JONES DAY

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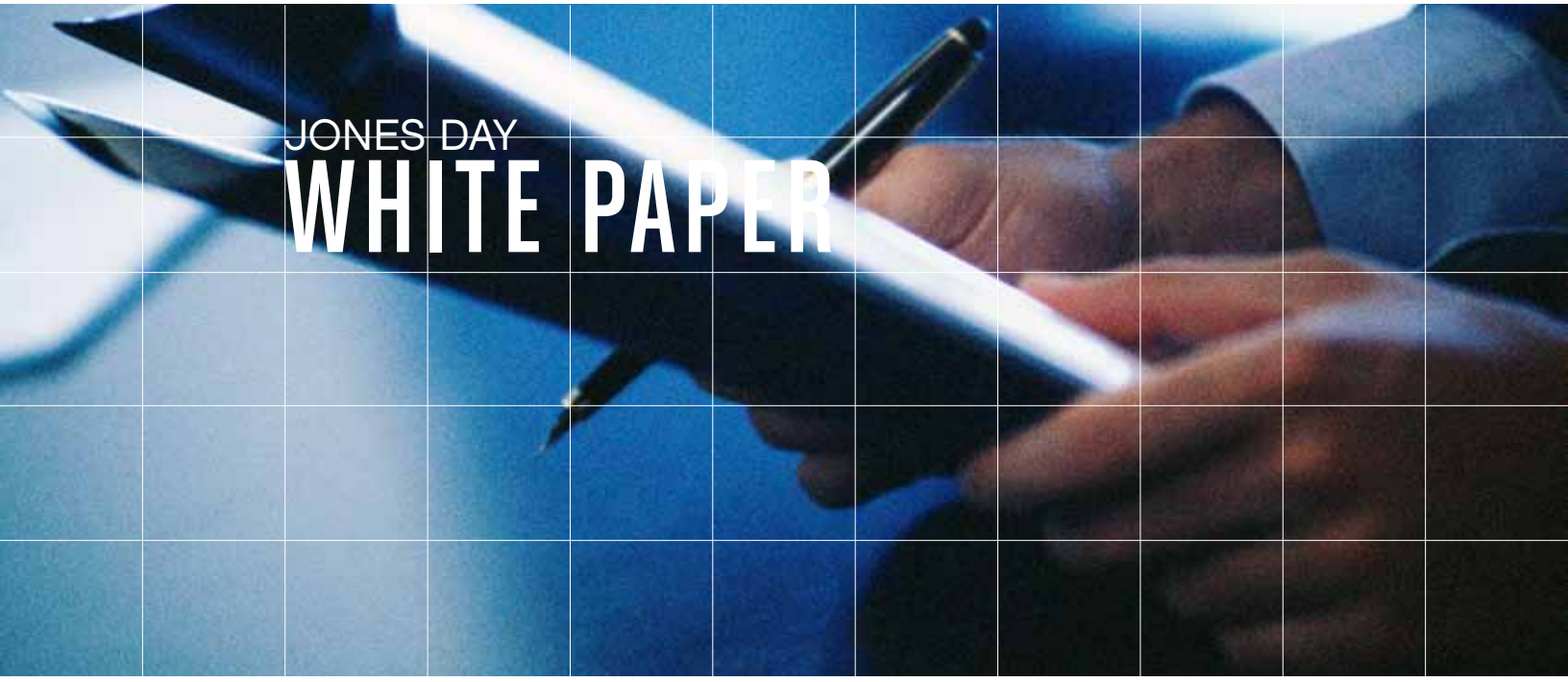

IMPACT OF HEALTH CARE REFORM LEGISLATION ON EMPLOYER-SPONSORED GROUP HEALTH PLANS

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IMPACT OF HEALTH CARE REFORM LEGISLATION ON EMPLOYER-SPONSORED GROUP HEALTH PLANS

I. OVERVIEW

On March 23, 2010, President Obama signed into law H.R. 3590, the "Patient Protection and Affordable Care Act" (P.L. 111–148, 124 Stat. 119), the health care reform bill originally drafted by the Senate. One week later, the President signed into law H.R. 4872, the "Health Care and Education Reconciliation Act of 2010" (P.L. 111–152, 124 Stat. 1029), which amended and modified H.R. 3590 as part of the budget reconciliation process (collectively, the "New Law"). The New Law makes a remarkable number of changes to the U.S. health care system, many of which directly affect employers in their role as sponsors of group health plans offered to current and former employees and their dependents. The New Law also significantly alters many other facets of the U.S. health care delivery and payment system, such as Medicare, Medicaid, and community health services.

Structurally, the New Law primarily amends two existing statutory schemes—the Public Health Service Act ("PHSA") and the Internal Revenue Code of 1986 (the "Code"). Although the New Law grants an important role to states in structuring insurance exchanges through which many individuals and small employers will, in the future, obtain health insurance, the New Law nonetheless federalizes to a significant degree the regulation of health insurance products, heretofore a regulatory area occupied almost exclusively by states. Moreover, historically, the primary federal law that regulated the design and administration of employer-provided health benefits was the Employee Retirement Income Security Act of 1974 ("ERISA"), and most of the pertinent regulations applicable to employer-provided health benefits were issued by the Department of Labor ("DOL"). But because the New Law codifies its substantive rules primarily in the PHSA and the Code—and adds only a few new provisions to ERISA, including a provision to incorporate by reference in ERISA the statutory changes to the PHSA (New ERISA § 715)—the Department of Health and Human Services ("HHS") and the Treasury Department ("Treasury") will likely displace the DOL as the primary regulatory agencies to interpret the myriad new coverage and disclosure mandates that will apply to employers.

The discussion and analysis contained in this White Paper focus almost exclusively on the changes that will be of interest to employers, both large and small. Because many provisions in both H.R. 3590 and H.R. 4872 were the result of hastily made and sometimes bitter compromise, a good deal of the statutory language is ambiguous and subject to multiple reasonable interpretations. Additionally, a significant piece of the overall reform architecture was left to HHS and the IRS to frame out in regulations and new disclosure forms. Accordingly, future government agency regulations and pronouncements as to the meaning of the New Law will be crucial in establishing the overall legal framework, as will any future technical correction legislation, assuming Congress has the political stomach for more health care reform.

II. THE LEGISLATIVE DESIGN TO INCREASE THE NUMBER OF INSURED AMERICANS

Perhaps the most important legislative purpose of the New Law is to increase the number of Americans with health insurance coverage, and to ensure that such health insurance satisfies certain minimum thresholds. The New Law does so in four ways: (1) by requiring most Americans to purchase health insurance coverage or pay an income tax penalty, (2) by facilitating the purchase of health insurance through "American Health Benefit Exchanges" ("Exchanges"), (3) by ensuring that health insurance offered through the Exchanges provides a minimum level of basic coverage, and (4) by requiring employers with 50 or more employees to offer health insurance coverage or pay a tax. These new rules provide a crucial context to the many other rules that directly affect employers.

A. THE INDIVIDUAL COVERAGE MANDATE

Under the New Law, most Americans will be required to purchase health insurance coverage or pay an income tax penalty. (New Code § 5000A(b)). The penalty phase begins in 2014, and in 2016 will generally be $695 annually per individual. Following 2016, the penalty will be indexed for inflation. (New Code § 5000A(c)(3)(D)). A taxpayer without health insurance coverage will be liable not only for his or her penalty

but also that of his or her tax dependents, to the extent they too are required, but fail, to obtain health insurance. The total family penalty will generally be capped at 300 percent of the $695 annual penalty. (New Code § 5000A(c)(2)). Certain taxpayers who cannot afford coverage, such as those whose gross income for the taxable year is below 100 percent of the federal poverty line or the threshold for filing a federal income tax return, will not have to pay the penalty. (New Code § 5000A(e)(2)). In addition, in order to help individuals purchase coverage, premium tax credits or cost-sharing subsidies will be available to persons with incomes below certain levels (New Code § 36B (premium tax credit); H.R. 3590 § 1402 (cost-sharing subsidy)). Individuals eligible for premium tax credits or cost-sharing subsidies are individuals whose household incomes exceed 100 percent but do not exceed 400 percent of the federal poverty line. Currently, the federal poverty line varies by household size.

