

RATING RULES IN THE INDIVIDUAL MARKET

The Chairman's Mark would establish Federal rating, issue, renewability, and pre-existing condition rules for the individual market. Issuers in the individual market could vary premiums based only on the following characteristics: tobacco use, age, and family composition. Specifically, premiums could vary no more than the ratio specified for each characteristic:

- Tobacco use – 1.5:1
- Age – 5:1
- Family composition:
 - Single – 1:1
 - Adult with child – 1.8:1
 - Two adults – 2:1
 - Family – 3:1

Premiums could also vary among, but not within, rating areas to reflect geographic differences. States would define geographic rating areas. Taking together all permissible risk factors, premiums within a family category could not vary by more than a 7.5:1 composite ratio.

Issuers in the individual market would be required to offer coverage on a guaranteed issue basis. Under guaranteed issue, if a plan has a capacity limit and the Secretary determines that the number of individuals who elect that plan would exceed the limit, the issuer would be allowed to limit the number of enrollees according to specified rules. Also, issuers would be required to offer coverage on a guaranteed renewability basis, and rate those policies on the same factors used when initially issuing such policies. Issuers would be prohibited from excluding coverage for pre-existing health conditions and from rescinding health coverage.

Immediate Assistance for Those with Pre-existing Conditions

Chairman's Mark

Within a year of enactment, any uninsured individual who has been denied health care coverage due to a pre-existing condition can enroll in a high-risk pool. Premiums in the high-risk pool will be calculated based on the same rating factors described above and will be 100 percent of the standard premium rate for a Bronze plan (described below). Currently covered individuals must be uninsured for six months before gaining access to the high-risk pool. The high-risk pool will exist until 2013 and \$5 billion in funding will be provided to subsidize premiums in the pool.

RATING RULES FOR THE SMALL GROUP MARKET

Chairman's Mark

The rules for the small group market would be the same as those for the individual market, except that they would be phased in over a period of up to five years beginning January 1, 2013, as determined by each state with approval from the Secretary.

CAFETERIA PLANS FOR SMALL EMPLOYERS

Chairman's Mark

The Chairman's Mark would provide for a safe harbor from the nondiscrimination requirements for cafeteria plans for an eligible small employer. The safe harbor under the Mark also applies to the nondiscrimination requirements for specified qualified benefits offered under the cafeteria plan, including group term life insurance, coverage under a self insured group health plan, and benefits under a dependent care assistance program. The safe harbor requires that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum flex-credit contribution requirements.

Eligibility Requirement. The eligibility requirement is met only if all employees (other than excludible employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan (subject to the terms and conditions applicable to all participants). However, a cafeteria plan will not fail to satisfy this eligibility requirement merely because the plan excludes employees who: (1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year; (2) had fewer than 1,000 hours of service for the preceding plan year; (3) have less than one year of service with the employer as of any day during the plan year; (4) are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer; or (5) are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

Minimum Contribution Requirement. The minimum contribution requirement is met if: (1) the employer provides flex-credits available for use during the plan year equal to at least two percent of each eligible employee's compensation for the plan year; or (2) the value of employer-paid benefits is at least six percent of each eligible employee's compensation for the plan year or, if less, twice the amount of the salary reduction amount for the year of each eligible employee who is not a highly compensated (within the meaning of section 414(q))¹¹ or a key employee (within the meaning of section 416(i)) and who participates in the plan. An employer is permitted to provide flex credits under the cafeteria plan in addition to the minimum required matching or non-elective contributions. However, the contribution requirement is not satisfied if the matching contributions for any highly compensated or key employee are at a greater rate than matching contributions for any employee who is not a highly compensated or key employee, with respect to salary reduction contributions.

