



HR Compliance Focus

Healthcare Reform

*Everything You
Need to Know Now*



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Executive Publisher and
Editor in Chief: Robert L. Brady, J.D.
Senior Legal Editor: Martin Simon, J.D.
Production Editor: Elaine Quayle
Production Supervisor: Isabelle B. Smith
Graphic Design: Catherine A. Downie
Layout and Production: Susan Dumas
Marketing Manager: Agnes D. Franks

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Questions or comments about this publication? Contact:

Business & Legal Reports, Inc.
141 Mill Rock Road East
P.O. Box 6001
Old Saybrook, CT 06475-6001
860-510-0100

www.blr.com

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HEALTHCARE REFORM— EVERYTHING YOU NEED TO KNOW NOW

Introduction

The enactment of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), collectively referred to as the Affordable Care Act (ACA), launches an extended period during which far-reaching changes to the American healthcare system will take effect.

These reforms are built on the current employer-based system and will impact every employer in the country.

Reform on this scale is multifaceted and initially takes effect in uneven increments between 2010 and 2018. This report will focus on what employers need to know and do now, in the spring of 2010, but will also cover what has to be planned for in 2011, 2012, 2013, 2014, and 2018 as the pieces of the reform package come into play.

Keep in mind that the two biggest pieces of the reform process, the individual mandate and employer play-or-pay, don't take effect until 2014.

Healthcare Reform: What Happens When

The provisions of the ACA take effect over several years. The following is a summary of the most important provisions of the law arranged by the year during which the provision first takes effect and impacts employers. This summary may be used to help locate items in the detailed analysis that follows.

2010

Dependent Coverage to Age 26

Health plans that cover dependents will have to cover dependents on a parent's plan until their 26th birthday. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

Ban on Lifetime Limits and Restriction on Annual Limits

Plans and insurers may not place lifetime dollar limits and unreasonable annual limits on coverage of participants and beneficiaries. These provisions apply to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

Preexisting Condition Restrictions on Children

Plans and insurers may not deny coverage of children because of preexisting conditions. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

Coverage Rescissions

Insurers and plans may not rescind coverage except in cases of fraud. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010.

Minimum Coverage Without Cost-Sharing for Preventive Services

Qualified health plans must provide coverage without cost-sharing for preventive services, including immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women. This provision is effective for the first plan year beginning on or after September 23, 2010, but does not apply to plans in existence on March 23, 2010.

Tax Credits to Small Employers

Small employers with no more than 25 employees and average annual per-employee wages of less than \$50,000 may claim a tax credit for the cost of providing health insurance to their employees. For tax years beginning in 2010, the credit is 35 percent of the cost.

Reinsurance Program for Employers Providing Health Insurance Coverage to Retirees over Age 55

A reinsurance program for employers providing health insurance coverage to early retirees who are over age 55 but are not yet eligible for Medicare is available from June 21, 2010, until insurance exchanges are available on January 1, 2014.

Requirement to Report Medical Loss Ratio

Health insurers and plans must annually report the percentage of premiums spent on health care effective for plan years beginning on or after March 23, 2010.

Nondiscrimination Testing

The existing rules barring discrimination in favor of the highly compensated apply to insured group health plans established after March 23, 2010, effective for plan years beginning on or after September 23, 2010.

Other Coverage Requirements

Effective for plan years beginning on or after September 23, 2010, group health plans established on or after March 23, 2010, will:

- Have to allow plan participants to choose any participating primary care provider.
- Be prohibited from requiring prior authorization or referrals for visits to an obstetrician/gynecologist.
- Have to treat an obstetrician/gynecologist as a primary care provider.
- Have to provide emergency care services without prior authorization and with the same cost-sharing both in and out of network.

Grandfather Rules

Grandfather rules exempt group health plans that were in existence on March 23, 2010, from many of the new insurance requirements. Grandfather protections do not apply to:

- Dependent coverage until age 26
- Preexisting exclusions for children
- Lifetime maximums
- Annual maximums
- Rescission of coverage

2011

Wellness Grants for Small Employers

Employers with fewer than 100 employees will be eligible for grants to provide comprehensive workplace wellness programs. Two hundred million dollars is authorized to be appropriated for the period of fiscal years 2011 through 2015 to fund the grants.

Exclusion of the Costs for Over-the-Counter Drugs for Reimbursement from HRAs, HSAs, FSAs, and MSAs

Effective for taxable years beginning after December 31, 2010, the costs of over-the-counter drugs not prescribed by a doctor (except insulin) may no longer be reimbursed through a health reimbursement account (HRA) or health flexible spending account (FSA) and may no longer be reimbursed on a tax-free basis through a health savings account (HSA) or Archer medical savings account (MSA).

Tax on HSA and MSA Distributions Not Used for Qualified Expenses

Effective for taxable years beginning after December 31, 2010, the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses increase from 10 percent to 20 percent of the disbursed amount.

Requirement to Provide Value for Premium Payments

Beginning not later than January 1, 2011, plans and insurers in the individual and small group market must maintain a medical loss ratio (MLR) of 80 percent, and plans and insurers in the large group market must maintain an MLR of 85 percent. For each plan year, plans and insurers must provide a rebate to each enrollee on a pro rata basis equal to the amount that premium revenue spent on nonmedical costs that exceed the percentage limits.

Informing Employees of the Cost of Their Health Coverage on W-2 Forms

Effective for tax years beginning after December 31, 2010, employers are required to report on Form W-2 the total cost of group health coverage, including the portion paid by the employer and the portion paid by the employee.

CLASS Act

The Community Living Assistance Services and Supports Act (CLASS Act) creates a national voluntary insurance program for purchasing community living assistance services and supports to provide individuals with functional limitations the tools that will allow them to maintain their personal and financial independence and live in the community.

Benefit Summary Requirement

By March 23, 2011, national standards must be issued for use in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under group health plans and group or individual health insurance coverage.

