



TOWERS
PERRIN

Employers, Healthcare Reform and Wellness Programs: Overview and State of Play

December 3, 2009

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Principal



Will we have health a care reform law?

- Remains more likely than not to be enacted into law, process may carry into 2010
- House approved the Affordable Health Care for America Act (H.R.3962), by a vote of 220-215 on November 7, 2009
 - Estimated to cover 96% of population at 10-year cost of \$1.052T, reducing deficit by \$138B
- Senate bill, the Patient Protection and Affordable Care Act (H.R.3590) now under consideration; vote likely by year-end 2009
 - Estimated to cover 94% of population at 10-year cost of \$848B; reducing deficit by \$130B
- House-Senate Conference Committee will need to compromise on a final version in order for President Obama to sign a law
- Implementation would take several years beginning in 2010

The building blocks of health care reform

Key Element	Congressional Direction
Individual mandate	<ul style="list-style-type: none"> All individuals required to enroll in basic health coverage, with limited exemptions
Individual / small group market reform	<ul style="list-style-type: none"> Insurers required to offer guaranteed issue coverage, no health status underwriting, standard plan designs Limits on maximum premium differentials; permitted only for certain factors (e.g., tobacco use, age, place of residence, family size)
Subsidies to low- and middle-income individuals	<ul style="list-style-type: none"> Federal premium subsidies provided to individuals earning up to a specified percentage of the federal poverty level (FPL) Federal premium subsidies only for health coverage obtained through insurance Exchanges/Gateways (including public plan option), not through employer-sponsored plans.
Health Insurance Exchanges / Gateways	<ul style="list-style-type: none"> National, regional or state insurance Exchanges/Gateways established to structure a market for individual and small group health insurance
Employer pay or pay mandate	<ul style="list-style-type: none"> Employer required to offer employees who work a specified number of hours a health plan that meets minimum requirements, and subsidize a certain percentage of the cost of that coverage, or pay a per employee, or percentage of payroll, assessment to the government.
Create new public plan	<ul style="list-style-type: none"> Establish new public health plan to compete with private insurer plans offered through Exchanges/Gateways Public plan might be administered on a federal, state, regional level Private, nonprofit Health Insurance Cooperative may be an alternative to a public plan
Tax penalty on 'high-cost' health plans to 'cap' employer health coverage	<ul style="list-style-type: none"> Excise tax on carriers (insured plan) or administrators\employers (self-insured) plan when employer-offered health coverage exceeds specified value per year (e.g., \$8,000 single coverage / \$21,000 family coverage)

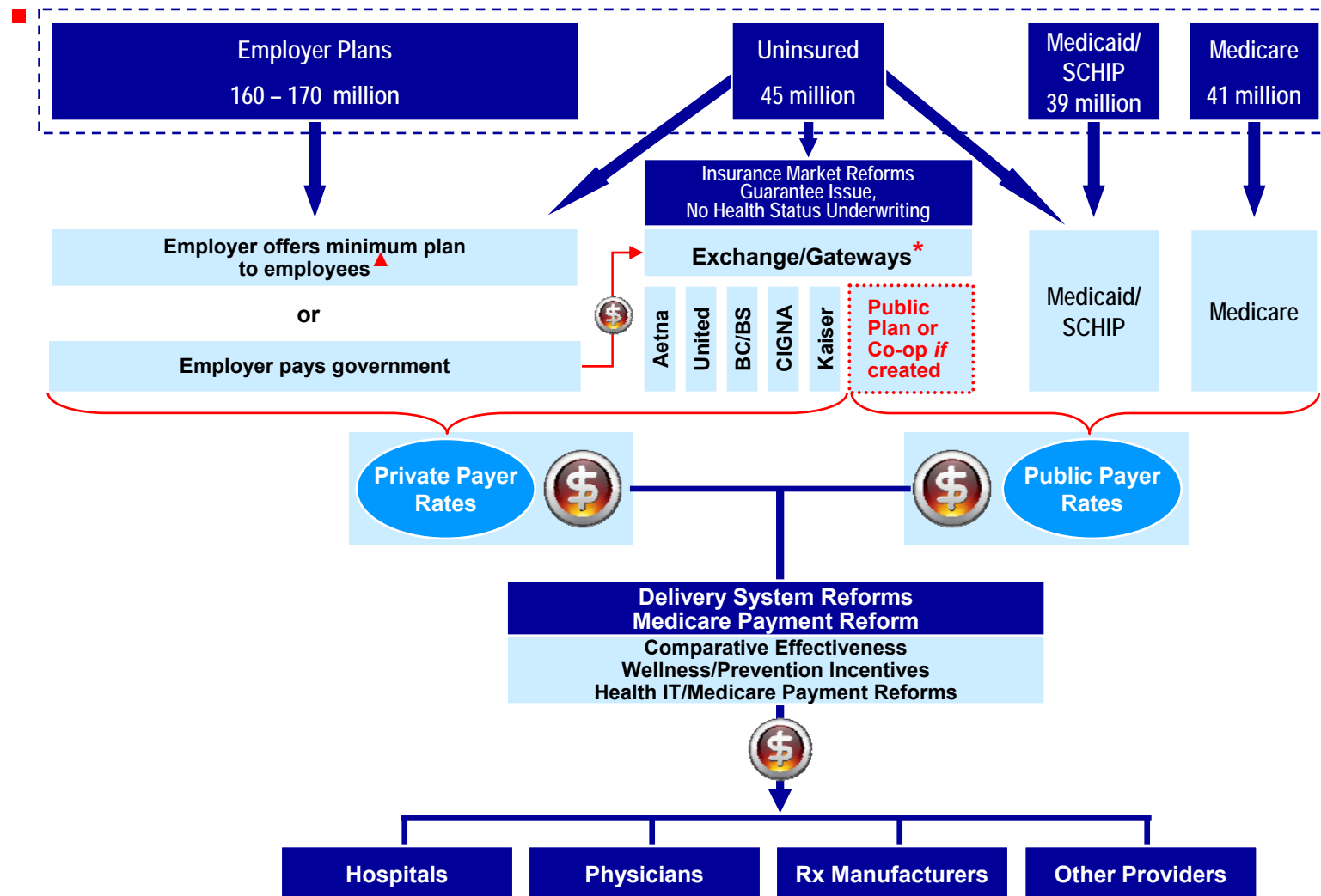
House and Senate: Key elements of the two bills

	Senate H.R. 3590 <i>Awaits vote by full Senate</i>	House H.R. 3962 <i>Passed Nov 7, 2009</i>
Individual mandate	✓	✓
Individual and small group market reform	✓	✓
Low- and middle-income premium subsidies	✓	✓
Health insurance exchanges	✓	✓
Standard benefit packages	✓	✓
Employer pay or play mandate	✓ ("free rider")	✓ (8% of employer's average wages)
Cap health FSAs at \$2,500 per year	✓	✓
Public option	✓	✓
Tax employers on 'high-cost' plans	✓ (40%)	No
New taxes on high income individuals	✓ (Medicare payroll tax)	✓ (Income tax surcharge)

Now the differences are in the details

	Senate H.R. 3590	House H.R. 3962
Individual mandate – penalty	\$95/yr per person rising to \$750/yr in 2016; max of 3 x \$750/ family	2.5% of income, capped at national average premium amount
Expand Medicaid eligibility	133% of federal poverty level (FPL)	150% of federal poverty level (FPL)
Federal premium subsidies for Exchange-based coverage	Those at 10% to 400% FPL; declining amount from 2% to 9.8% of household income	Those at 133% to 400% FPL; declining amount from 1.5% to 12% of household income
Employer mandate	F-T employees only (30 hrs/week); employer pays \$750/yr per F-T for noncompliant plan; \$3,000/year for F-T who gets subsidy in Exchange	F-T <i>and</i> P-T employees; employer pays 8% of <i>its</i> 'average wage' for those who decline
Employer minimum plan	Actuarial value ≥60%, employee contribution ≤9.8% household income	Employer pays 72.5% single, 65% family for its lowest cost option; design grandfather 5 yrs.
New tax on 'high-cost' employer health coverage	40% employer tax on health coverage >\$8,500/\$23,000	None
Health FSA limit	\$2,500/yr in employee pre-tax salary reduction	\$2,500/yr in employee pre-tax salary reduction
New taxes on high-income individuals	Medicare payroll tax to 1.95% on wages > \$200,000/single, >\$250,000/couples; now 1.45%	5.4% tax on MAGI >\$1M (joint) and \$500,000 (single)

