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APRIL 7, 2010 VOLUME 6, NUMBER 3

HEALTH REFORM: BAD FOR BUSINESS?

"[The new health reform legislation] is freighted with benefit mandates, new recordkeeping and reporting obligations, stultifying complexity, and, in all likelihood, substantial additional costs for employers in the near-term."

by
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Whatever one's philosophical view on health reform, its impact on mid-size and large employers will be costly and burdensome in the near and mid-term. The recently enacted Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (which we may refer to together by the acronym "PPACA"), is freighted with benefit mandates, new recordkeeping and reporting obligations, stultifying complexity, and, in all likelihood, substantial additional costs for employers in the near-term. In the long view, we think health reform will be in the best interest of the employer-community only if one of the following occurs: (1) the health care system shaped by the legislation reduces the rate at which health care costs increase, or (2) health reform ultimately leads to a succession of events that takes employers out of the business of providing health care for Americans.

To be clear, we are not commenting on the wisdom of this massive transformation of the American health care system. We are instead making only an observation about the prodigiously burdensome consequences of that reform for mid-size and large employers. For small employers, the picture is more complex, and, on whole, the result may be good. As we will explain more fully below, small employers are, under the legislation, generally those with either 50 or fewer, or 100 or fewer, employees (depending on the particular provision under consideration).

As seems appropriate given the scope and complexity of the new legislation, full implementation of the PPACA will take many years. There will be a great deal for employers and their advisors to do in each of the next many years, as various tranches of the legislation become effective. Given that a few of the new law's provisions are already effective, and many become effective either later this year or early in 2011, we will endeavor to address some of the rules with earlier effective dates toward the beginning of this newsletter, though we confess we are not attempting to tackle the topics in effective date order.

Just another word before we begin our discussion in earnest. The new legislation is truly massive in scope. The length of the bill matches the ambition of its goals. Note that the legislation was passed in two pieces, enacted within a week of one another. Taken together, the text of the two bills runs over 2,500 pages in length. Even then, many of the details, as well as the full meaning of some of the phrases and concepts introduced in the legislation, have been left to the appropriate regulatory agencies, such as the Department of Health and Human Services ("HHS") and the Treasury. This makes good sense, but we should all realize that it will likely be some time before those agencies will have an opportunity themselves to digest the law, give it thoughtful consideration, and issue regulations or other guidance. This is all by way of saying that there are many ambiguities and puzzlements in the legislation, so be forewarned that some

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of what we say may require revision as the government agencies, and perhaps later the courts, interpret the words of the law. It may also mean that some points in our explanation will seem to you ambiguous. Although that could well reflect a flaw in our writing, it will in some cases simply reflect inherent ambiguities found in certain provisions of the new law.

Given the number of topics we need to cover, it might be helpful to offer a preview of where we are headed, in the form of the following table of contents:

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Among the provisions with the earliest effective dates are new benefit mandates and other requirements for all group health plans. Generally, group health plans include plans that provide medical care to employees or their dependents and are subject to ERISA. Although governmental and church plans are generally not subject to ERISA, the group health plan requirements will have an effect on governmental and church plans (other than plans of the federal government) to the extent those plans are insured (as opposed to self-insured). That is because the new requirements apply not only to group health plans, but also to health insurance issuers, such as insurance companies and HMOs, offering group (or individual) health insurance coverage. So, an insurer offering coverage to a governmental or church plan will need to offer a product that complies with the new requirements. In addition, the rules apply directly to self-insured governmental plans (other than plans of the federal government), though apparently not to self-insured church plans.

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The new group health plan requirements generally apply for plan years beginning on or after September 23, 2010. There are, however, some exceptions, including a partial exception for "grandfathered plans." More on the grandfathered plan rules later. For calendar year plans, then, these new requirements will become effective January 1, 2011, unless a grandfathered plan provision (or some other exception) is effective to delay that starting date or exempt the plan from the requirements altogether.

So, what are the new requirements? We will list them below, in relatively cursory fashion. As with everything we cover in this newsletter, you can fairly assume there are some subtleties we will not explain. That makes it particularly important to take a careful and specific look at any issues of particular interest to you as you move forward.

A Note about Terminology: Although the new benefit mandates and restrictions generally apply both to group health plans and to insurance companies (and HMOs), in describing the rules we will typically refer simply to "plans." Unless we indicate otherwise, our reference to a "plan" or "plans" will typically be intended to include a reference to health insurance issuers, such as insurance companies and HMOs.

Group Market Reforms

The following provisions are effective for Plan Years Beginning on or After September 23, 2010, unless otherwise indicated:

No Lifetime or Annual Limits. A plan may not apply lifetime dollar limits on what are known as "essential health benefits." Essential health benefits are the types of benefits that must be included in health plans offered under the state insurance clearinghouses referred to in the new law as "exchanges." The Secretary of Health and Human Services ("HHS") will define what constitutes an essential health benefit, but that list is to include at least the following general categories (and the items and services covered within these categories):

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care.

The Secretary of HHS is to ensure that the scope of the list of essential health benefits is equal to the scope of benefits provided under a "typical" employer plan. To help in this effort, the Secretary of Labor is to conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on that survey to the Secretary of HHS.

In addition to the prohibition on lifetime dollar limits, a plan may not apply any annual dollar limits on essential health benefits for plan years beginning on or after January 1, 2014. For plan years beginning prior to January 2014, some restricted annual limits may apply to essential health benefits, if those limits would not violate other federal or state laws. The Secretary of HHS is supposed to issue regulations offering guidance on how these pre-2014 annual limits may be set.

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A plan may set lifetime or annual beneficiary limits on specific covered benefits that are not essential benefits (that is, not benefits required to be offered in health plans sold through the state exchanges). The details of how a plan may do so may remain a bit fuzzy until the Secretary of HHS issues guidance describing precisely what constitutes an "essential health benefit." Similarly, it will be unclear what "restricted annual limits" may be applied to essential health benefits prior to the 2014 plan year until the Secretary of HHS issues guidance. The legislation instructs the Secretary to define the term "restricted annual limit" in a way that ensures access to needed services will be made available with a "minimal impact" on premiums.

Prohibition on Rescissions of Coverage. A plan must not rescind coverage once a participant has become covered, unless the individual has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, "as prohibited by the terms of the plan." In addition, it appears that a plan, or a participant's coverage under a plan may not be cancelled except with prior notice to the participant. This presumably does not prohibit an employer from terminating a health plan with appropriate prior notice to participants, but instead addresses only an employer's ability to retroactively take away coverage.

Importantly, the law's reference to the "terms of the plan" suggests that even where a participant has engaged in fraud – such as by lying about a claim, or trying to gain coverage for an individual by wrongly asserting that she or he is the employee's spouse or dependent – the participant may be retroactively removed as a participant only if the plan language so provides. Employers and other plan sponsors may, therefore, wish to amend their plans to provide for the retroactive cessation of coverage upon a participant or beneficiary's commission of fraud or making an intentional misrepresentation of material fact, to the extent those plans do not already so provide.

Preventative Services. A plan must provide coverage for, and may not impose any cost-sharing requirements with respect to, certain preventative care, including recommended immunizations. The statute refers to particular lists of recommendations and guidelines for determining which preventative services are subject to this prohibition on cost-sharing.

Dependent Coverage for Older Children. A plan that provides dependent coverage of children must continue to make that coverage available for an adult child until the child turns 26 years of age. This requirement applies even to married children. Plans are not required to make coverage available for a child of a child receiving dependent coverage (that is, for example, for a grandchild of a participant).

Uniform Explanation of Coverage. The Secretary of HHS is required to develop standards for plans to use in summarizing plan benefits and coverage for participants. The Secretary is supposed to develop these standards by March 23, 2011. It appears this required summary will be a short "highlights" description of the plan. In particular, the new summary must not exceed four pages in length and must not include print smaller than 12-point font. The new requirement does not seem to replace the requirement under ERISA that participants receive a more complete summary plan description. The new summary must be presented in a "culturally and linguistically appropriate manner" and must use terminology understandable by the average plan participant.

The statute describes the information that must be covered by the summary, which includes the following:

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- A description of the coverage, including cost-sharing for each of the categories of "essential health benefits" (the categories of benefits required to be included in health plans offered under the state exchanges)
- A description of any exceptions, reductions, or limitations on coverage
- A description of any cost-sharing provisions, including deductible, coinsurance, and co-payment obligations
- A description of any renewability and continuation of coverage provisions
- A "coverage facts label" that includes examples to illustrate common benefit scenarios, including pregnancy and serious or chronic medical conditions and related cost-sharing, with these scenarios based on recognized clinical practice guidelines
- A statement of whether the plan provides "minimum essential coverage" (this is the standard employer plans must meet for employers to avoid penalties under the employer mandate provisions described later; it is much different from the list "essential health benefits" required to be included in plans offered through the state exchanges) and ensures that the plan's share of the total allowed cost of benefits provided under the plan is not less than 60 percent of those costs (again, this is a standard that must be met for employers to be certain they will not suffer a penalty under the employer mandate provisions)
- A statement that the outline is a summary of the "insurance policy or certificate" and that the policy or certificate itself should be consulted to determine the governing provisions, and
- A contact number to call with additional questions, as well as a website address where a copy of the "group certificate of coverage" can be reviewed and obtained.

