Summary of the Patient Protection and Affordable Care Act of 2010

Provided by:

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The Patient Protection and Affordable Care Act (H.R. 3590), originally approved by the Senate on December 24, 2009, was passed by the House on March 21, 2010 and signed into law by President Obama on March 23, 2010.

On the same day it approved the Patient Protection and Affordable Care Act (the Patient Protection Act), the House also passed H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) and sent it to the Senate, where it was approved with minor changes and returned to the House for final approval on March 25, 2010. Signed into law by President Obama on March 30, 2010, the Reconciliation Act removes or modifies some provisions in the original Patient Protection Act to which House members objected.

This paper reviews provisions of the Patient Protection Act, as amended by the Reconciliation Act, as they relate to both individuals and employers.

As you review the attached summary, pay particular attention to any provisions you feel may impact on your situation, keeping in mind that the protections and requirements of the Patient Protection Act will be phased in over a period of years. It is also very possible that a future Congress may amend or even overturn certain provisions.

If you would like additional information on the Patient Protection and Affordable Care Act of 2010 or to discuss the impact of specific provisions on your planning, please call my office.

Table of Contents

	Page
Core Principles	1
Financing Health Care Reform	2
Impact on Individuals and Families	3
Insurance Reforms	4 - 5
Medicare Changes	6
Tax Changes	7
Impact on Employers	8
Impact on Small Employers	8
Impact on Large Employers	9 - 10

The Patient Protection and Affordable Care Act of 2010

Core Principles

The Patient Protection Act, as amended by the Reconciliation Act, fundamentally alters the health care landscape in the United States:

- **Individual Mandate:** Individuals not covered by Medicare or Medicaid will be required to have health insurance or pay a penalty ("play or pay"). In addition, insurance companies will no longer be able to deny coverage for pre-existing conditions, rescind existing health insurance coverage when a person gets sick or impose lifetime limits on benefits.

- **Affordable Coverage:** Lower-income individuals and families, together with some middle-income individuals and families, will receive financial assistance to help pay for health insurance. In addition, insurance companies will have to annually report the share of premium dollars spent on actual medical care and provide customer rebates for plans that spend a lower percentage of premium dollars on medical services than that required by the Act.

- **Employer Mandate:** With the exception of small businesses, employers that do not provide qualifying health insurance coverage will be subject to an additional tax. Small employers will be encouraged to provide health care coverage through a new tax credit.

- **Cover Preventive Health Services:** New group health insurance plans, as well as individual health insurance policies, will have to provide "first dollar" coverage for certain preventive services and immunizations.

- **Transforming the Health Care Delivery System:** Provides for research and demonstration projects to test payment and service delivery models designed to reduce health care costs and improve the quality of care provided.

Financing Health Care Reform

The Congressional Budget Office (CBO) estimates that while the Patient Protection Act, as amended by the Reconciliation Act, will cost approximately $940 billion over 10 years, that cost will be fully offset by new taxes and fees and, further, will result in a federal budget deficit reduction over those same 10 years. In reality though, no one really knows with any accuracy what health care reform will cost.

While there are provisions for research and pilot programs in the Act, the legislation doesn't include any proven strategies for tackling what many consider to be the biggest concern: health care costs that are rising at twice the rate of inflation. As a result, it's impossible to predict at this point in time what impact health care reform will have on family budgets. The hope is that the current legislation, together with possible future changes, will transform an industry that currently pays doctors and hospitals based on the volume of services provided to a system that rewards medical providers on the basis of health care outcomes.

To help finance the cost of health care reform, the Patient Protection Act, as amended by the Reconciliation Act, includes a number of taxes and fees that will take effect over a period of years:

- 40% excise tax on "high dollar" health insurance plans (takes effect in 2018);
- increase in Medicare payroll taxes paid by higher-income taxpayers beginning in 2013;
- for tax years beginning after December 31, 2012, an increase in the threshold for the itemized medical expense deduction from 7.5% to 10% of adjusted gross income;
- 10% tax on qualified indoor tanning services provided on or after July 1, 2010.
- annual nondeductible fees imposed on certain health-related industries, such as medical device manufacturers and importers, sales of brand-name pharmaceuticals and health insurance providers (effective dates ranging from 2011 to 2014); and
- beginning in 2010, limits on the deduction of compensation paid by health insurance providers to high-level executives.

The Patient Protection Act:
Impact on Individuals and Families

The impact of the Patient Protection Act on you and your family depends to a large extent on your age, for whom you work, the amount and sources of your income and your health status.