*Where Congress is headed
Reformed health coverage system*



■ Source: U.S. Census Bureau. Does not depict 15 million now with individual insurance expected to move to Exchange or other sources
 ❖ Low- and middle-income premium subsidies expected; e.g., perhaps up to 400% of federal poverty level
 ▲ TBD if employees may decline employer plan in favor of Exchange-based coverage and/or premium subsidies

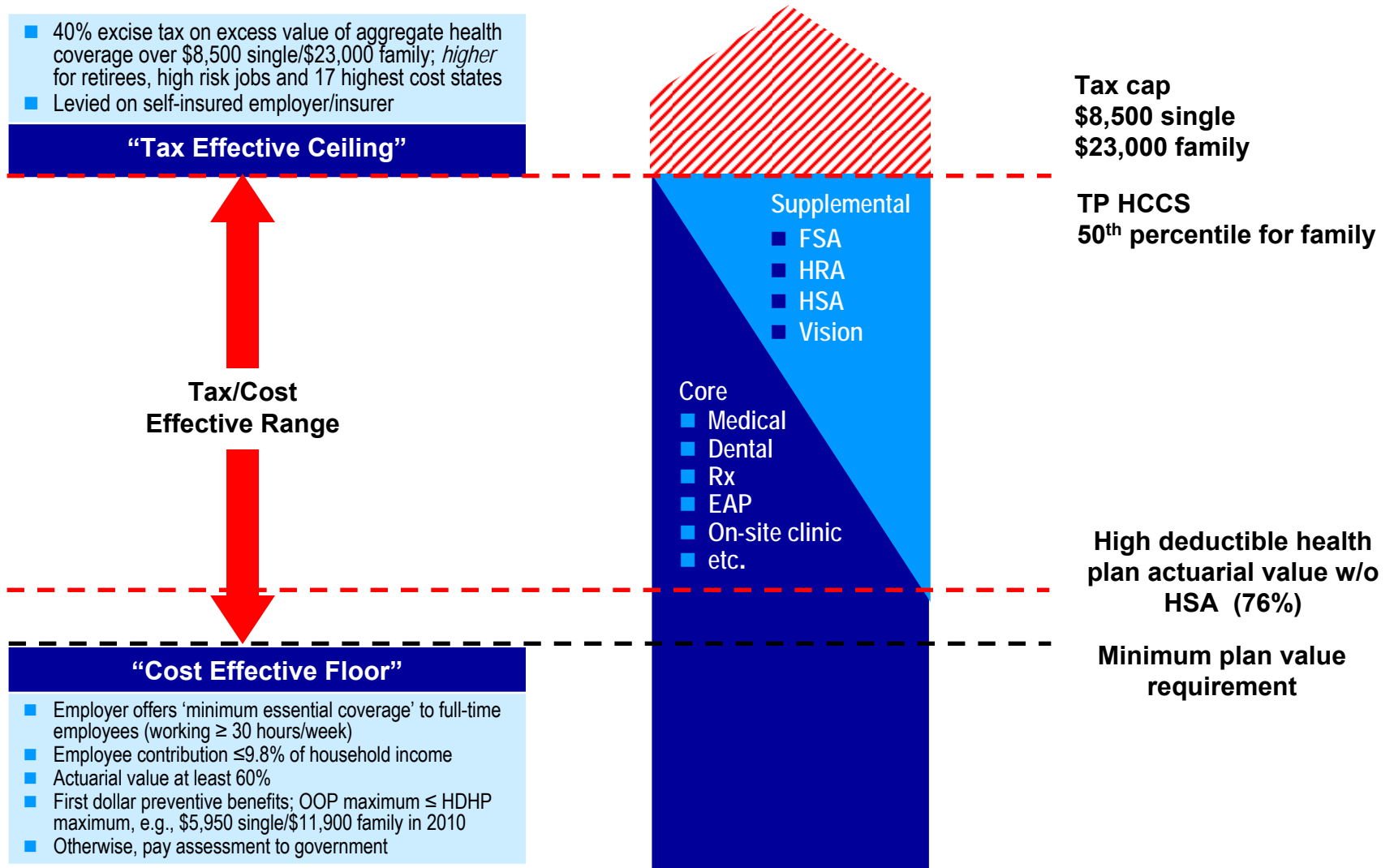
*Employers may pay for a lot of reform directly or indirectly—
What would be the effect be on your organization?*

Senate Bill: Select Provisions Affecting Employers*	2010–2019 Savings/ Revenue**	Potential Employer Impact
Reduced provider payments under Medicare, Medicaid, SCHIP	\$ 436B	Cost shifting to employers and other private payers
40% excise tax on insurers' and employers' high-cost health plans (nondeductible)	\$ 149B	Employer limits health benefits or pays excise tax; affects total rewards strategy
Free-rider assessment on noncompliant employers whose employees (≥ 30 hours/week) obtain subsidies in a Health Insurance Exchange	\$ 28B	New tax liability for affected employers
Annual tax on insurers and self-insurers to fund comparative effectiveness research	\$ 3B	Pass-through item; new tax liability for employers
Annual assessments on health insurers	\$ 60B	Pass-through; new expense for employers and other payers
Annual assessments on pharmaceutical manufacturers	\$ 22B	Pass-through; new expense for employers and other payers
Annual assessments on medical device manufacturers	\$ 19B	Pass-through; new expense for employers and other payers
Eliminate employer deduction for expenses allocable to Medicare Part D subsidy	\$ 5B	Reduced employer federal income tax deduction
Limit employees' pretax salary contributions from health FSAs to \$2,500 per year	\$ 15B	Alters FSA design, possibly affects out-of-pocket features of related group health plan
Prohibit reimbursement of over-the-counter (OTC) medicines from FSAs/HRAs/HSAs, unless doctor-prescribed	\$ 5B	Alters eligible medical expenses under account-based plans; increased administration to process OTC expenses
Total of select provisions over 10 years	\$ 742B	

