



2011 Health and Welfare Planning

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2011 Health and Welfare Planning

- Overview

- Health Care Reform
- Mental Health Parity and Addiction Equity Act
- CHIPRA Update
- GINA Update
- COBRA Subsidy Update

Health Care Reform

- Health Care Reform
 - Patient Protection and Affordable Care Act (PPACA), H.R. 3590
 - Signed into law on March 23, 2010
 - Amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), H.R. 4872
 - Signed into law on March 30, 2010

- PPACA Provisions Impacting Group Health Plans
 - Health Plan Mandates
 - Revenue Raising Provisions
 - Reporting Provisions
 - Employer and Individual Mandates
 - Miscellaneous

What Employer Health Plans Are Impacted?

What Employer Plans are Impacted?

- PPACA impacts most employer-sponsored insured and self-insured group health plans
 - Examples: major medical plans, EAPs, HRAs
- Limited exemptions
 - Plans providing HIPAA-excepted benefits
 - Grandfathered plans



What Employer Plans are Impacted?



- Limited Exemption for HIPAA-Excepted Benefits
 - PPACA amends the PHSAs to impose certain health plan coverage standards
 - PHSAs amendments are incorporated into Part 7 of ERISA
 - ERISA Part 7 contains an existing exemption for certain health plans, including –
 - stand alone retiree medical plans,
 - limited-scope dental and vision plans,
 - most health FSAs
 - on-site medical clinics

What Employer Plans Are Impacted?

- Limited Grandfathered Plan Exemption
 - PPACA (as passed on 3/23/10)
 - Grandfathered plans were exempt from the PHSA amendments (e.g., the health plan mandates)
 - HCERA
 - Amended PPACA to make grandfathered plans subject to some of the PHSA amendments
 - Other provisions of PPACA apply

What Employer Plans Are Impacted?

- Grandfathered Plan Exemption
 - What is a grandfathered plan?
 - Any group health plan in effect on the date of enactment
 - New employees and dependents may join a grandfathered plan without losing the exemption
 - Impact of other plan changes (e.g., addition or modification of a benefit; plan merger; consolidation of plans for ERISA purposes)
 - Application to collectively bargained plans

2010 PPACA Group Health Plan Provisions

- **Retiree Reinsurance Program**

- HHS program reimburses 80% (minus negotiated cost concessions) for early retiree health claims between \$15,000 and \$90,000, indexed for inflation
- Plans must cover early retirees – not actively employed, age 55 or older, not eligible for Medicare

- **Retiree Reinsurance Program**

- Proceeds must be use to lower health costs for enrollees (e.g., premiums, copayments, deductibles etc.)
- Program runs from 6/23/2010 until 1/1/2014 or earlier if appropriated funds are expended (\$5 billion appropriated under PPACA)
- Applications available no later than 6/23/2010 and are expected to resemble Retiree Drug Subsidy applications

- **Retiree Reinsurance Program**

- Self-funded and insured health plans are eligible
- Plans must implement cost-saving programs and procedures for participants with chronic and high cost conditions
- Participating plans may be audited for compliance
- White House Fact Sheet:
http://www.whitehouse.gov/sites/default/files/rss_viewer/reinsurance_early_retirees_fact_sheet.pdf

CLASS Act

CLASS Act

- CLASS Act

- Voluntary assisted living/long term care governmental insurance program
- Benefits paid to participants who are unable to perform normal activities of daily living (e.g., eating, bathing, dressing) or require substantial supervision to protect them from threats to their health or safety due to cognitive impairment for periods of at least 90 days.

- CLASS Act
 - Voluntary employer involvement in
 - Auto enrollment of employees (similar to 401(k) plan auto enrollment)
 - Withholding employee premiums
 - HHS required to make the CLASS Program actuarially sound
 - Effective January 1, 2011

2011 PPACA Provisions

- 2011 PPACA Provisions
 - Group health plan mandates
 - Provisions affecting all employer-sponsored group health plans (*i.e.*, grandfathered and non-grandfathered plans)
 - Provisions affecting only non-grandfathered plans
 - Reporting provisions
 - Revenue raising provisions