- **Young Adults:** Young adults will have to purchase insurance unless they qualify for an exemption. If under age 27, they may be able to continue health care coverage through a parent's policy. In addition, young adults under age 30 will have access to less expensive catastrophic coverage.

- **Non-Elderly Adults:** Unless they qualify for an exemption, all U.S. citizens and legal residents will be required to have health care coverage or pay a penalty (exemptions include a hardship waiver or the cheapest plans available exceeding 8% of income). Insurers will no longer be able to turn down people with pre-existing conditions or charge them higher premiums. Lower-income earners who earn less than 400% of the federal poverty level ($88,200 in 2009) will be eligible for subsidies to help purchase coverage. The lowest-income earners (up to 133% of the federal poverty level) will become eligible for Medicaid, regardless of whether or not they have children or a disability.

- **Employees of Large Companies:** Employment in an employer's large group plan generally will satisfy the individual mandate. Companies with 50 or more employees will not be required to provide health care coverage, but those that don't may have to pay a per-employee fine. Existing benefit packages are grandfathered, but must still meet certain requirements. New plans will have to meet minimum requirements, including limits on out-of-pocket spending.

- **Employees of Small Businesses:** A business with 25 or fewer employees may qualify for a federal tax credit to help with the cost of providing health insurance. In addition, small business health exchanges through which coverage can be purchased will be established by each state.

- **Higher-Income Individuals:** Beginning in 2013, additional Medicare taxes will be paid by higher-income individuals on their wages and, for the first time, on net investment income.

- **The Elderly:** Medicare will add free preventive services and the Medicare Part D prescription drug coverage gap will slowly be closed by 2020. Higher-income Medicare beneficiaries will pay higher Medicare Part B premiums for hospital insurance. Medicare currently covers about 38 million people and, as a result, has tremendous clout in the way medical providers are paid. As a result, expect to see Medicare pilot programs designed to develop and implement new approaches to how medical providers are compensated. The government currently pays about 14% more for each Medicare Advantage beneficiary than it does for someone in Traditional Medicare. This additional subsidization will be gradually eliminated beginning in 2011, which may result higher costs and/or reduced benefits for Medicare Advantage beneficiaries.

Impact on Individuals and Families: Insurance Reform

2010 :

- Access to a temporary national high-risk pool for people who are uninsured because of pre-existing health conditions. Provides coverage through 2014 when state insurance exchanges become operational.
- Non-dependent adult children must be allowed to remain on a parent's health insurance policy up to age 27.
- Insurers cannot deny coverage to children with pre-existing conditions.
- Insurers cannot place lifetime limits on the dollar value of coverage. Prohibits use of restrictive annual limits on coverage.
- Insurers cannot deny or rescind coverage of insureds who become sick.
- All new group health plans and plans in the individual market must provide first-dollar coverage for certain preventive services and immunizations.

2011:

- Large group plans must spend at least 85% of premium dollars on medical services; 80% for small group and individual plans. Effective January 1, 2011, rebates must be provided to customers of plans that spend a lower percentage of premium dollars on medical services.
- A national, voluntary long-term care insurance program is established.
- Chain restaurants and food sold from vending machines must disclose the nutritional content of each food item.

2013:

- Create the CO-OP (Consumer Operated and Oriented Plan) program to foster creation of non-profit, member-run health insurance companies.
- Limit annual contributions to health FSAs to $2,500 per year, indexed for inflation in subsequent years.
- Adopt a single set of operating rules for eligibility, enrollment and claims processing.
- Require disclosure of financial relationships between all health entities.

2014:

- Unless they qualify for an exemption, U.S. citizens and legal residents are required to have minimum essential health insurance coverage or pay a penalty.
- Individuals who fail to maintain minimum essential coverage in 2014 are liable for a penalty equal to the greater of $95 or 1% of income.
- Health insurance premium subsidies are available to eligible individuals and families with incomes between 133% and 400% of the federal poverty level (currently $29,327 to $88,200).

