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The LEGAL MONITOR

October 2010 Vol. XII, No. 3

Our New Mission Statement Says It All

by Chris Sackett, Managing Member

Strategic planning has never been more important than it is today. As part of our strategic planning process, we recently adopted a new mission statement that we believe aligns our interests, objectives and values with those of our clients. We think this alignment is one of the most critical elements in building the most powerful and effective attorney-client team possible. Our new mission statement also reaffirms those values that we hold most closely. By focusing both externally – on providing service, value and innovation; and internally – on cooperation, integrity, trust and respect – we believe we have charted a course that intertwines our success with yours and clearly reflects our firm's commitment to your business and the fulfillment of your mission. We hope you agree.

Our mission

BrownWinick will be the premier full service business law firm in our marketplace by providing the highest quality client service, creating value, and delivering timely and innovative solutions. We will cooperate to attract, service and retain clients and build loyal client relationships in an environment based on integrity, trust and mutual respect. ■

Healthcare Reform 2010

by Alice Eastman Helle

Key Provisions For Employers

The sweeping healthcare reform legislation enacted this year is complex and raises innumerable issues for employers. The new rules have varying effective dates, from 2010 to as late as 2018, and the rules for employers vary depending on the number of employees. The "large employer" threshold may be 25, 50, 100 or 200 employees, depending on the provision. Employee number thresholds for particular provisions will be noted where applicable.

Also, grandfather rules apply to existing plans and may alter or delay the requirements for those plans. A "grandfathered plan" is a group health plan or individual health policy that was in effect on the date of enactment (March 23, 2010). Grandfathered plans are exempt from some of the new rules and have later effective dates for others. The different rules for such plans are noted where applicable. *A separate article addressing the grandfathering rules is included in this issue for your reference.*

Similarly, health coverage maintained pursuant to a pre-March 23, 2010 collective bargaining agreement ("CBA") is exempt from certain provisions of the new law until the termination of the CBA. Those provisions are *not* specifically set out in this issue. Please contact your BrownWinick attorney if you have questions about a collectively bargained health plan.

Effective 2010

Tax Credits For Certain Small Employers (25 or less)

The new law provides small employers with a tax credit (i.e., a dollar-for-dollar reduction in tax) for employer contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its alternative minimum tax ("AMT") liability.

Small business employers eligible for the credit. A "small business" for purposes of the credit is a business that has **no more than 25** full-time equivalent employees ("FTEs"), and those employees must have annual full-time equivalent wages that average no more than $50,000. For this purpose, an FTE is an individual who works at least 40 hours per week. The full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than $25,000. The credit is phased out above those levels. To qualify for the credit, a business must offer health insurance to its employees and pay at least half the total premium cost. The IRS posted a flow chart on its website to assist employers in determining eligibility for the credit. The chart is online at: http://www.irs.gov/pub/irs-utl/3_simple_steps.pdf.

Years the credit is available. The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this period is coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees

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through a state exchange. That credit is available for only two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014. Thus, an eligible small employer could potentially qualify for this credit for six tax years - four years under the first phase and two years under the second phase.

Calculating the amount of the credit. For tax years beginning in 2010, 2011, 2012, or 2013, the credit is generally 35% (50% for tax years beginning after 2013) of the employer's contributions toward the employees' health insurance premiums. The credit phases out as company size and average wages increase. Tax-exempt employers meeting these requirements are eligible for payroll tax credits of up to 25% for tax years beginning in 2010, 2011, 2012, or 2013 (35% in tax years beginning after 2013) of the employer's contributions toward the employees' health insurance premiums.

Special rules. The employer will still be entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost, the employer can claim a deduction for the other 50% of the premium cost.

Self-employed individuals, including partners and sole proprietors, 2% shareholders of an S corporation, and 5% owners of the employer are not treated as employees for purposes of this credit. Any employee with respect to a self-employed individual is not an employee of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of FTEs or average full-time equivalent wages.

