

Legislative Brief

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Health Care Reform: Quick Reference Chart

This memorandum is the second installment in our effort to address the critical and imminent changes brought about by the Patient Protection and Affordable Care Act ((H.R. 3590; Reform Bill) and the Health Care and Education and Affordability Reconciliation Act (H.R. 4872; Reconciliation Bill), collectively referred to as the Health Care Reform Bills.

The BIG Exemption

Section 1251 of the Reform Bill (attached) exempts individual and group health plans from some but not all of the requirements established under Health Care Reform. This exemption is not a blanket exemption. The exemption lasts until the plan undergoes a "change". Unfortunately, we must wait for regulations before we will know for sure what actually constitutes a change.

Who Gets the Exemption

The exemption applies to all group health plans with at least one participant (insured or self-funded) and individual health policies in effect on March 23, 2010 (date of enactment). The exemption is not effected by:

- Policy/Plan Renewals (having no benefit changes);
- Enrollment of new or existing employees of the employer;
- Additional or removal of eligible spouse or dependents; and,
- Collective Bargaining Agreements in effect on March 23, 2010.

Applying the Extention

As you will see from the chart that follows, the exemption is not universal and not forever. Some of the big early changes brought about by Health Care Reform will apply to all plans and policies regardless of their existence on March 23, 2010. Note: PYB means "Plan Years Beginning on or After."

Applying the Extention

Health Reform Provsion	Plans Must Comply		If so, when
	Yes	No	
Elimination of Pre-existing condition limitations for children age 19 (Section 2704)	<input checked="" type="checkbox"/>		PYB: 9/23/10
Elimination of maximum lifetime benefit limit (Section 2711)	<input checked="" type="checkbox"/>		PYB: 9/23/10
Elimination of annual benefit limits (except for limits set by HHS in regulations) (2711)	<input checked="" type="checkbox"/>		PYB: 9/23/10
Dependent covered to age 26 (Section 2714)	<input checked="" type="checkbox"/>		PYB: 9/23/10
Rescission of Coverage (Section 2712)	<input checked="" type="checkbox"/>		PYB: 9/23/10
Non-Discrimination testing of insured plans (Section 2716)		<input type="checkbox"/>	
Preventive care expanded benefits (Section 2713)		<input type="checkbox"/>	
Health FSAs over-the-counter drugs no longer covered (Section 9003)	<input checked="" type="checkbox"/>		Tax Year 1/1/2011
Health FSA annual contribtion limit to \$2,500 (Section 9005)	<input checked="" type="checkbox"/>		Tax Year 1/1/2013
IRS W-2 reporting on value of coverage (Section 9002)	<input checked="" type="checkbox"/>		Tax year 1/1/2011
Access by gatekeeper only (Section 3101)		<input type="checkbox"/>	
Annual reports by plans to HHS regarding health care quality and wellness initiatives (Section 2793)		<input type="checkbox"/>	
Medicare tax increase (2.35% on wages over \$200,000) (Section 9015)	<input checked="" type="checkbox"/>		
Waiting periods limited to 90 days; Essential Health Benefits; cost sharing, etc. (Section 2708 et al.)	<input checked="" type="checkbox"/>		PYB: 1/1/2014

Note: PYB means "Plan Years Beginning on or After"

Losing the Exemption

The law is mostly silent about the kind of plan changes that would result in the loss of the current plan exemption. Perhaps the only clear loss of the exemption is when a Collective Bargaining Agreement in effect on the date of enactment expires (discussed below). Although it is not clear, we believe that amending the plan to comply with Health Care Reform mandated changes (e.g. dependents to age 26) will not constitute a change that would result in the loss of exemption.

What we don't know is how big a voluntary change must occur to terminate the exemption. Is changing a plan's office visit co-pay from \$20 per visit to \$25 per visit big enough of a change? What about the elimination of the PPO plan option from a triple option (i.e. HMO, PPO, HDHP) program or the addition of a new HMO due to business expansion to a new location?

For self-funded plans, in our view, a change in stop loss limits or stop loss insurer, or a change in third party administrators do not change the plan per se, and should not result in the elimination of the exemption. However, until we have regulations, we cannot be certain of the result.

Collectively Bargained Plans

H.R. 3950 allows Collectively Bargained Agreements (CBA) ratified prior to date of enactment to remain exempt from the Health Care Reform changes specified in Subtitle A (Sections 2711-2719). CBAs will be required to comply with all others. Please refer to our chart regarding Section 2711-2719. In the event that the plan applies to multiple CBAs, the changes will not apply to the plan until the last CBA expires. Again, without regulations, we only can assume that the changes would apply as of the plan years beginning on or after the expiration of the CBA (or final CBA) or tax years beginning on or after expiration as applicable under the law.

Action Plan

1. Consult with your employee benefits professional on the timing of the changes you must comply with at this time.
2. Avoid making substantive plan changes without determining their effect on your exemption and the cost/benefit ratio resulting from the change. Mandates such as the applicability of discrimination testing or inclusion of expansive preventive care benefits do have an economic component.
3. Wait for regulations!

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