Simple Cafeteria Plans for Small Employers

Effective for years beginning after December 31, 2010, Internal Revenue Code Sec. 125 provides for simple cafeteria plans for small businesses that include a safe harbor from nondiscrimination requirements. Small businesses are defined as those that employed an average of 100 or fewer employees during either of the 2 preceding years. If an employer qualifies as a small employer, it retains the status until it employs an average of 200 or more employees during the preceding year.

2012

Benefits Summary Requirement

By March 23, 2012, a summary of benefits and coverage explanation that meets the national standards for providing a summary of benefits and coverage must be provided to applicants at the time of application, enrollees prior to the time of enrollment or reenrollment, and policyholders or certificate holders at the time of issuance of the policy or delivery of the certificate.

Quality-of-Care Reporting

No later than March 23, 2012, regulations are to be issued detailing the requirement on group health plans and health insurance issuers offering group or individual health insurance coverage for reporting benefits and healthcare provider reimbursement structures that improve health outcomes.

2013

Health Insurance Administration Simplification

Regulations establishing a single set of operating rules for eligibility verification and claim status must be adopted by July 1, 2011, and take effect January 1, 2013. Rules for electronic fund transfer and healthcare payment and remittance rules must be adopted by July 1, 2012, and take effect January 1, 2014. Rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization rules are to be adopted by July 1, 2014, and take effect January 1, 2016.

Medicare Tax

Effective January 1, 2013, the Medicare Part A (hospital insurance) tax rate on wages goes up by 0.9 percent (from 1.45 percent to 2.3 percent) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly. There is also a 3.8 percent Medicare tax assessment on investment income from interest, dividends, royalties, rents, gross income from a trade or business, and net gain from disposition of property for individuals earning over \$200,000 and families earning over \$250,000.

FSA Contribution Limit

Effective January 1, 2013, contributions to an FSA for medical expenses are limited to \$2,500 per year increased annually by the cost-of-living adjustment.

Elimination of Tax Deduction for Part D Subsidy Payment

Effective January 1, 2013, the tax deduction for employers that receive Medicare Part D retiree drug subsidy payments is eliminated.

Requirement on Employers to Inform Employees of Coverage Options

Employers are to provide to each employee, at the time of hiring (or with respect to current employees, not later than March 1, 2013), written notice informing the employee about insurance Exchanges.

2014

Individual Mandate

U.S. citizens and legal residents with few exceptions will be required to have qualifying health coverage beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5 percent of household income, phased in from 2014–2016. There will be exceptions given for financial hardship and religious objections.

Employer Play or Pay—The Employer Mandate

Effective in 2014, employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit will be assessed a fee of \$2,000 per full-time employee. The first 30 employees are not counted for assessing the fee. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Employers that offer coverage will be required to provide a voucher to employees with incomes below 400 percent of the poverty level if their share of the premium cost is between 8 percent and 9.8 percent of income to enable them to enroll in a plan in an Exchange. (Employers that provide vouchers will not be subject to the above penalty.)

Large Employer Automatic Enrollment Requirement

Effective in 2014, large employers with more than 200 full-time employees that offer coverage will be required to automatically enroll employees into the employer's lowest cost plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Insurance Exchanges for Individuals and Small Businesses

By 2014, state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization are to be operating so that individuals and small businesses with up to 100 employees can purchase qualified coverage.

Guaranteed Issue, Renewability, and Rating Variation Requirements

Effective January 1, 2014, insurers will be required to guarantee issue and renewability and can allow rating variation based only on age (limited to 3-to-1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5-to-1 ratio) in the individual and the small group market and the Exchanges.

Annual Limits

Effective for plan years beginning on or after January 1, 2014, plans and insurers may no longer impose annual dollar limits on coverage.

Limit on Waiting Periods

Effective for plan years beginning on or after January 1, 2014, insurers and plans must limit any waiting periods for coverage to 90 days.

Wellness Incentives

Effective for plan years beginning on or after January 1, 2014, employers may offer employees rewards of up to 30 percent, increasing to 50 percent if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

Preexisting Condition Exclusions

The application of preexisting condition exclusions for plan years beginning on or after January 1, 2014, is prohibited.

Comprehensive Health Insurance Coverage

Effective for plan years beginning on or after January 1, 2014, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package.

Limits on Cost-Sharing and Deductibles

Effective for plan years beginning on or after January 1, 2014, a group health plan may not provide any annual cost-sharing in excess of those that apply to health savings accounts.

Coverage of Clinical Trials

Effective for plan years beginning on or after January 1, 2014, a group health plan not in existence on March 23, 2010, must provide coverage for clinical trials.

2018

Excise Tax on Cadillac Plans

Effective January 1, 2018, an excise tax is imposed on insurers of employer-sponsored health plans with total values that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

2010 in Detail

Small Employer Health Care Tax Credit

The ACA provides a tax credit to certain small employers that provide healthcare coverage to their employees, effective with tax years beginning in 2010. The Internal Revenue Service (IRS) has issued information on the credit as it applies for 2010–2013, including information on transition relief for 2010. An enhanced version of the credit takes effect in 2014.

Eligible small employers. Small employers that provide healthcare coverage to their employees and that meet certain requirements (qualified employers) generally are eligible for a federal income tax credit for health insurance premiums they pay for certain employees. In order to be a qualified employer:

- An employer must have fewer than 25 full-time equivalent employees (FTEs) for the tax year,
- The average annual wages of its employees for the year must be less than \$50,000 per FTE, *and*
- The employer must pay the premiums under a “qualifying arrangement.”

The IRS has stated that tax exempt organizations are entitled to the credit, but must calculate the credit under special rules.

