IVINS, PHILLIPS & BARKER
CHARTERED

Your Large-Employer Health Plan: Timeline for Compliance With Health Reform

April 2010

Introduction: Who is this Timeline for?

The new law[1] affects nearly all actors in the U.S. economy and is phased in over eight years. This Timeline tells you how ***large employers*** (over 100 employees) must implement the new law ***for each year through 2018***.— including all relevant provisions affecting coverage mandates and compensation-related taxes and reporting.

Aren't my plans grandfathered — and what does the grandfather do for me?

A plan in effect on March 23, 2010, is "grandfathered." The grandfather covers all employees enrolled on March 23, 2010, their family members even if not yet enrolled, and all "new employees." While not entirely clear, the preferred reading of "new employees" is any employee, no matter when hired, who first enrolls in the plan even after March 23, 2010. It is also unclear if and how a plan could lose its grandfathered status. Until guidance is issued, and absent major design changes, employers may assume that the grandfather covers any plan existing on March 23, 2010.

A grandfathered plan is permanently exempt from ***some but not all*** coverage mandates. This Timeline lists mandates applicable to all plans, including grandfathered plans, and separately lists those that apply if the grandfather is lost or does not apply. Generally, grandfathered union plans are subject to the same rules as other grandfathered plans, except that insured union plans appear to have a delayed effective date until the relevant collective bargaining agreements expire. Grandfathered plans are not exempt from the law's new taxes and IRS reporting requirements.

Press reports say that coverage mandates become effective in six months. Is this right?

No. The ***earliest*** mandates are effective in the first plan year beginning six months after March 23, 2010 (date of enactment). For a calendar year plan, this is ***January 1, 2011***. Accordingly, ***no coverage mandates*** apply ***before 2011*** for a calendar year plan.

How are the provisions enforced?

Violations of the new coverage mandates are subject to a HIPAA-like tax penalty under Code § 4980D of $100 per day for each affected participant, from the date of failure to the date of correction. For unintentional failures, the penalty is capped at the lesser of $500,000, or 10% of the employer's health plan costs. These mandates are also subject to ERISA. Retiree only plans are not subject to the $100-per-day penalty, and, while the statute is unclear, may be exempt from the coverage mandates under ERISA as well.

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, signed into law March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), signed into law March 30, 2010.

Effective TBD

Automatic Enrollment[2]

- Fair Labor Standards Act amended to require that employer with more than 200 full time employees)must automatically enroll new full-time employees (subject to permitted waiting periods) and re-enroll current employees
- Must provide notice and opt-out opportunity
- State payroll laws preempted as necessary to permit auto-enrollment
- Applies to ***grandfathered plans***
- Effective "in accordance with regulations"

Transparency Reporting

- Labor Department is instructed to follow disclosure requirements to be developed for plans participating in State Exchanges, and "harmonize" them with participant disclosures required by employer health plans.
  - » Required disclosure to include, *e.g.,* financial data, data on claims payments and denials, enrollment cost sharing, etc.
- Unclear whether "transparency reporting" applies to grandfathered plans
- Effective date unclear

Effective 2010

Retiree Health Subsidy Effective in 2010

Temporary Subsidy for Retiree Health Benefits

- Temporary program reimburses participating employers for portion of cost of health insurance for retirees age 55 or older
- Reimbursement may offset employer's or retiree's costs
- Reimbursement is 80% of claims between $15,00 -$90,000 (indexed)
  - » Unclear how "claims" defined for this purpose
- Employer must apply to participate, proposing cost-savings procedures
- Reimbursements excludible from gross income of participating employer
- Sunsets in 2014, or when $5 billion appropriation is exhausted
- Program must open not later than **90 days** after March 23, 2010

Taxes and Reporting Effective in 2010

Medicare Part D Deduction: Book Impact

- Write-down of deferred income-tax asset to reflect loss of deduction after 2012 for retiree drug benefit subsidized by Medicare Part D.

Non-Taxable Coverage of Non-Dependent Adult Children

- Code § 105 amended to provide income exclusion for medical care of employee's child who has not attained ***age 27*** by end of year
  - » Exclusion applies even if child is not a "dependent" under Code § 152
  - » Effective in 2010, even though mandate to cover adult children until ***age 26*** does not apply until 2011
  - » No change in present law that coverage expansions are eligible for Code § 105 exclusion only ***after*** date of plan amendment

Non-Taxable Employer-Provided Adoption Assistance

- Increases nontaxable maximum adoption assistance in 2010 to $13,170 (up from $12,170 for 2009)
- Delays EGTRRA sunset for one year, so the adoption assistance exclusion is extended through 2011 but will not apply beginning in 2012

[2] FLSA requirements are not subject to the I.R.C. § 4980D tax or ERISA.

