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Re: **Historic Health Care Reform Becomes Law**

Dear Clients and Other Friends:

Regardless of your political views of the new health care reform law, it is now in effect. Although legal, legislative and fiscal challenges await and many provisions are not effective until a few years from now, some provisions were effective upon President Obama's signing of the bill. Therefore, employers and service providers must familiarize themselves with the legal requirements and begin to react to the new reform law.

The bill signed into law by President Obama on March 23 was the Senate's version of health care reform, known as the Patient Protection and Affordable Care Act ("PPACA"). This new law is supplemented by the Health Care and Education Affordability Reconciliation Act (the "Reconciliation Act") which put the "finishing touches" on the massive health care reform package. Passed by both houses of Congress with minor changes, the Reconciliation Act was signed into law by the President today.

Key elements of the reform law will create health care insurance exchanges, establish health care coverage mandates for individuals and impose penalties on certain employers if they do not offer health care coverage for employees. Importantly, these key provisions do not become effective until 2014. Various fee and tax provisions become effective in future years. Other requirements of the health reform law, however, become effective right away. As indicated by its name, the Reconciliation Act also includes certain education changes, including changes to student loans.

To highlight the immediate changes of the health care reform law, this client letter only includes a summary of the provisions that are effective now or will be effective by January 1, 2011.

Changes Effective Now (as of March 23, 2010)

- Small business tax credits – Tax credits of up to 35% of premiums are available to small businesses that choose to offer coverage. The full credit will be available to businesses with 10 or fewer employees with average annual wages of \$25,000 while businesses with up to 25 or fewer employees and average annual wages of up to \$50,000 will be eligible for a reduced credit. Tax-exempt organizations may also be eligible for a limited tax credit.
- Closing the coverage gap in the Medicare (Part D) drug benefit – The law provides a \$250 rebate to Medicare beneficiaries who hit the so-called “donut hole” in 2010. Additional relief is provided in 2011 as a 50% price discount is guaranteed on brand-name drugs. The donut hole will completely close by 2020.
- Investment in community health centers for vulnerable populations – PPACA makes an immediate investment in community health centers to provide the funding needed to expand access to health care in communities where it is needed most. This \$10 billion investment begins in 2010 and extends for five years.
- Public access to comparable information on insurance options – PPACA enables the creation of a new website to provide information and facilitate informed consumer choice of insurance options.
- Health insurance consumer information – PPACA provides assistance to States in establishing health insurance consumer assistance offices or health insurance ombudsman programs to assist individuals with the filing of complaints and appeals, enrollment in a health plan, and, eventually, to assist consumers with resolving problems with tax credit eligibility.

Changes Effective in 90 Days (June 21, 2010)

- Access to coverage for uninsured with pre-existing conditions – PPACA provides \$5 billion in federal support for a new program to provide affordable coverage to uninsured Americans with pre-existing conditions. This program will continue until it is replaced by the health insurance exchanges that are to be operational in 2014.
- Re-insurance for retiree health benefit plans – PPACA creates access to re-insurance for employer health plans providing coverage for early retirees (ages 55 through 64). This re-insurance is intended to help protect coverage while reducing premiums for employers and early retirees. This program will also receive \$5 billion in federal support and will continue until it is replaced by the health insurance exchanges.

Changes Effective in 6 Months (for Plan Years Beginning on or after September 23, 2010)

Key provisions concerning health care coverage become effective for plan years beginning on or after September 23, 2010. PPACA distinguishes between several types of health plans for purposes of applying rules and restrictions. Generally, PPACA applies to both self-insured and fully-insured employer plans. Although individual and group health plans in existence prior to March 23, 2010 (“grandfathered plans”) are exempt from some new mandates, most of the following apply to all health plans regardless of a plan’s effective date:

