

**NAHU Legislative Town Hall Meeting
January 8, 2010
Question and Answers**

Role of Health Insurance Agents and Brokers

Q: Do you think there will still be a role for agents with this Health Reform?

A: Yes, we have worked exceptionally hard to ensure that both bills include specific language ensuring the role of agents and brokers, both within any exchange and in the traditional private market too. Both bills very clearly establish our role.

Q: Just to recap, agents and brokers will be able to sell the programs within the exchanges to individuals, as well as companies, and receive commissions? Will all health insurance programs be required to be part of the exchange?

A: Agents and brokers would be allowed to sell products both inside and outside of the exchange under both bills. The Senate bill preserves the private market for individuals and groups outside the exchange, and allows individuals and groups of 100 or less to purchase coverage through the exchange initially as well. The House bill would create a national exchange, and that would be only place where individual coverage could be purchased. It would phase in the option of small groups purchasing coverage through the exchange over a three-year period, but also would always retain the traditional small group market.

Q: Is NAHU or our other CIAB partners calling for a rally in DC when congress comes back in from recess?

A: No, although we are doing targeted visits and phone conferences, both in DC and in the districts, with some of our biggest grass top contacts, so that they can provide specific recommendations. People with true personal relationships with specific members of Congress who have leverage in the negotiating process are the most critical meetings we can have right now.

Q: Are any of our fellow insurance broker associations totally against these reforms? If so which ones?

A: NAHU is a leading member of the Agent/Broker Alliance, which includes NAIFA, CIAB and IIABA, and is specifically focused on the health reform effort and preserving the role of agents, brokers and consultants in any reformed system. I believe all of these groups are opposed to both bills in their current forms. NAHU has certainly come out in complete opposition to both the Senate and House passed bills. However, all of us view it as our professional obligation to continue to work with lawmakers to preserve your role in the system and make any improvements we possibly can to ensure the future of the private market.

Q: How will small brokers like me that specialize in groups of 5-200 are affected? What commission rates can we anticipate? What about LTC products?

A: Carriers will continue to set commissions as the language currently stands, and we anticipate that commission rates will continue to vary by carrier, by product, by group size and by region of the country. One of the biggest changes for the mid-market and small groups in most states is how the premium rates will be determined for these groups and what type of benefits may be included. Other employer requirements, such as potential mandate to provide coverage are still under debate.

As for LTC, the private market isn't really impacted directly, but the CLASS Act provisions, which create a voluntary new national LTC program, will obviously change the scope of the private market.

Q: Do we have a guess as to what commissions might look like?

A: The carriers will continue to set commissions as they do today. It is impossible to predict how commissions may change over time or as a result of this potential legislation specifically, but we have worked very hard to ensure that commissions will still be paid and that the private companies your contract with will establish the commission rate, not a government entity, as is the case with the Massachusetts Connector. In all likelihood, commission rates will continue to

vary by carrier, by product, by market segment and by state, just as they do today. Carriers will make adjustments to how commissions or fees are paid over time as a result of future economic and market changes beyond this legislation, just as they have historically and do today.

Q: Are we getting any support from any of the major insurance companies?

A: Absolutely. We are working with all of the health insurance carriers in a coalition on a daily basis and they have been nothing but supportive of agents and brokers.

Q: Given the pressure on carriers to achieve and maintain certain targets (MLRs etc) do you foresee carriers eliminating agents and distributing through fee-based consultants?

A: Carriers have historically used the agent/broker based sales force because it is the most efficient and affordable way for them to market products. They will still need to market and service their products under any reformed system and have remained nothing but committed to the agent/broker community throughout this process.

Q: Will health insurance brokers be permitted to receive compensation from carriers once the new regulations are implemented?

A: Yes, and carriers will determine the compensation levels, not the government, just as they do today.

Q: We are a General Agency. With the Exchange a near certainty, how will our role be affected for the under 100 life cases. I am very concerned that our role will be eliminated due to this Legislation.

A: The role for GAs will probably vary significantly based on whether or not any potential exchange is state-based or national. State-based exchanges will allow for much greater flexibility and probably a greater role. It is important to keep in mind, though, that small group coverage will also be allowed to be sold outside of the exchange under both bills, which will impact general agencies as well.

Q: With the pending legislation the role of the General Agency or Master General Agency seem threatened. How do you see the role of the GA/MGA surviving this Legislation?

A: The role of a general agency or a managing general agency can vary a great deal by geographic area, so the degree to which MGA or GA will be impacted may be different. In general, we think that state-based exchanges will have less of an impact, and that it is important to keep in mind that the exchange, either national or state-based, will not be the only avenue for group insurance sales.

Q: Will agents and brokers be the only ones to sell health insurance in the exchanges? If not, who else, and what type of training will they have?

A: The Senate bill does contain provisions that give the states the ability to also allow some other entities (like state SHIP programs) to become license navigators to also help with enrollment, but the state doesn't have to develop a navigator program if they don't want to and navigators would have to be licensed too. The House bill has some duplicative provisions about having the Small Business Administration provide small businesses with enrollment education information that we are working to have stricken from any final bill.

Q: Where can an agent get information in regards to exchanges and the impact to the agent?

A: Agents and brokers are clearly included in the exchange provisions in both bills. For up to date information on the impact of the legislation on agents and brokers, please check your weekly Washington Update from NAHU and our website. We will also continue to regularly hold webinars like this one to keep our members informed.

Q: While the agents role is protected is it likely that the \$35 billion earmarked for "government employee education" (basically duplicating what the agent does) be removed from the bill. If not what is the future of the agent community?

A: The carriers still plan to contract with agents and brokers, and agents and brokers are very clearly included in both bills. There is some duplication proposed with employer education relative to the Small Business Administration in the House bill, but it does not include a \$35

billion earmark, and we are working with moderate Senators and House members to have that provision stricken, should there be a merged bill.

Q: What about the Community Advocates (ACORM) used instead of agents, to instruct participants on maximizing their benefits?

A: There are no provisions in either bill to that effect.

Q: When do we transition for "valued resource" to "working actively against legislation"

A: We have come out in opposition to both the Senate and House bills as they currently stand. That being said, if something is to pass, it is our professional obligation to make sure that the legislation includes health insurance agents, brokers and consultants, and we will continue to do so as long as there are bills on the table.

Legislative Process

Q: Assuming something passes that is not palatable, what will be our next steps?

A: Most of the provisions in both bills take effect in 2014 (Senate) or 2013 (House). The GOP and Democrats alike on this hill are very clear that they expect several clean-up bills in the next few years if something from these two bills actually were to pass. We will spend the next few years working on improving the problematic provisions before they go into effect and working with the states and federal regulators on the best possible implementation.

Q: How can they get this done without a formal open conference committee?

A: Formal conference committees have historically been convened for measures of this magnitude, such as the Social Security and Medicare Programs, and the Medicare Modernization Act. But major pieces of legislation are reconciled all of the time without going through the conference process too; it is a fairly common practice no matter which party is in power. Examples of recent major bills that bypassed the conference process include the American Reinvestment and Recovery Act of 2009 (economic stimulus bill) signed by President Obama last February and the Troubled Asset Relief Program (TARP Act) signed by President Bush in 2008. Essentially, the House and Senate simply need to agree to amend their respective pieces of legislation so that the two measures contain identical language to send to the President. Since it can take several back-and-forth rounds between the two chambers to get an identical bill, the process is sometimes referred to in Washington as amendment ping-pong. In some ways, the avoidance of the public conference committee could be more helpful to us, as it gives rank-and-file members of the Democratic Caucus more power negotiate the details of the final end product directly with their leadership.

Q: I heard that there a provision in the bills that says this can never be repealed? Is this true?

A: The "unrepealable" issue has been raised by some regarding language creating the Independent Medicare Advisory Board.

On page 1020 of the original Reid bill, under section (c,) titled "limitations on changes to this subsection" the bill reads: "it shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment or conference report that would repeal or otherwise change this subsection." It also follows with section (d) entitled "Waiver": "This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the members, duly chosen and sworn."

This language would not change the Senate's Standing Rules but rather make an exception to them. It would require a supermajority to make any changes to this section of the bill. Apparently, language similar to that used here to except certain provisions from the Senate's Standing Rules has been used dozens of times in the past. So while this provision is not "unrepealable," it certainly would be more difficult to repeal than other provisions of this bill.

Q: I know the House and Senate vote on the bills, but who actually writes the bills? Who came up with the ideas and the language?

A: The leading members of Congress certainly work on the bills, but their staff, in particular the health care staff of the House and Senate Committees of jurisdiction—Senate Finance, Senate Health, Education, Labor and Pensions and House Energy and Commerce, Education and

Workforce and Ways and Means—as well as the personal health care staff of members of Congress who serve on these committees, have great influence over the bills and their contents. There is a legislative counsel's office who does the actual drafting of the legislation, based on the ideas presented by these individuals.