In the case of a self-insured plan, the references to policies and certificates presumably should be read as references to the plan.

Plans will have until March 23, 2012, to begin using these new summaries. Although a bit unclear, it appears these summaries must be provided when employees (or other individuals, such as COBRA beneficiaries) apply for coverage, and prior to their becoming participants (though, hopefully, an individual need not be provided with a summary prior to becoming a participant if she or he already received one upon applying for coverage). In the case of an insured plan, it appears that the summaries may need to be provided not only when employees (or other individuals) apply for coverage, but also when the policy is issued or a certificate is delivered to the participant. Again, whether this duplicate disclosure is required is not clear. In addition, it may also be necessary to provide the summary prior to a former participant again becoming a participant. The rules on precisely when the summaries must be delivered will require some agency guidance.

In the case of a self-insured plan, the plan sponsor or plan administrator must provide the summary. For an insured plan, the law is a little unclear as to whether it is the insurer or instead the plan that must provide the summary. The summaries may be delivered electronically (or in paper).

Deadline for Summaries of Material Modification. Importantly, the new legislation requires that notice of any material modification be given to participants at least 60 days prior to the date the plan modification is to become effective. Although this provision is generally effective for plan years beginning on or after September 23, 2010, the legislation includes a surprising, and perhaps inadvertent, rule for plans that are in effect on March 23, 2010. Under grandfathered plan rules described later, for plans in effect on March 23, 2010, this advance SMM requirement seems to be effective for plan years beginning on

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"The new legislation generally extends [the highly compensated individual] nondiscrimination rules to insured plans."

or after March 23, 2010, at least with respect to employees covered on that date. Curiously, this is earlier than the effective date for other plans (which is the first plan year beginning on or after September 23, 2010).

Penalty for Failure to Provide New Summary or SMM. A penalty of not more than $1,000 may apply for each willful failure to provide the required plan summary or advance summary of a material modification. Each participant who fails to receive a required summary (or summary of material modification) is counted separately in determining the amount of the penalty, so it appears that a willful failure to timely provide 5 participants with a summary could result in a fine of up to $5,000. Presumably, the Secretary of HHS (or another agency) will have discretion to assess a smaller penalty.

Standardized Definitions. The new law requires the Secretary of HHS to promulgate regulations providing for the development of standardized definitions of terms used in insured plans. The required four-page plan summary described above must include these definitions, to enable participants to better understand and compare coverage. It is not clear whether these standardized definitions must be used in the terms of an insured plan itself, or whether they need only be used in the new mandatory four-page summary. For the terms to make sense and be used with precision, it may well be that the only practical approach will be to require that they be used in insured plans themselves and the related insurance policies. It also is unclear whether the use of uniform definitions is required with respect to self-insured plans, though it appears there is no such requirement.

The terms for which standardized definitions are to be developed include the following: premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual, customary and reasonable) fees, excluded services, grievance and appeals, hospitalization, hospital outpatient care, emergency care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary of HHS determines should be standardized.

Prohibition on Insured Plans Discriminating in Favor of Highly Compensated Individuals. Self-insured health plans have long been subject to nondiscrimination rules prohibiting them from favoring highly compensated individuals. Those rules are set forth in the Tax Code. The consequence of a self-insured plan failing to meet those requirements is a bad tax result for highly compensated individuals.

The new legislation generally extends these nondiscrimination rules to insured plans. Interestingly, it does so by including the discrimination prohibition in the Public Health Service Act ("PHSA"), as well as in ERISA. The rules are also included in the Tax Code, but only in the excise tax provisions and not the income tax provisions. This means the consequences of failing to meet the requirements will be different than for self-insured plans. For both insured and self-insured plans, an employer will be prohibited from discriminating. But if an insured plan violates the new rules, there will be no adverse tax consequence for highly compensated individuals, though there may be for the employer (or multiemployer plan) in the form of an excise tax (generally, in the amount of $100 per day per participant with respect to which the failure relates).

Self-insured plans are also prohibited from discriminating, but only under the Tax Code. As a consequence, neither employees nor HHS would seem to have a right to demand coverage because the prohibition for self-insured plans would not apply under ERISA or the PHSA. The only result of discriminating under a self-insured plan would be a bad tax result for highly compensated individuals (and, if the plan were funded under a VEBA, the possible loss of tax-exempt status for the VEBA).

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Generally, the highly compensated individuals in whose favor a plan may not discriminate are those who are (a) among the five highest paid officers, (b) shareholders owning more than 10 percent of the employer, and (c) most importantly, the highest paid 25 percent of employees (ignoring certain categories of employees if they are not plan participants, such as employees who have not completed three years of service, have not attained age 25, are part-time or seasonal, are included in a bargaining unit covered by a collective bargaining agreement where accident and health benefits were the subject of good faith bargaining, and nonresident aliens with no U.S.-source earned income).

Under the new rules, a plan (whether insured or self-insured) must not discriminate in favor of highly compensated individuals in terms of eligibility to participate, nor may it discriminate in benefits provided to employees who do participate.

Additional Reporting Requirement: Quality of Care. By March 23, 2012, the Secretary of HHS is to develop requirements for plans to report on a variety of issues. This reporting is to include information relating to (1) improving health outcomes through "quality reporting," effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, (2) activities to prevent hospital readmissions (including through education and counseling), (3) activities to improve patient safety and reduce medical errors through use of best clinical practices, evidence based medicine, and health information technology, and (4) wellness and health promotion activities.

A plan (and insurer in the case of an insured plan) will be required to submit an annual report with this information to the Secretary of HHS and to participants. The required information is not to include information relating to the lawful ownership or possession of a firearm or ammunition, nor the lawful use of such a firearm or ammunition.

Cost Reporting and Limit on Insurers' Profits. Insurers (not plans) will, with respect to each plan year, be required to submit to the Secretary of HHS a report concerning loss ratios and expenses, including the percentage of total premium revenue expended on reimbursement for clinical services, activities that improve health care quality, and non-claims costs other than taxes, licensing, or regulatory fees. The Secretary of HHS will make these reports available to the public on its website.

In addition, the new law effectively caps insurers' profit margins on health insurance, beginning no later than January 1, 2011. It does so by requiring that insurers provide rebates to participants if the insurers' premium revenues spent on reimbursement for clinical services and activities that improve health care quality are less than 85 percent in the large group market, or 80 percent in the small group market, of the total amount of premium revenue (excluding taxes, licensing, and regulatory fees, as well as certain other payments). States may, by regulation, set a higher percentage than the 85 or 80 percent figures above.

The new legislation also requires hospitals, on an annual basis, to establish, update, and make public a list of the hospital's standard charges for items and services provided by the hospital.

Appeals Process. The legislation adds new claims appeals process requirements. These are added to the Public Health Service Act, and do not seem to displace (and, in fact, to some degree explicitly incorporate) the claims and appeals requirements of ERISA and related Department of Labor regulations. Notably, the new provisions require plans, including self-insured plans, to have an external review process. The particulars of that required review will, it appears, be described in guidance to be issued by the Secretary of HHS, though for insured plans the new law largely defers to state external review requirements.

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Plans must provide participants with notice, in a culturally and linguistically appropriate manner, of the available internal and external appeals processes. A plan must allow a participant to review his or her file, present evidence and testimony as part of the appeals process, and, very importantly, receive continued coverage pending outcome of the appeals process. As to this continued coverage requirement, it presumably means, for example, that if a participant is undergoing a course of treatment for which a plan has indicated it is denying coverage, the plan will be required to continue to pay those expenses until the appeals process had been exhausted. This may pose a number of tricky questions, including how quickly a reluctant plan must make payment for disputed coverage during the pendency of a participant's appeal.

Choice of Health Care Professional. If a plan provides for designation by a participant or beneficiary of a participating primary care provider, the plan must permit a participant or beneficiary to designate any participating primary care provider who is available to accept that individual.

Emergency Services. If a plan provides or covers any benefits with respect to services in an emergency department of a hospital, the plan must cover emergency services without requiring prior authorization and must provide coverage whether or not the health care provider is a participating provider under the plan with respect to those services. In addition, a plan must provide for such coverage by a nonparticipating provider without imposing limitations on coverage more restrictive than those applicable to emergency department services from providers who have a contractual relationship with the plan. If emergency services are provided out-of-network, the cost-sharing requirement (expressed as co-payment amount or co-insurance rate) must be the same as if the services were provided in-network.

