HUMAN CAPITAL PRACTICE

ALERT: HEALTH CARE REFORM BILL

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THE DEVIL IN THE DETAILS OF HEALTHCARE REFORM

Employers are asking: What about our employee health care plans? Are they subject to the new health care reform law? Whose job is it to make sure they comply with health care reform? Are any parts of our current plans exempt from the new reform measures? The answers vary and depend on the health care reform provision in question as well as on whether a plan was in effect on March 23, 2010.

For example, some health care reform provisions impose no obligations on employers or their plans; they make insurers or other third parties responsible for compliance. Other provisions apply to employers or employer-sponsored plans, but exempt certain employers or plans. And for some provisions – we just don't know. We must wait for regulatory guidance to clarify who is responsible for compliance and exactly which plans are subject to the requirement.

Even so, some provisions are already effective and others will be soon, so employers need to understand how and where the provisions with the earliest effective dates apply. See the attached chart for an overview of the applicability of several health care reform provisions that become effective during 2010 and 2011. Below, we provide some important background information to consider when reviewing the chart.

WHAT WE LEFT OUT – AND KEPT

The chart provides applicability information for health care reform provisions that become effective during 2010 and 2011 and apply to employer-sponsored plans. To keep the chart as brief as possible, we omitted details of the health care reform provisions, almost all of which are explained in Willis' Human Capital Practice *Alert,* Vol. 3, No. 3, **"First Things First: Health Care Reform in 2010 and 2011."** (For a short overview of health care reform provisions that will affect employer plans and their effective dates, see Willis Human Capital Practice *Alert,* Vol. 3, No. 1, **"What Do We Do Now? Health Care Reform Timeline."**)

We also omitted the following health care reform provisions from the attached chart, even though they are effective in 2010 or 2011:

- Small employer tax credits, so-called simple cafeteria plans, and other provisions that apply exclusively to small employers (we are covering those provisions and their applicability separately)
- Increased penalties in the case of distributions from HSAs and Archer MSAs for non-qualifying expenses (as long as the employer does not provide guidance on reimbursable expenses or take actions that would make these accounts subject to ERISA, individual owners of these accounts – not employers – are responsible for compliance)
- Preparing and providing uniform explanations of coverage and other health care reform provisions that, although technically effective in 2010 or 2011, will not require compliance before 2012

EMPLOYERS SUBJECT TO THE PROVISIONS

Most health care reform provisions apply across the board to all types of employers that sponsor health plans for their employees, so the attached chart does not include separate categories for plans maintained by different types of employers. For example, plans maintained by church and governmental employers generally are subject to the same requirements as those maintained by private sector employers (although the remedies available for noncompliance differ). Plans of both for-profit and not-for-profit organizations are likewise subject to the requirements, and there is no general exemption for small employers. (Some provisions have specific small-employer carve-outs, however.)

PLANS SUBJECT TO THE PROVISIONS

Any plan that provides, pays for or reimburses the cost of health care may be subject to one or more provisions of the health care reform law. Therefore, non-health plans that incidentally include health benefits (e.g., an accident plan that includes medical evacuation benefits) generally will be subject to health care reform requirements with respect to the health benefits. Similarly, non-health benefits included in a health plan (e.g., a medical plan that provides fitness club reimbursement) generally do not become subject to health care reform provisions.

Health care is defined broadly for purposes of identifying health benefits. It includes "diagnosis, cure, mitigation, treatment, or prevention of disease," and services and supplies used for "affecting any structure or function of the body." The definition includes medical, dental and vision coverage, as well as health care flexible spending accounts, executive physical programs, and employee assistance programs. If the plan is available through employment, then the employer may have responsibility for compliance with respect to that plan. While most employment-based health benefits are provided as group coverage, it is important to note that an employer may have obligations with respect to individual health insurance coverage.

TYPES OF COVERAGE SUBJECT TO THE PROVISIONS

The attached chart shows our current understanding of which types of coverage will be subject to the health care reform provisions listed. Where there are variations in applicability based on the type of employer or plan providing the coverage, those are noted. Each of the coverage types listed in the chart is described below. When the chart notes that a particular coverage type is exempt from a requirement, it is important to read the description of that coverage type carefully. In many cases, the description sets out the conditions that must be met for the coverage to be exempted from a requirement.

Here is how we define the coverage types identified in the overview table.

MAJOR MEDICAL refers to a plan that provides coverage of most medical expenses with either no or very high lifetime or annual limits on coverage. Examples of major medical plans are typical HMOs, PPOs and high-deductible health plans associated with health savings accounts.

MINI-MED plans are those that employers often offer to part-time or low-paid employees for whom the cost of major medical coverage is prohibitive. Some mini-med plans reimburse or pay a percentage of covered medical expenses, subject to very low lifetime or annual limits on benefits. Other mini-med plans provide benefits consisting of indemnity-type payments (e.g., $15 for a physician visit, regardless of actual cost). In some cases, mini-med plans include both types of benefits. It is possible for mini-med plans to be self-insured, but most are insured.