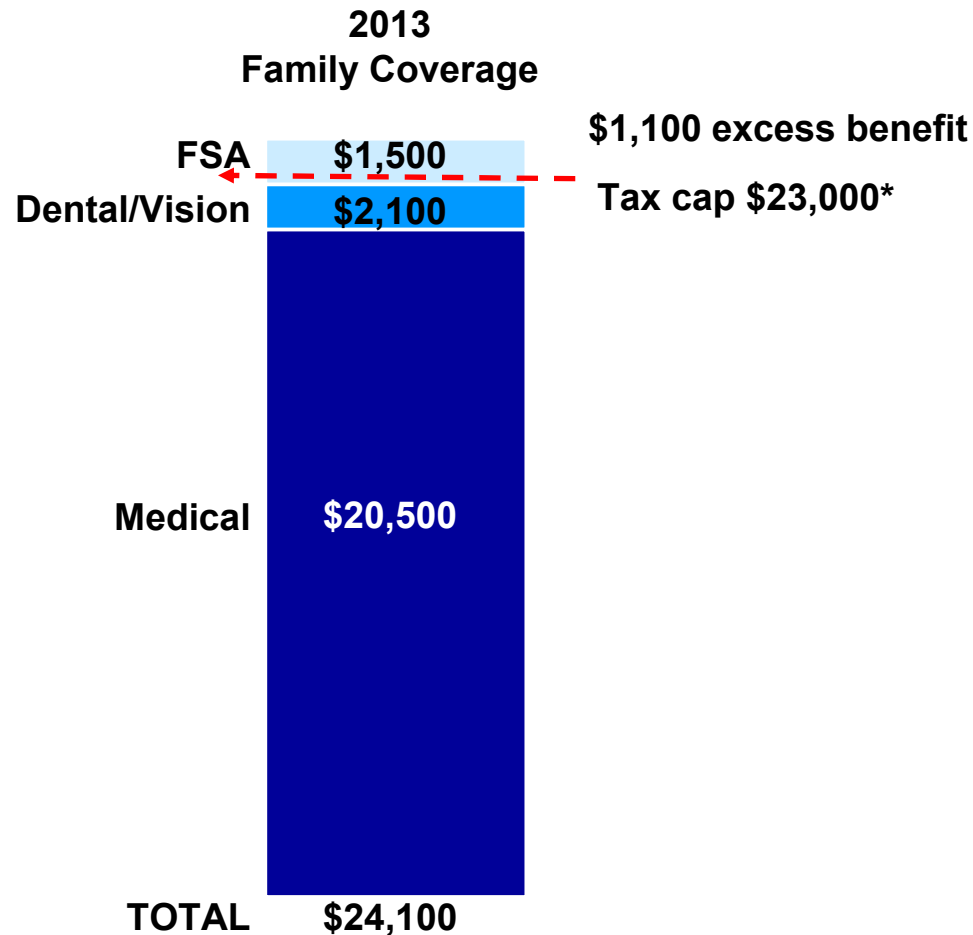
*Select provisions chosen based on direct and indirect cost impact on employer sponsors of employee group health plans; numerous other provisions in Senate bill omitted under this criterion.

**CBO-JCT projection 11/18/2009; all amounts rounded to next whole billion.

"New normal" for employers under Senate bill



Tax cap under Senate bill



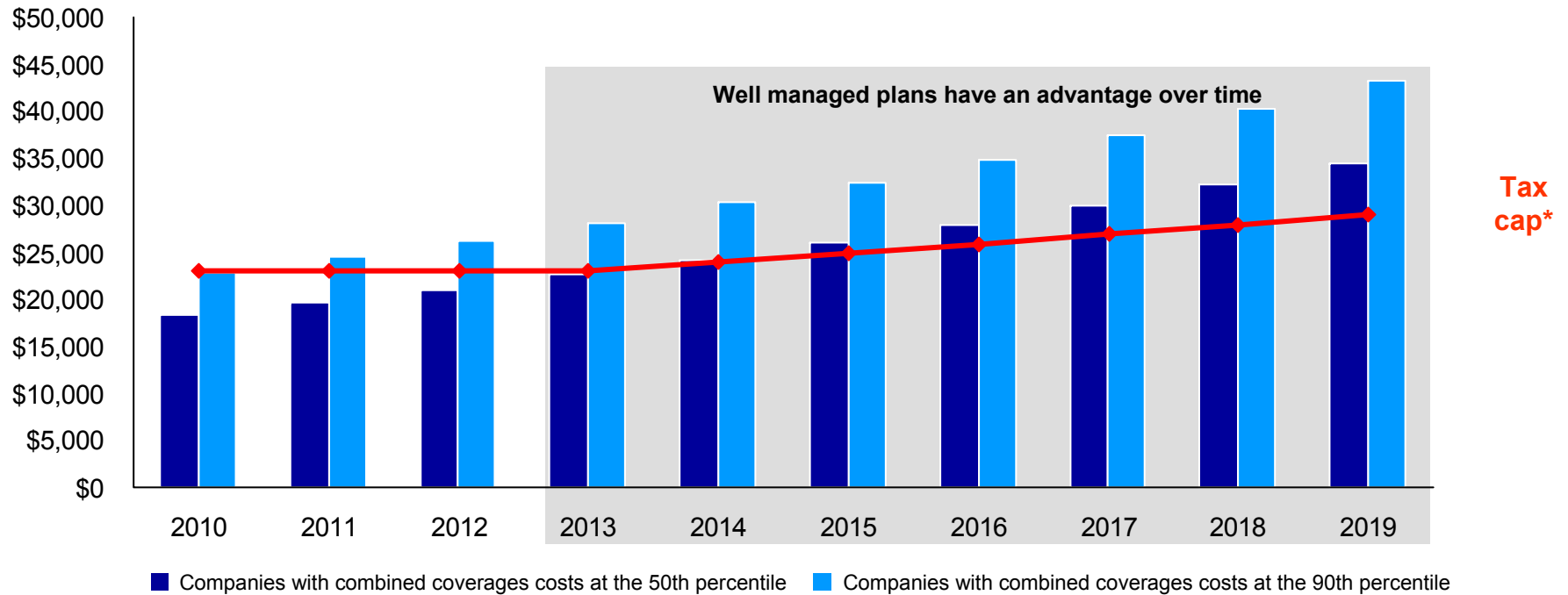
Employer cost offset options

- Employer pays excise tax of \$1,100
- Employer reduces overall value of health benefits offered by \$1,100, e.g., reduces FSA elections, reduce medical plan value
- Employer passes \$1,100 cost of excise tax along to employee

*Illustration based on standard 'cap' in Senate Bill (HR 3590). Under special rules threshold amounts are (i) increased to \$9,850/\$26,000 for retirees and for high-risk jobs, and (ii) set higher during transition period for 17 highest-cost states as determined by Secretary of Treasury.

*Re-cap: Excise tax on "Cadillac" plans
Managing the cap*

Family Rates for Combined Coverages (e.g., Medical, Dental, Vision, FSA)



*Tax cap assumes future index of 4%
Medical trend 8%, dental 5%, HRA/FSA/HSA 3%
Source: Towers Perrin 2010 Health Care Cost Survey

Other provisions relevant to employers

- **'Vested' retiree health benefits** — Prohibits employers from reducing benefits for retirees unless same reductions made to active employees (House)
- **Reinsurance for employer-provided retiree health coverage** — Creates temporary reinsurance program to reimburse employers for part of pre-65 retiree health expense (80% of cost per enrollee in excess of \$15,000 and below \$90,000) (House and Senate)
- **Extension of COBRA coverage** — Allows those on COBRA after enactment to continue coverage until earlier of becoming *eligible* for “acceptable coverage” (including employer coverage) or for exchange-based coverage (i.e., in 2013) (House)
- **Preexisting condition exclusions** — Immediately limits group health plans ability to use pre-existing condition exclusions, until general prohibition in 2013 (House, Senate beginning 2014)
- **HIPAA wellness programs** — Increases HIPAA limit on financial incentives for participation in wellness program from 20% to 30% of total plan cost; permits government to increase limit to 50% if appropriate (Senate)
- **Tax-free employer-provided health coverage for non-federal tax dependents** — Excludes from employee gross income health coverage for anyone employer plan defines as “eligible beneficiary” (e.g., domestic partner, same-sex spouse, older children, etc.) (House)
- **Dependent child coverage through age 25 or 26** — Requires insured and self-insured employer group health plans to permit dependent children to remain on parent’s plan through age 26 (House) or through age 25 (Senate)
- **Mandated coverage for reconstructive surgery of child deformities** — Requires employer group health plans to provide coverage for outpatient and inpatient diagnosis and treatment (e.g., reconstructive surgery) of a minor child’s (under age 22) congenital or developmental deformity, disease or injury (House)

