

## **Updated Summary of Health Care Reform for Employers** *Preparing for the Future*

Reissued October 14, 2010, to Include Implementation Guidance

### **Summary Updated to Include Implementation Guidance**

Ice Miller originally issued this summary on the Patient Protection and Affordable Care Act (PPACA) on March 30, 2010. Since that date, the Departments of Health and Human Services (HHS), Labor, and the Treasury have issued several rounds of interim final rules and other guidance regarding the PPACA provisions that apply to [Group Health Plans](#). As of the date of this reissue, guidance has been published with respect to:

- a tax credit available to small employers that offer health coverage to their employees;
- the extension of dependent coverage mandate and related tax relief;
- the Early Retiree Reinsurance Program;
- rules for maintaining [Grandfathered Plan](#) status;
- application of the PPACA coverage reforms on retiree-only health plans and HIPAA [excepted benefits](#);
- the prohibition on lifetime and annual dollar limits and procedures for a temporary waiver;
- the prohibition on pre-existing condition exclusions;
- the prohibition on rescissions in health plans;
- patient protections afforded under the PPACA;
- coverage for preventive health services with no cost-sharing requirements;
- requirements for internal claims and appeals processes and external reviews; and
- the HIPAA opt-out for self-funded nonfederal governmental health plans.

The text of the PPACA regulations and other guidance and notices can generally be found at [www.hhs.gov/ociio](http://www.hhs.gov/ociio).

While there is still more expected, a critical mass of guidance has now been issued that allows employers sponsoring Group Health Plans to move toward finalizing plan design changes for next plan year. As employers begin preparing for open enrollment season in the coming weeks and months, the PPACA provisions discussed in this summary require a fresh look. Ice Miller has, therefore, revised this summary to include discussion of relevant guidance and the obligations such guidance places on employers sponsoring Group Health Plans to timely amend plan materials, make required disclosures to employees, and offer special enrollment opportunities to their employees.

## How to Use This Summary

This summary identifies the main provisions of the PPACA, as amended by the Health Care and Education Reconciliation Act (Reconciliation Act), that directly affect employers. Where applicable, the summary also includes information from regulations and other guidance issued by the Departments of HHS, Labor, and the Treasury since the enactment of the PPACA and Reconciliation Act. The "Ice Miller Comments" column provides Ice Miller's analysis of specific provisions, which is intended to help employers understand and plan for changes required or desired as a result of the PPACA. In addition, a special section at the beginning of the summary is dedicated to two important threshold issues that determine whether and to what extent a Group Health Plan is subject to the PPACA. This section discusses (1) the definition of a Group Health Plan for purposes of the PPACA coverage mandates, and (2) the rules for maintaining Grandfathered Plan status.

The brief introduction to this summary places the employer-sponsored Group Health Plan coverage and reporting mandates into the larger context of the PPACA's requirement on individuals to have health coverage and the creation of state-based health insurance exchanges. Several terms in this introduction and the summary are capitalized and link directly to the term's definition on the first reference for each topic. The link references the [glossary](#) at the end of the summary.

*This publication is intended for general information purposes only and does not and is not intended to constitute legal advice. The reader must consult with legal counsel to determine how laws or decisions discussed herein apply to the reader's specific circumstances. Consult your [Ice Miller employee benefits attorney](#) for specific questions related to your obligations under the PPACA.*

## The Employer's Continued Role in Coverage After Health Care Reform

The PPACA builds upon the existing role that many employers already play in providing health coverage to employees. The PPACA does not affirmatively require employers to offer coverage, but it does change some of the rules regarding the coverage offered and an employer's responsibilities if the employer chooses not to offer [Minimum Essential Coverage](#). In the short term, any employer that sponsors a Group Health Plan will be required to make certain changes, such as extending dependent coverage, eliminating annual and lifetime limits, and ending pre-existing condition exclusions for children. Beginning generally in 2014, additional changes, such as ending *all* pre-existing condition exclusions, limiting waiting periods to 90 days or less, and cost-sharing limits, will be required of any employer sponsoring a Group Health Plan. [Large Employers](#) will additionally be required to pay certain penalties, depending on whether Minimum Essential Coverage is offered or not offered, when their employees obtain government-subsidized health insurance through an [Exchange](#).

## Individual Mandate

One of the PPACA's most sweeping changes is to require most individuals to obtain Minimum Essential Coverage for themselves and their dependents beginning in

2014. Individuals can obtain coverage through their employer (if available), through an Exchange (discussed below), or through government programs such as Medicare or Medicaid (if eligible). Individuals who do not obtain health plan coverage will generally be required to pay a penalty.

To assist individuals for whom the cost of obtaining health coverage is too high, the PPACA provides subsidies in the form of tax credits and reduced costs for coverage. Large Employer penalties are triggered when an employer's employee qualifies for these subsidies. Generally, individuals are eligible for the subsidies if their household income is between 133 percent and 400 percent of the federal poverty line and they are not eligible for Minimum Essential Coverage other than through the individual market (individuals with a household income of less than 133 percent are eligible for Minimum Essential Coverage under the significantly expanded Medicaid program). However, individuals who are offered health coverage that is Minimum Essential Coverage through their employer may also be eligible for subsidies if the cost of their employer's coverage either exceeds 9.5 percent of their household income or their employer does not pay for at least 60 percent of the actuarial value of the benefits provided under the health plan.

## **The Exchange**

The PPACA requires each state to establish private insurance marketplaces, called Exchanges, by 2014 under which individuals and [Small Employers](#) can purchase health insurance at varying coverage and cost levels. The primary purpose of the Exchange is to provide individuals who cannot obtain health coverage through an employer (or who cannot afford health coverage offered by their employer) health insurance coverage options that meet uniform minimum standards in order to meet their individual coverage responsibilities. A [Health Insurance Issuer](#) seeking to offer coverage through an Exchange must meet certain criteria and provide a plan that covers [Essential Health Benefits](#) and meets specified cost-sharing requirements.

Ice Miller has been carefully and diligently tracking the regulations and other guidance issued under the PPACA. For a more detailed discussion of the regulations and guidance that affect Group Health Plans that goes beyond the scope of this summary, visit the [Ice Miller Health Care Reform Web site](#).

Defined terms have been capitalized in this summary. The definitions of these terms are in the "Glossary of Terms" at the end of this summary.

## INITIAL CONSIDERATIONS – THRESHOLD ISSUES FOR GROUP HEALTH PLANS

TOPIC	SUMMARY OF PROVISIONS	ICE MILLER COMMENTS
<p><b>Group Health Plan Definition</b></p> <p><b>PPACA §§ 1563, 10107</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> are subject to the PPACA coverage mandates. A "Group Health Plan" is defined as any plan, fund or program established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the plan) directly or through insurance, reimbursement or otherwise.               <ul style="list-style-type: none"> <li>➤ The definition generally <i>includes</i> major medical benefits (both self insured and fully insured), voluntary employees' beneficiary associations (VEBAs), and health reimbursement arrangements (HRAs).</li> <li>➤ The definition generally <i>excludes</i> retiree-only plans, stand-alone dental and vision plans that are either fully-insured or self-insured and separately electable from major medical benefits for which the participant must pay an additional premium, health savings accounts, and <a href="#">Excepted Benefits</a>.</li> </ul> </li> <li>• Prior to the enactment of the PPACA, sponsors of retiree health coverage were able to exempt their retiree-only health plans from many of the HIPAA portability requirements based on an exception that applies to Group Health Plans that have less than two participants who are current employees. This <a href="#">Small Employer</a> exception therefore also served as a "retiree-only exception" to several HIPAA requirements. This retiree-only</li> </ul>	<ul style="list-style-type: none"> <li>• There is no guidance that defines a "retiree-only plan." In the absence of guidance, a plan sponsor should ensure that it is able to clearly demonstrate that its retiree health plan is truly separate from its active health plan(s) in order to take advantage of the retiree-only exception. Some steps that a plan sponsor could take to demonstrate that its retiree plan is separate from its active plan include maintaining separate plan documents and summary plan descriptions, separately administering retiree and active plans, separately determining premiums based on the retiree plan's experience (not the retirees and actives together), filing separate Form 5500s, maintaining separate funding mechanisms, and maintaining separate stop loss policies.</li> </ul>

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	<p>exception was identical in the Public Health Service Act (PHSA), ERISA, and the Internal Revenue Code.</p> <ul style="list-style-type: none"> <li>The PPACA eliminated the retiree-only exception from the PHSA, but not from the Internal Revenue Code or ERISA. In the preamble to the June 17, 2010, interim final rules with respect to <a href="#">Grandfathered Plans</a>, the Secretaries of HHS, Labor, and the Treasury set forth their interpretation of the PPACA's impact on retiree-only plans, concluding that such plans would continue to be excepted from existing HIPAA portability requirements, and by reason of the same exception, would also not be subject to the new PPACA coverage mandates. This interpretation is based on (1) an understanding among the three Departments that HIPAA provisions will be administered consistently across all three agencies, and (2) a lack of finding of any congressional intent to treat nonfederal governmental retiree plans (which are subject to the PHSA) differently than private sector retiree plans. Accordingly, the exception is still in force with respect to ERISA and the Internal Revenue Code, and the Secretaries adopted a non-enforcement position with respect to the application of the PPACA mandates to a nonfederal retiree plan.</li> </ul>	
<p><b>Grandfathered Plan Status</b></p> <p><i>Effective March 23, 2010.</i></p> <p><b>PPACA §§ 1251, 10103; Reconciliation Act 2301</b></p>	<ul style="list-style-type: none"> <li><a href="#">Group Health Plans</a> that were in existence on March 23, 2010 - <a href="#">Grandfathered Plans</a> - are exempt from several, but not all, of the PPACA coverage mandates discussed in this summary. A Grandfathered Plan remains grandfathered even if the plan renews coverage for existing participants, enrolls family members of existing participants, or enrolls new or existing employees and their families.</li> <li>The June 17, 2010, interim final rule issued with respect to Grandfathered Plans set forth specific limits on the changes a Group Health Plan that wishes to maintain</li> </ul>	<ul style="list-style-type: none"> <li>Plan changes that do not exceed the standards set forth in the interim final rule will not cause a Group Health Plan to lose grandfathered status. For example, the interim final rule permits a Grandfathered Plan to make voluntary changes to the plan to increase benefits, to conform to required legal changes, to voluntarily adopt other coverage mandates in the Act, and to change third-party administrators without losing</li> </ul>

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	<p>grandfathered status may make to its coverage terms (as compared to the terms of coverage in effect on March 23, 2010). Under the rules, if a Group Health Plan wishes to maintain its grandfathered status, it <i>cannot</i> do the following:</p> <ul style="list-style-type: none"> <li>➤ eliminate all or substantially all benefits to diagnose or treat a particular condition;</li> <li>➤ increase percentage cost-sharing requirements (e.g., coinsurance amounts);</li> <li>➤ significantly increase fixed-amount cost-sharing requirements (the interim final regulations generally set cost increase thresholds based on medical inflation plus 15 percent);</li> <li>➤ decrease the premium contribution rate of employers and/or employee organizations by more than 5 percent;</li> <li>➤ implement or reduce an annual limit (see right column for more details); or</li> <li>➤ change insurance issuers.</li> </ul> <ul style="list-style-type: none"> <li>• Under the interim final rule, a Group Health Plan will also lose its grandfathered status if the employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 (which is not a renewal of an existing policy, certificate, or contract of insurance). An exception applies to collectively bargained insured plans that allows them to change insurers as long as the plan is still maintained pursuant to a collective bargaining agreement that was in effect on March 23, 2010.</li> <li>• There is a special grandfathering rule for fully insured Group Health Plans maintained pursuant to a collective bargaining agreement. These Group Health Plans will remain grandfathered until the last of the collective bargaining</li> </ul>	<p>grandfathered status. In addition, changes in premiums do not impact a Group Health Plan's grandfathered status.</p> <ul style="list-style-type: none"> <li>• The restriction on changes to a Grandfathered Plan's annual limits must be read in conjunction with the PPACA's elimination of annual and lifetime limits. Beginning with the first plan year on or after September 23, 2010, Group Health Plans may not impose an overall lifetime limit on the dollar value of Essential Health Benefits. However, plans may still impose "restricted" annual limits on the dollar value of Essential Health Benefits (\$750,000 for 2011). The "restricted" annual limits are further restricted if the plan chooses to remain grandfathered, as follows: <ul style="list-style-type: none"> <li>➤ If a Group Health Plan did not impose an overall annual or lifetime limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it imposes an overall annual limit on the dollar value of benefits.</li> <li>➤ If a Group Health Plan imposed an overall lifetime limit but not an overall annual limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it imposes an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.</li> <li>➤ If a Group Health Plan imposed an overall annual</li> </ul> </li> </ul>

