

## Health Care Reform Key Contacts

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### Senate Begins Debate on Health Reform

The formal debate on the Senate's health reform bill began today at 3:00 p.m. The Republicans have requested six weeks to debate the Patient Protection and Affordable Care Act (the "Act") and the Democrats want to conclude debate as quickly as possible since there are only 25 calendar days remaining until the Senate recesses for Christmas. During the formal debate, numerous amendments are expected to be offered on the Senate floor by both Republican and Democratic Senators. These amendments will likely address a wide range of topics from the substantive measures to accomplish reform, to the most controversial features of the bill (*i.e.*, the public option, abortion coverage, the size and scope of federal subsidies, Medicare cuts and the other mechanisms to pay for reform), to technical matters and a slew of items which fall in between.

Although we certainly should pay attention to what transpires on the Senate floor over the next several weeks, real progress will be determined by what Senate Majority

Leader Reid (D-NV) is able to accomplish behind closed doors in bringing together the disparate views and interests of his Democratic Caucus and Sen. Joseph Lieberman (I-CT) who caucuses with them. In practical terms, debate of the Senate reform bill need only continue for so long as it takes Reid to find the right combination of reform proposals and measures to pay for them on which 60 Senators can agree. At that point, Reid will file for cloture on the bill to stage a vote to cut off all further debate. If and when Reid believes he has 60 votes to approve the cloture motion, passage of the Act will be scheduled for a Senate vote.

Still, there is no telling how long it will take Reid to find just the right reform package to please 60 Senators. The prevailing view is that a compromise can and will be struck on the public option. As to other matters in which liberal, moderate and conservative Democratic Senators claim to have divergent, yet vested interests, a path towards a compromise is less clear.

### Wellness and Prevention Under The Patient Protection and Affordable Care Act

Many have argued that, to save money in the long-run, health reform must include prevention and wellness initiatives that focus on improving or preventing certain lifestyle choices that can lead to chronic disease. These advocates believe that the American health care system should not be exclusively a system that cares for the sick, but also one that encourages healthy behavior. Last month, Sen. Tom Carper (D-DE) conveyed to the Senate Finance Committee ("SFC") that "[r]ecent findings have shown us that the biggest factor contributing to most people's health status is their behavior. Roughly 40 percent of our health status is a direct result of our choices about food and physical activity. Another 20 percent is a direct result of social and physical environments, such as our homes and places of work. That means for most people, the way we eat, drink and exercise, as well as our work and home environments, shape as much as 60 percent of our underlying health status." Similarly, Sen. John Ensign (R-NV) recently expressed that "[w]eight gain and unhealthy lifestyles that focus on smoking and lack of exercise have sky-rocketed our healthcare costs [and] these costs could be lowered by focusing on what makes us healthy - through weight loss programs, smoking cessation and preventive care." Due to many similar opinions, the Act includes a number of prevention and wellness provisions that are intended to improve lifestyle choices, reduce chronic disease and, ultimately, decrease health care spending.

One of the more controversial wellness and prevention initiatives is found in Section 2705 of the Act. Section 2705 is a proposal championed through the SFC by Sens. John Ensign and Tom Carper which would codify and expand existing wellness program regulations under the Health Insurance Portability and Accountability Act ("HIPAA") to allow employer-sponsored insurance plans

to further reduce premiums for those who participate in wellness programs. While Section 2705 prohibits a group health plan and a health insurance issuer from establishing rules for eligibility (including continued eligibility) based on certain health status or related factors, the proposal permits two types of wellness programs that could be used to offer rewards to participating employees. Current HIPAA regulations allow employee wellness programs to offer financial incentives to participating individuals. These incentives may include discounts or rebates of health insurance premiums, reductions in cost-sharing amount and the absence of a surcharge on health benefits for those who meet a certain health standard. The value of the incentives under current HIPAA regulations is capped at 20 percent of employee-only premiums. Section 2705 of the Act proposes to increase this cap.