Emergency services covered under this rule are only those relating to an "emergency medical condition." An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, result in serious impairment to bodily functions, or result in serious dysfunction of any bodily organ or part. The emergency services subject to the new rule are, with respect to an emergency medical condition, a medical screening examination, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition, and such further medical examination and treatment as are required to stabilize the patient. "To stabilize" means to provide treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, transfer of the individual.

Pediatric Care. If a plan requires, or provides for, the designation of a participating primary care provider for the child of a participant or beneficiary, the plan must permit the designation of a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider, if the provider participates in the plan's network. This does not, however, require a plan to waive any coverage exclusions under the terms of the plan relating to the coverage of pediatric care.

Obstetrical and Gynecological Care. A plan that provides coverage for obstetric or gynecology care and requires the designation of a participating primary care provider may not require authorization or referral by the plan or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

"[T]he states would, through these programs, assist individuals with plan enrollment and with the filing of complaints and appeals . . . ."

That professional must, however, agree to otherwise adhere to the plan's policies and procedures, including those regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

A plan that requires designation of a participating primary care provider (and provides coverage for obstetric or gynecological care) must treat the provision of obstetrical and gynecological care by the professional chosen by the participant or beneficiary as the authorization of a primary care provider. This does not require a plan to waive coverage exclusions under the plan's terms relating to obstetrical or gynecological care. Nor does it preclude a plan from requiring that the provider notify the primary care health care professional or the plan of treatment decisions.

State Consumer Assistance. Beginning in 2010, the Secretary of HHS is to award grants to states (or to the health insurance exchanges that will serve as clearinghouses for "qualified health coverage") to establish, expand, or provide support for health insurance ombudsman programs or offices of health insurance consumer assistance. Under these programs, the state office or ombudsman would respond to inquiries or complaints about insured plans not only with respect to state law, but also with respect to federal health insurance requirements.

Notably, the states would, through these programs, assist individuals with plan enrollment and with the filing of complaints and appeals, including appeals under a plan's internal appeal or grievance process. They would do so not only with respect to insurance companies' processes, but also with respect to employer's plans if they are insured, and arguably even if they are self-insured.

Time will tell, but this could result in an unprecedented interjection of state government into the operation of self-insured plans. And the states will be required to collect and report data to the Secretary of HHS about the types of problems and inquiries encountered by individuals. HHS will in turn use this data to identify areas where more enforcement action is necessary, and it will be required to share this information with state insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in their enforcement activities.

Monitoring Insurers' Premium Increases. The Secretary of HHS, in conjunction with the states, is required to establish an annual review process, beginning with the 2010 plan year, for "unreasonable" increases in premiums for insured plans. Under this process, an insurer is to be required to submit a justification for any unreasonable premium increase prior to implementation of that increase. It will be interesting to observe how these determinations of reasonableness are made, and precisely how the requirement can practically be applied for 2010 plan years.

Starting with plan years beginning in 2014, the Secretary of HHS, in conjunction with the states, is to monitor premium increases, whether reasonable or unreasonable.

States are to take into account the difference in premium increases in coverage offered (a) through an exchange, and (b) outside an exchange, in determining whether to later permit (perhaps, as early as 2017) health plans in the large group market to be offered through an exchange. In general, the "large group market" is the market for large employers, which are those employers with an average of at least 101 employees on business days during the preceding calendar year (or in the case of new employers, are reasonably expected to employ an average of at least 101 employees during the current year).

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Preserving and Expanding Coverage

The following provisions became effective on March 23, 2010.

No "Dumping" of Participants. The new legislation requires the Secretary of HHS to establish a temporary high risk health insurance pool program for persons with pre-existing conditions who have not had creditable coverage for at least six months. This pool is to be established no later than the 90th day after enactment of the legislation. The date of enactment was March 23, 2010, so this presumably means the pool should be operational by June 21, 2010. The pool is temporary because it will, for the most part, cease operation on January 1, 2014, when eligibility for coverage should be better available under other of the legislation's reforms.

To prevent insurers and employers from effectively transferring participants to the high risk pool, the legislation includes "anti-dumping" rules. In particular, the Secretary of HHS is to establish criteria for determining whether an insurer or an employment-based health plan has discouraged an individual from remaining covered based on the individual's health status. An "employment-based plan" seems to be a group health plan that is maintained by one or more current or former employers (including a government), an employee organization (such as a labor union), a VEBA (that is, a tax exempt trust fund used to provide health and welfare benefits), or a committee or board of individuals appointed to administer a group benefits plan providing health benefits; the term seems to include a multiemployer plan.

If an insurer or employment-based health plan has discouraged an individual from remaining covered based on that individual's health status, the insurer or plan must reimburse the high risk program for the cost of medical expenses for that individual.

For coverage obtained through an employer, it appears one of the prohibited acts will be for the employer, plan, or insurance company, to provide money or other financial consideration to a participant or beneficiary for disenrolling. Where coverage prior to being in the high risk pool was obtained directly from an insurance company or under an employment-based health plan (apparently as opposed to being obtained "through" an employer), it appears there may be a violation if (a) the individual's premium for that prior plan coverage was higher than the premium required under the high risk pool (adjusted based on any age factors applied to that prior coverage), and (b) the prior coverage was provided under an insurance policy for which duration of coverage from issue or health status are factors that can be considered in determining premiums at renewal. Though not clear, it appears this rule relating to how premiums are determined at renewal applies only to insured programs, and not to self insured plans.

Reinsurance for Early Retirees. The Secretary of HHS is to establish a temporary reinsurance program to reimburse employment-based plans for a portion of their cost of providing health coverage to early retirees and their dependents. This program is to be established no later than 90 days after the date the law was enacted, which, as we noted earlier, would presumably be June 21, 2010. The plans that can participate in this program are those "employment-based plans" that provide health benefits to early retirees. We described above, in the section on the anti-dumping rules and the temporary high risk pool, what it means to be an employment-based plan.

Early retirees for purposes of the reinsurance program are individuals who are age 55 or older, not eligible for Medicare, and not active employees of (a) an employer maintaining, or current contributing to, the plan, or (b) any employer that has made substantial contributions to fund the plan. In the case of a

"A plan may not impose any pre-existing condition exclusion."

multiemployer plan, this reference to former employers that have in the past made contributions raises a question as to whether an individual will be considered an early retiree under the reinsurance program if she or he is not working for a current employer in the plan, but is working for an employer that withdrew years ago (and during earlier years made substantial contributions to the plan).

A plan wishing to participate in the early retiree reinsurance program must submit an application to the Secretary of HHS. A participating plan can then submit claims for reimbursement of certain costs. The reimbursement rules have many twists and turns, but in general a participating plan may be entitled to reimbursement for 80 percent of the portion of its costs for a plan year for an early retiree, or the spouse or dependent of such a retiree, that exceeds $15,000. Any portion of costs exceeding $90,000 will, however, not be eligible for reimbursement.

Payments from the reinsurance program to the plan must be used to lower costs for the plan, such as by reducing contributions, co-payments, deductibles, co-insurance, or other out-of-pocket cost for participants. Though not entirely clear, it appears that payments from the reinsurance program may also be used to reduce premium costs for an employer, former employer, employee organization (such as a union), or VEBA maintaining the plan, a committee or board of individuals appointed to administer the plan, or if the plan is a multiemployer plan, the plan itself, but may not be used as general revenues for such an entity. There is a limit on the dollars available under the program (generally, $5 billion). There is an appeals process for claims for reimbursement that are denied. Payments from the reinsurance program to a plan are not included in the gross income of any employer or other entity that maintains or currently contributes to the plan.

Health Insurance Market Reforms

The following provisions are effective for plan years beginning on or after January 1, 2014.

Pre-existing Conditions. A plan may not impose any pre-existing condition exclusion. This will be the case whether or not an individual has prior creditable coverage and whether or not the individual is a late enrollee. Although this rule is generally not effective until plan years beginning on or after January 1, 2014, it is effective earlier for participants (and apparently dependents) who are under age 19. For those individuals the rule is effective for plan years beginning on or after September 23, 2010. This presumably means the rules apply early to an individual who is under age 19 on the first day of the first plan year beginning on or after September 23, 2010.