• Adult Dependent Coverage

- Health plans that provide dependent coverage must cover adult dependent children until age 26
 - Includes married dependents
 - Excludes grandchildren
 - Coverage is non-taxable
- Effective January 1, 2011 for calendar year plans
- Prior to 2014, grandfathered health plans do not have to cover an adult dependent that is eligible for other employer-sponsored health coverage

- **Adult Dependent Coverage**
 - Who is a “dependent”?
 - Not defined but guidance to be issued
 - Implementation Issues
 - Extension of adult dependent children coverage before the effective date
 - Extension of eligibility to exempt plans (e.g., dental, vision, life, etc.)
 - Contribution / charges for dependent coverage

2011 PPACA Provisions - All Health Plans

- Annual Limits

- Annual limits on the dollar value of “essential benefits” are prohibited unless specifically authorized by HHS
 - Effective January 1, 2011 for calendar year plans
 - HHS to issue guidance regarding permitted annual limits
 - In 2014, annual limits on the dollar value of essential benefits are prohibited altogether
- What is still allowed?

2011 PPACA Provisions - All Health Plans

- Annual Limits

- What are “Essential Benefits”?

- PPACA directs HHS to issue guidance
 - Must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care

- Lifetime Limits

- Lifetime limits on the dollar value of “essential benefits” are prohibited
 - Effective January 1, 2011 for calendar year plans
- Lifetime limits can be imposed on non-essential benefits

- **Pre-Existing Condition Exclusions**

- Health Plans may not impose a pre-existing condition exclusion for enrollees under age 19
 - Effective January 1, 2011 for calendar year plans
 - In 2014 expands to include all enrollees

- Coverage Rescission

- No rescission of coverage once an enrollee is covered except for fraud or intentional misrepresentation of material fact
- No cancellation of coverage except for nonpayment of premiums and plan termination
- Application to self-insured health plans
- Effective January 1, 2011 for calendar plan years

- **New Form W-2 Reporting Requirement**

- Employers must calculate and report the aggregate cost of all employer-provided health coverage on each employee's Form W-2
 - Must include all “applicable employer-sponsored coverage”
- How is the “aggregate cost” determined?
 - Apply rules similar to the COBRA premium rules
- Effective for the 2011 tax year (January 2012 W-2s)

- **Over-The-Counter (OTC) Drugs**
 - HRAs, FSAs and HSAs may not reimburse OTC drug expenses on a non-taxable basis
 - Exception for prescribed OTC drugs
 - **Effective Dates**
 - HRAs & FSAs – effective for expenses incurred with respect to taxable years beginning 1/1/2011
 - HSAs – effective for amounts paid with respect to taxable years beginning 1/1/2011

- **Over-the-Counter (OTC) Drugs**
 - Implementation Issues
 - Plans which operate on a non-calendar plan year
 - Reimbursement of OTC drugs without a prescription during the 2 ½ month grace period
 - Impact on debit cards

2012 PPACA Provisions

- Uniform Explanation of Coverage
 - Summary of plan benefits and coverage must be given to enrollees, participants and beneficiaries before enrollment and reenrollment in the health plan
 - Summary must satisfy certain standards relating to appearance and content
 - HHS (working with the NAIC) must issue guidance regarding the standards prior to 3/23/2011

- Uniform Explanation of Coverage
 - Must provide 60 days advance notice of any material change in coverage not described in the last summary distributed to participants (*i.e.*, material mid-year changes)
 - Penalty of \$1,000 per participant for each willful violation

2012 PPACA Provisions - All Health Plans

- **Plan Fees**

- Temporary fee imposed on insured and self-insured plans based on the average number of lives covered during the plan or policy year
 - Fee is \$2 (\$1 for fiscal years ending in 2013)
 - Not applicable to HIPAA-excepted benefit plans
- Effective for plan years ending after 9/30/2012
- Scheduled to expire for plan years ending after 9/30/2019

2013 PPACA Provisions

2013 PPACA – All Health Plans

- Health FSA Limits - 2013
 - Cap on Health FSA *employee* contributions
 - \$2,500 (as adjusted for inflation)
- Elimination of Retiree Drug Subsidy Deduction
 - Effective 2013, employers will not be entitled to a tax deduction for Medicare Part D retiree drug subsidy payments
 - Special application of accounting rules