Q: Is there a reason why we have not written a bill of our own?

A: NAHU has its own health reform plan, An American Solution: NAHU's Vision for Affordable and Responsible Health Reform. It is a revision of the Healthy Access plan the NAHU board adopted in 2007, and was released in June of 2009. Many of its components were included as part of the House GOP alternative bill, particularly the ones relative to individual market improvements and the risk adjustment provisions.

Q: What is the next step after the bills are combined?

A: If they are able to come to terms on an agreement on a merged bill, it will be approved by both Houses and sent to the President for signature. Based on the politically charged current climate, it is extraordinarily unlikely that the leadership of either Chamber would let a bill come to the floor that would not have the certainty of passage.

Q: Is there any opportunity to delay a vote until after the next election cycle?

A: The special election in Massachusetts will have a tremendous impact on the overall status of reform. It's still likely that something relative to health insurance reform will pass between now and then, but it is possible that no action will be taken.

Q: What are the chances of seeing what passed being repealed if we have a change of regime after mid term elections?

A: If they actually pass a new bill, a complete repeal of all provisions is unlikely, particularly of provisions that will go into effect right away. But certainly a change in either or both House of Congress will have a substantial impact on new legislation that may repeal provisions that have not yet gone into effect, or make changes to them before they do.

Q: Do you think there is a chance of repeal to this such as what happened with the old section 89 and Medicare C debacle back in the early 1990's?

A: Perhaps not an out and out repeal, but if something does pass, there will definitely bill at least one, possibly more "clean-up" bills to revise many of the provisions between now and 2014, when most are scheduled to take effect. The next two Congressional elections in 2010 and 2012 will obviously have a huge impact on the amount of changes that are actually enacted.

Q: If the Democrats loose their 60 votes in the forth coming election, could the Republicans make some changes in the final bill.

A: That is certainly the hope, although the Democrats are already strategizing as to how they can avoid it. Some possible options include the House accepting the Senate vote verbatim, which would prevent another Senate vote (but would be politically tough to achieve in the House due to the language on illegal immigrants, the lack of the Stupak amendment on the public financing of abortion, the public option difference, etc.) or trying to railroad changes through during the upcoming budget process.

Q: If the structure of majority gets overturned in Nov, would some of this be able to be overturned?

A: Yes, if something does pass, the majority of the changes in both bills do not take effect until either January 1, 2013 (House Bill) or January 2014 (Senate Bill). If the shape of either or both houses of Congress change in 2010 and or 2012, that could certainly have an impact on whether or not certain provisions are repealed or dramatically improved before they even ever go into effect.

Grassroots Action

Q: Are there any plans to push for voting members out of office by using our grassroots with our clients? As well as campaign donations?

A: NAHU's primary election work is done through our political action committee HUPAC. NAHU members and their families can contribute to HUPAC by going to www.hupac.org. Certainly the result of this legislation will have a large bearing on HUPAC's distributions to candidates for the 2010 and 2012 election cycles. In addition, we will strongly encourage our members and chapters to get involved in the 2010 campaigns, which could include educating your clients. We

will have a session about this at Capitol Conference 2010.

Q: Will you be sending letters that are for our clients?

You can visit our client resource center online for letters, sample newsletters, power points and other resources to share with clients. <http://www.nahu.org/legislative/clients/index.cfm>

Q: Can we get a list of those Blue Dogs who have helped?

A: You can access a list of those who voted against the bill and their affiliation here. <http://www.nytimes.com/interactive/2009/11/08/us/politics/1108-health-care-vote.html> The list includes 24 "Blue Dog" Democrats.

Q: How do you address the broken campaign promises by Obama?

A: We can't. That's something that he will have to do in his upcoming state of the union address, as well as during the next two campaign cycles.

Q: Other than continuing to send letters and make calls in states like Michigan where our senators are a lost cause, what extra can we be doing?

A: Contributing to HUPAC and GRIP, sending letters to the editor, talking to your clients, participating in media opportunities wherever and whenever possible, attending public events, etc. all help the cause and continue to raise public awareness and attention about the dissatisfaction the majority of Americans have with both of these bills is all helpful.

Q: How can we (NAHU) impact key state votes that impact Senator or Congress up from re-elections in key states - MA?

A: NAHU, through our political action committee, HUPAC, contributed the maximum amount allowable by law to the MA Senate race in support of Scott Brown. Our MA AHU members personally dropped off the contribution and many of them did a great deal of work in his campaign effort.

Q: Is there any realistic lobbying opportunities with legislators or is each legislator already decided? If we are in a "friendly state" with sympathetic legislators, what can we do to be effective?

A: Absolutely, there are lobbying opportunities. In fact, without a formal conference committee, there may be more of them. In particular we need to target soft yes votes in the House and moderates Democrats that voted no before, particularly on the state-based issues like keeping the state-based exchanges and the minimum loss ratio provisions. We need them to insist that this is important.

Q: Operation Shout appears to fall on deaf ears. All I get back even from personalized emails are Form Letters, any suggestions for getting to speak directly to my legislators?

A: It is frustrating and we all get auto replies because our legislators get so many emails. The important thing though is not the response that you get, but that you keep sending them. The response you get may be slightly off topic and clearly canned, but each office is carefully keeping track of the overall tallies of pro and con, and that makes a huge difference, particularly now. One of the best ways to speak personally to your legislators is to make an appointment or attend a town hall, either when he or she is in the district or by attending events like NAHU's Capitol Conference.

Impact on Consumer-Directed Products

Q: Are the FSA and HSA changes apt to survive to the final bill?

A: Probably most of the changes proposed in the Senate-passed legislation will prevail. The Senate bill assumes inclusion of consumer directed and account-based products like HSAs, HRAs and FSAs and clearly includes them in the outlines of minimal creditable coverage. The 60% minimum actuarial value for Bronze level plans should be sufficient to cover many account-based consumer directed high-deductible plans.

However, the Senate bill does include some changes for these plans. The definition of medical expenses for purposes of employer provided health coverage (including HRAs, HSAs and FSAs) would be changed to the definition for purposes of the itemized deduction for medical expenses. This means that over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs. The bill also increases the tax on distributions from a health savings account

that are not used for qualified medical expenses to 20% (from 10%). FSA contributions for medical expenses would also be limited to \$2,500 per year with the limit indexed for inflation.

For more detailed information about the potential impact of this legislation on consumer-directed products, we highly recommend reading this message from Roy Ranthum, President of HSA Consulting Services, who led the U.S. Treasury Department's implementation of HSAs since their creation in 2003 and then became the senior health policy advisor to President George W. Bush.

<http://newsmanager.commpartners.com/nahuw/downloads/Message%20from%20Roy%20Ranthum.doc>

Q: Did you say that it looks like OTC would be removed from Section 125 plans?

A: Yes, under both bills the definition of medical expenses for purposes of employer provided health coverage (including section 125 plans, HRAs, HSAs and FSAs) would be changed to the definition for purposes of the itemized deduction for medical expenses. This means that over-the-counter prescription drugs may not be reimbursed through HRAs, HSAs and FSAs. This provision saves several billion annually, and is in both versions of the bill, so it is highly likely to be included in any final legislative product.

Q: Does the limit on the FSA apply to premium only plans?

A: No, it would appear to apply to traditional FSA plans. Premium-only cafeteria plans would not be affected by the cap.

Q: HSA \$2500 contribution - can Janet give more detail? Is it that they are reducing annual contributions?

A: The \$2500 annual cap actually applies to FSA contributions. It is reduced to this level in both the House and Senate bill, but amended to be indexed for inflation in the Senate language. The Senate bill has the change going into effect in 2011 and the House has it going into effect in 2013. While the effective date is uncertain, the change will likely prevail because it is in both bills and is a revenue-saver for the federal government.

Q: If the FSA max will be 2,500, what happens to the 2010 elections already in force?

A: This provision would not go into effect until either 2011 or 2013, depending on whether or not the Senate or House bill language is used, so it would not impact current FSA plan contracts.

Q: What are the chances of FSA and HRA plans being left out of the "Cadillac plan" valuation?

A: They are currently included. There has been some talk about changing the benefits included in the valuation as part of the deal President Obama and Democratic leaders struck with the unions last week, but details have not been released and it wasn't clear that FSA and HRA plans would be included or excluded.

Q: It appears that HSA and FSA Plans will have reduced limits, are they going to be succeed on these proposals?

A: There will be reduced contribution limits for FSA plans, indexed for inflation. Both bills include a role for both HSAs and FSAs.