Eligible Employer. An eligible small employer under the Chairman's Mark is, with respect to any year, an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. For purposes of the Mark, a year may only be taken into account if the employer was in existence throughout the year. If an employer was not in existence throughout the preceding year, the determination is based on the average number of employees that it is reasonably expected such employer will employ on business days in the

current year. If an employer was an eligible employer for any year and maintained a simple cafeteria plan for its employees for such year, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer until the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year. The determination of whether an employer is an eligible small employer is determined by applying the control group rules of section 52 (a) and (b) under which all members of the controlled group are treated as a single employer. In addition, the definition of employee includes leased employees within the meaning of section 414(n) and (o). 12

Effective Date

This section is effective for taxable years beginning after December 31, 2010

POOLING REQUIREMENTS FOR INDIVIDUAL AND SMALL GROUP MARKETS

Chairman's Mark

States would be required to apply the new Federal rating rules to two distinct markets (1) the individual market and (2) the small group market, defined as groups of 1-50 or up to 100 at state option. States would have the option to merge the pooling and rating requirements for the individual and small group markets.

Risk-adjustment. All plans in the individual and small group markets would be subject to the same system of risk-adjustment. Risk-adjustment will be applied within rating areas (described below).

The Secretary would be required to pre-qualify entities capable of conducting risk-adjustment and the states would have the option to pick among those entities. The entities pre-qualified by the Secretary cannot be owned or operated by insurance carriers. The Secretary of HHS would define qualified risk-adjustment models which can be used by states. States can also choose to develop their own risk-adjustment model but it must produce similar results and not increase Federal costs. After risk-adjustment is applied, reinsurance and risk corridors (described below) would apply.

Reinsurance. As a condition of issuing commercial, major medical health insurance policies or administering benefit plans for major medical coverage in years 2013, 2014, and 2015, all health insurance issuers would be required to contribute to a reinsurance program for individual policies that is administered by a non-profit reinsurance entity that would function as described below. This requirement would be enforced at the state level in a manner consistent with new the insurance market reforms. National Association of Insurance Commissioners (NAIC) would be directed to develop a model for states to adopt. If the NAIC does not act or a state does not adopt the new requirements, new Federal regulations would preempt state laws that conflict with the new reinsurance requirements.

In order to meet the requirement above, insurers shall contribute to a reinsurance entity that is a non-profit entity (referred to as the —Non Profit□). The purpose of the Non Profit must be to help stabilize premiums for individual coverage during the first few years of operation of the state exchanges when the risk of adverse selection related to new rating rules and market changes is greatest. A duty of the Non Profit must be to coordinate the funding and operation of a risk spreading mechanism that takes the form of reinsurance.

The Non Profit must use funds collected to support a reinsurance mechanism applied to individuals (individual) enrolled in plans offered within the state exchange. The mechanism would be invisible to the individual and take the form of reinsurance for those defined as —high risk.□ Individuals for whom reinsurance payments are applicable must be objectively identified using a limited list of 50-100 high-risk conditions or other comparable objective method recommended by the American Academy of Actuaries (the —Academy□). The

formula for reinsurance payments must be designed on a per condition basis or other comparable method recommended by the Academy that encourages the use of care coordination and care management programs for high-risk conditions. The formula shall equitably allocate the available funds through reconciliation (e.g., at year-end).

Contributions collected by the Non Profit must total \$20 billion in 2013 to 2015 in order for insurers to meet the requirement. Contributions could be collected in advance or on a periodic basis throughout each applicable year as long as \$10 billion in reinsurance payments could be made by the Non Profit for individual policies sold in the state exchanges for 2013, \$6 billion for 2014, and \$4 billion for 2015. In the event that all funds are not expended in the three year period, the non-profits may continue to make payments through 2017, but no new funds would be collected beyond 2015. The contribution amounts allocated and used in any of the three years may vary based on the reinsurance needs of a particular year or to reflect experience in the prior year. The contribution amount must proportionally reflect each entity's fully insured commercial book of business for all major medical products and third-party administrators (TPA) fees (e.g., based on percentage of revenue or flat, per enrollee amount). Separate contributions from insurers would fund the administrative expenses of the Non Profit. Nothing would preclude the Non Profit from collecting additional funding on a voluntary basis or in conjunction with state requirements applicable to new individual policies offered outside the state exchanges.

State insurance commissioners would be able to review the actuarial soundness of the risk spreading activities conducted by and the contributions made by the Non Profit.