EXECUTIVE MERP are medical expense reimbursement plans typically provided to a select group of senior executives and often simply reimburse those individuals for any health care expenses that are not covered by the plans made available to employees generally. They are almost always insured in order to avoid nondiscrimination provisions that apply to self-insured plans.

STAND-ALONE DENTAL OR VISION coverage provides dental or vision benefits through a policy, certificate or contract of insurance separate from a major medical plan or is optional, with employees who elect the coverage being required to pay an additional amount.

HEALTH FSA is one type of flexible spending account offered through a cafeteria plan. In most cases, employers do not contribute to health FSAs – all contributions are employee pre-tax amounts. We use this term to refer to a program that: (1) is offered in addition to a major medical plan that has an annual open enrollment, and (2) has a maximum available benefit no greater than twice the employee's pre-tax contribution or, if greater, $500 plus the employee's pre-tax contribution.

HRA (health reimbursement arrangement) is a plan under which an employer makes a specified dollar amount available to each participant to reimburse health care expenses, with no employee contributions allowed.

HOSPITAL OR FIXED INDEMNITY coverage is provided under a separate policy, certificate or contract of insurance, and pays a specified dollar amount for each day (or other period) that a covered individual is hospitalized or ill, regardless of whether or how much the individual incurs for care while hospitalized or ill and regardless of whether or how much any other plan of the employer pays.

SPECIFIED DISEASE is a separate policy, certificate or contract of insurance that provides coverage, including reimbursement of expenses for treatment, of a specified disease or illness, such as cancer or heart disease.

EAP refers to an employee assistance program that includes coverage for several mental health or substance abuse counseling sessions with a trained professional. Because those sessions are considered health care, EAPs usually are considered to be group health plans.

PROVISIONS UNRELATED TO HEALTH COVERAGE

Two provisions included in the health care reform law will affect employers, but not health plans.

TAX BREAK FOR ADOPTION BENEFITS

Starting this year, the amount of tax-favored benefits that an employer may provide through a qualified adoption assistance program increases to $13,170 per eligible child.

NURSING MOTHERS

Starting March 23, 2010, all employers that are subject to the federal Fair Labor Standards Act must provide for a nursing mother, during the year after her child's birth, as many unpaid breaks as needed to express breast milk for her child. The employer must also provide a place, other than a bathroom, that is shielded from view and free from intrusion for an employee to use when expressing breast milk.

WORK IN PROGRESS

Because we expect that regulatory guidance will refine our understanding of the employers, plans and coverage subject to various health care reform provisions, our focus in the attached chart is on provisions with early effective dates. This chart will be revised in coming months as guidance becomes available.

OVERVIEW: APPLICABILITY OF HEALTH CARE REFORM PROVISIONS

<table>
<tr><th>HEALTH CARE REFORM PROVISION</th><th colspan="9">TYPES OF GROUP HEALTH PLAN COVERAGE</th></tr>
<tr><th></th><th>MAJOR MEDICAL</th><th>HRA</th><th>EXECUTIVE MERP</th><th>MINI-MED</th><th>EAP</th><th>QUALIFYING HEALTH FSA</th><th>STAND-ALONE DENTAL OR VISION</th><th>HOSPITAL OR FIXED INDEMNITY</th><th>SPECIFIED DISEASE</th></tr>
<tr><td>Automatic enrollment of new employees and retention of current enrollees (subject to opt-out)</td><td colspan="9">Provision applies directly to employers who are subject to the FLSA and have more than 200 full-time employees with respect to “health benefits plans” (an undefined term that is unlikely to include all of these coverage types)
■ Enrollment is to be implemented according to DOL regulations and we believe that employers will not be required to comply until 2014, as we have stated in previous publications
■ Even so, effectiveness is not contingent on regulations being issued and no other effective date is specified, so the most conservative interpretation would say this provision is effective March 23, 2010 (upon enactment), regardless of plan year, grandfathered plan status (see definition below) or applicability of a collective bargaining agreement</td></tr>
<tr><td>No lifetime dollar limits on essential health benefits</td><td colspan="6" rowspan="4">Provisions apply to these coverage types during plan years starting on or after September 23, 2010 and employer is responsible for compliance, unless item 1, 2 or 3 applies:

1. Coverage includes no benefit that pays for or reimburses the cost of health care

2. Coverage is provided as a voluntary, employee-pay-all program under which:
■ Employer involvement is limited to allowing insurance representatives to publicize coverage to employees and collecting premiums through payroll deductions AND
■ The employer does not contribute toward the cost of the coverage, receive any compensation in connection with the program, or endorse the program in any way

3. Coverage is maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, so that provisions apply no earlier than the date that the last such collective bargaining agreement terminates