Fair Health Insurance Premiums (Small Group Market. Premiums charged by insurers in the small group market may vary with respect to a particular plan or coverage only by (1) whether the plan or coverage covers an individual or family, (2) the rating area, as established under state standards, (3) age, except that the rate may not vary by more than a factor of 3 to 1 for adults, and (4) tobacco use, except the rate may not vary by a factor of more than 1.5 to 1. The Secretary of HHS will define the permissible age bands for age rating. As to different rates for tobacco users, for family coverage a higher tobacco rate is to be applied based on the portion of the premium attributable to those family members who are tobacco users. If states later permit insurers to offer coverage in the large group market through a state exchange (which could occur as early as 2017), these "fair health insurance premium" rules will apply to the large group market as well.

Guaranteed Availability of Coverage. In general, insurers offering coverage in a group market in a state must accept every employer in that state

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"The new law introduces a new set of rules governing wellness programs . . . ."

that applies for coverage. The insurer may, though, restrict enrollment to open or special enrollment periods, so long as it establishes special enrollment periods for COBRA qualifying events.

Guaranteed Renewability of Coverage. Insurers offering coverage in the group market must renew or continue in force coverage at the option of the plan sponsor.

Wellness. The new law introduces a new set of rules governing wellness programs – that is, programs offered by employers designed to promote health and prevent disease. To some degree, these rules are similar to those set forth in current regulations. In other respects the new legislation refines the provisions of current law.

As under current regulations, how wellness programs are treated depends on whether an individual is rewarded for satisfying a standard related to a health status factor. If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, it appears the wellness program will not violate the new rules so long as participation in the program is made available to all similarly situated individuals. There is, however, an ambiguity in the statute that can be read to make permissible under this rule only programs that fall into one of the following five types:

- A program that reimburses all or part of the cost for memberships in a fitness center
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes
- A program that encourages preventative care related to a health condition through the waiver of the copayment or deductible requirement under a group health plan for the costs of certain items or services related to a health condition (such as prenatal care or well-baby visits)
- A program that reimburses individuals for the cost of smoking cessation programs without regard to whether the individual quits smoking, and
- A program that provides a reward to individuals for attending a periodic health education seminar

An alternative, and perhaps better, reading of the statute is that the five types of programs above are deemed to meet the requirement that they not offer a reward based on a standard related to a health status factor. If that is the case, other programs that do not offer a reward based on satisfying a standard related to a health status factor will be permissible if made available to all similarly situated individuals.

Even if one or more of the conditions for obtaining a premium discount, rebate, or reward is based on satisfying a standard related to a health status factor, a wellness program will not violate the new provision if each of the following requirements is met:

- The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, does not exceed 30 percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents (such as spouses or spouses and dependent children) may participate fully in the wellness program, the reward may not exceed 30 percent of the cost of the coverage in which the employee or individual and any dependents are

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"A plan must not discriminate . . . against any health care provider acting within the scope of the provider's license or certification . . . ."

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enrolled. The cost of coverage will be based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, co-payments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and Treasury may increase the maximum reward from 30 percent to as much as 50 percent, if they think appropriate.

- The wellness program is reasonably designed to promote health and prevent disease. This requirement will be met if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it 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.
- The plan gives eligible individuals the opportunity to qualify for the reward at least once each year.
- The full reward is available to all similarly situated individuals. For this purpose the reward will not be considered available to all similarly situated individuals for a period unless, among other requirements, the wellness program allows (1) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, and (2) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard. If reasonable under the circumstances, the plan (or insurance company) may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.
- The plan (or insurance company) involved must disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or the possibility of a waiver of the otherwise applicable standard). Alternatively, plan materials may disclose that a wellness program is available without describing its terms, in which case there will be no need to describe the alternative standard.

Under an important grandfather provision, the new rules do not make impermissible a wellness program established prior to March 23, 2010, that complied with all applicable regulations, and that was operating on March 23, 2010. Such a program may continue to operate for as long as the previously applicable regulations remain in effect, apparently without the need to comply with the new rules during that time period.

For purposes of preparing a report on the effectiveness of wellness programs, the Secretaries of Health and Human Services, Treasury, and Labor are directed to gather relevant information from employers providing their employees with access to wellness programs.

Provider Discrimination. A plan must not discriminate with respect to participation under the plan (or with respect to coverage) against any health care provider acting within the scope of the provider's license or certification under applicable state law. This does not, however, require that a plan contract with any provider willing to abide by the plan's terms and conditions, such as a provider seeking to become a preferred provider. The new requirement also does not appear to prevent a plan from establishing different reimbursement rates based on quality or performance measures.

"Insurers will be limited in the annual cost-sharing they may impose under a group health plan."

The precise meaning of this provision is a bit foggy. The rule permitting a plan to choose not to contract with a provider suggests that the provision is not intended to require plans to include in their networks all physicians (or other providers) willing to accept the plans' preferred reimbursement rates. Instead, it appears the rule is designed to prohibit discrimination against types of providers, such as chiropractors, osteopathic doctors (as opposed to medical doctors), or optometrists (as opposed to ophthalmologists). Note, again, however that a plan may vary reimbursement rates based on "quality or performance measures." It will be interesting to watch how these quality and performance measures are established, and when they will be considered legitimate and permissible.

The reference to a provider acting within his or her license or certification under applicable state law may suggest that where a state does not license or certify a particular type of provider – perhaps someone engaged in administering herbal remedies – discrimination would be permissible, and in particular that a plan could refuse to cover services provided by such a provider.

Anti-Retaliation Provision. The new legislation amends the Fair Labor Standards Act to prohibit an employer from discharging, or in any manner discriminating against, any employee with respect to her or his compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has received a premium tax credit or cost-sharing subsidy under the legislation's provisions for helping individuals afford coverage. This same rule appears to apply to health plans and insurers offering coverage.

Small Group Market: Must Include Essential Health Benefits. An insurer that offers coverage in the small group market must include in that coverage the "essential health benefits package" required for plans offered through the state exchanges. This requirement seems to apply even to plans not offered through an exchange.

Cost-Sharing. Insurers will be limited in the annual cost-sharing they may impose under a group health plan. The law is ambiguous as to whether self-insured plans are subject to these same constraints. For plan years beginning in 2014, a plan must not impose cost-sharing in excess of the maximum out-of-pocket amount in effect for high deductible health plans for 2014. (To offer a sense of perspective, those limits for 2010 are $5,950 for self-only coverage and $11,900 for family coverage.) For 2015 and later years, the maximum is subject to increase.

For the purpose of this rule, "cost-sharing" includes (1) deductibles, coinsurance, copayments, or similar charges, and (2) any other expenditure required by a participant for a qualified medical expense with respect to essential health benefits covered under the plan. (The term "qualified medical expense" has the same meaning as under the HSA rules, which generally means a medical expense of a type that is tax-deductible.) The term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

In addition, for insured products in the small group market, the annual deductible must not exceed (1) $2,000, in the case of a plan covering a single individual, or (2) $4,000 in the case of any other plan. These $2,000 and $4,000 figures will be indexed and may increase for years after 2014. The maximum deductible amounts in the small group market may be increased by the maximum amount of reimbursement reasonably available to a participant under a "flexible spending arrangement" (determined without regard to any salary reduction arrangement). These "flexible spending arrangements" are programs providing reimbursement of specified incurred expenses (subject to reimbursement maximums and other reasonable conditions), where the maximum amount of

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"A plan must not apply a waiting period that exceeds 90 days."

reimbursement reasonably available to a participant is less than 500 percent of the value of the coverage. The "value" of FSA coverage is, for this purpose, generally the total payment for the coverage for the plan year, including both salary reduction contributions and employer flex-credits.

Waiting Periods. A plan must not apply a waiting period that exceeds 90 days.

Clinical Trials. If a plan offers coverage to a "qualified individual" (as defined below), the plan may not deny that individual participation in certain clinical trials, nor deny coverage for routine patient costs for items and services furnished in connection with participation in those trials. Further, the plan may not discriminate against the individual on the basis of her or his participation in the trial. Although routine patient costs include all items and services normally covered when not enrolled in a clinical trial, they do not include (1) the investigational item, device, or service, itself, (2) items and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient, or (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more in-network providers is participating in a clinical trial, the plan may require that a qualified individual participate in the trial through that provider, if the provider will accept the participant in the trial. The requirement that clinical trials be covered expenses includes an approved clinical trial even if it is conducted outside of the state in which the qualified individual resides.

A "qualified individual," who may be eligible for coverage of the expenses of a clinical trial, is an individual who is a plan participant or beneficiary and meets the following conditions: (1) the individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition, and (2) either (a) the referring health care professional is a participating health care provider (that is, an in-network provider) and has concluded that the individual's participation in the trial would be appropriate, or (b) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in the trial would be appropriate. A "life-threatening condition" is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The statute includes a list of types of clinical trials that will be considered approved clinical trials. These include a phase I, II, III, or IV clinical trial approved or funded by certain arms of the federal government, a study conducted under an investigational new drug application reviewed by the Food and Drug Administration, or a drug trial that is exempt from having such an investigational new drug application. The provision does not require that a plan provide benefits for routine patient services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan. The new provisions do not preempt state laws that require a clinical trials policy for state-regulated plans (in addition to the policy required under the new federal law).