Q: Will funding of HRAs (MERPs really - no roll over for EE) be limited or eliminated. Often an employer will use an HRA to reimburse from a high deductible to mimic a lower deductible plan. Will that be allowed?

A: The funding of HRAs is not limited by either bill. Very high deductible plans may be limited by the actuarial value requirements though, so such plans may not be available for employers to pick from.

Q: What is the future of HSA's? (And existing HSA monies?)

A: HSAs and HDHPs are included in both versions of the new legislation, and people's existing HSA monies are unaffected.

Q: Will the rules for FSA change in 2011?

A: The Senate bill would implement their cap on FSA contributions in 2011, but the House bill would begin the cap in 2013.

Q: Have you heard anything significant in regards to HSAs surviving?

A: Yes, HSAs will survive although there will be some changes. We have a great summary of the impact on CDHC plans in both bills by Roy Ranthum in today's Washington Update.
<http://newsmanager.commpartners.com/nahuw/downloads/Message%20from%20Roy%20Ranthum.doc>

Self-Funded Plans

Q: What impact will reform have on ERISA self-funded plans?

A: The impact would differ between the House and Senate passed bills. The House bill have a significant impact on self-funded group health plans in that it would end ERISA's preemption by exposing self-funded groups to potential state criminal and civil actions. It would also create new tax on self-funded groups to fund comparative effective research, and require federal approval of ERISA health plans (similar to the requirement for retirement plans under ERISA). The House bill would also require all health plans, whether fully insured or self-funded, to issue coverage regardless of health status, and would eliminate the use of pre-existing conditions exclusions and annual or lifetime limits on benefits. Dependents would have to be covered to age 26, and the employer mandate provisions would also apply to self-funded plans.

The Senate bill requires employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. Waiting periods in existing law can apply. Employees may opt out if they have another source of coverage. It also requires all employers provide notice to their employees informing them of the existence of an Exchange, and self-funded plans would be required to report coverage status data on all plan participants to the IRS annually as part of the individual mandate. In addition, all coverage plans must comply with the terms of the employer mandate (minimum standard for benefit plans) that would apply to all size groups (regardless of whether insured or self-funded) or pay a penalty. Self-funded employers must also report the value of health benefits on W-2 forms, and businesses that receive subsidies for providing prescription drug plans valued at as much as Medicare Part D for their retirees no longer would be allowed to exclude the subsidy payments from their gross income under the bill. Also, self-funded plans that met the Cadillac plan standard would have to pay the 40% excise tax.

Under both bills, all employers would have to auto-enroll people in the CLASS ACT new national long-term care plan unless they opted out. In addition, the individual mandate standards imposed on all Americans by both bills will likely have a strong impact on the benefits that will need to be offered by self-funded employers in order to maintain value to employees.

Q: Any idea what will happen with college self funded plans?

A: College self-funded plans will be treated like all other self-funded groups under any potential legislation. There has been no effort made to carve them out in any way.

Q: Define self-funded, does it include partially self funded plans?

A: The definition of a self-funded plan is not entirely clear and will likely be further defined by regulation. Right now it would appear that fully and partially funded self-funded plans that are governed by ERISA will fall under the definition of a self-funded plan. However, there have been widespread indications by both federal regulators and the state insurance commissioners that policies with a low attachment points that are sometimes marketed to much smaller groups will much more strictly regulated, and will likely not be considered self-funded.

Q: For small group-partially self-insured plans, how will these be affected?

A: If the plan is governed by ERISA, all of the same provisions for other self-funded plans, described above, would apply.

Q: Janet mentioned that ERISA guidelines for over 200 ee's would have an LTC component, could you clarify/elaborate?

A: All employers, regardless of size, would be required to enroll employees in the new CLASS ACT long-term care program. Employees could opt out of the plan. All employers over 200 lives, regardless of whether or not they self-fund their coverage or not, will be required to auto-enroll new employees in their employer-sponsored plan if one is offered, unless the employee

can document another source of qualified coverage.

Q: Please explain automatic enrollment. What it applies to and impact on employer as it pertains to self-funded plans.

A: The Senate bill would require employers of 200 or more employees to auto-enroll all new employees into any available employer-sponsored health insurance plan. An employer could apply a benefit waiting period, although if it exceeded 60 days, they would have to pay a penalty. Employees would be able to opt out if they have another source of coverage.

Q: One of my partners believes that his area of self insured programs for government entities will not be impacted by the pending legislation. Is this accurate?

A: While ERISA still exists and there are many protections for self-funded plans, there will still be a number of new mandates and requirements on them, regardless of whether or not they are state and local government plans or traditional self-funded plans.

Q: Will HHS regulations for non-federal governmental self funded plans (school districts) follow ERISA as they generally do now?

A: The legislation does not appear to change the current HIPAA exemption for state and local government plans.

Q: Will ERISA plans forced to be guaranteed issue?

A: Yes, in all likelihood the guarantee issue provisions will apply to all markets.

Employer Mandate and Responsibility Provisions

Q: Do these requirements extend to dependents of an employee?

A: The House bill's employer mandate language would require employers to pay for 60% of dependent's coverage. The Senate bill's employer responsibility provisions would not apply to dependents.

Q: Is the employer \$750 penalty per employee per month or a one time penalty?

A: The \$750 per employee penalty in the Senate bill is an annual penalty. It would apply to employers of more than 50 full-time employees for each full time employee they don't cover, and coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. In addition, according to the Senate bill the employer could be subject to more annual penalties if they impose too strict of a waiting period for benefits, and if they have employees who The House employer mandate language is even stricter would impose greater penalties.

For a detailed side-by-side comparison of the structure of the employer mandate and other provisions in both bills, NAHU has prepared this chart.

<http://www.nahu.org/federal%20sbs%20jan%204%20revised.pdf>.

Q: For large employers that do not provide insurance for all employees, when will these penalties come into play?

A: The employer mandate provisions would be effective in 2013 under the House bill and 2014 according to the Senate-passed legislation.

Q: If employer opts to pay the penalty, how does that help the employee obtain coverage?

A: It doesn't. The penalty money goes to the federal Treasury and does not directly benefit the employee in any way. The employee is then eligible to purchase exchange-based coverage, and depending on income level, may be eligible for federally subsidized coverage rather than subsidized employer-sponsored coverage, but there is no direct benefit.

Q: What is the group size proposed for employer mandate in House bill vs. Senate bill?

A: The Senate bill language would impose their employer responsibility requirement on groups of 50 or more, with the exception of the construction industry. For construction companies, it would apply to those with 5 or more workers whose payroll that exceeds more than \$500k annually. The House employer mandate is not based on a number of employees, but on payroll, and also begins to apply at payrolls that exceed \$500k.

Q: Is the waiting period mandate for all employers or is this 50+ as well?

A: The penalty for having a waiting period for coverage that exceeds 60 days is just in the Senate bill and applies to only employers of more than 50 people.

Q: Robert Pear NYT had great article on contractor requirement you may want to link in Washington Update if not done so.

A: Here is the link to the article, which talks about the impact the Senate bill could have on independent construction contractors and the small business construction industry.

<http://www.nytimes.com/2010/01/04/health/policy/04health.html>

Q: How do you feel that very small groups, i.e. 2 - 50 employee segment, will be specifically affected? Will it be easier for them to pay a penalty and put their employees out on their own?

A: Under the Senate language, most smaller groups would not be subject to any penalty if they do not provide coverage, and under the House bill it would be dependent on their payroll and the 8% of payroll penalty is pretty stiff. It will probably vary upon the specific financial situation and their desire to provide employee benefits directly or not as to whether or not a very small employers chose to provide coverage, just as it does today.

Q: Is there anything in the bill that will mandate an employer to purchase workers comp insurance if they currently self-insure this?

A: No worker's compensation insurance is not addressed by this legislation.

Q: With regard to restrictions on employer contributions based on salary, is this designed to help lower income employees? It has been our experience that this typically helps lower income employees and has employees who earn higher amount pay more.

Q: Are the penalties mentioned annual or monthly?

A: The penalty provisions in the bills are annual penalties.

Q: Please explain how employers could be penalized (\$750 up to \$3000 each EE) for not offering coverage and how the use exchanges would affect costs for employers. Could this actually be good news for sales people since most employers will be purchasing the coverage for all full time employees?"

A: Under the Senate bill's employer responsibility provisions, employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of \$750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than \$250,000. Any employer with more than 50 employees that does offer coverage *but has at least one full-time employee receiving the premium assistance tax credit* will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total.

The House bill penalty for non-compliance with their employer mandate language would be 8% of payroll.

Q: RE: employer mandate - do you know what percentage of premium they will be required to contribute?