- Notice Regarding the Exchange
 - Existing employees of all employers (not just large employers) must be notified by March 1, 2013 and new hires must be notified upon hire of:
 - the right to purchase coverage under an Exchange,
 - that the employee may be eligible for a premium tax credit, if the plan's share of total costs is less than 60%, and
 - the potential loss of the employer contribution if coverage is purchased through the Exchange (unless they are eligible for a free choice voucher)

2014 PPACA Provisions

- Automatic Enrollment
 - Employers with more than 200 full-time employees must automatically enroll new employees in medical coverage
 - Must provide notice and an opt out procedure
 - IRS could establish an earlier effective date

2014 PPACA – All Health Plans

- Expanded Reporting Requirements
 - To the IRS and, in summary fashion, to each full-time employee
 - Large employers (and any employer that offers minimum essential coverage and pays a portion of the cost where the required employee contribution exceeds 8% of wages) must report:
 - Whether they offer minimum essential coverage, the lowest cost premium option in each enrollment category, waiting periods, the employer's share of the total allowed costs of benefits, and the number and name, address and TIN of each full-time employee enrolled and the months during which the employee (and dependents) were covered

- Design Mandates
 - No annual limits can be imposed on “essential health benefits”
 - No pre-existing condition exclusions can be applied (not just to those under 19)
 - Dependent children can remain covered until age 26, regardless of whether they are eligible for other employer coverage
 - No waiting periods in excess of 90 days

PPACA Changes for Non-Grandfathered Plans Only

PPACA – Non-Grandfathered Plans Only

- Grandfathered plans are exempt from many requirements that will apply to new plans or plans that lose their grandfathered status
- Changes Only for Non-Grandfathered Plans for plan years beginning on or after September 23, 2010
 - No cost-sharing permitted for preventive care measures, including visits, immunizations and screenings
 - This means no deductibles, copays, coinsurance
 - Fully-insured plans cannot discriminate in favor of HCEs
 - This extends the rule that currently applies to self-insured plans to fully-insured plans
 - This affects the use of executive-only fully insured plans or insurance policies to sidestep nondiscrimination rules imposed on self-funded plans

PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans for plan years beginning on or after September 23, 2010
 - New rules for appeals process
 - Must notify participants where to get help with appeals process
 - Notice of the process must be in “culturally and linguistically appropriate manner”
 - Participants may review their file, present evidence and testimony, and receive continued coverage during the appeals process
 - In addition to an internal review process, plans must provide both an external review process that complies with applicable State external review processes, or for self-insured plans, that meets the minimum standards established by the Secretary

PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, for plan years on or after September 23, 2010
 - New patient protections include:
 - Allow designation of any participating primary physician available to take new patients, if the plan requires a designation
 - For children, allow designation of a pediatrician as the PCP, if the plan requires a designation
 - Access to emergency services without prior authorization and treat as in-network – ER surcharges questionable
 - Access to an OB/GYN, without prior authorization

PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, for plan years on or after September 23, 2010
 - Reporting Requirements
 - Must report to HHS, state insurance commissioners and make available to the public, information intended to improve health outcomes

PPACA – Non-Grandfathered Plans Only

- Changes Only for Non-Grandfathered Plans, effective January 1, 2014
 - Must cover routine costs related to clinical trials for individuals with cancer or other life-threatening disease or condition
 - this excludes the investigational service itself or those clearly inconsistent with established standards of care
 - Cannot discriminate against such individuals
 - No cost-sharing provision in excess of the limits under Code Section 223(c)(2)(A)(ii) (the HDHP out of pocket maximum, which is currently \$5,950 for individuals and \$11,900 for families)
 - Cost-sharing includes deductibles, copays, co-insurance
 - No discrimination based on health status
 - Rewards under a wellness program are increased to 30% of the cost of coverage (currently limited to 20%)

Employer and Individual Mandates

- **Employer Mandate**
 - Large employers must provide “minimum essential coverage” to full-time employees or pay a monthly penalty if a full-time employee is eligible for and obtains subsidized coverage through the Exchange
 - Effective January 1, 2014

- Employer Mandate
 - Large employer = average of 50 or more full-time employees during the prior year
 - Determined on a controlled group basis
 - Must include full-time equivalents
 - Full-time employee = one who works on average 30 hours or more per week

- **Employer Mandate**
 - **Minimum Essential Coverage**
 - Coverage under an eligible employer-sponsored group health plan
 - Employer must pay at least 60% of the allowed health plan costs
 - Employee may not be required to pay more than 9.5% of the employee's household income