B. THE INSURANCE EXCHANGES

The New Law authorizes each state, beginning in 2014, to create Exchanges where individuals and small employers can purchase health insurance coverage. (H.R. 3590 § 1311(b)). If a state fails to create an Exchange and to comply with HHS regulations respecting the structure of the Exchanges, HHS is tasked with establishing and operating an Exchange within that state. For these purposes, a "small employer" is an employer with 100 or fewer employees. (H.R. 3590 § 1304(b)(2)). Beginning in 2017, states may choose whether to allow employers with more than 100 employees to offer coverage for their employees through an Exchange. Participation by individuals and employers in coverage through an Exchange will be completely voluntary, and employers may continue to offer (and individuals to accept) coverage through non-Exchange health insurance arrangements. In order to ensure that the health insurance offered through the Exchanges satisfies a minimum threshold of coverage, a "health plan" offered through an Exchange must be certified by the Exchange, pursuant to HHS regulations, as a "qualified health plan." (H.R. 3590 § 1311(c)–(e)). For these purposes, a "health plan" needs to be offered by a licensed insurer, and it cannot be a self-insured plan sponsored by an employer and exempt from state regulation under ERISA's preemption rules. (H.R. 3590 § 1301(b)(1)).

Essentially, a "qualified health plan" will need to satisfy three categories of requirements. First, it will need to provide coverage that includes "essential health benefits." Essential health benefits will include coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse care, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric care (including pediatric oral and vision care). (H.R. 3590 § 1302). Although HHS is required to promulgate regulations that establish the complete requirements for "essential health benefits," coverage for emergency services may not be subject to prior authorization requirements, and the cost-sharing for out-of-network emergency services cannot exceed the cost-sharing that would apply if the services were obtained in-network. (H.R. 3590 § 1302(b)(4)(E)).

Second, for a health plan to be deemed to provide "essential health benefits," and thus constitute a "qualified health plan," it also must satisfy limits on cost-sharing. Specifically, the cost-sharing —*i.e.*, the sum of the annual deductible, coinsurance, and copayments—for a health plan that provides essential health benefits cannot in year 2014 exceed the limits applicable to a so-called high deductible plan under section 223(c)(2)(A)(ii) of the Code (currently, $5,950 for self-only coverage, and $11,900 for family coverage). Such amounts will be indexed after 2014. (H.R. 3590 § 1302(c)(1)). There also will be separate limits on annual deductibles for essential health benefit plans. (H.R. 3590 § 1302(c)(2)).

Third, the level of coverage that a "qualified health plan" must provide needs to satisfy one of five actuarial thresholds in to-be-prescribed HHS regulations: (1) a "platinum level" plan (providing coverage equal to 90 percent of actuarial value), (2) a "gold level" plan (providing coverage equal to 80 percent of actuarial value), (3) a "silver level" plan (providing coverage equal to 70 percent of actuarial value, (4) a "bronze level" plan (providing coverage equal to 60 percent of actuarial value, or (5) a catastrophic plan for persons under the age of 30 (at the beginning of the plan year) or those otherwise exempt from the individual mandate penalty tax. (H.R. 3590 § 1302(d), (e)(catastrophic plan)).

III. THE NEW LAW'S PROVISIONS AFFECTING EMPLOYERS

A. "PLAY OR PAY" MANDATE FOR EMPLOYERS WITH 50 OR MORE FULL-TIME EMPLOYEES

The New Law will generally require all employers with 50 or more full-time employees (which the New Law defines for this purpose as a "Large Employer") to either offer health insurance coverage constituting "minimum essential coverage" or be subject to a tax equal to $2,000 annually ($166.67 per month) for each full-time employee of the employer in excess of 30 employees. (New Code § 4980H(a), (c)(1)). For these purposes, an employer is defined by the controlled group rules of section 414 of the Code. The term "full-time employee" is defined as an employee working 30 hours or more each week. Also for this purpose, the hours of part-time employees are aggregated and counted as equivalent to a full-time employee, but only for determining Large Employer status for "play or pay" purposes. (New Code § 4980H(c)(2)). Additionally, an employer will not be subject to the play or pay rule if, in the prior year, the employer's workforce exceeded 50 full-time employees for only 120 or fewer days, and the employees in excess of 50 during that maximum 120-day period were seasonal workers. (New Code § 4980H(c)(2)(B)). This play or pay system will generally become effective for months beginning after December 31, 2013. (H.R. 3590 § 1513(d)).

Interestingly, the term "minimum essential coverage" does not require the employer to provide certain types of coverage or maintain certain cost-sharing limits, such as would apply to an "essential health benefits" plan eligible for certification by an Exchange as a "qualified health plan." (But see discussion below at Section II.E.5). Minimum essential coverage merely needs to be a group health plan offered by an employer. (New Code § 5000A(f)(defining "minimum essential coverage")). Furthermore, in order for the $2,000 per full-time employee annual tax to apply, at least one of the employer's full-time employees must enroll in a health plan offered by an Exchange and also qualify for a premium tax credit or cost-sharing reduction (discussed above at Section II.A).

However, if the "minimum essential coverage" provided by a Large Employer is not affordable to that employer's employees, other tax penalties will apply. Coverage provided by a Large Employer will not be considered affordable if either (1) the employee's share of the cost of coverage exceeds 9.5 percent of the employee's household income, or (2) the plan's share of the actuarial value of covered benefits (*i.e.,* the amount that the plan would pay toward the actuarially projected cost of covered services) is less than 60 percent. If the plan fails to meet either of these requirements with respect to an employee, the employee could decline such coverage and enroll in a qualified health plan through an Exchange and be eligible for a premium tax credit (despite the employer-offered coverage). If any full-time employee declines the employer plan under these circumstances and enrolls in a qualified health plan through an Exchange, the employer would be subject to a tax of $3,000 annually ($250 per month), times the number of such employees who enroll in the Exchange-offered "qualified health plan." (New Code § 4980H(b)(1)). The total monthly tax on an employer for any such month would, however, be capped at the amount that the employer would otherwise be taxed (as described in the paragraph above) if it did not offer a health insurance plan. (New Code § 4980H(b)(2)). Note that the $3,000 tax applies only with respect to full-time employees. Part-time employees who are eligible to enroll in the employer's plan and who eschew coverage and opt to enroll in an Exchange plan will not be aggregated and counted for purposes of calculating the $3,000 annual tax. This tax is effective for months beginning after December 31, 2013.

B. FREE CHOICE VOUCHERS

If an employer of any size—large or small—maintains a contributory health plan for employees, the employer must offer "free choice vouchers" to certain employees. More specifically, if an employee eligible for a free choice voucher opts out of the employer-provided plan and enrolls in an Exchange plan, the employer must pay to the applicable Exchange an amount equal to the monthly portion of the cost the employer would have paid had the employee chosen to enroll in the employer's plan. (H.R. 3590 § 10108). An employee who chooses not to enroll in the employer-provided plan qualifies for the free choice voucher if the employee's share of the cost of the employer-provided plan

exceeds 8 percent (but does not exceed 9.8 percent[1]) of such employee's household income, and the employee's household income exceeds 100 percent but not 400 percent of the poverty line. (H.R. 3590 § 10108(c)). The parameters of 8 percent and 9.8 percent of household income will be indexed for calendar years beginning after 2014 to reflect the rate of premium growth over the rate of income growth. It is not clear under the New Law which federal agency will have the regulatory authority under this provision, but it is likely to be HHS, since administration of the voucher program is linked to operation of Exchanges, and HHS will have the federal regulatory authority over determining Exchange-provided "qualified health plans."