Risk Corridors. After reinsurance is applied, in the case of a plan that offers coverage in the individual and small group market in 2013, 2014, and 2015, risk corridors modeled after that applied to regional Participating Provider Organizations in Medicare Part D will be provided if a plan chooses to participate. For the purpose of this provision, allowable costs means the total amount of costs that the plan incurred in providing benefits covered by the plan reduced by the portion of such costs attributable to administrative expenses. The term *target amount* means an amount equal to the total annual premium (including any premium subsidies) collectable for the enrollees for the year reduced by the amount of administrative expenses. If the allowable costs for the plan for the year are at least 97 percent, but do not exceed 103 percent, of the target amount for the plan and year, there would be no payment adjustment for the plan and year. If the allowable costs for the plan for the year are greater than 103 percent, but not greater than 108 percent, of the target amount for the plan and year, the Secretary would make a payment to the plan equal to 50 percent of the difference between the allowable costs and 103 percent of the target amount. If the allowable costs for the plan for the year are greater than 108 percent of the target amount for the plan and year, the Secretary would make a payment to the plan equal to the sum of 2.5 percent of the target amount and 80 percent of the difference between the allowable costs and 108 percent of the target amount. If the allowable costs for the plan for the year are less than 97 percent, but greater than or equal to 92 percent, of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs. If the allowable costs for the plan for the year are less than 92 percent of the target amount for the plan and year, the Secretary would receive a payment from the plan equal to the sum of 2.5 percent of the target amount; and 80 percent of the difference between 92 percent of such target amount and such allowable costs.

STATE INSURANCE COMMISSIONERS

Chairman's Mark

Roles and Responsibilities. State insurance commissioners would continue to provide oversight of plans with regard to consumer protections (e.g., grievance procedures, external review, agent practices and training, market conduct), rate reviews, solvency, reserve requirements, premium taxes, and all requirements imposed on insured plans as specified in this Mark. They would provide oversight of plans with regards to Federal rating rules and any additional state rating rules, facilitate risk-adjustment within service areas, and establish rate schedules for broker commissions in the state exchanges.

Enforcement Mechanism. The National Association of Insurance Commissioners (NAIC) will devise an NAIC Model Regulation within 12 months of enactment that is consistent with the new Federal law with regards to Federal health insurance rating, issuance and marketing requirements. This model becomes the new Federal minimum standard without any further Congressional action. The new model should be developed by NAIC with input from all NAIC members, health insurance issuers, consumer groups and other qualified individuals. Representatives shall be selected in a manner so as to assure balanced representation among the interested parties.

Once completed, the NAIC Model is written into Federal regulation. If NAIC does not act within the 12 month time period, the Secretary of HHS promulgates regulations within six months in a manner consistent with the new Federal law. Once the Model is completed, states must adopt the new NAIC Model (or adopt the HHS Model if the NAIC did not act in the specified time period) through changes in state regulation and/or legislation. States may also, with approval from the Secretary of HHS, implement a rule or provision differently as long as it is still consistent with the intent of the new Federal law and provides the same level of consumer protections.

If a state fails to adopt the changes in conformance with the new Federal minimum standards either by adopting the NAIC Model or through Secretarial approval, conflicting state laws would be preempted. In such a case, insurers would then offer coverage under Federal law and be overseen by HHS until the state adopts the necessary changes.

States must establish an exchange that complies with the requirements set forth in the Federal law. If a state does not establish an exchange within 24 months of enactment, the Secretary of HHS shall contract with a non-governmental entity to establish a state exchange that complies with the Federal legislation.

RATING AREAS

Chairman's Mark

Rating areas would be defined by state insurance commissioners and reviewed by the Secretary for adequacy. Rating areas (1) could allow for exceptions (e.g., a high-quality plan that does not have the capacity to serve the entire rating area could be allowed to serve less than a full rating area), (2) would be required to allow for pooling of similar cost people, and (3) would be risk adjusted within each area and across all plans in each market (individual and small group).

Grandfathered Plans

Chairman's Mark

Individuals and groups who wish to renew coverage in an existing policy would be permitted to do so. Plans could continue to offer coverage in a grandfathered policy, but only to those who were currently enrolled, dependents, or in the case of an employer, to new employees and their dependents. No tax credits would be offered for grandfathered plans.

Beginning January 1, 2013, Federal rating rules would be phased in for grandfathered policies in the small group market, over a period of up to five years, as determined by the state with approval from the Secretary. These plans could continue to exist after the transition period, but would be subject to the new rating rules.

