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January 2010

Employee Benefits Briefing

THE SENATE'S TURN AT SHAPING HEALTH CARE REFORM—RECONCILIATION AWAITS

On December 24, 2009, the United States Senate passed its version of Health Care Reform, known as the Patient Protection and Affordable Care Act (H.R. 3590). Presently, the House and Senate Democratic leaderships are negotiating a compromise version of Health Care Reform with an articulated goal of achieving final passage by Congress by the end of January or early February (in time for President Obama's yet-to-be-scheduled State of the Union address).

Vedder Price previously published a summary of provisions of the version passed by the House of Representatives (see EMPLOYEE BENEFITS BRIEFING, November 2009, *http://www.vedderprice.com/benefits1109/*).

The House and Senate bills have the same broad structure, with both creating insurance exchanges, individual mandates and employer play-or-pay obligations. Both bills also generally place limits on pre-existing condition clauses, lifetime or annual caps on benefits and cost sharing for preventative care, and both bills seek to expand eligibility for family coverage to certain young adults. That said, the bills contain significant differences regarding financing, governmental subsidies and the general role of the Federal government in providing medical coverage.

The primary provisions of the Senate-passed legislation (insurance exchanges, employer obligations, individual mandates) take effect on January 1, 2014 (one year later than the House provisions). Prior to that date, employers will be subject to certain requirements that are designed to lay the groundwork for the full program in 2014. Also, one of the primary revenue provisions of the Senate bill (the excise tax on so-called Cadillac plans) takes effect beginning in 2013.

Although what passed the Senate is expected to form the basis for the ultimate legislation, many of the details described below may change as part of the reconciliation process. This briefing focuses on the principal impact the Senate bill would have on employer-sponsored health plans.

Upcoming Webinar

Vedder Price attorneys have been closely monitoring the progress of the Health Care Reform legislation and are uniquely positioned to assist employers in unraveling these ensuing reforms. If a reconciled Health Care Reform bill ultimately passes Congress and is signed by President Obama, Vedder Price will hold a subsequent webinar to address the immediate and continuing impact of this legislation on our employer clients. These new developments will present both obstacles and opportunities. We will offer practical advice on ways in which employers can best position themselves for future success.

Interim Requirements

Between the date of enactment and 2014, the Senate bill envisions a series of interim requirements that will take effect. Some of these provisions are intended to preserve existing benefits. Others are intended to limit adverse actions in advance of final reforms. These interim requirements are summarized in the following chart:

INTERIM REQUIREMENTS	
Permitted Grandfathering of Existing Coverage (Immediate)	A plan may provide that individuals who are covered by the plan on the date the Act becomes law can continue coverage under the plan generally without regard to the requirements of the Act. Family members may enroll in the grandfathered plan in the future if family coverage was permitted under the the terms of the plan as in effect on the date of enactment. New employees may join the grandfathered plan in the future if the plan permitted new employees to join on the date of enactment. Plans in effect pursuant to a collective bargaining agreement will remain in effect until the collective bargaining agreement expires.
Reinsurance for Early Retirees (Within 90 days of Enactment)	The Department of Health and Human Services (HHS) 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. Payments received by employers under the program are not considered taxable income, but must be used to reduce costs under the plan. The program will end on January 1, 2014. *Note*: As with the House bill, the legislative language regarding this program is very broad and leaves many of the details to be developed.
Lifetime and Annual Limits (2011)	No lifetime limits. No unreasonable annual limits. Prior to 2014, plans may only establish a restricted annual limit (to be determined by HHS) on the dollar value of benefits with respect to the scope of benefits that are essential health benefits under the Act. To the extent that a plan offers benefits over and above those that are considered essential health benefits under the Act, the plan may impose otherwise permissible annual or lifetime limits on benefits.
No Rescission of Coverage (2011)	Plans cannot rescind coverage unless the participant or beneficiary has engaged in fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan.
Coverage for Preventative Care (2011)	Plans must cover the following services without cost sharing: ✦ Preventative services with an “A” or “B” rating from the United States Preventative Services Task Force. ✦ Immunizations. ✦ Preventative care and screenings for infants, children and adolescents. ✦ Additional preventative care for women (*Note*: The legislation would negate the November 2009 recommendation regarding mammograms for women in their ‘40s). If the Preventative Services Task Force makes a recommendation regarding preventative services, there must be at least a one-plan year interval between the recommendation and its required application under the plan.