Calculation of the credit. Only premiums paid by the employer under an arrangement meeting certain requirements (“a qualifying arrangement”) are counted in calculating the credit. Under a qualifying arrangement, the employer pays premiums for each employee enrolled in healthcare coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the total premium cost of the coverage. If an employer pays only a portion of the premiums, only the portion paid by the employer is counted in calculating the credit. For purposes of the credit (including the 50 percent requirement), any premium paid pursuant to a salary reduction arrangement under a Sec. 125 cafeteria plan is not treated as paid by the employer. The IRS has clarified that premiums paid by the employer in 2010, but before the healthcare reform legislation was enacted on March 23, 2010, may be counted in calculating the credit.

The amount of an employer's premium payments that counts when calculating the credit may not exceed the average premium for the small group market in the particular state (or an area within the state) in which the employer offers coverage for the same arrangement. The average premium for the small group market in a state (or an area within the state) will be determined by the U.S. Department of Health and Human Services (HHS). The IRS has published this information in Rev. Rul. 2010-13, which is posted on the IRS website at <http://www.irs.gov/pub/irs-drop/rr-10-13.pdf>. HHS has stated that for the 2010 taxable year, it may provide additional average premium rates for the small group market in certain areas within states. However, in no case will any such additional substate rates be lower than the applicable rate for each state that is set forth in Rev. Rul. 2010-13.

Maximum credit amount. For tax years beginning in 2010 through 2013, the maximum credit is 35 percent of the employer's premium expenses that count toward the credit.

Maximum credit for a tax-exempt qualified employer. For tax years beginning in 2010 through 2013, the maximum credit for a tax-exempt qualified employer is 25 percent of the employer's premium expenses that count toward the credit. However, the amount of the credit cannot exceed the total amount of income and Medicare tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages.

Credit reductions. If the number of FTEs exceeds 10 or if average annual wages exceed \$25,000 per employee, the amount of the credit is reduced. If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed \$25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed \$25,000 and the denominator of which is \$25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding \$25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual per-employee wages of less than \$50,000.

Determining the number of FTEs. The number of an employer's FTEs is determined by dividing the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by 2,080. The result, if not a whole number, is then rounded to the next lowest whole number. Because the limitation on the number of employees is based on FTEs, an employer with 25 or more employees could qualify for the credit if some of its employees work part-time.

Determining the amount of average annual wages. The amount of average annual wages is determined by first dividing the total wages paid by the employer to employees during the employer's tax year by the number of the employer's FTEs for the year. The result is then rounded down to the nearest \$1,000. For this purpose, wages means wages as defined for FICA purposes (without regard to the wage base limitation).

Disregarded workers. Seasonal workers are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the tax year. A sole proprietor, a partner in a partnership, a shareholder owning more than 2 percent of an S corporation, and any owner of more than 5 percent of other businesses are not considered

employees for purposes of the credit. Thus, the wages or hours of these business owners and partners are not counted in determining either the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit.

A family member of any of the business owners or partners or a member of the business owner's or partner's household is also not considered an employee for purposes of the credit. For this purpose, a "family member" is defined as a child (or descendant of a child); a sibling or stepsibling; a parent (or ancestor of a parent); a stepparent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.

Controlled groups. Members of a controlled group (e.g., businesses with the same owners) or an affiliated service group (e.g., related businesses of which one performs services for the other) are treated as a single employer for purposes of the credit. Thus, for example, all employees of the controlled group or affiliated service group and all wages paid to employees by the controlled group or affiliated service group are counted in determining whether any member of the controlled group or affiliated service group is a qualified employer.

Claiming the credit. The credit is claimed on the employer's annual income tax return. The IRS says it will provide further information on how tax exempt organizations are to claim the credit. As a general business credit, an unused credit amount can generally be carried back 1 year and carried forward 20 years. Because an unused credit amount cannot be carried back to a year before the effective date of the credit, an unused credit amount for 2010 can only be carried forward. The IRS says that the credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules.

For a tax-exempt employer, the credit is a refundable credit, so that even if the employer has no taxable income, the employer may receive a refund as long as it does not exceed the income tax withholding and Medicare tax liability.

Effect on employer's deduction for health insurance premiums. In determining the employer's deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

Transition relief for tax years beginning in 2010. The IRS expects that transition relief will be provided for tax years beginning in 2010 to make it easier for taxpayers to meet the requirements for a qualifying arrangement. The IRS says that guidance will provide that, for tax years beginning in 2010, an employer that pays at least 50 percent of the premium for each enrolled employee will not fail to maintain a qualifying arrangement merely because the employer does not pay a uniform percentage of the premium for each employee. Accordingly, if the employer otherwise satisfies the requirements for the credit, it will qualify for the credit even though the percentage of the premium it pays is not uniform for all such employees.

The requirement that the employer pay at least 50 percent of the premium for an employee applies to the premium for single (employee-only) coverage. Therefore, if the employee is receiving single coverage, the employer satisfies the 50 percent requirement if it pays at least 50 percent of the premium for that coverage. If the employee is receiving coverage that is more expensive than single coverage, the employer satisfies the 50 percent requirement if the employer pays an amount of the premium that is at least 50 percent of the premium for single coverage even if it is less than 50 percent of the premium for the coverage the employee is actually receiving.

Dependent Coverage to Age 26

Effective for plan years beginning on or after September 23, 2010, group health plans and health insurers that offer group or individual coverage that cover dependents must allow coverage of dependents on a parent's plan until the dependent's 26th birthday.

While this requirement is generally exempt from the grandfather rules, a group health plan that was in existence on March 23, 2010, does not have to make coverage available to an adult child if the child is eligible to enroll in another employer-sponsored group health plan until plan years beginning before January 1, 2014.

There is no requirement to make coverage available to a grandchild even if that child's parent is covered as a dependent. Regulations defining which dependents are eligible for coverage have been issued. The definitions of a dependent under existing law, however, remain unchanged.