Interstate Sale of Insurance

Current Law

No provision.

Chairman's Mark

No later than 2013, the National Association of Insurance Commissioners (NAIC) shall develop model rules for the creation of —health care choice compacts.□ Starting in 2015, states may form —health care choice compacts□ to allow for the purchase of individual health insurance across state lines. —Health care choice compacts□ may exist between two or more states. Once compacts have been agreed to, insurers would be allowed to sell policies in any state participating in the compact. Insurers selling policies through a —health care choice compact□ would only be subject to the laws and regulations of the state where the policy is written or issued.

Compacts shall provide that the state where the consumer lives retains authority to address market conduct, unfair trade practices, network adequacy and consumer protection standards, including addressing disputes as to the performance of the contract. Insurers either must be licensed in both states or submit to the jurisdiction of each state with regard to these issues (including allowing access to records as if the insurer were licensed in the state.) Before selling a individual policy through a —health care choice compact,□ insurers must clearly notify consumers that the policy may not be subject to all the laws and regulations of the state in which the purchaser resides.

Effective Date

The effective date for this subtitle is January 1, 2013 unless otherwise indicated

National Plans

Current Law.

No provision.

Chairman's Mark

The Chairman's Mark would allow national plans, with uniform benefit packages that are offered across state lines. These national plans must be licensed in every state that they choose to operate and would be regulated by the states in terms of solvency and other key consumer protections and would offer coverage through the state exchanges.

Such national plans must be compliant with the benefit levels and categories detailed in the Mark, but would preempt state benefit mandates— thereby allowing these national plans to offer a single, uniform benefit package. The National Association of Insurance Commissioners (NAIC), in consultation with consumer groups, business interests, including small businesses, the insurance industry, federal regulators, and benefit experts, will develop standards as to how benefit categories should be implemented (e.g., what constitute prescription drug coverage) taking into consideration how each benefit is offered in a majority (26) of the states. After NAIC publishes these standards, the state insurance commissioners will ensure that insurance companies offering national plans are providing plans that are compliant.

Premiums for national plans will be determined based on rating rules in each state and will reflect geographic variation among rating areas. National plans would be subject to the requirement to offer silver and gold benefit levels. If an insurer offers a national plan(s) in

one state, it must offer the same plan(s) in any other state in which it chooses to participate. For national plans, the NAIC will also develop harmonization standards for processes of state insurance regulation that pertain to form filing and rate filing.

STATE EXCHANGES AND MARKETING REQUIREMENTS

Chairman's Mark

Plan Participation. All private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must be available in a newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements).

Establishment of State Exchanges. States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. The Secretary would be required to establish and maintain a database of plan offerings for use by state exchanges. The database would enable the review of state-specific information. The Secretary could contract out to a private entity for the operation of the plan database.

In 2010, 2011 and 2012, so-called —mini-medical□ plans with limited benefits and low annual caps would be prohibited from being offered in the state exchanges. All other policies would be offered in the state exchange. Beginning January 1, 2013, all plans offered in the individual and small group market, whether through the exchange or outside of the exchange, would have to comply with the rating reforms and benefit options detailed in the Chairman's Mark.

Legal U.S. residents will be able to obtain insurance through the state exchanges. Parents who are in the country illegally will not be able to buy personal insurance coverage through the state exchange but will be able to buy insurance for their U.S. citizen or lawfully present children.

Functions Performed by Secretary and/or States. The Secretary and/or states would do the following:

1. After consultation with state insurance commissioners, develop a standard enrollment application for eligible individuals and small businesses seeking health insurance through the state exchange, whether done electronically or on paper;
2. Provide a standardized format for presenting insurance options in the state exchange, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers);
3. Develop standardized marketing requirements consistent with the NAIC model regulation;
4. Maintain call center support for customer service that includes multilingual assistance — the center would have the ability to mail relevant information to residents based on their inquiry and ZIP code;