A: The Senate bill does not require employer contributions of a specific percentage of premium. The House bill would require coverage at 72% for employees and 60% for family/dependent coverage.

Q: Why would an employer continue to offer health insurance to employees. Isn't the \$750 penalty per employee much less expensive to the employer?

A: Many employers will continue to offer coverage to their employees for the same reason they do now—to attract and retain the best possible workers.

Q: What kind of employee subsidies will count in the employer mandate? What if an employee chooses to take an individual product?

A: Generally, if the employee has qualified, affordable employer-based coverage available to him or her, then the only subsidy he or she is qualified for is the existing tax exclusion for employer-sponsored health insurance coverage. If a low-income employee does not receive affordable coverage, or an employee's does not meet the standards outlined for a qualified plan, then he or she can go to the exchange to get coverage, and depending on income, they employee may be eligible for a subsidy. There is a provision in the Senate bill for higher income employees to seek individual coverage with a voucher under specified circumstances, known as the Wyden free choice amendment, but this provision is unlikely to survive if there is a merged bill.

Q: Will the \$750 and \$600 penalties be annually or monthly?

A: The penalty provisions in the bills are all annual penalties.

Q: Please clarify the 750.00 penalty relative to one employee being eligible for subsidy?

A. Under the Senate bill's employer responsibility provisions, employers do not have to offer coverage, but if they employ more than 50 full-time employees they must pay a fine of \$750 per year for each full time employee they don't cover. Coverage must meet the essential benefits requirements in order to be considered compliant with the mandate. For the construction industry only, the responsibility requirement to provide affordable coverage applies to employers of more than 5 people with annual payrolls of more than \$250,000. Any employer with more than 50 employees that does offer coverage but has at least one full-time employee receiving the premium assistance tax credit will pay the lesser of \$3,000 for each of those employees receiving a tax credit or \$750 for each of their full-time employees total.

Q: Why is the construction industry being singled out with a lower employee threshold than everyone else?

The Manager's amendment to the Senate bill contained a last-minute addition to the employer mandate language, basically applying the much stricter House employer mandate provisions to just construction companies with more than five employees. The unions contend that it's necessary because 90% of construction firms employ fewer than 20 workers, and the Senate bill would put these workers at a competitive disadvantage.

Financing the Legislation

Q: Are the taxes under both the House & Senate bill?

A: There will be increased taxes under both bills, just what who will be taxed and how the taxes will structured varies considerably under the two different bills.

For a detailed side-by-side comparison of the structure of the financing proposals and other provisions in both bills, NAHU has prepared this chart.

<http://www.nahu.org/federal%20sbs%20jan%204%20revised.pdf>.

Q: Who collects the Cadillac tax -- the carrier? If so, will the carrier be allowed to tell the insured what the taxes are?

A: As it is currently structured, the carrier/self-funded plan is responsible for paying the excise tax, which will be passed directly down to the employers/consumers.

Q: What are the ranges of how new taxes will effect pricing?

A: The BlueCross BlueShield Association estimates that premiums will increase by \$360 per year on small-employer family coverage from the new national premium tax on insurance carriers alone.

Q: What about support of the larger non-profits such as the Michigan blues plan that are looking at a special exemption of the carrier tax. Will we be losing their support?

A: There are really only three carriers that will be exempt from the tax under the current Senate bill language—Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Nebraska and Mutual of Omaha—and it is not certainty that they will keep their exemption once the bills are merged or even if the provider tax generally will prevail. All of the carriers are working together in a coalition with us, and in support of us and one another.

Q: I started the call a little late. Did we discuss the possibility of employer contributions to health plans being taxed. Please readdress.

A: The federal tax exemption for employer contributions to health plans is no longer being considered as a financing mechanism. However, the Senate legislation contains a 40% excise tax on high-cost Cadillac plans, as well as a national \$6.8 billion a year, premium tax on plans, that will be assessed to carriers based on premium volume. Both would be passed on directly to consumers.

Q: Could essential benefits be so high as to cause everyone to have Cadillac benefits and therefore subject to the tax?

A: Yes, the concern is that the plan premium thresholds are not properly indexed for medical inflation, so eventually most plans would meet the definition of a Cadillac plan.

Q: If the tax on "Cadillac plans" is the route decided upon, how are they discussing future indexing of that cap? If not addressed properly, it will be a chronic annual problem similar to AMT.

A: Currently the legislation sets the index rate CPI plus one percent, which is not sufficient to keep up with the rate of medical inflation. The concern is if this level is kept and this means of taxation is used, all plans will eventually become Cadillac plans. The "deal" struck with the unions on the Cadillac tax allegedly includes some improvements to the indexing provisions, but the details and whether or not the terms of this deal will hold remain to be seen.

Q: Can you please be specific on the new taxes that will get priced into the 2011 fully-insured group 2010/2011 renewals? Thank you.

A: The Senate bill language contains a new \$6.8 billion dollar annual national premium tax assessment on almost all carriers, that would be assessed based on premium volume. It would take effect for the 2010 tax year, but clearly, since it is not law yet, and since most 2010 contracts are already in force, the price of this new tax is not included in the 2010 rates. If this tax prevails, there will most certainly be an impact on 2011 rates because of it.

Q: Excise tax for the Cadillac plan is it 40% of the total premium and how is that paid on the member's tax filing?

A: The insurer will be responsible for paying the tax, and it will be filtered down to the employer/employee. If self-funded, then the employer will pay through their TPA.

Q: What is included in the definition of Cadillac plans? My understanding is it is based on premium cost, not benefits. Are HSAs and dental included in calculation? Would this negatively impact HSAs, FSAs and employer sponsored dental?

A: The Senate bill contains a proposed 40% excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$8,500 for individual coverage and \$23,000 for family coverage (indexed annually by CPI plus 1%), beginning January 1, 2013. Values of health plans include reimbursements from FSAs, HRAs and employer contributions to HSAs. The tax would also include coverage for dental, vision, and other supplementary health insurance coverage.

The recently announced deal with the unions would make unspecified changes to the values

calculation (possibly exempting some benefits) and also would change the indexing formula. But details, including if these changes would apply to all plans or just collectively bargained plans, have not been released. Also, this is just a media-reported deal and is not included in the text of any actual legislation.

Q: What will the taxes be based on?

A: The two bills have a wide variety of new taxation options. The NAHU side by side comparing the two bills lists all of the taxes can be accessed here.

http://www.nahu.org/legislative/charts/HCR%20sbs%20Tax%20Timeline%20Jan%202010_FINA_L.pdf

Q: How can Congress be talking about increasing the Medicare payroll tax to pay for this bill if the funds will not be used to pay for Medicare?

The revenues raised by the payroll tax do not specifically have to go to Medicare now (there is no Medicare lock-box), and I suppose also it could also be argued that they will be applied to Medicare-related provisions of the measure.

Q: The government isn't actually providing services, but merely mandating coverage and processes -- so this new tax increase is really just creating a new bureaucracy - correct?

A: The taxes are mostly needed to fund the huge expansion of Medicaid and the subsidy provisions contained in both bills.

Constitutional Issues

Q: Do Constitutional grounds exist to successfully challenge an individual mandate?

A: There are strong constitutional arguments on both sides, and it is very clear that some states and other groups will file suit if legislation that includes an individual mandate passes. The constitutional grounds those opposed to a mandate cite most often are a violation of the interstate commerce clause and also improper taxation. However, many constitutional scholars for the other side do not think these are valid concerns, and some have argued that the recent direction of the federal courts lean against them being supportive of a constitutional challenge. Clearly, whichever groups file suit will target the federal circuit they feel will be most sympathetic. The major constitutional arguments for both sides are addressed fairly thoroughly in these pieces:

- [The Heritage Foundation analysis](#) critiquing the individual mandate
- A [floor speech by Senator Max Baucus \(D-MT\)](#) defending the individual mandate

Q: What happened to the South Carolina Judge that felt this legislation was illegal?

A: There are 12-16 state attorney generals who continue to publicly contemplate a constitutional challenge to various parts of the proposed bills if something is actually passed. But legislation needs to be enacted before a court challenge can occur.

Q: Have you heard if there will be a serious constitutional challenge to the bill? Could this be decided by the Supreme Court?

A: In all likelihood there will be multiple constitutional challenges to the bill if it becomes law, particularly relative to the individual mandate provisions. It's unclear how they would progress through the federal courts, although the Supreme Court would be the ultimate authority. The challenge process could take years to exhaust.

Q: I am curious, even if this bill passes - do you think they will question the Constitutionality of this - regarding the unfair distribution states responsibility on Medicaid, hence the Cornhusker Deal, and also requiring people to purchase health insurance.