Impact on Individuals and Families: Insurance Reform

2014 (continued):

- Medicaid coverage is provided to all individuals under age 65 with incomes up to 133% of the federal poverty level, based on modified adjusted gross income.
- Taxpayers below the threshold for filing an income tax return are exempt from the minimum essential coverage penalty.
- State-based American Health Benefit Exchanges and Small Business Health Options Programs are created, through which individuals and small businesses with up to 100 employees can comparison shop for standardized health insurance coverage. At least two multi-state options must be offered in each Exchange.
- To be offered through an Exchange, a qualified health plan must provide essential health benefits which include cost sharing limits. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family. Coverage will be offered at four levels based on how much the insurer pays: Platinum – 90%; Gold – 80%; Silver – 70%; and Bronze – 60%. A lower-benefit catastrophic plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.
- Guaranteed issue and renewability is required, meaning that insurers cannot deny or cancel coverage to anyone with a pre-existing condition.
- Any waiting periods for coverage cannot exceed 90 days.
- Health insurance plans cannot impose annual limits on the amount of coverage an individual may receive.
- For individual and small group policies, as well as policies sold through Exchanges, premium rating variations can be based only on age, premium rating area, family composition and tobacco use.
- The out-of-pocket limits paid by those with incomes up to 400% of the federal poverty level are reduced.
- Employers with 50 or more full-time employees must offer health care coverage or pay penalties.

2015:

- Individuals who fail to maintain minimum essential coverage in 2015 are liable for a penalty equal to the greater of $325 or 2% of income.

2016:

- Individuals who fail to maintain minimum essential coverage in 2016 are liable for a penalty equal to the greater of $695 or 2.5% of income. The flat-dollar portion of the penalty is indexed for inflation after 2016.

Impact on Individuals and Families: Medicare Changes

2010:

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D prescription drug coverage gap in 2010. Gradually eliminate the coverage gap by 2020.
- Prohibit new physician-owned hospitals in Medicare and limit the growth of certain grandfathered physician-owned hospitals.

2011:

- Require pharmaceutical companies to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage cap; begin phasing-in federal subsidies for generic subscriptions filled in the Medicare Part D coverage gap.
- Improve coverage provided for certain preventive services.
- Provide Medicare beneficiaries with access to a comprehensive health risk assessment and creation of a personalized prevention plan, including incentives to complete behavior modification programs.
- Freeze 2011 Medicare Advantage payments at 2010 levels to begin transition to reformed subsidy payments to Medicare Advantage plans.
- Prohibit Medicare Advantage plans from requiring higher cost-sharing arrangements for some Medicare covered benefits than is required under Traditional Medicare.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels.
- Reduce the Medicare Part D premium subsidy for those with incomes above $85,000 individual/$170,000 couple.

2012:

- Provide bonus payment to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

2013:

- Begin phasing in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap.

2014:

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D.
- Require Medicare Advantage plans to spend at least 85% of premium dollars on medical services.

Impact on Individuals and Families: Tax Changes

2010:

- A 10% tax on the amount paid for indoor tanning services provided on or after July 1, 2010 must be paid.

2011:

- Costs for over-the-counter drugs not prescribed by a doctor cannot be reimbursed through an HRA or health FSA, or reimbursed on a tax-free basis through an HSA.
- The penalty tax on distributions from an HSA that are not used for qualified medical expenses is increased from 10% to 20% of the distribution.

2013:

- Increase the itemized deduction threshold for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income.
- The itemized deduction threshold increase is waived for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A payroll tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and over $250,000 for married taxpayers filing jointly; applies only to the employee portion of the tax.
- Impose an unearned income 3.8% Medicare contribution on net investment income received by higher-income taxpayers (over $200,000 individual/$250,000 married filing jointly). Net investment income includes interest, dividends, rents, royalties, gain from disposing of property, and income earned from a trade or business that is a passive activity. Self-employed individuals, as well as estates and trusts, will also be liable for this tax. Distributions from qualified retirement plans, however, will be exempt from paying the additional tax.
- Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2018:

- Impose a 40% nonrefundable excise tax on group insurers of employer-sponsored plans on the portion of annual premiums that exceed an inflation-adjusted $10,200 for individual coverage and $27,500 for family coverage.
- Higher premium thresholds ($11,850 individual/$30,950 family) will be available to certain high-risk professions, as well as to retired individuals age 55 and older.
- While insurers will be responsible for calculating and paying the tax, they can pass along the excise tax to their customers in the form of higher premiums.

The Patient Protection Act:
Impact on Employers

The impact of the Patient Protection Act on employers depends largely on the size of the business:

- **Small Employers:** A small employer is defined as a business with no more than 25 full-time employees and average annual wages of less than $50,000. While not required to provide health insurance coverage, small employers will be encouraged to do so through a temporary small employer tax credit that can be used to help offset the cost of employer-provided health insurance coverage.

- **Large Employers:** A large employer is defined as a business with 50 or more full-time employees. While large employers are not required to provide their employees with health insurance coverage, those that do not may be liable for an additional tax.

The Patient Protection Act:
Impact on Small Employers

- **2010 through 2013:** Eligible small employers may qualify for a tax credit of up to 35% of their contributions toward employees' health insurance premiums.