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	<p>agreements pursuant to which they are maintained expires, at which time the general grandfathering rule will apply.</p> <ul style="list-style-type: none"> <li>• Grandfathered Plan requirements: <ul style="list-style-type: none"> <li>➤ <b>Disclosure requirement:</b> Grandfathered Plans must include a statement regarding the plan's grandfathered status in all plan materials provided to participants or beneficiaries describing the benefits provided under the plan. The interim final rule contains model language that may be used by Group Health Plans to satisfy this disclosure requirement.</li> <li>➤ <b>Recordkeeping requirement:</b> Grandfathered Plans must maintain records documenting the plan or policy terms in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a Grandfathered Plan. These records must be made available for examination upon request.</li> </ul> </li> <li>• The interim final rule contains anti-abuse provisions to prevent employers from shifting employees to other Grandfathered Plans with fewer benefits to circumvent the limits on plan changes.</li> <li>• The interim final rule provides transitional relief for employers that implemented plan changes that became effective after March 23, 2010, but prior to the publication of the interim final rule in the Federal Register on June 17, 2010, including options to revoke or modify such changes, as necessary, effective as of the first day of the first plan year beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans).</li> </ul>	<p>limit on the dollar value of benefits as of March 23, 2010, the plan will lose its grandfathered status if it decreases the dollar value of the annual limit.</p> <ul style="list-style-type: none"> <li>• A self insured Group Health Plan may change its third-party administrator without losing grandfathered status. However, under the interim final rule, a fully insured Group Health Plan will lose its grandfathered status if it changes insurance carriers. The Departments have indicated in sub-regulatory guidance that they will soon address the circumstances under which Grandfathered Plans may change insurance carriers without losing grandfathered status.</li> </ul>

**COVERAGE MANDATES, REPORTING AND DISCLOSURE REQUIREMENTS,  
TAXES & OTHER PPACA PROVISIONS THAT IMPACT EMPLOYERS**

TOPIC	SUMMARY OF PROVISIONS	ICE MILLER COMMENTS
<b>EXPANSION OF GROUP HEALTH PLAN COVERAGE REQUIREMENTS</b>		
<i>The following coverage mandates apply to ALL GROUP HEALTH PLANS as of the first plan year beginning on or after September 23, 2010.</i>		
<p><b>Prohibition on Pre-Existing Condition Exclusions</b></p> <p><i>Effective for plan years beginning on or after January 1, 2014; however, for enrollees under age 19, effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2704</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) are prohibited from imposing any pre-existing condition exclusions:               <ul style="list-style-type: none"> <li>➤ for plan years beginning prior to January 1, 2014, on enrollees under age 19; and</li> <li>➤ for plan years beginning on or after January 1, 2014, on any enrollees.</li> </ul> </li> <li>• The June 28, 2010, interim final rule defines a pre-existing condition exclusion as <i>any</i> limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage under a Group Health Plan, <i>whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date</i>. Therefore, it does not matter whether or not the condition was known, unknown, treated, or untreated at any time before the effective date of coverage under the Group Health Plan.</li> <li>• A Group Health Plan is prohibited under the interim final rule from both (i) denying <b>coverage</b> for a pre-existing condition to an enrollee, and (ii) denying <b>enrollment</b> to an individual based on a pre-existing condition.</li> </ul>	<ul style="list-style-type: none"> <li>• While many Group Health Plans have already eliminated pre-existing condition exclusions altogether, those that have not must do so completely by 2014. In the meantime, Group Health Plans will have to eliminate these exclusions for children under 19 beginning as of their first plan year beginning on or after September 23, 2010.</li> <li>• With the elimination of pre-existing condition exclusions by 2014, Congress could repeal the creditable coverage and portability provisions of HIPAA and/or the Departments of Treasury, Labor and HHS could suspend the need to provide creditable coverage notices when a participant loses coverage under an employer health plan.</li> <li>• A plan that enrolls an adult child over age 19 who was not previously enrolled can impose a pre-existing condition exclusion with respect to that child (consistent with the limitations under HIPAA for special enrollees) until 2014.</li> <li>• The Secretary of the HHS was directed to establish a temporary high risk insurance pool to cover persons who cannot get coverage due to preexisting conditions and who have been uninsured for at least six months. Coverage under the high risk pool will be available for eligible individuals from July 1, 2010, until January 1, 2014, subject</li> </ul>

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		to a federal funding cap of \$5 billion.

<p><b>No Lifetime or Annual Coverage Limits</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>Public Health Service Act (PHSA) § 2711</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) may generally not establish any lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary. <ul style="list-style-type: none"> <li>➤ Group Health Plans may still place annual or lifetime limits on specific covered benefits that are <b>not</b> <a href="#">Essential Health Benefits</a>.</li> <li>➤ For plan years beginning prior to 2014, Group Health Plans may impose "restricted" annual limits (but <u>not</u> lifetime limits) with respect to Essential Health Benefits. The Secretary of HHS defines "restricted" annual limits in three phases, such that the minimum annual limit on the dollar value of benefits is: <ul style="list-style-type: none"> <li>○ \$750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;</li> <li>○ \$1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and</li> <li>○ \$2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.</li> </ul> </li> </ul> <p>Amounts paid by a Group Health Plan for non-Essential Health Benefits cannot accrue toward the restricted annual limits permitted before 2014. <i>All</i> annual limits on Essential Health Benefits must be eliminated by the first plan year beginning on or after January 1, 2014.</p> </li> <li>• Individuals who have already met their lifetime limits, but who would otherwise be eligible for coverage under a Group Health Plan, must be provided with notice and a special enrollment opportunity to reenroll in the Group Health Plan. The notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010, and the coverage must be effective as of the first day of that plan year. The enrollment period must last at least 30 days. All benefit packages available to similarly situated individuals must be made available to the special enrollee individual. If a dependent has the opportunity to enroll during this special enrollment period, the Group Health Plan must also permit the employee to enroll if not already enrolled,</li> </ul>	<ul style="list-style-type: none"> <li>• A Group Health Plan's continued ability to impose benefit-specific lifetime and annual limits will depend on how the Secretary of HHS defines the scope of Essential Health Benefits. The preamble to the June 28, 2010 interim final rule indicates that, in the absence of regulations, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term Essential Health Benefits. The Secretary of HHS is directed by the PPACA to ensure that the scope of Essential Health Benefits is equal to the scope of benefits provided under a typical employer plan, and to inform this determination, she must conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans.</li> <li>• The rules regarding restricted annual limits must be considered in conjunction with the grandfathering rules that prohibit a Grandfathered Plan from reducing or implementing an annual limit. Thus, if a Grandfathered Plan does not have an overall annual limit in effect on March 23, 2010, and chooses to impose a restricted annual limit</li> </ul>
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	<p>or if already enrolled, to switch to a different benefit package. A plan is not required to enroll a dependent unless the employee also enrolls in the plan. The Departments have issued a model notice that employers can use to comply with this rule, which can be found at <a href="http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc">www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc</a>.</p> <ul style="list-style-type: none"> <li>• The prohibition on annual limits does <u>not</u> apply with respect to health flexible spending arrangements, health savings accounts, or health reimbursement arrangements that are integrated with a major medical plan.</li> <li>• Employers that sponsor a non-integrated health reimbursement account, mini-med or limited benefit plan, or other Group Health Plan may apply for a waiver from the annual limit restrictions for plan years beginning before January 1, 2014, if the employer can demonstrate that compliance with the rule would result in a significant decrease in access to benefits or a significant increase in premiums.</li> </ul>	<p>until 2014, the plan will lose grandfathered status.</p> <ul style="list-style-type: none"> <li>• This prohibition applies to lifetime and annual limits on the <i>dollar value</i> of benefits. Employers may continue to impose other limitations on benefits, such as visit limits, quantity limits, and general cost-sharing requirements. If a Group Health Plan wants to maintain Grandfathered Plan status, the decision to implement one of these alternative benefit limitations should be carefully reviewed to ensure that the change will not violate the grandfathering rules regarding the elimination of benefits and/or the limitations on increasing cost-sharing requirements.</li> <li>• Group Health Plans must provide a notice of special enrollment opportunity to all individuals who previously exceeded the plan's lifetime limit, but who are otherwise eligible for coverage. Rather than attempt to determine each individual for whom the notice is required, we recommend providing the notice to all employees (and retirees, if included in the active plan) who are eligible to participate in the plan on the first day of the first plan year beginning on or after</li> </ul>
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		<p>September 23, 2010.</p> <ul style="list-style-type: none"> <li>• While only health reimbursement arrangements integrated with a major medical plan are expressly exempted from the prohibition on annual limits, the preamble to the interim final rule requests comments on the proper treatment of stand-alone health reimbursement arrangements going forward.</li> </ul>
<p><b>Extension of Dependent Coverage</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><i>Associated tax relief effective beginning March 30, 2010.</i></p> <p><b>PHSA § 2714; Reconciliation Act § 1004(d); amends Internal Revenue Code (Code) §§ 105(b), 162(l), 501(c)(9), and 401(h)</b></p> <p><b>This requirement</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) that provide dependent coverage of children must continue to make such coverage available for a dependent child until the child turns age 26. <ul style="list-style-type: none"> <li>➤ No eligibility restrictions are permitted based on parental support, marital status, student status, residency, or similar criteria; however, a Group Health Plan is not required to provide coverage for the spouses or children of such children.</li> <li>➤ Frequently asked questions issued by the Departments on September 20, 2010, provide that the mandate applies to any child who is the son, daughter, stepchild, adopted child (or child placed for adoption), or foster child of the eligible employee. Group Health Plans that offer coverage to other classes of children (e.g., grandchildren, domestic partner children) may, but are not required to, similarly extend coverage to such children.</li> <li>➤ To the extent that state law mandates coverage for dependents more broadly than the PPACA, the state law will continue to apply.</li> <li>➤ The May 13, 2010, interim final rule provides that Group Health Plans may not charge higher premiums to, or impose other coverage differences on, adult children; however, premium tiers may be changed to add an incremental premium increase for each new child (regardless of age) added to the Group Health Plan (note, however, that such change could affect whether a Group Health Plan remains a Grandfathered Plan).</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Many Group Health Plans base dependent eligibility on the definition of a dependent under Internal Revenue Code Section 152. Section 152 outlines a number of criteria that must be satisfied to achieve dependency status, such as financial dependency, residency requirements, and full-time student status for older children. These types of restrictions <b>are no longer permitted</b> with respect to children under age 26 beginning with the first plan year on or after September 23, 2010 (January 1, 2011, for calendar year plans). For purposes of this mandate, children include the sons, daughters, stepchildren, adopted children (or children placed for adoption), or foster children of the eligible employee. Therefore, a Group Health Plan that covers domestic partner children or children after</li> </ul>

**applies to all Group Health Plans, including Grandfathered Plans.**

However, for plan years beginning before January 1, 2014, this rule applies to Grandfathered Plans that are Group Health Plans only if the adult child is not eligible to enroll in any other Eligible Employer Sponsored Health Plan, other than the health plan of a parent.

- Coverage provided to adult children who, as of the end of the tax year, have not turned age 27 receives the same tax favorable treatment as coverage provided to tax dependents. Therefore, such coverage will not result in imputed income to the employee.
- Group Health Plans must provide a special enrollment opportunity for children who previously lost coverage, were denied coverage, or were never eligible for coverage under the Group Health Plan because of their age, and who will become eligible for coverage under this rule. The notice and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010, and the coverage must be effective as of the first day of that plan year. The enrollment period must last at least 30 days. All benefit packages available to similarly situated individuals must be made available to the special enrollee adult child. If an adult child has the opportunity to enroll during this special enrollment period, the Group Health Plan must also permit the employee to enroll if not already enrolled, or if already enrolled, to switch to a different benefit package. A plan is not required to enroll an adult child unless the employee also enrolls in the plan. The Departments have issued a model notice that employers can use to comply with this rule, which can be found at [www.dol.gov/ebsa/dependentsmodelnotice.doc](http://www.dol.gov/ebsa/dependentsmodelnotice.doc).

age 26 may continue to restrict the eligibility of such individuals based on residency, support, or other factors.

- Note that employers will not need to impute income for coverage provided to an enrollee's child who is not a tax dependent as long as the child has not reached age 27 by the end of the taxable year. Thus, a Group Health Plan could allow children who turn age 26 to remain on the plan through the end of that calendar year without needing to impute income. On the other hand, the Group Health Plan could be designed so that children lose their eligibility immediately upon turning age 26.
- The tax relief associated with this new coverage requirement is effective March 30, 2010, and is, therefore, available now to eliminate many imputed income concerns, which often arise due to state insurance mandates that require coverage of children for longer than they can be treated as dependents for purposes of exemptions under the Internal Revenue Code.
- For employers that administer health flexible spending arrangements (health FSAs) or health reimbursement arrangements (HRAs), the tax relief will also allow health FSA and HRA parti

Participants to submit reimbursement requests for the medical expenses of their children who have not turned age 27 by the end of the taxable year. To the extent that a health FSA or HRA permits reimbursements for adult children in 2010, Plan amendments to effect this change must be made prior to December 31, 2010. However, similar changes were not made to the rules relating to health savings accounts (HSAs), so it does not appear that "adult child" expenses may be submitted to an HSA on a tax-free basis. This could be a communication issue for open enrollment.

