Hill Ward Henderson

Attorneys at Law

ERISA Group Benefits Alert

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MASSIVE HEALTH CARE REFORM WILL HAVE IMPACT ON EMPLOYERS FOR YEARS TO COME

The Patient Protection and Affordable Care Act together with the Health Care and Education Tax Credits Reconciliation Act (collectively, the "Act"), which were signed into law by President Obama in March 2010, make sweeping changes to the U.S. healthcare system. Although many of the intricacies of the law will need to be more fully explained by regulation or other guidance, the major changes that impact employee benefit plans are outlined below.

CHANGES THAT ARE EFFECTIVE IN 2010 AND 2011

Small Employer Tax Credit. Eligible small employers can receive a tax credit based upon their contributions to purchase employee health insurance starting in calendar year 2010, provided they contribute at least 50% of the cost. For this purpose, a small employer can have no more than 25 full-time equivalent employees with average annual wages of no more than $50,000. The maximum credit equals 35% of employer paid premiums in 2010 through 2013, and increase to 50% in 2014. The amount of credit is phased out for employers with more than 10 employees or average annual wages of no more than $25,000. The credit can be claimed for six years, and excess credits can be carried forward. The normal business deductions for employer premiums must be reduced when the credit is claimed, reducing its value to many employers. Small non-profit employers can benefit from a reduced tax credit.

Auto Enrollment for Large Employers. The Act requires that employers with more than 200 full-time employees provide for automatic enrollment of employees into their health plan.

Dependent Coverage. Health plans are no longer able to exclude pre-existing medical conditions from coverage for children under the age of 19. In addition, for plan years beginning on or after September 23, 2010, all health plans will be required to allow adult children (even if married) to remain on a parent's health plan until their 26th birthday. However, until 2014, coverage does not have to be provided if a child has coverage available, whether enrolled or not, through his or her job.

State High Risk Pool. The Act requires states to set up high risk pools for individuals who have preexisting conditions and have been without coverage for six months. Employers who encourage individuals to disenroll in their plans and join high risk pools must reimburse the pools for expenses.

Early Retiree Reinsurance. The Act establishes a $5 billion reinsurance fund to help employers with the cost of certain early retiree medical claims for retirees age 55 through 64. Beginning June 23, 2010 through December 31, 2013 (or until the funds are exhausted), the Act provides

that employers will be reinsured for 80% of their annual claims between $15,000 and $90,000.

Taxation of Retiree Drug Subsidy. In 2013, the Act eliminates the income tax deduction that has been available to employers that receive a federal subsidy for offering retiree prescription drug benefits. More immediately, the accounting rules require recognition in 2010 of the change in tax treatment in an employer's financial statements.

Limits on Coverage and Rescission. Effective for the first plan year beginning after September 23, 2010, the Act prohibits lifetime limits and annual limits on the value of "essential" benefits. However, for plan years beginning before January 1, 2014, the Act allows a plan to establish a restricted annual limit on essential benefits, and allows annual or lifetime limits on "non-essential" benefits. Moreover, the Act prohibits the rescission of coverage once an individual is covered under the plan except in cases of fraud or intentional misrepresentation.

New Plan Rules and Grandfathered Plans. The Act provides that certain of its provisions do not apply to grandfathered plans (generally a group health plan or health insurance coverage that existed prior to March 23, 2010). Unfortunately, until further guidance is issued, it is not clear what exactly is required to maintain a "grandfathered plan." Grandfathered plans are not required to comply with the following provisions, which are generally applicable to most plans the first plan year after September 23, 2010, although new plans and nongrandfathered plans will be required to comply.

- Nondiscrimination. Fully insured plans sponsored by employers will generally be required to satisfy the nondiscrimination rules that currently apply only to self-funded plans.
- First dollar coverage must be provided for certain preventative care, including well child care and certain immunizations.
- Covered individuals under a group health plan must be allowed to select any available participating primary care provider.
- No preauthorization requirement or increased cost sharing may be imposed for emergency services, in or out of network, and no preauthorization or referral can be required for obstetrical or gynecological care.
- The appeals process for claims has been greatly expanded.

Nursing Mothers. Generally, employers with at least 50 employees must now provide "reasonable" unpaid break time for an employee to express breast milk for her nursing child for one year after birth.

Adoption Assistance. The Act extended adoption assistance another year, through 2011, and the permitted tax free employer contribution was increased by $1,000 to $13,170.

Class Act. The Act creates a new national voluntary employee-funded long-term care benefit known as the "Community Living Assistance Services and Support Act" (the "CLASS Act").

Health Care Rebate. Generally, group health plan insurance issuers will have to provide rebates to participants to the extent they expend more than 20% of premium revenue on non-claim costs.

SPENDING ACCOUNT AND CAFETERIA PLAN CHANGES. Several provisions in the Act impact various spending account plans and cafeteria plans for calendar year 2011 and beyond.