- Employer Mandate
 - Penalty for Offering No Coverage
 - \$2,000 per full-time employee (excluding first 30 employees) if one full-time employee receives subsidized coverage through the Exchange
 - FTE's not included in calculating the penalty

- Employer Mandate
 - Penalty for “Under Subsidizing” Health Coverage
 - \$3,000 per full-time employee who receives subsidized coverage through the Exchange (excluding employees who received a Free Choice Voucher)
 - Not greater than the penalty that applies for not offering any coverage

- Free Choice Vouchers

- All employers who offer subsidized health plan coverage must provide a voucher to employees who opt-out of the plan if:
 - The employee's household income does not exceed 400% of the FPL for a family of the size involved; and
 - The employee's share of the cost of coverage would be between 8% and 9.8% of household income
- The voucher may be used to purchase coverage through the exchange

- Individual Mandate
 - Individuals must maintain Minimum Essential Coverage or pay a penalty.
 - Exceptions
 - Cost of coverage exceeds 8% of the individual's household income
 - Short gaps (less than 3 months) in coverage
 - Not required to file a federal tax return
 - Effective January 1, 2014

- Individual Mandate
 - Individuals may be eligible for subsidized coverage through the Exchange if –
 - The individual's household income ranges from 100% to 400% of the federal poverty line.
 - No subsidy if the employer provides Minimum Essential Coverage (*i.e.*, employer covers 60% of allowed plan costs and individual is not required to pay more than 9.5% of household income for coverage)
 - Certain reporting requirements apply

“Cadillac Plan Tax”

- Cadillac Plan Tax

- Employers and insurers must pay a 40% tax on “excess health coverage”

- Excess Health Coverage = Total cost of coverage exceeding \$10,200 for self-only coverage and \$27,500 for all other coverage
 - Certain high risk professions have a higher threshold
 - Amount is adjusted for inflation
 - Does not apply to coverage under stand alone dental and vision plans (unclear if exemption only applies to insured plans)

- Effective January 1, 2018

Reform Wrap-Up

- Health Care Reform Wrap-Up and Concluding Comments

**Paul Wellstone and Pete Domenici
Mental Health Parity and
Addiction Equity Act of 2008
(the “Wellstone Act”)**

- ## Overview

- Significantly broader than the Mental Health Parity Act of 1996
- Also applies to substance abuse benefits
- Strives to provide actual parity with medical and surgical benefits
- Interim final regulations were issued February 2, 2010
- Plans redesigned in 2010 to comply with the Wellstone Act need to be reviewed for compliance with the regulations that are more expansive than the statute

- **Effective Date**

- The Wellstone Act generally became effective January 1, 2010 for calendar year plans
- These regulations apply for plan years beginning on and after July 1, 2010, which means January 1, 2011 for calendar year plans (special rules apply to plans maintained pursuant to a collective bargaining agreement)
- Government agencies will take into account good faith efforts to comply with a reasonable interpretation of the Wellstone Act prior to the effective date of the regulations, but this does not prevent participants from bringing claims

Wellstone Act - Applicability

- **Plans Subject to the Wellstone Act**
 - Applies to coverage that provides mental health or substance use disorder benefits, even if no medical/surgical benefits are provided, if such coverage is offered in connection with a health plan that otherwise offers medical/surgical benefits
 - The point of this rule is to close a loophole that would have allowed employers to circumvent the rules by establishing separate plans for mental health or substance use benefits

Wellstone Act - Exemptions

- Limited Exemptions Are Available
 - Employers who employed an average of at least 2 but no more than 50 employees during the preceding calendar year
 - Plans with fewer than 2 participants who are current employees
 - This includes stand-alone retiree health plans
 - Plans subject to the increased cost exemption (if the plan complies for one year, the exemption applies to the following year only)

Wellstone Act – Coverage is Not Required, But...