- Group Health Plans that are contemplating changing their premium rate structure to impose an incremental premium increase for each new dependent (regardless of age) are permitted to do so. However, Group Health Plans that wish to maintain Grandfathered Plan status must ensure that the premium contribution *percentage* applicable to an individual does not increase due to the conversion of the premium rate structure by more than five percent. Such a percentage increase would likely cause the Group Health Plan to lose Grandfathered Plan status under the interim final

		rules.
<p><b>Rescission of Coverage Prohibited</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2712</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) are prohibited from rescinding coverage with respect to a participant once covered under the plan, except in the event of fraud or intentional misrepresentation of material fact. In the event of fraud or intentional misrepresentation, the June 28, 2010, interim final rules require a Group Health Plan to provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded.</li> <li>• A rescission is a cancellation or discontinuance of coverage that has <b>retroactive</b> effect. A cancellation of coverage on a prospective basis is <b>not</b> a rescission, and a Group Health is still permitted to cancel coverage prospectively.</li> <li>• A Group Health Plan is still permitted to cancel coverage <b>retroactively</b> to the extent that cancellation is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.</li> <li>• The interim final rules provide a useful example with regard to the application of the rescission rule to Group Health Plans. Under the example, a Group Health Plan mistakenly continues to provide health coverage to an employee who is no longer eligible for coverage, collecting premiums from the employee and paying claims submitted by the employee. After the mistake is discovered, the plan rescinds the employee's coverage effective back to the loss of eligibility. According to this example, the plan <b>cannot</b> rescind the employee's coverage because there was no fraud or intentional misrepresentation of material fact. The plan may only cancel coverage for the employee <b>prospectively</b>, subject to other applicable federal and state laws.</li> </ul>	<ul style="list-style-type: none"> <li>• Group Health Plans are already prohibited from rescinding coverage based on an individual's health status.</li> <li>• This rule heightens the importance of diligent monitoring of employee eligibility for health plan coverage. Under the new rescission rule, a Group Health Plan will no longer be able to retroactively cancel an employee's coverage unless the coverage was in force due to the employee's fraud or intentional misrepresentation of material fact. Thus, an employer's or third party administrator's neglect in monitoring the eligibility of its employees for Group Health Plan coverage will no longer justify a retroactive rescission of coverage.</li> <li>• To protect the Group Health Plan, employers may want to consider including affirmative language in plan materials that a participant's failure to notify the plan of a change in eligibility status within 30 days of the change will constitute a fraud on the plan. Although such language does not guarantee that the plan would be permitted to rescind coverage, it puts the plan in a better position to make the argument if it chooses.</li> </ul>

		<ul style="list-style-type: none"> <li>• This rule will impact plan sponsors who retroactively discontinue coverage as a result of dependent audits. This rule will also impact plan sponsors who have spousal carve-out policies that provide coverage to a spouse prior to receipt of a certification that the spouse does not have other employer coverage available.</li> </ul>
<p><b>Cost Ratio Requirements</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2718</b></p> <p><b>This requirement applies to all fully-insured Group Health Plans, including fully-insured Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• Beginning no later than January 1, 2011, a <a href="#">Health Insurance Issuer</a> offering <a href="#">Group Health Plans</a>, including <a href="#">Grandfathered Plans</a>, must provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on (i) reimbursement for clinical services provided to enrollees and (ii) for activities that improve healthcare quality, to the total amount of premium revenue is less than 85 percent in the large group market, or 80 percent in the small group market.</li> <li>• A Health Insurance Issuer must also provide an annual report to the Secretary of HHS concerning its medical loss ratio.</li> <li>• The National Association of Insurance Commissioners (NAIC), subject to certification by the Secretary of the HHS, is required to establish a uniform definition of the phrase "activities that improve health care quality" by no later than December 31, 2010. The NAIC is in the process of developing recommendations in response to the April 14, 2010, request for information from the Departments of HHS, Labor, and the Treasury regarding this provision.</li> <li>• On September 30, 2010, the Department of HHS Office of Consumer Information and Insurance Oversight issued a public statement that suggests some flexibility of the application of the medical loss ratio standards with respect to limited benefit plans, sometimes called "mini-med" plans.</li> </ul>	<ul style="list-style-type: none"> <li>• This requirement should have no effect on <i>self-funded</i> Group Health Plans. However, employers that provide fully-insured Group Health Plans could be affected if the Health Insurance Issuer's medical loss ratio does not comply with these standards. In other words (and in very general terms), if the insurer spends less than 85 cents of every premium dollar on reimbursement for clinical services and healthcare quality improvements, then enrollees in the plan must receive rebates.</li> <li>• It is not yet clear how these rebates will be calculated or distributed. For example, if an employer pays a part of the premium and the employee pays a part of the premium, it is not clear whether the employer will receive any part of the rebate, whether the rebate will be distributed on a pro-rata</li> </ul>

		<p>basis between the employer and the employee, or whether it will be distributed in some other manner. It is also not clear what "activities that improve healthcare quality" include, and whether this requirement will limit an insurer's ability to provide wellness programs.</p>
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***The following coverage mandates apply ONLY to NON-GRANDFATHERED GROUP HEALTH PLANS as of the first plan year beginning on or after September 23, 2010.***

<p><b>Mandated Coverage for Preventive Health Services</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2713</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) must provide first dollar coverage, without any cost sharing requirements (e.g. deductibles, co-pays, co-insurance) for: <ul style="list-style-type: none"> <li>➢ evidence-based items or services recommended by the U.S. Preventive Services Task Force;</li> <li>➢ immunizations recommended by the Centers for Disease Control and Prevention;</li> <li>➢ with respect to infants, children, and adolescents, evidence-informed preventive care provided for in guidelines supported by the Health Resources and Services Administration; and</li> <li>➢ with respect to women, to the extent not already required above, evidence-informed preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration. The Department of HHS is developing these guidelines and expects to issue them no later than August 1, 2011.</li> </ul> </li> <li>• The July 19, 2010, interim final rule provides that recommendations and guidelines issued <i>before</i> September 23, 2009, must be included in Group Health Plans without cost-sharing requirements as of the first plan year beginning on or after September 23, 2010 (January 1, 2011, for calendar year plans). Recommendations and guidelines that were issued <i>on or after</i> September 23, 2009, are not required to be provided on a first-dollar basis until the first plan year that begins on or after the date that is one year after the date the recommendation or guideline is issued. A current listing of all the required recommendations and</li> </ul>	<ul style="list-style-type: none"> <li>• While many Group Health Plans provide some level of preventive care services on a first-dollar basis, plans frequently limit the services that are considered preventive or impose a dollar limit on preventive services or wellness benefits. This provision will require plans to cover, without dollar limits and without any cost sharing, a defined set of preventive care services.</li> <li>• The recommendations and guidelines that outline the preventive services required to be covered by Group Health Plans under this coverage mandate were not written for this purpose, and it is not always clear how a particular recommendation translates to a mandated coverage under a Group Health Plan. Employers will need to work with their insurers or third party administrators to</li> </ul>
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guidelines, including the dates on which they were issued, is available

at: <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.

- Whether a Group Health Plan may impose cost-sharing requirements on office visits during which preventive services are provided is subject to the following rules:
  - If the preventive item or service is **billed separately** (or tracked as individual encounter data) from the office visit, then the plan **may** impose cost-sharing requirements with respect to the office visit.
  - If the preventive item or service is **not billed separately** (or is not tracked as individual encounter data) from the office visit **and** the primary purpose of the office visit is to deliver the preventive item or service, then the plan **may not** impose cost-sharing requirements with respect to the office visit.
  - If the preventive item or service is **not billed separately** (or is not tracked as individual encounter data) from the office visit **and** the primary purpose of the office visit is **not** to deliver the preventive item or service, then the plan **may** impose cost-sharing requirements with respect to the office visit.
- To the extent not specified in a recommendation or guideline, a Group Health Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service. Thus, in the absence of specific guidance, a Group Health Plan may fill in gaps in the federal preventive service guidelines using reasonable medical management techniques.
- A Group Health Plan is **not** required to provide coverage for preventive services on an out-of-network basis at all, provided that the plan complies with the mandate through in-network providers. To the extent a Group Health Plan provides coverage for preventive services delivered by out-of-network providers, the plan may continue to impose cost-sharing requirements for preventive services received from those out-of-network providers.
- To the extent that a Group Health Plan provides

ensure that their Group Health Plan provides coverage for each of the preventive services and items required to be covered under these recommendations and guidelines, and to determine the frequency, method, treatment or setting for such recommended preventive items or services where not otherwise specified in the recommendations and guidelines.

- The recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in November 2009, which were the subject of some controversy, will not be considered current for purposes of this mandate. Instead, the prior recommendation (which recommends a screening mammography for women with or without a clinical breast examination every one to two years for women aged 40 or older) is considered current and will be required to be covered.
- Although this rule will impose a cost on Group Health Plans in the short term, if covering these preventive care services meets the goal of catching health conditions in their early states, plans could see long-term cost savings in

	<p>coverage for preventive services or items that are not included in the list of recommended preventive services or items subject to this mandate, the Group Health Plan may continue to impose cost-sharing requirements on such services and items. Similarly, a Group Health Plan can still impose cost-sharing requirements with respect to recommended preventive services or items that go beyond the specific recommendation or the plan's reasonable medical management guidelines for the preventive service or item.</p>	<p>reducing the high-cost claims for diseases that are not typically caught until in advanced stages.</p>
<p><b>Mandated Claims Appeals Processes</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2719</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• <b>Group Health Plans</b> (self and fully insured) are required to have an <i>internal claims and appeals process</i> that generally follows the existing ERISA claims regulations, as modified to comply with additional standards set forth in the July 23, 2010, interim final rule: <ul style="list-style-type: none"> <li>➤ A rescission of coverage must be treated as an adverse benefit determination, whether or not there is an adverse effect on any particular benefit at the time of rescission.</li> <li>➤ Claimants must be notified of an initial benefit determination with respect to an urgent care claim within 24 – rather than 72 – hours after receipt of the claim (this new timeframe does not apply to urgent care claim appeals).</li> <li>➤ The Group Health Plan must provide notices in a "culturally and linguistically appropriate manner" and provide additional information in denial notices, including provision of the diagnosis code, treatment code, denial code and corresponding meanings, as well as a discussion of the decision in the case of a notice of final internal adverse benefit determination.</li> <li>➤ The Group Health Plan must provide a claimant, free of charge, any new or additional evidence considered, relied upon, or generated by the plan with respect to a claim, or any new or additional rationale for the decision, sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided so that the claimant has a reasonable opportunity to respond.</li> <li>➤ The Group Health Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• The "strict adherence" standard that is applied to a Group Health Plan's internal appeals process under this mandate can result in the plan administrator losing its ability to make a benefit determination internally due to even an insignificant or a de minimis failure to follow the internal claims and appeals procedures. Avoiding this consequence will require coordination with third party administrators and internal appeals committees to ensure that proper procedures are developed and followed.</li> <li>• The Federal external review process does not apply to adverse benefit determinations that relate to a participant's failure to meet the requirements for eligibility under the terms of a Group Health Plan. Therefore, decisions regarding eligibility classifications will remain with the Group Health Plan if it is subject to the Federal external review process.</li> </ul>

impartiality of the persons involved in making the decisions.

- There is deemed exhaustion of the internal claims and appeals process if the Group Health Plan or [Health Insurance Issuer](#) fails to *strictly adhere* to all of the requirements discussed above.
- The provision of notices in a "culturally and linguistically appropriate manner" requires Group Health Plans to provide notices in non-English languages if certain thresholds of non-English speaking participants are met, depending on the number of participants in the Plan.
- Group Health Plans (self and fully insured) are also required to have an *external review process*:
  - Fully and self insured Group Health Plans that are subject to a State external review process must meet the State external review process, provided that the process includes, at a minimum, the consumer protections in the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the NAIC Uniform Model Act).
  - Fully and self insured Group Health Plans that are either not subject to a State external review process, or are subject but such process does not meet the minimum standards under the NAIC Uniform Model Act, must meet similar Federal standards for external review established by the Secretary of HHS.
- The Department of Labor issued sub-regulatory guidance that provides an interim enforcement safe harbor for non-grandfathered self-insured Group Health Plans that are subject to the Federal external review process. Details on the interim safe harbor are available at <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>. The NAIC Uniform Model Act establishes standardized protocols for external review to ensure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination regarding benefits for specific procedures or services.
- The Departments have provided transitional enforcement relief:
  - For the **internal** claims and appeals process, the

- This interim safe harbor for compliance is only a *safe harbor*. Group Health Plans may comply with the mandate without satisfying the safe harbor; in such cases, the external review process will be considered on a case-by-case basis. For example, a failure to contract with at least three independent review organizations (IROs) does not mean the plan automatically violates the coverage mandate.
- Group Health Plans that are subject to the Federal external review process may satisfy the interim safe harbor by contracting with their third party administrators that will, in turn, contract with the IROs. Note that this arrangement does not relieve the plan from responsibility from providing external review, and ERISA plans have fiduciary duties to monitor their third party administrators.
- The Department of Labor has posted model notices for the adverse benefit determination, the final internal adverse benefit determination, and the final external review decision. The model notices are available at <http://www.dol.gov/ebsa/healthreform/>.