Employers will likely have to cover additional dependents because of this provision. Keeping track of the coverage eligibility of dependents has always been a problem for employer. Employers are advised to obtain all the information needed for determining dependents' coverage eligibility before this provision impacts their plan and keep it up to date to minimize paying for ineligible dependents.

Many states have existing laws that require insured plans to provide similar or more expansive coverage of dependents. These provisions still apply to insured plans in those states.

Definition of Children Eligible for Tax-Free Healthcare Coverage

On and after March 30, 2010, both coverage under an employer-provided health plan and amounts paid or reimbursed under such a plan for medical care expenses of an employee's child who has not attained age 27 as of the end of the employee's taxable year are excluded from the employee's gross income under IRC Sec. 105(b) and Sec. 106. An employer may assume an employee's taxable year is the calendar year. Previously, a child who was not a dependent had to be younger than either age 19 or age 24, if enrolled in school.

For this purpose, a child is the son, daughter, stepson, or stepdaughter of the employee, including those who are legally adopted or lawfully placed with the employee for legal adoption and "eligible foster children," defined as individuals who are placed with an employee by an authorized placement agency or by judgment, decree, or court order. This provision applies to a child of the employee even if the child is not the employee's dependent within the meaning of IRC Sec. 152(a). Thus, the age limit, residency, support, and other tests described in Sec. 152(c) do not apply to a child for this purpose.

Because the exclusion of coverage and reimbursements from an employee's gross income under IRC Secs. 106 and 105(b) carries forward automatically to the definition of qualified benefits for Sec. 125 cafeteria plans, including health FSAs, the IRS has stated it intends to amend the regulations on change of status events that justify a midyear change in cafeteria plan elections to include change in status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost it. This change will be retroactive to March 30, 2010.

As a result, healthcare plans can now allow parents to add their children under age 27 to their health coverage on a tax-free basis. Employers may permit employees to increase their FSA elections to reflect coverage of children under age 27. Employers may allow this change under their cafeteria plan even if the cafeteria plan has not yet been amended to reflect the change in coverage options. Employers have until the end of 2010 to amend their cafeteria plan language to incorporate this change.

HRAs are covered by the change to Secs. 105(b) and 106, but there is no corresponding change in the definition for purposes of health savings accounts (HSAs). So to qualify for tax-free reimbursement from an HSA, the child must either qualify as a dependent or be younger than either age 19 or age 24, if enrolled in school.

Preexisting Condition Coverage Restrictions on Children

Effective for the first plan year beginning on or after September 23, 2010, plans and insurers may not deny coverage of children under age 19 because of preexisting conditions. This provision applies to both existing and new plans. **Note:** The ban on preexisting condition coverage restrictions applies to individuals age 19 and older in the first plan year beginning on or after January 1, 2014.

Ban on Lifetime Limits and Restriction on Annual Limits

Plans and insurers may not place lifetime dollar limits on coverage of participants and beneficiaries. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. For plan years beginning on or after September 21, 2010, but before January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may establish only a restricted annual limit. For plan years beginning on or after January 1, 2014, annual limits on the dollar value of coverage of participants and beneficiaries are banned.

Regulations are to define what annual limit may be set on essential health benefits. The regulation defining the term “restricted annual limit” for purposes of the preceding is to ensure that access to needed services is made available with a minimal impact on premiums.

Annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits are allowed to the extent that such limits are otherwise permitted under federal or state law.

Essential health benefits include at least the following general categories and the items and services covered within these categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment

- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Regulations will be issued defining other items that are essential benefits so that an essential benefits package equals in scope the benefits provided under a typical employer plan.

Coverage Rescissions

Insurers and plans may not rescind coverage of a covered individual except if the individual commits fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the plan. This provision applies to both existing and new plans effective for the first plan year beginning on or after September 23, 2010. Prior notice of canceled coverage must be provided to the individual.

Coverage Without Cost-Sharing of Preventive Services

Insurers and group health plans must provide coverage without cost-sharing for preventive services. This provision is effective for the first plan year beginning on or after September 23, 2010, but does not apply to plans in existence on March 23, 2010. At a minimum, the coverage must include:

- Evidence-based items or services rated A or B in the current recommendations of the U.S. Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for the individual involved;
- For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; *and*
- For women, any additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The current recommendations of the U.S. Preventive Services Task Force regarding breast cancer screening, mammography, and prevention are considered the most current other than the controversial guidelines issued in or around November 2009.

A plan may provide coverage for services in addition to those recommended by U.S. Preventive Services Task Force and may deny coverage for services that are not recommended by the Task Force.

HHS is authorized to set a minimum interval of not less than 1 year between when a preventive services recommendation or guideline is issued and the plan year for which the recommendation or guideline applies.

Other Coverage Requirements

Effective for plan years beginning on or after September 23, 2010, group health plans established on or after March 23, 2010, must:

- Allow plan participants to choose any participating primary care provider.
- Not require prior authorization or referrals for visits to an obstetrician/gynecologist.
- Treat an obstetrician/gynecologist as a primary care provider.
- Provide coverage of emergency care services without prior authorization and with the same cost-sharing both in and out of network.

Nondiscrimination Testing

The rules barring discrimination in favor of the highly compensated will apply to insured group health plans established after March 23, 2010, effective for plan years beginning on or after September 23, 2010. These rules currently apply to self-insured plans only.

Grandfather Rules

Grandfather rules exempt group health plans that were in existence on March 23, 2010, from many of the new insurance requirements. Regulations are expected to clarify what kind of changes could be made to a plan without losing grandfather status. The reconciliation law substantially narrowed the grandfather protections and makes the following provisions applicable to both existing and new plans:

- Dependent coverage until age 26
- Preexisting exclusions
- Lifetime maximums
- Annual maximums
- Rescission of coverage

Breastfeeding/Expressing Breast Milk

The ACA amends the Fair Labor Standards Act (FLSA) by requiring that employers provide a reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth each time the employee has need to express milk.

