On March 23, 2010, President Obama signed The Patient Protection and Affordability Care Act (the "Act") and he signed the reconciliation bill to "fix" the Act on March 30, 2010. So we now have all the pieces of the puzzle to the law of the land when it comes to health care reform. The legislation is over 2,500 pages. Some of the changes are immediate and others are delayed for more than eight years. We will be hosting seminars in late April to go over the Act.

Until that time, we will keep you posted on major developments. Our focus will be to provide information regarding various provisions that impact employer sponsored plans based on the chronological order of their effective dates.

To that end, one of the earliest meaningful provisions impacting employers who sponsor early retirement health coverage is a reinsurance program for certain claims which is effective within 90 days of the date the Act was signed. For all other employers (i.e. those not sponsoring early retirement plans) the first effective date for change under the Act takes place for plan years beginning six months after the President signed the Act. Basically this means plans renewing on or after October 1, 2010, (i.e. January 1, 2011, for plans maintained on a calendar year basis) will become subject to the Act.

As you can imagine, this early in the process there are legitimate questions where the answers are not clearly addressed, or are subject to some interpretation. As these effective dates draw nearer it is our experience that most issues will become better defined. It is our recommendation that employers attempting to comply with the Act avoid the temptation to digest the Act in its entirety, but rather take steps over time to implement the various provisions as they become effective.

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The first step towards compliance is for employers to categorize their plan as either a "**Grandfathered Plan**" or as a "**Non-Grandfathered Plan**". A Grandfathered Plan is a health plan that was in existence on the date of enactment (i.e. March 23, 2010). A Non-Grandfathered Plan is a health plan that was established after the date of enactment. Unfortunately, the Act is unclear about what changes to a Grandfathered Plan might cause it to be considered a Non-Grandfathered Plan. For example, modifying the eligibility requirements or switching insurance companies may or may not change the status of the plan. The reason the plan status is important is because a Grandfathered Plan may be permitted to defer or even ignore some of the provisions under the Act.

The following is a list of those major provisions that are on the horizon (i.e. effective for plan years beginning six months after the enactment date).

<u>Rules Applicable to Grandfathered Plans:</u>

1. Elimination of Annual and Lifetime Limits on Benefits

   Plans may not impose lifetime limits on benefits. Additionally, plans may not impose annual limits on certain benefits; specifically those identified as essential benefits as defined by the Department of Health and Human Services (HHS). HHS is required to develop a complete list of essential benefits. Until then, essential benefits include but are not limited to:

   - ambulatory patient services
   - emergency services
   - hospitalization
   - maternity and newborn care

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- prescription drugs
- preventive and wellness services

You should note that this provision under the Act does not require the plan to provide any specific benefit; it only precludes the plan from placing limits on those benefits covered under the plan. *(NOTE: Bottom line - plans can only impose annual limits on non-essential benefits and, beginning in 2014, the plan must eliminate all annual limits - even for non-essential benefits.)*

2. Limitation on Pre-Existing Conditions

Plans can no longer impose pre-existing condition limitations on children under age 19. It is important to note that just because a plan cannot exclude coverage for a pre-existing condition, it does not mean an individual can enroll in the plan at any time. *(NOTE: Beginning in 2014 the pre-existing condition limitations are eliminated for all enrollees.)*

3. Coverage for Adult Children

All plans must provide coverage for children up to age 26, even if married. However, the coverage under "grandfathered" plans only has to be provided to children (both married and unmarried) if the child is not eligible for other employer sponsored coverage. The Internal Revenue Code has been amended to say that the value of the coverage is tax free (i.e. there is no imputed income) to the employee. *(NOTE: Beginning in 2014 all children up*

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to age 26 will be eligible to participate in their parents' plan even if they are eligible for other employer sponsored coverage.)

4. New Claims Rules

Plans must implement external appeal procedures which claimants can use to appeal claims that are denied in whole or in part.

5. Prohibition on Rescissions

Under the Act plan coverage can only be rescinded if the person committed fraud or there was an intentional misrepresentation. It would be our expectation that this rule would have limited impact to employer sponsored group plans.

6. Free Choice of Primary Care Physician

Plan must allow the enrollee to select his or her primary care provider (in the case of a child a pediatrician) from any available participating primary care provider. Plans also are precluded from requiring prior authorization for obstetrical or gynecological care from a specialist.

<u>Rules Applicable to Non-Grandfathered Plans:</u>

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If the health plan is a Non-Grandfathered plan, then all the rules above apply **plus** the following rules also apply. (A Non-Grandfathered Plan is a plan that was established on or after March 24, 2010.)

1. Preventative Care

   Plans must provide first dollar coverage for preventative care and cover certain child preventative services as recommended by designated government agencies.

2. Emergency Services

   Plans can not require prior authorization for emergency room services and the plan can not impose additional or special co-payments or coinsurance charges if the emergency facility is outside of the plan's provider network.

3. Non-Discrimination Rules

   Self-funded health plans have been subject to discrimination rules under the Internal Revenue Code for some time. Those rules are designed to preclude employers from disproportionately benefiting higher paid employees when it comes to eligibility and benefits. The Internal Revenue Code's discrimination rules now apply to all plans (i.e. both self-funded and fully insured plans).

4. Loss Ratio

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In an attempt to require health plans to be more efficient, the new rules require plans to spend at least 85% of premiums (80% for small group plans) on medical expenses.

Miscellaneous Provisions

1. Small Employer Tax Credits

   To help reduce the burden on smaller employers, the Act provides a temporary sliding-scale small employer tax credit that varies depending on the size and wage scale of the workforce. This credit is available beginning in 2010 and is phased out over time. The maximum credit in 2010 can be up to 35% of the employer's contributions and is available to employers with 10 or fewer employees with an average annual salary of less than $25,000. The credit is completely phased out for employers with more than 25 employees whose average annual salary is $50,000 or more.

2. New Reporting Requirements

   Employers will be required to report the cost of coverage on the employee's Form W-2.

3. Elimination of Tax Favored Treatment of Over the Counter Drugs

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Effective January 1, 2011 over the counter medication obtained without a prescription (other than insulin) will no longer be eligible for reimbursement under FSA, HRA, or HSA plans. Employers must amend applicable plan documents to comply with the new rules.

4. Increased HSA Distributions Penalty

Currently there is a 10% penalty (i.e. additional tax) for using HSA distributions for non-medical expenses. Beginning January 1, 2011, the penalty is increased to 20%.

The Act incorporates most of the new requirements on plan design, described above, into the HIPAA provisions of ERISA and the Internal Revenue Code. Therefore, employers that maintain health plans not brought into compliance with the new provisions may be subject to an excise tax as equal to $100 per participant per day during the period of noncompliance, up to an annual maximum of $500,000 or, if less, 10% of the plan expenses for the prior year.

We will continue to keep you updated on other provisions of the Act that become effective in 2012 and beyond. As always, if you have any questions about the Act please contact your McGohan Brabender Account Team.

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