If any employer offers several benefit plan options to employees, the monthly amount of the free choice voucher will equal the monthly cost of coverage under that option with respect to which the employer pays the largest portion of the cost for its employees. The statutory language is far less clear on which plan or option is required to be taken into account for purposes of determining whether the employee's share will exceed the 8 percent threshold to potentially trigger an employee's free choice voucher right. If the option with the greatest employer contribution is the exclusive option to be referenced in determining employee eligibility for vouchers, that might trigger the lowest number of eligible voucher employees. From the standpoint of administrative cost, such a rule would probably be the most favorable employer result. On the other hand, employers might wish to have a large pool of eligible voucher recipients, if they believe that lower paid employees carry adverse health risk. The regulations will need to clarify the issue of which employer option is to be referenced to determine eligibility for a free choice voucher.

An employee who receives the free choice voucher may use it as a credit against the premiums he or she would be required to pay for a premium under a "qualified health plan" offered through an Exchange. (H.R. 3590 § 10108). The value of the free choice voucher is generally exempt from federal income taxation (New Code § 139D), but if the value of the free choice voucher exceeds the monthly premium of the qualified health plan in which the employee chooses to enroll, the difference will be taxable income to the employee. As for the employer, the cost to the employer of the voucher is deductible compensation under Code section 162(a) (under an amendment to Code § 162), and the employer will not be assessed any taxes under New Code section 4980H, discussed above at Section III.A, with respect to employees who receive free choice vouchers. (New Code § 4980H(b)(3)).

C. AUTOMATIC ENROLLMENT RULE FOR EMPLOYERS WITH MORE THAN 200 EMPLOYEES

Employers who have more than 200 full-time employees, and provide one or more health benefits plans or options, will be required to automatically enroll full-time employees in one of the employer's health benefits plans or options (subject to any authorized waiting periods), and to continue the enrollment of current employees in such plan or option. This new rule is an amendment to the Fair Labor Standards Act (New FLSA § 18A, 29 U.S.C. § 218A), and is one of the few changes made by the New Law that will be implemented pursuant to DOL regulations (although the regulatory authority within the DOL will lie with the Wage and Hour Division of the Employment Standards Administration, not the Employee Benefits Security Administration, which has authority over ERISA). Under new FLSA section 18A, employers also will be required to give adequate notice to employees of the automatic enrollment protocol and an opportunity to opt out of such coverage.

Interestingly, for those employers that offer more than one health benefit plan or benefit option, the automatic enrollment requirement does not dictate the particular option or plan into which the employer is required to automatically enroll the new employee. On its face, the statute leaves that determination to the employer (although the forthcoming regulations may, contrary to the plain language of the statute, circumscribe the choice). Similarly, on its face, new section 18A of the FLSA appears to require only that the full-time employee be automatically enrolled, and not his or her spouse or dependents. Furthermore, it does not provide a time frame by which the employer must enroll the new employee, although the new provision can be read to require the enrollment as of the first day on which the new employee is eligible for coverage.

1 The 9.8 percent was supposed to be 9.5 percent in order to dovetail with the premium tax credit and cost-sharing subsidy rules, respectively, but the conforming language was never added.

It is unclear when the new automatic enrollment rule will be effective. The new rule states that automatic enrollment shall be "in accordance with regulations," which have yet to be promulgated. Although that language is susceptible to a reading that the rule is not effective until the regulations are issued, the better reading is that employers are required to comply with the statutory dictates consistent with the regulations, if there are any. Under the latter interpretation, the new rule would be effective as of the date of enactment, *i.e.,* March 23, 2010. Pending regulatory guidance, employers should engage in a good-faith effort to work with their insurers or third-party administrators to comply with the requirements as soon as practicable, and should consider requiring employees to execute a short "decline coverage" form.

We are aware that some commentators are taking the position that the new automatic enrollment rule will not be effective until the applicable regulations are issued, while others take the position that Congress intended that the rule was not to be effective until 2014. In light of how courts have interpreted similar statutory language in certain sections of ERISA, and the uncertainty respecting potential remedial relief, we do not recommend such an approach if it can be practically avoided. *See generally Donovan v. Cunningham*, 716 F.2d 1455 (5th Cir. 1983)(acknowledging DOL's failure to issue regulations to determine ERISA's "adequate consideration" requirement, where statute requires adequate consideration determination "in accordance with [DOL] regulations," and interpreting and applying statutory requirement in any event).

D. KEY RETIREE HEALTH PROVISIONS IN THE NEW LAW

1. Limits on Deductions for Certain Retiree Prescription-Drug Expenses

Under existing Medicare Part D rules, plan sponsors of certain qualified, employment-based retiree health plans that cover prescription drug expenses are eligible for subsidy payments from HHS for a portion of each "qualifying covered retiree's" prescription drug costs. The Medicare Part D subsidy, as it is called, encourages plan sponsors to provide retiree prescription drug coverage that is at least equivalent to Part D coverage, and thus avoid the need for those retirees to join the Part D system. The subsidy is currently excludible from the plan sponsor's income, and such exclusion is *not* taken into account in determining whether the plan sponsor may claim a tax deduction for those covered retiree prescription drug expenses. (Code § 139A). For taxable years beginning after December 31, 2012, however, the New Law modifies this regime so that the plan sponsor cannot take a deduction for retiree prescription drug expenses for which subsidy payments are received, effectively making the Medicare Part D subsidy payments taxable to the recipient. (H.R. 3590 § 9012 (amending Code § 139A); and H.R. 4872 § 1407).

This future tax law change has caused an immediate accounting issue for large employers that receive the Part D subsidy. Under Financial Accounting Standard 109 ("FAS 109"), employers are required to show as an asset on their balance sheets the present value of future tax deductions relating to future Part D subsidy payments. The New Law change, however, has the effect of reducing the FAS 109 value of the tax asset, and accountants have interpreted the accounting rules as immediately requiring employers to take a charge against earnings for the reduced value of this tax asset. We are not aware of any serious consideration being given by the Financial Accounting Standards Board to providing relief from this immediate adverse accounting change. It is unclear the extent to which this adverse accounting and tax treatment will cause employers to re-evaluate whether to continue to provide retiree drug coverage at current levels.

2. Government Reinsurance for Early Retiree Medical Costs

Although the loss of tax deductibility for the Part D subsidy will harm employers that provide retiree health benefits, the New Law also provides potential financial reimbursement to employers if their retiree health arrangements cover early retirees. The New Law establishes a temporary reinsurance program through which the government will reimburse eligible plans for a portion of the cost of providing coverage to early retirees and their spouses, surviving spouses, and dependents. (H.R. 3590 § 1102). On the face of section 1102, the reinsurance program does not require a plan to provide certain minimum levels of coverage in order for the plan to be eligible for reimbursement, but forthcoming HHS regulations might impose such a requirement.

The program is to begin no later than 90 days after enactment (June 21, 2010), but sunset on January 1, 2014. The program will be available to a group health plan providing health benefits to early retirees that is maintained by one or more current or former employers (employee organizations and other entities also qualify). The coverage offered to early retirees may be self-insured or delivered through an insurance product. "Early retirees" are defined as individuals who are age 55 or older, who are not eligible for Medicare, and who are not covered under the plan as active employees. A group health plan must apply to participate in the program (under future HHS regulations), must implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions, must provide documentation of the actual cost of medical claims involved, and HHS must certify the plan as eligible for reinsurance payments.