To promote healthy behaviors, Section 2705 permits wellness programs that condition premium discounts, rebates or rewards on an individual satisfying a health-related standard so long as the program meets certain requirements. Under Section 2705 of the Act, the allowable reward is increased to 30 percent of the cost of the employee-only coverage and affords the Secretaries of Health and Human Services, Department of Labor, and Department of the Treasury the discretion to increase the reward up to 50 percent of the cost of coverage. Among other things, a wellness program which rewards participants for satisfying certain health standards must be reasonably designed to promote health or prevent disease, must have a reasonable chance of improving the health of, or preventing disease in, participating individuals and must not be overly burdensome or highly suspect in the method chosen to promote health or prevent disease. Such a wellness program also must give individuals the opportunity to qualify for the reward under the program at least once each year

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Wellness and Prevention Under The Patient Protection and Affordable Care Act (cont'd.)

and the full reward under such wellness program must be made available to all similarly situated individuals. If the reward is not available to all similarly situated individuals, then there must be a reasonable alternative standard for similarly situated individuals or the possibility that the standards would be waived. Accommodations must be made for those who cannot obtain the reward due to a medical condition or if it would be medically inadvisable to attempt to satisfy the condition.

Section 2705 also permits wellness programs which do not require an individual to satisfy a health standard as a condition for obtaining a reward as long as participation is made available to all similarly situated individuals. Wellness programs that satisfy this criteria include those that reimburse all or part of the cost for memberships in a fitness center, provide diagnostic testing, and encourage preventive care related to a health condition through decreased cost-sharing, without regard to the participant satisfying or achieving any specific health outcome.

As the Senate health care battle heats up, this wellness proposal will likely come under fire. Proponents of this measure – including industry advocacy groups such as DMAA and the Health Promotion Alliance, employers such as Safeway and Johnson & Johnson, as well as various health plans – point to the merits of keeping Americans healthy and reducing overall health care spending. On the other hand, a number of patient-advocacy groups oppose the measure, arguing that allowing employers to vary premiums by up to 50 percent of the total cost of insurance coverage could lead to discriminatory practices and make health coverage unaffordable for those who need it most. Opponents also argue that lowering premiums for some could shift costs to others and that the wellness programs could violate employee privacy. Among those opposed are the AARP, the American Heart Association and the American Cancer Society. Locke Lord will continue to follow the Senate debates on wellness and prevention, as such measures significantly affect insurers, providers, employers and consumers.

Senate Debate May Impact Timelines for Health Reform Roll-Out

The balancing act in which Reid will be engaging as he tries to gather enough solid votes to finally pass a health reform bill this year will include determining when the various reform provisions will take effect. The implementation dates, in turn, will impact the costs, as originally calculated by the Congressional Budget Office, and as revised by future amendments to the Senate package. The current health reform implementation timeline includes a number of items which will take effect relatively quickly. A brief rundown of significant provisions scheduled to take effect in 2010, assuming that reform is passed this year or in early 2010, includes:

- Elimination of coverage exclusions for people with pre-existing conditions;
- Elimination of lifetime limits on benefits for all group and individual health plans, and restrictions on annual limits;
- Reinsurance program for early retirees to assist companies that provide benefits for retirees between 55 and 64 years old;
- First dollar coverage of preventive health services and dependent coverage to age 26;
- Medicare Part D “donut hole” coverage gap will shrink by \$500 (with the coverage gap being eliminated altogether over time);
- Medicare beneficiaries will be allowed a 50% discount on drugs while they are in the donut hole coverage gap;
- Pharmaceutical manufacturing fee allocated according to market share will be imposed, along with a medical device manufacturers fee, both totaling \$4.3 billion annually;
- 5% excise tax on voluntary cosmetic surgical procedures to be collected at the point of service;

- Flat fee of \$6.7 billion imposed on health insurers allocated based on market share; and
- Beginning implementation of new programs for national quality strategy and quality measurement development through HHS, and establishment of a private, non-profit medical outcomes research institute.

Among the many items slated for 2011 implementation under the current plan, the following stand out:

- 10% bonus in Medicare payments for primary care physicians and general surgeons;
- Improved preventive health programs and required coverage for Medicare beneficiaries, eliminating cost sharing for preventive services;
- Small business tax credit takes effect for contributions to purchase health coverage for employees;
- Beginning of the transition to competitive bidding for Medicare Advantage plans;
- Employers required to disclose the value of employee health benefits provided by the employer on the annual W-2 forms; and
- Standardized definition of “Qualified Medical Expense” for use in health savings accounts, flexible spending accounts and health reimbursement accounts.

Items drawing considerable debate under the reform packages, such as health insurance exchanges and the public option coverage, are not slated to take effect until 2014, under the current schedule. If the reform package does become law before the end of the first quarter of 2010, it is estimated that the current fiscal cost estimates will hold. However, if there are delays of any magnitude, both cost estimates and implementation will be subject to significant revisions.