Major Health Care Legislation in Congress

Information courtesy of the National Association of Insurance Commissioners

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House of Representatives

On Thursday, October 29, House leaders introduced H.R. 3962, the Affordable Health Care for America Act. This bill combines the action of the three committees of jurisdiction, and makes additional changes to reduce the cost of the legislation over its first 10 years.

Like the original legislation that was introduced in July, the bill would create a new independent federal agency, the Health Choices Administration, led by a Health Choices Commissioner, which would be responsible for operating a national Health Insurance Exchange. Individuals could purchase nongroup coverage through the exchange and employers could allow employees to enroll in coverage through the exchange while providing a contribution towards the cost of coverage. Plans would be sold at four different benefit levels. States could apply to operate the exchange themselves. Within this Exchange would be a public plan option competing against private insurers. The new bill requires the public plan to negotiate reimbursement rates with providers, instead of using Medicare-based rates as the original bill required. Subsidies will be available on a sliding scale for all individuals between 133% and 400% of the federal poverty level (FPL), though subsidies for those above 150% FPL are less generous than they were in the original bill. All individuals up to 150% FPL would now be eligible for Medicaid, with the federal government assuming 100% of the cost for newly-eligible individuals after through 2014, and 91% thereafter. (The original bill made all individuals up to 133% FPL eligible, and had the federal government permanently assuming the full cost of the expansion population.)

As in the original House bill, the Health Choices Commissioner would also be responsible for implementing a number of insurance market reforms, including guaranteed issue, elimination of preexisting condition exclusions, and adjusted community rating. Premiums could vary only by age (2:1 max) and geography. The Commissioner is also tasked with developing new federal standards for essential benefits, marketing, network adequacy, grievances and appeals, and coordination of benefits. These federal standards would be floors, not ceilings, and states that wished to could go beyond them.

In addition, all individuals would be required to obtain health insurance coverage of one form or another. This requirement would be enforced with a tax penalty of 2.5% of modified adjusted gross income. This penalty would amount to approximately $875 per year for someone earning $45,000. Employers would also be required to provide qualifying coverage to employees. This would be enforced through an 8% payroll tax for the largest businesses.

A number of additional provisions and changes were made in the new bill, including:

- Limiting the applicability of the McCarran-Ferguson antitrust exemption to instances of price-fixing, market allocations, and monopolization by health insurance and medical malpractice insurance companies;
- Allowing states to form compacts to allow interstate sales of insurance;
- A transitional program to provide $5 billion in assistance to high risk pools to help individuals with preexisting conditions to obtain coverage before market reforms go into place;
- A new federal long-term care insurance program to provide a cash benefit to individuals with functional limitations.

Senate Finance Bill

The Senate Finance Committee approved legislation (S. 1796) on October 19. The legislation would delegate the development and operation of insurance exchanges to the states with broad flexibility to tailor them to local needs. If states fail to do so, the federal government would contract with nonprofit entities to operate exchanges. Federal minimum standards are created, but development of detailed regulations and guidelines are generally delegated to state regulators acting through the NAIC. The Senate Finance bill does not contain a public plan, but instead provides startup assistance to cooperative health plans in the form of grants and loans. It also does not contain an employer mandate, but instead penalizes employers whose employees receive subsidies through the exchange.

Like the other bills, the Finance bill contains an individual mandate. An amendment by Sens. Snowe (R-ME) and Schumer (D-NY) was adopted that significantly weakens the individual mandate by reducing the amount of the penalty, expanding the number of individuals exempted from it, and limiting the government's ability to collect penalties levied against those who fail to get coverage. Subsidies for low-income individuals are also significantly lower than in those in the Senate HELP bill or the House bills.

Merged Senate Legislation

Senate leaders are currently working to reconcile the Senate HELP and Finance Committee bills. This new bill is expected in the next several days. On Monday, October 26, Sen. Majority Leader Harry Reid (D-NV) announced that the merged legislation would contain a public plan using negotiated provider payment rates. There would also be a provision allowing states to opt-out of having the public plan available in their markets. It is also likely that merged Senate legislation would also contain a provision limiting the applicability of the McCarran-Ferguson antitrust exemption to health insurers and medical malpractice insurers.