HHS will reimburse the plan for valid early retiree health care claims at a rate of 80 percent of the amount of the "claim," but it will only reimburse claims that are greater than $15,000 but not in excess of $90,000 (as adjusted for inflation each fiscal year). Because reimbursement will not be available for claims less than $15,000, as a practical matter the reinsurance program will apply overwhelmingly to inpatient hospital stays and high-end chronic conditions, although the definition of the term "claim" in the forthcoming regulations will be crucial in determining what medical costs will be considered to be part of a single claim.

Reinsurance program payments must be used to lower costs for the plan or participants. Thus, in situations in which the plan is funded by the employer, the statutory language is properly read to allow employers to use reimbursements to reduce the employer's future premium costs. Reimbursements also may be used to reduce employee premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket plan costs of plan participants. The payments may not be used as general revenues for the plan sponsor. Payments received under the program are not included in the gross income of the recipient. Funding for the program, however, is limited to $5 billion, and therefore interested, eligible employer plans should move swiftly once the regulations are proposed to be able to identify reimbursable claims and apply to receive benefits.

E. MANDATES FOR EMPLOYER-PROVIDED PLANS

1. The General Structure of the Employer-Mandate Rules, Including Incorporation of PHSA Changes in the Tax Code, and "Grandfathered Health Plans"

As widely discussed in the popular press, the New Law imposes a variety of mandates on "group health plans" and "health insurance issuers." These new requirements include rules governing who must be afforded coverage by such plans and insurers, what types of services must be covered, cost-sharing rules governing such coverage, and what coverage limitations can be imposed. The new requirements are primarily added to the PHSA. The term "group health plan" was previously added to the PHSA by the HIPAA legislation of 1996 and, for purposes of the requirements added by the New Law, is defined to mean "an employee welfare benefit plan . . . to the extent that the plan provides medical care . . . to employees or their dependents . . . directly or through insurance, reimbursement or otherwise." (PHSA § 2791(a)). Because an employee welfare benefit plan, in turn, means an insured or self-insured health arrangement sponsored or maintained by an employer or union (or both) for employees, *see* ERISA § 3(1), by imposing these new requirements on "group health plans," the New Law effectively imposes them on virtually all employer-provided health programs for employees. The term "health insurance issuer" is defined to mean an "insurance company, insurance service, or insurance organization . . . licensed to engage in the business of insurance in a State and which is subject to State law . . . ." (PHSA § 2791(b)). Therefore the mandates imposed by the New Law also will apply to any health insurance policies issued by carriers, whether for the individual or group market. Note, however, that the new requirements do not apply to limited scope benefits (such as dental and vision benefits) that are provided under a separate policy or are not otherwise an integral part of the group health plan. (New Code § 5000A(f)(3)).

As discussed in the Overview above, the New Law incorporates into ERISA by reference the provisions it adds to Part A of Title XXVII of the PHSA. (New ERISA § 715). Similarly, the New Law incorporates into the Code by reference the same provisions it adds to Part A of Title XXVII. (New Code § 9815). Because New Code section 9815 is located within Chapter 100 of Subtitle K of the Code, and Code section 4980D applies to "any failure of a group health plan to meet [any of]

the requirements of Chapter 100," the effect of incorporating these PHSA provisions through New Code section 9815 is to penalize violations of these new mandates through the Code section 4980D penalty. Specifically, violations of the new PHSA provisions discussed at Sections E.2, 3, 4, 5, 6, and 7 below would be subject to the Code section 4980D tax. Under section 4980D, employers who sponsor or maintain group health plans are required to pay a tax of $100 per day during the noncompliance period with respect to each individual to whom a violation relates (although the tax is limited in cases of unintentional failure, and small employers (less than 50 employees) are exempt to the extent they provide coverage through insurance).

The New Law also contains certain grandfathering rules. It effectively provides that group health plans or health insurance coverage do not need to comply with certain of the new mandates made in the PHSA for "individuals who were enrolled" in such plans or coverage on March 23, 2010. Such plans are defined as "grandfathered health plans." (H.R. 3590 §§ 1251(e), 10103(d), and H.R. 4872 § 2301). In addition, the grandfathered health plan status extends to new enrollees in an otherwise grandfathered health plan, including family members of current enrollees, new employees, and family members of new employees. In the discussion of the mandates that follow, we identify which new rules will apply to "grandfathered health plans."

On its face, the definition of "grandfathered health plan" would appear to include collectively bargained plans, because such plans fall within the definition of a "group health plan." Nonetheless, section 1251(d) of H.R. 3590 creates a special effective date for "health insurance coverage maintained pursuant to [a] collective bargaining agreement," which includes both single and multiemployer bargained plans. Section 1251(d) provides that the new mandates "shall not apply ***until the date*** on which the last of the collective bargaining agreements relating to the coverage terminates." (Emphasis added.) This subsection thus appears to carve out collectively bargained plans from the ambit of "grandfathered health plans," and it has the effect of applying the new mandates to all such plans when the last applicable collective bargaining agreement expires.

2. New Rules on Who Must Be Covered by Employer Plans

- **Extension of dependent coverage to age 26.** Group health plans and health insurance issuers that offer coverage for dependent children will be required to continue to make such coverage available for an adult child until such child turns 26 years of age, whether or not such child is married. (New PHSA § 2714). This provision will not, however, require group health plans and insurers to make coverage available for a child of a child receiving dependent coverage (*i.e.,* there is no "grandchildren" coverage requirement). This reform will become effective for plan years on or after September 23, 2010, and it applies to grandfathered health plans. Thus, all employer-sponsored plans will be required to comply with the new age 26 rule, except that, for plan years before January 1, 2014, grandfathered plans do not need to extend coverage to adult dependents who are eligible to enroll in another plan that is sponsored by the adult dependent's employer. A conforming change was made to section 105(b) of the Code, providing beneficial tax treatment for dependent health coverage until the child attains age 27.

  Although New PHSA section 2714 requires coverage only "until" the child turns age 26, while the new language in Code section 105(b) extends the tax exclusion to a child who "has not attained age 27," the provisions are probably not in conflict. It is common for group health plans to continue to allow enrolled dependent children to keep their coverage until the end of the month (or even until the end of the plan year) in which they "age out" of the plan. By having the Code definition of "dependent" in section 105(b) extend to age 27, an employee will be able to continue coverage of a dependent through age 26, without adverse tax consequences to the employee.

- **Waiting periods.** Group health plans and health insurers will be prohibited from imposing more than a 90-day "waiting period," *i.e.,* the period that a new employee and family members must wait before coverage is provided under a plan. (New PHSA

§ 2708). Presumably, this rule will not override the more aggressive requirement currently in the PHSA (and ERISA and the Code) respecting newborn and adopted children, but that is not clear. The existing rule requires that such children and their parents have a special right to enroll in group health plans as of the date of birth or placement for adoption, as long as enrollment is requested within 30 days from the birth or adoption placement date. (PHSA § 2701(f)(2(C), ERISA § 701(f)(2(C), Code § 9801(f)(2)(C)). The rule in new PHSA section 2708 is effective for plan years beginning on or after January 1, 2014, and will apply to grandfathered health plans.

3. **New Rules on Limitations of Coverage**

- **Prohibition against pre-existing condition exclusions.** Group health plans and insurers will be prohibited from excluding individuals from coverage "on the basis of any pre-existing condition exclusion." (New PHSA § 2704(a)). This rule will apply with respect to enrollees under the age of 19 for plan years beginning on or after September 23, 2010. For enrollees age 19 and over, the prohibition will apply for plan years beginning on or after January 1, 2014. This prohibition on pre-existing condition exclusions will also apply to grandfathered health plans.