- No pre-existing coverage exclusions for children – Although some insurers are contesting the September 23, 2010 effective date, PPACA prohibits all group health plans and issuers offering group or individual health insurance from excluding coverage of pre-existing conditions for children under the age of 19. Beginning in 2014, this prohibition on pre-existing condition coverage exclusions will apply to all persons.
- Patient protections – PPACA protects a patient’s choice of doctors by allowing plan members to pick any participating primary care provider (PCP), prohibiting insurers from requiring prior authorization before a woman sees an ob-gyn and ensuring access to emergency care regardless of whether the care provider is in-network or out-of-network.
- Extension of dependent coverage of young adults – All new group health plans and issuers offering new group or individual health insurance plans must permit children to stay on a family’s policy until age 26. Grandfathered plans are required to cover children until age 26, unless the dependent is eligible to enroll under another employer’s group health plan.
- Free prevention benefits – Coverage of prevention and wellness benefits are required and these benefits are exempt from deductibles and other cost-sharing requirements in public and private insurance coverage. This requirement applies only to new group health plans and issuers offering new group or individual health insurance plans; grandfathered plans are exempt until 2014 when the insurance exchanges are operational.
- No lifetime limits on coverage – All group health plans and issuers offering group or individual health insurance are prohibited from imposing lifetime limits on benefits.
- Restricted annual limits on coverage – An insurer’s use of annual limits will be tightly restricted with the intention to ensure access to needed care. The tight restrictions will be defined by the Secretary of Health and Human Services. When the insurance exchanges are operational in 2014, the use of annual limits will be banned.
- Protections from rescissions of existing coverage – All group health plans and issuers offering group or individual health insurance are prohibited from rescinding insurance when claims are filed, except in cases of fraud or intentional misrepresentation of material fact.

- Prohibits discrimination based on salary – Group health plans are prohibited from establishing any eligibility rules for health care coverage that have the effect of discriminating in favor of higher wage employees. Self-insured health plans, however, will remain subject to the non-discrimination rules in effect prior to PPACA.
- Appeals process – All plans will implement an effective process for appeals of coverage determinations and claims. States will provide an external appeals process to ensure an independent review for fully-insured plans. Self-insured plans not subject to state law will be required to implement an external review process that meets the administrative appeals process standards set by the Secretary of Health and Human Services.

Changes Effective on January 1, 2011

- Free prevention benefits – Medicare beneficiaries will receive a free, annual wellness visit and will have all cost-sharing waived for prevention services.
- Establishment of premium payment values – Standards for insurance overhead will be established and require public disclosure to ensure that enrollees get value for their premium dollars. This change will require plans in the individual and small group market to spend 80% of premium dollars on clinical services and quality activities, and 85% for plans in the large group market. Health insurance plans that do not meet these thresholds will provide rebates to their policyholders. This provision is not applicable to self-insured plans.
- Availability of SIMPLE Cafeteria Plans for Small Businesses – An eligible small employer (generally, an employer with 100 or fewer employees during either of the two preceding years) has a safe harbor from cafeteria plan nondiscrimination rules if the employer offers all employees a SIMPLE cafeteria plan and makes a specified minimum contribution for non-highly compensated employees.
- Reporting health care coverage costs on Form W-2 – All employers must report on each employee's Form W-2 the aggregate cost of employer-provided group health coverage that is excluded from the employee's gross income. This reporting requirement does not apply to contributions made to a Health Savings Account or an Archer MSA or employee salary reduction contributions to a flexible spending arrangement offered under a cafeteria plan.
- Standardizing the definition of qualified medical expenses – The definition of qualified medical expenses for Health Savings Accounts (HSAs), Flexible Spending Arrangement (FSAs) and Health Care Reimbursement Accounts (HRAs) is amended to conform to the definition used for itemized deductions. Due to this change, over-the-counter drugs will no longer be eligible for reimbursement under HSAs, FSAs and HRAs unless prescribed.

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- Health savings account penalty – The excise tax on non-medical distributions from HSAs is increased from 10% to 20%. This change is also applicable to Archer MSAs.
- New requirements for non-profit hospitals – Non-profit hospitals must satisfy new requirements to maintain tax-exempt status, including community health needs assessments, maintenance of a qualified financial assistance policy, limitations on charges and certain billing and collections activities.

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This new legislation establishes a new foundation of health care law in the United States. We will continue to review the new health care reform law and provide additional information in future client letters.

Please contact us at Kelly, Hannaford & Battles if you have any questions or wish to discuss how these changes may affect your company.

Sincerely,

Theodore K. Rice

Sincerely,

Holly A. Fistler