Automatic Enrollment (200+)

Employers who maintain one or more group health plans and employee at least 200 people must automatically enroll new employees in one of the plans subject to permissible waiting periods. Employees must be given adequate notice and the opportunity to opt out of coverage. No specific effective date for this provision was stated in the legislation, so it is technically effective this year, but the actual implementation date will be set out in regulations, which have not yet been issued.

Effective for Plan Years Beginning After September 23, 2010

Various coverage and benefit requirements are effective for plan years beginning after September 23, 2010 (January 1, 2011 for calendar year plans). These include the following, and apply regardless of employer size. Some requirements do not apply to grandfathered plans, as noted.

Dependent coverage extended to certain adult children. Group health plans and insurers that offer dependent coverage must allow uninsured children to remain on parent's health insurance until age 26. *Prior to 2014, this provision applies to grandfathered plans only to extent the "child" is not eligible for another employer-sponsored health plan.*

Lifetime and annual limits. Group plans cannot impose lifetime limits on coverage. Until 2014, plans may impose certain annual limits on essential health benefits, which is yet to be defined by regulations.

Preventative services. Plans must provide coverage for preventative services and immunizations with no cost-sharing. *This provision is not applicable to grandfathered plans.*

Rescissions. Insurers may not rescind coverage. There is, however an exception for fraud or misrepresentation.

Pre-existing conditions. Pre-existing condition limitations for children under age 19 will be prohibited.

Appeal procedures. Plans must implement an appeals process that includes an external review for appeals of both coverage determinations and benefit claims. *This provision is not applicable to grandfathered plans.*

Nondiscrimination. Insured group health plans are subject to the nondiscrimination tests of Internal Revenue Code § 105(h)(2), which previously applied only to self-insured plans. In a nutshell, this means that benefits must be equally available to all employees. Key employees cannot get special benefits. *This provision is not applicable to grandfathered plans.*

Effective 2011

HSA/HRA/FSA Changes

Over-the-Counter ("OTC") Drugs. The definition of qualified medical expense for Health Savings Accounts ("HSA"), Health Reimbursement Arrangements ("HRA") and Flexible Spending Accounts ("FSA") under cafeteria plans is amended to exclude over-the-counter medications (except for insulin) unless obtained with a prescription.

HSA distributions. The excise tax on distributions from HSAs not used for qualified medical expense is increased from 10% to 20%.

Simple Cafeteria Plans (100 or less)

Small employers (under 100) may establish a "simple cafeteria plan" that is deemed to satisfy the nondiscrimination requirements that would otherwise apply under Internal Revenue Code § 125. *A separate article about simple cafeteria plans is included in this issue for your reference.*

Effective 2012

Summaries of Insurance Plans

Health plans and insurers must distribute a document to all enrollees that provides required information including definitions of standard and medical terms, a summary of coverage provided, descriptions of

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any coverage limitations, examples of common benefit scenarios and a statement of whether the plan provides minimum essential coverage. This requirement essentially expands on the existing Department of Labor ("DOL") requirements for summary plan descriptions ("SPDs"). However, the new requirement is under the jurisdiction of the Department of Health and Human Services ("HHS"), and it will issue guidance on content and formatting requirements.

Reporting on Form W-2

All employers must reflect the value of health insurance provided to an employee on the employee's W-2 form. This does not mean that the benefit is taxable. The reporting is informational only. *This requirement originally applied to W-2 forms beginning with those issued in January of 2012 for 2011, but the IRS issued a Notice on October 12 that delays this requirement for one year.*

Reporting on Form 1099

The Internal Revenue Code now generally requires persons engaged in a trade or business who make payments to another person totaling $600 or more during a year to file Form 1099. The Act expands this reporting requirement to remove the automatic filing exemption for payments to corporations and to expand the types of reportable payments to include amounts paid for most services and merchandise. This new reporting requirement is potentially quite burdensome and has therefore generated considerable controversy. Legislation that would repeal this provision is pending in Congress, and it appears that there is a good chance that the requirement will be repealed before it would take effect in 2012.

