} \times 365 \text{ days} = \$328,500,000$. Each agency appears to have similar authorities and thus the amount can triple.

One of the items that can make this all the more complicated is that the sanctions apply to a qualified health benefits offering entity. This is the plan sponsor. Over the years the relative liabilities between plans and sponsors have been sorted out in court and in statute. The new requirements under this bill are often confusing and would many would be very difficult to apply to plan sponsors.

XV. The Government in the Dual Role as a Competitor and a Regulator May Distract the Government from Other Important Challenges and Create Conflicts

The Secretary has a tremendous range of unsolved problems and responsibilities—unfunded obligations under Medicare and Medicaid in the tens of trillions of dollars, necessary changes to payment policy, implementation of new provisions under the American Recovery and Reinvestment Act, critical roles as a regulator, new roles as a regulator under the health care reform bills, public health issues, and more. The budget of the HHS including Medicare and Medicaid is already larger than most countries. Do we really want to place further demands on the Secretary and HHS to be market participants in the health insurance market?

There are many conflicts that arise by making HHS an insurance market participant. Are we expecting the Exchange to be able to credibly regulate HHS? What keeps the tremendous decisions from being politically motivated? HHS or the Commissioner will have responsibilities on determining employer eligibility and individual subsidies. These and other roles will likely lead to an inherent advantage and the perception of unfairness.

There has been much discussion on the implication of the government run plan on the market. This document has not focused on such analysis, though there are many issues involved.

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ENDNOTES

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- ⁱ Lyke, Bob. *Congressional Research Service*. "Health Care Reform: An Introduction." April 14, 2009. <http://assets.opencrs.com/rpts/R40517_20090414.pdf>.
- ⁱⁱ Fronstin, Paul. *Employee Benefit Research Institute*. Issue Brief No. 321: "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey." September 2008. <http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf>.
- ⁱⁱⁱ Chaikind, Hinda et al. *Congressional Research Service*. "Private Health Insurance Provisions of H.R. 3200." July 27, 2009. <http://assets.opencrs.com/rpts/R40724_20090727.pdf>.
- ^{iv} Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2008 Annual Survey*. <<http://ehbs.kff.org/pdf/7790.pdf>>.
- ^v Lyke, Id.
- ^{vi} Staman, Jennifer. *Congressional Research Service*. CRS Report for Congress: "Regulation of Health Benefits under ERISA: An Outline." April 12, 2008. <http://assets.opencrs.com/rpts/RS22643_20070412.pdf>.
- ^{vii} Chaikind, Id.
- ^{viii} Elmendorf, Doug, *Congressional Budget Office*, Letter to Chairman Charles Rangel, July 17, 2009. <<http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>>.
- ^{ix} Elmendorf, Doug, *Congressional Budget Office*, Letter to Senator Kent Conrad, July 16, 2009. <<http://www.cbo.gov/ftpdocs/103xx/doc10311/06-16-HealthReformAndFederalBudget.pdf>>.
- ^x Elmendorf, Doug, *Congressional Budget Office*, Letter to Chairman Charles Rangel, July 17, 2009. <<http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>>.
- ^{xi} Elmendorf, Doug, *Congressional Budget Office*, Letter to Congressman Dave Camp, July 26, 2009. <<http://www.cbo.gov/ftpdocs/104xx/doc10400/07-26-InfoOnTriCommProposal.pdf>>.
- ^{xii} Id.
- ^{xiii} Elmendorf, Doug, *Congressional Budget Office*, Letter to Chairman Charles Rangel, July 17, 2009. <<http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf>>.