

An Overview of: The Affordable Health Care for America Act



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Client Alert:

*From the Law Offices of Proskauer Rose in association with
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The Affordable Health Care for America Act (“AHCAA”)

The U.S. House of Representatives moved closer to an overhaul of the nation’s health care delivery system by passing the Affordable Health Care for America Act (“AHCAA” or the “Act”) late in the evening of November 7, 2009. Passage of AHCAA was not a foregone conclusion headed into the weekend. However, a visit to the Hill by President Obama and adoption of an amendment restricting public funding for abortions ultimately swayed a number of key Democrats who originally had opposed it to vote for the Act. The Act was approved by the House with a vote of 220-215.

The key provisions of the Act include employer mandates, individual mandates, a regulated health insurance marketplace, known as the “Exchange,” a public health plan and various revenue generators to pay for the program. The key provisions of the Act are summarized below:

Employer Mandate - Play or Pay

Starting in 2013, the Act will require employers to either provide health coverage (an “offering employer”) to employees and their eligible dependents or pay a federal payroll tax equal to 8% of all compensation paid to employees (certain small employers are exempt from this tax or are subject to a graduated tax rate). An offering employer generally must automatically enroll eligible employees in their employment-based health plan and offer the employees the option of selecting individual or family health coverage. Under the Act, employers must contribute 72.5% of the premium cost for individual and 65% of the premium cost for family coverage, for the lowest-cost qualified plan. Family coverage under AHCAA includes the employee’s spouse and qualifying children. The Act also requires an offering employer to contribute to the Exchange for each employee who declines employer coverage but enters the “Exchange” (described below) for insurance if the cost of the employer’s insurance is greater than 12% of the employee’s income. The contribution is generally 8% of the average salary for the employee. Small employers with annual payrolls at or below \$500,000 are exempt from this requirement. The contribution phases up from 0-8% between an annual payroll of \$500,000 and \$750,000, at which point employers are subject to the full 8% contribution requirement.

Individual Mandates

Beginning in 2013, all individuals will be required to have acceptable health insurance coverage that meets or exceeds the qualifications of the federally-defined minimum benefit plan. The federal government will establish the baseline qualifications for coverage. Those who do not have this type of coverage will be required to pay a penalty equal to 2.5% of their income. Waivers are allowed for Native Americans, those with religious objections, dependents and individuals with a financial hardship, defined as premiums over 12% of income. Acceptable coverage generally includes grandfathered individual and employer plans, certain government coverage (e.g., Medicare, Medicaid, certain coverage provided to veterans, military employees, retirees and their families, and members of Indian tribes), and coverage obtained pursuant to the Exchange or an employer offer of coverage.



Health Insurance Exchange

AHCAA establishes a Health Insurance Exchange (to begin in 2013) (the “Exchange”) under the purview of the Health Choices Administration. The Exchange will be a regulated marketplace for individuals and small employers to comparison shop among private and public insurers, including new health insurance co-ops. The Commissioner of the Health Choices Administration is charged with establishing a process through which to obtain bids, negotiate and enter into contracts with qualified plans as well as to ensure that different levels of benefits are offered through the Exchange with appropriate oversight and enforcement. In Year One, individuals not enrolled in other acceptable coverage, as well as small employers with 25 or fewer employees, are allowed into the Exchange. In Year Two, employers with 50 and fewer employees are allowed into the Exchange. In Year Three, the Commissioner is, at a minimum, required to open the Exchange to employers with 100 and fewer employees, but is permitted from that year forward to expand employer participation as appropriate, with the goal of allowing all employers access to the Exchange. States may opt to operate the Exchange at the state level in lieu of participating in the national Exchange, provided an electing state follows the federal rules.

Public Health Insurance Option

Under the Act, a national public plan will be established in 2013 to compete with private insurers in the Exchange. The public option will operate on a “level playing field” with private insurers, offering the same benefits, abiding by the same insurance market reforms, following provider network requirements and other consumer protections. The Secretary of Health and Human Services will administer the public option and negotiate rates for providers that participate in it. The public health insurance option is provided startup administrative funding, but is required to amortize these costs into future premiums as the option must be self-sustaining – *i.e.*, financed through premiums – after the initial funding. Significantly, providers are presumed to be participants in the public option unless they opt out of participation.

Revenue Generation

The Act contains various provisions meant to generate revenue to pay for the expanded health care coverage called for under AHCAA. Revenue generators under the Act include:

- **Distributions from FSAs, HRAs, and HSAs for medicine qualify only if for prescribed drugs or insulin.** The Act limits nontaxable reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts to medicines and drugs prescribed by a medical provider, or insulin. Over-the-counter drugs will no longer be reimbursable through these arrangements under the Act.
- **Limitation on health flexible spending arrangements under cafeteria plans.** The Act limits salary reduction contributions to health flexible spending arrangements to \$2,500 (indexed to the consumer price index).
- **Increase in penalty for nonqualified distributions from health savings accounts.** The Act increases the 10% penalty on distributions from health savings accounts that are not used to pay for health-related expenditures to 20%.
- **Denial of deduction for Federal subsidies for prescription drug plans which have been excluded from gross income.** Certain employers are eligible for Federal subsidies with respect to prescription drug benefits provided to retirees, and the subsidies are excluded from gross income. The Act eliminates the ability of employers to deduct expenses for which they are subsidized.
- **Surcharge on high income individuals.** The Act levies a 5.4 % tax on modified adjusted gross income in excess of \$1 million in the case of a joint return (\$500,000 in the case of other returns).
- **Excise tax on medical devices.** The Act establishes a 2.5 % excise tax on medical devices sold for use in the U.S. The excise tax does not apply to exported devices and does not apply to retail sales of devices.