Incorporation of Mandates and Restrictions into ERISA and the Tax Code

In general, the mandated benefits and restrictions groped together above under the headings "Group Market Reforms" and "Health Insurance Market Reforms" are part of the Public Health Service Act. These provisions have largely been incorporated by reference into ERISA and the Tax Code, except that the provisions on prohibiting discrimination in favor of highly compensated individuals, and cost reporting and limits on insurance companies' profits, do not apply under ERISA or the Tax Code to self-insured group health plans.

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Grandfathered Plan Rules

Certain rules do not apply to "grandfathered plans," or at least do not apply to certain participants in those plans. The general rule for grandfathered plans is that the requirements grouped together above under the headings "Group Health Reforms" and "Health Insurance Market Reforms" do not apply to a plan's coverage of an individual if that individual was enrolled in the plan on March 23, 2010. In addition, the rules do not apply to family members of such a grandfathered individual who are permitted to enroll after March 23, 2010, if the enrollment of those family members was permitted under the terms of the plan as in effect on March 23, 2010, and the plan is "renewed" after March 23, 2010. Further, a plan that provided coverage on March 23, 2010, may permit "new" employees (and their family members) to enroll in the plan without having the provisions of the law described to this point in the newsletter apply to those new employees (and their families).

The result of these rules is that a plan in existence on March 23, 2010, may for many of its participants avoid the rules we have described above under the headings "Group Health Reforms" and "Health Insurance Market Reforms." (We will, though, note below that some of those rules will apply to grandfathered plans).

Some participants in a plan that existed on March 23, 2010, would not seem to be grandfathered. For example, it appears that individuals who were employees on March 23, 2010, but who were not participants in the plan on that date may not be grandfathered (nor would their family members be grandfathered). This could include individuals who were employees on March 23, 2010, but who (a) chose not to be covered, (b) were not in a group of employees eligible for coverage, or (c) wanted coverage but had not yet satisfied the plan's waiting period.

It will be interesting to see how guidance from the agencies addresses the question whether an individual was enrolled on March 23, 2010. We wonder, for example, whether individuals will lose grandfathered status if their plan merges with another plan or the plan sponsor changes. The question in that case, presumably, would be whether the resulting plan is the same as the plan that provided coverage on March 23, 2010.

There are a number of exceptions to the general rule that the provisions grouped together above under the headings "Group Health Reforms" and "Health Insurance Market Reforms" do not apply to grandfathered plans. First, (a) the rules requiring insured plans to issue a standard plan summary (the four page "highlights" description) and use standardized definitions in that summary, and (b) most importantly, the rules requiring insured and self-insured plans to distribute summaries of material modification 60 days in advance of any material change, apply to grandfathered plans for plan years beginning on or after March 23, 2010. The same is true for the rules effectively limiting profits for insurers and requiring reporting to the Secretary of HHS with respect to loss ratios. Notably, these effective dates are earlier than for non-grandfathered plans.

The following provisions also apply to grandfathered plans, and will do so at the same time they would apply to non-grandfathered plans:

- The waiting period rules
- The restrictions on lifetime and annual limits
- The rules on rescission
- The pre-existing condition prohibition, and
- The rules on covering adult children (up to age 26) as dependents, although for plan years beginning before January 1, 2014, the rules will apply only to an adult child who is not eligible to enroll in an

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"eligible employer-sponsored health plan" other than the grandfathered plan. The term "eligible employer-sponsored health plan" means a plan offered by an employer to an employee that is subject to ERISA, a governmental plan, or an insured plan (whether or not subject to ERISA or a governmental plan).

Collectively Bargained Plans

In the case of an insured plan maintained pursuant to one or more collective bargaining agreements between employee representatives (such as a union) and one or more employers that was ratified before March 23, 2010, the provisions we have grouped together above under the headings "Group Health Reforms" and "Health Insurance Market Reforms" may have a delayed effective date. In particular, those rules will not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement that changes the coverage solely to conform to a requirement added by the "Group Health Reforms" and "Health Insurance Market Reforms" provisions will not be treated as a termination of the collective bargaining agreement for this purpose. It appears that the delayed effective date does not apply to self-insured plans, though it is possible this distinction was inadvertent.

A (Relatively) Tiny Comment on the "Exchanges

As alluded to earlier, the "exchanges" to be set up in the states are, effectively, clearinghouses for making available "qualified health plans" to individuals and small employers. These exchanges will determine whether plans meet the minimal requirements set under the legislation for constituting a qualified health plan. They will also serve a critical role in gathering and sharing information among individuals, employers, and the federal government. This informational role is necessary, in part, to help establish which individuals are eligible for refundable premium tax credits (to help them pay for the cost of their coverage), or assistance to reduce their deductibles, co-pays, or other "cost-sharing" obligations.

In addition, the exchanges will be responsible for granting certifications attesting that individuals are not responsible for the penalty applicable to those who fail to purchase necessary coverage because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets other exemptions from the so-called "individual responsibility" requirement to obtain coverage. All of this means that the exchanges need to learn something about an individual's employer and the plans available through that employer.

The exchanges will transfer to the Secretary of the Treasury a list of individuals for whom it has issued a certification. Importantly as concerns employers, it will also notify the Secretary of the Treasury when an individual is an employee of an employer but is eligible for a premium tax credit because either (a) the employer did not provide "minimum essential coverage," or (b) the employer provided minimum essential coverage but it was determined either to be unaffordable to the employee or to not provide the required minimum actuarial value.

The exchanges will also communicate directly with employers. They will, for example, provide to each employer the name of each of its employees who ceases coverage under a qualified health plan.

In general, the exchanges are to be in place by January 1, 2014. Coverage may be available through those exchanges not only to individuals, but also to small employers. Beginning in 2017, states may choose to make coverage available through the exchanges for large employers.

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"[L]arge employers must provide coverage to their full-time employees or pay a financial penalty."

A small employer may make use of an exchange by electing to make all its full-time employees eligible for one or more qualified health plans offered through the exchange in the small group market. The employer may select the level of coverage to be made available to its employees. The levels available for small employers are bronze (providing benefits actuarially equivalent to 60 percent of the full actuarial value of benefits under the plan), silver (paying 70 percent of the value of benefits), gold (paying 80 percent), and platinum (90 percent).

Generally, "small employers" are those that employ on average at least one, but not more than 100, employees on business days during the preceding calendar year (and that still employ at least one employee on the first day of the current plan year). States may, however, choose to lower the 100 employee threshold to 50 employees. In determining employer size, control group and similar Tax Code aggregation rules apply. For employers not in existence throughout the preceding calendar year, the determination of employer size is based on the average number of employees the employer is reasonably expected to employ on business days during the current calendar year. An employer will be considered, for purposes of determining the number of its employees, to include any predecessor of the employer. We look forward to receiving guidance on how to determine the "average" number of employees an employer had in a prior year.

If an employer is a small employer at the time it makes enrollment in a qualified plan available to its employees through an exchange, it will continue to be able to offer small employer coverage through an exchange even as its workforce grows in size. It will be permitted to do so until it no longer makes available to employees enrollment in a qualified plan through an exchange. Though not clear, we assume an employer need not make the same plan available in future years to enjoy this rule, but may instead switch to a different small employer coverage without losing the benefit of the rule.

Employer Mandate

Now, at long last, to the heart of the matter. In addition to the mandated benefit rules and other requirements described above, large employers must provide coverage to their full-time employees or pay a financial penalty. This mandate applies beginning January 1, 2014 (technically, it applies for months beginning after December 31, 2013).

Large Employers. The mandate applies to "large employers." An employer is large if it employed an average of at least 50 full-time employees on business days during the preceding calendar year. There is, however, an exception where (1) the employer's workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and (2) the employees in excess of 50 employed during the 120 day period were seasonal workers. (It is odd, and perhaps an error, that this rule refers to a workforce in excess of 50, whereas the general rule requires only 50 full-time employees to be large.) For this purpose, a seasonal worker is one who performs labor or services on a seasonal basis as defined by the Secretary of Labor. The term includes retail workers employed exclusively during holiday seasons.

Solely in determining whether an employer is a large employer for purposes of the penalty tax, an employer must count not only its full-time employees for a month, but must add to that a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. That is, employees must be counted in terms of full-time equivalents.

In determining an employer's size, companies will be aggregated as a single employer under the Tax Code's control group and similar aggregation rules.

