



On Sunday, March 21, 2010, the United States House of Representatives passed the Senate health care bill entitled the Patient Protection and Affordable Care Act. The bill passed the House by a vote of 219 to 212. Thirty-four democrats joined a unanimous republican contingent in an unsuccessful attempt to block the bill's passage.

Within hours of passing the Senate health care bill, the House approved a package of changes to the legislation that was considered under budget reconciliation rules preventing republican Senators from blocking the bill with a filibuster. House democrats also blocked a GOP attempt to recommit the Senate bill by a vote of 199 to 232.

On Tuesday, March 23, 2010, President Obama signed the Senate health care bill into law, and on Tuesday, March 30, 2010 President Obama signed the House Reconciliation bill into law. To be sure, the Obama administration crossed a significant hurdle with the execution these laws; however, the drama that is health care reform is far from over.

Immediately following the President's execution of the Patient Protection and Affordable Care Act, several state attorneys general filed separate lawsuits in federal court to oppose the Act. As of Wednesday, March 24, 2010, fourteen state attorneys general filed such lawsuits. Each action differs slightly from the others, and ultimately, the conservative United States Supreme Court will rule on the Constitutionality of some of the more central aspects of the legislated reforms contained in the Act.

While it is too early to accurately predict the full impact of this historic legislation, there are several key areas of the reform legislation that employers should monitor.

Individual & Employer Responsibilities

Individual Responsibility and Penalty

- individuals must obtain minimum essential coverage for them and their dependents, effective 2014 - failure to obtain minimum essential coverage will result in a tax as follows: \$325 in 2015; \$695 in 2016 and beyond (indexed by a cost-of-living adjustment)

Employer Responsibility and Penalty

- employers with more than 50 employees must offer qualified coverage to their employees
- for employers with more than 50 employees that do not offer qualified coverage and have at least one employee receiving the premium assistance tax credit, they will be fined \$2,000 multiplied by the number of employees - the first 30 employees will not be counted for the penalty calculation

Insurance Reforms

Annual Limits

- small and large group market plans may only establish "restricted" annual limits, effective six months from enactment
- small and large group market plans are prohibited from establishing annual limits, effective 2014

Benefit Package

- plans in the individual or small group market must provide the essential health benefits package, effective 2014

Dependent Coverage

- requires insurers that offer dependent coverage to allow uninsured children to remain on their parents' health insurance up until age

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26, effective six months from enactment

- catastrophic coverage plans available for individuals under age 30

Guaranteed Issue and Guaranteed Renewal

- guaranteed issue and renewal effective 2014

Insurance Rating

- permits variation based only on tobacco use, family composition, and geographic area, effective 2014
- no rating based on health or gender, effective 2014

Lifetime Limits

- small and large group market plans, including grandfathered health plans, may not impose lifetime limits on coverage, effective six months from enactment

Medical Loss Ratio (MLR)

- health plans would be required to report the proportion of premium dollars that are spent on items other than medical care
- rebates would be provided to enrollees if plans failed to have an acceptable MLR, effective 2011

National High Risk Pool

- HHS will establish a temporary insurance program for uninsured people denied coverage due to pre-existing conditions, effective 90 days from enactment

Non-Discrimination & Pre-Existing Conditions

- insurers prohibited from discriminating based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or any factor determined appropriate by HHS, effective 2014
- prohibits group health plans from excluding patients on the basis of pre-existing conditions, effective 2014

Preventive Services

- plans must provide coverage, without cost-sharing, for preventive services and immunizations, effective six months from enactment

Quality Reporting

- insurance companies must report to HHS and their enrollees regarding a plans' implementation of the following activities: improving health outcomes through quality reporting; preventing hospital readmissions; improved patient safety and reduced medical errors; and wellness and health promotion activities
- reporting required within two years of enactment

Creates a Health Benefits Advisory Committee to recommend covered benefits in qualified plans and the level of benefits in essential plans.