- Plans Can Define Covered Mental Health Disorders
 - Plans are not required to provide benefits for mental health or substance abuse disorders
 - If such benefits are provided, benefits for ALL such disorders are not required
 - Plans can define what benefits are covered
 - The definition must be consistent with generally recognized independent standards of current medical practice, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM)

- **General Rule**

- A group health plan or insurer cannot apply financial requirements or treatment limitations on mental health or substance abuse disorders that are more restrictive than the “predominant” restriction or limitation imposed on substantially all medical/surgical benefits *in the same classification*
 - Financial requirements include deductibles, copays, out-of-pocket limits, annual and lifetime dollar limits
 - Treatment limitations include number and frequency of covered visits/days
 - Predominant means greater than one-half; substantially all means at least two-thirds

Wellstone Act – Parity Within Classifications

- The classifications are:
 - inpatient/in-network (IN)
 - inpatient/out-of-network (OON)
 - outpatient/IN
 - outpatient/OON
 - emergency care
 - prescription drugs

- Must analyze benefits provided within each classification in which medical/surgical benefits are provided

Wellstone Act – Exclusions Are Difficult

- Exclusions are difficult as a practical matter
 - If a plan provides a benefit for a disorder, the benefits for that disorder must comply with the Wellstone Act
 - Cannot exclude coverage for anxiety disorders but cover prescription drugs for that disorder
 - Issue: the plan will not be providing benefits in all the classifications for which medical/surgical benefits are provided (such as out-patient/in-patient expenses)

Wellstone Act – Nonquantitative Limits

- Rules Also Apply to Non-quantitative Treatment Limits

- Nonquantitative treatment limits include (but are not limited to):

- Medical management standards, such as limits based on medical necessity or preauthorization requirements
- Prescription drug formulary design
- Determination of UCR amounts
- Requirements for using lower cost therapies first
- Conditioning benefits on the completion of a course of treatment

Wellstone Act – Nonquantitative Limits

– Factors Must Be Comparable

- The factors used for mental health/substance use benefits must be comparable to (and not applied more stringently than) those applied to medical/surgical benefits, unless recognized clinically appropriate standards of care permit a difference

– Example

- Some plans require a participant to exhaust EAP benefits first
- This design violates the regulations because it imposes a “gatekeeper” requirement that is not imposed on other medical/surgical benefits

Wellstone Act - Deductibles

- No separate deductibles or out-of-pocket maximums permitted
 - The Wellstone Act could be read to allow a plan to impose a separate deductible or out-of-pocket maximum for mental health/substance abuse benefits
 - The regulations specifically provide that this is not permissible
 - Cannot have a \$500 deductible for medical expenses and a separate \$500 deductible for mental health/substance abuse; can have a \$1,000 combined deductible

Wellstone Act – Action Items

- SPDs and requirements imposed for benefits must be reviewed again in light of the regulations issued in February
 - Confirm no separate deductibles, OOP, etc.
 - Confirm benefits for mental/substance abuse are not conditioned on satisfying rules that are more stringent than are required for medical/surgical benefits, such as
 - Requiring use of a gatekeeper first
 - Requiring completion of a program of treatment
 - Use of other medical management tools
 - If the plan attempts to carve out benefits for a condition, confirm that NO benefits are provided (such as prescription drugs or services from an internist for that condition)

2011 Health and Welfare Planning

- CHIPRA Update
- GINA Update
- COBRA Subsidy Update

ITEMS OF INTEREST FOR EMPLOYERS
Patient Protection and Affordable Care Act (“PPACA”)
Health Care and Education Reconciliation Act of 2010 (“HCERA”)

Topic	Explanation	Effective Date	Applicable to Grandfathered Plans	PPACA HR 3590 Section (Enactment Date 3/23/2010)	HCERA HR 4872 Section (Enactment Date 3/30/2010)	Regulatory Guidance
GENERAL PROVISIONS						
Adoption Assistance	Increases limit for reimbursable expenses under adoption assistance programs and makes credit refundable.	1/1/2010	N/A	10909	N/A	
Medicare Part D Donut Hole	Immediate decrease in Medicare Part D Donut Hole and total elimination in 2020.	1/1/2010	Yes	3315	1101	
ERISA / Code Application	Applies Part A of Section XXVII Public Health Service Act (PHSA) to ERISA and the Internal Revenue Code by adding new Sections 715 and 9815, respectively.	3/23/2010	Yes	1562(e) and (f) (changed to 1563(e) and (f) in 10107(b))	N/A	
Grandfather Rules	Grandfathers existing health plans from PHSA provisions of PPACA. HCERA takes away grandfathering for certain provisions.	3/23/2010	Yes	1251, 10103(d) and (e)	2301	
Tax Free Coverage for Dependents	Expands tax-free coverage under IRC 105(b) to any child described in 152(f)(1) who has not attained age 27.	3/30/2010	Yes	N/A	1004(d)	IRS Notice 2010-38 (April 27, 2010)
Early Retirees	Establishes government program for reinsurance of early retirees age 55-65 for employer-based health plans.	Within 90 days of enactment (i.e., by June 23, 2010)	Yes	1102	N/A	HHS announced applications available in June and payments to employers are tax-free.