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"There are two scenarios in which a large employer may be required to pay a penalty (in the form of a nondeductible excise tax)."

For an employer that was not in existence throughout the preceding calendar year, the determination will be based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year. An employer will be considered to include a predecessor employer.

A full-time employee for this purpose is one who is employed on average at least 30 hours of service per week. The Secretary of HHS, in consultation with the Secretary of Labor, is to prescribe guidance for determining an employee's number of hours of service, including rules for employees not compensated on an hourly basis.

Employer Liability. There are two scenarios in which a large employer may be required to pay a penalty (in the form of a nondeductible excise tax). First, it will be liable for a penalty if (a) it fails to offer its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" for any month, and (b) at least one full-time employee has been certified to the employer as having enrolled for that month in a qualified health plan with respect to which the employee is entitled to a premium tax credit or cost-sharing reduction. In this event, the employer must pay an amount for the month equal to the product of (a) the "applicable payment amount," and (b) the number of full-time employees employed by the employer during the month, reduced by 30 employees. The "applicable payment amount" means, with respect to any month, 1/12th of $2,000 (or $166.67). For calendar years after 2014, this dollar amount, and the other employer penalties described below, will be increased to the extent appropriate under an indexing scheme described in the new law.

The second way in which a large employer may be assessed a payment is where (a) it offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for a month, but (b) one or more full-time employees has been certified to the employer as having enrolled for that month in a qualified health plan with respect to which the individual is entitled to a premium tax credit or cost-sharing reduction. In that event, the employer must pay an amount, but only for those full-time employees enrolled in a qualified health plan who were allowed a premium tax credit or cost-sharing reduction. The penalty for the month will equal the product of (a) the number of the employer's full-time employees in a qualified health plan who are entitled to a premium tax credit or cost-sharing reduction, and (b) 1/12th of $3,000 (or $250). There is an overall limit on the aggregate amount of tax for any month for which the employer offers the opportunity to enroll in minimum essential coverage. That overall limit is the product of (a) the "applicable payment amount" (1/12th of $2,000), and (b) the number of individuals employed by the employer as full-time employees during the month, reduced by 30 employees.

Note that for a large employer to avoid an excise tax under the employer mandate, it must offer full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" (and it cannot have any full-time employees purchasing qualified health plans who receive a premium tax credit or cost-sharing reduction). Though the law is not entirely clear on this point, it appears that "minimum essential coverage" may be a pretty low bar to clear. This term is different from the term "essential health benefits." The latter describes the benefits that must be included in qualified health plans offered through an exchange. The "minimum essential coverage" requirement seems basically to be a requirement that the coverage not be "excepted benefits" under the Public Health Service Act, though for non-grandfathered plans there is some chance the term could be interpreted to mean any coverage of a type sold by insurers in the large group market (whether or not through an exchange). Generally, "excepted benefits" are the following:

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"If a large employer fails to offer all its full-time employees affordable coverage under a plan bearing at least 60 percent of the cost of covered claims, the employer will likely need to pay an excise tax."

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- Coverage only for accident, or disability income insurance, or any combination thereof
- Coverage issued as a supplement to liability insurance
- Liability insurance, including general liability insurance and automobile insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar insurance coverage specified in regulations, under which benefits for medical coverage are secondary or incidental to other insurance benefits
- Any of the following if provided under a separate policy, certificate, or contract of insurance:
  - Limited scope dental or vision benefits
  - Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
  - Other limited benefits similar to those in the two bullets above, to the extent specified in regulations
  - Coverage only for a specified disease or illness
  - Hospital indemnity or other fixed indemnity insurance
  - Medicare supplemental health insurance, coverage supplemental to TRICARE, or similar coverage supplemental to coverage under a group health plan

At bottom, the effect of the employer mandate rules is that large employers must either offer coverage to all full-time employees or run the risk of having to pay a nondeductible excise tax. For reasons we will explain below (relating to which employees are eligible for a premium tax credit or cost-sharing reduction), to be certain to avoid a penalty an employer must offer "affordable" health coverage to all its full-time employees (and their dependents), and the plan must be structured so participants do not pay more than 40 percent of covered claims costs. For this purpose, coverage will be considered affordable only if an employee's premium is no more than 9.5 percent of the employee's household income. (This percentage will be indexed to the per capita growth in premiums for the health insurance market.) Though not clear, it appears the 40 percent limitation is intended to be measured by the percentage (or perhaps expected percentage) of covered claims plan participants must pay, taking into account any deductibles, co-pays, and coinsurance levels they are required to pay under the terms of the plan. In other words, it appears this means that the plan must bear at least 60 percent of the cost of covered claims.

If a large employer fails to offer all its full-time employees affordable coverage under a plan bearing at least 60 percent of the cost of covered claims, the employer will likely need to pay an excise tax. In particular, it must pay an excise tax if any of its full-time employees purchases health insurance through the new insurance clearinghouses to be set up by the states (that is, the "exchanges") and the employee receives a premium tax credit or cost-sharing credit from the government in that connection. The reason this is likely to occur is that most individuals will be required to have coverage, and they will typically be eligible for some credit if their household income is between 100 percent and 400 percent of the federal poverty level (the "FPL"). The FPL depends on family size, but for the 48 contiguous states and the District of Columbia, the FPL for 2010 for a family of one is $10,830. For a family of three the FPL is $18,310. For a family of five it is $25,790. For a family of seven it is $33,270. These are examples; there is a fuller table published by the federal government. Since individuals with household incomes as high as 400 percent of these numbers may be eligible for a premium tax credit or cost-sharing credit from the government, it seems likely that most employers will have to pay an excise tax unless they provide the mandated health coverage to all their full-time employees, or at least to all full-time employees whose household incomes are between 100 percent and 400 percent of the FPL.

"[A]n employer is not responsible for any excise tax unless one of its full-time employees receives a tax credit for purchasing coverage through an exchange . . . ."

Otherwise, an employer runs the risk an employee will not have the required coverage under a spouse's employer's plan, and will therefore use the premium tax credit to purchase coverage under an exchange, which in turn will subject the employer to penalty.

Penalty Amount. Remember, as noted above, the amount of the penalty (the excise tax) an employer must pay will depend on whether the employer offers coverage (whether or not that coverage is affordable, and whether or not the plan pays at least 60 percent of covered claims costs). If it does not offer its full-time employees and their dependents the opportunity to enroll in health coverage, the annual penalty is the product of (a) the employer's total number of full-time employees in excess of 30, and (b) $2,000. So, for example, assume that in 2014 a large employer does not offer its full-time employees coverage. Let's say it has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state exchange-offered health plan. For each full-time employee over 30, the employer would owe $2,000, for a total penalty of $140,000 (this is (100-30), multiplied by $2,000). Although full-time equivalent employees are counted in determining whether an employer is large, they are not counted in calculating the excise tax. As noted earlier, the $2,000 figure will be indexed for years after years 2014.

If an employer does offer its full-time employees and their dependents coverage (again, whether or not that coverage is affordable, and whether or not the plan pays at least 60 percent of covered claims costs), but one or more of those full-time employees nevertheless chooses instead to purchase coverage through an exchange and receives a premium tax credit or cost-sharing reduction for doing so, the employer must pay a penalty of $3,000 for each such employee. This $3,000 figures will be indexed for years after 2014. Unlike the $2,000 penalty applicable to an employer that does not offer coverage, and which applies to the total number of full-time employees in excess of 30, this $3,000 penalty applies only to those full-time employees who actually receive the premium tax credit or cost-sharing reduction. This penalty is capped at the amount the employer would be required to pay if it did not offer coverage, which is its number of full-time employees in excess of 30, multiplied by $2,000.

So, let's assume that in 2014 a large employer offers coverage and has 100 full-time employees, 20 of whom nevertheless receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee receiving a tax credit, the employer would owe $3,000, for a total penalty of $60,000. The maximum penalty for the employer would be capped at the amount of the penalty it would be assessed for a failure to provide coverage, which would be $140,000 ($2,000 multiplied by 70 (100-30)). Because the $60,000 penalty is less than this cap, the employer would owe $60,000.

Avoiding the Potential for Any Penalty. Importantly, an employee is not entitled to a premium tax credit (or cost-sharing reduction) if her or his employer offers to the employee affordable coverage, and the plan's share of the total costs of benefits is at least 60 percent. Because an employer is not responsible for any excise tax unless one of its full-time employees receives a tax credit for purchasing coverage through an exchange, if an employer offers all its full-time employees affordable coverage under which the plan's share of the total cost of benefits is at least 60 percent, the employer cannot owe any penalty. This will be true even if some of the employer's full-time employees decline coverage and instead purchase coverage through an exchange. Their doing so would not hurt the employer because those employees would not be eligible for a premium tax credit since the employer offered them adequate coverage. Of course, offering "affordable" coverage raises an administrative difficulty since whether a plan is affordable for an employee depends on the employee's household income, which the employer typically will not know.