Effective 2013

Reduced Health FSA Contribution Limit

The maximum annual contribution to a health FSA under a cafeteria plan is reduced to $2,500 (indexed).

Medicare Part D Subsidy

Employers will no longer be allowed to deduct expenses allocable to Medicare Part D subsidies.

Effective 2014

Some of the most significant changes under the Act become effective in 2014, including insurance market forms and individual and employer mandates, as discussed briefly below. Additional coverage and benefit requirements also take effect, including the following.

Pre-existing conditions. Plans may not impose any pre-existing condition limitations.

Waiting periods. Waiting periods may not exceed 90 days.

Wellness programs. Wellness program rewards based on satisfaction of health standards cannot exceed 30% of the cost of employee-only coverage. *Not applicable to grandfathered plans*.

Cost-sharing. Plans may not have out-of-pocket limits greater than the limits for high-deductible health plans (which are paired with HSAs). These limits are currently $5,950 for individual coverage and $11,900 for family coverage. *Not applicable to grandfathered plans*.

Reporting. Plans must report to the IRS and provide a statement to employees regarding whether the employee was covered under the employer's plan for minimum essential health coverage. The deadline is the same as for Form W-2. The first deadline for this reporting requirement is January 31, 2015.

Exchanges

Each state must establish Exchanges through which individuals and small employers (100 or fewer employees) may purchase health insurance. States are to establish one exchange for individuals and one for businesses, but may merge the two.

Individual Mandate

Individuals will generally be required to maintain "minimum essential coverage" or pay a penalty. Penalties vary depending on income and individuals who can't afford coverage are exempt. Federal premium assistance may be available, depending on income.

Employer Mandate (50+)

Employers with at least 50 employees generally must offer "minimum essential coverage" to their employees or pay a penalty. This is sometimes referred to as the "pay or play" penalty. It applies if the employer had at least one full-time employee who qualified for federal premium assistance through an Exchange (referred to as a "Governmental Assistance Full-Time Employee" or "GAFTE") who did not receive a free choice voucher from the employer (see below).

The amount of the penalty depends on whether the employer offers minimum essential coverage under an employer-sponsored plan. If coverage is not offered, the annual penalty is $2,000 (indexed) per full-time employee, except that the number of employees is reduced by 30 in calculating the penalty. A "full-time employee" for purposes of this provision is one who works at least 30 hours per week. If coverage is offered, the annual penalty is $3,000 for each GAFTE who does not receive a free choice voucher. The penalty cannot exceed the amount of the penalty the employer would have incurred if it did not offer coverage.

Free Choice Vouchers

Employers who offer minimum essential coverage through an employer-sponsored plan and pay a portion of the cost of the plan must provide a "free choice voucher" to each "qualified employee." A qualified employee is an employee (1) whose income is less than 400% of the federal poverty level; (2) whose share of premium exceeds 8% but is less than 9.8% of household income; and (3) who chooses to enroll in an "Exchange" plan rather than the employer plan.

The amount of the voucher is equal to amount the employer would have paid to provide coverage to the employee under the employer's

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plan with the highest employer contribution. The voucher is used to offset the employee's premium cost for the Exchange plan. The voucher amount is not taxable to employee to the extent it is used to purchase coverage. If voucher amount exceeds cost of coverage, the excess is taxable wages to employee. Voucher amounts are deductible by the employer as compensation.

Effective 2018

"Cadillac Tax" on High-Cost Health Plans

The Act places an excise tax on high-cost employer-sponsored health coverage, which is often referred to as "Cadillac" health plans. This is a 40% excise tax on the aggregate value of employer-sponsored health plan coverage that exceeds $10,200 per year for self-only coverage or $27,500 for family coverage. Those premium thresholds will be indexed. The tax is not on employers themselves unless they are self-funded. The excise tax for high-cost insured plans is on the insurer, but it will undoubtedly be passed on to the employer sponsoring the plan.