Other provisions relevant to employers

- **No OTC medicine reimbursement in health accounts** — Prohibits costs of over-the-counter medicines from reimbursement under health FSA/HRA/HSA (House and Senate)
- **Limit health FSA contributions** — Limits employee pre-tax contributions to health FSAs to \$2,500 per year (House and Senate)
- **Increase penalty for HSA funds used for non-qualified medical expenses** — Increases tax penalty for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20% (House and Senate)
- **Comparative effectiveness tax** — Assesses annual per-capita tax (e.g., \$2 per covered life) on insured and self-insured plans to fund comparative effectiveness research (House and Senate)
- **Eliminate business deduction for employer 28% Part D retiree drug subsidy payments** — The amount otherwise allowable as employer business deduction for retiree prescription drug expenses reduced by amount of retiree drug subsidy (House and Senate)
- **Health care industry annual fees** — Imposes *annual* fees of \$11B on pharmaceutical and medical device manufacturers and health insurers (Senate); 2.5% excise tax on medical devices sold in U.S., non-retail (House)
- **Employer W-2 reporting of value of health benefits** — Requires employers to disclose aggregate value of employer-provided health coverage on employee Form W-2 (House and Senate)
- **Modify itemized deductions for medical expenses** — Increases adjusted gross income (AGI) threshold for claiming itemized deduction for medical expenses from 7.5% of AGI to 10% of AGI, with delayed effective date for individuals age 65+ (House and Senate)

Other provisions relevant to employers

- **Generic biological drugs** — FDA could approve generic versions of biological or biotech drugs (“follow-on biologics”) determined to be safe and effective. Manufacturers of patented biotechnology products get 12 years of market exclusivity (House and Senate)
- **Part D prescription drug premiums** — Makes Medicare Part D premium income-related (Senate)
- **Voluntary, public long-term care insurance program** – “CLASS Act” provides daily or weekly cash benefit to individuals with functional limitations who are not covered by private long-term care insurance or Medicaid, to help purchase the services needed to maintain personal and financial independence; employees default enrolled at 100% employee contribution, unless employee declines (House and Senate)
- **Government negotiation of Part D prescription drug costs** — The government *must* negotiate Part D drug prices with manufacturers (House)
- **Part D prescription drug discount program and elimination of donut hole** — Provides 50% discount off negotiated price for brand-name drugs covered under Part D for drug costs incurred during coverage gap (i.e., donut hole) (Senate and House). One-time \$500 reduction in donut hole in 2010 (Senate). Immediately shrinks size of donut hole by \$500 increments from 2010 to 2019 (House)

Implementation of health care reform would take several years

2009	<ul style="list-style-type: none"> ■ President signs legislation into law ■ Retiree health cutbacks permitted only if employer also imposes on active participants (H)
2010	<ul style="list-style-type: none"> ■ Employers required to report aggregate value of employees' health coverage on Form W-2 (H) (S 2011) ■ Annual fees imposed on drug and medical device manufacturers and health insurers (S) ■ Temporary reinsurance program for employer-provided health coverage for retirees age 55-64 (H and S) ■ Qualified beneficiaries retain COBRA coverage until exchange implemented (H) ■ New limits on scope and duration of permissible pre-existing condition exclusions (H and S) ■ Employer group health plans must permit children of enrolled parents to be covered through age 25 (S) (H 2011) ■ Voluntary, public long-term care insurance program established ("CLASS Act") ■ Medicare Part D donut hole decreases by \$500; completely eliminated by 2019 (H)
2011	<ul style="list-style-type: none"> ■ Tax-favored treatment of Medicare Part D Retiree Drug Subsidy eliminated for employers (S) (H 2013) ■ Penalty on HSA withdrawals for non-medical expenses increased from 10% to 20% (H and S) ■ Annual health FSA contributions limited to \$2,500 (S) (H 2013) ■ Over-the-counter drugs no longer reimbursable under FSAs, HRAs, HSAs (H and S)
2012	<ul style="list-style-type: none"> ■ <i>November.</i> Presidential election ■ Deduction for executive compensation paid by certain health insurers limited to \$500,000 (S)
2013	<ul style="list-style-type: none"> ■ U.S. citizens and legal residents required to enroll in health coverage (H) (S 2014) ■ Employer pay or play mandate takes effect (H) (S 2014) ■ Excise tax on employers/insurers for aggregate value of employees' health coverage above specified limits (S) ■ Individual and small group health insurance reforms phased in (guaranteed issue; no pre-X exclusions) (H) (S 2014) ■ Health insurance exchange facilitates enrollment and administers program (H) (S 2014) ■ Tax credits and subsidies take effect to offset health insurance premium costs for lower income individuals (H) (S 2014) ■ Medicaid expanded to 150% of federal poverty level (H) (S to 133% FPL 2014) ■ Increase Medicare payroll tax to 1.95% on wages >\$200,000 single; \$250,000 joint filers (S)
2014	<ul style="list-style-type: none"> ■ Access to exchange expanded to employees if offer of employer health coverage is "unaffordable" (H and S)
2015	<ul style="list-style-type: none"> ■ States may form "compacts" to permit purchase of individual health insurance across state lines (H and S)

* (H) means House bill H.R. 3962; (S) means Senate bill H.R. 3590

Wellness Program Compliance



Overview of GINA Interim Final Regulations: Group Health Plan “No No’s”

- Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits group health plans from:
 - Adjusting premium or contribution amounts on the basis of genetic information
 - Requesting or requiring genetic testing of an individual or family member
 - Collecting genetic information for underwriting purposes
 - Collecting genetic information prior to an individual’s effective date of plan coverage, or in connection with such enrollment
- Key definitions for purposes of GINA and health risk assessment (HRA) analysis
 - Genetic information - Information about (i) the individual or family member’s genetic tests, (ii) the manifestation of a disease or disorder in the individual’s family members (e.g., family medical history), or (iii) any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or family member
 - Family member - A dependent who is, or may become, eligible for coverage (as defined under the terms of the group health plan), or any other person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or of a dependent of the individual
 - Underwriting – Includes (i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan; and (ii) the computation of premium or contribution amounts under the plan. Underwriting includes changing deductibles or other cost-sharing mechanisms, or providing discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a HRA or participating in a wellness program)
- GINA’s group health plan regulations apply to group health plans for plan years that begin on or after December 7, 2009; i.e., January 1, 2010 for calendar year plans
- Comments on the interim final rules are due by January 5, 2010

Health Risk Assessments: What's Permitted by GINA?

Example	HRA Permissible Under GINA?	Explanation
<p>Example 1. A group health plan provides a premium reduction to enrollees who complete a HRA. The HRA is requested to be completed after enrollment. Whether or not it is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The HRA includes questions about the individual's family medical history.</p>	No	The HRA includes a request for genetic information (that is, the individual's family medical history). Because completing the HRA results in a premium reduction, the request for genetic information is for underwriting purposes.
<p>Example 2. The same facts as <i>Example 1</i>, except there is no premium reduction or any other reward for completing the HRA.</p>	Yes	The request is not for underwriting purposes, nor is it prior to or in connection with enrollment. Therefore, it does not violate the prohibition on the collection of genetic information.
<p>Example 3. A group health plan requests that enrollees complete a HRA prior to enrollment, and includes questions about the individual's family medical history. There is no reward or penalty for completing the HRA.</p>	No	Because the HRA includes a request for genetic information (that is, the individual's family medical history), and requests the information prior to enrollment, the request violates the prohibition on the collection of genetic information. Moreover, because it is a request for genetic information, it is not within the incidental collection exception.
<p>Example 4. The facts are the same as in <i>Example 1</i>, except there is no premium reduction or any other reward given for completion of the HRA. However, certain people completing the HRA may become eligible for additional benefits under the plan by being enrolled in a disease management program based on their answers to questions about family medical history. Other people may become eligible for the disease management program based solely on their answers to questions about their individual medical history.</p>	No	The request for information about an individual's family medical history could result in the individual being eligible for benefits for which the individual would not otherwise be eligible. Therefore, the questions about family medical history on the HRA are a request for genetic information for underwriting purposes and are prohibited. Although the plan conditions eligibility for the disease management program based on determinations of medical appropriateness, the exception for determinations of medical appropriateness does not apply because the individual is not seeking benefits.