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CLASS Act	- Establishes a voluntary assisted living/long term care insurance program. - Employers may elect to auto enroll employees and withhold premiums. - Employers not required to participate.	1/1/2011	N/A	8001, 8002 and 10801	N/A	
Premium Assistance for Medicaid or CHIP	Requires states to provide group health plan premium assistance to Medicaid or CHIP eligible individuals when it is cost effective to do so.	1/1/2014	Yes	2003 and 10203(b)	N/A	
MEDICAL BENEFIT DESIGN CHANGES AFFECTING EMPLOYER SPONSORED HEALTH PLANS						
Appeals – PHSA 2719	Requires standardized appeals process.	First plan year after 9/23/2010	No	1001 and 10101(g)	N/A	
Compliance with Exchange Requirements – PHSA 2715A	Requires group health plans to report to HHS, state insurance commissioners and to make available to the public certain financial disclosures, information regarding claims policies and practices, and other information.	First plan year after 9/23/2010	No	10101(c)	N/A	
Coverage Rescission – PHSA 2712	- Prohibits rescission of coverage except for fraud or misrepresentation. - Requires prior notice of cancellation of coverage for nonpayment of premiums or termination of plan.	First plan year after 9/23/2010	Yes	1001	N/A	

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Dependent Coverage – PHSA 2714	<ul style="list-style-type: none"> - Requires coverage of dependents until the child turns age 26 – i.e., 26th birthday. - Applies to married dependents. - Prior to 1/1/2014 applies only if dependent not eligible to enroll in other employer provided coverage. - Does not require coverage of grandchildren. 	First plan year after 9/23/2010	Yes	1001	2301 and 1004(d)	
Discrimination Based on Salary – PHSA 2716	<ul style="list-style-type: none"> - Applies similar IRC 105(h) rules to insured plans. - Not applicable to self-insured plans. 	First plan year after 9/23/2010	No	1001; 10101(d)	N/A	
Lifetime and Annual Limits – PHSA 2711	<ul style="list-style-type: none"> - Prevents lifetime dollar limits and annual dollar limits on essential benefits. - Allows per benefit annual or lifetime dollar limits on non-essential benefits. - Allows certain annual dollar limits on essential benefits prior to 1/1/2014. 	First plan year after 9/23/2010	Yes	1001, 10101(a)	N/A	
Patient Protections – PHSA 2719A	<ul style="list-style-type: none"> - Guarantees choice of health care professionals. - Guarantees certain rights with respect to emergency room services and other access to care. 	First plan year after 9/23/2010	No	10101(h)	N/A	
Pre-existing Conditions – PHSA 2704	<ul style="list-style-type: none"> - Prevents pre-existing condition exclusions for children under age 19. - Extended to all plan participants on 1/1/2014. 	First plan year after 9/23/2010	Yes	1201 and 10103(e)	N/A	

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Preventive Care – PHSA 2713	Requires coverage of preventive care visits, immunizations and other wellness services.	First plan year after 9/23/2010	No	1001	N/A	
Reporting – PHSA 2717	Requires reporting of health outcomes and wellness activities.	First plan year after 9/23/2010; various other effective dates	No	1001 and 10101(e)	N/A	
Reporting – PHSA 2718	- Requires reporting on premiums and other revenue related issues. - Not applicable to self-insured plans.	First plan year after 9/23/2010; various other effective dates	Yes	1001, 10101(f), and 10103(d) [reference is to extension of application to grandfathered plans]	N/A	April 14, 2010, HHS issued request for information
Uniform Coverage Explanation and Standardized Definitions – PHSA 2715	- Requires HHS to develop uniform explanation of coverage documents and uniform standard definitions for coverage. - Requires plans to provide the standard documents. - Requires prior notice of coverage modifications.	First plan year after 9/23/2010; various other effective dates	Yes	1001, 10101(b), and 10103(d) [reference is to extension of application to grandfathered]	N/A	