  To be sure, as a consequence of the HIPAA rules of 1996, there are existing rules applicable to the imposition of pre-existing condition exclusions on group health plans and insurers in the individual market. (PHSA § 2701, ERISA § 701, Code § 9801). The New Law, however, effectively creates a blanket prohibition on pre-existing condition exclusions for all individual insurance policies and employer plans. Further, as a consequence of the HIPAA rules, the term "pre-existing condition exclusion" is already defined in the PHSA, ERISA, and the Code (*see, e.g.,* PHSA § 2701(b)(1)), and HHS, DOL, and Treasury promulgated final regulations in 2004 that interpret and apply the term "pre-existing condition exclusion." (45 C.F.R. §§ 144.103, 146.111-119, 29 C.F.R. §§ 2590.701-1 – 2590.701-7, 26 C.F.R. §§ 9801-1 – 9801- 6). Presumably the existing regulations will continue to apply to the extent they define what constitutes a "pre-existing condition exclusion," but not to the extent they guide employers as to what types of exclusions are lawful, given the New Law's blanket prohibition.

  Moreover, the current legal requirement to provide certificates of creditable coverage was not removed from the law, which is temporarily sensible given that the New Law's elimination of pre-existing condition exclusions will not apply until 2014 for adults. Current regulatory action is needed, however, to promptly eliminate the burden of creditable coverage certificates in connection with children under age 19 when the New Law becomes applicable.

- **No lifetime or annual benefit limits.** Group health plans, and insurers, are also prohibited from providing coverage that contains a lifetime limitation on the dollar value of "essential health benefits" for any participant or beneficiary. Similarly, group health plans and insurers are prohibited from imposing annual limitations on the dollar value of "essential health benefits" to any participant or beneficiary. (New PHSA § 2711(a)(1)). This provision is otherwise applicable for plan years beginning on or after September 23, 2010, and it will apply to grandfathered health plans. Prior to January 1, 2014, however, a group health plan is free to establish a "restricted annual limit" on the dollar value of an individual's benefits that are part of "essential health benefits" as determined by HHS. Additionally, group health plans and insurance carriers will remain free to impose either lifetime or annual limits on benefits that will not constitute "essential health benefits."

- **No rescissions.** Group health plans and health insurers will generally be prohibited from rescinding coverage with respect to an enrollee once such enrollee is covered. The exceptions will be for fraud or intentional misrepresentation by the enrollee, nonpayment of premiums, termination of the plan, or loss of eligibility. (New PHSA § 2712). This new rule is effective for plan years beginning on or after September 23, 2010, and will apply to grandfathered health plans.

4. **New Anti-Discrimination Requirements**

   - **Prohibition against discrimination based on "health status" factors and exception for wellness programs.** Group health plans and insurers are prohibited from establishing eligibility rules based on certain enumerated health-status-related factors with respect to an individual or a dependent (*e.g.,* health status, medical condition (physical or mental), claims experience, medical history). (New PHSA § 2705(a)). This new section is almost identical to existing statutory rules prohibiting discrimination based on health status factors applicable to employer-provided group health plans under section 2702(a) of the PHSA, section 702(a) of ERISA, and section 9802(a) of the Code. Presumably, the existing regulations jointly promulgated by the Department of Labor, HHS, and Treasury interpreting and applying existing law will apply to new PHSA section 2705.

     A key change that the New Law makes, however, is in connection with wellness programs. Existing law allows employer-provided health plans to include wellness programs that have the effect of granting premium discounts, rebates, and other favorable terms for certain participants based on wellness considerations. (ERISA § 702(b)(2)(B), PHSA § 2702(b)(2)(B), Code § 9802(b)(2)(B)). DOL, HHS, and Treasury have promulgated joint regulations to allow various types of wellness arrangements. (45 C.F.R. § 146.121(f), 29 C.F.R. § 2590.702(f), 26 C.F.R. § 9802-1(f)). New PHSA section 2705(j) codifies as statutory law virtually all elements of the existing regulation, with some minor language changes and one important difference. Under existing regulations, the reward for successful participation in an otherwise lawful wellness program cannot exceed 20 percent of the cost of the coverage for the employee (20 percent of the cost of family coverage if family members participate). Under new PHSA section 2705(j)(3)(A), the reward may not exceed 30 percent of the cost of employee-only coverage under the plan (or 30 percent of family coverage for family participation). HHS, Labor, and Treasury are authorized to increase this percentage to 50 percent if appropriate. For example, if the 50 percent ceiling were put into effect and an employer offered health insurance in which the cost of single-employee coverage was $1,000 per month, the employer could implement an anti-smoking wellness program in which nicotine-free employees would contribute $200 a month toward coverage, and employees with a nicotine habit would contribute $700 a month toward coverage (as long as the employer also granted smokers the opportunity, in accordance with existing regulations, to participate in an anti-smoking program and earn the lower $200 premium).

     We have two initial observations regarding this change. One is the interplay between these new statutory wellness rules and the Americans With Disabilities Act ("ADA"). The ADA prohibits an employer from requiring an employee to undertake a medical examination unless, *inter alia*, the exam is voluntary and part of an employee health program. (42 U.S.C. § 12112(d)(4)). The EEOC has interpreted the term "medical examination" broadly and has taken the position that wellness programs that penalize employees who do not participate will not be treated as voluntary. Consequently, these ADA prohibitions have historically impeded the development of creative wellness programs. The New Law did not modify these ADA rules, and we have found nothing in the New Law that would indicate that it overrules existing ADA law. Therefore, the ability of employers to design wellness programs with incentives of up to 30 percent of premium cost might be prohibited by ADA rules.

     Second, new PHSA section 2705, including the wellness rules, applies for plan years beginning on or after January 1, 2014, but does not apply to grandfathered health plans. This raises the question whether grandfathered health plans would be prohibited from using the new incentive ceiling of 30 percent of premium cost in designing wellness plans. The better argument is that grandfathered health plans should not be so precluded.

- **Prohibition against discrimination in favor of highly compensated individuals in insured health plans.** Currently, under Code section 105(h), the value of amounts that a discriminatory self-insured plan pays or covers for "highly compensated individuals" are taxable to such individuals. Moreover, Code section 105(h)(2) prohibits discrimination both in connection with eligibility for benefits and benefits actually provided to highly compensated individuals. The New Law does not amend Code section 105(h) to extend its prohibitions to insured arrangements. However, new PHSA section 2716 requires group health plans that are not self-insured plans to satisfy the requirements of Code section 105(h)(2). Because this new rule is embedded in the PHSA and incorporated into the Code through new Code section 9185 (see discussion above at Section III.E.1), rather than by amendment to Code section 105(h), the penalty for violation of new PHSA section 2716 will be a tax on the employer under Code section 4980D. This is in contrast to Code section 105(h), which prohibits discrimination in favor of the highly compensated in self-insured plans by penalizing the recipient of the discriminatory benefit. In addition, because new ERISA section 715 (discussed above at Section I) incorporates by reference the changes made to the PHSA by the New Law, there could be the prospect of private party litigation under ERISA brought by lower paid employees alleging violations of new PHSA section 2716, and seeking retroactive equal treatment in the form of the better benefits allegedly provided to "highly compensated employees."