A: We are sure there will be constitutional challenges to some parts of the bill, particularly the individual mandate provisions. The Medicaid language will probably be stricken from any merged bill to avoid challenges. It's our understanding that there are pretty valid constitutional arguments on both sides of the individual mandate issue, that such a challenge will take years to work through the court system and its success will really depend on where the challenge originates and the make-up of the lower courts.

Q: What is your opinion of attorney general challenge of constitutionality?

A: A number of state attorneys general have indicated that they will challenge both the Medicaid provisions that apply unequally to states, and also the individual mandate provisions, and maybe others. In all likelihood, the unequal Medicaid provisions will be eliminated from a final bill for political reasons. It is an almost certainty that the individual mandate provisions will be included in any final bill, and that they will be subject to legal challenges if enacted, either by the state attorneys general, other groups or both.

Q: Regarding the "Nelson" Medicaid deal...per AHIP now he says he wants it for all states...how big of an issue is this or is it just politics?

A: In all likelihood, the deal Senator Nelson struck for Nebraska in the final Senate-passed legislation will be eliminated in any merged bill. The language establishes that the federal government will pay all states share of expanded Medicaid coverage up to 133% of the FPL until 2017, and then the states will need to begin paying their matching rate for the expansion population. The exception is Nebraska, where the federal government would pick up their share of the full expansion population in perpetuity. While Senator Nelson has repeatedly stated that he would like all states to get the same treatment as Nebraska, there is no way that the federal government can afford to pay for the entire expansion population for every state (most of which would have much larger Medicaid expansion populations than Nebraska) forevermore, any more than the states can afford to pay for it. It makes much more political and economic senses for the negotiators to drop the Nebraska exception provisions from any final bill.

Q: What, if any, is the status of the various Attorney Generals regarding the pork barrel deals made in the Senate bill?

A: At least 13 have threatened a suit, but in all likelihood the Medicaid deals will just be dropped from any final bill instead. It would reduce costs and eliminate the controversy

Q: Will the individual mandate prevail and withstand constitutional challenge and if it doesn't, how does that impact the market?

A: It's hard to say about how constitutional challenge to any individual mandate provisions may turn out, and in any case, the challenges could take years to work their way through the courts. We are more concerned with how the individual mandate will be enforced immediately. In addition to a more significant penalty, we have suggested the use of insurance-related consequences, multiple points of enforcement, and increased employer-responsibility in enrolling and enforcing coverage if there is a qualified employee benefit plan available.

Medical Loss Ratios

Q: What is MLR?

A: MLR stands for medical loss ratio. The term refers to the percentage of claims dollars an insurer spends on provider reimbursements (and possibly other items depending on how the term is defined). So if the medical loss ratio were limited by law to 85%, that means the carrier must spend 85% of the money it takes in from premiums on provider reimbursements and anything else included in the MLR definition. The remaining 15% of premium dollars would be all that they could spend on all other services not included in the MLR definition (for example things that could be excluded would be claims processing, fraud protections, commissions, profits, etc.).

Q: Can you explain the 85% min. ratio?

A: Both bills would place limits on the amount a carrier could spend on non-claims costs. The House bill dictates that carriers in all markets spend 85% of premium dollars on claims-related costs and would have DHHS define what those claims-related costs could be. The Senate bill would require carriers in the individual and small group markets spend 80% of premium dollars on medical claims and 85% in the large group market. The National Association of Insurance Commissioners would devise the definition under this version.

Q: If the MLR is immediate, won't premiums have to rise drastically just to cover the costs of the insurance company administrative mandates?

A: The Senate bill is the one that would make the MLR requirements effective quickly. The definition of what would have to be included in the MLR calculation would be developed by the NAIC during 2010, and would apply to the 2011 plan year. Refunds, if necessary, would be paid in 2012. If the requirements aren't changed somewhat, in all likelihood we will see all kinds of adjustments on the part of the carriers to cover the increased costs.

Q: Now that the bills are in conference committee and this is being done behind closed doors what chance is there to influence changes in the language, in particular the minimum loss ratio?

A: In many ways actually better, because moderate democrats who are concerned about this issue are having a say now with leadership, and they would have not have been included as members of a formal conference committee.

Q: What is the likelihood that they're going to ease off on the MLR requirement?

A: Making that change is our top priority as the bills are potentially merged into one law. While we might not be able to get the numbers reduced for the long-term, we are working on changes to the definition, how it is regulated and reducing the numbers in the transition to make the change less difficult for agents, carriers and consumers alike.

Q: What are we doing to lower the medical loss ratios?

A: We are working with key moderates on this issue and it is also being pushed by the insurance commissioners and many governors. Lowering the ratio particularly in the individual and small group market are a priority, but almost more important is making sure that the state regulators retain control of the definition and regulatory process on MLRs and that the definition is crafted correctly so that the marketplace continues to function.

Q: Are you working on lowering the MLRs themselves? Or lowering the MLR REQUIREMENTS? Two different animals.

A: There will be a MLR in this bill in all likelihood. We are working on getting both the percentages reduced and also making sure that what falls into the percentages is both reasonable and controlled by the states, not DHHS, and that the exemption process is also controlled by the states.

Cost Containment

Q: So does any of this legislation address the issue of rising health care costs?

A: Both bills do contain some cost control provisions and payment reforms, mainly directed at existing public programs. Neither bill goes anywhere near far enough on this issue.

Q: Health care cost increases have many drivers. I believe Small Group reforms (with accompanying mandates) have caused many of the price increases. Why hasn't this been discussed or publicized?

A: The price impact on small group plans has been repeatedly addressed. One of the best resources is this study. <http://www.bcbs.com/issues/uninsured/background/patient-protection-affordable-care-act.html>

Q: Everyone is talking about the POTENTIAL impact of Health Care reform but NO ONE is talking about the looming federal & state deficits which will approach \$12+ trillion. Do you see any effect of these deficits on the continued growth of ALL employee benefits in the future?

A: Of course. We actually have a panel dedicated to this topic confirmed for Capitol Conference 2010 featuring noted health economists Douglas Holtz Eakin and Len Nichols.

Q: Has anyone addressed some of the things that are driving the cost of health care such as, many hospitals going to private rooms in lieu of semi private rooms, need for tort reform, Pharmaceutical companies using expensive commercials on TV and Radio, etc.

A: The need to contain medical care costs first and foremost has always been central to NAHU's message and the message of many other organizations as well. While both bills do contain cost containment provisions, particularly relative to Medicare, neither bill goes anywhere far enough.

Q: Is there a part of this bill that encourages wellness in American citizens?

A: Both bills do include wellness provisions, but the Senate bill is much more extensive in this area than the House. The Senate bill includes, among other things, improvements to the HIPAA bona fide wellness program rules, including increasing the value of workplace wellness incentives to 50% of premiums. It also establishes a 10-state pilot program to apply the rules to the individual market in 2014-2017 with potential expansion to all states after 2017, calls for a new federal study on wellness program effectiveness and cost savings and would include a number of new wellness and prevention programs as part of Medicare and Medicaid.

Both bills create grants for small employer-based wellness programs. Beyond the grant program, the House bill authorizes some national wellness and prevention-related taskforces.

Q: Does any part of this legislation address malpractice reform / the practice of defensive medicine?

A: Both bills include limited grant funding for state-based demonstration projects relative to medical liability alternatives. Neither addresses true medical liability reform. If they did, then they would have to have been approved by the Judiciary committees in both houses, and efforts to get medical liability reform measures through either of those committees have failed for more than 10 years, even when the Congress was controlled by the GOP.

Q: It's interesting how the issue became "Health INSURANCE reform" as compared to "Health CARE reform." Does any of this proposed legislation do much to help control the underlying cost of health care?

A: There are some cost containment provisions in both bills, including grants for small business wellness programs, greater transparency, payment reforms in and Medicaid and Medicare, and the Senate bill also includes some additional provisions like wellness program improvements. But in general, neither bill goes anywhere near far enough on bending the cost curve relative to medical care spending, and both actually increase federal health care spending.

Q: Is there any language (of substance) in either of the Bills that actual addresses the core source of Health Care cost (i.e. Providers, Hospitals, Doctors, Pharmaceutical Cos Etc.

A: both bills do include cost containment provisions, particularly relating to existing public programs like Medicare and Medicaid. However, few extend to the private market and neither bill goes anywhere nearly as far enough as would be needed to truly contain medical care costs nationwide.

Q: Please address how the two bills differ in regard to outcomes based wellness (i.e., 20% of premium, 50% of premium, etc.)... and what is likely to be the final rule?

A: The Senate bill codifies and improves upon the HIPAA bona fide wellness program rules and increases the value of workplace wellness incentives to 50% of premiums. It also allow for some limited group rating based on wellness program existence and tobacco use, and creates a pilot program for individual market wellness programs beginning in 2017. The House bill does not include any provisions that would improve the bona fide wellness rules or allow for wellness factors to be used as rating criteria, but both bills do include limited grant funds for small employer wellness programs.

