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Employee Benefit Consultants

Executive Summary

Health Care Reform: Its here! Are you Ready?

In March, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (HCERA). The bills were signed on two separate days, thus creating two separate effective dates for provisions that are effective based on the "date of enactment" of the provision. H.R. 3590 became law on March 23, while H.R. 4872 became law on March 30. This summary will refer to the two bills collectively as Health Care Reform or HCR.

This detailed executive summary of HCR includes a number of provisions that will have a significant impact on employer sponsored group health plans. Some of these provisions are effective immediately, while others become effective much later, in some cases, as late as 2018. The key to complying with health care reform is knowing what applies to <u>your</u> employee benefit plans and when!

To help you understand your obligations as an employer / plan sponsor, we have provided a detailed discussion of health care reform as it relates to group health plans, beginning with a general timeline of the applicable provisions. Please note the references to "the Secretary" are references to the Secretary of Heath and Human Services (HHS).

To help you get your hands around this mammoth piece of legislation, we have organized this summary into the following sections:

1. Timeline of Group Health Plan HCR Provisions
2. Health Insurance Reforms, including Grandfathered Plans
3. Employer Responsibility Provisions
4. High Cost Plan "Cadillac" Tax

1. Timeline of Group Health Plan HCR Provisions

Effective in 2010

- **Credit for Small Employers.** Effective for taxable years beginning on or after January 1, 2010, small employers with 25 or fewer "full-time equivalent" employees and average annual wages of $50,000 or less are eligible for a tax credit equal to a portion of the employer's cost to provide health insurance. The credit begins to phase out for employers with more than 10 full-time equivalent employees and/or average annual wages of more than $25,000.

- **Change in Definition of "Dependent" for Purposes of Tax Free Health Coverage.** Effective March 30, 2010, health care reform expanded the definition of "dependent" for purposes of tax free health coverage to include a "child" who will not yet turn age 27 during the year, regardless of whether the child otherwise qualifies as a tax dependent. See IRS Notice 2010-38. A "child" for this purpose is defined as in Internal Revenue Code (IRC) Section 152(f)(1), and includes children, stepchildren, adopted children and eligible foster children. This provision will have an immediate impact on plans such as flexible spending account

accounts (FSAs) or health reimbursement accounts (HRAs) that condition eligibility on a child qualifying as a tax dependent for health coverage purposes (i.e., under IRC Section 105(b)). **HCR changed the definition of "dependent" for purposes of tax-free health coverage only; it did not change the definition of "tax dependent" for purposes of the individual income tax rules.**

- **Retiree Reinsurance.** By June 21, 2010 (90 days after March 23, 2010), HHS will establish a retiree reinsurance program that will reimburse eligible employer based plans for 80 percent of eligible claims between $15,000 and $90,000 for retirees (and their covered dependents) who are age 55 or older and are not eligible for Medicare. Both fully insured and self-insured plans are eligible for the program. All reimbursements must be used to lower the cost of the plan. Plans must apply in accordance with procedures established by HHS. HHS has indicated that applications will be available in June and that the application process will be similar to that for the Medicare Part D subsidy.
- **High-Risk Pools.** By June 21, 2010 (90 days after March 23, 2010), HHS will establish a high-risk pool for individuals with a preexisting condition who could not otherwise obtain coverage. Until the high-risk pool is terminated in 2014, a group health plan must reimburse the high-risk pool for medical expenses incurred by the pool for individuals found to have been offered financial incentives to disenroll from the group health plan.
- **"Immediate" Health Insurance Reforms.** Health care reform contains two "phase ins" of individual and group health insurance reforms. The first of these "phase in" is effective for the first plan year beginning on or after September 23, 2010 (i.e., the immediate reforms are generally not effective for calendar year plans until January 1, 2011). The immediate health insurance reforms include but are not limited to a prohibition on annual and/or lifetime limits on "essential benefits", coverage of adult dependent children up to age 26, and a prohibition on preexisting condition exclusions for enrollees under the age of 19. See "Health Insurance Reforms" below for a more detailed discussion of these health insurance reforms.