Health Insurance Exchange

Establishment, Purpose, and Duties of Exchange

- states required to establish an American Health Benefit Exchange by January 1, 2014
- the exchanges will facilitate the purchase of qualified health plans and establish a Small Business Health Options Program (SHOP) to assist small employers in obtaining coverage for employees
- an exchange may only be a governmental agency or non-profit entity established by a state
- states may form regional exchanges with other states, subject to the approval of each state legislature

Benefit Packages

- all plans must provide basic services
- states may require additional benefits to be covered
- catastrophic coverage available for individuals under age 30

Eligibility

- qualified employers and qualified individuals are eligible to obtain coverage through an exchange
- small employers with 100 or less employees may enroll in the exchange

Wellness Programs

Establishment, Purpose, and Duties of Exchange

Employer Wellness Programs

- HHS will develop criteria for comprehensive workplace wellness programs; grants will be available for such programs
- requires HHS to award grants to small employers for the purpose of providing their employees with access to workplace wellness programs (this grant program will be in place for five years)
- requires the CDC to evaluate best employer-based wellness programs

Focus on Wellness

- creates a 10 state pilot project that tests the impact of providing wellness programs to at-risk communities (e.g., nutritional counseling, physical activity plans, smoking cessation)
- specific focus on wellness programs for individuals with disabilities and the pre-Medicare population to prevent incidents of chronic disease

Tax Provisions

Tax on High- Cost Health Insurance (“Cadillac” tax)

- 40% excise tax on health coverage that exceeds \$10,200 for an individual and \$27,500 for families, effective 2018 (annually indexed to CPI-U + 1%)

Flexible Spending Accounts (FSAs)

- contributions to FSAs are capped at \$2,500 annually, effective 2013 (indexed to CPI-U) and over the counter drugs are excluded starting in 2011

Health Insurance Provider Industry User Fee

- annual fee on health insurance provider industry, effective 2014 as follows: \$8 billion in 2014, \$11.3 billion in 2015-2016, \$13.9 billion in 2017, \$14.3 billion in 2018, and \$14.3 billion + rate of premium growth in 2019 and beyond

Individual Income Taxes

- increases the Medicare Part A payroll tax by 0.9% on individuals earning over \$200,000 and joint filers earning over \$250,000, effective 2013 (not indexed to inflation)
- applies a 3.8% Medicare tax on investment income from interest, dividends, royalties, rents, gross income from a trade or business, and net gain from disposition of property for individuals earning over \$200,000 and joint filers earning \$250,000 (not indexed to inflation)

Medical Device Industry Excise Tax

- 2.9% excise tax on medical devices sold in the U.S., effective 2013

Prescription Drug Industry User Fee

- annual fee on brand name prescription drug manufacturers, effective 2011 as follows: \$2.5 billion in 2011, \$3 billion in 2012-2016, \$3.5 billion in 2017, \$4.2 billion in 2018, and \$2.8 billion in 2019 and beyond

Small Business Credits

- tax credits equal to 50% of the amount paid by a small employer (10 or fewer employees and average annual wages below \$25,000) for employee health coverage
- limited to firms with 25 or fewer full-time employees and with average annual wages below \$50,000

Tax Deduction for Part D Expenses

- eliminates the deduction for the employer subsidy for employers who provide prescription drug coverage to employees eligible for Medicare Part D, effective 2013

Miscellaneous

Congressional Budget Office (CBO) Analysis

- \$940 billion cost over 2010-2019
- \$138 billion reduction in federal deficit over 2010-2019
- \$1.2 trillion reduction in federal deficit over 2020-2029
- 32 million reduction in the number of uninsured by 2019 (95% insured rate)

Pharmacy Benefit Manager (PBM) Disclosure

- PBMs participating in Part D or the exchanges must report to HHS information regarding rebates, discounts, or price concessions, along with generic drug utilization