INTERIM REQUIREMENTS	
Coverage for Emergency Services (2011)	Participants may use emergency room services without the need for prior authorization. In addition, plans may not impose any additional co-payment or coinsurance requirements if the emergency facility is not part of the plan's network.
Dependent Coverage (2011)	Unmarried adult children can continue to be covered until they turn 26. Children of children are not required to be covered. Tax definition of dependents is *not* changed. *Note*: The House bill would change the tax definition to make such coverage tax free (other than FSA reimbursements).
Uniform Summary of Benefits (2011)	Standards for providing summaries of benefits and coverage explanation to be developed within one year of enactment: ✦ Uniform format. ✦ Uniform definitions of insurance and medical terms. ✦ Description of coverage (including cost sharing). ✦ Description of exceptions, reductions and limitations of coverage. ✦ Statement about whether the plan provides minimum essential coverage, and whether the plan covers at least 60% of the cost of coverage. Summary to be provided to participants within two years after the Act becomes law. Material modifications to plan benefits are to be provided at least 60 days *before* they become effective.
Expanded Non-Discrimination Rules (2011)	Insured plans may not discriminate in favor of higher-waged employees. The non-discrimination concepts in Code Section 105(h) relating to self-insured plans would be expanded to apply to insured plans.
Expanded Appeals Process (2011)	Plans must provide for appropriate appeals processes. The ERISA claims procedures will be the initial claims procedure under this provision for employer-sponsored plans. However, plans are required to establish an effective external review process. Notice of available internal and external appeals processes and the availability of any applicable office of health insurance consumer assistance or ombudsman assistance under the Act must be provided to enrollees in a culturally and linguistically appropriate manner. Enrollees must be permitted to receive continued coverage pending the outcome of the appeals process.
Limits on Medical FSAs (2011)	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 2012. Over-the-counter drugs could not be reimbursed under FSAs.
Increase in Penalty for Non-Qualified Distributions from HSAs and Archer MSAs (2011)	The excise tax imposed on non-qualified distributions from HSAs and Archer MSAs (i.e., distributions used for non-medical purposes before age 65 or disability) is increased to 20%.

INTERIM REQUIREMENTS	
Reporting Cost of Employer-Sponsored Coverage on W-2s (2011)	The aggregate cost of applicable employer-sponsored coverage will be provided annually on the participant's Form W-2.

2014 Requirements

Once the Senate provisions are fully implemented (which is generally 2014), the following requirements will apply:

2014 REQUIREMENTS	
Individual Responsibility	Individuals will be required to maintain insurance. Individuals who do not maintain coverage will be required to pay a penalty equal to the greater of $750 or 2% of the individual's income. Families that do not maintain coverage will be required to pay a penalty equal to the greater of $750 for each non-covered family member (capped at $2,250) or 2% of the family's income. The legislation contains phase-ins for the penalty for 2014 and 2015. It also provides for waivers and subsidies for individuals with lower incomes.
Employer Responsibility	If a "large employer" (defined below) fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an employer-sponsored plan (with at least 60% of the cost of benefits covered under the plan), and *any* full-time employee enrolls for government-subsidized health care through an Exchange, the employer is charged a monthly fee of $62.50 ($750 on an annualized basis) for *each* full-time employee (not just for the employee(s) who receive the governmental subsidy). If a large employer imposes more than a 30-day waiting period, but not more than a 60-day waiting period, it will be assessed $400 per full-time employee to whom the waiting period applies. If a large employer imposes a waiting period that exceeds 60 days, it will be assessed $600 per full-time employee to whom the waiting period applies. A large employer is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. An employer will not be considered to employ more than 50 full-time employees if the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year.
Waiting Periods	Plans may not impose waiting periods that exceed 90 days.
No Pre-Existing Conditions	Plans may not impose any pre-existing condition exclusions.