Effective 2011

- **Limitation on Over-the-Counter Reimbursements.** Effective for tax years beginning on or after January 1, 2011, over-the-counter (OTC) medicines or drugs are not eligible for reimbursement under an FSA, HRA or HSA unless the medicine or drug is "prescribed" by a physician (regardless of whether a prescription is required to obtain the item). This requirement would not apply to eligible OTC medical items other than medicines or drugs (e.g., bandages or contact lens solution). <u>This limitation takes effect January 1, 2011, without regard to the plan year of the health FSA or HRA.</u>
- **HSA Distributions.** The excise tax for non-qualified distributions from Health Savings Accounts is increased from 10 to 20 percent.
- **"SIMPLE" Cafeteria Plan Safe Harbor.** A new safe harbor from the applicable nondiscrimination rules for cafeteria plans (and certain plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance benefits) is provided for plans maintained by eligible employers to the extent certain requirements are met. An eligible employer is an employer with 100 or fewer employees during either of the two complete preceding years.
- **W-2 Reporting.** Beginning with the 2011 calendar year, employers must begin to report the "value"(i.e., the COBRA cost) of employer-provided health coverage on each employee's W-2. Thus, the first W-2 affected will be the W-2 sent no later than January 31, 2012.

Effective 2012

- **CER Fee.** Effective for policy/plan years ending after September 30, 2012, insurers of fully insured plans and employers of self-insured plans will be charged a fee equal to $2 ($1 in the case of policy/plan years ending during fiscal year 2013 (i.e, the federal governmental fiscal year, October 1, 2012, to September 30,

2013) multiplied by the average number of covered lives. The fee is for funding **Comparative Effectiveness Research**. The fee applies to accident or health insurance policies other than policies covering benefits exempt under HIPAA. The fee does not apply to policy/plan years ending after September 30, 2019.

Effective 2013

- **FSA Cap.** Effective for taxable years beginning on or after January 1, 2013, health FSA salary reductions are limited to $2,500 each year. The cap does not apply to employer contributions. The limit is indexed for inflation based on the CPI beginning in 2014.
- **Deduction of Retiree Medical Costs.** Effective for tax years beginning on or after January 1, 2013, the deduction previously permitted for amounts allocable to the Medicare Retiree Part D subsidy is eliminated.
- **Increased Medicare Tax.** Beginning in 2013, there is a 0.9 percent increase in Medicare taxes for those earning more than $200,000 for single individuals and $250,000 for those who file jointly. Also, such individuals would also be subject to a 3.8 percent tax on their net investment income (to the extent that total income exceeds the thresholds).
- **Compensation Deduction Limitation.** Effective for taxable years beginning after December 31, 2012, the deduction for compensation for workers who provide services to a "covered health insurance provider" is limited to $500,000 per year. There is no exception for performance-based compensation and the limitation also applies to deferred deduction remuneration (deferred compensation). For years beginning after 2012, a "covered health insurance provider" is a health insurance issuer with 25 percent or more of their gross premiums received from providing minimum essential coverage. A special rule applies the deduction limitation to any deferred deduction remuneration attributable to services performed during any taxable year beginning after December 31, 2009, and before 2013 but which is paid after December 31, 2012. For purposes of this rule, a covered provider is not limited to providers that provide minimum essential coverage. Thus, this rule may apply to insurers, such as those that provide only disability benefits, even though they are not subject to the restriction after 2012. This appears to be a drafting error, which hopefully will be addressed in regulations.
- **"Exchange" Reporting.** Effective March 1, 2013, employers must begin providing notice to employees of the existence of the exchange, how to qualify for a subsidy and the fact that the employee will lose the employer's contributions for health coverage if he/she enrolls in the exchange (except as otherwise required for the free choice voucher).
- **Electronic Transaction Standards.** Plans must implement certain electronic transaction standards and certify compliance to HHS. The timing of certification varies depending on the type of transaction. For example, the health plan must certify compliance with electronic fund transfer, health claim status and health care payment and remittance advice standards established by health care reform by no later than December 31, 2013. Compliance with other standards, such as the health claims or equivalent encounter standard, is due no later than December 31, 2015.

Effective 2014

- **Exchanges.** Effective January 1, 2014, the state-based insurance exchanges will be created. Although primarily for individuals, small employers with 50 or fewer employees may participate. For years before 2016, a state may limit small employers to those with 100 or fewer employees. Beginning in 2017, states may allow employers of any size to participate.
- **Individual Responsibility.** Effective January 1, 2014, most individuals are required to maintain "minimum essential coverage" or pay a penalty.
- **Employer Responsibility Requirements.** Effective January 1, 2014, employers become subject to a

variety of requirements, including the "Pay or Play" mandate and free choice vouchers. See "Employer Responsibility" below for more detail on the employer responsibility requirements.

