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2010 HEALTH CARE COVERAGE REFORM LEGISLATION

The following is only a summary overview of this very extensive and complex federal legislation. Naturally, the following should not be viewed as legal advice for any particular situation, but rather should only be seen as a starting point for further discussion.

A. Overview. The recently enacted health care reform law actually is the combination of the Patient Protection and Affordable Care Act enacted on March 23, 2010 and the Health Care and Education Reconciliation Act enacted on March 30, 2010.

The law continues the current American system of the provision of health care coverage through a combination of governmental programs (Medicare, Medicaid, Tricare, etc.), for-profit health insurance, and self-funded employer-provided plans. That is, the involvement of employers in the provision of health care coverage is maintained, and in fact is mandated beginning in 2014.

The one structural change included in the law is the concept of mandating that American citizens and lawful residents begin paying into the health care coverage system in 2014.

Note that the law generally applies to all employer health plans, whether insured, self-funded, large, small, governmental, for-profit or non-profit. Note also that many provisions of the law will require regulatory clarification before they can be fully understood and implemented.

B. The Two Sets of Rules. The law contains a rather extensive set of new rules for "new" health plans, and a more limited set of rules for "grandfathered" health plans. Grandfathered health plans are those in existence on March 23, 2010. Unfortunately, there is no guidance in the statute about what could cause a grandfathered plan to lose its grandfathered status, so employers should monitor developments in this area very carefully.

C. Tasks for Employers. Employers should: 1. review the employer-related provisions of the law; 2. identify their grandfathered and non-grandfathered health plans; 3. consider carefully any contemplated post-March 23, 2010 changes that might cause a loss of grandfathering; 4. create a compliance deadline calendar and "to do list" that anticipates the applicable changes; 5. consult with their advisors about the various strategic "big picture" decisions that must be made as a result of the law (e.g., whether to "pay" or "play" beginning in 2014); and 5. carefully monitor regulatory and other developments.

D. Chronological Listing of Changes Directed at Employers.

1. June 23, 2010 – New free federal re-insurance plan for self-funded early retiree plans opens and continues until \$5B in funding is utilized.

2. First Plan Year Beginning After September 22, 2010 Changes:

- a. Eliminate any lifetime coverage maximums on essential benefits.
- b. Eliminate any annual coverage maximums on essential benefits that do not qualify as "restricted annual limits" under the recent guidance. Specifically, eliminate annual maximums on essential benefits under \$750,000 for the first plan year beginning after 9/22/10, \$1.25 M for the second, and \$2M for the third. Eliminate all annual maximums beginning with the Plan Year beginning after 9/22/13.
- c. Eliminate any rescission provisions (except for fraud or misrepresentation).
- d. Eliminate pre-ex limitations for children under age 19.
- e. Provide for coverage for children until age 26. (Grandfathered plans need not provide if other employer-based coverage available.)
- f. Eliminate cost-sharing for preventive care. (Not applicable to grandfathered plans.)
- g. Apply new nondiscrimination rules to insured coverages (similar, but not identical, to Code Section 105(h) rules). (Not applicable to grandfathered plans.)
- h. Permit selection of any primary care provider. (Not applicable to grandfathered plans.)
- i. Permit children to select pediatrician as primary care provider. (Not applicable to grandfathered plans.)
- j. No pre-authorization required for emergency care. (Not applicable to grandfathered plans.)
- k. No pre-authorization or referral required for ob-gyn care. (Not applicable to grandfathered plans.)
- l. Provide required internal and external appeals mechanisms. (Not applicable to grandfathered plans.)
- m. "Simple" Section 125 plans available to employers with fewer than 100 employees.
- n. "Qualified Small Employers" (e.g., generally, fewer than 26 FTEs with average wages of \$50,000 or less) eligible for health plan tax credit.

3. 2011 Changes:

- a. OTC drugs not reimbursable from HFSAs, HRAs and HSAs unless per a prescription.
- b. Optional CLASS long term care program may be offered or auto enrolled by employers.

4. 2012 Changes:

a. 2011 W2s issued by January 31, 2012 must include value of employer health plan coverage.

b. By March 23, 2012, issue to employees new "Uniform Explanation of Coverage" in the form specified in HHS regulations and sample.

c. Beginning March 23, 2012, satisfy requirement of 60 days' advance written notice to participants of health plan "material changes".

d. For plan years beginning after September 30, 2012, pay the required federal fee of \$1 times average number of covered lives (for "Patient-Centered Outcomes Research Trust Fund").

4. 2013 Changes:

a. \$2500 cap on HFSAs.

b. Employee Medicare tax increases to 2.35% for Medicare wages over \$250,000 joint/\$200,000 separate.

c. Cease employer deduction for Part D retiree coverage subsidy.

d. Patient-Centered Outcomes Research Trust Fund fee increases from \$1 to \$2 times average number of covered lives.

e. Comply with HHS regulations on required annual reports to HHS and employees on health plan benefits that "improve health".

f. Provide employees with HHS information notices about 2014 exchanges and subsidies.

5. 2014 Changes:

a. Provide Employee Free Choice Vouchers to eligible employees.

b. Eliminate waiting periods over 90 days.

c. Eliminate all pre-ex limitations.

- d. Report minimum essential coverage information to employees and regulators (per regulations to be issued).
 - e. Provide coverage for "routine costs" incurred in connection with clinical trials. (Not applicable to grandfathered plans.)
 - f. Cease "discrimination" against licensed providers. (Not applicable to grandfathered plans.)
 - g. Ensure that out-of-pocket exposure is no higher than is permitted for HDHPs. (Not applicable to grandfathered plans.)
 - h. Ensure that deductibles are no higher than \$2,000 for self-only coverage and \$4,000 for other coverages. (Not applicable to grandfathered plans.)
 - i. Qualifying wellness program penalties/rewards may be raised from 20% to 30% of cost (and perhaps as high as 50% if permitted by the regulators).
 - j. If 200 or more FTEs, auto enroll employees in health plan.
 - k. Continue to provide required notices concerning exchanges and subsidies.
 - l. Decide whether to participate through the exchanges, and whether to permit salary reduction contributions for exchange-based coverage. (Exchanges only open in 2014 for employers with fewer than 50 employees.)
 - m. Play, or pay, under play-or-pay rules.
 - n. If applicable, pay under play-and-pay rules.
 - o. Grandfathered, insured, non-ERISA plans must remove annual maximums on essential benefits. (Note that there is ambiguity about this rule that requires clarification.)
 - p. Grandfathered plans must begin coverage for children until age 26 even if other employment-based coverage is available.
6. 2016 Change: Exchanges begin to operate for employers with up to 100 employees.
 7. 2017 Change: Exchanges may begin to operate for all employers.
 8. 2018 Change: Excise tax on "Cadillac Plans" equal to 40% of excess value over the limit of \$27,500 family, \$10,200 self-only (as adjusted).
 9. 2020 Change: Patient-Centered Outcomes Research Trust Fund fee no longer applicable.