5. Enable consumers to enroll in health care plans in local hospitals, schools, Departments of Motor Vehicles, local Social Security offices, and any other offices designated by the state;
6. Develop a model template for a Web portal for use by the states that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator so individuals and small businesses can determine their true cost of coverage, informs individuals of eligibility for public programs, and presents standardized information related to insurance options, including quality ratings;
7. Conduct eligibility determinations for tax credits and subsidies (as performed by a Federal agency that also reports the information to the Internal Revenue Service (IRS) for end-of-year reconciliation) and enable enrollment of individuals and small businesses;
8. Establish procedures for granting an annual certification upon request of a resident who has sought health insurance coverage through the state exchange, attesting that, for the purposes of enforcing the individual requirement, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the exchange for that individual—and maintain a list of individuals for whom certificates have been granted and share this information with the Secretary and Treasury Secretary in order for the IRS to effectively enforce the personal responsibility requirement;
9. Establish procedures for appeals of eligibility decisions for subsidies; and
10. Establish a plan for publicizing the existence of the state exchange and the annual open-enrollment period.

State Exchange Related Functions Performed by State Insurance Commissioners. State insurance commissioners would establish procedures for reviewing plans to be offered through the state exchanges and would develop criteria for determining whether certain health benefit plans can be available for sale in the market.

Multiple Exchanges. After states adopt Federal rating rules and the exchange is functional for at least three years, states could permit other entities to operate an exchange — but only if it met specified requirements, and subject to approval by the Secretary.

Regional Exchanges. States could, through interstate compacts, form regional exchanges, subject to approval by the Secretary.

SHOP Exchange. States would assist small employers that opt to use the SHOP exchange as the enrollment option for their employees. Small firms offering through the exchange could not self-insure. Small employers that made age-adjusted contributions on behalf of their employees would be granted a safe harbor from non-discrimination rules.

Administrator. The Secretary of HHS would designate an office within the Department to provide technical assistance to states on incorporating small businesses into SHOP exchanges.

Large Employers. In 2017, states must develop and submit to the Secretary a phase-in schedule (not to exceed five years), including applicable rating rules, for incorporating firms

with 50 or more (or 100 or more for those states that already included firms with 51-100 employees) into the state exchanges. The Secretary must develop regulations to address the potential for any risk selection issues associated with allowing larger employers into the state exchanges. Initial phase in for these firms would begin in plan years in 2018 and beyond.

Funding for Operation of the Exchanges. The state exchanges would receive initial Federal funding but then would be self-sustaining in future years.

Effective Date

The effective date for this subtitle is July 1, 2010 unless otherwise indicated

BENEFIT OPTIONS

Chairman's Mark

Definition of Four Benefit Categories. Four benefit categories would be available: bronze, silver, gold and platinum. No policies could be issued in the individual or small group market (other than grandfathered plans) that did not meet the actuarial standards described below. All health insurance plans in the individual and small group market would be required, at a minimum, to offer coverage in the silver and gold categories.

All plans must provide preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by Federal and state laws. In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design¹⁶ is used. Plans could also not include lifetime limits on coverage or annual limits on any benefits. Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco cessation programs including counseling and pharmacotherapy (prescription and non-prescription). The provisions in this paragraph would all be within the actuarial value of the appropriate benefit level.

Each plan design for products in the state exchanges would be required to apply parity for cost-sharing for treatment of conditions within each of the following categories of benefits: (1) inpatient hospital; (2) outpatient hospital; (3) physician services; and (4) other items and services, except in cases where value-based insurance design is used. Each plan design would also be required to meet the class and category of drug coverage requirements specified in Medicare Part D. (Generally, Part D plans must offer two drugs in each class or category.) States may permit some flexibility in plan design to encourage widely agreed upon cost and quality effective services. These requirements would not add to or change the actuarial value of the benefit designs.

Insurers participating in the state exchanges would be required to charge the same price for the same products in the entire service area as defined by the state regardless of how an individual purchases the policy (i.e., whether the policy is purchased inside or outside the state exchange from the carrier or an agent).

Definition of Levels. The bronze benefit package, which would represent minimum creditable coverage (MCC), would be equal to the actuarial value of 65 percent with an out-of-pocket limit up to the Health Savings Account (HSA) current law limit (\$5,950 for individuals and \$11,900 for families in 2010) indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. The silver benefit package would have an actuarial value of 70 percent with the out-of-pocket limits for MCC. The gold benefit package would have an actuarial value of 80 percent with the out-of-pocket limits for MCC. The platinum benefit package would have an actuarial value of 90 percent with the

out-of-pocket limits for MCC. A separate —young invincible□ policy would be available for those 25 years or younger. This plan would be a catastrophic only policy in which the catastrophic coverage level would be set at the HSA current law limit, but prevention benefits would be exempt from the deductible.