Source: Interim final GINA regulations issued by IRS, DOL & CMS on October 7, 2009

Health Risk Assessments: What's Permitted by GINA?

Example	HRA Permissible Under GINA?	Explanation
<p>Example 5. A group health plan requests enrollees to complete two distinct HRAs after and unrelated to enrollment. The first HRA instructs the individual to answer only for the individual and not for the individual's family. The first HRA does not ask about any genetic tests the individual has undergone or any genetic services the individual has received. The plan offers a reward for completing the first HRA. The second HRA asks about family medical history and the results of genetic tests the individual has undergone. The plan offers no reward for completing the second HRA and the instructions make clear that completion of the second HRA is wholly voluntary and will not affect the reward given for completion of the first HRA.</p>	Yes	No genetic information is collected in connection with the first HRA, which offers a reward, and no benefits or other rewards are conditioned on the request for genetic information in the second HRA. Consequently, the request for genetic information in the second HRA is not for underwriting purposes, and the two HRAs do not violate the prohibition on the collection of genetic information.
<p>Example 6. A group health plan waives its annual deductible for enrollees who complete a HRA. The HRA is requested to be completed after enrollment. Whether or not the HRA is completed or what responses are given on it has no effect on an individual's enrollment status. The HRA does not include any direct questions about the individual's genetic information (including family medical history). However, the last question reads, "Is there anything else relevant to your health that you would like us to know or discuss with you?"</p>	No	The plan's request for medical information does not explicitly state that genetic information should not be provided. Therefore, any genetic information collected in response to the question is not within the incidental collection exception and is prohibited.
<p>Example 7. Same facts as <i>Example 6</i>, except that the last question states, "In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk."</p>	Yes	The plan's request for medical information explicitly states that genetic information should not be provided. Therefore, any genetic information collected in response to the question is within the incidental collection exception. However, the plan may not use any genetic information it obtains incidentally for underwriting purposes.

Source: Interim final GINA regulations issued by IRS, DOL & CMS on October 7, 2009

EEOC Shoots Down Another Incentive-Based Health Risk Assessment Under the ADA

- EEOC issued an “informal discussion” letter dated August 10, which concludes that an employer cannot condition reimbursement of medical expenses from a health reimbursement arrangement on completing a health risk assessment (HRA)
- EEOC’s analysis was as follows:
 - The HRA included many questions that are “disability-related inquiries“, that is, questions likely to elicit information about a disability
 - Under the ADA, once employment begins, an employer may make disability-related inquiries (or require medical examinations) only if they are “job-related and consistent with business necessity“ or part of a “voluntary wellness program”
 - Requiring employees to complete an HRA as a prerequisite for obtaining reimbursement of health expenses does not appear to be job-related and consistent with business necessity
 - For example, the questions were not asked (i) because of a concern that a particular employee will be unable to do his job or pose a direct threat in the workplace because of a medical condition, (ii) to obtain medical information in response to a request for a reasonable accommodation, or (iii) because the employer is monitoring employees in positions affecting public safety
 - This wellness program was not voluntary because it penalizes any employee who doesn't complete the HRA by making him/her ineligible for medical expense reimbursements
 - The HRA also included a number of questions which were not disability-related inquiries; these questions are not subject to the ADA's restrictions

Health Risk Assessments & HIPAA/ADA/GINA Compliance

May an employer...	Health Insurance Portability and Accountability Act (HIPAA)	Americans with Disabilities Act (ADA)	Genetic Information Non-Discrimination Act (GINA) ¹
Condition group health plan (GHP) enrollment on HRA completion?	Yes, because enrollment is not based on a health factor	No, not considered a voluntary wellness program [see 3/6/2009 EEOC opinion letter]	No, if HRA asks for “genetic information” ² , since HRA is requested prior to or in connection with enrollment and used for “underwriting purposes” ³
Provide GHP financial incentives (e.g., lower contributions, deductibles, payments in kind) for HRA completion?	Yes, because financial incentive is not based on a health factor	Yes, if financial incentive doesn’t exceed undefined limit; EEOC rescinded opinion letter that applied HIPAA 20% limit for ADA purposes	No, if HRA asks for “genetic information” ² , and HRA is requested prior to or in connection with enrollment, or at any time for “underwriting purposes” ³
Condition GHP enrollment based on HRA “healthy” results?	No, violates HIPAA health status nondiscrimination rules, i.e., conditions enrollment based on health factors	No, not considered a voluntary wellness program [see 3/6/2009 EEOC opinion letter]	No, if HRA asks for “genetic information” ² , since HRA is requested prior to or in connection with enrollment and used for “underwriting purposes” ³
Provide GHP financial incentives (e.g., lower contributions, deductibles, payments in kind) based on HRA “healthy” results?	No, unless HIPAA wellness program requirements are met (e.g., reasonable alternative standard offered; incentives do not exceed 20% of plan cost)	Yes, if financial incentive doesn’t exceed undefined limit; EEOC rescinded opinion letter that applied HIPAA 20% limit for ADA purposes	No, if HRA asks for “genetic information” ² , and HRA is requested prior to or in connection with enrollment, or at any time for “underwriting purposes” ³
Provide a cash payment, or other financial incentive or reward, outside the GHP for HRA completion?	Yes, HIPAA not applicable	Yes, if financial incentive doesn’t exceed undefined limit; EEOC rescinded opinion letter that applied HIPAA 20% limit for ADA purposes	Yes, even if HRA asks for “genetic information” ² , as long as GINA Title II voluntary wellness program exception is met (as defined in yet-to-be released EEOC regulations)
Provide a cash payment, or other financial incentive or reward, outside the GHP based on HRA “healthy” results?	Yes, HIPAA not applicable	Yes, if financial incentive doesn’t exceed undefined limit; EEOC rescinded opinion letter that applied HIPAA 20% limit for ADA purposes	Yes, even if HRA asks for “genetic information” ² , as long as GINA Title II voluntary wellness program exception is met (as defined in yet-to-be released EEOC regulations)

1. GINA Title I rules apply to employer-sponsored group health plans and insurers; Title II applies to employers

2. “Genetic information” includes family medical history and information about an individual’s/family member’s genetic tests

3. “Underwriting purposes” includes: (i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for plan benefits (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a HRA or participating in a wellness program); and (ii) the computation of plan premium or contribution amounts (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a HRA or participating in a wellness program).

External Resources

- **HIPAA Nondiscrimination and Wellness Program Final Regulations (December 2006):** <http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf>
- **Department of Labor Field Assistance Bulletin (FAB) No. 2008-02 – Wellness Program Analysis and Checklist (February 2008):** <http://www.dol.gov/ebsa/pdf/fab2008-2.pdf>
- **Department of Labor FAQs on the HIPAA Nondiscrimination Requirements:** http://www.dol.gov/ebsa/FAQs/faq_hipaa_ND.html
- **EEOC's Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans with Disabilities Act (ADA) (July 2000):** <http://www.eeoc.gov/policy/docs/guidance-inquiries.html> and <http://www.eeoc.gov/policy/docs/qanda-inquiries.html>
- **EEOC's Informal Discussion Letter - ADA: Disability-Related Inquiries and Medical Examinations; Health Risk Assessment (March 6, 2009):** http://www.eeoc.gov/foia/letters/2009/ada_disability_medexam_healthrisk.html
- **EEOC's Informal Discussion Letter - ADA: Health Risk Assessment (August 10, 2009):** http://www.eeoc.gov/foia/letters/2009/ada_health_risk_assessment.html
- **May 2005 Joint Committee of Employee Benefits Technical Session with the EEOC (see Q&A # 6):** <http://www.abanet.org/jceb/2005/qa05eeoc.pdf>
- **May 2006 Joint Committee of Employee Benefits Technical Session with the EEOC (see Q&A #'s 1-3):** <http://www.abanet.org/jceb/2006/EEOC2006final.pdf>
- **May 2007 Joint Committee of Employee Benefits Technical Session with the EEOC (see Q&A # 4):** <http://www.abanet.org/jceb/2007/EEOC07Final.pdf>
- **May 2008 Joint Committee of Employee Benefits Technical Session with the EEOC (see Q&A # 2):** <http://www.abanet.org/jceb/2008/EEOC2008FINAL.pdf>
- **May 2009 Joint Committee of Employee Benefits Technical Session with the EEOC (see Q&A # 2):** <http://www.abanet.org/jceb/2009/EEOC2009.pdf>
- **May 2008 Joint Committee of Employee Benefits Technical Session with the DOL (see Q&A # 8):** <http://www.abanet.org/jceb/2008/DOL2008.pdf>
- **Genetic Information Nondiscrimination Act of 2008 (GINA) Statutory Text:** <http://www.gpo.gov/fdsys/pkg/PLAW-110publ233/pdf/PLAW-110publ233.pdf>
- **EEOC's GINA Proposed Regulations (March 2009):** <http://edocket.access.gpo.gov/2009/pdf/E9-4221.pdf> and http://www.eeoc.gov/policy/docs/qanda_geneticinfo.html
- **DOL/IRS/HHS GINA Interim Final Regulations (October 2009):** <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23182>