- Beginning January 1, 2011, the cost of over-the-counter medicine cannot be reimbursed through a health flexible spending account, (health FSA), health reimbursement accounts (HRA), health savings accounts (HSA) or Archer MSA.
- For 2011, a "simple" cafeteria plan can be adopted that would be exempt from the nondiscrimination tests applicable to cafeteria plans. Generally, an employer must have had fewer than 100 employees in the previous year to be eligible. Simple cafeteria plans will require an employer contribution.
- In 2011, the tax on HSA distributions that are made prior to age 65 and are not used for qualifying medical expenses, increases to 20%, from the current 10%.
- Beginning January 1, 2013, medical and dental expenses under a health FSA will be limited to $2,500. This cap in indexed to the CPI beginning in 2014.

CHANGES EFFECTIVE FOR LATER YEARS

State Health Benefit Exchanges. Effective in 2014, states must establish Exchanges through which individuals and small businesses (usually, 100 or fewer employees) may purchase health insurance. In 2017, states may allow larger employers to purchase coverage through Exchanges.

Individual Responsibility. Effective January 1, 2014, individuals not enrolled in qualifying coverage must pay a penalty. The penalty will not apply to individuals who cannot afford coverage because its cost will exceed 8% of household income, or who have only short gaps in coverage, or who have household incomes less than the threshold for filing a federal tax return. Individuals with household incomes ranging from 133% to 400% of the federal poverty level who acquire coverage may be eligible for a subsidy in the form of a tax credit or reduced costs for coverage purchased through an Exchange. Employers who offer "minimum essential coverage" through a group health plan and pay a portion of the costs are required to provide vouchers to certain lower paid employees who opt out of coverage. The vouchers can be used to purchase insurance through an Exchange.

Employer Mandate. Effective in 2014, large employers (for these purposes, generally those with 50 or more full-time employees) who do not offer affordable "minimum essential coverage" are subject to a monthly penalty if any full-time employee enrolls in an Exchange plan and qualifies for taxpayer subsidized coverage for the month. Health insurance issuers or group health plans that provide minimum essential coverage to an individual are required to report the coverage to the IRS, including any portion of the premium paid by the employer, and provide a statement to the individual. Also, effective March 1, 2013, employers must provide a notice informing employees of the Exchange and the potential rights of employers

with respect to the Exchange.

Notice Requirement. The Act requires the Department of Health and Human Services to develop uniform terms and formats for summaries of benefits for enrollees under a plan. These summaries must be provided within 24 months of enactment of a plan and to enrollees at the time of enrollment. Also, plans must provide 60 days' advance notice of a material modification, or face a $1,000 per participant penalty for each willful failure.

Revenue and Reporting Provisions. The Act is paid for by several different taxes and fees. It also establishes new reporting requirements.

- Beginning with the 2011 tax year, employers will be required to report the aggregate cost of each employee's employer sponsored coverage on Form W-2.
- Medicare Taxes. Beginning January 2013, an additional 0.9% Medicare tax is imposed on wages in excess of $250,000 for joint return filers, or $200,000 for other filers. The additional tax applies to the employee portion only. The Act also imposes a 3.8% tax on unearned income for joint return filers with modified AGI in excess of $250,000 or $200,000 for other taxpayers.
- Fees for Group Health Plans. Effective for years beginning after September 30, 2012, a fee will be assessed on insurers of insured plans and sponsors of self-insured plans in the amount of $1 per participant for the year ending in 2013 and $2 for each life covered under the plan for the year ending in 2014 (and indexed thereafter). These fees will not apply to plan years ending after September 30, 2019.
- Cadillac Plan Tax. Effective January 1, 2018, a 40% excise tax is imposed on "excessive" health coverage, defined as coverage where the costs exceed $10,200 for single coverage or $27,500 for family coverage. These amounts are adjusted over time. Employees who engage in certain high risk provisions are subject to a higher threshold.

Other Changes in 2014. The following provisions are generally applicable for plan years beginning on or after January 1, 2014.

- The prohibition on pre-existing condition exclusions is extended to all participants and beneficiaries under each group health plan.
- Group health plans are not permitted to impose a waiting period exceeding 90 days.
- Group health plans, other than grandfathered plans, must limit cost-sharing to the out-of-pocket maximum for high-deductible health plans.
- The maximum incentive amount under a wellness program is increased from 20% to 30% of the COBRA cost of coverage.

Please note that this *Benefits Alert* only highlights the most significant changes in the law. The details of

these changes are complex and beyond the scope of this Alert. We look forward to discussing these changes and how they may impact your plans with you. Please do not hesitate to contact any of the following members of our Employee Benefits and Executive Compensation Practice if you have any questions or if you would like additional information.


Al Ward
award@hwhlaw.com
813.222.8703


Dennis Tweed
dtweed@hwhlaw.com
813.222.8707


Bret Hamlin
bhamlin@hwhlaw.com
813.222.8717


Kirsten Vignec
kvignec@hwhlaw.com
813.222.8731


Melanie Hancock
mhancock@hwhlaw.com
813.222.8747


Mary Snyder
msnyder@hwhlaw.com
813.222.8709


Eric Hall
ehall@hwhlaw.com
813.227.8408

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