Employers must now 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 an employee to express breast milk. The FLSA does not require employers to pay employees for such break time.

Exceptions. The requirements do not apply to employers with fewer than 50 employees, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the

employer's business. The FLSA's provisions do not preempt a state law that provides greater protections to employees.

Most states have passed legislation that explicitly allows mothers to nurse/express breast milk in public or semipublic places, such as restaurants, public transportation facilities, and other locations where the public is present. Some state laws require that employers provide reasonable time for an employee to breastfeed or express breast milk, or to coordinate designated break times to coincide with the employee's need to breastfeed or express breast milk.

Accommodating breastfeeding and expressing breast milk. To allow employees to take advantage of the many health benefits of breastfeeding, employers may wish to consider drafting a written policy on breastfeeding and expressing breast milk in the workplace. The policy should include elements such as:

- Flexible work schedules to provide time for expression of milk;
- Provision of an accessible location allowing privacy (e.g., shielded from view and free from intrusion from co-workers and the public, a lock on the door);
- Access to a nearby clean and safe water source and a sink for washing hands and rinsing out any breast-pump equipment; *and*
- Access to hygienic/refrigerated storage alternatives for the mother to store her breast milk.

Note: It is generally accepted that bathrooms are not sanitary, acceptable places for breastfeeding or expressing breast milk. Therefore, the federal law bars employers designating employee or public bathrooms as the location for breastfeeding or expressing breast milk.

2011 in Detail

Wellness Grants for Small Employers

Employers with fewer than 100 employees who work 25 or more hours per week and who did not have a workplace wellness program as of March 23, 2010, will be eligible for grants to provide comprehensive workplace wellness programs for their employees. Two hundred million dollars is authorized to be appropriated for the period of fiscal years 2011 through 2015 to fund the grants.

Eligible employers must make available to all employees a comprehensive workplace wellness program that includes:

- Health awareness initiatives (including health education, preventive screenings, and health risk assessments)
- Efforts to maximize employee engagement (including mechanisms to encourage employee participation)
- Initiatives to change unhealthful behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials)
- Supportive environment efforts (including workplace policies to encourage healthful lifestyles, healthy eating, increased physical activity, and improved mental health)

An eligible employer that wants to participate in the grant program will have to submit an application to HHS.

Benefits Summary Requirement

By March 23, 2011, HHS must issue national standards for providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under group health plans and group or individual health insurance coverage. The summary of benefits is to be provided to applicants, enrollees, and policyholders or certificate holders. While developing the standards, HHS must consult with the National Association of Insurance Commissioners (NAIC), a working group composed of representatives of health insurance-related consumer advocacy organizations, health insurance issuers, healthcare professionals, patient advocates (including those representing individuals with limited English proficiency), and other qualified individuals.

The standards must require that the summary is presented in a uniform format that does not exceed four pages in length and does not include print smaller than 12-point font; is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee; and includes the following:

- Uniform definitions of standard insurance terms and medical terms so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);
- A description of the coverage, including cost-sharing for each of the categories of the essential health benefits that must be provided and other benefits identified by HHS;
- The exceptions, reductions, and limitations on coverage;
- The cost-sharing provisions, including deductible, coinsurance, and copayment obligations;
- The 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 and related cost sharing;
- A statement of whether the plan or coverage provides minimum essential coverage (as defined under IRC Sec. 5000A(f)) and ensures that the plan or coverage share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of those costs;
- A statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions;
and
- A contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

Simple Cafeteria Plans for Small Employers

Effective for years beginning after December 31, 2010, small businesses may adopt simple cafeteria plans for small businesses that include a safe harbor from nondiscrimination requirements. A simple cafeteria plan is one that is established and maintained by an eligible employer and meets specific contribution, eligibility, and participation requirements.

Eligible employer. An eligible employer for any year is an employer that employed an average of 100 or fewer employees on business days during either of the 2 preceding years. A year may be taken into account only if the employer was in existence throughout the year. If an employer was not in existence throughout the preceding year, the determination of the number of employees is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current year.

Treatment of growing employers. An employer that was an eligible employer for any year is treated as an eligible employer for subsequent years when it has grown to more than 100 employees until the employer employs an average of 200 or more employees on business days during any preceding year preceding any such subsequent year.

Contribution requirements. The contribution requirements are met if the plan requires the employer, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to:

- A uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, *or*
- An amount that is not less than the lesser of 6 percent of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee.

The contribution requirements will not be met if, under the plan, the rate of contributions for any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that for an employee who is not a highly compensated or key employee.

The contribution requirement does not prohibit an employer from making additional contributions to provide qualified benefits under the plan.

Minimum eligibility and participation requirements. The minimum eligibility and participation requirements are generally met for any year if:

- All employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, *and*
- Each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

Exclusion of the Costs for Over-the-Counter Drugs for Reimbursement from HRAs, HSAs, FSAs, and MSAs

Effective for taxable years beginning after December 31, 2010, the costs of over-the-counter drugs not prescribed by a doctor (except insulin) may no longer be reimbursed through an HRA or health flexible spending account (FSA) and may no longer be reimbursed on a tax-free basis through an HSA or Archer MSA.

Tax on HSA and MSA Distributions Not Used for Qualified Expenses

Effective for taxable years beginning after December 31, 2010, the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses increases from 10 percent to 20 percent of the disbursed amount.

Requirement to Provide Value for Premium Payments

Beginning not later than January 1, 2011, health insurers in the individual and small group market must maintain a medical loss ratio (MLR) of 80 percent, and insurers in the large group market must maintain a MLR of 85 percent. Insurers must provide a rebate to each enrollee on a pro rata basis equal to the amount of premium revenue spent on nonmedical costs that exceed the percentage limits.