Appendix



Health care reform state of play— Comparison of emerging legislation

	H.R. 3590 - Senate Bill Patient Protection and Affordable Care Act (as introduced on 11/19/2009)	H.R. 3962 - House Bill Affordable Health Care for America Act (as approved 11/7/2009)
Individual mandate	<p>Yes. Would require all U.S. citizens, nationals, and legal residents to maintain “minimum essential coverage” for themselves and their tax dependents through: (i) a government sponsored program (i.e., Medicare, Medicaid, CHIP, VA coverage, TRICARE, or a Peace Corps plan), (ii) an eligible employer-sponsored plan, (iii) a plan in the individual market, (iv) a grandfathered health plan, and (v) any other plan approved by HHS. Insurers and self-insured employer plan sponsors would be required to report information on health insurance coverage information to both the covered individual and to the IRS. Individuals who do not maintain minimum essential coverage for themselves and/or their tax dependents would be required to pay an annual penalty. The amount of the penalty would be phased in, starting at \$95 per year per adult in 2014, increasing to \$350 in 2015, and reaching \$750 per year per adult in 2016. All penalty amounts would be indexed for inflation thereafter. The penalty for uninsured individuals under age 18 would be equal to ½ of the penalty amounts for adults. The amount of the annual penalty imposed on any taxpayer with respect to all individuals for whom the taxpayer is liable would be capped at 300% of the penalty amount for adults (e.g., \$2,250 in 2016). The amount of the penalty would be calculated on a monthly basis. Exemptions from the penalty would apply to individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds 8% of the individual’s household modified AGI. Other limited exemptions would be available (e.g., religious exemptions).</p>	<p>Yes. Would require all U.S. adult residents to obtain and maintain “acceptable coverage” for themselves and their tax dependent qualifying children. “Acceptable coverage” would include grandfathered individual and employer-provided coverage, certain government plans (e.g., Medicare, Medicaid, VA coverage, and TRICARE), and coverage obtained through Exchanges or an employer offer of coverage. Individuals who do not obtain “acceptable coverage” would be required to pay a tax based on 2.5% of their modified adjusted gross income above a specified threshold, but in no case more than the “applicable national average premium” for self-only (or family) coverage under an Exchange-based basic plan. Limited exemptions would be available.</p>

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Individual and small group market reform	Yes. Would require all private health insurers to offer a “qualified health plans” that cover an “essential health benefits package”, are guaranteed issue and guaranteed renewable, with no health status underwriting, no pre-existing condition exclusions, no lifetime limits or “unreasonable” annual limits on the dollar value of benefits, no waiting periods in excess of 90 days, and have maximum rating bands which would be permissible only for certain factors (i.e., age (capped at 3:1), tobacco use (capped at 1.5:1), family size, and geographic area). Health insurers would not be permitted to limit eligibility based on employees’ salaries or wages.	Yes. Generally the same as Senate bill, except maximum rating bands based on age of 2:1; other rating factors (e.g., geographic area, family size) subject to regulation by State or Exchange.
Low- and middle-income premium subsidies	Yes. Would provide refundable, advanceable premium assistance tax credits to individuals and families with household modified adjusted gross income (MAGI) of up to 400% of federal poverty level (FPL) (\$32,490 individual / \$43,710 couple / \$66,150 family of four in 2009). The premium assistance tax credits, which could only be used to purchase Exchange-based plans, would be based on the percentage of income the cost of premiums for the purchase of the second lowest cost silver plan represents, rising on a sliding-scale from 2% of income for those at 100% of FPL to 9.8% of income for those at 400% of FPL. No illegal immigrants would be eligible for health care tax credits. In addition, reduced cost sharing would be provided to eligible individuals up to 400% of the FPL who enrolled in a silver plan. Employees who were <i>offered</i> employer-sponsored minimum essential coverage would be ineligible to receive Exchange-based premium tax credits unless either their employer’s plan does not have an actuarial value of at least 60%, or their employer’s plan is unaffordable because it costs the employee over 9.8% of the employee’s household income.	Yes. Would provide premium and cost-sharing “affordability credits” on a sliding-scale basis to individuals and families up to 400% of federal poverty level (FPL) (\$43,320 individual / \$58,280 couple / \$88,200 family of four in 2009). Employees who were <i>offered</i> employer coverage would be ineligible to receive Exchange-based affordability credits. However beginning in Year 2, <i>full-time employees</i> would be eligible for Exchange-based affordability credits if they opt out of employer plan, but only if their employer’s plan is “unaffordable” because it costs the employee over 12% of their modified adjusted gross income.

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Health Insurance Exchanges	Yes. Would create state-based American Health Benefit Exchanges to provide easier, more efficient comparison of health insurance plan benefits and premium costs, and would facilitate enrollment for legal U.S. residents, and separately for small groups. Information about coverage, cost-sharing and enrollment would be available in a standardized format. Beginning in 2017, states may allow large employers (100+ employees) to purchase Exchange-based coverage for employees. The Exchanges would make available four benefit categories (i.e., bronze, silver, gold, platinum), each of which must include a core set of covered benefits. Employees would be allowed to waive an employer’s offer of health coverage and go to Exchange, but see ‘Subsidies’ above.	Yes. Would create Health Insurance Exchanges which would give individuals who are not enrolled in other acceptable coverage, small employers, and, in time, larger employers, the ability to choose from a variety of private plans or a new public health insurance option. The Exchanges would make available four tiers of standard benefit plans (i.e., basic, enhanced, premium, premium plus), each of which must include a core set of covered benefits. Employees would be allowed to waive an employer’s offer of health coverage and go to Exchange, but see ‘Subsidies’ above. The annual increase in premiums charged under Exchanged-based plan would be limited.
Standard benefit packages	Yes. Would create four “essential health benefit packages” with actuarial values of 90% (platinum), 80% (gold), 70% (silver) and 60% (bronze). A separate “catastrophic” policy would be available for those 29 years of age or younger. Plans’ out-of-pocket (OOP) limits for in-network benefits would be tied to HSA standards (e.g., \$5,950 for self-only/ \$11,900 family coverage in 2010). Cost-sharing (e.g., deductibles, copayments) would be eliminated for preventive services. ERISA-covered self-insured group health plans and multiple employer welfare arrangements (MEWAs) would not have to meet the “essential health benefits package” requirements; however, such employer plans must still have an actuarial value of at least 60% and be “affordable”.	Yes. Would require “qualified health benefit plans” to provide coverage that at least meets the benefit standards adopted for the “essential benefits package”, as recommended by a newly created Health Benefits Advisory Committee. An essential benefits package would limit annual out-of-pocket spending to \$5,000 self-only/\$10,000 family coverage (indexed to CPI). The initial essential benefits package would have an actuarial value of 70% of the package if there were no cost-sharing imposed.
Public plan option	Yes. Would create a “Community Health Insurance Option” which would be available through the state-based Exchanges. States would have the right to pass legislation to opt-out of offering the public plan option. Provider participation would be voluntary. Public plan would follow same rules as private plans for defining benefits, protecting consumers, and setting premiums. Government would be required to negotiate premiums and provider reimbursement rates. In addition, would authorize \$6B in funding for a “Consumer Operated and Oriented Plan” (CO-OP) program to foster the creation of private, nonprofit, member-run health insurance companies that serve individuals in one or more states. Would also raise Medicaid eligibility to 133% of FPL.	Yes. Would be available through the Exchanges, and must meet the same benefit requirements, comply with the same insurance market reforms as private plans. Public plan would have to be financially self-sustaining and would have to build contingency funds into its rates and adjust premiums annually in order to assure its financial viability. The government would negotiate provider reimbursement rates, using Medicare rates as a floor. In addition, would authorize \$5B in funding for a “Consumer Operated and Oriented Plan” (CO-OP) program to foster the creation of private, nonprofit, member-run health insurance companies that serve individuals in one or more states. Would also raise national uniform Medicaid eligibility to 150% of FPL.

