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Employee Benefits Briefing

Health Care Reform Passed by the U.S. House of Representatives—Future Unknown

On November 7, 2009, the U.S. House of Representatives passed its version of health care reform, known as the Affordable HealthCare for America Act (H.R. 3962). As the media has noted, this House vote is merely one step for legislation that may or may not ever be enacted. Similar legislation is pending in the U.S. Senate, and debate is expected to begin on the Senate's version in the near future. Any legislation that passes the Senate will then need to be reconciled with what the House passed, and then ultimately passed by both chambers and signed by the President before becoming law.

The primary provisions of the House-passed legislation (insurance exchanges, employer mandates, individual mandates) take effect on January 1, 2013. Prior to that date, employers will be subject to certain restrictions that are designed to lay the groundwork for the full program in 2013.

Although what passed the House may bear little resemblance to what (if anything) ultimately becomes law, the elements of this legislation, and their impact on employers, are worth noting. Below are charts showing the principal impact the House bill would have on employer-sponsored health plans.

INTERIM REQUIREMENTS	
Extended COBRA Coverage (Immediate)	Individuals who are receiving COBRA coverage as of the date of enactment may continue on COBRA until the Health Insurance Exchanges contemplated by the legislation are functioning (expected to be 2013). Normal COBRA termination events apply (e.g., coverage under another group health plan). However, the maximum period of coverage (18, 29 or 36 months) would not apply until after the insurance exchanges are functioning.
Maintaining the Status Quo for Retiree Medical Benefits (Immediate)	Retiree medical benefits may not be reduced or eliminated after an employee retires unless the same reduction or elimination of benefits also applies to active employees. A reduction occurs when the retiree's share of the premium increases by more than 5% or when there is a greater than 5% reduction in the actuarial value of the benefits package. This provision does not prohibit a plan from enforcing an aggregate cap on benefits in effect at the time of retirement. An employer may seek a waiver of these requirements if the employer can reasonably demonstrate to the Secretary of Labor that meeting these requirements would impose an undue hardship on the employer.

INTERIM REQUIREMENTS	
Retiree Reinsurance Program (within 90 days after enactment)	The Secretary of Health and Human Services will establish a reinsurance program for sponsors of retiree medical programs covering retirees who are 55 or older and not yet eligible for Medicare. An employer participating in the reinsurance program may be eligible to be reimbursed for up to 80% of expenses incurred on a medical claim between $15,000 and $90,000. The employer may use these reimbursements only to reduce costs of the medical program or to reduce premiums. The legislative language regarding this program is very broad and leaves many of the details to be developed.
Extension of Coverage for Uninsured Young Adults (2010)	Eligible children who (but for age) would be treated as a dependent child of the participant, and who are not otherwise covered under a group medical plan, would be able to remain enrolled on their parent's plan through age 26.
Tax-free medical coverage extended to non-dependent children and to domestic partners (2010)	Medical coverage for children who are eligible for benefits under the plan, but who are not dependents under the Code (such as uninsured young adults) and for domestic partners who are not dependents under the Code, will no longer result in imputed income to the employee. Medical expenses incurred by such individuals may be reimbursed tax-free from flexible spending arrangements (FSAs) and healthcare reimbursement arrangements (HRAs).
Coverage for Congenital or Developmental Deformities (2010)	Plans would be required to cover a minor child's (i.e., a child who is 21 or younger) congenital or developmental deformity, disease or injury. Plans would be required to provide annual notices of these provisions.
No Lifetime Limits (2010)	Plans would be prohibited from imposing lifetime dollar limits on benefits.
Restricted Pre-Existing Condition Exclusions (2010)	The period for reviewing pre-existing conditions would be reduced from 6 months to 30 days. Plans may not, on the basis of domestic violence, impose any pre-existing condition limitation.
Wellness Program Grants (July 1, 2010)	Small employers (to be defined) may be eligible for up to $50,000 in grants to offset up to 50% of the costs incurred in a qualified wellness program.
Insurance Rebates (2010)	If health insurers have a medical loss ratio (generally the ratio of premiums to medical bills paid) below a threshold set by the Secretary of HHS (but not below 85%), the insurer will be required to provide rebates as determined by the Secretary of HHS.
Increases in Health Insurance Premiums (2010)	Health insurers would have to submit justification to the Secretary of HHS for any increases in insurance premiums. This provision does not apply to self-funded medical plans.
Increase in Penalty for Non-Qualified Distributions from HSAs (2011)	The excise tax imposed on non-qualified distributions from HSAs (i.e., distributions used for non-medical purposes before age 65 or disability) is increased from 10% to 20%.

Once the new program is implemented in 2013, the following requirements will apply:

<table>
<tr><th colspan="2">2013 REQUIREMENTS</th></tr>
<tr><td>Individual Mandate</td><td>An individual who does not maintain acceptable medical coverage may be subject to a tax of up to 2.5% of his/her adjusted gross income.