The MLR is the ratio of the amount of premium revenue expended by the issuer on reimbursement for clinical services provided to enrollees and for activities that improve healthcare quality to the total amount of premium revenue (excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and specified reinsurance for the plan year).

Informing Employees of the Cost of Their Health Coverage On W-2 Forms

Effective for tax years beginning after December 31, 2010, employers are required to report on Form W-2 the total cost of group health coverage, including the portion paid by the employer and the portion paid by the employee. This amount is to be calculated using the same method that is used to calculate the premium for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. For this purpose, group health coverage includes on-site medical clinics but not separate dental or vision plans. The amount reported is not to include contributions to HSAs, MSAs, or salary reduction contributions to FSAs.

Long-Term Care Assistance—The CLASS Act

The CLASS Act creates a national voluntary insurance program for purchasing community living assistance services and supports for individuals with functional limitations. The program will be administered by HHS and will provide cash benefits for individuals to purchase a variety of

long-term care services such as home health aide, transportation assistive technology (e.g., wheelchairs, lifts), text telephones and sensors with alarms, adult day care, respite care to give the family caregiver a break, and household modifications. There will be no preexisting condition restrictions. HHS will be writing rules for the program and will set premium and benefit levels.

Employers will be encouraged to participate in the CLASS Act and to adopt automatic enrollment rules that default employees into the CLASS Act, starting January 1, 2011.

2012 in Detail

Benefits Summary Requirement

By March 23, 2012, a summary of benefits and coverage explanation that meets the national standards for providing a summary of benefits and coverage must be provided to applicants at the time of application, enrollee prior to the time of enrollment or reenrollment; and a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate. The summary may be provided in paper or electronic form.

Entities that must provide a summary include health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States and, in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan.

Notice of modifications. If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for ERISA Sec. 102) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of the modification to enrollees at least 60 days before the modification will become effective.

Preemption. The national summary standard will preempt any related state standards that require a summary of benefits and coverage that provides less information to consumers than the national standard.

Penalty for failure to provide. An entity that willfully fails to provide a summary of benefits and coverage explanation may be fined not more than \$1,000 for each failure. A failure with respect to each individual enrollee is a separate offense.

Quality-of Care-Reporting

No later than March 23, 2012, requirements for group health plans and health insurance issuers offering group or individual health insurance coverage for reporting benefits and healthcare provider reimbursement structures that improve health outcomes through the implementation of activities are to be issued.

Examples of the categories of activities to be reported include:

- Quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives;

- Activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate healthcare professional;
- Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; *and*
- Wellness and health promotion activities.

Plans and insurers must annually report to HHS whether the benefits under the plan or coverage satisfy these elements. The report must be made available to plan enrollees during each open enrollment period. HHS is to make the reports available to the public on an Internet site.

2013 in Detail

Health Insurance Administration Simplification

HHS is to develop uniform standards to reduce the clerical burden on patients, healthcare providers, and health plans.

The standards and associated operating rules should:

- Enable determination of an individual's eligibility and financial responsibility for specific services before or at the point of care;
- Be comprehensive, requiring minimal added paper or other communications;
- Provide for timely acknowledgment, response, and status reporting that supports a transparent claim management process (including adjudication and appeals); *and*
- Describe all data elements in unambiguous terms, require that data elements be required or conditioned on set values in other fields, and prohibit additional conditions (except where necessary to implement state or federal law, or to protect against fraud and abuse).

HHS is directed to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.

HHS is mandated to adopt the following:

- Rules establishing a single set of operating rules for eligibility verification and claims status by July 1, 2011, effective January 1, 2013
- Rules for electronic funds transfer and healthcare payment and remittance rules by July 1, 2012, effective January 1, 2014
- Rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization rules by July 1, 2014, effective January 1, 2016

By December 31, 2013, a health plan must file a statement with HHS certifying that the data and information systems for the plan are in compliance with any applicable standards and associated operating rules for electronic funds transfers, eligibility for a health plan, health claim status, and healthcare payment and remittance advice. A health plan must comply with the new requirements by the effective date of the applicable standard or operating rule.

By April 1, 2014, and annually thereafter, HHS will assess a fine for noncompliance of up to \$1 per covered life per day of noncompliance.

Medicare Tax

Effective for wages received during taxable years beginning after December 31, 2012, the Medicare Part A (hospital insurance) tax rate on an individual's wages goes up by 0.9 percent (from 1.45 percent to 2.3 percent) on earnings over \$200,000 if the individual files his or her federal income tax return as a single taxpayer and \$250,000 if the individual files as married filing jointly.

There is also a new 3.8 percent Medicare tax assessment for a taxable year on investment income from interest, dividends, royalties, rents, gross income from certain trade or businesses, and net gain from disposition of property. The tax applies to individuals earning over \$200,000 and on married couples earning over \$250,000.

Trade or business income is subject to the tax if the trade or business is a passive activity or is trading in financial instruments or commodities. Net investment income does not include any distribution from a qualified retirement plan or self-employment income.

FSA Contribution Limit

Effective January 1, 2013, salary reduction contributions to a flexible spending account for medical expenses are limited to \$2,500 per year. This amount will be adjusted annually in \$50 increments rounded to the next lowest multiple of \$50 for changes in the cost of living.

Elimination of Tax Deduction for Part D Subsidy Payment

Effective January 1, 2013, the tax deduction for employers that receive Medicare Part D retiree drug subsidy payments is eliminated.

Requirement on Employers to Inform Employees of Coverage Options

Employers are to provide to each employee at the time of hiring (or for current employees, not later than March 1, 2013), written notice informing the employee of the following:

- The existence of an Exchange, including a description of the services provided by such an Exchange and how the employee may contact the Exchange to request assistance;

- If the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under IRC Sec. 36B and a cost-sharing reduction under Sec. 1402 of the (Patient Protection and Affordable Care Act) if the employee purchases a qualified health plan through the Exchange; *and*
- If the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.

