

The Affordable Health Care for America Act (H.R. 3962)

Background

The House bill will spend more than \$1 trillion over the next ten years to expand Medicaid and create health care exchanges to provide health care to the uninsured. New taxes to pay for this coverage will begin in 2011, new health care exchanges will begin to appear in 2012 and individuals will be required to have health care coverage in 2013. The legislation contains a government insurance option that will compete with private health insurance providers.

The majority of the Affordable Health Care for America Act is financed through a surtax on married couples with adjusted gross incomes exceeding \$1 million a year and individuals earning over \$500,000 a year. The surtax is not indexed for inflation and would begin in 2011 at a 5.4 percent rate. Previous drafts of the legislation had thresholds of \$280,000 for individuals and \$350,000 for couples, but it was indexed for inflation. The tax is expected to generate \$460.5 billion, much of it from small business owners who pay taxes for their companies organized as Subchapter S corporations.

In addition to the surtax, businesses with a combined annual payroll exceeding \$750,000 but not able to provide health coverage will be required to pay an 8 percent penalty for its uninsured workers. Employers who choose to offer coverage must meet government standards for "qualified coverage" and contribute at least 72.5 percent of premiums for individuals and 65 percent for families.

The legislation includes credits for small businesses but they provide limited value. It also includes a corporate information reporting proposal, which would require reporting on most third-party transactions, limits the amount employees can contribute to health care flexible spending accounts, ends deductions companies can take for retiree prescription drug coverage, and increases penalties for nonqualified distributions from health savings accounts.

Key Provisions

What is missing? The bill is conspicuous for what it is missing in the form of health care reform like Association Health Plans that we think would increase health care options and medical malpractice reform which the Congressional Budget Office estimates will save \$5.4 billion per year in health care costs associated with defensive medicine and frivolous law suits.

Employer mandate impacts employers who provide health coverage and those who do not. The bill includes an employer mandate that will require employers to offer health care to full- and part-time employees.

An employer who offers health care must offer "qualified" individual and family coverage and must meet the premium contribution requirement of at least 72.5% for individual coverage and 65% for family coverage.

The bill extends the employer mandate to part-time employees at a level to be determined at a later time. The limited exemption for employers would be firms with total payroll under \$500,000. Employers with payroll between \$500,000 and \$750,000 would be subject to a tax penalty of 2 to 6 percent of payroll. Firms over \$750,000 in payroll would be subject to an 8 percent tax. The rates are not indexed for inflation and would impact even smaller employers in the future as wages rise. Employers would be subject to increased audits for compliance with this mandate and could face fines of \$100 per employee per day for non-compliance.

Government board will continue to define "qualified health care benefits." "Qualified health care benefits" must at a minimum ensure mandatory enrollment and mandatory renewal. Insurers would not be able to deny coverage based on preexisting conditions or even consider the health of the enrollee when determining premiums. Plans would also be required to include lifetime and annual caps on out of pocket costs. Additionally, the bill creates a board that will have the power to further define and redefine "qualified health benefits" on an

ongoing basis. There is nothing in this process that would guarantee a reduction in health care costs. In fact, experts predict that the “qualified plans” will likely be more costly than many plans offered today. The mandate to comply with this requirement will be phased in over 5 years.

Individual mandate. The bill requires individuals without health care coverage to be taxed 2.5 percent of their adjusted gross income up to the level of the premium of plans in the exchange.

New Health insurance exchange. The nationwide exchange would provide eligible individuals and small businesses with access to insurers' plans in a comparable way, but would not act as insurers themselves. The exchange would also offer a government-run public option. All plans in the exchange would be required to meet a new benefit standard determined by the Commissioner. Eligibility for the exchange is limited to individuals with employer coverage deemed “insufficient” and employees of small employers. Employers with 25 or fewer employees would be eligible in the first year, employers with 25-50 employees in the second year, and employers with fewer than 100 employees in the third year. Larger employers may be eligible to enter exchange in later years.

New government-run plan. A new “public health insurance option” would be offered in the exchange. This option would meet the criteria of “qualified health benefits.” The plan would require the HHS Secretary to negotiate reimbursement rates with doctors and hospitals, establish premium rates, and establish conditions of participation for health care providers. This plan would be like Medicare but separate from Medicare.

Impact on private insurance market. Many health care insurers believe that the new regulations on private insurers could eliminate the market for individual health insurance that is below the “qualified benefits level” and would increase the cost of employer-provided coverage after the five year grace period. The increased costs could force many of employers to abandon health care benefits for employees and instead force them into the government exchange.

Medicaid expansion. The bill would expand Medicaid to all individuals with incomes under 150 percent of poverty. The bill is projected to expand participation by 15 million individuals (covering an estimated 50 million people by 2018). Under the current version of the bill, the federal government would pay the cost of the increased Medicaid coverage until 2014. Later years would be an unfunded mandate on the states.

Income surtax. The bill imposes a 5.4 percent surtax on individuals with income of \$500,000 and families with incomes over \$1 million. The tax begins in 2011 and is not indexed for inflation. It is estimated that more than half of filers at this income level are small business owners who pay corporate taxes as shareholders of Subchapter S Corporations. Earlier versions of the bill said that this tax could be expanded to cover the cost of the bill if the bill does not realize the estimated \$425 billion reduction in Medicare costs over the next 10 years.

Reduced effectiveness of HSAs, MSAs and HRAs. The bill would prohibit reimbursement for over-the-counter pharmaceuticals from Health Savings Accounts, Medical Savings Accounts, Flexible Spending Arrangements and Health Reimbursement Arrangements. Penalties would be increased for non-qualified Health Savings Account withdrawals. Flexible Spending Arrangement would be limited to \$2,500 a year.

Additional taxes on health products. The bill imposes a 2.5 percent excise tax on medical devices.

For more information go to www.agc.org/healthcare