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"[A]n employer with more than 200 full-time employees [must] automatically enroll new full-time employees . . . and continue the enrollment of current employees."

The law is, unfortunately, not clear as to which of the two penalties regimes ((a) $2,000 multiplied by all full-time employees over 30, or (b) $3,000 multiplied only by the number of full-time employees receiving the premium tax credit or cost-sharing reduction) applies where an employer offers coverage to some, but not all, of its full-time employees. Under what seems to us the more logical reading of the law, where an employer offers some but not all of its full-time employees coverage, the applicable rules are probably those that apply where an employer offers no coverage. That is, the more logical result would seem to be to apply the rules subjecting the employer to a penalty of $2,000 multiplied by the total number of its full-time employees in excess of 30.

Automatic Enrollment. The legislation modifies the Fair Labor Standards Act (the "FLSA") to require that an employer with more than 200 full-time employees that offers employees enrollment in one or more health benefit plans automatically enroll new full-time employees in one of those plans (subject to any permissible waiting period) and continue the enrollment of current employees. Employees must be provided with adequate notice of this automatic enrollment program and of the employees' opportunity to opt out of coverage in which they were automatically enrolled.

State laws are superseded to the extent they would prevent an employer from instituting automatic enrollment. This preemption provision is presumably addressed in part at state prohibitions on taking deductions from employees' paychecks to pay for coverage without the employees' express consent.

The effective date of this requirement is unclear. One possible reading is that it is not effective until the Secretary of Labor issues regulations providing guidance on the requirement.

Notice to Employees. The Fair Labor Standards Act was amended to provide that an employer subject to the FLSA must, effective March 1, 2013, provide to each employee at the time of hiring (or with respect to current employees, no later than March 1, 2013), a written notice with certain information concerning health coverage. This notice must inform an employee (1) of the existence of an exchange, including a description of the services to be provided by that exchange and the way in which the employee may contact the exchange to request assistance, (2) if the employer's plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of those costs, that the employee may be eligible for a premium tax credit and a cost-sharing reduction if she or he purchases a qualified health plan through the exchange, and (3) if the employee purchases a qualified health plan through the exchange, that she or he will lose any employer contribution to any health benefits plan offered by the employer, and that all or a portion of that employer contribution may be excludible from income for federal income tax purposes.

At least for 2013, this new notice will need to be carefully drafted to avoid confusion. That is because the exchanges may not be operational until 2014, yet employers will be providing notices as early as March 1, 2013, when the particulars of how the exchanges will operate may not yet be fully clear.

Reporting of Employer Health Insurance Coverage. Effective for periods beginning after December 31, 2013, the Tax Code reporting requirements have been modified to require large employers (generally, those with at least 50 full-time employees) to provide information about any health coverage they offer. In particular, a large employer must include a certification as to whether it offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan. If the employer does offer such coverage, it must describe the length of any waiting period with respect to that coverage, the monthly premium for the lowest cost option in each "enrollment category" under the plan, and the employer's share of

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"[A]n employer must report on an employee's W-2 the aggregate cost of the employee's health insurance coverage sponsored by the employer, ..."

the total allowed cost of benefits provided under the plan. A large employer must also report the number of its full-time employees for each month, and provide certain information about each of its full-time employees covered under any of its health plans.

In addition to reporting this information to the Treasury, the employer must provide a statement to employees covered under the plans with respect to which the employer was required to report. This statement must be provided to employees by January 31 of the year following the calendar year for which the return was required to be made by the employer.

Reporting Cost of Health Coverage on W-2. Effective for years beginning after December 31, 2010, an employer must report on an employee's W-2 the aggregate cost of the employee's health insurance coverage sponsored by the employer, excluding the amount of any salary reduction contribution to a flexible spending arrangement.

Free Choice Vouchers. Effective January 1, 2014, employers that offer minimum essential coverage through an eligible employer-sponsored plan and pay a portion of that coverage must provide qualified employees with a voucher the value of which can be applied by an employee to purchase of a health plan through an exchange. Qualified employees are employees (a) whose required contribution for employer-sponsored minimum essential coverage exceeds eight percent, but does not exceed 9.8 percent, of the employee's household income for the taxable year, and (b) whose total household income does not exceed 400 percent of the poverty line for the family. In addition, the employee must not participate in the employer's health plan. For years after 2014, the eight percent and the 9.8 percent figures are indexed to a measure of excess premium growth over "income growth." It is possible the 9.8 percent figure was meant instead to be 9.5 percent, to correspond to the trigger for determining "affordability" of a plan (see page 21 above), but the legislation nevertheless establishes a 9.8 percent rule.

The voucher must have a dollar value equal to the employer's contribution to the employer-offered health plan. If multiple plans are offered by the employer, the value of the voucher is the dollar amount that would be paid if the employee chose the plan for which the employer would pay the largest percentage of the premium cost. The value of the voucher is for self-only coverage unless the individual purchases family coverage in the exchange.

Vouchers may be applied toward the monthly premium of any qualified health plan offered in the exchange. The value of the voucher, to the extent it is used for the purchase of a health plan, is not includable in the employee's gross income. If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid the excess value of the voucher. That excess amount received by the employee is includible in the employee's gross income.

If an individual receives a voucher, the individual is disqualified from receiving any tax credit or cost-sharing reduction for the purchase of a plan in the exchange. Similarly, if any employee receives a voucher, the employer will not be assessed a penalty under the employer mandate rules with respect to that employee.

Multiple Employer Welfare Arrangements ("MEWAs)

False Statements. The health reform legislation adds a new criminal provision prohibiting a person from making a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of a MEWA to an employee, member of an employee organization (such as a

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"The ['Cadillac plan'] tax is equal to 40 percent of the aggregate value that exceeds [a] threshold amount."

labor union), beneficiary, employer, employee organization, the Secretary of Labor, a state, or the representative or agent of any of those parties, concerning (1) the financial condition or solvency of the MEWA, (2) the benefits provided by the MEWA, (3) the regulatory status of the MEWA under federal or state law governing collective bargaining, labor management relations, or internal union affairs, or (4) the regulatory status of the MEWA as relates to any exemption from state regulatory authority under ERISA. A person who violates this prohibition may be imprisoned for up to 10 years, fined, or both imprisoned and fined.

Cease and Desist Orders. ERISA has been amended to permit the Secretary of Labor to issue a cease and desist order if it appears to the Secretary that the alleged conduct of a MEWA is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury. The Secretary may issue such an order *ex parte*, that is, on its own without any advance hearing. A MEWA or other person adversely affected by a cease and desist order may, however, after issuance of the order, request a hearing by the Secretary regarding the order. The Secretary may also issue a summary seizure order if it appears a MEWA is in a financially hazardous condition.

Registration of MEWAs with DOL. ERISA has been modified to require that MEWAs register with the Secretary of Labor prior to operating in a state

Other Provisions

"Cadillac" Plan Tax. The new law imposes an excise tax, if the aggregate value of employer-sponsored health insurance coverage for an employee (including, for purposes of the new law, any former employee, surviving spouse and any other primary insured individual) exceeds a threshold amount. The tax is equal to 40 percent of the aggregate value that exceeds the threshold amount. For 2018, the threshold amount is $10,200 for individual coverage and $27,500 for family coverage, multiplied by a "health cost adjustment percentage" and increased by the "age and gender adjusted excess premium amount."

The "health cost adjustment percentage" is designed to increase the thresholds in the event that the actual growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period. For each employee (other than for certain retirees and employees in high risk professions, whose thresholds are adjusted under rules described below), the "age and gender adjusted excess premium amount" is equal to the excess, if any, of (1) the premium cost of standard coverage under the federal employees health benefits system for the type of coverage provided to the individual if priced for the age and gender characteristics of all employees of the individual's employer, over (2) the premium cost, determined under procedures prescribed by the Secretary of HHS, for that coverage if priced for the age and gender characteristics of the national workforce.

The excise tax is imposed pro rata on the issuers of the insurance. In the case of a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the entity that administers benefits under the plan or arrangement (the "plan administrator"). Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the employer. Where an employer contributes to an HSA or an Archer MSA, the employer is responsible for payment of the excise tax, as the insurer.

Employer-sponsored health insurance coverage includes both fully-insured and self-insured health coverage excludable from the employee's gross income, including, in the self-insured context, on-site medical clinics that offer more than a de minimis amount of medical care to employees and executive physical programs. In determining the amount by which the value of employer-sponsored health insurance coverage exceeds the threshold amount, the aggregate value of

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"[A] tax credit is available to certain small employers for nonelective contributions to purchase health insurance for their employees."

all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, contributions to an HSA or Archer MSA, and, except in limited circumstances, other supplementary health insurance coverage.