Once concern is that voluntary health groups, like the American Cancer Society and American Heart Association, have been attacking Senate provisions to try and get them excluded from a final bill because they see them as a back door to medical underwriting. We are working hard to preserve these provisions, which have a lot of bipartisan support.

Q: What are we doing to get to some price/outcome transparency? Consumers do not have the tools to put price pressure on providers. Works great for Plastic Surgery and Radial Kerotomy procedures (not covered by insurance and consumer pd).

A: There are actually strong provider transparency provisions included in the Senate bill that we hope would be included in any merged bill.

Q: What is going on with words that say a higher rate can be charged for smoking?

A: The Senate bill language allows for a rating variation for tobacco use, but the House bill does not.

Market Reforms

Q: What is the real story on the guaranteed issue provisions for individuals?

A: All individual coverage would be required to be offered on a guarantee issue basis under both bills, as would all other coverage options.

Q: If coverage is moving to guaranteed issue and no pre-ex, why are high risk pools still necessary?

A: The guarantee issue and preexisting condition limitation provisions would not go into effect until either 2013 or 2014, depending on if the House or Senate bill language is used. So there will still be a need for high-risk pools until then, which is why both bills contain provisions to provide for high-risk pool coverage in the interim in the 15 states where such coverage is not currently available. Also, once the market reforms take effect, both the House and Senate bills contain language to establish risk-adjustment mechanisms, and the state high-risk pools could be converted to fill that purpose.

Q: In New York, small group begins at 2 lives. Will that remain under reform?

A: The small group market would actually be 1 to potentially up to 100 employees under the two different bills.

Q: NJ already has dependant to Age 31. Will state law supersede Federal in that case?

A: Yes. If a state already has a higher dependent age requirement, in all likelihood that requirement at the state-level will prevail.

Q: If the law in our state (NY) is more stringent regarding things like GI, will that change?

A: It depends on the provision how much state-based control is eventually allowed, but in many cases the bills set a federal floor, so that if the state law is stricter than the federal law, that state law will be allowed prevail, just not the reverse.

Q: Coverage across state lines. How? A California insurer won't sell a New Jersey applicant CA rates. What is the point? And what are the proposed details?

A: Both bills allow for the creation of interstate compacts and the Senate bill also calls for national plans for the sale of similar insurance products in different states and creates multistate plans to be offered through the exchange, provided by private insurers and administered by the federal Office of Personnel Management (OPM). The plans would be similarly regulated, either through the compact or nationally. Without the variances in state regulation which account for the price differences, there is question as to how this will decrease costs.

Q: Actuarial equivalents - equivalent to what? In general...what do these provisions mean?

A: Both bills outline a list of mandated benefits, cost sharing requirements and other provisions that must be included in a qualified benefit plan. Then each bill sets a minimum actuarial value (Senate bill is 60% and House bill is 70%) that the lowest level plan must achieve relative to those mandated benefits and other requirements. The greater the percentage of the listed services covered by the insurance plan, the higher the score. Most current individual policies would fall into the 55-65% actuarial value range. Most group plans, with richer benefit packages, score higher. A concern is that some HDHPs will not meet the 70% threshold set by the House bill, but the health insurance carriers indicate the 60% threshold set by the Senate (which is likely to prevail) would be sufficient to cover all but the highest deductible plans.

Q: Portability. I never hear anything about portability.

A: It's not the hot topic it was once was, perhaps due to the other market reforms in the bills, which would ensure that anyone could basically buy new coverage at any time. Therefore, keeping your current coverage becomes less important.

Q: The GI requirement, particularly on individual plans, without a strong mandate (high penalty) for those who don't purchase coverage, will send rates through the roof. An example is in NJ, where rates are 3 to 4 times those in PA. The proposed purchase mandates seem weak. Is NAHU discussing this with legislators?

A: Absolutely. We have a number of suggestions as how to make the individual mandate requirement more effective and enforceable, including strengthening the penalty, insurance-related consequences like a late-enrollment penalty, increased employer involvement and also multiple points of enforcement.

Q: Pre-ex is ultimately eliminated correct?

A: Yes, under both bills, once the requirements are fully phased in, the use of pre-existing condition exclusions and look-back periods will be eliminated in all markets.

Q: In discussing the age-rate issue, wouldn't it be more impactful to verbalize it as the minimum rates for young people is 1/2 of the rates for old people, or 1/3rd the cost, rather than the limit for old people is twice or three times the rates for young people?

A: That is a good way to describe it, particularly to people who are not in the insurance industry.

Q: Does the dependent age of 26 mean a Federal tax dependent or any child of a subscriber?

A: The dependent age change, which is 26 in the Senate Bill and 27 in the House bill would be for health plan coverage purposes only, and wouldn't raise the age of a federal tax dependent.

Q: Would the provision for NO annual limitations include prescription coverage and/or doc visits limited to a certain amount per year?

A: Eventually, yes. The House bill eliminates annual limits by 2013 and the Senate bill would eliminate limits except for nonessential benefits within 6 months of passage. The Secretary of DHHS would determine which benefits were nonessential. Then, by 2014, all annual limits would have to be eliminated.

Q: Will dental and vision coverage have to be included in Group health plans, or will they continue to be stand alone plans?

A: Stand-alone plans will still be allowed.

Q: What about limited medical plans? Will they go away?

A: Limited medical plans and mini-med plans will most likely not be considered acceptable coverage under the terms of any individual mandate that may pass, which could certainly impact their future marketability.

Q: What are the maximum out-of-pocket limits described in the Senate bill? And to what size groups will this limited out-of-pocket mandate apply?

A: The limitations would apply to all fully insured plans and would be defined later by DHHS regulation so as to not be "excessive" and to meet the actuarial value requirements.

Q: What are the minimum plan coverage requirements going to be?

A: Under the Senate Bill, to be an "essential benefit plan" the standard would be:

The essential benefits determined by the Secretary must include coverage of the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

In addition to the benefits that must be included, there can be no cost-sharing for preventive care and there are specified cost-sharing limits for plans, with separate limits for self-only coverage and indexed deductible limitations for employer-sponsored plans.

Each level of coverage must meet its own actuarial value of the mandatory covered services as determined by the Secretary of DHHS. Bronze level policies must equal 60% of the value of the benefits, silver 70%, gold 80% and platinum 90%.

A separate catastrophic-only policy would be available for those 30 and younger.

Under the House Bill:

The basic package will include preventive services and well child care with no cost-sharing, hospitalization, outpatient hospital and outpatient clinic services, including emergency department services, physician and other health professional services, prescription drugs, rehabilitative services, mental health, behavioral health and substance use services, durable medical equipment, prosthetics and orthotics, maternity care, well baby and well child care and oral health, vision, and hearing services, equipment and supplies up to 21 years of age.

The out-of-pocket maximum will be \$5,000 for individuals and \$10,000 for families, indexed to the CPI. Copayments are preferred over co-insurance.

There will be three levels (actuarially equivalent) of coverage. The basic package will look at the benefits above, as modified by the Health Benefits Advisory Committee, and be required to provide the required benefits, with no more than 30% cost-sharing (not counting premiums).

The enhanced package will consist of the same benefits, but with 15% cost-sharing.

Q: Capping deductibles, then mandating coverage forces prices up. Period. It's the path we're heading down. How quickly will they start modifying these standards, and will that be done easily at a federal level?

A: Most of these market reforms do not take effect until 2013 or 2014, including the mandated benefit standards. Clearly the congressional 2010 elections will have a huge impact on whether or not these standards are modified before they go into effect and how easily. If the make-up of either or both houses of Congress changes significantly, we could see major changes prior to implementation.

Q: Will carriers such as the blues be able to market in a multi state environment?

A: Yes, both bills contain provisions that allow for multi-state marketing of plans.

Q: Age rating 3:1 in Senate bill - at what age is the premium 3 times higher than the younger age.

A: The age bands would be set later via regulation.

Exchanges

Q: Will states have the option of opting out of state based exchanges?

A: The structure of the exchanges and the role of the states with the exchanges are some of the more contentious issues relative to merging the two bills, so it is very difficult to say at this point. It's very unlikely that a state will be able to opt out completely. What is much more likely is that the Senate-based language which permits states to apply for waivers through DHHS relative to exchange implementation beginning in 2014 will prevail.

Q: Do you know how the exchanges will work?

A: The structure and mechanics of the exchange will be one of the most contentious issues resolved as the two bills are merged, so it is difficult to say exactly how they will work at this time. Both versions of the bill include provisions to specifically guarantee agents and brokers the ability to sell all products in any exchange, be it state-based or a national one.