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Employer pay or play mandate	<p>Yes. Would require employers with more than 50 employees to either: (i) “play” by offering their <i>full-time employees</i> (working on average 30+ hours per week) and their dependents the opportunity to enroll in “minimum essential coverage”, or (ii) “pay” an annual assessment equal to \$750 per full-time employee, if at least one full-time employee received government-subsidized Exchange-based coverage. In addition, even if an employer offered minimum essential coverage to full-time employees, that employer would still have to pay an annual assessment equal to the <u>lesser</u> of: (i) \$3,000 multiplied by the number of full-time employees who decline the employer’s plan and who are certified to receive subsidized health coverage in a health plan offered through an Exchange, or (ii) \$750 multiplied by the total number of full-time employees, if at least one full-time employee received government-subsidized Exchange-based coverage. Additional assessments would apply to employer plans that include waiting periods of 30 to 60 days (\$400 per full-time employee in the waiting period) or 60 to 90 days (\$600 per full-time employee in the waiting period). All assessment amounts noted above would be indexed annually. Generally, if an employee is <i>offered</i> employer-provided health coverage, the employee would be ineligible for the Exchange-based premium tax credit. However, an employee who is offered health coverage that either does not have an actuarial value of at least 60% or costs the employee more than 9.8% of his or her household income would be eligible for the premium tax credit. Employers with 200+ employees would be required to automatically enroll new full-time employees in the employer’s health plan, and continue the health plan enrollment of current employees; employees would be allowed to opt out of such coverage.</p>	<p>Yes. Would require employers to “play” by offering all full-time and part-time employees self-only and family coverage under a “qualified health benefits plan” (or under a current group health plan), and making a contribution on behalf of full-time employees of at least 72.5% for self-only coverage and 65% for family coverage of the lowest cost plan offered by the employer, or else “pay” a fee to the Exchanges in an amount equal to 8% of the employer’s “average wages” paid during the period of enrollment (determined by taking into account all employees of the employer). The minimum required employer contributions would be prorated for part-timers (to be defined by a government commission). Employers would be allowed to make separate elections to play with respect to employers’ “separate lines of business”, as well as for full-time and part-time employees. Beginning in Year 2, if an employee “opts out” of employer’s offer of coverage, and instead obtains coverage in an Exchange-based health benefits plan (other than by reason of being covered as a spouse or dependent), the employer is required to make a contribution to the Exchange, even if such employer coverage was affordable. In Year 5 after the Exchange begins, an employer that offers group health plan coverage through a plan that was in existence prior to Year 1, would have to meet minimum coverage standards like those required of Exchange-based plans. Employer hardship exemption available based on potential job losses. Employers offering health coverage would be required to automatically enroll employees for individual coverage under the employer plan option with the lowest premium; employees would be allowed to opt-out of such coverage.</p>

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Tax insurers / self-insured employers on 'high-cost' plans	<p>Yes. Would impose a 40% excise tax (nondeductible) on the insurer, or plan administrator (e.g., employers) of self-insured group health plans, if aggregate value of employer-sponsored health coverage for an employee generally exceeded \$8,500 for individual coverage and \$23,000 for family coverage for 2013 (indexed to CPI-U plus 1%). The amount subject to 40% excise tax would be the sum of: (i) the aggregate premiums for health coverage (including active and retiree medical, dental, vision and any other supplementary health insurance coverage), (ii) the amount of any pre-tax contributions to a health FSA, (iii) any employer contributions to an HSA, and (iv) the applicable premium for an HRA, minus the \$8,500/\$23,000 threshold amount. Higher amounts would apply for retirees 55 64 and certain high-risk professions (i.e., an additional \$1,350 for individual coverage/\$3,000 for family coverage). The value of employer-sponsored health coverage generally would be calculated in same manner as the premiums for COBRA. In determining the coverage value for retirees, employers would be allowed to elect to treat pre-65 retirees together with post-65 retirees. The excise tax would be imposed pro rata across insurance companies. For self-insured group health plans (including a health FSA or HRA), the excise tax would be paid by the plan administrator/employer. The employer would be responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and the Treasury. A transition rule would raise the threshold by 20%, 10%, and 5% for the 17 highest cost states for the first three years.</p>	No.

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Reinsurance for employer-provided retiree health coverage	Yes. Would establish a temporary federal reinsurance program to provide reimbursement to employers and insurers for part of the cost of providing health benefits to retirees (and their families) older than age 55 but not yet eligible for Medicare. The program would reimburse eligible employers or insurers for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000 (indexed for medical CPI). Amounts paid to an employer plan sponsor must be used to lower costs for the plan. Such payments may be used to reduce premium costs for an employer plan sponsor or to reduce premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. However, such payments may not be used as general revenues for an employer. The federal government must develop a mechanism to monitor the appropriate use of such payments by employers.	Yes, same as the Senate Bill.
Vesting of retiree health benefits	No.	Yes. Would amend ERISA to prohibit employers from reducing retiree health benefits after those retirees have retired, unless such reduction is also made with respect to active participants. With respect to premiums, a reduction in benefits occurs when a participant's share of the total premium (or, in the case of a self-insured plan, the costs of coverage) of the plan substantially increases. With respect to other cost-sharing and benefits, a reduction in benefits occurs when there is a substantial decrease in the actuarial value of the benefit package under the plan. The term 'substantial' means an increase in the total premium share or a decrease in the actuarial value of the benefit package that is greater than 5%.
Modify health FSA, HRA and HSA rules	Yes. Would limit employee pre-tax contributions to a health FSA to \$2,500 per year. Would increase the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10% to 20%. Would make the costs of non-prescription over-the-counter medicines ineligible for reimbursement under a health FSA, health reimbursement arrangement (HRA), or health savings account (HSA), unless prescribed by a doctor.	Yes, essentially the same as the Senate bill.