  New PHSA section 2716 is effective for plan years beginning on or after September 23, 2010 and does not apply to grandfathered health plans. Under the grandfathered plan exception, it would appear that such plans could apply existing design provisions that might be deemed discriminatory to current, and even newly hired, "highly compensated employees" without running afoul of new PHSA section 2716. It also is a fair reading of the grandfathered health plan rules to allow existing insured plans to be amended to provide new benefits exclusively to current or newly hired "highly compensated employees" without application of section 2716, but HHS regulations might say otherwise. If so, it is worth noting that while most of the mandates in the New Law apply to both group health plans and group health insurance issuers, new PHSA section 2716 applies only to insured group health plans. Accordingly, even if section 2716 were interpreted to apply to future modifications to existing health benefit designs that are discriminatory in favor of highly compensated employees, there may be structures available to an employer whereby it can cause an insurer to issue a special benefits policy, or to provide special coverage, to such highly compensated individuals without such policy and arrangement being treated as part of a new (non-grandfathered) group health plan. These arrangements, however, need to be very carefully considered in light of new PHSA section 2716. *See, e.g., Tucker v. Employers Life Ins. Co*, 689 F Supp 1073 (N.D. Ala. 1988) (individual policies issued to several employees collectively constituted a group health plan governed by ERISA).

- **Prohibition on discrimination against employees who exercise PHSA rights.** The New Law amends the Fair Labor Standards Act to prohibit employers from discharging an employee or discriminating against an employee with respect to any of the terms of his or her employment merely because the employee has received a premium tax credit for use in paying for a "qualified health plan," or obtained a cost-sharing subsidy, or provided information about a violation of the PHSA provisions. (New FLSA § 18C, 29 U.S.C. § 218C). The relief available to such employee in the event of such a violation will be the same as that provided under the whistleblower protections of the Consumer Product Safety Improvement Act.

5. **New Coverage Requirements**
   - **"Essential health benefits" requirement for insurance sold to small groups.** As noted in the "play or pay" discussion above at Section III.A, for purposes of the Code section 4980H tax on employers, the employer is not required to provide a group health plan that includes a certain minimum level of benefit. Yet as a practical matter, virtually all employers

with 100 or fewer employees provide health benefits through an insured product rather than self-insurance. Consequently, such employers' ability to shape the design of their health plans is at the mercy of the insurance market, which heretofore was regulated almost exclusively by the respective states. In many states, catastrophic only or minimum benefit products have been made available to employers. New section 2707(a) of the PHSA, however, potentially alters that equation. That section provides that a health insurance issuer that offers health insurance in the "small group market" (*i.e.,* for "small employers") must "ensure that such coverage includes the essential health benefits package required" for "qualified health plans" under the Exchanges. For these purposes, a "small employer" is considered an employer that employed on average no more than 100 employees on business days during the prior calendar year. (H.R. 3590 § 1304(b)(2)). As discussed above in Section II.B., an "essential health benefits" package must provide broad levels of coverage and must limit cost-sharing.

It is unclear whether the language of PHSA section 2707(a) effectively means that any and all insurance products offered to employers with fewer than 100 employees will contain the "essential health benefits" minimums, or whether at least one such product offered to such employers must contain such minimums. The statutory language, while susceptible to either reading, is likely to be interpreted to require that all insurance product offerings contain the minimums. If so (and HHS will advise by regulation), it would appear that the ability of a small employer to acquire a low-cost, catastrophic only type product is eliminated by the New Law, and that may significantly increase the cost of coverage for small employers. Moreover, it is unclear how the grandfathered health plan rules will be affected by this new insurance carrier obligation. It may be the case that the forthcoming HHS regulations will prohibit carriers from renewing any existing policies unless the renewal arrangement satisfies new PHSA section 2707(a). New PHSA section 2707(a) will become effective for plan years beginning on or after January 1, 2014.

- **Cost-sharing limitations for all group health plans, insured and self-insured.** In addition to the cost-sharing limitations described above on products in the small group market by virtue of new PHSA section 2707(a), new PHSA section 2707(b) bars group health plans—and therefore self-insured plans for large employers as well as insured arrangements for small employers—from imposing annual cost-sharing rules that are different from those imposed for "essential health benefits" arrangements. Annual cost-sharing (including the annual deductible) may not exceed $5,950 for individual coverage and $11,500 for family coverage, and annual deductibles may not exceed $2,000 for single individuals and $4,000 for spouse and family coverage (with such limits allowed to be increased by amounts "readily available" for reimbursement under a flexible spending account). For plan years beginning in 2015, HHS also may index this limit relative to the increase in the per capita cost of health insurance in the United States. Nonetheless, this limit on deductibles may significantly impede the ability of employers to offer truly high deductible plans. This limitation is effective for plan years beginning on or after January 1, 2014, and will not apply to grandfathered health plans.

- **No cost-sharing for certain preventive services.** It is common for employer-provided health insurance to impose co-payments or co-insurance in connection with nearly all categories of covered services, including many preventive services. But the New Law will require group health plans and insurers to cover certain preventive medicine services—including certain immunizations and certain screenings for infants, children, adolescents, and women—and prohibit imposition of any cost-sharing for such preventive services. (New PHSA § 2713). While new PHSA section 2713 does not define the term "cost-sharing," other sections of the PHSA indicate that cost-sharing includes deductibles. (New PHSA § 2715(b)(3)(D)). Therefore, deductibles likely will not be permitted to be imposed in connection with the services covered by PHSA section 2713. New PHSA section 2713 will be effective for plan years beginning on or after September 23, 2010, and will not apply to grandfathered health plans.

- **Limitations on prior authorization requirements, primary care provider designation restrictions, and restrictions for emergency services coverage.** The New Law will subject group health plans and health insurance issuers to several "patient protection" requirements. A plan that requires the designation of a participating primary care provider will be required to allow participants to choose any such provider who is available (including the choice of a pediatric specialist as the primary care provider for a child). Additionally, group health plans that cover emergency services will be required to cover such services without the need for prior authorization and without regard to any term or condition of the coverage, or whether the provider participates in such plan. Group health plans also will not be able to require authorization or a referral before a female participant/beneficiary could seek obstetrical or gynecological care from a professional specializing in such care. (New PHSA § 2719A). These requirements will be effective for plan years beginning on or after January 1, 2014, but will not apply to grandfathered health plans.

6. **New Disclosure Requirements**

- **Uniform explanation of coverage.** Currently under ERISA, administrators of group health plans are required to provide enrollees with a summary plan description ("SPD") that explains the material terms of the plan, and a summary of material modification when material changes are made to such plans. (ERISA § 104(b)). The New Law creates separate summary benefit disclosure obligations under the PHSA that, at the very least, overlap with the SPD rules of ERISA. Specifically, new PHSA section 2715 requires HHS, by March 23, 2011, to develop standards for group health plans and insurers to provide to each applicant and enrollee a four-page summary of benefits and coverage explanation. The summary must be in at least 12-point font, and must describe the coverage under such plan, including details on cost-sharing, "exceptions, reductions, and limitations on coverage," and whether the coverage meets the standard to constitute "minimum essential coverage." For insured plans, the health insurer will be required to provide the summary. For self-insured plans, the plan sponsor (*i.e.,* the employer) or the plan administrator will need to provide the summary. (New PHSA § 2715(d)(2)). The summary must be provided to any applicant for coverage at the time he or she applies for coverage, and to an enrollee prior to the time of enrollment or reenrollment. (New PHSA § 2715(d)(1)). Failure to provide the summary would subject the health insurance issuer or plan sponsor/administrator to a penalty of up to $1,000 for *each* such failure. (New PHSA § 2715(f)). In addition, a violation of new PHSA section 2715 will subject employers to the $100 per day, per individual tax under Code section 4980D. (*See* discussion above at Section III.E.1). This new PHSA section 2715 will apply to grandfathered plans. (H.R. 3590 §§ 1251(a)(3), 10103(d)).