For those between 100-200 percent of FPL, the benefit will include an out-of-pocket limit equal to one-third of the HSA current law limit. For those between 200-300 percent of FPL, the benefit will include an out-of-pocket limit equal to one-half of the HSA current law limit. State insurance commissioners are permitted to allow de minimus variation around the benefit target valuations to account for differences in actuarial estimates.

SMALL BUSINESS TAX CREDIT

Chairman's Mark

Small Employers Eligible for the Credit. The Chairman's Mark would provide a tax credit for a qualified small employer for contributions to purchase health insurance for its employees. A qualified small employer for this purpose generally would be an employer with no more than 25 fulltime equivalent employees (FTEs) employed during the employer's taxable year, and whose employees have annual fulltime equivalent wages that average no more than \$40,000. However, the full amount of the credit would be available only to an employer with ten or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than \$20,000. Under the Mark, an employer's FTEs would be calculated by dividing the total hours worked by all employees during the employer's tax year by 2080. For this purpose, the maximum amount of hours that would be counted for any single employee would be 2080. Wages would be defined the same as for purposes of FICA and the average wage would be determined by dividing the total wages paid by the small employer by the number of FTEs. The credit would only be available to offset actual tax liability and would be claimed on the employer's tax return. The credit would not be payable in advance to the taxpayer or refundable. Thus, the employer would pay the employees' premiums during the year and claim the credit only at the end of the year on its income tax return. The credit would be a general business credit, and can be carried back for one year and carried forward for 20 years. The credit would be available for tax liability under the alternative minimum tax.

Years the Credit is Available. Phase I. Under the Mark, the credit would initially be available for a maximum of two taxable years for any qualified small business offering health insurance. Health insurance coverage for Phase I would be health insurance coverage within the meaning of Code section 9832 which is generally health insurance coverage purchased from an insurance company licensed under State law. This initial phase of the credit would be available for tax years 2011 and 2012.

Phase II. Beginning with taxable years ending after December 31, 2012, the credit would only be available for a small employer that purchases health insurance coverage for its employees through the state exchange. If a State has not yet adopted the reformed rating rules, qualifying small employers in the state would not be eligible to receive the credit. The credit would be available for the first two years that a qualified small employer purchases health insurance coverage for its employees through the state exchange. This would apply to qualified small employers.

Calculation of Credit Amount. Phase I. The credit would be equal to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 would not be treated as

an employer contribution for purposes of this credit. The credit would be equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage would be to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business benchmark premium. This tax credit would only be available if this percentage is at least 50. If the percentage is at least 50, the applicable percentage would be 35. The benchmark premium would be the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium would vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

Phase II. The credit would be equal to the applicable percentage of the small employer's contribution to the health insurance premium for each covered employee. Only non-elective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 would not be treated as an employer contribution for purposes of this credit. The credit would be equal to the dollar amount of the employer's contribution multiplied by an applicable percentage. The first step in determining the applicable percentage would be to calculate the employer's contribution as a percentage of the lesser of (1) the total premium for an employee's coverage or (2) a small business benchmark premium. This tax credit would only be available if this percentage is at least 50. If the percentage is at least 50, the applicable percentage would be 50. The benchmark premium would be the average total premium cost in the small group market for employer sponsored coverage in the employer's State. The premium and the benchmark premium would vary based on the type of coverage being provided to the employee (i.e., single, adult with child, family or two adults).

For both the Phase I and Phase II credits, the employer would be entitled to a deduction under section 162 equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if a qualified small employer pays 100 percent of the cost of its employees' health insurance coverage and the tax credit under this provision is 50 percent of that cost, the employer would be able to claim a section 162 deduction for the other 50 percent of the premium cost.

The credit would be phased out for employers with more than ten FTEs but not more than 25 FTEs by six percent of the base credit percentage for each employee above ten.