2014 REQUIREMENTS	
No Health Status Discrimination	Plans may not impose coverage rules based on any health status related factor. *Note*: Not clear how (or if) this requirement differs from the existing HIPAA non-discrimination rules.
Wellness Programs	The wellness program provisions of the Senate bill are similar to those contained in current regulations. Wellness programs that do not depend on health status factors: ✦ Program must be made available to all similarly situated individuals. ✦ Can reimburse all or a part of the cost for membership in a fitness center. ✦ Diagnostic testing program that provides rewards for participation, not outcomes. ✦ Encourages preventative care related to a health condition. ✦ Reimbursements for costs of smoking cessation programs regardless of outcomes. ✦ Rewards for attending periodic health education seminars. Wellness programs that depend on health factors:· ✦ Reward cannot exceed 30% of the cost of employee-only coverage if the employee is the only individual eligible to participate. ✦ If the program is made available to covered dependents, reward cannot exceed 30% of the cost of the coverage in which the dependent participates. ✦ Administrative agencies may increase the reward to up to 50% of the cost of coverage as they determine to be appropriate. ✦ Wellness program must have a reasonable chance of improving the health of, or preventing disease in, participating individuals and is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease. ✦ Must allow the opportunity to qualify for the reward at least once each year. ✦ Must provide a reasonable alternative standard if it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the regular standard. Wellness programs currently in existence under existing regulations may continue to follow those regulations as long as those regulations remain in effect.
Automatic Enrollment	Employers with more than 200 full-time employees who maintain health plans are required to automatically enroll new full-time employees in a plan and continue current enrollees in their existing plans.

2014 REQUIREMENTS	
Employee Notice (2013)	Even though the Senate provisions do not become fully effective until 2014, current employees must be notified by March 1, 2013 of the following: ✦ Informing the employee about the health insurance Exchange available in his/her area. ✦ If the plan's share of the costs of benefits is less than 60%, the employee may be eligible for premium credits and cost-share reductions. ✦ If the employee purchases coverage through an Exchange and the employer is providing minimum essential coverage, the employee will lose the benefit of the employer subsidy under the plan. Beginning March 1, 2013, new employees will be required to receive this notice as part of their new-hire materials.

Revenue Provisions

The Senate bill contains numerous revenue provisions, some affecting individuals, others affecting medical device manufacturers, others affecting services (e.g., indoor sun tanning). The following chart summarizes revenue provisions that will have a direct impact on employers:

EMPLOYER RELATED REVENUE PROVISIONS	
Excise Tax on Cadillac Plans (2013)	Beginning in 2013, a 40% excise tax will be imposed on the value of medical coverage above $8,500 for single participants and $23,000 for family coverage. Insurers will be responsible for paying the excise tax on insured plans. Employers will be responsible for paying the excise tax on self-insured plans. For eligible retirees who have attained age 55, the excise tax threshold in 2013 will be increased to $9,850 for single participants and $28,000 for family coverage. The $8,500/$23,000 limitations are increased for employees in certain high-risk professions (e.g., law enforcement, fire protection, emergency medical care, construction, mining, agriculture, forestry and fishing) and for participants in the 17 highest-cost states as determined by HHS. Beginning in 2014, the dollar limits will be increased by the medical cost of living adjustments provided for under the Act. The medical coverage being measured is the coverage that is excludable from the employee's gross income, and is determined without regard to whether the employer or employee is paying for the coverage. The value of the coverage is to be determined in a manner similar to how COBRA premiums are determined.

EMPLOYER RELATED REVENUE PROVISIONS	
Per Head Fee (2012)	Both insured plans and self-insured plans will be charged a $2 fee for each plan year ending after September 30, 2012 ($1 for plan years ending during fiscal year 2013) times the average number of covered lives under the plan. Beginning in 2014, this per-head charge will be increased by the percentage increase in health care spending. The per-head charge will not apply to plan years ending after September 30, 2019. These fees will be used to fund a "Patient-Centered Outcomes Research Trust Fund."

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The Employee Benefits Group

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