The U.S. Department of Labor (DOL) will issue regulations on providing this notice.

2014 in Detail

Individual Mandate

U.S. citizens and legal residents will be required to have qualifying health coverage beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5 percent of household income, phased in from 2014 through 2016. There will be exceptions given for financial hardship and religious objections.

Requirement to maintain minimum essential coverage. The basis of the individual mandate is the requirement to maintain minimum essential coverage. This provision requires an applicable individual to ensure that he or she, and any of his or her dependents who are applicable individuals, is covered under minimum essential coverage for each month beginning after 2013.

A penalty is imposed for each month during which an applicable individual or his or her dependent is not so covered. The penalty is paid with the individual's federal income tax return. The monthly penalty amount is $\frac{1}{2}$ of the greater of:

- A flat dollar amount equal to the lesser of the sum of the applicable dollar amounts for all individuals with respect to whom a failure occurred during a month, or 300 percent of the applicable dollar amount for the calendar year with or within which the taxable year ends; *or*
- A percentage of income equal to a percentage of the excess of the taxpayer's household income for the taxable year over the amount of the gross income cutoff for requiring the filing of a return for the taxpayer for the taxable year. The percentage is 1.0 percent for taxable years beginning in 2014, 2.0 percent for taxable years beginning in 2015, and 2.5 percent for taxable years beginning after 2015.

The applicable dollar amount is phased in and is \$95 for 2014, \$325 for 2015, and \$695 thereafter. After 2016, this amount is indexed for inflation. If an applicable individual has not attained the age of 18 as of the beginning of a month, his or her applicable dollar amount for the month is one-half of the applicable dollar amount for the calendar year in which the month occurs.

An applicable individual is anyone who does not qualify for a religious exemption, is not incarcerated, or is not an alien unlawfully present in the United States. Also exempt are certain low-income individuals.

Minimum essential coverage. Minimum essential coverage means coverage under any of the following:

- Government-sponsored programs, including Medicare, Medicaid, state children’s health insurance programs (CHIPs), TRICARE for Life, the veteran’s healthcare program, a health plan for Peace Corps volunteers;
- Eligible employer-sponsored plans;
- Coverage under a health plan offered in the individual market within a state;
- A grandfathered health plan; *and*
- Other health benefits coverage, such as a state health benefits risk pool, that HHS, in coordination with the IRS, recognizes for this purpose.

Eligible employer-sponsored plan. An eligible employer-sponsored plan is a group health plan or group health insurance coverage offered by an employer to the employee that is a governmental plan (within the meaning of section or any other plan or coverage offered in the small or large group market within a state, including a grandfathered health plan offered in a group market).

Penalty payment. The penalty is paid upon notice and demand from the IRS and will generally be assessed and collected in the same way as other tax penalties except that failure by a taxpayer to timely pay the penalty for failure to maintain minimum essential coverage will not be subject to any criminal prosecution or penalty for the failure, and the IRS may not file notice of lien with respect to any property of a taxpayer because of a failure to pay the penalty or levy on the property because of the failure to pay.

Employer Play or Pay—The Employer Mandate

The ACA does not require employers to provide healthcare insurance for their employees. Instead, it imposes penalties on those that do not. This type of scheme is referred to as play or pay. Beginning in 2014, applicable large employers must decide if they want to play by providing minimum essential coverage under an eligible employer-sponsored plan or pay by paying a variety of fines.

Covered employers. Play or pay covers “applicable large employers.” This term means, for a calendar year, an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year. An employer will not be considered to employ more than 50 full-time employees if the employer’s workforce exceeds 50 full-time employees for more than 120 days during the calendar year, and the employees in excess of 50 are seasonal workers. A “full-time employee” for this purpose is defined as an employee who is employed for an average of 30 hours per week during a month.

The term “seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by DOL, including migrant agricultural workers and retail workers employed exclusively during holiday seasons.

All businesses treated as a single employer by IRC Sec. 414 are treated as one employer for this purpose also. IRC Sec. 414 is the frequently used rule for determining when related businesses should be treated as a single employer (for example when determining if an employer qualifies for the small employer exemption from COBRA).

If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is an applicable large employer is based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year.

Solely for purposes of determining whether an employer is an applicable large employer, an employer must include in the count of full-time employees for any month the number of full-time equivalent employees it has. This number is determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

The IRS, in consultation with DOL, is to issue any necessary regulations, rules, and guidance for determining the hours of service of an employee, including rules for employees who are not compensated on an hourly basis.

Penalty for failure to play. For any month that an applicable large employer does not offer minimal essential coverage and has at least one full-time employee who uses financial assistance to obtain healthcare coverage, the employer will be assessed a fee of \$2,000 per each full-time employee. The first 30 employees are not counted when assessing the fee.

An applicable large employer that offers coverage but has at least one full-time employee receiving financial assistance to pay for coverage will be assessed the greater of \$3,000 for each employee receiving assistance or \$2,000 for each full-time employee. Employers that offer coverage will be required to provide a voucher to employees with incomes below 400 percent of the poverty level if their share of the premium cost is between 8 percent and 9.8 percent of income to enable them to enroll in an Exchange plan. (Employers that provide vouchers will not be subject to the penalty.)

The term “applicable premium tax credit and cost-sharing reduction” means any premium tax credit allowed under IRC Sec. 36B and any cost-sharing reduction under PPACA Sec. 1402, including any advance payment of a credit or reduction.

Large Employer Automatic Enrollment Requirement

Large employers with more than 200 full-time employees that offer coverage will be required to automatically enroll employees into the employer’s lowest cost plan if the employee does not sign up for employer coverage or does not opt out of coverage. Any automatic enrollment program must include adequate notice and the opportunity for an employee to opt out of any coverage.

The provision does not supersede any state law with a requirement related to deductions from pay except to the extent that the requirement prevents an employer from instituting an automatic enrollment program.