	<p>Departments provided an enforcement grace period until July 1, 2011, with respect to the second, third, and sixth standard described above, provided the plan is working in good faith to implement such additional standards.</p> <ul style="list-style-type: none"> <li>➤ For the <b>external</b> review process, a State external review process that does not currently meet the minimum standards under the NAIC Uniform Model Act will be treated as compliant for plan years beginning before July 1, 2011.</li> </ul>	
<p><b>Mandated Patient Protections</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2719A</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) must contain certain patient protections.</li> <li>• If a Group Health Plan requires a participant or beneficiary to affirmatively designate a primary care provider or a pediatrician, the plan must permit the participant or beneficiary to designate any participating primary care provider or pediatrician who is available to accept the participant or beneficiary and who is in the plan's network. <ul style="list-style-type: none"> <li>➤ The June 28, 2010, interim final rule provides that if a Group Health Plan requires the designation by the participant beneficiary of a primary care provider, the Group Health Plan must provide a notice informing each participant of the terms of the plan regarding designation of a primary care provider and the participant's rights with respect to choosing a health care professional. The Departments have issued a model notice that employers can use to comply with this rule, which can be found at <a href="http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc">www.dol.gov/ebsa/patientprotectionmodelnotice.doc</a>.</li> <li>➤ The interim final rule confirms that the choice of primary care providers and pediatricians can be confined to in-network providers.</li> </ul> </li> <li>• If a Group Health Plan covers obstetrical and gynecological care, women participants must have direct access to such care without referral or authorization from a primary care physician. The interim final rule confirms that the choice of provider can be confined to in-network providers.</li> <li>• If a Group Health Plan covers hospital emergency department services, it must do so without requiring prior authorization, regardless of whether the service provider is a participating provider, without imposing requirements or costs different than those imposed on</li> </ul>	<ul style="list-style-type: none"> <li>• Group Health Plans that do not require or provide for designation by a participant or beneficiary of a participating primary care provider and pediatrician are not impacted by the provisions of this mandate that apply to choosing a health care professional. Similarly, Group Health Plans that do not require prior authorization or referral for obstetrical or gynecological care by a participating provider are not impacted by the provision of this mandate regarding OB/GYN care. Such plans are not required to provide the patient protection notice.</li> <li>• Group Health Plans need to review their current definitions of "emergency" and "emergency services" or similar terms to ensure that they track the definitions provided under this mandate. For example, if the plan's definition of "emergency" is determined by a medical professional's standard, it is likely not</li> </ul>

	<p>in-network participating providers, and generally without regard to any other term or condition of coverage.</p> <ul style="list-style-type: none"> <li>➤ For purposes of the coverage of emergency services, "emergency services" means a medical screening examination that is within the capability of the emergency department of a hospital, and of the staff and facilities available at the hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.</li> <li>➤ An "emergency" medical condition for these purposes is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a <i>prudent layperson</i> (not a medical professional) who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.</li> </ul>	<p>broad enough for this mandate, which determines an "emergency" under a prudent layperson standard.</p> <ul style="list-style-type: none"> <li>• This coverage mandate generally requires Group Health Plans that are not Grandfathered Plans to provide out-of-network emergency services at the in-network level of coverage. However, the mandate does not require plans to cover amounts that out-of-network providers may "balance bill." To protect patients from being financially penalized for obtaining emergency services out-of-network, the interim final rule sets forth minimum payment standards on the plan. Sub-regulatory guidance clarifies that such minimum standards do not apply either: (1) where State law prohibits balance billing; or (2) where the plan is contractually obligated to bear the costs of any amounts balance billed.</li> </ul>
<p><b>Extension of Nondiscrimination Rules</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2716</b></p> <p><b>Grandfather</b></p>	<ul style="list-style-type: none"> <li>• Nondiscrimination rules similar to those set forth under Internal Revenue Code Section 105(h)(2) that currently apply to self-insured <a href="#">Group Health Plans</a> are extended to <i>fully-insured</i> Group Health Plans.</li> <li>• If a <i>self-insured</i> Group Health Plan violates the Section 105(h)(2) nondiscrimination rules, highly-compensated individuals in the plan are taxed on the discriminatory reimbursements they receive under the discriminatory plan. If a <i>fully-insured</i> Group Health Plan fails to comply with these new nondiscrimination rules, however, rather than resulting in the loss of a tax benefit for highly compensated individuals, the plan will be subject to</li> </ul>	<ul style="list-style-type: none"> <li>• The nondiscrimination rules under Internal Revenue Code Section 105(h)(2) already prevent <i>self-insured</i> Group Health Plans from discriminating in favor of highly compensated employees in terms of eligibility to participate and the level of benefits under a plan. The expansion of</li> </ul>

<p><b>ed Plans are exempt from this requirement.</b></p>	<p>an excise tax or civil money penalty of \$100 per day per individual discriminated against.</p> <ul style="list-style-type: none"> <li>The Department of the Treasury and the Internal Revenue Service have invited comments concerning the application of Section 105(h)(2) to fully-insured Group Health Plans.</li> </ul>	<p>the nondiscrimination rules to <b>fully-insured</b> plans will likely result in more scrutiny being placed on self-insured plans.</p> <ul style="list-style-type: none"> <li>This extension of the nondiscrimination rules to fully-insured plans could impact employers who provide health care coverage to executives through fully-insured plans to avoid the nondiscrimination test that has previously only been applicable to self-insured plans.</li> </ul>
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***The following coverage mandate applies to ALL GROUP HEALTH PLANS as of the first plan year beginning on or after January 1, 2014.***

<p><b>Waiting Period Restrictions</b></p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p> <p><b>PHSA § 2708</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li><a href="#">Group Health Plans</a> (self and fully insured) may not impose any waiting period in excess of 90 days.</li> </ul>	<ul style="list-style-type: none"> <li><i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>This provision will have the biggest impact on employers with more transient employee populations such as the retail and food service industries.</li> </ul>
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***The following coverage mandates apply ONLY to NON-GRANDFATHERED GROUP HEALTH PLANS as of the first plan year beginning on or after January 1, 2014.***

<p><b>Mandated Cost-Sharing Limits</b></p>	<ul style="list-style-type: none"> <li><a href="#">Group Health Plans</a> (self and fully insured) must limit cost-sharing amounts (out-of-pocket expenses) (e.g., deductibles, co-insurance, co-pays) incurred by</li> </ul>	<ul style="list-style-type: none"> <li><i>Note that no guidance has been issued on this provision, and that this</i></li> </ul>
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<p><i>Effective for plan years beginning on or after January 1, 2014.</i></p> <p><b>PHSA § 2707</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<p>participants to the limits applicable to high deductible health plans under Internal Revenue Code Section 223.</p> <ul style="list-style-type: none"> <li>• When this provision goes into effect in 2014, the high deductible health plan limits in effect in 2014 will apply. For years after 2014, the law provides adjustment factors to increase the limits in future years.</li> <li>• Group Health Plans (self and fully insured) cannot have deductibles that exceed \$2,000 for single coverage and \$4,000 for any other coverage, subject to adjustments for cost-of-living after 2014. Deductibles may be increased by the amount of reimbursement available to participants under flexible spending accounts (regardless of whether employee or employer contributions).</li> </ul>	<p><i>analysis is, therefore, based solely on the statutory text.</i></p> <ul style="list-style-type: none"> <li>• Out-of-pocket maximums will be limited to the out-of-pocket maximums that are allowed under a high deductible health plan under Internal Revenue Code Section 223. To put this into context, the out-of-pocket maximum limitations for high deductible health plans in 2010 are \$5,950 for single coverage and \$11,900 for family coverage.</li> <li>• The requirement that Group Health Plans cannot have deductibles that exceed \$2,000 for single coverage and \$4,000 for family coverage could theoretically collide with the <i>minimum</i> deductible requirements for high deductible health plans under Internal Revenue Code Section 223. In 2010, a high deductible health plan must have a deductible of <i>at least</i> \$1,200 for single coverage and \$2,400 for family coverage. These amounts generally increase every year.</li> </ul>
<p><b>Mandated Coverage for Clinical Trials</b></p> <p><i>Effective for plan years beginning on</i></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) cannot deny the participation of a qualified individual in a clinical trial, deny coverage of routine costs in connection with the clinical trial, or discriminate on the basis of participation in a clinical trial.</li> <li>• A qualified individual is a participant or beneficiary in the Group Health Plan who:</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• Group Health Plans will need to review their</li> </ul>

<p><i>or after January 1, 2014.</i></p> <p><b>PHSA § 2709</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>➤ Is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; or</li> <li>➤ Is referred by a participating health care provider who has concluded that the individual's participation in the trial is appropriate, or provides information establishing that his or her participation would be appropriate.</li> </ul>	<p>coverage provisions regarding clinical trials when guidance relating to this mandate is issued to ensure that the plan meets the coverage requirements. Group Health Plans will similarly need to review their definition of "Experimental or Investigational" or similar terms to ensure that coverage required by this mandate is not excluded under the plan as experimental or investigational.</p>
<p><b>No Discrimination Based on Health Status</b></p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p> <p><b>PHSA § 2705</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• <u>Group Health Plans</u> (self and fully insured) may not establish rules for eligibility (including continued eligibility) to enroll based on the following health status-related factors in relation to an individual or a dependent of the individual: <ul style="list-style-type: none"> <li>a. Health status;</li> <li>b. Medical condition (physical and mental);</li> <li>c. Claims experience;</li> <li>d. Receipt of health care;</li> <li>e. Medical history;</li> <li>f. Genetic information;</li> <li>g. Evidence of insurability;</li> <li>h. Disability; and</li> <li>i. Any other health status-related factor determined appropriate by the Secretary.</li> </ul> </li> <li>• Employers can establish wellness programs that provide a premium discount or rebate or other reward for participation in a Group Health Plan without violating this coverage mandated under the following circumstances: <ul style="list-style-type: none"> <li>➤ If the reward <i>is not</i> based on the participant satisfying a health standard, the program is permitted if the reward is made available to all similarly situated individuals.</li> <li>➤ If the reward <i>is</i> based on the participant satisfying a health standard, the program is</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This requirement is not new for, and already applies to, Group Health Plans. ERISA, the Internal Revenue Code, and the Public Health Service Act have all prevented discrimination in eligibility on the basis of health status since 1996 upon the passage of HIPAA.</li> <li>• The rules regarding wellness programs essentially codify the wellness regulations that were issued by the Secretaries of Labor, Treasury, and HHS under the portability provisions of HIPAA that already applied to Group Health Plans, and broaden them to include Health</li> </ul>

permitted if:

- (i) The reward is not greater than 30 percent of the cost of the health plan's coverage (taking into account both employer *and* employee contributions to the coverage);
  - (ii) The program is reasonably designed to promote health or prevent disease;
  - (iii) Individuals eligible for the program have an opportunity to qualify for the reward at least once per year;
  - (iv) The full reward is available to all similarly situated individuals (including provision of reasonable alternatives for those unable to satisfy the health standard due to a medical condition); and
  - (v) The availability of reasonable alternatives is disclosed in plan materials describing the terms of the program.
- The PPACA permits the Secretaries of Labor, HHS and the Treasury to increase by regulation the reward available to up to 50 percent of the cost of coverage.
  - The PPACA also creates wellness program demonstration projects for ten states under which the participating states will apply the wellness program rules to programs of health promotion offered by a [Health Insurance Issuer](#) that offers health insurance coverage in the individual market in each state.

Insurance Issuers.