Simultaneously, the credit would phase out for an employer for whom the average wages per employee is between \$20,000 and \$40,000 at a rate of five percent for each \$1,000 increase of average wages above \$20,000.

The employer would be determined by applying the employer aggregations rules in section 414(b), (c), and (m). In addition, the definition of employee would include a leased employee within the meaning of section 414(n).¹⁹

Self employed individuals, including partners and sole proprietors, two percent share-holders of an S Corporation, and five percent owners of a C Corporation would not be treated as employees for purposes of this credit. There will also be a special rule for sole proprietorships to prevent them from receiving the credit for the owner and their family members. Thus, no credit would be available for contribution to the purchase of health insurance for these individuals and the individual would not be taken into account in determining the number of employees or the average full time equivalent wages.

Effective Date

The effective date for this subtitle is January 1, 2013 unless otherwise indicated

PERSONAL RESPONSIBILITY REQUIREMENT

Chairman's Mark

Personal Responsibility Requirement. Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through (1) the individual market, a public program such as Medicare, Medicaid, the Children's Health Insurance Program, Veteran's Health Care Program, or TRICARE or through an employer (or as a dependent of a covered employee) in the small group market, meeting at least the requirements of a bronze plan, or (2) in the large group market, in a plan with first dollar coverage for prevention-related services as recommended by the U.S. Preventive Services Task Force – except in cases where value-based insurance design is used and cannot have a maximum out-of-pocket limit greater than that provided by the standards established for HSA current law limit. Exemptions from the requirement to have health coverage would be allowed for religious objections that are consistent with those allowed under Medicare, and for undocumented aliens. An individual enrolled in a grandfathered plan would be deemed to have met the responsibility requirement. In order to ensure compliance, individuals would be required to report on their Federal income tax return the months for which they maintain the required minimum health coverage for themselves and all dependents under age 18. In addition to this self-attestation by individuals of qualified coverage, insurers (including employers who self-insure and therefore act as insurers), must report information on health insurance coverage information to both the covered individual and to the Internal Revenue Service. This information includes months of coverage in the tax year and individuals covered on the policy and may include other relevant information. A similar reporting requirement would apply to employers with respect to individuals enrolled in group health plans if the reporting is not provided by the insurer (for example in the case of self-insured plans) and for those enrolled in public health insurance plans.

Open Enrollment in the Individual Market. An initial open-enrollment period for eligible individuals in the individual and small-group market (excluding grandfathered plans) would be from September 1, 2012 through November 30, 2012. For every year thereafter, the open enrollment period would be from October 15 through November 30. Special enrollment periods would be allowed for qualifying events, consistent with those included in the Public Health Service Act (PHSA), such as when an individual becomes a dependent through marriage or birth, or when an individual loses other health insurance coverage. There may be additional special enrollment periods allowed, consistent with those allowed under Medicare Part D (for example, special enrollment periods may be allowed for exceptional circumstances as determined by the Secretary of Health and Human Services). During the annual open enrollment period (October 15- November 30 of each year) individuals could change plans, or remain in their current plan

Excise Tax. The consequence for not maintaining insurance would be an excise tax. If a taxpayer's MAGI is between 100-300 percent of FPL, the excise tax for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or an individual claimed as a dependent) is \$750 per year. However, the maximum penalty for the taxpayer unit is \$1,500. If a taxpayer's MAGI is above 300 percent of FPL the penalty for failing to obtain coverage for an individual in a taxpayer unit (either as a taxpayer or as an individual claimed as a dependent) is \$950 year. However, the maximum penalty amount a family above 300 percent of FPL would pay is \$3,800.

The excise tax would apply for any period for which the individual is not covered by a health insurance plan with the minimum required benefit but would be prorated for partial years of noncompliance. The excise tax would be assessed through the tax code and applied as an additional amount of Federal tax owed. No excise tax will be assessed for individuals not maintaining health insurance for a period less than or equal to three months in the tax year. However, assessed excise taxes for those not insured for more than three months include the entire duration the individual was uninsured during the tax year.