The legislation contains hardship exceptions and subsidies to assist individuals in satisfying this mandate.</td></tr>
<tr><td>Employer Mandate</td><td>An employer must either (i) offer individual and family coverage under a Qualified Health Benefits Plan (QHBP) or (ii) if its aggregate annual wages exceed $750,000, pay an excise tax of 8% of its payroll to the Health Choices Commissioner.

This excise tax is scaled for employers with aggregate annual wages of $750,000 and below:

<table><tr><th>Payroll</th><th>Percentage</th></tr><tr><td>$500,000 or less</td><td>0%</td></tr><tr><td>> $500,000 to $585,000</td><td>2%</td></tr><tr><td>> $585,000 to $670,000</td><td>4%</td></tr><tr><td>> $670,000 to $750,000</td><td>6%</td></tr></table></td></tr>
<tr><td>Qualified Health Benefits Plan</td><td>A plan that provides the “Essential Benefits Package.”
✦ Covers benefits defined in the statute (general benefits categories appear to be similar to benefits covered by typical employer plans).
✦ Limits cost sharing (deductibility and coinsurance):
■ $5,000 individual annual maximum.
■ $10,000 family annual maximum.
✦ Includes no cost sharing for certain preventative services.
✦ The essential benefits package will be designed to cover approximately 70% of an average individual’s medical costs.</td></tr>
<tr><td>5-Year Grandfather for Health Plans as of December 31, 2012</td><td>Health plans in effect on December 31, 2012 would be grandfathered for 5 years (i.e., until 2018), at which point the health plan would be required to qualify as a QHBP.</td></tr>
<tr><td>Employer Subsidy</td><td>Employee-only Coverage: Employers would be required to contribute at least 72.5% of the lowest-cost QHBP.

Family Coverage: Employers would be required to contribute at least 65% of the lowest-cost QHBP

Part-Time Employees: The Employer subsidy (for either Employee-only or Family coverage) would be prorated based on the level of the employee’s work.

Employee salary reductions do not count as part of the employer subsidy.</td></tr>
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2013 REQUIREMENTS	
Automatic Enrollment in Coverage	Employees would be automatically enrolled in their employer's coverage with the lowest associated employee premium unless the employee elected a different plan or opted out of employer coverage. Employers would be required to provide employees with written notice detailing the employee's rights and obligations relating to automatic enrollment.
Excise Tax for Failure to Provide Coverage	If an employer elects to provide health coverage but fails to do so, the employer will be subject to a tax of up to $100 per day for each employee to whom the failure applied. This excise tax does not apply if the employer elects not to provide coverage and elects to pay the payroll-based excise tax described above.
No Pre-Existing Condition Exclusions	Plans may not impose any pre-existing condition limitations or exclusions.
Employer Substantiation Requirements	Employers would be required to provide substantiation with respect to the following: ✦ Certification as to whether the employer offered its full-time employees (and dependents) enrollment in a QHBP or current employer-based plan. ✦ Monthly premiums for the lowest-cost plan. ✦ Name, address and other information of each full-time employee enrolled in the plan. ✦ Other information as required.
Limits on Medical FSAs	Employees may contribute only up to $2,500 to a medical FSA each year. This limit may increase in $50 increments based on cost-of-living increases beginning in 2014.

We will continue to monitor developments in the Senate and elsewhere. If you have any questions regarding this Bulletin, please contact **Philip L. Mowery** (312-609-7642), **Paul F. Russell** (312-609-7740) or any Vedder Price attorney with whom you currently work.

VEDDERPRICE®

222 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60601
312-609-7500 FAX: 312-609-5005

1633 BROADWAY, 47th FLOOR
NEW YORK, NEW YORK 10019
212-407-7700 FAX: 212-407-7799

875 15th STREET NW, SUITE 725
WASHINGTON, D.C. 20005
202-312-3320 FAX: 202-312-3322

www.vedderprice.com

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Employee Benefits Group Members

Mark I. Bogart	312-609-7878
Sara Stewart Champion	212-407-7785
Michael G. Cleveland	312-609-7860
Christopher T. Collins	312-609-7706
Megan J. Crowhurst	312-609-7622
Thomas P. Desmond	312-609-7647
John H. Eickemeyer	212-407-7760
Thomas G. Hancuch	312-609-7824
Jonathan E. Hyun	312-609-7791
John J. Jacobsen, Jr.	312-609-7680
Michael C. Joyce	312-609-7627
Neal I. Korval	212-407-7780
Philip L. Mowery *(Practice Leader)*	312-609-7642
Stewart Reifler	212-407-7742
Paul F. Russell	312-609-7740
Robert F. Simon	312-609-7550
Patrick W. Spangler	312-609-7797
Kelly A. Starr	312-609-7768
Lawrence L. Summers	312-609-7750
Jessica L. Winski	312-609-7678
Charles B. Wolf	312-609-7888

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