- This provision (and other wellness provisions included in the PPACA) demonstrate the federal government's promotion of wellness programs. Note that the wellness incentive limit has been raised from 20 percent (as provided in the regulations under HIPAA) to 30 percent, and this rule gives the Secretaries discretion to raise it to 50 percent if deemed appropriate.
- This rule does not, however, address other issues about which employers offering wellness programs need to be aware such as ensuring that wellness programs comply with the Genetic Information Nondiscrimination Act (*e.g.*, ensuring that family history or other genetic information questions are not asked before enrollment, or that health risk assessments that are tied to a reward do not contain questions about genetic information, including family history). Another concern about which employers should be aware is increasing informal guidance from the Equal Employment Opportunity Commission that requiring employees to participate in medical exams or to answer disability related questions as a condition

		of participating in a health plan could violate the Americans with Disabilities Act.
<p><b>Guaranteed Availability and Renewability of Coverage</b></p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p> <p><b>PHSA §§ 2702 and 2703</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• If a <a href="#">Health Insurance Issuer</a> offers coverage in a state, the issuer must accept every employer and individual in that state that applies for coverage.</li> <li>• If a Health Insurance Issuer offers health insurance coverage for a <a href="#">Group Health Plan</a>, the issuer must renew or continue in force such coverage at the option of the Group Health Plan sponsor.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This provision will prevent Health Insurance Issuers from cancelling an employer’s Group Health Plan coverage in the event that the employer’s Group Health Plan suffers poor claims experience.</li> <li>• This guarantee issue rule should ensure that coverage is <b>available</b> for employers to purchase for their employees; however, given the absence of direct premium controls in the PPACA it is not clear whether the coverage will be affordable.</li> </ul>

**EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES**

<p><b>Cost of Employer-Sponsored Health Coverage Included on W-2</b></p> <p><i>Effective January 1, 2011.</i></p> <p><b>PPACA § 9002; amends Code § 6051(a)</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• Employers must report the aggregate cost of employer-provided health care coverage (employee plus employer share) on their employees' Form W-2s.</li> <li>• For fully-insured plans, the aggregate cost is the total premium paid. For self-insured plans, the aggregate cost is determined using rules similar to those used for determining COBRA premiums. Aggregate costs include employer contributions to an HRA, but do not include employer or employee contributions to Archer MSAs or HSAs. They also do not include employee contributions to a medical FSA.</li> <li>• IRS Notice 2010-69 provides that this requirement is <i>optional</i> for the 2011 tax year in order to give employers additional time to make any necessary changes to their payroll systems or procedures. The requirement will be <i>mandatory</i> for the 2012 tax year, meaning generally that it must be reported on the 2012 Form W-2 issued in early 2013. Employees who terminate employment during 2012 may request a Form W-2 upon termination, however, so employers should be prepared to satisfy this requirement beginning in 2012. The IRS and Department of Treasury intend to issue guidance on this reporting requirement before the end of 2010.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, therefore this analysis is based solely on the statutory text.</i></li> <li>• The aggregate cost required to be reported on the Form W-2 excludes the cost of fully-insured dental and vision plans, but includes the cost of self-insured dental and vision plans regardless of whether otherwise exempt from the PPACA coverage mandates as limited scope plans. There does not seem to be any policy reason for this distinction, particularly since they are treated the same for purposes of the PPACA coverage mandates.</li> <li>• It is unclear how this requirement will be met with respect to retiree health care since retired employees do not receive Form W-2s. Because the value of retiree coverage appears to be subject to the excess coverage penalty tax in 2018, it seems likely that a similar reporting requirement will be imposed on retiree plans in the future.</li> </ul>
<p><b>Uniform Notice of Coverage Requirements</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> <li>• By March 23, 2012, plan administrators, sponsors and insurers must provide a summary of benefits and coverage explanation that accurately describes benefits and coverage under the <a href="#">Group Health Plan</a> to participants prior to enrollment. The summary must be presented in a culturally and linguistically appropriate manner utilizing terminology understandable by</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This new requirement is essentially a summary of a summary plan description. While church and governmental plans have not been required to provide a</li> </ul>

<p><b>PHSA § 2715</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<p>the average plan enrollee.</p> <ul style="list-style-type: none"> <li>• The content and format is prescribed by statute and standards developed by the Secretary of HHS. The summary must state whether the Group Health Plan: <ul style="list-style-type: none"> <li>➢ Provides <a href="#">Minimum Essential Coverage</a>; and</li> <li>➢ Pays less than 60 percent of the total cost of benefits provided under the plan.</li> </ul> </li> <li>• In addition, the summary must provide the following information: uniform definitions of standard insurance terms and medical terms; a description of coverage and cost-sharing under the plan; exceptions, reductions and limitations on coverage; the plan's cost-sharing provisions, including deductible, coinsurance, and co-payment obligations; renewability and continuation of coverage provisions; a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions; a statement that the outline is a summary and that the plan document should be consulted to determine governing contractual provisions; and contact numbers and Web addresses where the actual group certificate or policy may be obtained.</li> <li>• If a Group Health Plan or <a href="#">Health Insurance Issuer</a> makes any material modification in any of the terms of the plan or coverage involved that is not reflected in the most recently provided summary, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.</li> <li>• Penalty for willful noncompliance is \$1,000 per failure.</li> </ul>	<p>summary plan description under ERISA (because of their ERISA exemption), they will now have to provide this new notice.</p> <ul style="list-style-type: none"> <li>• ERISA plans will apparently still have to provide the summary plan description required by ERISA, as well as this new notice. However, the Department of Labor is required to update its regulations concerning the accurate and timely disclosure of plan terms and conditions to harmonize with the PPACA.</li> <li>• States may adopt more stringent standards for the summary.</li> <li>• The Secretary is required to provide standards for developing this summary by March 23, 2011, and plans will be required to distribute the new summary by March 23, 2012.</li> <li>• After the summary is distributed, Group Health Plans need to be very aware that they must provide notice to participants of any material modification to the plan's terms or coverage no later than 60 days prior to the effective date of the change. This may have a significant impact on the timing of plan design decisions and notice of those decisions for upcoming plan years, including an impact on the timing of open enrollment periods, which are often held within 60 days of the start of the next plan year.</li> </ul>
<p><b>Information to Secretary</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) must provide information</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that</i></li> </ul>

<p><b>of HHS</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2715A</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<p>regarding the following to the Secretary of HHS and make such information publicly available:</p> <ul style="list-style-type: none"> <li>➤ Claims payment policies and practices.</li> <li>➤ Periodic financial disclosures.</li> <li>➤ Data on enrollment.</li> <li>➤ Data on disenrollment.</li> <li>➤ Data on the number of claims that are denied.</li> <li>➤ Data on rating practices.</li> <li>➤ Information on cost-sharing and payments with respect to any out of network coverage.</li> <li>➤ Information on enrollee and participant rights.</li> <li>➤ Other information determined appropriate by the Secretary of HHS.</li> </ul> <ul style="list-style-type: none"> <li>• The information must be provided in "plain language" that the intended audience can readily understand.</li> <li>• The Group Health Plan must also provide participant information regarding the amount of cost-sharing that the participant would be responsible for paying with respect to a specific service in a timely manner at the request of the participant.</li> </ul>	<p><i>this analysis is, therefore, based solely on the statutory text.</i></p> <ul style="list-style-type: none"> <li>• Additional guidance will be necessary to understand the impact of this requirement. However, new data gathering and reporting processes will need to be implemented.</li> </ul>
<p><b>Employer Annual Reporting Requirements regarding Quality of Care</b></p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p> <p><b>PHSA § 2717</b></p> <p><b>Grandfathered</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> must provide an annual report to participants at open enrollment and to the Secretary of HHS regarding Group Health Plan and health care provider reimbursement structures that improve the quality of care, including wellness and health promotion activities.</li> <li>• The Secretary of HHS is required to develop reporting requirements and issue regulations by March 23, 2012.</li> <li>• The Secretary of HHS is required to make these reports public on the Internet.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, therefore this analysis is based solely on the statutory text.</i></li> <li>• Additional guidance will be necessary to understand the impact of this requirement. However, new data gathering and reporting processes will need to be implemented.</li> </ul>

<p><b>Plans are exempt from this requirement.</b></p>		
<p><b>Employee Notices Regarding Exchange</b></p> <p><i>Effective March 1, 2013.</i></p> <p><b>PPACA § 1512; adds Fair Labor Standards Act § 18B</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• Employers must provide written notices to employees regarding the <a href="#">Exchange</a> at the time of hire for new employees and for all other employees by March 1, 2013.</li> <li>• The notice must inform the employee of: the existence of an Exchange, its services, and how to contact the Exchange; that if the employer plan’s share of the total allowed costs of benefits under the plan is less than 60 percent of such costs, that the employee may be eligible for a <a href="#">Premium Tax Credit</a> or a <a href="#">Cost Sharing Reduction</a> through the Exchange; and that if the employee purchases a plan through the Exchange, the employee will lose the employer contribution (if any) to any health plan offered by the employer and that all or a portion of such contribution may be excludable from federal income taxes.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This notice is intended to provide information to employees about the existence of the Exchange, as well as provide information so that the employee can evaluate whether he or she is eligible for Premium Tax Credits or Cost Sharing Reductions under the Exchange.</li> <li>• Additional guidance will be necessary to implement this requirement. However, employers will need a process to draft and distribute the new notice.</li> </ul>
<p><b>Reporting to Internal Revenue Service of Health Insurance Coverage</b></p> <p><i>Effective January 1, 2014.</i></p> <p><b>PPACA § 1502; adds Code § 6055</b></p> <p><b>This requirement applies to all Group Health Plans, including Grandfathered Plans.</b></p>	<ul style="list-style-type: none"> <li>• Employers that provide <a href="#">Minimum Essential Coverage</a> are required to file a report with the Internal Revenue Service that provides information about the employees who are covered by the Minimum Essential Coverage, the portion of the premium (if any) required to be paid by the employer, and such additional information as may be required if the Minimum Essential Coverage is offered through an <a href="#">Exchange</a>.</li> <li>• The employer must provide to each employee included in the report a statement showing the information reported with respect to that employee by January 31 of the following year.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, therefore this analysis is based solely on the statutory text.</i></li> <li>• The purpose of this reporting requirement is to assist the Internal Revenue Service in its determination of whether individuals are meeting their obligations to have coverage and to determine whether such individuals are eligible for a Premium Tax Credit or Cost Sharing Reduction.</li> <li>• Additional guidance will be necessary to understand the impact of this requirement. However, new data gathering and reporting processes will need to be implemented.</li> </ul>

**Large Employer Reporting to Internal Revenue Service Regarding Coverage Offered**

*Effective January 1, 2014.*

**PPACA § 1514; adds Code § 6056**

**This requirement applies to all Group Health Plans, including Grandfathered Plans.**

- [Large Employers](#) (for purposes of applying the employer penalties) and employers who have any employees who would be eligible for vouchers are required to file a report with the Internal Revenue Service that provides certification as to whether the employer offers full-time employees (FTEs) the opportunity to enroll in [Minimum Essential Coverage](#) through an [Eligible Employer Sponsored Health Plan](#), and if so, information on the length of waiting periods imposed, costs of premiums, total cost paid by the employer, number of FTEs, and information on each FTE and the months covered under the plan.
  - The information required to be reported must also be provided in a statement to each FTE by January 31 of the following year.
- *Note that no guidance has been issued on this provision, therefore this analysis is based solely on the statutory text.*
  - The purpose of this reporting requirement is to provide the Internal Revenue Service with the information necessary to determine whether the employer may be subject to a penalty.
  - To the extent possible, the Secretary of the Treasury may permit that a return required to be provided by Large Employers under this provision be included as part of the return required to be provided by employers offering Minimum Essential Coverage generally (see above).
  - Employers may contract with their insurer to report this information.
  - Additional guidance will be necessary to understand the impact of this requirement. However, new data gathering and reporting processes will need to be implemented.

**EMPLOYER COVERAGE RESPONSIBILITIES**

<p><b>Automatic Enrollment for Employers Offering Coverage</b></p> <p><i>Effective by regulation.</i></p> <p><b>PPACA § 1511; adds Fair Labor Standards Act § 18A</b></p>	<ul style="list-style-type: none"> <li>• Employers with more than 200 full-time employees that offer health coverage are required to automatically enroll new full-time employees, subject to any waiting period of 90 or less days.</li> <li>• Automatic enrollment must include adequate notice and opportunity for an employee to opt out of coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This requirement will impose the greatest burden on employers with transient workforces.</li> <li>• In the absence of regulatory guidance, it appears that an employer that offers multiple health plan options may choose the default option into which employees will be automatically enrolled.</li> <li>• This provision is not effective until the Secretary of HHS promulgates regulations implementing it. Much more detail in the form of regulations will be needed to implement this provision. At the least, employers will need to institute an auto-enrollment procedure and an opt-out procedure. This may create administrative difficulties because some number of employees will be enrolled in the Group Health Plan, only to be removed almost immediately when they opt-out of the coverage.</li> </ul>
<p><b>Penalties for Employers Not Offering Coverage</b></p> <p><i>Effective January 1, 2014.</i></p> <p><b>PPACA § 1513; adds Code § 4980H</b></p>	<ul style="list-style-type: none"> <li>• This penalty applies to <a href="#">Large Employers</a> that employed an average of at least 50 full-time employees (FTEs) in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (<i>i.e.</i>, whether the employer employed an average of at least 50 full-time employees on business days during the preceding calendar year), but they are <i>not</i> counted to determine the amount of the penalty. FTE equivalents are computed by adding the total hours of</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This penalty is imposed on a monthly basis and the penalty must be paid for <i>every</i> FTE employed by the employer in that month – even if only <i>one</i> FTE enrolls in an Exchange and qualifies for a Premium Tax Credit or Cost Sharing Reduction for that month.</li> <li>• The Secretary shall certify to an employer whether the penalty is due</li> </ul>