The amount subject to the excise tax on high cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA or an Archer MSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health insurance coverage including coverage for any supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount.

The threshold amounts are increased for an individual who has attained age of 55 who is non-Medicare eligible and receiving employer-sponsored retiree health coverage or who is covered by a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high risk profession or employed to repair or install electrical and telecommunications lines. For these individuals, the threshold amount in 2018 is increased by (1) $1,650 for individual coverage or $3,450 for family coverage and (2) the age and gender adjusted excess premium amount (as defined above). In 2019, the additional $1,650 and $3,450 amounts are indexed to the CPI-U, plus one percentage point, rounded to the nearest $50. In 2020 and thereafter, the additional threshold amounts are indexed to the CPI-U, rounded to the nearest $50.

For purposes of this rule, employees considered to be engaged in a high risk profession are law enforcement officers, employees who engage in fire protection activities, individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. A retiree with at least 20 years of employment in a high risk profession is also eligible for the increased threshold.

Under this new law, an individual's threshold cannot be increased by more than $1,650 for individual coverage or $3,450 for family coverage (indexed as described above) and the age and gender adjusted excess premium amount, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

This new excise tax, which is nondeductible, is effective for taxable years beginning after December 31, 2017. There are other twists and turns in the applicable rules, but given the distant effective date, we will defer any further discussion for the time being.

Tax Credit for Small Businesses. Effective for taxable years beginning after December 31, 2009, a tax credit is available to certain small employers for nonelective contributions to purchase health insurance for their employees. Small employers eligible for this credit are those with no more than 25 full-time equivalent employees ("FTEs") employed during the employer's taxable year, and whose employees have annual full-time equivalent wages that average no more than $50,000. The full amount of the credit is, however, available only to an employer with 10 or fewer FTEs whose employees have average annual full-time equivalent wages from the employer of less than $25,000. These $25,000 and $50,000 wage limits are indexed for inflation for the years beginning in 2014.

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"[T]he deduction for retiree prescription drug plan subsidies has been eliminated, effective for taxable years beginning after December 31, 2012."

To be eligible for the credit, a small employer must make a nonelective contribution on behalf of each employee who enrolls in certain qualifying health insurance the employer offers its employees. This employer contribution must be a uniform percentage (not less than 50 percent) of the premium cost of the plan. The employer must pay the employees' premiums during the year and claim the credit only at the end of the year on its income tax return. The credit is a general business credit, which can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax.

The credit is initially available for taxable years beginning in 2010, 2011, 2012, or 2013. For taxable years beginning in years after 2013, the credit is only available for purchases through a state exchange and is only available for a maximum coverage period of two consecutive taxable years beginning with the first year in which the employer (or any predecessor) first offers one or more qualified plans to its employees through an exchange. The maximum two year coverage period does not take into account any taxable years beginning in years before 2014. So, a small employer could potentially qualify for the credit for a total of six taxable years.

The amount of the credit is generally equal to the "applicable tax credit percentage" (35 percent for the years 2010-13, or 50 percent thereafter) of the employer's contribution to the health insurance premium for each covered employee. Only nonelective contributions by the employer are taken into account in calculating the credit. As a consequence, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan is not treated as an employer contribution for this purpose.

More precisely, the credit is equal to the lesser of the following two amounts, multiplied by the applicable tax credit percentage: (1) the amount of contributions the employer made on behalf of employees during the taxable year, or (2) the amount of contributions the employer would have made if each employee had enrolled in coverage with a "benchmark premium." Under the second of these two amounts, the benchmark premium is multiplied by the number of employees enrolled in coverage, and then multiplied by the uniform percentage that applies for calculating the level of coverage selected by the employer (which must be at least 50 percent).

For the first phase of the credit (for taxable years beginning in 2010 through 2013), the "applicable tax credit percentage" is 35 percent. The "benchmark premium" is the average total premium cost in the small group market for employer-sponsored coverage in the employer's state. The benchmark premium will vary based on the type of coverage provided to the employee (that is, single, adult with child, family or two adults). For taxable years beginning in years after 2013, the applicable tax credit percentage is 50 percent.

The credit is reduced for employers with more than 10 FTEs but not more than 25 FTEs. The credit is also reduced for an employer for which the average wage of its employees is between $25,000 and $50,000.

Elimination of Deduction for Retiree Prescription Drug Subsidy. In a change that has made headlines for its financial effect on public companies, the deduction for retiree prescription drug plan subsidies has been eliminated, effective for taxable years beginning after December 31, 2012.

Tax Code Provisions for Dependent Children. The new legislation modifies the Tax Code provision that excludes from employees' income the value of employer-sponsored health coverage. It does so by extending that exclusion to the coverage of certain adult children. In particular, the legislation extends the general exclusion for the reimbursement for medical care expenses (that is, benefit payments) under an employer-provided accident or health plan to any

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"Benefits payable under a health flexible spending account under a cafeteria plan will be limited to $2,500 per employee for any taxable year."

child of an employee who has not attained age 27 as of the end of the taxable year. The legislative history suggests that this change is also intended to apply to the exclusion for employer-provided coverage (that is, the value of coverage) under an accident or health plan for injuries or sickness for such a child, though the language of the legislation does not itself seem to make this change. A similar change has been made in the rules for VEBAs and Section 401(h) accounts. Further, the legislation in a similar fashion amends the Tax Code to permit self-employed individuals to take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the taxable year.

For these purposes, the term "child" means an individual who is a son, daughter, stepson, stepdaughter, or eligible foster child of the taxpayer. (Under the Tax Code, a legally adopted child of the taxpayer or an individual who is lawfully placed with the taxpayer for legal adoption by the taxpayer is treated as a child of the taxpayer by blood.) An eligible foster child means an individual who is placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

This change in the tax rules appears to be effective as of either March 23, 2010, or March 30, 2010.

Cafeteria Plans, HSAs, and HRAs

Offering Exchange-Participating Qualified Health Plans. Effective for years beginning after December 31, 2013, qualified health plans offered through an exchange are not "qualified benefits" permitted to be offered through a cafeteria plan. There is, however, an exception for a small employer offering employees the opportunity to enroll in a qualified health plan in a group market through such an exchange. Beginning in 2017, if a state allows insurance companies to offer qualified health plans in the large group market through an exchange, a large employer may make available under its cafeteria plan a qualified health plan that it offers through an exchange.

Medicine Under HSAs, FSAs, and HRAs. Reimbursement for medicine or a drug will be a qualified medical expense eligible for favorable tax treatment under a health savings account only if it is a prescribed drug or is insulin. A drug that is available without a prescription, but which is in fact prescribed, will qualify for favorable treatment. Similar rules will apply to health plans, flexible spending accounts, and health reimbursement arrangements. The rules for health savings accounts (and similar rules for Archer MSAs) are effective for amounts paid with respect to taxable years beginning after December 31, 2010. The rules for health plans, FSAs, and HRAs are effective for expenses incurred with respect to taxable years beginning after December 31, 2010.

Increase in Tax on HSA Distributions. The tax on distributions from HSAs and Archer MSAs that are not for qualified medical expenses is increased from 10 percent to 20 percent, effective for distributions made after December 31, 2010.

Health FSAs Limited to $2,500. Benefits payable under a health flexible spending account under a cafeteria plan will be limited to $2,500 per employee for any taxable year. This change is effective for taxable years beginning after December 31, 2012. The $2,500 figure will be adjusted for inflation for years beginning after December 31, 2013.

Simple Cafeteria Plans for Small Businesses. The legislation adds a provision allowing small businesses to establish "simple cafeteria plans," effective for years beginning after December 31, 2010. Under this provision, if certain requirements are met a small employer, which is an employer that employed an average of 100 or fewer employees on business days during either of the two preceding years, enjoys a safe harbor from the nondiscrimination requirements

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for cafeteria plans. It also enjoys a safe harbor from the nondiscrimination requirements for specified qualified benefits offered under a cafeteria plan, including group term life insurance, benefits under a self-insured medical expense reimbursement plan, and benefits under a dependent care assistance program. The plan must, however, meet minimum eligibility and participation requirements, as well as minimum contribution requirements.

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Conclusion

It seems almost certain that modifications will be made to the health reform legislation over the next few years. Refinements seem inevitable given that the legislation makes such bold changes in current law and affects roughly one-sixth of the U.S. economy. In addition to substantive modifications to the law, we would expect future legislation to include certain "technical corrections" designed to clarify ambiguities in the law as passed last month, and to correct clear omissions and errors. We will be paying careful attention to these developments over the next several years, and to what is certain to be a massive volume of guidance from the regulatory agencies.

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