- **Fee on Insurance Providers.** Effective January 1, 2014, an annual fee is imposed on health insurance providers. The aggregate amount of the fee in each year on all "covered entities" is set forth in the statute and is allocated among covered entities based on market share. Covered entities subject to the fee generally include any entity that provides health insurance for United States health risks. The fee does not apply with respect to self-insured plans or to administrative fees received by insurers. Insurance that provides coverage described in IRC Section 9832(c) (i.e., coverage only for accident or disability income insurance, or any combination thereof, coverage only for a specified disease or illness, and hospital indemnity or other fixed indemnity insurance), long-term care insurance and Medicare supplemental health insurance are not taken into account for purposes of the fee. Certain tax-exempt entities and VEBAs (other than those established by an employer) are also exempt from the fee.
- **Health Insurance Reforms.** "Phase in" #2 of the health insurance reforms go into effect for plan years beginning on or after January 1, 2014. Such health insurance reforms include but are not limited to a prohibition on exclusions based on preexisting conditions for all enrollees, cost sharing limitations and a requirement to provide essential benefits for fully insured plans in the small group market. See "Health Insurance Reforms" below for more detail regarding the second "phase in" of health insurance reforms.

Effective 2018

- **High Cost Plan "Cadillac" Tax.** Beginning in 2018, the value of coverage in excess of certain thresholds is subject to a 40 percent excise tax. See "High Cost Plan Tax" below for more detail regarding the nuances of the high-cost plan tax.

2. Health Insurance Reforms

As noted previously, health care reform includes several health insurance improvements and reforms, some of which are effective for plan years beginning on or after September 23, 2010, and others that are effective for plan years beginning on or after January 1, 2014. These reforms are added to the "HIPAA portability" subpart of the Public Health Service Act (generally applicable to health insurers and non-federal governmental plans), ERISA and the IRC. Thus, it would appear that such reforms do not apply to benefits that are "excepted benefits" under HIPAA (e.g., stand alone dental or vision, and non-coordinated cancer or hospital indemnity offered pursuant to a separate contract, etc). "Grandfathered" plans are also exempt from some but not all of the requirements. It appears that these health insurance reforms also do not apply to self-insured stand alone retiree health plans, but further clarification is required.

Plans subject to collective bargaining agreements that were ratified prior to March 23, 2010, are not subject to the health insurance reforms until the later of the general effective date or the date the last applicable collective bargaining agreement expires.

We have identified and discuss the health insurance reforms below, and provide a chart that identifies the insurance reforms applicable to "grandfathered" health plans. Provisions that are applicable to grandfathered plans (i.e., applicable to all plans) are denoted with an "NGF" ("no grandfather") designation below.

a. The following health insurance reforms are effective for plan years beginning on or after September 23, 2010.

- **(NGF) Annual and lifetime limits on the dollar value of benefits.** Plans may not impose lifetime limits and only restricted annual limits, as determined by the Secretary, on the dollar value of essential benefits for any participant or beneficiary. For plan years beginning on or after January 1, 2014, group health plans and group health insurers may not impose any annual limits on essential benefits. Otherwise, permissible lifetime or annual limits may be imposed on specified covered benefits that are not essential health benefits.

- **(NGF) Prohibition on rescissions.** Plans may not rescind coverage except in cases of fraud or intentional misrepresentation. This does not appear to prohibit employers from terminating group health plans.

- **Coverage of preventive care.** Plans must provide first dollar coverage (i.e., no cost sharing) for certain evidence-based preventive care, including well childcare and certain immunizations.

- **(NGF) Coverage of adult children.** Plans that cover dependent children must provide for coverage of children until age 27. There is no requirement to cover children of covered dependent children, and the requirement is applicable even if the child is married or is not a tax dependent. Until January 1, 2014, grandfathered plans do not have to extend coverage if the child is eligible for other employer coverage.

- **Nondiscrimination rules for insured plans.** The nondiscrimination rules of IRC Section 105(h) previously applicable only to self-insured health plans are extended to fully insured group health plans.

- **(NGF) Preexisting condition exclusions.** With respect to enrollees under age 19, plans may not impose a preexisting condition exclusion or limitation.