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Miscellaneous ERISA changes	<p><u>Dependent child coverage through age 25</u> – Would require group health plans, and issuers of group and individual health insurance, that provide coverage for dependent children permit unmarried dependent children to remain on their parent’s plan through age 25.</p> <p><u>HIPAA wellness programs</u> – Would increase the HIPAA limit on financial incentives for participation in a wellness program from 20% to 30% of total plan cost, and would permit the federal government to increase this limit to 50% if deemed appropriate.</p> <p><u>State waivers from federal regulation</u> – Unclear. Would allow States to apply for a waiver from the Secretary of HHS for up to 5 years from the requirements related to qualified health plans, Exchanges, cost-sharing reductions, tax credits, the individual mandate, and employers pay-or-play mandate. States would be required to enact a law and to comply with regulations that ensure transparency. Would require the Secretary of HHS to provide to a State the aggregate amount of tax credits and cost-sharing reductions that would have been paid to residents of the State in the absence of a waiver. Would also require the Secretary of HHS to determine that the State plan for a waiver will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as this Act would provide, and that it will not increase the Federal deficit. Secretary of HHS may not waive any Federal law or requirement that is not within the authority of the HHS Secretary. Since HHS does not administer or enforce ERISA, it is unclear whether the HHS Secretary could issue a waiver of ERISA.</p>	<p><u>Dependent child coverage through age 26</u> – Would require group health plans, and issuers of group and individual health insurance, that provide coverage for dependent children permit dependent children, at the parents’ option, to remain on the parent’s plan through age 26.</p> <p><u>Preexisting condition exclusions</u> – Would provide additional limitations on preexisting condition exclusions for group health plans in advance of applicability of general prohibition against all preexisting condition exclusions. Would reduce from 12 months to 3 months (or from 18 months to 9 months for late enrollees) the maximum “look-forward” period during which a plan may subject an individual to a preexisting condition exclusion, and would reduce from 6 months to 30 days, the maximum “look-back” period during which a plan may treat a condition for which an individual received medical advice, diagnosis, care, or treatment as a preexisting condition.</p> <p><u>Extension of COBRA coverage</u> – Would temporarily waive the durational time limits for COBRA coverage for a qualified beneficiary who is or becomes covered under COBRA on or after the date of enactment, extending COBRA coverage until the earlier of the date on which such QB becomes <i>eligible</i> for “acceptable coverage” (including qualified employer-provided coverage) or Exchange-based coverage (i.e., 2013).</p> <p><u>Mandated coverage for reconstructive surgery of child deformities</u> – Would require that employer group health plans provide coverage for outpatient and inpatient diagnosis and treatment (e.g., reconstructive surgery) of a minor child’s (under age 22) congenital or developmental deformity, disease or injury.</p> <p><u>Other</u> – Would: (a) change ERISA remedies to allow employees to sue in state court if state law permits, and (b) require a study whether self-insurance should still be permitted.</p>

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Provisions related to prescription drug coverage	<p><u>Modify deduction for employer Part D retiree drug subsidy</u> – Would amend the IRC so that the amount otherwise allowable as an employer business deduction for retiree prescription drug expenses would be reduced by the amount of the 28% Medicare Part D retiree drug subsidy (RDS) employers receive from the federal government.</p> <p><u>Part D prescription drug discount program and temporary reduction of donut hole</u> – Would provide Medicare Part D eligible beneficiaries a 50% discount off the negotiated price for brand-name prescription drugs and biologics that are covered under Part D. The discount would be available for drug costs incurred during an eligible beneficiary’s coverage gap (i.e., donut hole). In addition, for 2010 only, would immediately shrink the size of the Part D donut hole by \$500.</p> <p><u>Part D prescription drug premiums</u> – Would make the Medicare Part D premium income-related by requiring that higher-income beneficiaries pay a greater share of their premiums under the Medicare prescription drug program.</p> <p><u>Generic biological drugs</u> – Would authorize the Food and Drug Administration (FDA) to approve generic versions of biological or biotech drugs (“follow-on biologics”) that have been determined to be both safe and effective. Brand-name manufacturers of biotechnology products would get 12 years of market exclusivity. The first interchangeable follow-on biologic to be approved for any given brand name biologic would get 1 year of market exclusivity.</p>	<p><u>Modify deduction for employer Part D retiree drug subsidy</u> – Yes, same as Senate bill.</p> <p><u>Part D prescription drug discount program and elimination of donut hole</u> – Same as Senate bill, except that the bill would immediately shrink the size of the Part D donut hole by \$500 in 2010, and would continue to narrow the donut hole over the coming years until it is fully eliminated by 2019.</p> <p><u>Government negotiation of Part D prescription drug costs</u> – Would <i>require</i> the Secretary of HHS to negotiate with pharmaceutical manufactures for lower prices of covered Part D drugs on behalf of Medicare beneficiaries enrolled in PDPs and MA-PDs. The bill would prohibit the Secretary from establishing a particular formulary and would allow PDPs and MA-PDs to negotiate prices that are lower than those obtained by the Secretary.</p> <p><u>Generic biological drugs</u> – Yes, essentially the same as the Senate bill.</p>

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Miscellaneous changes that directly (or indirectly) impact employers and employees / retirees	<p><u>Employer W-2 reporting of value of health benefits</u> – Would require employers to disclose the aggregate value of employer-provided health coverage (excluding health FSA coverage) on employees’ annual Form W-2.</p> <p><u>Comparative effectiveness fund tax on insured and self-insured health plans</u> – Would establish the Patient-Centered Outcomes Research Trust Fund, which would be funded, in part, by an annual assessment on private health insurers and plan sponsors (e.g., employers, unions) of self-insured health plans beginning in FY2013. The assessment would be equal to \$1 in FY2013, and \$2 in FY2014 – FY 2019 multiplied by the number of covered lives under the plan (indexed for medical CPI).</p> <p><u>Health care industry annual fees</u> – Would impose annual fees of approximately \$11B on pharmaceutical and medical device manufacturers and health insurers. These assessments potentially could be passed through to consumers and employer plan sponsors.</p> <p><u>Voluntary, public, long-term care insurance program</u> – “CLASS Act” would create a new, voluntary, public long-term care insurance program to help purchase services and support for individuals with functional limitations not covered by private long-term care insurance or Medicaid. Individuals would receive a daily or weekly cash benefit to help purchase the services and supports needed to maintain personal and financial independence. Employees would be default-enrolled by employers at 100% employee contribution, unless employees decline.</p>	<p><u>Tax-free employer health coverage for an employee’s non-spouse, non-tax dependent</u> – Would extend the exclusion from an employee’s gross income (and from payroll tax withholding) for employer-provided health coverage and reimbursements to include individuals designated as “eligible beneficiaries” under an employer’s plan who are not the spouse or tax dependent of the employee (e.g., domestic partner, same-sex spouse, older children, etc.). Would also permit a VEBA to provide payment for sick and accident benefits to such eligible beneficiaries. Additionally, the Secretary of Treasury would be required to issue guidance specifying that a health FSA and/or HRA may reimburse qualifying medical expenses of an employee’s non-spouse, non-dependent eligible beneficiary.</p> <p><u>Comparative effectiveness fund tax on insured and self-insured health plans</u> – Would establish the Health Care Comparative Effectiveness Research Trust Fund, which would be funded, in part, by an annual assessment on private health insurers and plan sponsors (e.g., employers, unions) of self-insured health plans beginning in FY2013. The assessment would be equal to a “fair share per capita amount” (e.g., \$2) multiplied by the average number of covered lives under the plan (indexed for medical CPI).</p> <p><u>Voluntary, public, long-term care insurance program</u> – Yes, same as Senate bill.</p>

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Other Revenue Raising Provisions that Impact Individual Taxpayers	<p><u>Modify itemized deductions for medical expenses</u> –Would increase the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses from 7.5% of AGI to 10% of AGI. Individuals age 65+ would be exempt from the 10% threshold, permitting them to continue to be subject to the 7.5% AGI threshold until 2017.</p> <p><u>Cosmetic Surgery Tax</u> – Would imposes a 5% excise tax on voluntary cosmetic surgical and medical procedures performed by a licensed medical professional. The tax would be collected by the medical professional at the point of service.</p> <p><u>Additional Medicare tax on high-income taxpayers</u> –Would increase the Medicare hospital insurance tax rate from 1.45% to 1.95% on the amount of an individual taxpayer's earned wages in excess of \$200,000 single filers / \$250,000 for married individuals filing jointly.</p>	<p><u>Income tax surcharge on high-income taxpayers</u> – Would impose a 5.4% income tax surcharge on higher income taxpayers on the their AGI in excess of \$500,000 single filers / \$1 million married individuals filing jointly (NOT indexed for inflation).</p>