JONES WALKER

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EMPLOYEE BENEFITS, ERISA & EXECUTIVE COMPENSATION

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HEALTH CARE REFORM IS NOW LAW: WILL THE LIGHT COME ON WHEN YOUR EMPLOYEES OPEN THE FRIDGE?

On March 30, 2010, the President signed the Health Care and Education Reconciliation Act of 2010 into law (the "Reconciliation Act"). The Patient Protection and Affordable Care Act, commonly referred to as the Senate bill, was signed a week earlier. The Reconciliation Act made changes to the Senate bill necessary to achieve passage in the House while avoiding a Senate filibuster, enabling the enactment of comprehensive health care reform. The combined acts are referred to in this E*Bulletin as the "Act".

Not surprisingly, the Act is complicated. Perhaps acknowledging this, a prominent member of Congress remarked that health care reform is ". . . like the back of the refrigerator. You see all these wires and the rest . . . All you need to know is, you open the door. The light goes on."

Employers will play an important role in making sure the light goes on, and now is the time for HR and benefits personnel to start getting familiar with the many changes that will impact employer-provided coverage. Some employees are apparently already opening the door, as health insurers and HR departments are reporting calls asking about free or subsidized coverage. While some changes do not take place until the end of the decade, others are effective this year.

This E*Bulletin provides a timeline for major changes affecting employers. Future E*Bulletins will focus on specific issues, such as impacts specific to small and large employers, individuals, grandfathered plans, retiree coverage, taxes and tax credits, penalties for noncompliance, what constitutes an essential benefits package, and others. For further information and updates, consult our Health Care Reform Resource Center. New information will be posted to the Resource Center as guidance is released, so please check back frequently.

Key changes affecting employers are listed below, in order of effective date. Unless otherwise noted, the changes apply to both grandfathered and non-grandfathered health plans. Exactly what is a "grandfathered health plan" is expected to be defined in the future by regulations, though it is known that plans that were not in existence as of March 23, 2010, will not be grandfathered. It is unclear what will cause a plan to lose grandfathered status.

Effective Date Not Specified

Automatic Enrollment: employers with more than 200 full-time employees must automatically enroll new full-time employees in health coverage and continue the enrollment of current employees, though employees may opt out. The Act does not provide a specific effective date for this provision, and the effective date is likely to be set by regulation. Employers should watch for additional guidance.

2010

Participant Communications: employers must communicate material health plan changes to participants 60 days in advance of the effective date of such changes (rather than 60 days after the change is effective under current law). This may impact the timing of distribution of open enrollment materials, if employers wish to avoid multiple year-end

communications. The change applies to plan years beginning on or after September 23, 2010. Thus, if a calendar year plan has material changes that are effective January 1, 2011, it appears that such changes must be communicated to participants by November 1, 2010.

Early Retiree Reinsurance: by June 23, 2010, the government will have established a program to provide a subsidy to employers who provide health coverage to retirees age 55–64 (and eligible spouses, surviving spouses, and dependents of such retirees), in the amount of 80% of the cost of claims that are between $15,000–$90,000, for each such individual. Subsidies must be used to lower costs of the plan. The Act allocates $5 billion to pay for such subsidies, which expire as of the earlier of when the funding runs out or January 1, 2014 (the former is likely to be the case). In light of the limited funding, employers who provide health coverage to early retirees should stay alert for guidance regarding how to apply for the subsidy.

Tax Credits for Small Employers: employers with fewer than 25 full-time equivalent employees who provide health coverage to their employees will be eligible for tax credits to help pay the cost of such coverage, provided certain requirements are met (*e.g.*, average salary less than $50,000).

High-Risk Pool: the Act requires the establishment of a temporary national high-risk pool by June 23, 2010, designed to enable those with preexisting conditions and other risk factors to have guaranteed access to coverage until January 1, 2014. However, to be eligible, individuals must have gone without health insurance coverage for at least six months prior to applying for the high-risk pool, and must have a pre-existing condition (to be determined in accordance with regulations to be issued). Insurers and group health plans are subject to penalties if they are found to have "encouraged" an individual to drop the insurer's or employer's coverage prior to enrolling in the high-risk pool (including but not limited to the use of financial inducements). The Act allocates $5 billion to pay for the claims and administrative costs of the high-risk pool over the next four years.

Plan Years Beginning on or after September 23, 2010 (January 1, 2011, for Calendar-Year Plans)

Annual Caps: annual caps on the dollar value of "essential health benefits" (to be defined in regulations) must not exceed amounts that will be established via regulations. Such limits must be removed for the first plan year beginning on or after January 1, 2014. Annual caps may be imposed on specific covered benefits that are not essential health benefits, both before and after 2014.

Lifetime Caps: prohibited, although lifetime caps may be imposed on specific covered benefits that are not essential health benefits.

Dependents: children may remain covered under a parent's policy until the child attains age 26. Before January 1, 2014, grandfathered plans are not required to provide this coverage with respect to dependents who are eligible to enroll in another employer-sponsored health plan. The definition of "dependent" for this purpose will be defined by regulation. Plans have the option to allow children to remain on a parent's group health plan through the end of the calendar year in which the child attains age 26, and in such case the parent will not be deemed to have taxable income with respect to such coverage.

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Preventive care: must be provided to participants at no charge (*i.e.* no copays or deductibles) (applicable only to non-grandfathered plans).

Emergency Care: must cover out-of-network emergency providers at same cost to participant as in-network providers (applicable only to non-grandfathered plans)

Pre-existing Condition Exclusions: no longer applicable to children under age 19 (a glitch in the language of the Act would have resulted in this provision not taking effect until 2014, but the administration will clarify through regulations that the effective date is plan years beginning on or after September 23, 2010, and representatives of the insurance industry have indicated that they will not challenge the effective date).