- **(NGF) Cost reporting and rebate requirements.** A health insurance issuer that insures group health coverage must submit to the Secretary a report relating to loss ratios. Rebates to enrollees must be provided if the medical loss ratio is 85 percent (80 percent in the small group market) or such higher amount as permitted under State law. These requirements do not apply to self-insured plans.

- **Claims procedures.** Plans must establish an internal claims appeals process that:

  i. provides notice in a culturally and linguistically appropriate manner of the review process and availability of any applicable health insurance ombudsman created by a state to assist claimants with appeals;

  ii. allows claimants to review the entire claim file and present evidence;

  iii. allows claimants to continue receiving coverage during the appeals process; and

  iv. complies with the claims review procedures set forth in Department of Labor (DOL) regulations that apply to plans covered by ERISA.

  Plans must also establish an external review process that complies with applicable state law and that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act developed by the National Association of Insurance Commissioners (NAIC) or, in the case of self-insured plans, meets similar requirements as provided by the Secretary. The Secretary may deem the existing external review process of a group health plan to be in compliance with the provisions of health care reform.

- **Patient protections.** Plans that require or provide for a designation of a primary care provider must permit each participant to designate any participating primary care provider who is available to accept such individual. Health care reform also requires plans to comply with requirements regarding access to emergency services and obstetrical and gynecological care, and to allow designation of a pediatrician as a primary care provider for children.

- **Transparency requirements.** Group health plans and health issuers in the group market are subject to the same transparency requirements applicable to plans offered in the state exchanges. Under these requirements, such plans and issuers must provide to the Secretary, the applicable state insurance commissioner and the public the following information: claims payment policies and data, financial disclosures, enrollment (and disenrollment) data, data on rating policies, information on cost sharing and payments with respect to out-of-network coverage, information on participant rights and other information as determined by the Secretary.

- **Ensuring quality of care.** Plans must annually report to HHS and to enrollees (during each open enrollment period) regarding benefits under the plan that improve health, such as case management, disease management and wellness and health promotion activities. (HHS is to develop the reporting standards within two years of March 23, 2010).

- **(NGF) Uniform explanation of coverage.** The plan administrator (in the case of a self-insured plan) or the insurer (in the case of a fully insured plan) must prepare and distribute a paper or electronic Summary of Coverage to all applicants and all enrollees, both at the time of initial enrollment and at annual enrollment. This is in addition to the Summary Plan Description otherwise required by ERISA. The Summary must satisfy certain uniform standards developed by the Secretary. HHS is directed to establish the standards within 12 months of March 23, 2010, and the summary must be provided within 24 months after that date. In addition, the plan or the issuer (as applicable) must notify enrollees of material changes to the coverage reflected in the most recent summary no less than 60 days in advance of the effective date of such coverage. Failure to comply may result in a $1,000 penalty for each failure. N.B. This rule is effective for grandfathered plans beginning with plan years beginning on or after the date of enactment. Nevertheless, it does not appear as though the rule will have a practical effect until after HHS develops the reporting criteria.

B. The following health insurance reforms are effective for plan years beginning on or after January 1, 2014.

- **(NGF) Prohibition on preexisting exclusion limitations.** No preexisting condition exclusions or limitations are permitted for any enrollee regardless of age.
- **Fair health insurance premiums.** Health care reform identifies the factors that determine premium rate variances for coverage insured by health insurers in the small group market. For example, premiums may vary only by (i) individual or family coverage; (ii) rating area (as described in health care reform); (iii) age, except the rate may not vary by more than 3 to 1 for adults; (iv) tobacco cessation, except that the rate may not vary by more than 1.5 to 1.
- **Guaranteed availability of coverage.** Every health insurance issuer in the individual or group market in a state must generally accept every small employer and every individual in the state who applies for such coverage.
- **Guaranteed renewability of coverage.** Every health insurance issuer in the individual or group market must renew each employer and individual's coverage (as applicable) upon request.
- **No discrimination based on health status.** Essentially, the same rules that currently exist under the Health Insurance Portability and Accountability Act (HIPAA) are included in health care reform. Health care reform does however raise the maximum incentive amount for wellness programs that provide the incentive based on achieving a health standard from 20 to 30 percent of the COBRA cost of coverage for those participating in the program (and allows the Secretaries of DOL, HHS and Treasury leeway to increase the percentage to 50 percent).
- **Prohibition on discrimination against providers.** No discrimination against a provider who is acting within the scope of his or her license is permitted. <u>This does not mean, however, that a health plan must contract with any willing provider.</u>
- **Cost-sharing limitations.** Certain cost-sharing requirements must be satisfied so out-of-pocket (OOP) expenses do not exceed the amount applicable to HSA-related coverage, and deductibles do not exceed $2,000 for single coverage and $4,000 for family coverage (as indexed). Although unclear, there is some language that suggests the limit on deductibles only applies to fully insured plans in the small group market (100 employees or fewer).
- **Requirement to provide essential benefits.** Fully insured plans in the small group market (100 or fewer employees) must provide the "essential benefits" required to be offered by insurers in the exchange.
- **(NGF) Limitation on waiting periods.** Plans may not impose a waiting period in excess of 90 days.
- **Participation in clinical trials.** A plan may not prohibit qualifying individuals from participating in certain clinical trials or deny the coverage of routine patient costs for items and services furnished in connection

