Summary of Pending Healthcare Legislation

PRACTICE AREAS

Benefits & Compensation

Health & Welfare

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There are numerous health care reform bills wandering through Congress simultaneously, including multiple versions of H.R. 3200 as approved by separate committees, and a new Senate HELP Committee bill called the Affordable Health Choices Act.

The changes proposed by Congress will impact your benefits program in both large and small ways. Also, keep in mind that these changes are in addition to, and do not replace, numerous existing laws which govern health and welfare plans, including ERISA, COBRA, HIPAA, and nondiscrimination requirements like Section 105(h) of the Internal Revenue Code.

Below is a list of twelve significant features common to the proposed bills and how they might impact your program.

1. **Qualified Health Benefits Plan.** What does this mean for us?

The federal government would set up insurance "exchanges" through each state. All U.S. legal residents would be expected to purchase health care coverage through an exchange, if they do not have a qualifying offer of coverage from an employer (or Medicare, Medicaid, etc.). Lower-income individuals would be eligible for subsidized coverage.

Employers could continue to maintain their own health plans for employees, outside the exchange. However, employers - especially those who sponsor self-insured plans - will have far less freedom to design company benefits because the federal government will dictate how the plans must be structured. Some of the requirements of a "qualified health benefits plan" with regard to coverage, benefits and cost are listed below.

Coverage required: Each large employer must make a pay-or-play election with regard to whether to offer health care coverage to its employees. If qualifying coverage is not offered, then the employer is liable for a payroll tax, subject to a $100/per day penalty. The bills vary on the amount of the payroll tax, with the House favoring a tax equal to 8% of average wages, and the Senate favoring a flat $750 per full-time employee. If qualifying coverage is offered but the employee opts out, then you would still have to pay the payroll tax.

Auto enrollment may be required for the lowest cost option.

- **Tip**: Under the House bill, separate elections can be made for full-time and part-time employees, as well as for separate lines of business (SLOBs). You may want to closely examine whether your business model can be divided into SLOBs. It may be cost-effective to offer coverage to some groups while allowing other (lower-paid) groups to obtain coverage through the government exchange - even though you would still be on the hook for the payroll tax on their behalf. Offering coverage actually may *limit* a low-paid employee's access to government subsidies through the exchange. Such federal subsidies may be more generous than subsidies offered by employer plans.

Benefits required (overview):

- No pre-existing condition exclusion
- Preventive care, maternity care, professional services
- Hospitalization and outpatient care
- Prescription drugs
- Rehabilitative services
- Mental health and substance abuse parity
- Nondiscrimination in benefits (based on personal traits, not income)

Cost requirements:

- No annual or lifetime limits on benefits
- No cost-sharing for preventive care (except for de minimis co-pays)
- Limited out-of-pocket costs for participants (e.g., $5,000 per year for individuals and $10,000 per year for family, indexed by CPI)
- Mandatory employer contributions of at least 60% of premium (higher under House bill: 65% to 72.5%)
- Co-pays may be limited

- Restrictions on premium disparity among participants
- **Tip**: Given across-the-board budget pressures, these significant cost-sharing changes may force you to reexamine your entire compensation and benefits package.

1. **Effective Date**. Do we have to change our plan for 2010?

No. Current employer-sponsored group health plans are grandfathered, postponing the conversion to a "qualified health benefits plan" until January 1, 2018.

1. **ERISA Preemption**. Will we lose ERISA preemption?

This is definitely a risk. The legislation generally seems to preserve ERISA preemption for employment-based group health plans that operate outside the Exchange. Plans that operate through an exchange, however, may be subject to state-law claims and remedies.

At least one House amendment would require the Secretary of Labor, acting in consultation with the Secretary of Health and Human Services, to waive ERISA preemption (except under extraordinary circumstances) for any state that institutes a single-payer health care system. Such a system would force employer participation in the state program, and it would expose the employer plan to state-law causes of action.

1. **Claims Process**. Would our claims process change?

Not right away. For employment-based group health plans, the claims process would remain unchangedat least initially. The claims process introduced by Congress would apply only to plans operated through the Exchange. This claims process, however, may be extended to employer plans at a future date, at the discretion of the Health Choices Commissioner (to be appointed to head a newly-created agency).

The Commissioner would implement a new claims process which would significantly change the current regime. This process would establish an external review process to conduct an independent and *de novo* review of claims that are denied in an internal administrative review. The determination would be binding.

While the details are vague on the external review process, it appears that it may be built upon existing state law procedures. The bills reference the preservation of rights and remedies under state law, which raises frightening questions about the possibility of potential state law causes of action against employers. At a minimum, the bills indicate that your internal administrative decisions would no longer be granted deference upon review.