	<p>all part-time employees for the month and dividing by 120.</p> <ul style="list-style-type: none"> <li>If a Large Employer with at least 50 FTEs (including FTE equivalents) does <b>not</b> provide health coverage to its FTEs in any month <b>and</b> at least one FTE of the employer enrolls in an <a href="#">Exchange</a> and qualifies for a <a href="#">Premium Tax Credit</a> or <a href="#">Cost Sharing Reduction</a> for that month, <b>then</b> the employer must pay a penalty: <ul style="list-style-type: none"> <li>for that <b>month</b> equal to the <b>total number of FTEs x \$166.67</b>; or</li> <li>for that <b>year</b> equal to the <b>total number of FTEs x \$2,000</b></li> </ul> <p>In calculating this penalty, the first 30 FTEs do not count.</p> </li> <li>After 2014, the penalty amounts are subject to an inflation adjustment formula.</li> <li>When no employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400 percent of the federal poverty line).</li> </ul>	<p>and the time for payment. This process will be more fully described in upcoming regulations, but the Secretary has the discretion to require payment on an annual, monthly or other periodic basis.</p> <ul style="list-style-type: none"> <li>In determining whether an employer employs 50 FTEs, an employer must apply the “controlled group” and “affiliated service group” rules under the Internal Revenue Code. <b>In very general terms</b>, this means that subsidiaries and affiliated companies may have to be combined and considered to be a <b>single</b> employer for purposes of counting FTEs and paying the penalty.</li> <li>It is not yet clear how to calculate whether an employee is employed on average at least 30 hours per week, particularly with regard to employees who are not employed on an hourly basis. The PPACA gives the Secretary of the HHS discretion to promulgate regulations to perform this calculation.</li> <li>Anticipating that some employers might reduce employees’ wages to offset penalty amounts owed by employers, the PPACA requires the Secretary of Labor to conduct a study to determine whether this occurs and to present the report to the Committee on Ways and Means of the House of Representatives and the Committee of Finance of the Senate. This offset is not currently prohibited by the PPACA, but abuses could lead to further legislation.</li> </ul>
<p><b>Penalties for Employers Offering Coverage</b></p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> <li>This penalty applies to <a href="#">Large Employers</a> that employed an average of at least 50 FTEs in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (<i>i.e.</i>, whether the employer employed an</li> </ul>	<ul style="list-style-type: none"> <li><i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>This penalty is imposed on a monthly basis and the penalty must be paid <b>only</b> for FTEs who enroll in an Exchange and qualify for a</li> </ul>

**PPACA § 1513; adds Code § 4980H**

average of at least 50 FTEs on business days during the preceding calendar year), but they are *not* counted to determine the amount of the penalty. FTE equivalents are computed by adding the total hours of all part-time employees for the month and dividing by 120.

- If a Large Employer with at least 50 FTEs (including FTE equivalents) *provides* health coverage to its FTEs in any month; *and* at least one FTE of the employer enrolls in an [Exchange](#) and qualifies for a [Premium Tax Credit](#) or [Cost Sharing Reduction](#) for that month, then the employer must pay a penalty:
  - for that *month* equal to the *lesser* of (i) **the total number of FTEs actually receiving a Premium Tax Credit and/or Cost Sharing Reduction x \$250** or (ii) **the total number of FTEs x \$166.67**, or
  - for that *year* equal to the *lesser* of (i) **the total number of FTEs actually receiving a Premium Tax Credit and/or Cost Sharing Reduction x \$3,000** or (ii) **the total number of FTEs x \$2,000**

In calculating the maximum penalty, the first 30 FTEs do not count.

- After 2014, the penalty amounts are subject to an inflation adjustment formula.
- An employer is not assessed a penalty with respect to any employee receiving a free choice voucher (see below).
- When employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400 percent of the federal poverty line); *and* either:
  - The employee's contribution under

Premium Tax Credit or Cost Sharing Reduction for that month.

- The Secretary shall certify to an employer whether the penalty is due and the time for payment. This process will be more fully described in upcoming regulations, but the Secretary has the discretion to require payment on an annual, monthly or other periodic basis.
- In determining whether an employer employs 50 FTEs, an employer must apply the “controlled group” and “affiliated service group” rules under the Internal Revenue Code. *In very general terms*, this means that subsidiaries and affiliated companies may have to be combined and considered to be *asingle* employer for purposes of counting FTEs.
- It is not yet clear how to calculate whether an employee is employed on average at least 30 hours of service per week, particularly with regard to employees who are not employed on an hourly basis. The PPACA gives the Secretary discretion to promulgate regulations to perform this calculation.
- Anticipating that some employers might reduce employees’ wages to offset penalty amounts owed by employers, the PPACA requires the Secretary of Labor to conduct a study to determine whether this occurs and to present the report to the Committee on Ways and Means of the House of Representatives and the Committee of Finance of the Senate. This offset is not currently prohibited by the PPACA, but abuses could lead to further legislation.

the employer plan exceeds 9.5 percent of household income (indexed after 2014); *or*

- The employer plan pays less than 60 percent of the total cost of benefits provided under the plan.

**Employers Offering Coverage: Free Choice Vouchers for Certain Low-Income Employees**

*Effective January 1, 2014.*

**PPACA § 10108**

- Employers that offer [Minimum Essential Coverage](#) to employees and pay a portion of the premiums of that coverage are required to provide vouchers to eligible employees for purchase of coverage in an [Exchange](#).
  - An employee is eligible if the employee's required premium contribution under the employer's health plan is between eight percent and 9.8 percent of the employee's household income for the year, the employee's household income does not exceed 400 percent of the federal poverty line, *and* the employee does not participate in the employer's plan. The percentages are indexed after 2014.
  - The voucher equals the amount the employer would have paid to provide single coverage for the employee under the plan (or family coverage if elected by the employee) with respect to which the employer pays the largest portion of the cost of the plan.
  - The employer is required to pay the voucher amounts to the Exchange, and the Exchange is required to credit the amount of any voucher to the monthly premium of any [Qualified Health Plan](#) in the Exchange in which the qualified employee is enrolled.
  - The voucher amount is not taxable to the employee to the extent used to pay for coverage on the Exchange.
  - Any amount of the voucher in excess of the cost of coverage on the Exchange is paid to the employee, but is taxable.
  - Employers may deduct the amount of a free choice voucher as an amount for compensation for personal services actually rendered.
  - Employers are not required to pay any penalties with regard to employees
- *Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.*
  - The free choice voucher is designed to assist individuals for whom employer coverage is a large percentage of their household income, but who have too much income to qualify for Premium Tax Credits or Cost Sharing Reductions on the Exchanges.
  - There appears to be a legislative disconnect between the eligibility for free choice vouchers and the eligibility for the Premium Tax Credit and the Cost Sharing Reduction on the Exchanges. Individuals for whom employer coverage costs up to 9.8 percent of their household income may be eligible for a free choice voucher; however, Premium Tax Credits and Cost Sharing Reductions may be available to individuals whose share of employer provided coverage is as low as 9.5 percent. This disconnect may be corrected in future legislation.

	to whom they provide free choice vouchers.	
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**PROVISIONS APPLICABLE TO SMALL EMPLOYERS ONLY**

**Coverage through an Exchange**

*Effective January 1, 2014.*

**PPACA § 1312**

- A [Small Employer](#) can offer [Qualified Health Plan](#) coverage to its full-time employees through an [Exchange](#). An employer in the small group market generally must have between one and 100 employees during the preceding year, applying the controlled group rules. However, for plan years beginning before January 1, 2016, a state can elect to limit the small group market to employers with no more than 50 employees.
  - An employer providing coverage through an Exchange that outgrows the parameters for the small group market is permitted to continue to offer coverage through the Exchange until such time as the employer discontinues coverage.
  - Beginning in 2017, states may elect to permit employers in the large group market to offer insurance through an Exchange.
- *Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.*
  - In determining the number of FTEs employed by an employer, an employer must apply the “controlled group” and “affiliated service group” rules under the Internal Revenue Code. ***In very general terms***, this means that subsidiaries and affiliated companies may have to be combined and considered to be ***asingle*** employer for purposes of determining whether an employer may purchase coverage through an Exchange.
  - There has been much discussion regarding the provision of coverage for abortions and how no Federal funds may be used to pay for such coverage. There has been less discussion of how these rules apply with respect to Small Employers who offer coverage through an Exchange. If an employee seeking such coverage qualifies for a Premium Tax Credit or Cost Sharing Reduction, and that employee pays his or her portion of the premiums through employee payroll deposit, separate payroll deposits must be made to segregate out the portion of the premium equal to the actuarial value of coverage for abortion services.
  - Employers offering coverage through an Exchange must ***allowall*** full-time employees to

		<p>be eligible.</p> <ul style="list-style-type: none"> <li>• Coverage through an Exchange is limited to lawful residents of the United States.</li> </ul>
<p><b>Transitional Small Employer Tax Credit</b></p> <p><i>Effective January 1, 2010.</i></p> <p><b>PPACA § 1421; adds Code § 45R</b></p>	<ul style="list-style-type: none"> <li>• An employer with no more than 25 FTEs and average wages of less than \$50,000 that purchases health insurance for its employees <b>and</b> covers at least 50 percent of total premium cost is eligible for a tax credit: <ul style="list-style-type: none"> <li>➤ For 2010-2013, the tax credit equals up to 35 percent (up to 25 percent for tax-exempt employers) of the lesser of: <ul style="list-style-type: none"> <li>○ the aggregate amount the employer paid toward premiums in the taxable year, or</li> <li>○ the aggregate amount the employer <b>would have paid</b> based on the average premium contribution in the small group market. The average premium contribution is determined by the Secretary of HHS on a state-by-state basis.</li> </ul> </li> <li>➤ For 2014 forward, the tax credit equals up to 50 percent (up to 35 percent for tax-exempt employers) of the lesser of: <ul style="list-style-type: none"> <li>○ the aggregate amount the employer paid toward premiums for insurance that is purchased through an <a href="#">Exchange</a>, or</li> <li>○ the aggregate amount the employer <b>would have paid</b> based on the average premium contribution (as determined by the Secretary of HHS) in the small group market in the rating area in which the employee enrolls for coverage.</li> </ul> </li> </ul> </li> <li>• The amount of the credit is phased-out based on the small employer's number of employees and average wages.</li> <li>• If the amount of the credit calculated for</li> </ul>	<ul style="list-style-type: none"> <li>• When determining “full-time equivalents” for purposes of this credit, an employer calculates the total number of hours of service for which wages were paid by the employer during the taxable year and divides that number by 2,080; however, no more than 2,080 hours may be counted for any individual employee. The Secretary may issue regulations to clarify how to count hours for this purpose.</li> <li>• In addition, an employer must apply the “controlled group” and “affiliated service group” rules under the Internal Revenue Code. <b><i>In very general terms</i></b>, this means that subsidiaries and affiliated companies may have to be combined and considered to be a <b>single</b> employer for purposes of counting full-time equivalent employees.</li> <li>• Small employers that may be eligible for this tax credit should be aware that the credit is available beginning with the 2010 tax year.</li> </ul>

	<p>a tax-exempt <a href="#">Small Employer</a> is greater than the employer's payroll taxes for the taxable year, the credit is limited to the amount of the payroll taxes for such year.</p> <ul style="list-style-type: none"> <li>• Beginning in 2014, the credit is only available for two years.</li> <li>• IRS Revenue Ruling 2010-13 provides more information on this tax credit, including a chart that sets forth the average premium contribution in the small group market by state for 2010, as determined by the Secretary of HHS.</li> </ul>	
<p><b>Insurance Access and Premium Rating</b></p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p> <p><b>PHSA § 2701</b></p> <p><b>Grandfathered Plans are exempt from this requirement.</b></p>	<ul style="list-style-type: none"> <li>• Premium rates charged by <a href="#">Health Insurance Issuers</a> for health insurance coverage offered in the small group market (and large group market if offered through an <a href="#">Exchange</a>) cannot vary except with respect to certain factors: <ul style="list-style-type: none"> <li>➢ Individual vs. family coverage;</li> <li>➢ Rating area;</li> <li>➢ Age (limit of 3 to 1); and</li> <li>➢ Tobacco use (limit of 1.5 to 1).</li> </ul> </li> </ul>	<p><i>Note that no guidance has been issued on this provision.</i></p>
<p><b>Simple Cafeteria Plans</b></p> <p><i>Effective January 1, 2011.</i></p> <p><b>PPACA § 9022; amends Code § 125</b></p>	<ul style="list-style-type: none"> <li>• An employer that employed on average 100 or fewer employees in the preceding two years is permitted to establish a "Simple Cafeteria Plan" by complying with the contribution, eligibility, and participation requirements established for "Simple Cafeteria Plans."</li> <li>• Employers that establish a Simple Cafeteria Plan, but later grow beyond 100 employees may continue to offer the Simple Cafeteria Plan until they reach 200 employees.</li> <li>• The contribution requirements require an employer to make <b>employer</b> contributions to qualified benefits under a cafeteria plan (regardless of whether an employee makes salary reduction contributions) in an amount</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• The Simple Cafeteria Plan essentially creates a safe harbor from the rules under Internal Revenue Code Section 125 that prevent discrimination with respect to eligibility and benefits in favor of highly compensated employees in a cafeteria plan. By making minimum required contributions to benefits under a cafeteria plan and providing broad eligibility for the plan, the employer's cafeteria plan will be deemed to pass the Internal Revenue Code Section 125</li> </ul>