with the clinical trial.

What is a grandfathered plan?

Under health care reform, group health plans in effect on the date of enactment are exempt from many of the health care reforms. The grandfather rule is not limited to individuals enrolled on the date of enactment, but rather new employees (and their families) may be covered under an employer's grandfathered plan and family members of current employees who are covered by the grandfathered plan may also be added. Current employees without coverage, has not been expressly addressed in the legislation.

The most significant outstanding issue surrounding grandfathered plan status is whether changes made to the plan in the future will terminate the plan's "grandfather status". Given the language in the legislation, it is not clear whether plan changes in the future will jeopardize the grandfathered status of a plan. That issue will need to be addressed by regulations.

The following chart identifies which insurance reforms apply to grandfathered plans.

Insurance Reform	Effective Date	NGF – Applies to Grandfathered Plans
Prohibition on lifetime limits	First plan year beginning on or after September 23, 2010	Yes
Prohibition on lifetime limits	First plan year beginning on or after September 23, 2010	Yes
Restricted annual limits	First plan year beginning on or after September 23, 2010	Yes
Prohibition on preexisting condition exclusion for enrollees under age 19	First plan year beginning on or after September 23, 2010	Yes
Prohibition on rescissions	First plan year beginning on or after September 23, 2010	Yes
Coverage of preventive care	First plan year beginning on or after September 23, 2010	No
Coverage of adult children	First plan year beginning on or after September 23, 2010; for group plans, coverage required before 2014 only if the child is not eligible for other employer coverage	Yes
Nondiscrimination rules for insured plans	First plan year beginning on or after September 23, 2010	No
Cost reporting and rebate requirements	First plan year beginning on or after September 23, 2010	Yes
Claims appeal procedures	First plan year beginning on or after September 23, 2010	No
Transparency requirements	First plan year beginning on or after September 23, 2010*	No

Insurance Reform	Effective Date	NGF – Applies to Grandfathered Plans
Ensuring quality of care	First plan year beginning on or after September 23, 2010*	No
Uniform explanation of coverage	First plan year beginning on or after September 23, 2010*	Yes
Prohibition on preexisting condition exclusions	First plan year beginning on or after January 1, 2014	Yes
Prohibition on annual limits	First plan year beginning on or after January 1, 2014	Yes
Fair health insurance premiums	First plan year beginning on or after January 1, 2014	No
Non-discrimination based on health status	First plan year beginning on or after January 1, 2014	No**
Prohibition on discrimination against providers	First plan year beginning on or after January 1, 2014	No
Cost sharing limitations	First plan year beginning on or after January 1, 2014	No
Requirement to provide essential benefits	First plan year beginning on or after January 1, 2014	No
Limitation on waiting periods	First plan year beginning on or after January 1, 2014	Yes
Participation in clinical trials	First plan year beginning on or after January 1, 2014	No

* Requirements contingent on guidance from HHS, which is not expected until a later date.

** Although not subject to the new health insurance reform added by health care reform, grandfathered plans would presumably still be subject to the existing requirements under HIPAA that currently prohibit such discrimination for group health plans.

3. Employer Responsibility

Effective for months beginning on or after January 1, 2014 (except as noted below), employers must satisfy several requirements related to group health plan coverage.