This requirement is to take effect when regulations are issued and theoretically could be made effective at any time once regulations are issued. Related provisions, however, do not take effect until 2014.

Insurance Exchanges for Individuals and Small Businesses

By 2014, state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or nonprofit organization, are to be operating so that individuals and small employers can purchase qualified coverage.

For this purpose a small employer that employed an average of at least 1, but not more than 100, employees on business days during the preceding calendar year and that employs at least 1 employee on the first day of the plan year. For plan years beginning before January 1, 2016, a state may elect to define a small employer as employing not more than 50 employees.

In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage available to employees through an Exchange. Each employee of a qualified employer may then choose to enroll in a qualified health plan that offers coverage at that level. The term “qualified employer” means a small employer that elects to make all of its full-time employees eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

Beginning in 2017, each state may allow issuers of health insurance coverage in the large group market in the state to offer qualified health plans through an Exchange.

Guaranteed Issue, Renewability, and Rating Variation Requirements

Effective January 1, 2014, insurers will be required to guarantee issue and renewability. Insurers in the small group market will be allowed to use rating variation based only on age (limited to a 3-to-1 ratio), premium rating area, family composition, and tobacco use (limited to a 1.5-to-1 ratio) in the individual and the small group market and the Exchanges. If a state expands its Exchange to include the large group market, the rating variation limits will also apply in that market.

Annual Limits

Effective for plan years beginning on or after January 1, 2014, plans and insurers may no longer impose annual dollar limits on coverage.

Note. Group health plans and insurers may place annual or lifetime per-beneficiary limits on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under federal or state law. Essential health benefits include at least the following general categories and the items and services covered within these categories:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Regulations will define other items that are essential benefits so that an essential benefits package equals in scope the benefits provided under a typical employer plan.

Limit on Waiting Periods

Effective for plan years beginning on or after January 1, 2014, insurers and plans must limit any waiting periods for coverage to 90 days. A “waiting period” is defined as the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

Wellness Incentives

Effective for plan years beginning on or after January 1, 2014, employers may offer employees rewards of up to 30 percent of the cost of coverage for participating in a wellness program and meeting certain health-related standards. DOL, HHS, and the IRS may increase the reward available to 50 percent of the cost of coverage if they determine that such an increase is appropriate. A reward may be in the form of a discount or rebate of a premium or cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

Preexisting Condition Exclusions

Effective for plan years beginning on or after January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

Comprehensive Health Insurance Coverage

Effective for plan years beginning on or after January 1, 2014, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure that the coverage includes the essential health benefits package. Essential health benefits include at least the following general categories and the items and services covered within these categories:

- Ambulatory patient services
- Emergency services

- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Regulations are to define other items that are essential benefits so that an essential benefits package equals in scope the benefits provided under a typical employer plan.

Limits on Cost-Sharing and Deductibles

Effective for plan years beginning on or after January 1, 2014, a group health plan may not provide any annual cost-sharing in excess of those that apply to health savings accounts. Cost sharing does not include premiums, balance billing amounts for nonnetwork providers, or spending for noncovered services.

Coverage of Clinical Trials

Effective for plan years beginning on or after January 1, 2014, a group health plan not in existence on March 23, 2010, must provide coverage of certain costs of clinical trials. Thus, a group health plan will not be allowed to:

- Deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; *or*
- Discriminate against the individual on the basis of the individual's participation in a trial.

2018

Excise Tax on Cadillac Plans

Effective January 1, 2018, an excise tax is imposed on insurers of employer-sponsored health plans with total values that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

2010	2011	2012	2013	2014
Dependent Coverage to Age 26	Wellness Grants for Small Employers	Benefit Summary Requirement	Health Insurance Administration Simplification	Individual Mandate
Ban on Lifetime Limits and Restriction on Annual Limits	Exclusion of the Costs for Over-the-Counter Drugs for Reimbursement from HRAs, HSAs, FSAs, and MSAs	Quality of Care Reporting	Medicare Tax	Employer Pay or Pay—The Employer Mandate
Preexisting Condition Restrictions on Children	Tax on HSA and MSA Distributions Not Used for Qualified Expenses		FSA Contribution Limit	Large Employer Automatic Enrollment Requirement
Coverage Recissions	Requirement to Provide Value for Premium Payments			Insurance Exchanges for Individuals and Small Businesses
Minimum Coverage Without Cost-Sharing for Preventive Services	Informing Employees of The Cost of Their Health Coverage on W-2 for Form		Elimination of Tax Deduction for Part D Subsidy Payment	Guaranteed Issue, Renewability and Rating Variation Requirements
Tax Credits to Small Employers	The CLASS Act		Requirement on Employers to Inform Employees of Coverage Options	Annual Limits Limit on Waiting Periods
Reinsurance Program for Employers Providing Health Insurance Coverage to Retirees over Age 55	Benefit Summary Requirement			Wellness Incentives
Requirement to Report Medical Loss Ratio	Simple Cafeteria Plans for Small Employers			Preexisting Condition Exclusions
Nondiscrimination Testing Grandfather Rules	Requirement to Provide Value for Premium Payments			Comprehensive Health Insurance Coverage
Other Coverage Requirements				Limits on Cost Sharing and Deductibles Coverage of Clinical Trials

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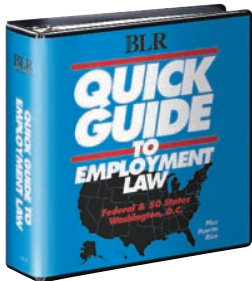
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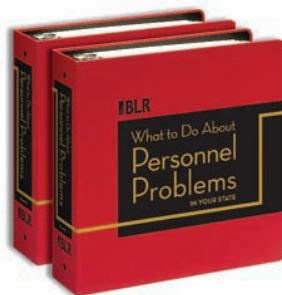
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