	<p>equal to: (i) a uniform percentage (of at least two percent) of an employee's compensation for a plan year; or (ii) the lesser of six percent of an employee's plan year compensation or twice the amount of the salary reduction amounts of the employee.</p> <ul style="list-style-type: none"><li>• The eligibility requirements require that all employees who had at least 1,000 hours of service in the preceding plan year be eligible to participate and be able to elect any benefit offered through the cafeteria plan. Certain employees are excludable such as those under age 21, those with less than one year of service, those who are collectively bargained, and those who are nonresident aliens.</li><li>• If the Simple Cafeteria Plan requirements are met by an eligible employer, the plan is treated as meeting any applicable non-discrimination requirements under Internal Revenue Code Section 125.</li></ul>	<p>nondiscrimination rules. In concept, this is similar to safe harbor 401(k) and 403(b) plans.</p>
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## CHANGES FOR RETIREE HEALTH INSURANCE

### Temporary Reinsurance Program for Early Retirees

*Effective June 1, 2010.*

#### PPACA § 1102

- Employment-based plans (self or fully insured) providing health benefits, including prescription drugs, to early retirees (retirees at least age 55 and not Medicare-eligible) and their dependents can apply to receive reimbursement for a portion of the cost of coverage.
- An employment-based plan is a plan maintained by a current or former employer (including a state or local government), employee organization, VEBA, or multiemployer plan.
- Reimbursement is 80 percent of a valid retiree claim between \$15,000 and \$90,000 (as adjusted each year based on the Medicare percentage increases).
- Reimbursements must be used to lower costs for the plan.
  - If used to lower plan sponsor health costs or health premium costs, reimbursements must be limited to **offsetting increases** to such costs.
  - If used to lower participant costs, reimbursements can be used to offset or reduce plan participant (not just early retiree) premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs (or any combination of these).
  - Reimbursements may be used for a combination of any of the permitted purposes above.
- An employment-based plan that participates in the reinsurance program must have in place programs and procedures to generate cost savings with respect to participants with chronic or high cost conditions (*i.e.*, conditions for which \$15,000 or more in health benefit claims are likely to be incurred during a plan year
- The reinsurance program for early retirees is an incentive for employers to continue offering retiree coverage at least through the inception of the Exchange in 2014 (when the reinsurance program is scheduled to end, subject to funding limitations). It can be an important funding opportunity to entities providing retiree health coverage.
- The program application requires plan sponsors to demonstrate compliance with the program's requirements regarding chronic and high-cost conditions and the use of reimbursement proceeds. An applicant must also provide a projection of the reimbursements the plan would require during the first two plan year cycles under the program. Plans that intend to apply for the program need to consult their vendors to make sure they have sufficient information to complete the application.
- While the application window is open, all qualified applications will be approved and processed in the order received. The Department of HHS has indicated that it will not stop accepting applications prior to the beginning of the claims reimbursement period and then not until it appears that there is insufficient funding. Therefore, the "first come, first served" concept of the program relates less to the application process than to the claims submission process. Claims submissions will be reimbursed in the order received, until the earlier of

	<p>by one plan participant).</p> <ul style="list-style-type: none"> <li>• Reimbursements are not included in the employer's gross income.</li> <li>• The reinsurance program ends on January 1, 2014; however, only \$5 billion has been allocated to this program and the Secretary has authority to stop taking applications for the program based on the availability of funding.</li> <li>• The application process for the program opened on June 29, 2010. The application for the program, along with program requirements and information for approved plan sponsors is available at <a href="http://www.errp.gov/">http://www.errp.gov/</a>.</li> </ul>	<p>January 1, 2014, or when funding is exhausted.</p> <ul style="list-style-type: none"> <li>• Applicants should carefully review the information available on the program's Web site prior to submitting their application.</li> </ul>
<p><b>Elimination of Deduction for Retiree Prescription Drug Subsidy</b></p> <p><i>Effective for tax years after December 31, 2012.</i></p> <p><b>PPACA § 9012; amends Code § 139A</b></p>	<p>Employers who receive a federal subsidy for maintaining retiree prescription drug coverage can no longer deduct the amount of the subsidy.</p>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This change has an immediate impact on the accounting statements of employers that receive this subsidy because the value of the subsidy will be reduced, and thus the actual cost to an employer to provide retiree prescription drug coverage will increase. The increase should have already been recognized as an increased future liability for accounting purposes.</li> <li>• The loss of this deduction, in combination with the elimination of the Medicare Part D "doughnut hole" (see below), could lead employers to reevaluate whether they want to continue to provide retiree prescription drug coverage at all.</li> </ul>
<p><b>Elimination of Medicare Doughnut Hole</b></p> <p><i>Effective beginning in 2010 with the</i></p>	<ul style="list-style-type: none"> <li>• Part D Medicare beneficiaries who hit the doughnut hole in 2010 will receive a \$250 rebate.</li> <li>• In 2011, Part D Medicare beneficiaries who hit the doughnut hole are eligible for a 50 percent discount in brand name</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• In 2010 dollars, Part D Medicare enrollees are responsible for 25 percent of their drug costs until</li> </ul>

<p><i>complete elimination of the doughnut hole effective by 2020.</i></p> <p><b>Reconciliation Act 2011</b></p>	<p>drugs.</p> <ul style="list-style-type: none"> <li>• Beginning in 2010, preventive care is free of co-payments and deductibles.</li> <li>• The doughnut hole will be eliminated by 2020.</li> </ul>	<p>they incur \$2,700 in costs, then they are responsible for 100 percent of their drug costs until they incur \$4,350 in costs, at which time they are responsible for only five percent of their drug costs. This gap between \$2,700 and \$4,350 is referred to as the "doughnut hole."</p> <ul style="list-style-type: none"> <li>• The elimination of the doughnut hole, in combination with the elimination of the tax deduction for the retiree drug subsidy (see above), may cause many employers to rethink whether they wish to continue providing retiree prescription drug benefits.</li> </ul>
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**TAX PROVISIONS AFFECTING EMPLOYER-BASED HEALTH CARE**

**Excise Tax on High Cost Employer-Sponsored Health Coverage**

*Effective January 1, 2018.*

**PPACA § 9001; Reconciliation Act § 1401; adds Code § 4980I**

- A tax is imposed on the coverage provider of high-cost health plans which is equal to 40 percent of the "excess benefit." For insured plans, the coverage provider will be the issuer and for self-insured plans the coverage provider will generally be the plan administrator.
- The "excess benefit" is the amount of annual coverage that costs *more than* \$10,200 for single coverage and *more than* \$27,500 for family coverage. These limits are for 2018, but may be adjusted before that time under a formula set forth in the PPACA.
- Any coverage provided under a [Group Health Plan](#) that is excludable from an employee's gross income under Internal Revenue Code Section 106 is included in the cost calculation, including employer and employee pre-tax contributions to flexible spending accounts, health reimbursement accounts, and employer contributions to health savings accounts. The following are *not* included in the cost calculation:
  - Coverage for long-term care;
  - Dental and vision coverage offered under separate policies or certificates; and
  - Specific disease or hospital indemnity policies if the payment for the coverage is not excludable from any employee's income.
- There is a higher dollar threshold for qualified retirees and high risk professions, and adjustments are made for age and gender.
- The employer is responsible for
  - *Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.*
  - In earlier versions of health care reform bills, this tax was set to begin much sooner. Compromises pushed the effective date back to 2018 and excluded a number of kinds of plans from inclusion in the plan value calculation.
  - Although they agreed to the tax's higher thresholds and delayed effective date, labor unions in particular continue to be concerned about the tax's impact on coverage provided to collectively-bargained employees.

calculating the tax and notifying  
providers and the Secretary of HHS.

This tax does not go into effect until  
2018.

<p><b>Revenue Provisions Affecting HSAs, FSAs and HRAs</b></p> <p><i>Effective January 1, 2011; however, the dollar limits on contributions to a health FSA is effective January 1, 2013.</i></p> <p><b>PPACA §§ 9003, 9004, and 9005; Reconciliation Act § 1403; amends Code §§ 106, 125, 220, and 223</b></p>	<ul style="list-style-type: none"> <li>• Over the counter (OTC) drugs are no longer qualified for purposes of distributions/reimbursements under HSAs, Archer MSAs, health FSAs and HRAs, <b>except for</b> prescription medicines and insulin. This provision is effective January 1, 2011.</li> <li>• The tax on distributions from HSAs for nonqualified medical expenses is increased from 10 percent to 20 percent. This provision is effective January 1, 2011.</li> <li>• The tax on distributions from Archer MSAs for nonqualified medical expenses is increased from 15 percent to 20 percent. This provision is effective January 1, 2011.</li> <li>• Contributions to a health FSA under a cafeteria plan is limited to \$2,500 per year, indexed for inflation after 2013. This provision is effective January 1, 2013.</li> </ul>	<ul style="list-style-type: none"> <li>• When reimbursement for OTC drugs became available a few years ago, many flexible spending account plans were amended to allow for these reimbursements. Those amendments will now need to be reversed.</li> <li>• The OTC policy change applies to all expenses incurred after December 31, 2010, <b>even if</b> the expenses are incurred within the "grace period" that relates to the 2010 plan year. This is an important employee communication for participants who may have based their 2010 election on OTC drugs they intended to purchase in early 2011 within the plan's grace period. Regardless of whether a grace period applies, employees need to be aware of this change at open enrollment, prior to making their 2011 elections.</li> <li>• Because current debit card systems are not capable of reflecting that an OTC drug was prescribed, health FSA and HRA debit cards may generally not be used to purchase OTC drugs after December 31, 2010. There is an enforcement grace period for health FSA and HRA debit card expenses incurred through January 15, 2011, if the use of the debit cards otherwise complies with current guidance. In addition, debit cards may continue to be used to purchase OTC drugs that have been prescribed if used at a pharmacy where 90 percent of the store's gross receipts during the prior taxable year consists of items which qualify as expenses for medical care under Internal</li> </ul>
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		<p>Revenue Code Section 213(d). In all cases, OTC drugs must be substantiated before reimbursement can be made (e.g., the prescription or other documentation that a prescription has been issued). Health FSA and HRA debit cards may continue to be used for medical expenses other than OTC drugs.</p> <ul style="list-style-type: none"> <li>• Traditionally, health FSAs have only been subject to limits imposed by the employer in designing the plan. Many employers allowed elections of up to \$5,000 or even more. This new limit of \$2,500 will dramatically lower limits in many plans. This new limit is intended as a revenue raiser for the federal government because it will limit the amount of wages an employee may exclude from income and will also raise additional payroll taxes.</li> </ul>
<p><b>Increase in FICA Taxes on Earned Income</b></p> <p><i>Effective for compensation received after December 31, 2012.</i></p> <p><b>PPACA § 9015; Reconciliation Act § 1402(b); amends Code §§3101 and 3102</b></p>	<ul style="list-style-type: none"> <li>• There will be an increase of 0.9 percent in the FICA tax paid on wages during a taxable year above \$200,000 (\$250,000 for joint returns).</li> <li>• The increase applies only to the employee-paid FICA taxes.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• Although this tax does not apply to the employer-paid FICA taxes, employers will still be responsible for the withholding and reporting obligations with respect to this increase in employee-paid FICA taxes.</li> </ul>
<p><b>Increase in FICA Taxes on Unearned Income</b></p> <p><i>Effective for taxable years beginning after December 31, 2012.</i></p> <p><b>Reconciliation Act § 1402(a); adds Code § 1411</b></p>	<ul style="list-style-type: none"> <li>• There will be a new tax imposed that is equal to 3.8 percent of the lesser of: the net investment income for a taxpayer's taxable year, or the modified adjusted gross income for such taxable year over \$250,000 for joint filers (or \$150,000</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• This new tax does <b>not</b> affect employers and their withholding and reporting</li> </ul>

	<p>for married individuals filing as single, or \$200,000 for single filers).</p> <ul style="list-style-type: none"> <li>• Net investment income includes gross income from interest, dividends, annuities royalties, rents other gross income derived from passive activities related to a trade or business, and net gain attributable to the disposition of property other than property held in a trade or business (subject to exceptions).</li> <li>• This tax does not apply to distributions under retirement plans under Internal Revenue Code Sections 401(a), 403(a), 403(b), 408, 408A or 457(b).</li> </ul>	<p>obligations. Affected taxpayers will report any applicable income on their personal tax returns. This tax replaces the so-called "millionaires' tax" that appeared in earlier versions of health care reform bills.</p>
<p><b>New Federal Premium Fee</b></p> <p><i>Effective for plans/policies ending after September 30, 2012.</i></p> <p><b>PPACA § 6301; adds Code §§ 4375, 4376, and 4377</b></p>	<ul style="list-style-type: none"> <li>• <a href="#">Group Health Plans</a> (self and fully insured) will be assessed a fee of \$2 (\$1 in the case of plan years during fiscal year 2013) per average number of insured lives to finance a comparative effectiveness research program.</li> <li>• This fee will be paid by the plan sponsor, which is the employer in the case of a single employer plan, an employee organization in the case of a plan established by such an organization, or associations, committees, or trustees in the case of a VEBA, MEWA or other multiple employer plan.</li> <li>• This fee will be indexed annually, and sunset for plan years ending after</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• Excepted Benefits are not subject to this fee.</li> <li>• Comparative effectiveness research provides information on the relative strengths and weaknesses of various medical interventions. Its goal is to provide clinicians and patients with objective information to evaluate the effectiveness of particular treatment procedures to improve the health care system and provide better and more efficient care. This fee will be used to fund this research.</li> </ul>

September 30, 2019.