Effective 2011

Taxes and Reporting Effective in 2011[3]

W-2 Reporting

- Must report aggregate value of all employer-provided health coverage
  - » excluding contributions to Archer MSAs, HSAs, and salary reduction contributions to FSAs
  - » including any portion paid by employee through after-tax premiums
- Value computed using rules similar to COBRA continuation coverage under Code § 4980B(f)(4) (and accompanying Treasury regulations), including the special rule for self-insured plans

Non-Prescription Drugs Through FSA

- Payments for Over-the-Counter (OTC) drugs not eligible for nontaxable reimbursement from employer-provided plans (e.g., FSAs, HRAs, HSAs)
- Exception for insulin and OTC drugs ***prescribed by physician***

Nonqualified Withdrawals From HSAs, etc.

- Excise tax on withdrawals for nonmedical expenses increased as follows:

Program	Excise Tax
HSAs	20% (now 10%)
Archer MSAs	20% (now 15%)

Coverage Mandates Effective in 2011 For Grandfathered Plans[4]

Lifetime Limits

- Lifetime limits prohibited on dollar value of "essential health benefits" for any participant or beneficiary
- Essential health benefits to be defined by HHS under statutory guidelines

Annual Limits

- Regulations will set forth permitted annual limits on dollar value of coverage for "essential health benefits"
- HHS instructed to set these "restricted limits" to "ensure that access to needed services is made available with a limited impact on premiums"
- More comprehensive ban on annual limits becomes effective in 2014

Adult Children (Not Eligible Under Another Employer Plan)

- Coverage must be made available to participant 's adult child until age 26
  - » Applies only if plan offers dependent coverage
  - » For grandfathered plan, applies only to child not eligible to enroll in another employer-provided plan
  - » Not clear if child must be economically "dependent" on participant — HHS instructed to write regulations defining "dependents" to whom coverage must be made available.
  - » Coverage not required for the child of a child, or spouse of a child

Pre-Existing Conditions For Children

- Pre-existing condition exclusions prohibited for enrollees under age 19

[3] The new law's tax and IRS reporting requirements apply to grandfathered plans, and are not subject to the I.R.C. § 4980D tax penalty or ERISA.

[4] The 2011 coverage mandates apply to any plan year beginning on or after September 23, 2010. For certain non-calendar year plans, these mandates may thus begin before 2011.

Effective 2011 (Cont.)

Additional Coverage Mandates Effective In 2011 — Non-Grandfathered Plans[5]

Adult Children

- Coverage must be made available to participant 's adult child until age 26
  - » Identical to mandate applicable to grandfathered plans, ***except that*** for non-grandfathered plan, mandate applies even if child is eligible to enroll in another employer-provided plan

Preventive Care With No Cost Sharing

- Plan must provide coverage for specified preventive care, with no cost sharing
- Preventive care specified by Act includes, *e.g.*, services recommended by US Preventive Services Task Force with grade "A" or "B"; immunizations recommended by Centers for Disease Control and Prevention; preventive care and screenings for children, adolescents and women (*e.g.*, breast cancer screening, mammography) recommended by Health Resources and Services Administration.
- Additional recommendations as provided by HHS

Code Section 105(h) "Nondiscrimination" Rules For Insured Plans

- Applies Code § 105(h)(2) nondiscrimination rules to insured plans (currently apply only to employer's self-insured plans)
- Rules prevent providing significantly better coverage to high-paid employees than to other employees
- Penalty for violation is COBRA-like $100-per-day penalty per affected participant (rather than taxation of medical reimbursements, as presently applies under Code § 105(h))

Claims and Appeals — Internal Process and External Review

- Plan must establish internal claims and appeals process satisfying regulations under ERISA § 503 [Note: This is ***current law*** for all private-sector employer-provided plans]
- In addition, Plan must establish ***external review process*** meeting (i) state law (insured plans), or (ii) Labor Department regulations (self-insured plans)
- Must provide notice to employees of internal and external review processes, and the availability of the ombudsman's office established under the new law to assist claimants in the appeals process

Emergency Services

- Emergency services must be covered by plan without prior authorization. whether or not provider is a participating provider, and using same cost sharing as in-network services (whether or not provider is in-network)
- It is ***not entirely clear*** whether grandfather applies.