Clearly, this new summary benefit description obligation will, to a significant degree, duplicate the current SPD obligations imposed on plan administrators under ERISA. Moreover, it may not be feasible for plan administrators—even if authorized to do so by regulation, which would appear unlikely—to include the four-page summary required by PHSA section 2715 within the four corners of an SPD, in light of the number of occasions that the new summary will need to be provided to employees. Indeed, as benefit plans have become increasingly complex, plan administrators have struggled with how to keep SPDs relatively short in size and informative to average employees. The ability to include in a four-page summary the information required by new PHSA section 2715 would appear difficult. Finally, to the extent that employers (or insurers in the case of insured health arrangements) will have to provide a separate summary benefit description as required by PHSA section 2715, and a separate SPD as required by ERISA section 104, it will be crucial to ensure that the two documents are synchronized and do not contain conflicting rules. If any such documents are in conflict, the employer may bear the risk that if litigation were brought based on the conflict, a court would find that the document whose language

is most favorable to participants wins the conflict. *Cf. Burke v. Kodak Retirement Income Plan*, 336 F.3d 103(2d Cir. 2003)("the consequences of an inaccurate SPD must be placed on the employer").

- **Reporting of health insurance coverage.** The New Law adds reporting requirements under new sections 6055 and 6056 to the Code, designed to collect information regarding compliance with the employer "play or pay" rules and the individual coverage mandate. Large employers subject to the "play or pay" rules will be required to file a return regarding their compliance. In addition, all entities providing coverage that allows an individual to meet the individual coverage mandate will be required to file a return regarding the coverage provided to individuals. In both instances, the return will include specific information about the coverage, who was covered, and the dates of coverage. It may be feasible for the IRS to allow employers to satisfy these new reporting demands through a revised Form 5500 rather than new IRS form, but it is unclear at this time whether it will do so.

  In connection with the filing of each of these returns, the employer will be required to provide a statement to each individual the employer lists in the filing that advises the individual of the information the employer has reported to the IRS with respect to him or her. Thie requirement appears to be similar to the current W-2 and 1099 processes. Because one of the goals is to determine whether the individual coverage mandate is met with respect to all individuals enrolled in the plan, group health plans and health insurance issuers will need to collect tax identification numbers (Social Security numbers) from all participants. Such a collection effort has begun for many group health plans to meet Medicare Secondary Payer Reporting requirements, but it will need to be expanded in order to comply with these reporting requirements. These requirements will apply beginning with the 2014 calendar year.

- **"Transparency" disclosures.** Group health plans and issuers will be required to make certain "transparency" disclosures to HHS (and to the applicable state insurance commissioner and to the public), including information on claims-payment policies and practices, number of claims denied, rating practices, enrollment (and disenrollment), and information on cost-sharing and payments with respect to out-of-network coverage. (New PHSA § 2715A). To some degree, this new rule overlaps with the annual requirement to file Form 5500s and the disclosures required by the Form 5500, but it is conceivable employers will be required to satisfy these new filing obligations through new forms rather than by amendment to the existing Form 5500 structure. This requirement will apply to plans and issuers after guidance is issued by HHS. The effective date will likely not be until 2014 because this requirement mirrors a requirement imposed on coverage offered through an Exchange. This requirement does not apply to grandfathered plans.

- **Written Notice Upon Hiring.** Under changes made to the Fair Labor Standards Act, the New Law will require employers to provide all current employees, not later than March 1, 2013, and thereafter to all new employees, written notice apprising them of their health care coverage options. (New FLSA § 18B, 29 U.S.C. § 218B). This notice must include information regarding the available employer-sponsored coverage, as well as information about the Exchange and the employee's potential eligibility for a premium tax credit or cost-sharing subsidy. The DOL will issue regulations providing more guidance on the content and distribution of this notice.

- **W-2 Reporting.** Under the New Law, employers must include the aggregate cost of certain employer-sponsored health coverage on an employee's Form W-2. (New Code § 6051(a)(14)). The coverage to which this requirement relates is the coverage taken into account in determining whether the Cadillac-Plan Tax applies. (*See* discussion below at Section IV).

The cost of coverage will be determined in a manner similar to that used for determining cost for COBRA purposes. This provision is effective for taxable years beginning after December 31, 2010. Therefore, employers should be prepared to include this information when preparing Form W-2s in 2012, as this requirement will apply for the 2011 tax year.

7. New Benefit Claim Dispute Resolution Rules

The New Law requires all group health plans and health insurance issuers to implement an "effective appeals process" for appeals of coverage determinations and claims. (New PHSA § 2719). An effective appeals process will require the plan or issuer to (1) have in effect an internal claims appeal process, (2) provide notice to employees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollee in the appeals process, and (3) allow an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. Initially, a group health plan can comply with the internal claims and appeals processes that are currently contained in the ERISA regulations that were published in 2000 (including provisions applicable to urgent care claims), *see* 29 C.F.R. § 2560.503-1, and is required to "update such process" in accordance with future standards established by DOL. (New PHSA § 2719(a)).

A group health plan and health insurance issuer also must implement an external review process. The external review process is to be satisfied either (1) by complying with applicable state external review processes that, at a minimum, include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners, or (2) by implementing an effective external review process that meets minimum standards established by HHS through guidance and that is similar to the requirements in (1) above if either the applicable state has not issued appropriate guidance, or if the plan is a self-insured plan that is not subject to state insurance regulation. (New PHSA § 2719(b)). For the time being, HHS may deem the external review process of a group health plan or health insurance issuer that is in effect as of the date of enactment of the New Law to be in compliance with the new external review requirements. New PHSA section 2719 is effective for plan years beginning after September 23, 2010, but will not apply to grandfathered health plans.

Because of the exclusion for grandfathered health plans, existing group health plans should be immune from these new appeal provisions to the extent that the provisions go beyond ERISA section 503 and the applicable DOL regulations. However, because new PHSA section 2719 also applies to insurers, if the forthcoming HHS regulations require insurers to amend their existing policies to comply with these new rules, existing insured employer plans will find themselves subject to the new PHSA section 2719 requirements indirectly through regulation of insurers.

For those plans to which these new rules will apply, the biggest change from existing federal requirements will be the imposition of an external appeal right (certain states currently mandate external appeals for insured plans, although such state laws typically limit external appeal rights to claim disputes involving medical necessity denials). Such an additional dispute resolution layer obviously will increase the cost of claims administration, particularly if courts extend the judicially-created ERISA exhaustion doctrine and require claimants to also exhaust this new external appeal right prior to gaining access to federal court. New PHSA section 2719 also changes the existing regulatory framework by allowing benefit claimants to "present . . . testimony as part of the appeals process." It is unclear whether the regulations will limit that testimony right merely to the new external appeal stage. Under existing regulations, which provide only for internal appeals, the process authorizes parties to submit documents and records but there is no express requirement to allow testimony. Finally, it is unclear how the new requirement "to receive continued coverage pending the outcome of the appeals process" will be interpreted, and an unnecessarily expansive interpretation could provide significant administrative and cost burdens on plans and insurers.

F. TAX LAW CHANGES TO HFSAs, HSAs, HRAs, AND ARCHER MSAs

1. Contribution Limit on Maximum Health Flexible Spending Arrangements

Under the New Law, salary reduction contributions to a health flexible spending arrangement are limited to $2,500 for a taxable year. (New Code § 125(i)). This limitation is effective for taxable years beginning after December 31, 2012. This statutory maximum will be adjusted annually for inflation beginning in 2014.

2. Over-the-Counter Drug Coverage

Under the New Law, coverage for over-the-counter drugs (other than insulin) purchased without a prescription will be eliminated for Health Reimbursement Arrangements ("HRAs") and Health Flexible Spending Arrangements ("HFSAs"), and the cost of such drugs will be included in gross income when paid or reimbursed from Health Savings Accounts ("HSAs") and Archer MSAs. (Code §§ 223(d)(2), 220(d)(2), 106(f)). This change is effective for amounts paid (by HSAs or Archer MSAs) or expenses incurred (for HFSAs and HRAs) with respect to taxable years beginning after December 31, 2010.