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				plans]		
Clinical Trials – PHSA 2709	Requires coverage and standards for individuals participating in clinical trials.	1/1/2014	No	10103(c)	N/A	
Comprehensive Benefits – PHSA 2707	Requires coverage of essential health benefits in individual and small group market.	1/1/2014	No	1201	N/A	
Fair Premiums – PHSA 2701	Sets forth standards on how to calculate health coverage premiums.	1/1/2014	No	1201 and 10103(a)	N/A	
Guaranteed Availability – PHSA 2702	Requires guaranteed issuance in individual and group markets.	1/1/2014	No	1201	N/A	
Guaranteed Renewability – PHSA 2703	Requires guaranteed renewability.	1/1/2014	No	1201	N/A	
Non-Discrimination against Providers – PHSA 2706	Prohibits discrimination against providers.	1/1/2014	No	1201	N/A	
Non-Discrimination in Health Status – PHSA 2705	- Prohibits discrimination in health status. - Adds certain wellness rules.	1/1/2014	No	1201	N/A	
Waiting Periods – PHSA 2708	Prohibits waiting periods that exceed 90 days.	1/1/2014	Yes	1201 and 10103(b)	N/A	
REVENUE PROVISIONS						
Economic Substance Doctrine – IRC 7701(o), 6662(b)(6),	Codification of economic substance doctrine and imposition of penalties for underpayments relating to transactions not	3/30/2010	N/A	N/A	1409	

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6664(c)(2) and (d)(2), and 6667(c)	having economic substance.					
Additional HSA Distribution Tax	Increase in excise tax for distributions not used for qualified medical expenses from 10% to 20%.	1/1/2011	Yes	9004	N/A	
Form W-2	Employers must report the aggregate cost of group health coverage. First reporting requirement would be January 2012 for the 2011 tax year.	1/1/2011	Yes	9002	N/A	
Over-the-Counter Drugs	Over-the-counter drugs without a prescription cannot be reimbursed under a Health FSA, HSA or HRA.	1/1/2011	Yes	9003	N/A	
Plan Fees – IRC 4375, 4376, 4377	- Temporary fees on insured and self-insured plans equal to \$1 per covered life for plan years ending during fiscal year 2013 and \$2 per covered life thereafter, adjusted for inflation in healthcare costs. Based on average covered lives. - Scheduled to expire for plan years after 9/30/2019.	Plan years ending after 9/30/2012	Yes	6301	N/A	
Health FSA Limit	Limit on salary reduction under a cafeteria plan to \$2,500, adjusted for inflation.	1/1/2013	Yes	9005 and 10902	1403	
Itemized Deductions	- Increase in threshold for deducting qualified medical expenses from 7.5% to 10% of AGI. - Exception through 2017 for individuals	1/1/2013	N/A	9013	N/A	

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	who attain age 65 before the close of the tax year.					
Medicare Taxes	- Additional 0.9% Medicare withholding tax on wages in excess of \$250,000 for joint filers or \$200,000 for other filers – applicable to employee portion only. - Additional 3.8% tax on unearned income for taxpayers with MAGI of \$250,000 for joint filers or \$200,000 for other filers.	1/1/2013	N/A	9015 and 10906	1402	
Part D Subsidy	Eliminates the employer’s deduction for the retiree drug subsidy payments.	1/1/2013	Yes	9012	1407	
Excise Tax on Cadillac Plans – IRC 4980I	Imposes a 40% excise tax on health insurance issuers or administrators of self-insured plans for the value of health coverage that is greater than certain dollar thresholds.	1/1/2018	Yes	9001 and 10901	1401	
EMPLOYER MANDATES						
Employer Requirement to Inform Employees of Coverage Options	- Employers must provide notices to new employees at hiring and to current employees not later than the effective date informing them of the Exchange. - Notice must explain that the individual may be eligible for subsidies if the employer contributes less than 60% of allowed costs under a group health plan	3/1/2013	Yes	1512 and 10108(i)(2)	N/A	