Q: Regarding the exchanges, exactly how will they work and what involvement will agents have in them?

A: The structure and mechanics of the exchanges differ significantly between the House and the Senate bills, and the resolution of those differences is still being negotiated. In addition, the details of how the exchanges will work will most likely be determined later, through the regulatory process. However, we have been able to secure very clear language in both bills that establishes the continued role of health insurance agents and brokers in any state or national exchange.

Q: Is there anyway states can refuse to be involved in the exchanges?

A: No, not really. The House bill would create one national exchange with the option of additional state-based exchanges under limited circumstances. The Senate bill would allow states to seek waivers in the development of their exchanges beginning in 2014, but those waivers would be subject to federal approval by the Secretary of DHHS, so a complete opt-out would be impossibility. The Senate bill also establishes that if a state refuses to create an exchange, then one would be created by the Secretary of DHHS for that state. Finally, the Senate bill does allow for a state to completely design their own coverage system through a waiver process, which could theoretically not include an exchange, but what the state designed would have to be approved at the federal level and also be at least as stringent and provide coverage to as least as many people as the federal legislation. So for example, a state-level single-payer system would probably be approved, but an application for a state to opt out of the legislation or the exchange would be disallowed.

Q: By 'groups outside the exchange' you're referring to groups larger than 100, correct?

A: Any size group could purchase coverage outside the exchange at any time according to both bills. Both the House and Senate bills would limit the exchange to groups of 100 or less initially, but allow for larger groups to enter eventually.

Q: Will we see state or national exchanges?

A: We are pressing very hard for state-based exchanges. The Senate, White House, commissioners, governors and many others want this too for increased consumer protections and state flexibility. The problem is that some House members want to preserve their state-based exchanges for more federal control, and also so that they are perceived as getting a win on a big issue.

Q: Do you agree with the Richard Epstein article in the WSJ that Sen. Reid's bill turns HC into a regulated utility?

A: If enacted, either bill will certainly place an unbelievable layer of new regulation on private health insurance plans.

Individual Mandate

Q: Do you really think that a new 31 million people will get insurance via this legislation?

A: Not if the enforceability provisions relative to the individual mandate remain so weak and the rating and mandate provisions that will actually increase premiums for unsubsidized Americans prevail. There will be 10 million people or more added to Medicaid and many more that will receive subsidized coverage, but the numbers of people purchasing unsubsidized private coverage will probably drop, since people will find it less expensive to pay the fines rather than purchase coverage. Then they will just buy coverage when they are sick and need it using the guarantee issue provisions.

Q: What is our position on the legal right to mandate individual coverage?

A: NAHU has great concerns about the effectiveness and enforceability of an individual mandate in a country this large, particularly a mandate as structured in both of these bills, where the penalties are weak and the only enforcement mechanism is the federal tax code. But we think that if all of the other oppressive market reforms included in these bills are implemented, the only way that coverage could remain remotely affordable is if there is much greater participation in the system.

Q: Without a strong enforcement of an individual mandate, you will see people with serious medical conditions buying coverage, and healthier individuals may not see the need. How do you prevent the "death spiral" from occurring?

A: NAHU absolutely agrees. We have suggested, in addition to a more meaningful financial penalty, the use of insurance-related consequences, multiple points of enforcement, and increased employer-responsibility in enrolling and enforcing coverage if there is a qualified employee benefit plan available.

Q: Why would a person not just pay the \$750 penalty and wait for a health problem before buying a policy?

A: That's a very good question and we share your concerns. That is why we have continually focused attention on the fact that an individual mandate will only work if it is both enforceable and effective.

Public Option

Q: What is OPM?

A: OPM stands for the federal Office of Personnel Management, which is the entity responsible for managing the Federal Employees Health Benefit Plan. Under the Senate-passed legislation, OPM would be responsible for managing the new multistate plans that would replace the public option.

Q: You have said the public option is not going to survive. How about the trigger?

A: The trigger option has been excluded from both the House and Senate bills as they currently stand, and is not being discussed as a compromise option any more.

Q: Any studies available on the effect on state premium taxes if a public option plan is implemented?

A: While a public option plan is unlikely to survive, here is a link an op ed piece we had placed in the Detroit News earlier in the year about the impact on state premium taxes if included.

<http://publicplanfacts.org/2009/09/public-option-spells-disaster-for-state-economies/>

Q: While I agree that the public option won't survive in this bill, what is the likelihood they will make it an amendment and tack it into an appropriations bill like they have done with so many others (hate crimes, COBRA subsidy extension, etc.)?

A: In the current political climate, very unlikely.

Q: What about the cost of the government program? All the estimates, and supposition is that the plan will save money, but there is no benchmark or no reporting requirements of govt. Administrative costs, (which will be huge, and ever growing) Also, requirement of fraud and abuse, which was part of the cost justification - reducing Medicare fraud.....

A: A government-run public plan option would be extremely costly, but I think it is clear that that option has been eliminated at this point.

Voluntary/Ancillary Products

Q: Has NAHU been following any of the provisions in the bill that would eliminate stand-alone dental and vision plans. Right now 90% of dental plans are from stand alone carriers and the bill requires child dental coverage to be purchased from the medical plan. This takes away consumer choice in the market. I am not hearing about this in the news or from NAHU.

A: These provisions were removed from the bills and stand-alone dental and/or vision coverage is now specifically allowed to be purchased to meet the qualified benefit standards.

Q: Does any of this new legislation cover ancillary benefits (vision, dental, etc)? If so, how will those benefits be affected for groups and broker?

A: The biggest change for vision and dental policies is provisions in both bills specify that to be considered qualified coverage for dependents, some vision and dental benefits will need to be included. There are provisions in both bills that allow for stand-alone and child-only coverage plans for these products to be offered, so the new legislation will actually probably result in new marketing opportunities for these plans.

Q: How will this affect the voluntary/supplemental benefit market?

A: It depends on the product. Many of the voluntary benefits are largely unaffected. Some of them, like vision and dental will probably change for the better because there will be new requirements that qualified benefit plans must provide vision and dental coverage to children, and stand-alone products will allowed to be combined with other products to meet the terms of these requirements.

Long-Term Care

Q: How will the LTC provisions impact private policies?

A: Both bills would create a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. There would be a five-year vesting period before participants would be eligible for benefits. No underwriting would be required. Initial premiums are estimated at \$65 per month, although a provision was added to require that any premiums charged be actuarially sound for at least a 75 year period. Actuarially sound benefits are to be developed by the Secretary and have been estimated to begin at \$50 per day.

Financed through voluntary payroll deductions (with opt-out enrollment similar to Medicare Part B), this program will provide a cash benefit to individuals unable to perform two or more functional activities of daily living.

Since the benefit is so limited, it is expected that the CLASS Act provisions, should they actually be enacted (and they are very controversial because they are not priced appropriately and will be a huge financial cost to the federal government in the out-years) would actually be a supplement to private LTC policies, like social security is intended to supplement retirement products and savings. But if the CLASS program is created, it will definitely have an impact on the type of private long-term care policies that are marketed and sold.

Q: Is it correct to assume that private LTC insurance will still be a prudent purchase even with the CLASS Act? I have a client who just paid his second \$10,000 annual premium for a 10 pay policy for himself and his wife. Thank you.

A: The CLASS ACT product, if these provisions prevail or are not later repealed, would be voluntary product, with a very limited benefit, so there will in all likelihood be a strong market for private, more comprehensive long-term care insurance, as well as supplementary coverage.

Q: On the Class ACT, I understand you must auto enroll at 200 employees, but what size employer is required to offer the CLASS - all sizes down to 2 Employees?

A: All employers would be required to enroll people in the CLASS ACT program (similar to paying your Medicare and Social Security taxes) and employees could opt out. Employers of 200 or more would be required to enroll new employees in a group health insurance plan if one is offered, with the option for the employee to opt out if he/she can document another coverage source.

Medicare

Q: What is the status of lowering the Medicare eligibility to age 55?

A: These provisions have been eliminated from the Senate bill and were never included in the House bill. They are HIGHLY unlikely to be added back in, due to cost and political reasons.

Q: Do you see this provision to allow 55-64 year olds participating in Medicare actually being enacted?

A: No, this provision has been removed from the Senate bill as not politically viable.

Q: With lowered Medicare reimbursements what impact will it have on insured plans?

A: Every time provider-reimbursements are lowered, whether it be through Medicare, Medicaid, or another public plan, there is a documented cost-shift and price increase for those who hold private insurance coverage.

Q: What changes may occur in Medicare?