Prohibition of Discrimination Based on Salary: all plans become subject to rules that currently only prohibit self-insured plans from discriminating in favor of highly compensated individuals (applicable only to non-grandfathered plans).

2011

W-2 Changes: employers must report the value of health care coverage provided to employees and dependents on W-2s issued in 2012 (for 2011 wages).

Health Flexible Spending Arrangements (Health FSAs), Health Spending Accounts (HSAs) and Archer MSAs: over-the-counter medications no longer qualify for reimbursement, unless the medication is for insulin or is a prescribed drug (regardless of whether the medicine or drug is available without a prescription).

HSAs and Archer MSAs: income tax penalty on withdrawals for purposes other than medical care increases to 20%.

Medical Loss Ratios: insurance companies required to spend at least 80% of premiums on medical claims (in the case of small groups) or 85% (in the case of large groups) or provide a rebate to participants if they fail to meet this requirement. States may increase these percentages by regulation, and the Secretary of the Department of Health and Human Services has the discretion to adjust these percentages to account for volatility in the market caused by the establishment of the State Exchanges.

2012

Explanation of Coverage: effective March 23, 2012, health plans must distribute a standardized explanation of coverage document, the content and style of which will be set forth in regulations (among other requirements, the Act mandates that the explanation cannot be longer than four pages, no smaller than 12-point font, and must describe coverage in a "culturally and linguistically appropriate manner").

2013

Health FSAs: annual contributions capped at $2,500 (indexed for inflation).

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2014

Annual Caps: annual caps on essential health benefits prohibited altogether (as noted above, restricted caps established by regulation will apply for plan years beginning prior to January 1, 2014). Lifetime and annual caps may continue to be imposed on specific covered benefits that are not essential health benefits.

Waiting Periods: health plan eligibility waiting period cannot exceed 90 days.

Individual Mandate: requirement for individuals to obtain health insurance begins, with penalty for noncompliance phased in starting at the greater of $95 or 1.0% of income in 2014, increasing to the greater of $695 (indexed for inflation) or 2.5% of income in 2016.

Employer Coverage Requirements: employers with at least 50 employees (including part-time employees as a fraction of an employee based on their hours) may be subject to an excise tax if one or more of their employees satisfies the requirements for government-subsidized coverage through a health insurance exchange. If the employer does not offer coverage to all full-time employees, the tax is $2,000 per year (computed on a monthly basis and indexed for inflation), per full-time employee (not applicable to first 30 full-time employees), regardless of the number of employees qualifying for subsidized coverage. If the employer offers essential health benefits coverage to all full-time employees but the employer pays less than 60% of the actuarial value of the costs of benefits provided under the plan and the employee qualifies for government-subsidized coverage (see discussion of subsidies in next paragraph), the tax is $3,000 per year (computed on a monthly basis and indexed for inflation) per full-time employee receiving subsidized coverage. The tax imposed on an employer offering coverage is capped at the tax that the employer would have paid if the employer did not offer coverage. Multiple businesses are treated as a single employer if they would be so treated for purposes of the retirement plan rules of the Internal Revenue Code.

"Free Choice" Vouchers: employers that provide health coverage to employees and pay any portion of the cost may be required to provide vouchers to employees who decline coverage. The voucher could be used by the employee to help pay for coverage through a health insurance exchange, and would be worth the maximum amount the employer would have contributed towards the cost of coverage for the employee and his or her dependents, had the employee elected coverage. A voucher will be required if: (1) the employee's household income does not exceed 400% of the federal poverty level for the size of the employee's family (for illustration purposes, this amount is $88,200 for a family of 4 in 2010), and (2) the employee's portion of premiums under the employer's health plan would be between 8% and 9.8% of the employee's household income (federal subsidies are available to individuals whose share of premiums exceed 9.5% of household income, and it is expected that the employer voucher requirement will likewise be revised so that it does not apply above 9.5% of income, to remove this discrepancy).

Employer Reporting to IRS: employers with 50 or more full-time employees and employers who are required to provide free choice vouchers (described above) will have to report certain information to the IRS, including the following: (1) certification as to whether the employer offers minimum essential coverage to its full-time employees and their dependents; (2) the length of any waiting period; (3) the premium amount for the lowest-cost option; (4) the employer's share of the cost of benefits; (5) the number of full-time employees for each month of the year; (6) the name, address and

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tax ID number for each full-time employee and the months during which such employee and any dependents received coverage during the year; and (7) such other information as the Treasury Secretary may require.

Wellness Incentives: the maximum allowable premium discount, rebate or reward for participation in certain wellness programs increases from 20% to 30% of the cost of coverage. The discount may be further increased to 50% by regulation.

Pre-existing Condition Exclusions: prohibited.

Cost-Sharing: health plan out-of-pocket maximums cannot exceed high deductible health plan out-of-pocket limits (currently $5,950 for individual coverage and $11,900 for family coverage) (applicable only to non-grandfathered plans).

2018

"Cadillac Tax": health insurers (and self-insured employers) subject to a non-deductible tax equal to 40% of the amount by which the cost of the plan exceeds $10,200 for individual coverage and $27,500 for family coverage (these thresholds will increase if the cost of health insurance coverage increases more than the government projects between 2010 and 2018).

For additional information and questions regarding these issues, please contact one of the members of our Employee Benefits, ERISA & Executive Compensation practice group listed below or your Jones Walker relationship attorney.

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Remember that these legal principles may change and vary widely in their application to specific factual circumstances. You should consult with counsel about your individual circumstances. For further information regarding these issues, contact:

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