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	and that the individual may lose the employer’s contribution by purchasing insurance through the Exchange unless a free choice voucher is offered.					
Automatic Enrollment for Employees of Large Employers	<ul style="list-style-type: none"> - Employers must automatically enroll new full-time employees in a coverage option and carry forward existing coverage from year to year. - Applies to employers with more than 200 employees. - Employees must be provided with adequate notice and the ability to opt out of auto enrollments. 	1/1/2014 (unless applied sooner by regulation)	Yes	1511	N/A	
Free Choice Vouchers	<ul style="list-style-type: none"> - Employers who contribute to the cost of coverage under a group health plan must provide “free choice vouchers” for purchasing insurance through the Exchange to employees who have household income of not more than 400% of the poverty line and whose required contribution would be between 8% and 9.8% of household income. - The amount of the voucher is equal to the employer contribution under the option that the employer pays the most and for which the employee would be eligible. 	1/1/2014	Yes	10108	N/A	

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	- The free choice voucher is non-taxable for the employee and deductible for the employer.					
Offering of Exchange-Participating Qualified Health Plans through Cafeteria Plans	- Only qualified employers (small employers initially) may purchase group health insurance through an Exchange. - Only qualified employers may allow for the payment of premiums on a pre-tax basis for coverage purchased through an Exchange under a cafeteria plan.	1/1/2014 States may extend to large employers in 2017	N/A	1312 and 1515	N/A	
Reporting of Employer Health Insurance Coverage	- Group health plans that provide minimum essential coverage are required to file a return reporting individuals who were covered under the plan and provide a statement to the individuals. - Large employers and employers who offer free choice vouchers are subject to expanded reporting requirements.	1/1/2014	Yes	1502, 1514 and 10108	N/A	
Shared Responsibility for Employers – IRC 4980H	- Large employers must offer health coverage to full-time employees or be subject to a penalty. Penalty is equal to \$2,000 per year per full-time employee. - Large employers also subject to a separate penalty for under-subsidizing health coverage for full-time employees, if the employee enrolls in an Exchange plan	1/1/2014	Yes	1513 and 10108(i)(1)	1003	

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	and qualifies for taxpayer subsidized coverage (i.e., household income below 400% of poverty line, and employer does not pay at least 60% of allowed costs under the employer plan or employee’s required contribution greater than 9.5% of household income). - Large employer is one that has 50 or more full-time equivalent employees determined on controlled group basis. - Full time employees are employees who on average work at least 30 hours per week.					
Retaliation	Employers are prohibited from discharging or discriminating against employees who purchase subsidized coverage through the Exchange.	1/1/2014	Yes	1558	N/A	
INDIVIDUAL MANDATES						
Exchanges	- States are required to operate Exchanges, through which individuals and qualified employers (initially, small employers) can purchase private health insurance under standardized plans. - Insurance offered through the Exchanges must offer an essential benefits package similar to that under the typical employer	1/1/2014	N/A	1301-1304 and 1311	N/A	

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	plan, and with specified levels of coverage (<i>i.e.</i> , platinum, gold, silver, bronze and catastrophic plans for individuals under 30). - States may impose additional requirements for Exchange plans.					
Requirement to Maintain Minimum Essential Coverage – IRC 5000A	- Individuals required to maintain minimum essential coverage for themselves or pay a variable penalty based on the tax year and income. - Exceptions for members of certain religious groups, individuals not lawfully present, and incarcerated individuals. - No penalty applies for individuals who cannot afford coverage (<i>e.g.</i> , because the required contribution for coverage would be 8% of household income), who have household income less than the threshold for filing a Federal tax return, or for short (less than 3 months) gaps in coverage. - “Minimum essential coverage” includes coverage under an eligible group health plan, an individual insurance plan, or certain governmental programs (<i>e.g.</i> , Medicare, Medicaid, the CHIP Program or TRICARE).	1/1/2014	Yes	1501 and 10106	1002	

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Taxpayer-Subsidized Coverage – IRC 36B	- Taxpayers with household incomes between of not more than 400% of the Federal poverty line for the size of the family involved may qualify for taxpayer subsidized coverage for insurance purchased through the Exchange. - Individuals eligible under a group health plan where the employer covers less than 60% of required costs and whose required contribution is more than 9.5% of household income are eligible for subsidies.	1/1/2014	Yes	1401, 1402, 10105(a) - (d), 10108(h)(1)	1001	