Conclusion

This article provides only a brief summary of some of the key benefit provisions of more than 3,000 pages of legislation. Substantial guidance from the IRS, the DOL and HHS will continue to be issued over the coming months and years and additional legislation can also be expected. ■

Grandfathered Plans

The impact of the 2010 healthcare reform legislation on employer health plans depends in part on whether an employer's health plan is "grandfathered." Grandfathering relief allows such plans to avoid many of the new rules and delays the effective dates of others.

A grandfathered group health plan is a group health plan that had any participants on March 23, 2010 (the date of enactment). The statute did not address what circumstances would cause a loss of grandfathered status. On June 14, the Departments of the Treasury, Labor and Health and Human Services jointly issued interim guidance addressing this issue.

Maintaining Grandfathered Status

In order to maintain grandfathered status, a plan must:

1. include a statement in plan materials describing the benefits provided and stating that the plan is believed to be a grandfathered health plan; and

2. provide plan contact information for questions and complaints.

Model language is provided in the guidance.

Losing Grandfathered Status

The loss of grandfathered status is triggered by:

1. The elimination of all or substantially all benefits to diagnose or treat a particular condition.

2. Any increase in a percentage cost sharing requirement.

3. Increases in fixed-amount cost-sharing requirements other than copayments. Any increase after March 23, 2010 in an amount greater than medical inflation plus 15% will result in a loss of grandfathered status.

4. Increases in fixed-amount copayments. Any increase after March 23, 2010 exceeding the greater of (1) medical inflation plus 15% or (2) $5 increased by medical inflation will result in a loss of grandfathered status.

5. Decrease in employer contribution rate of more than 5%.

6. Certain changes in annual limits.

Future Guidance

Certain changes to a grandfathered plan will *not* result in loss of that status. These include amendments to comply with Federal or State law mandates (such as mental health parity) and amendments to voluntarily comply with provisions of the Act that are not mandatory for grandfathered plans. The Departments have solicited comments on whether the following changes will result in loss of grandfathered status: (a) changes to plan structure (such as switching from insured to self-insured); (b) changes in provider networks; (3) changes to a prescription drug formulary; and (4) any other substantial change to benefit design. Any future guidance that is more restrictive than the interim rules will apply only on a prospective basis.

Weighing Costs and Benefits of Grandfathered Status

The Departments acknowledged that plan sponsors must weigh the costs and benefits of retaining or relinquishing grandfathered status.

Benefits. As set out in the "Key Provisions" article in this newsletter, grandfathered plans are exempt from many of the requirements of the Act, including the nondiscrimination rules for insured plans. As also noted, certain requirements apply to grandfathered plans, but on a modified or delayed basis.

Costs. As also described in the "Key Provisions" article, grandfathered plans are not exempt from many of the requirements of the Act, including restrictions on pre-existing condition limitations, rescissions of coverage and coverage limits. Maintaining grandfathered status necessarily restricts the extent to which employers may shift costs to employees and also limits the employer's ability to "shop" for more affordable coverage.

Intangible factors such as employee morale also enter into benefit decisions. The key is to make an informed decision rather

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than inadvertently losing grandfathered status due to a lack of information. ■

Provisions Affecting Cafeteria Plans

The 2010 healthcare reform legislation made several changes to the cafeteria plan provisions of the Internal Revenue Code, including authorizing a new "Simple Cafeteria Plan" effective in 2011. The significant cafeteria plan provisions are outlined below.

Changes Affecting Existing Cafeteria Plans

Effective January 1, 2011, over-the-counter ("OTC") drugs are generally not eligible for reimbursement. Insulin will still be reimbursable, as will OTC medications prescribed by a physician. Plans that currently permit reimbursement of OTC drugs must be amended.