3. Increase in Penalty on Certain HSA and Archer MSA Distributions

The New Law increases the "penalty" for distributions from an HSA or Archer MSA that are used for purposes other than to pay "qualified medical expenses" to 20 percent, from the existing 10 percent for HSAs and 15 percent for Archer MSAs. (H.R. 3590 § 9004). These distributions also continue to be included in the recipient's gross income. This change is effective for distributions made after December 31, 2010.

IV. OTHER NEW TAXES AND TAX-LAW CHANGES

A. THE CADILLAC-PLAN TAX

For taxable years beginning after December 31, 2017, the New Law imposes an excise tax on "Cadillac Plans" (New Code § 4980I). Cadillac Plans are plans with a total coverage cost that exceeds $10,200 for individual coverage and $27,500 for other than individual coverage. The Cadillac Plan tax will equal 40 percent of the cost of the coverage on a monthly basis that exceeds the thresholds described above (the excess benefit). The threshold limits are higher for persons in high-risk professions set forth in the New Law, including emergency personnel, and persons in certain jobs related to construction, utilities, and agriculture. In addition, the New Law provides for adjustments to the thresholds for firms whose health care costs are higher because of the age and gender of their employees. The Cadillac Plan tax is imposed on health insurance issuers for insured plans and on the plan administrator for self-insured plans. The Cadillac Plan tax is not discussed further in this analysis because the effective date is not until 2018, and it is likely that significant changes to the provision will occur before it is effective.

B. FICA TAX INCREASE

The New Law increases the rate of the "Hospital Insurance" tax (part of FICA) on wages for certain taxpayers, from 1.45 percent to 2.35 percent. (Code § 3101(b)). The increase applies only to the employee portion of the Hospital Insurance tax, not to the employer portion of the tax. A parallel increase applies to the self-employed under the provisions applicable to SECA taxes. (Code § 1401(b)). The increase applies to wages in excess of the following amounts: (1) for married taxpayers who file joint returns, $250,000, (2) for married taxpayers who file separate returns, $125,000, and (3) for all others who file returns, $200,000. Although this tax is imposed on employees, an employer will still be obligated to deduct and withhold for the hospital insurance tax from wages paid to such employees. (Code § 3102(a)). These changes for the FICA tax will be effective for taxable years beginning after December 31, 2012.

C. NEW "UNEARNED INCOME" TAX

The New Law also imposes an additional income tax of 3.8 percent upon individuals as well as upon estates and trusts for "unearned" income. (New Code § 1411). For an individual, the tax would be imposed on the lesser of "the individual's net investment income" for the taxable year, or the excess, if any, of a specially defined "modified adjusted gross income" over the threshold amount for the taxable year. For this purpose the threshold amount is (1) $250,000 for married taxpayers filing a joint return, (2) $125,000 for taxpayers filing a return as married filing separately, and (3) $200,000 for all others who file returns. (New Code § 1411(b)). Net investment income for this purpose includes income from

"interest, dividends, annuities, royalties and rents," other than amounts that are derived in the ordinary course of a trade or business. (New Code § 1411(c)). Certain items are explicitly excluded from the definition of "net investment income" for these purposes, including distributions from qualified employer retirement plans, and items taken into account in determining self-employment income for the year if a tax is imposed on that income by Code section 1401(b), as described above in Section IV.B. The "unearned income" tax would apply to taxable years beginning after December 31, 2012.

D. New Taxes on Health Plans to Fund Outcomes Research

The New Law imposes new fees on "specified health insurance policies" and applicable self-insured health plans, for policy and plan years beginning after September 30, 2013. These new fees are scheduled to expire for policy years and plan years ending after September 30, 2019. (New Code §§ 4375, 4376, and 4377.) These fees will be deposited in a trust fund for the benefit of the newly established Patient-Centered Outcomes Research Institute (a nonprofit corporation), whose purpose is to advance the quality and relevance of evidence concerning the manner in which health conditions are effectively and appropriately prevented. For purposes of the new fees, "a specified health insurance policy" is any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States (except for limited-scope dental and vision coverage). Fixed payments or fixed premiums are treated as specified health insurance coverage if the fixed payments or fixed premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to U.S. residents. An applicable self-insured plan is a health benefit plan that does not provide coverage through an insurance policy, and in the case of an employer-funded self-insured plan, the employer will be liable for the tax. The fee is $2 for each year ($1 for the year ending in 2013) multiplied by the average number of lives covered under the plan. Thus, for an employer-funded self-insured plan covering 5,000 employees and 15,000 dependents, the annual fee would be $40,000.

E. SMALL EMPLOYER TAX CREDIT

The New Law provides for a tax credit for small businesses and tax-exempt organizations that provide health care coverage for their employees. (New Code § 45R). To qualify for the credit, the employer must have fewer than 25 full-time equivalent employees (based on a 40-hour work week) and pay wages averaging less than $50,000 per full-time equivalent employee per year. Because the qualification is based on full-time equivalent employees, an employer could have more than 25 employees and still qualify, if some of those employees work part-time. In addition, to qualify for the credit, the employer must contribute at least 50 percent of the premium cost of the coverage. New Code § 45R is effective immediately. For the 2010–2013 tax years, the maximum credit is 35 percent of employer-paid premiums (25 percent for tax-exempt organizations), with the premium amount used in this calculation capped by the average premium for the local small group market. Beginning with the 2014 tax year, the maximum credit increases to 50 percent (35 percent for tax-exempt organizations). An employer with 10 full-time equivalent employees and average annual wages per full-time equivalent employee of $25,000 would receive the maximum credit. The credit is subject to a gradual phase out for employers with full-time equivalent employees in excess of 10 or average annual wages in excess of $25,000. In other words, the credit is targeted to smaller employers with lower paid employees. In addition, for tax-exempt organizations, the total credit is capped by the total amount of the organization's employee income tax withholding and Medicare employment taxes for the year. Small businesses would claim the credit on their 2010 income tax return, while tax-exempt organizations would claim the credit as described in forthcoming guidance. On April 1, 2010, the IRS released FAQs in connection with the small employer tax credit. *See* IR News Release 2010-38.

V. EXPANDED REQUIREMENTS FOR ELECTRONIC STANDARD TRANSACTIONS

The New Law adds additional requirements regarding the performance of electronic standard transactions by health plans, health care providers, and health care clearinghouses under HIPAA. HHS is directed to issue additional guidance with the goals of providing as much uniformity as possible in the performance of electronic standard transactions, reducing the number and complexity of forms and data entry required, and eliminating, to the extent possible, the need for paper or other non-electronic communications. The New Law provides a staggered schedule for the issuance of new guidance, with guidance on different topics being issued no later than July 1 of 2011, 2012, and 2014. The new guidance will be effective also on a staggered schedule with effective dates on January 1 of 2013, 2014, and 2016. Health plans will be required to certify and provide documentation showing that their data and information systems are in compliance with the applicable standards and rules. This requirement will have the largest impact on health insurance issuers and third-party administrators, as these are the entities that generally perform electronic standard transactions on behalf of health plans. The cost of compliance will undoubtedly increase the cost of providing health coverage in the short term. However, in the longer term, it may result in increased operating efficiencies and therefore decreased administrative costs.

VI. CONCLUSION

There will be significant challenges and uncertainties confronting employers and health care administrators in applying the New Law and forthcoming regulatory guidance to their particular group health plans. To help clients and friends navigate these complex and often ambiguous rules, Jones Day will be issuing a series of *Commentaries* on the new health care reform law and regulations, and this *White Paper* is merely one in that series.

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