AHCAA grew out of H.R. 3200 (aka America’s Affordable Health Choices Act of 2009) and contains a series of compromises and new provisions not found within the predecessor act.

The chart below illustrates key differences between AHCAA and H.R. 3200:

	H.R. 3200 as introduced in the House	Affordable Health Care for America Act (AHCAA)
Geographic Variations In Medicare Payments and Payment Reform	No provision	Provides that Institutes of Medicine, through two studies, will make recommendations on how to fix the Medicare payment system, regarding geographic variations as well as changing the system to reward value and quality. CMS is charged with implementing IOM recommendations unless disapproved by Congress.
Small Businesses Exemption from Shared Responsibility Requirement	Exempts small businesses with payrolls below \$250,000 from shared responsibility requirements; provides only graduated penalty for firms with payrolls between \$250,000 and \$400,000.	Exempts small businesses with payrolls below \$500,000 from shared responsibility requirements; provides only graduated penalty for firms with payrolls between \$500,000 and \$750,000.
Small Businesses Access to Affordable Group Rates in the Health Insurance	Exchange In 2013, firms with up to 10 employees can enter the exchange; in 2014, firms with up to 20 employees; and in 2015 and beyond, Commissioner can allow larger employers as appropriate.	In 2013, firms with up to 25 employees can enter the Exchange; in 2014, firms with up to 50 employees; in 2015, firms with up to 100 employees; and in 2015 and beyond, Commissioner can allow larger employers as appropriate.
Health Care Surcharge	Taxpayers would pay a surcharge on the amount of their gross income in excess of \$280,000 (individuals) and \$350,000 (couples) to help finance health care reform.	Taxpayers would pay a surcharge on the amount of their gross income in excess of \$500,000 (individuals) and \$1,000,000 (couples) to help finance health care reform.
Public Health Insurance Option	Provides that doctors' rates would be Medicare plus 5%; hospitals' rates would be Medicare.	Provides that the Secretary of HHS will negotiate rates with doctors and hospitals – the government plans would be on a "level playing field" with private insurers.
Donut Hole Closing The Medicare Part D Donut Hole	Reduces the donut hole by \$500 and institutes a 50% discount for brand-name drugs in the donut hole, effective 2011. Phases out the donut hole by 2023.	Reduces the donut hole by \$500 and institutes a 50% discount for brand-name drugs in the donut hole, effective 2010. Phases out the donut hole by 2019.
Rx Negotiation HHS Negotiation of Drug Prices	No provision.	Require the Secretary of HHS to negotiate drug prices on behalf of Medicare beneficiaries.
Medical Malpractice Reform	No provision.	Establishes a voluntary state incentives grant program to encourage states to implement "certificate of merit" and "early offer" alternatives to traditional medical malpractice litigation.
Antitrust Exemption for Health Insurers	No provision.	Ends blanket exemption from antitrust laws.
Young Americans Coverage of Young People on their Parents' Policy	No provision.	Requires health plans to allow young people to remain on their parents' insurance policy up to their 27th birthday.
COBRA Extension	No provision.	Allows individuals to keep their COBRA coverage until the Exchange is set up and running.
Sunshine on Premium Increases	No provision.	Effective immediately, discourages excessive price increases by insurance companies through review of rate increases.
State Lines	No provision.	Allows for the creation of State Health Insurance Compacts – permitting states to enter into agreements to allow for the sale of insurance across state lines when the state legislatures agree.

The Senate will now take up deliberations regarding national health care reform. After the House bill passed, key Senators went on record as opposing prominent components of the Act, including the “public plan.” However, Senate Majority Leader Harry Reid has indicated he supports a public option, which includes the ability for states to opt out” if they can provide a reasonable alternative. Additionally, there are key differences between AHCCA and competing bills currently pending in the Senate, including the Health, Education, Labor and Pensions Committee’s HELP’s) *American Health Care Choices Act*, and the Finance Committee’s *American Health Future Act*. The American Health Future Act, for example, does not embrace the “Play or Pay” approach adopted in the Act with respect to an employer mandate. Rather, the Finance Committee bill provides that, starting in 2013, employers with more than 50 employees who do not offer health care coverage to an employee must reimburse the government for each full-time employee (30 or more hours a week) who receives a “health care affordability tax credit,” equal to the average national Exchange credit, and a penalty of up to \$400 per number of employees. While the Senate’s current proposed bills do not include the AHCCA’s surtax on high wage earners, the Finance Committee bill includes an excise tax on high-cost insurance plans. This so-called “Cadillac Tax,” which would again begin in 2013 (after the next presidential election), would be a nondeductible excise tax of 40% on premiums in excess of \$8,000 for group health individual coverage and \$21,000 for group health family coverage.

If these and other differences cannot be addressed in the Senate version of health care reform, the Act and whatever Senate legislation is passed, if any, will be sent to a joint committee for reconciliation. The reconciled bill would then need to be passed by both the House and the Senate.

In short, there is still a long way to go before we will know all of the requirements of health care reform. It is impossible for anyone to predict what will ultimately appear in a bill that would be sent to the President for his signature.

Through our relationship with the Benefit Advisors Network and our access to Peter Marathas, Esquire of Proskauer Rose LLP, we will continue to issue Health Care Alerts addressing key issues under the Act and Senate legislation.

This report was designed for clients and friends of the firm:

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