Participant Can Select Own MD (And Pediatrician And Ob/Gyn)

- Participant may designate provider of his/her choice as participating primary care provider
- Participant may designate pediatrician as primary care provider for child; and Ob/Gyn as primary care provider for female participant or beneficiary
- It is ***not entirely clear*** whether grandfather applies

[5] The 2011 coverage mandates apply to any plan year beginning on or after September 23, 2010. For certain non-calendar year plans, these mandates may thus begin before 2011.

Effective 2012

Tax and Reporting Effective in 2012

Per Participant "Fee" Under Internal Revenue Code

- Per participant fee to fund Patient Centered Outcomes Research Trust Fund for study of comparative effectiveness research
  - » $1 in first applicable plan year
  - » $2 in second applicable plan year (thereafter, indexed under complex formula)
- Fee does not apply to participation solely in a policy described in Code § 9832(c) (accident, disability, limited scope vision and dental, etc.)
- Collected under Code §§ 4375 (insured plans) and 4376 (self insured plans)
- Effective date: Policy or plan years ending after September 30, 2012.
- Does not apply for plan years ending after September 30, 2019

Coverage Mandates Effective in 2012 For Grandfathered Plans

Uniform Explanation Of Coverage

- Summary of benefits under plan, described according to standards developed by HHS using "culturally and linguistically appropriate" language, and not more than four pages, must be offered to enrollee upon enrollment in plan
- Requirement applies to insurers (for insured plans) and plan sponsor or administrator (self-insured plans)
- Required in addition to summary plan description (SPD) required by ERISA
- Penalty for noncompliance: up to $1,000 per failure per enrollee
- Effective March 23, 2012

Notice of Material Modifications

- Description of "material modification" in coverage must be furnished not later than ***60 days before*** effective date of modification
- Required in addition to summary of material modifications (SMM) required by ERISA
- Effective date and penalties for noncompliance apparently the same as for "Uniform Explanation of Coverage" described above

Additional Coverage Mandates Effective In 2012 — Non-Grandfathered Plans

Quality Reporting

- Plan must report annually to HHS annually, in accordance with HHS regulations, on plan designs to improve outcomes, reduce hospital readmissions, reduce medical error, implement wellness programs, etc.
- Report also must be provided ***to participants*** during open enrollment
- Requirement is effective "in accordance with regulations," which HHS must publish "within two years" of March 23, 2010 — so effective date could be before or after 2012

Effective 2013

Taxes and Reporting Effective in 2013

Cap on Health FSAs

- Salary Reduction Health FSAs capped at $2,500 in 2013, indexed to CPI-U (rounded to $50) thereafter
- Under regulations, cap will apply in the aggregate to all cafeteria plans offered by employer (as defined by Code §§ 414(b), (c), (m) and (o))
- Cap does not apply to HRA or FSA that is not part of a salary reduction arrangement under a cafeteria plan

Deduction for Medicare Part D Subsidy

- Eliminate employer deduction for reimbursements of retiree drug benefits to extent of Medicare Part D subsidy.

Addition To Employee HI Tax For High-Wage Employees

- Addition to employee's share of HI tax = .9% (for a total of 2.35%) of wages in excess of:
  - » $200,000 — single filers
  - » $250,000 — married filing jointly
- Employer's withholding liability for any employee is based on wages in excess of $200,000 paid by that employer to that employee for the year (without regard to filing status or wages of employee's spouse)

3.8% Medicare Tax On Unearned Income

Note: New 3.8% Medicare tax does not affect employers directly, but discussed here because of additional impact on high-wage employees]

- New Medicare tax on unearned income as follows:
  - » Individuals. 3.8% on lesser of (i) net investment income or (ii) the excess of modified adjusted gross income over the threshold amount ($250,000 married filing jointly, $200,000 single filers)
  - » Estate or trust. 3.8% of the lesser of (i) undistributed net investment income or (ii) excess of adjusted gross income (as defined in Code § 67(e)) over dollar amount at which highest income tax bracket applicable to an estate or trust begins
  - » Tax does not apply to a non-resident alien; trust all the unexpired interests in which are devoted to charitable purposes; a trust that is exempt from tax under Code § 501; a charitable remainder trust exempt from tax under Code § 664

Code § 162(m) — Health Insurers Only

- Code § 162(m) cap reduced to $500,000 for compensation paid by certain health insurance issuers

Coverage Mandates Effective in 2013 for Grandfathered Plans

New Notice To Employees Under Fair Labor Standards Act [6]
.