Effective January 1, 2013, contributions to a health flexible spending account under a cafeteria plan will be limited to $2,500 per year (indexed). Plan amendments will be required.

Some provisions of the Act affect cafeteria plans indirectly. For plan years beginning after September 23, 2010, health plans that offer dependent coverage must allow adult children to remain on their parent's health insurance until age 26. Plans are permitted to make this change early, and the value of the coverage is not taxable. Cafeteria plans may allow mid-year changes this year in salary reduction elections consistent with the coverage of adult children, as long as the cafeteria plan document is amended by December 31, 2010.

Simple Cafeteria Plans

Cafeteria plans generally must meet certain nondiscrimination tests that are designed to ensure that they do not disproportionately benefit highly compensated or key employees of the employer. Effective 2011, small employers may adopt new "Simple Cafeteria Plans." The concept is similar to that of the Simple 401(k) Plan, in that the usual nondiscrimination tests do not apply as long as the employer makes the required minimum contributions.

Small employer. An employer is eligible to adopt a Simple Cafeteria Plan as long is it had no more than 100 non-excludible employees on average in at least one of the preceding two years. New businesses are to determine eligibility based on the number of employees they reasonably expect to employ. A "growing employer" provision allows an employer maintaining a Simple Cafeteria Plan that grows beyond 100 employees to continue to maintain the plan until the year after the year it exceeds 200 employees.

Eligible employees. All non-excludible employees who had at least 1,000 hours of service the preceding year must be eligible to participate. Excludible employees are those who: (1) have not attained age 21 by the end of the plan year; (2) have less than one year of service as of any day during the plan year; (3) are covered under a collective bargaining agreement; or (4) are nonresident aliens.

Employer contribution requirement. The employer must contribute an amount equal to either:

- a uniform percentage (not less than 2%) of each non-excludible employee's compensation for the plan year, or
- an amount that is not less than the lesser of
    - 6% of the employee's compensation for the plan year, or
    - twice the amount of the salary reduction contributions of each employee.

Thus, the employer may choose between a fixed contribution of at least 2% of compensation (whether or not the employee defers) or a 200% match of salary deferrals, capped at 6% of compensation. Additional contributions may be made, but the match rate for highly compensated and key employees may not be greater than that for non-highly compensated employees.

Owner-Employee Rules

The legislation did not change the owner-employee rules. The new Simple Cafeteria Plan rules may enable C corporations that qualify as small employers to provide more tax-free benefits to their owner-employers. The law still, however, prevents sole proprietors, partners, members of LLCs treated as partners and 2% shareholders of S corporations from participating in their company cafeteria plans.

Alice Eastman Helle is a member of the firm and practices primarily in the areas of pensions and employee benefits. Alice can be reached at (515) 242-2407 or helle@brownwinick.com. ■

Outstanding Achievements

Chambers USA® 2010

BrownWinick has been ranked as a "leading law firm" in *Chambers USA® 2010 - America's Leading Lawyers for Business* in the areas of Corporate/M&A; Corporate/M&A: Banking and Finance; Labor & Employment; Litigation: General Commercial and Real Estate. Nine attorneys from BrownWinick were selected for inclusion in *Chambers USA® 2010* as "leaders in Iowa" in the following areas:

- Doug Gross – Corporate/M&A
- John Hunter – Corporate/M&A: Banking & Finance
- James Gilliam – Labor & Employment
- William Brown – Corporate/M&A
- Mike Green – Real Estate
- Christopher Sackett – Corporate/M&A
- Michael Blaser – Corporate/M&A

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- Thomas Johnson – Corporate/M&A
- Brian Rickert – Litigation: General Commercial

Chambers USA is published annually by Chambers & Partners to assess and rank the leading attorneys and law firms in the United States, based on peer and client reviews. Chambers' researchers conduct in-depth interviews of clients, colleagues and the lawyers themselves to develop the rankings for the law firms and attorneys. Chambers' rankings are based solely on the research team's findings, and there is no cost for inclusion.