Exemptions from the excise tax will be made for individuals where the full premium of the lowest cost option available to them (net of subsidies and employer contribution, if any) exceeds ten percent of their AGI. Available policies are defined as an employer policy in the case of an individual who works for an employer who offers coverage and an individual policy in the case of an individual who does not have access to an employer sponsored plan. Exemptions from the excise tax will also be made for individuals below 100 percent of FPL, any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs (e.g., such as those participating in Health Sharing Ministries), those experiencing hardship situations (as determined by the Secretary of Health and Human Services) and an individual who is an Indian as defined in Sec. 4 of the Indian Health Care Improvement Act. Additionally, in 2013, individuals at or below 133 percent of FPL will be exempt from the excise tax. When making these determinations, income from individuals not subject to the mandate should not be considered.

Auto Enrollment. Employers with 200 or more employees must automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of employer coverage, however, if they are able to demonstrate that they have coverage from another source (e.g., through a public program such as Medicare, Medicaid or the Children's Health Insurance Program or as a dependent in a spouse or other family member's health benefits).

Additionally, states will have the option to establish a process for auto-enrollment of individuals and families into policies offered in the individual and small group markets. State programs for auto enrollment must be approved by the Secretary of HHS.

EMPLOYER-PROVIDED HEALTH INSURANCE COVERAGE

Chairman's Mark

Employer Offer of Health Insurance Coverage. Under the Chairman's Mark as under current law, an employer would not be required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the exclusion from gross income would apply to the employer provided portion of the coverage. The tax treatment would be the same whether the employer offers coverage outside of a state exchange or the employer offers a coverage option through a state exchange.

As a general matter, if an employee is offered employer-provided health insurance coverage, the individual would be ineligible for a low income premium tax credit for health insurance purchased through a state exchange. An employee who is offered coverage that does not have an actuarial value of at least 65 percent or who is offered unaffordable coverage by their employer, however, can be eligible for the tax credit. Unaffordable is defined as 13 percent of the employee's income. For purposes of determining if coverage is unaffordable, salary reduction contributions would be treated as payments by the employer. The employee would seek an affordability waiver from the state exchange and would have to demonstrate family income and the premium of the lowest cost employer option offered to them. Employees would then present the waiver to the employer. The employer assessment would apply for

any employee(s) receiving an affordability waiver. Within five years of implementation, the Secretary must conduct a study to determine if the definition of affordable could be lowered without significantly increasing costs or decreasing employer coverage.

A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid. In this circumstance, the employer is not required to pay a fee.

Required Payments for Employees Receiving Premium Credits. All employers with more than 50 employees that do not offer coverage would be required to pay a fee for each employee who receives a tax credit for health insurance through a state exchange. The number of employees shall be accounted from the most recent year using the COBRA definition of employee that applies for purposes of determining if an employer is eligible for the small employer exception from continuation coverage.

For each full time employee (defined as working 30 hours or more each week) enrolled in a state exchange and receiving a tax credit, the employer would be required to pay a flat dollar amount set by the Secretary of HHS and published in a schedule each year. The flat dollar amount would be equal to the average tax credit in the state exchanges. These payments would not be linked to the individual, but would be contributed to a general fund. The assessment is capped for all employers at an amount equal to \$400 multiplied by the total number of employees at the firm (regardless of how many are receiving the state exchange credit).

The employer would pay the lesser of the flat dollar amount multiplied by the number of employees receiving a tax credit or a fee of \$400 per employee paid on its total number of employees.

For example, Employer A, who does not offer health coverage, has 100 employees, 30 of whom receive a tax credit for enrolling in a state exchange offered plan. If the flat dollar amount set by the Secretary of HHS for that year is \$3,000, Employer A should owe \$90,000. Since the maximum amount an employer must pay per year is limited to \$400 multiplied by the total number of employees (for Employer A, 100), however, Employer A must pay only \$40,000 (the lesser of the \$40,000 maximum and the \$90,000 calculated fee).

Effective Date

The effective date for this subtitle is January 1, 2013 unless otherwise indicated

MEDICAL LIABILITY

Chairman's Mark

The Chairman's Mark would express the Sense of the Senate that health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance. The Mark would further express the Sense of the Senate that states should be encouraged to develop and test alternatives to the current civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court. The Mark would express the Sense of the Senate that Congress should consider establishing a state demonstration program to evaluate alternatives to the current civil litigation system.