A: Potential changes to Medicare include substantial finding cuts to Medicare Advantage provider reimbursements (\$120-160 billion), other provider payment reforms with a focus on value-based purchasing, other funding cuts to traditional Medicare, changes to the open enrollment period and annual election periods and cost-sharing restrictions on Medicare Advantage plans.

Q: Everything I read says they are counting the 400billion twice...they say the extend Medicare AND provide health insurance. Are they really counting the same dollar twice? I've written my senators 3 times and no response

A: The CBO has indicated that the Medicare cuts and payment reforms proposed in this legislation are also being proposed as the funding source for shoring up the Medicare trust fund in other legislation, and indeed cannot be counted twice. In all likelihood they will spend the funds on this legislation, and not take any action to stabilize Medicare financially for the future at this time. The Medicare provisions in these bills represent \$400-500 billion in their proposed pay-fors, so it would be next to impossible for them to agree on another funding source sizable enough to replace it.

Public Financing of Abortion

Q: What is the official wording in both bills relating to the public funding of abortions? I know this is a tough subject.

A: NAHU does not have a position on the public financing of abortion language included in both bills. Nevertheless, we are well aware that it is a critical subject for many Americans and many Democrats have based their votes, in whole, or in part, on the differences in wording between the two bills.

The Senate compromise language can be found in Section 1303 of the Manager's amendment. The text of it is tacked on to the end of the final Senate-passed bill, H.R. 3590. You can view the text here. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf . This language is not the same as the Stupak amendment, which is part of the House bill. The Senate language allows health plans, in general, to choose whether to cover abortion or not. But states could block plans that cover abortion from being offered through the new insurance exchanges. The Senate would also allow people who receive federal subsidies to buy insurance to enroll in plans that cover abortion. But they would have to make two separate monthly payments: one for abortion coverage, and one for all other health coverage.

The House language is in Title II, subtitle F, section 265 and be viewed here.

http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3962pcs.txt.pdf

Known as the Stupak amendment, it establishes that the government-run public plan option in the House bill will not cover abortion, unless a doctor certifies that a woman is in danger of death without one, or the pregnancy is the result of rape or incest. In addition, government-funded coverage and/or subsidized private coverage could not include coverage of abortion services, but those receiving subsidized coverage could purchase a supplement to cover it using their own funds. State Medicaid programs could elect to purchase supplemental abortion coverage for all participants. Finally, private insurance companies that offer a non-subsidized health plan through the exchange are allowed to cover abortion. But if they're going to, the companies must also offer another plan that is identical in every way, except that it does not cover abortion.

Q: What role will the abortion issue play in this since it's a contentious issue in both chambers?

A: It is a huge issue within the Democratic Caucus. Most Democrats are opposed to public financing amendments beyond what is currently allowed by law under the Hyde amendment language that has prevailed for many years. But there are a sizable amount of pro-life Democratic moderates who feel that the Hyde amendment language is not strong enough with these types of subsidies, since the Hyde language would not preclude federal subsidies from going to buy private coverage in the Exchange, and that private coverage could potentially include coverage of elective abortions. The moderates, the Catholic community and many others are insisting on the stronger Stupak language, at minimum, which is only in the House bill. But there are many other pro-choice Democrats who say that anything beyond the Hyde language is a deal-breaker for them. Speaker Pelosi had to capitulate to the Stupak language to get her bill passed through the House, so in all likelihood, that is what will prevail in the merged bill, but it will be the subject of intense negotiations.

Q: I work in the Catholic Community and we are concerned about being forced to pay for abortion coverage and things that violate religious liberties. What is the status on the abortion issue?

A: Public financing of abortion and whether or not the Stupak amendment, which is only in the House bill and is the only language acceptable to most in the Catholic community, will prevail is a huge issue within the Democratic Caucus. Since the Stupak language is what was needed to pass the House bill, and since there are many moderate Democratic Senators like Senator Ben Nelson of NE that prefer it to the current Senate language, conventional wisdom is that eventually that is what will be inserted into any merged bill, but not without a big struggle first within the Democratic Caucus.

Impact on Congressional Health Coverage/FEHBP

Q: It appears that legislator's health coverage will be excluded from all of this--they will not be "drinking the Kool-Aid" so to speak. Are we pressing this issue?

A: That is not correct. The Federal Employee's Health Benefit Plan, which is the current coverage option for federal employees, including members of Congress, is subject to all of the same requirements as any large employer plan. And the Senate bill would eventually require Members of Congress and their staff to purchase exchange-based coverage, which would also be subject to all of the provisions of the legislation.

Q: WILL FEHP FALL IN "CADILLAC" STATUS?

A: The Federal Employees Health Benefits Plan is just our nation's largest employer-sponsored health benefit plan. The plan offers a wide variety of plan choices for government employees, at a wide range of price points. The difference between the federal government plan and many large or small employer options is the degree to which the federal government subsidizes the employee and dependent premium, not the actual benefits themselves. The average cost for the most commonly selected FEHBP plan choice is about 13K a year for a family premium, which is on par with the national average and would not be considered a Cadillac plan today. If an employee selected a higher-end plan, a FEHBP plan could be considered a Cadillac plan. Also, since the Cadillac tax is not properly indexed for medical inflation costs, eventually most FEHBP options, like most health plan options nationally, will fall into Cadillac range.

Q: Will Members of Congress have to abide by the same rules, regs and plans as everyone else?

A: Members of Congress currently have coverage through the Federal Employees Health Benefits Plan, which is really just the largest employer-sponsored health plan in the country. It would have to abide by the same rules as regular private-market plans would under either bill.

The Senate-passed bill includes a provision to require members of Congress and their staff to purchase coverage through any exchange, once established. Exchange plans would also be subject to the same rules as other plans.

Questions on Other Topics

Q: How is eligibility determined for subsidies?

A: As the bills currently stand, subsidies would only be available to those under 400% of the federal poverty level who do not have employer-sponsored coverage, or their employer-sponsored coverage does not meet set standards and/or is deemed to be unaffordable to them, and these subsidies would only be available through the exchange. The exchange(s) would be responsible for setting up a mechanism of subsidy application, eligibility verification, etc.

Q: Assuming the Senate bill is what is passed how much of a premium increase would you expect?

A: Premiums for the least generous insurance policies offered under the Senate health reform bill (H.R. 3590) would average between \$4,500 and \$5,000 for individuals annually in 2016, according to a Jan. 11 analysis by the Congressional Budget Office.

The analysis said family premiums for the "bronze" policies, the lowest tier created in the bill in terms of the portion of costs covered, would average between \$12,000 and \$12,500. This analysis, though, didn't take into account the medical loss ratio requirements on plans that were included as part of the manager's amendment and their impact on price, and it is for the lowest cost/lowest benefit policies, which would be actuarially equivalent to many individual policies sold today. Group coverage will be more expensive.

Q: How will this legislation affect COBRA moving forward?

A: The current legislation does not address the COBRA subsidy provisions at all. The House language would temporarily eliminate current eligibility limits and allow all eligible people to stay on COBRA until the exchanges are up and running, which under the current House language would be by January 1, 2013. The Senate bill does not contain any similar language, and it is unclear at this time if the House language will prevail.

Q: What of this rumor that if someone is 65 and older, the client will not receive services such as chemo, radiation, etc. If they are old, they will be allowed to die? There are so many rumors like this that the government will dictate what care can be given and to what ages. Is this true?

A: The specific concerns you have about chemo, etc, are not true. The concern is that with more government control eventually you have overall rationing of services as a cost containment measure is a valid one.

Q: Is there also written in the bills, mandatory immunizations?

A: Coverage of immunizations would be required for qualified benefit plans, but there is no language in either bill mandating that Americans receive specific immunizations. Existing laws that require immunizations for school attendance are not impacted by this legislation.

Q: Does 800 - 1500 dollars per month. Unaffordable affordable really mean affordable coverage? Guarantee issued at age 55 for me was between

A: No, one of our top concerns is the impact either or both bills could have on the cost of private coverage for both individuals and employers. For more information about the potential impact on premiums, the BCBSA study from Oliver Wyman is a tremendous resource.

<http://www.bcbs.com/issues/uninsured/background/patient-protection-affordable-care-act.html>

Q: What's the craziest thing you're seeing in this whole process that's not making it in the news out to us?

A: One provision that we think is surprising that hasn't gotten more play in the media was a last-minute change to the employer mandate language in Senate bill that came out of the manager's amendment. It would basically apply the house employer mandate language just to construction contractors with 5 or more employees. It's a pretty direct attack on small contractors/the construction industry and we are surprised no one is making a bigger deal out of it.

Q: What's your take on the School Based Health Clinics?

A: NAHU does not have a position on them, but generally we favor as many possible coverage and care options for people as possible, so that people have choice and access to coverage.