The Best Lawyers in America® 2011

BrownWinick is proud to announce that 13 of its attorneys have been named to *The Best Lawyers in America*® 2011, the oldest and most respected peer-review publication in the legal profession.

The lawyers included are:

- Ronni F. Begleiter (Employee Benefits Law; Trusts and Estates)
- William C. Brown (Tax Law)
- Paul E. Carey (Tax Law)
- James H. Gilliam (Labor and Employment Law)
- Michael J. Green (Land Use & Zoning Law)
- Douglas E. Gross (Government Relations Law)
- Alice E. Helle (Employee Benefits Law)
- G. Brian Pingel (Intellectual Property Law)
- James L. Pray (Environmental Law)
- Brian P. Rickert (Construction Law)
- Steven C. Schoenebaum (Government Relations Law)
- Philip E. Stoffregen (Communications Law; Energy Law)
- Camille L. Urban (Intellectual Property Law)

G. Brian Pingel and Philip Stoffregen have been listed in *Best Lawyers* for twenty years or longer and Ronni Begleiter, William Brown and Alice Helle have been listed for at least 10 years. *Best Lawyers* has been doing peer-review surveys of lawyers since 1983. Because lawyers do not pay a fee to be included in *Best Lawyers*, the book has become a reliable resource of legal professionals in the United States.

Leadership Achievements

Ashley Fuhrmeister, an attorney at Brown Winick, has been selected to participate in the 2010-2011 Community Leadership Program Class of the Greater Des Moines Leadership Institute. The goal of this nine-month program is to enhance leadership skills, inspire a higher level of community awareness and offer opportunities for community involvement. ■

NOTE:
Please e-mail DJB@brownwinick.com with your e-mail address if you would like to start receiving The Legal Monitor in a PDF format via e-mail instead of by U.S. Mail. ■

Upcoming Events

Employment Law and Intellectual Property Seminar

DATE: November 3, 2010

LOCATION: Hilton Garden Inn
Des Moines/Urbandale
8600 Northpark Drive
Johnston, Iowa

SEMINAR HIGHLIGHTS:

- FMLA Leave Issues
- Recent Development in Immigration and Workers' Compensation
- Employee or Independent Contractor
- Litigation Trends – 2011 and Beyond
- Top 10 Employment Issues For Start-Ups
- To Grandfather or Not to Grandfather: And Other Current Issues in Healthcare Reform
- What To Do When You Receive a Subpoena
- To Friend or Not to Friend: Social Media in the Workplace
- Legislative Developments
- All In The Family: Protecting IP From The Inside Out
- Building (and Keeping) the Fortress: Joint Ventures, Co-Invention, Independent Contractors
- Money Matters: Attracting the Right Investors Without Losing Control

Government Relations Seminars

DATE: December 14 or December 16, 2010

LOCATION: BrownWinick's Offices
666 Grand Avenue, Suite 2000
Des Moines, Iowa

TIME: December 14, 2010: 9:00 A.M. – 11:00 A.M.
December 16, 2010: 2:00 P.M. – 4:00 P.M.

SEMINAR HIGHLIGHTS:

You are invited to join BrownWinick's Government Relations team of Marc Beltrame and Adam Gregg for a 2011 Legislative Forecast. They will present their forecast twice, and at each event they will provide a review and analysis of November's Election results and provide a preview of the issues which may be debated in during the 2011 legislative session. Seating is limited, so please RSVP to Debi Bull for the event held either on Tuesday, December 14, 9:00 – 11:00 a.m. or Thursday, December 16, 2:00 – 4:00 p.m.

For more information on either of these events, please contact Debi Bull at djb@brownwinick or check out BrownWinick's website at www.brownwinick.com. ■