- Notice must inform of employees of:
  - » Availability of Exchanges (even though Exchanges do not become operational until 2014)
  - » If employer's share of health plan costs less than 60%, eligibility for Code § 36B premium tax credit, and "cost sharing reduction." If purchasing coverage through the Exchanges
  - » If employee purchases Exchange insurance, the employee will lose the employer contribution toward the value of coverage
- Effective Date is March 1, 2013, for existing employees, and on hiring date for new employees, with no exception for grandfathered plans.

[6] FLSA provisions are not subject to $100 per day penalty under I.R.C. § 4980D or ERISA.

Effective 2014

Taxes and Reporting Effective in 2014

Reporting to IRS And Covered Employees

- New Code § 6055 provides that every insurer and every employer providing a health plan (including a grandfathered plan) shall report to IRS and to covered individual on prescribed forms.
- Report must include health insurance coverage information, e.g., portion of premium paid by employer
- Effective Date: Calendar years beginning after December 31, 2013

"Free Rider" Nondeductible Excise Tax for No Coverage

(New Code § 4980H)

- $2,000 per employee for offering no coverage
  - » Applies to employer who fails to offer full-time employees coverage under a group health plan (including a grandfathered plan)
  - » Tax per month = $2,000 x 1/12 x total number of full time employees (excluding first 30 employees)
  - » Tax applies if at least one full-time employee is certified as having enrolled for coverage in an Exchange, and employee is eligible for Code § 36B tax credit or cost-sharing reduction (see explanation of terms below)

- Explanation of terms: Very generally, individual is eligible for "cost sharing reduction" or Code § 36B excise tax for health insurance purchased through an Exchange if employer makes available no "affordable" health coverage as to that individual (see immediately below) and (i) individual's household income is less than 400% of poverty line (cost sharing reduction), or (ii) individual is eligible for trade adjustment assistance or meets certain other requirements (Code § 36B excise tax)

"Free Rider" Nondeductible Excise Tax for Unaffordable Coverage

(New Code § 4980H, cont)

- $3,000 per affected employee for unaffordable coverage
  - » Tax applies only if, for any employee, employer offers only coverage (including coverage under a grandfathered plan) that is unaffordable — that is, coverage for which employee premium is greater than 9.5% of "household income" ***or*** employer pays less than 60% of total cost
  - » Tax applies for each employee for whom coverage is unaffordable (as defined above) and who declines coverage under employer plan, and enrolls in an exchange and is eligible for "cost sharing reduction or Code § 36B tax credit
  - » Employee is responsible for seeking "affordability" waiver and proving eligibility
  - » Employer is informed of each employee who meets these conditions
  - » Tax per month = number of such employees per month x $3,000 x 1/12
  - » Total tax capped at amount that that would apply if employer offered no coverage
  - » Salary reduction contributions are treated as employee-paid for this purpose (even though they are "employer" contributions for other Code purposes)
  - » Free Rider Tax does not apply for any employee to whom employer provides "free choice voucher" (see below)

Effective 2014 (Cont.)

Taxes and Reporting Effective in 2014 (Cont.)

Cafeteria Plans — No Exchange Coverage

- New Code § 125(f)(3) provides that a "qualified benefit" under a cafeteria plan does not include qualified health plan offered through an Exchange (with exception for certain small employers)
- Rule applies even in 2017 and thereafter, when employers with more than 100 employees may be permitted by States to offer health coverage through an Exchange (see below)

Additional IRS Reporting Requirements.

- New Code § 6056 requires certain employers to file additional information return to IRS and every full time employee
- Required only if, for any employee, required employee contribution exceeds eight percent of wages paid by the employer to that employee
- Requirement is distinct from reporting requirement under Code § 6055 (see above) but IRS is allowed to combine the two reports

Coverage Mandates Effective in 2014 for Grandfathered Plans[7]

Pre-Existing Conditions (All Enrollees)

- No exclusion for pre-existing health conditions
- Note that rule applied in 2011 as to enrollees under age 19

Waiting Periods

- Plan cannot have waiting period of over 90 days

Employer-Provided "Free Choice" Vouchers

- Employers who offer coverage under health plan (and pay portion of premium) "shall" offer vouchers to "qualified employees"
- Failure to offer voucher does not cause tax or penalty
- But voucher relieves employer of $3,000 unaffordable-coverage tax for each employee receiving voucher
- Voucher is deductible to employer, and tax-excludable to employee
- Employee uses voucher as credit against premium required for Exchange-provided coverage (employer actually pays voucher amount to Exchange)
- Employee is "qualified employee" if (i) employee's "required contribution for employer-sponsored health plan coverage (including a grandfathered plan) is greater than 8% but not in excess of 9.5% of "household income" for TY; (ii) household income is not greater than 400% of the poverty line; and (iii) employee does not participate in employer's health plan
- Amount of voucher is dollar value of employer's contribution to health plan (or, if multiple plans offered, dollar value of plan with largest percentage of employer-paid cost)
- Cost of plan determined like COBRA cost, except adjusted for age and category of enrollment in accordance with regulations
- Not clear if vouchers will be permitted (or required) for retiree coverage

[7] In contrast with the 2011 coverage mandates, which also affect plan years beginning on or after September 23, 2010, the 2014 coverage mandates are effective for "plan years beginning on or after January 1, 2014."