No exemption from these provisions is available for any “grandfathered plan” (any group health plan in effect and covering at least one individual on March 23, 2010 and any health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010)</td><td colspan="3" rowspan="4">Provisions do not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)</td></tr>
<tr><td>No annual dollar limits on essential health benefits, except as permitted by HHS</td></tr>
<tr><td>No rescission of coverage other than for fraud or intentional misrepresentation</td></tr>
<tr><td>No preexisting condition exclusions for children under age 19</td></tr>
</table>

HEALTH CARE REFORM PROVISION	TYPES OF GROUP HEALTH PLAN COVERAGE								
	MAJOR MEDICAL	HRA	EXECUTIVE MERP	MINI-MED	EAP	QUALIFYING HEALTH FSA	STAND-ALONE DENTAL OR VISION	HOSPITAL OR FIXED INDEMNITY	SPECIFIED DISEASE
No age limit lower than 26 years on dependent child coverage	Provision applies to these coverage types during plan years starting on or after September 23, 2010 and employer is responsible for compliance, unless: ■ Coverage does not provide for enrollment of dependent children ■ Item 1, 2 or 3 above applies Until the 2014 plan year, grandfathered plans (see definition above) may exclude children eligible for other employer coverage					Provision does not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			
No cost-sharing on specified preventive health services **Requirement for internal and external appeals processes**	Provisions apply to these coverage types during plan years starting on or after September 23, 2010, unless: ■ Coverage is provided through a grandfathered plan (see definition above) ■ Item 1, 2 or 3 above applies					Provisions do not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			
Protections regarding access to emergency care, pediatricians and obstetrician/gynecologists	Provision applies to these coverage types during plan years starting on or after September 23, 2010 and employer is responsible for compliance, unless: ■ Coverage is not network restricted and does not require designation of a primary care physician ■ Coverage is provided through a grandfathered plan (see definition above) ■ Item 1, 2 or 3 above applies					Provision does not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			
Extension of nondiscrimination rules to insured plans	Provision applies to these coverage types during plan years starting on or after September 23, 2010 and employer is responsible for compliance, unless: ■ Coverage is self-insured (provision changes the law to make insured plans subject to the same rules as self-insured plans) ■ Coverage is provided through a grandfathered plan (see definition above) ■ Item 1, 2 or 3 above applies					Provision does not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			

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No requiring disclosures about, or providing incentives based on, lawful possession or use of firearms	Provision applies to any "wellness and health promotion activity" and the effective date is specified as plan years starting on or after September 23, 2010, even though the provision apparently applies to wellness and health promotion activities undertaken by anyone in any setting, even if unrelated to health coverage If the provision is interpreted so that employers are responsible for compliance only in connection with the health plans they sponsor, it would apply to these coverage types during plan years starting on or after September 23, 2010 and employer would be responsible for compliance, unless: ■ Coverage is provided through a grandfathered plan (see definition above) ■ Item 1, 2 or 3 above applies					Provision applies to any "wellness and health promotion activity" and the effective date is specified as plan years starting on or after September 23, 2010, even though the provision apparently applies to wellness and health promotion activities undertaken by anyone in any setting, even if unrelated to health coverage If the provision is interpreted so that employers are responsible for compliance only in connection with the plans they sponsor, it would not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			
Federal tax exclusion for adult children's health coverage	IRS intends to issue regulations making the provision apply to premiums (or premium equivalents) for all of these coverage types starting March 30, 2010, regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement								
No incentives for employees to drop employer coverage in favor of coverage through temporary high-risk pool	Provision applies to "employment-based health plans" (an undefined term) starting March 23, 2010, regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement								
Medical loss ratios less than 85% (80% for small groups) result in rebates to enrollees	Provision may result in rebates to enrollees in these coverage types starting not later than January 1, 2011, unless: ■ Coverage includes no benefit that pays or reimburses health care costs ■ Coverage is maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, so that provisions apply no earlier than the date that the last such collective bargaining agreement terminates ■ Coverage is self-insured No exemption from this provision is available for any grandfathered plan (see definition above)					Provision does not apply to these coverage types (see descriptions of coverage types for details of the circumstances in which these types of coverage are exempt)			

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Restrictions on reimbursement of over-the-counter drugs	Provision applies to all of these types of coverage to the extent that they reimburse over-the-counter drugs starting January 1, 2011, regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement								
Requirement to report value of employment-based health coverage on W-2s	Provision applies to these coverage types starting with the W-2 issued for earnings during 2011 (usually issued in January 2012), regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement				To the extent that cost is attributable to coverage of health care, provision applies to this coverage type starting with the W-2 for pay during 2011 regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement	Provision does not apply to any health FSA, including one that does not meet the conditions noted in the description of this coverage type (except that any non-cashable employer contributions must be reported)	Provision does not apply to this coverage type (except that coverage must be reported if self-insured or provided under the same policy, certificate or contract of insurance as reportable coverage)	Unless payment for coverage is not excludable from employee's income, provision applies to this coverage type starting with the W-2 for pay during 2011, regardless of plan year, grandfathered plan status (see definition above) or applicability of a collective bargaining agreement	