- **2014 and later:** Eligible small employers will be able to purchase insurance for their employees through a state-based Small Business Health Options Program (SHOP), through which small businesses can pool together to spread their financial risk.

- **2014 and later:** Eligible small employers who purchase insurance for their employees through a state-based Small Business Health Options Program may qualify for a tax credit for two years of up to 50% of their contributions.

- **Other requirements:** Small employers will generally be required to contribute at least 50% of the total premium cost in order to receive a tax credit. In addition, salary reduction contributions are not counted toward the employer's contribution.

- **Simple Cafeteria Plan:** Beginning in 2011, more small businesses will be encouraged to offer tax-free benefits, including health insurance, through a cafeteria plan with reduced employer administrative burdens and exemption from nondiscrimination requirements.

The Patient Protection Act:
Impact on Large Employers

- **Grandfathered Plans:** Employers currently offering health insurance plans can elect to continue offering that coverage as long as their plans extend coverage to children under age 27 and meet certain minimum requirements, such as prohibiting lifetime and annual limits, waiting periods beyond 90 days, rescissions of coverage and pre-existing condition exclusions.

- **Temporary Retiree Reinsurance Program:** In 2010 through 2013, a $5 billion fund will be available to help offset the costs for companies that provide early retiree benefits to retirees ages 55 - 64 and their families. The program reimburses for 80% of the cost of care per enrollee between $15,000 and $90,000. The program will run through 2013 unless the fund is exhausted earlier.

- **Form W-2:** Beginning in 2011, employers must disclose the value of each employee's health insurance coverage provided by the employer on the employee's annual Form W-2.

- **CLASS Program:** Beginning in 2011, a voluntary federal program for long-term care insurance, the Community Living Assistance Services and Support (CLASS) program, will become available. For those employees whose employers elect to participate in the CLASS program, employees will pay premiums through payroll deduction.

- **Retiree Drug Subsidies:** Effective in 2013, the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments is eliminated.

- **Flexible Spending Arrangement Limit:** Beginning in 2013, the annual contributions to Flexible Spending Arrangements (FSAs) is limited to $2,500, indexed for inflation in subsequent years.

- **"Free Rider" Penalty:** The new law does not require employers to provide health insurance to employees. Beginning in 2014, however, employers with 50 or more full-time employees that do not offer qualifying health care coverage to full-time employees and their dependents (or offers "unaffordable" coverage) may have to pay a "free rider" penalty if a full-time employee enrolls in a plan through a state exchange and receives a premium subsidy.

  In order to avoid the penalty, the qualifying health care coverage provided must pay at least 60% of covered expenses and must be affordable (i.e., employee premiums may not exceed 9.5% of household income).

  The "free rider" penalty will be calculated as follows:

- An employer that does not offer qualifying health care coverage to its full-time employees will pay a penalty of $2,000 for each full-time employee, even if just one full-time employee receives a federal subsidy.
- If an employer provides health care coverage that pays less than 60% of covered expenses or is unaffordable, full-time employees will get access to a state exchange and federal subsidies based on household income. The employer will pay a penalty of $3,000 per year for each full-time employee receiving a federal subsidy, up to a maximum of $2,000 times the total number of full-time employees.
- The first 30 employees are excluded from the penalty calculations above. So, for example, a company with 100 full-time employees that does not offer health care coverage would pay a $2,000 "free rider" penalty for 70 employees.

- **Free Choice Vouchers:** Beginning in 2014, employees who qualify for an affordability exemption to the individual mandate but do not qualify for tax credits could take their employer contribution and join a state exchange plan. Employers that offer coverage and make plan contributions will be required to provide "free choice vouchers" to employees, who can then use the vouchers to purchase qualified health plans through a state exchange. Employees qualify for the vouchers if the employee's required contribution to the plan is between 8% and 9.8% of income and the employee's income is at or below 400% of the federal poverty level. The vouchers are tax-free to employees, who are then not eligible for a tax credit, and tax deductible by employers.

- **Automatic Enrollment and Reporting:** Effective in 2014, employers with more than 200 employees must automatically enroll new full-time employees in health insurance plans, subject to any waiting period not to exceed 90 days. Employers will be required to file information returns with the IRS regarding coverage provided and the amount of premium paid by employees.

- **Excise Tax on High-Cost Health Plans:** Effective in 2018, a 40% excise tax will be imposed on health care plans that cost more than $10,200 for individuals and $27,500 for families. While this excise tax will be paid by insurance companies, it's to be expected that at least part of the cost will be passed along to their customers in the form of higher premiums.

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