1. **Retiree Medical**. Does it make sense to continue our retiree medical plan?

You may not have a choice. A separate bill proposed by the House (H.R. 1132) would prohibit any reductions in employer-sponsored retiree health benefits after an individual retires, unless the same changes are made to benefits offered to active employees.

Both House and Senate bills also would offer a (temporary) financial incentive to encourage employers to maintain retiree medical coverage. This program would reimburse employers up to 80% of the cost per enrollee (age 55-64), for amounts in excess of $15,000 and up to $90,000. This reimbursement (up to $60,000 per enrollee) must be used to lower costs borne directly by participants and beneficiaries (i.e., premiums and co-pays). To be eligible to participate in the program, employers must apply for reimbursement.

This program would expire when the appropriated funds ($10 billion) run out.

If you maintain a VEBA as a retiree medical funding vehicle, you should be able to redirect these funds, in the event that you terminate your retiree medical program. VEBA assets could be used to provide other benefits to VEBA members, such as life or accident insurance, or vacation pay plans. In contrast, a 401(h) account in your pension plan can be used only to satisfy medical liabilities and expenses.

1. **Domestic Partners**. Can we still offer domestic partner benefits?

Yes. In fact, revisions made by the House Ways and Means Committee would *extend* current tax benefits for employer-provided health care to domestic partners, to the extent that domestic partners are eligible for coverage under your plan. This means that a domestic partner would not be taxed on the value of benefits under the plan - regardless of whether he or she qualifies as a dependent - and could pay for health care premiums with pre-tax dollars. This provision would take effect in 2010. Similar rules might apply to older children, and other relatives and beneficiaries.

1. **COBRA**. Will our COBRA obligations change?

Very likely. Proposed legislation approved by the House Education and Labor Committee includes an amendment that would dramatically expand COBRA coverage for former employees. This amendment would allow all COBRA beneficiaries to continue coverage until eligible for benefits under a new employer's health plan or through a federal or state health insurance exchange. These exchanges will not be established until 2013, but extended COBRA coverage could be required before then.

1. **Flexible Spending Accounts**. Can we still allow employees to pay for out-of-pocket medical costs on a pre-tax basis?

Probably, but subject to new restrictions. Flexible spending accounts have been a popular target of Congressional leaders looking to raise revenue. Some proposals would eliminate these accounts entirely.

The current legislative proposals support keeping FSAs, but imposing restrictions on their usage. For example, legislation will likely exclude over-the-counter drugs (other than insulin) from FSA coverage.

1. **Comparative Effectiveness**. What does this mean for us?

Congress has ordered HHS to undertake research on the comparative effectiveness of various medical programs and procedures. This will mean more taxes for employers because the research will be funded by an additional per capita tax on insurers and sponsors of self-funded plans, tentatively equal to $2 per covered individual under the plan (indexed by CPI).

1. **Wellness Programs.** Can we offer discounts for healthy behavior?

Probably. The Senate bill would permit employers to provide incentives (such as premium discounts, rebates, or reduced co-pays) of up to 30% to encourage participation in health promotion or disease prevention programs. Regulations could extend these discounts to 50%. Employers still would be subject to HIPAA privacy and nondiscrimination rules, however. It is considered likely that the House bills will be revised to include similar provisions.

1. **Reporting**. Do we have additional reporting obligations too?

Yes. At a minimum, employment-based group health plans likely will need to submit a return annually to the Secretary of Treasury, describing the names, addresses and TINs of all covered individuals. A similar statement would need to be sent to each insured, on the same timeline as the Form W-2. This would take effect for 2013, when the exchanges are established.

1. **Surtaxes on High Income Taxpayers.** How might the proposed surtaxes impact our highly paid employees?

Current proposals would impose an annual surtax on high income taxpayers that would take effect in 2011. This surtax would be equal to 5.4% on income over $1 million, under current proposals. Income between $350,000 and $1 million would be subject to a slightly smaller surtax.

Certain executives may wish to take their money out of your nonqualified plans before the surtaxes take effect. In order to avoid the surtax in 2011, any nonqualified plans subject to Section 409A would have to be terminated *in 2009*. This is because benefits cannot be distributed until at least 12 months have elapsed following termination of the plan. Grandfathered plans may permit additional flexibility.

Note: Code section 409A would prohibit you from establishing a new nonqualifed plan within three years following any nonqualified plan termination. Consequently, a plan termination should not be considered lightly, especially since executives may wish to make additional deferrals after the surtaxes take effect.