Effective 2014 (Cont.)

Additional Coverage Mandates Effective In 2011 — Non-Grandfathered Plans[8]

No Eligibility Discrimination

- Plan may not discriminate as to eligibility based on health-status related factors of individual or dependent

Wellness Programs

- Codifies HIPAA wellness rules and increases 20% incentive cap to 30% with Secretary discretion to increase to 50%

Discrimination as to Health Care Providers

- Group health plan/insurer cannot discriminate as to participation or coverage against "health care provider," except may vary reimbursement rates based on quality or performance measures

Cost Sharing

- A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of Code § 1302(c), which are:

	Statute	2010 indexed
Family	$10,000	$11,900
Singe	$5,000	$5,950

- Section does not apply to dental-only plans

Clinical Trial Coverage:

- Requires coverage for participation in approved clinical trials relating to life threatening diseases
- Does not preempt state laws requiring additional coverage
- But ERISA preemption for self-insured plans apparently prevails]
- Grandfather apparently applies – but this is not entirely clear

Effective 2015 and 2016

There are no new mandates for large employers that arise in 2015 or 2016.

Effective 2017

Exchanges May Be Opened To Large Employers

- States permitted but not required to insurers in the 'large group market"
- Any state who does so must allow large employers to purchase health insurance for their employees through an Exchange

[8] In contrast with the 2011 coverage mandates, which also affect plan years beginning on or after September 23, 2010, the 2014 coverage mandates are effective for "plan years beginning on or after January 1, 2014."

Effective 2018

Taxes and Reporting Effective in 2018

Cadillac Plan Tax

- Nondeductible 40% excise tax on aggregate value of coverage per covered employee that exceeds
  - » 2018 — $10,200, individual (adjusted as below); $27,500 family (adjusted as below)
- The 2018 thresholds may be adjusted to reflect excess of actual growth in US health care costs over expected growth
- Also, for any employer, 2018 thresholds are indexed to reflect age and gender-based cost of that employer's workforce
  - » 2019 — indexed by CPI-U+1%
  - » 2020, etc. — indexed by CPI-U
- Retirees: Higher threshold for retirees age 55+ as follows
  - » 2018 — Add $1,650, individual coverage; Add $3,450, family coverage
- High risk profession employees: same as retirees.
- Value of coverage calculated like COBRA coverage
- Coverage taken into account includes all employer-sponsored health coverage, including employee after tax premiums, reimbursements from Health FSA or an HRA, contributions to an HSA or Archer MSA, and, other supplementary health coverage.
- But does not include
  - » Employer coverage for long term care
  - » Benefits described in section 9832(c)(1) already except from HIPAA, COBRA etc (non-health benefits such as accident etc)
  - » Coverage under 9832(c)(3) (specified disease or illness, hospital, other fixed indemnity ins.) but only if paid by employee after tax premium
  - » Separately-provided dental or vision coverage
- Tax paid by
  - » Insurer for insured coverage;
  - » Employer for HSA and MSA contributions (106(b) or (d)) and
  - » Plan administrator for other employer sponsored coverage

For more information:

Carroll J. Savage
csavage@ipbtax.com
202.662.3405

Kevin P. O'Brien
kobrien@ipbta.com
x202.662.3411

Michael R Huffstetler
mhuffstetler@ipbtax.com
202.662.3417

Laurie E. Keenan
lkeenan@ipbtax.com
202.662.3461

Steven H. Witmer
switmer@ipbtax.com
310.407.5460

Rosina B. Barker
rbarker@ipbtax.com
202.662.3420

William L. Sollee, Jr.
wsollee@ipbtax.com
202.393.7600

Jodi H. Epstein
jepstein@ipbtax.com
202.662.3468

Robin M. Solomon
rsolomon@ipbtax.com
202.662.3474

Jonathan Zimmerman
Jzimmerman@ipbtax.com
202.662.3464

Victor S. Chang
vchang@ipbtax.com
202.662.3462

Nicole Occhuizzo
nocchuizzo@ipbtax.com
202.662.3427