**MISCELLANEOUS PPACA PROVISIONS IMPACTING EMPLOYERS**

**HIPAA Opt-Out for Self-Funded Nonfederal Governmental Plans**

*Effective for plan years beginning on or after September 23, 2010.*

**PPACA §§ 1563, 10107**

- Prior to the enactment of the PPACA, sponsors of self-funded nonfederal governmental health plans were permitted to elect an exemption from (or "opt-out" of) the following HIPAA requirements:
  - Limitations on pre-existing condition exclusion periods;
  - Requirements for special enrollment periods;
  - Prohibitions against discriminating against individual participants and beneficiaries based on health status (except for provisions added by the Genetic Information Nondiscrimination Act of 2008);
  - Standards relating to benefits for newborns and mothers;
  - Parity in the application of certain limits to mental health and substance use disorder benefits (including the requirements imposed by the Mental Health Parity and Addiction Equity
- Sponsors of self-funded nonfederal governmental plans should be aware that if they choose to exercise the opt-out, they must provide notice to enrollees and the Centers for Medicare and Medicaid Services of their decision. Details about these notices can be found at <https://www.cms.gov/SelfFundedNonFedGovPlans/>.

Act of 2008);

- Required coverage for reconstructive surgery following mastectomies; and
- Coverage of dependent students on a medically necessary leave of absence.
- The PPACA amended the HIPAA opt-out provisions of the Public Health Service Act so that self-funded nonfederal governmental health plans will no longer be able to opt-out of the first three requirements listed above.
- The HIPAA opt-out change is generally effective for plan years beginning on or after September 23, 2010. However, the Department of HHS will not take any enforcement actions related to this change for plan years beginning prior to April 1, 2011. With respect to collectively bargained self-funded nonfederal governmental plans, an opt-out election made pursuant to a collective bargaining agreement that was ratified prior to March 23, 2010, may remain in effect for the term of the agreement and the plan will not have to comply with the new restrictions until the first plan year that

	<p>begins after the expiration of such agreement.</p>	
<p><b>Voluntary Employer Participation in CLASS Program Premium Collection</b></p> <p><i>Effective January 1, 2011.</i></p> <p><b>PPACA § 8002; adds PHSA Title XXXII</b></p>	<ul style="list-style-type: none"> <li>• The Community Living Assistance Services and Supports Act (CLASS Act) is a national voluntary insurance program for purchasing community living assistance services and supports.</li> <li>• The Secretary is authorized to create a system under which employers will automatically enroll employees in the CLASS program in the same manner as an employer may elect to automatically enroll employees in a 401(k), 403(b), or 457(b) plan. Employees may elect to opt-out of the program.</li> <li>• Employers that enroll employees in the CLASS program are responsible for making the monthly payroll deduction for the premium applicable to each employee enrolled in the CLASS program.</li> <li>• An employer only has to make deductions and withhold premiums for individuals enrolled in the CLASS program if the employer so elects.</li> <li>• Benefits will be no less than an average of \$50 per day for qualifying individuals; however, there is a five year</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Note that no guidance has been issued on this provision, and that this analysis is, therefore, based solely on the statutory text.</i></li> <li>• Due to the delay in payments under the CLASS Act (<i>i.e.</i>, five year vesting before benefits can start), this provision is expected to be a significant revenue raiser in the early years of the PPACA.</li> </ul>

	<p>vesting period which means that an individual must pay premiums for five years before any benefits can be paid.</p>	
<p><b>Reasonable Break Time for Nursing Mothers</b></p> <p><i>Effective March 23, 2010.</i></p> <p><b>PPACA § 4207; amends Fair Labor Standards Act § 7</b></p>	<ul style="list-style-type: none"> <li>• Employers are required to provide a reasonable break to a non-exempt employee to express breast milk for a nursing child for one year after the child's birth each time such employee has need to express milk.</li> <li>• Employers must also provide a place, other than a bathroom, that is shielded from view and free from intrusion from co-workers and the public, which may be used by a non-exempt employee to express breast milk.</li> <li>• Employers are <i>not</i> required to compensate an employee receiving reasonable break time under this provision for any work time spent for such purpose.</li> <li>• An exception from this provision exists for employees with less than 50 employees who can prove that compliance with this provision would impose an undue hardship on the employer.</li> <li>• To the extent a state law provides greater protections for nursing mothers than this provision, the state law shall still apply.</li> </ul>	<ul style="list-style-type: none"> <li>• The nursing mother provision in the PPACA specifically provides that employers are not required to compensate nursing mothers for these breaks. Employers should be cautious not to rely too much on this unpaid break exception. Under the Fair Labor Standards Act, short breaks taken by employees are generally considered time for which an employee must be paid. While an exception may be made for nursing mothers taking more breaks than are provided to other employees, nursing mothers should still be paid for short breaks otherwise given to employees.</li> <li>• The new federal law is already in effect. It does not, however, change any state law to the extent that the law provides greater benefits. Many states already have laws related to nursing mothers that apply equally to employees who are exempt and non-exempt under the Fair Labor Standards Act. Employers need to understand how the PPACA provision works with existing state laws that apply to their workplaces.</li> </ul>

**Adoption Assistance**

*Effective January 1, 2010.*

**PPACA § 10909; re-designates Code § 23 as Code § 36C and amends Code §§ 36C and 137**

- The dollar limitation for the credit for qualified adoption expenses and for the tax exclusion from gross income for such expenses paid under an employer's adoption assistance program increases from \$10,000 to \$13,170, adjusted for inflation after 2010.
- The adoption credit and the tax exclusion from gross income for expenses reimbursed under an employer's adoption assistance program were set to expire after December 31, 2010. This sunset date is changed to December 31, 2011.
- The available adoption credit and tax exclusion begin to phase out for taxpayers with modified adjusted gross income in excess of \$182,250, and is completely phased out for taxpayers with modified adjusted gross income of \$222,250 or more.
- The adoption assistance exclusion from gross income and the adoption credit were originally enacted in 1997 and have been extended and increased twice since then. This has shown to be a popular tax break in recent years.
- Employers will retain the ability to deduct payments to employees under an adoption assistance plan regardless of whether Congress further extends the exclusion. In that event, employers would treat these payments as taxable employee compensation, subject to withholding.
- IRS Notice 2010-66 provides interim guidance and rules to assist individuals in computing and substantiating claims for the adoption credit for a taxable year beginning in 2010.

## Glossary of Terms

- (1) **Cost Sharing Reduction** – A reduction in the cost-sharing amounts required of certain low-income taxpayers (generally, taxpayers whose household income falls between 133 and 400 percent of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Cost Sharing Reduction is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Health Plan equal or exceed 9.5 percent of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Health Plan is less than 60 percent.
- (2) **Eligible Employer Sponsored Health Plan** – A Group Health Plan (self or fully insured) offered by an employer to an employee which is a governmental plan or any other plan or coverage offered in the small or large group market within a state, including a Grandfathered Plan offered in a group market.
- (3) **Essential Health Benefits** – Benefits that are required to be included as part of any Qualified Health Plan that is made available through an Exchange. The scope of Essential Health Benefits is intended to be equal to the scope of benefits provided under a typical employer plan, as defined by the Secretary of HHS. Essential Health Benefits include items and services covered within the following general categories:
  - a. Ambulatory patient services;
  - b. Emergency services;
  - c. Hospitalization;
  - d. Maternity and newborn care;
  - e. Mental health and substance use disorder services, including behavioral health treatment;
  - f. Prescription drugs;
  - g. Rehabilitative and habilitative services and devices;
  - h. Laboratory services;
  - i. Preventative and wellness services and chronic disease management; and
  - j. Pediatric services, including oral and vision care.

Until the Secretary of HHS issues guidance on Essential Health Benefits, the Departments will take into account a Group Health Plan's good faith efforts to comply with a reasonable interpretation of Essential Health Benefits.

- (4) **Essential Health Benefits Package** – Group Health Plan coverage that:
  - a. Provides for Essential Health Benefits;
  - b. Limits cost-sharing amounts (*e.g.*, deductibles, co-insurance, co-pays) incurred by participants to the limits on health savings accounts (currently \$5,950 for single coverage and \$11,900 for family coverage), indexed after 2014;
  - c. Limits the deductible to \$2,000 for single coverage and \$4,000 for family coverage, increased by employee and employer contributions to a flexible spending account, indexed after 2014; and
  - d. At minimum, excepting only catastrophic plans for certain young individuals, provides benefits that are actuarially equivalent to 60 percent of the full actuarial

value of the Essential Health Benefits provided under the plan, taking into account employer contributions to a health savings account.

- (5) **Excepted Benefits** – Benefits under one of the following:
- a. Coverage only for accident or disability income insurance;
  - b. Coverage issued as a supplement to liability insurance;
  - c. Liability insurance, including general liability insurance and automobile liability insurance;
  - d. Worker's compensation or similar insurance;
  - e. Automobile medical payment insurance;
  - f. Credit-only insurance;
  - g. Coverage for on-site medical clinics; and
  - h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Excepted Benefits also include, if provided under a separate policy, certificate or contract of insurance:

- a. Limited scope dental or vision benefits;
  - b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof;
  - c. Coverage only for a specified disease or illness; and
  - d. Hospital indemnity or other fixed indemnity insurance.
- (6) **Exchange** – A governmental agency or nonprofit entity that is established by the state for the purpose of making Qualified Health Plans available to qualified individuals and qualified employers.
- (7) **Grandfathered Plan** – A Group Health Plan (self or fully insured) in effect on March 23, 2010. A Grandfathered Plan retains grandfathered status even if (i) family members of a participant who was enrolled in the Grandfathered Plan on March 23, 2010, are permitted to enroll in the Plan after March 23, 2010; and (ii) new employees and their families are permitted to enroll in the plan after March 23, 2010. A Grandfathered Plan also includes any health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010.
- (8) **Group Health Plan** – Any plan, fund or program established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the plan) directly or through insurance, reimbursement or otherwise.
- (9) **Health Insurance Issuer** – An insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance, and does not include a Group Health Plan.

- (10) **Large Employer -**
- a. For purposes of applying the employer penalties, an employer who employed an average of at least 50 FTEs on business days during the preceding calendar year, applying the controlled group rules. A FTE means an employee who is employed on average at least 30 hours of service per week.
  - b. For purposes of eligibility to participate in the Exchange, an employer who employed an average of at least 101 employees on business days during the preceding calendar year, applying the controlled group rules, and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Large Employer as an employer who employed an average of at least 51 employees.
- (11) **Minimum Essential Coverage –** Coverage under Medicare, Medicaid, CHIP, TRICARE for Life, the Veteran's health care program, the Peace Corps volunteer program, an Eligible Employer Sponsored Health Plan, a health plan offered in the individual market, a Grandfathered Plan or a state health benefits risk pool. Excepted Benefits are *not* treated as Minimum Essential Coverage.
- (12) **Qualified Health Plan –** A fully-insured Group Health Plan that (i) has been certified that it meets the criteria for certification in an Exchange; (ii) provides an Essential Health Benefits Package; and (iii) is offered by a Health Insurance Issuer that is licensed to offer health insurance coverage in that state and meets certain other requirements.
- (13) **Premium Tax Credit –** A tax credit available to certain low-income taxpayers (generally, taxpayers whose household income falls between 133 and 400 percent of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Premium Tax Credit is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Health Plan equal or exceed 9.5 percent of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Health Plan is less than 60 percent.
- (14) **Small Employer –**
- a. For purposes of applying the employer penalties, an employer that is not a Large Employer.
  - b. For purposes of eligibility to participate in an Exchange, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Small Employer as an employer who employed an average of at least one but not more than 50 employees.

If you have additional questions, please contact an attorney in Ice Miller's [Employee Benefits Group](#).

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