- **Automatic Enrollment.** Subject to regulations to be issued by the DOL, large employers with 200 or more full-time employees that offer at least one health plan benefit option must automatically enroll all new employees in a benefit option and continue the enrollment of current employees in a health benefit plan offered by the employer. The auto-enrollment program should include adequate notice and the opportunity for an employee to opt out of the "auto" coverage and elect another option, or opt out altogether. N.B. The auto-enrollment requirement will be effective as of the date set forth in the regulations, and applies to large employers subject to the Fair Labor Standards Act.

- **Pay or Play Mandate.** Notwithstanding the obligation to comply with the reform requirements identified above, there is generally no requirement for employers to offer the same coverage that insurers offering coverage in the exchanges must offer. In fact, there is generally no requirement for employers to offer any coverage. However, employers with 50 or more full-time employees (Applicable Large Employers) are subject to penalties related to coverage that they offer or fail to offer to full-time employees (and their dependents).

  An *Applicable Large Employer* is defined as an employer (and any other employer within the same controlled group) who employed on average at least 50 full-time employees on business days during the preceding year. However, an employer is not considered to be an Applicable Large Employer if the employer did not employ more than 50 full-time employees for more than 120 days during the preceding year. A "*full-time employee*" is defined as an employee who is employed on average at least 30 hours of service per week. An employer who would be an Applicable Large Employer based solely on "seasonal employees" (employees who work fewer than 120 days) is not considered to be an Applicable Large Employer. N.B. Although not clear, it appears that seasonal employees are relevant only to the Applicable Large Employer determination. If the employer is an Applicable Large Employer without regard to the employer's seasonal employees, it would appear that failure to offer coverage to such employees could trigger a penalty. Part-time employees are taken into account solely for the purpose of determining if an employer is an applicable large employer. The number of full-time employees otherwise determined is increased by dividing the aggregate number of hours of service of employees who are not full-time by 120.

  - **Failure to offer minimum essential coverage to full-time employees.** Applicable Large Employers who fail to offer any full-time employees "minimum essential coverage" must pay a penalty with respect to each full-time employee in any month in which any employee enrolls in and receives a subsidy for an exchange. The penalty is determined on a monthly basis and is the product of the total number of full-time employees of the employer for that month (including those employees who did not receive a subsidy for the exchange) and 1/12 of $2,000. The first 30 employees are disregarded for calculating the penalty. Thus, for example, a business with 51 employees that does not offer coverage is subject to a tax equal to 21 times the applicable payment amount.

  - **Offering unaffordable coverage to full-time employees.** Applicable Large Employers offering "minimum essential coverage" for any month to a full-time employee who is certified as having enrolled in an exchange and received a tax subsidy are subject to a penalty equal to the product of the total number of such employees (i.e., employees receiving the credit) and 1/12 of $3,000. The amount of the tax in this instance is limited to 1/12 of $2,000 multiplied by the total number of the employer's full-time employees. An employee who is offered minimum essential coverage is not eligible for the subsidy unless the employee's required premium for the coverage exceeds 9.5 percent of the individual's household income or the plan's share of allowed costs under the plan is less than 60 percent of the plan's benefit cost (presumably 60% of the COBRA cost of the plan, less the 2 percent administrative fee).

"Minimum essential coverage" is defined in new IRC Section 5000A (as added by health care reform) as an "eligible employer sponsored plan" or a "grandfathered plan." It appears that any group health plan coverage offered by an employer (other than excepted benefits) will qualify as minimum essential coverage for purposes of the pay or play rules to the extent it complies with the applicable health insurance reforms mentioned above.

- **Reporting Requirements.** Applicable Large Employers must also report to the Secretary of Treasury each year, certifying:
  - – whether coverage is offered to full-time employees;
  - – the waiting period for any such coverage;
  - – the number of full-time employees of the employer during each month; and
  - – the name, address and Taxpayer Identification Number (TIN) of each full-time employee and the months during which they were covered under the plan.
- **"Free choice vouchers."** Employers that offer minimum essential coverage and make a contribution must offer "free choice vouchers" to qualified employees for the purchase of qualified health plans through the exchanges. The free choice voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their household income does not exceed 400 percent of the federal poverty level, and the required contribution under the employer's plan would be between 8 and 9.8 percent of their household income. Free choice vouchers are excludible from employees' incomes and deductible by the employer, and voucher recipients are not eligible for tax subsidies through the exchange. Although HCERA revised the minimum threshold percentage to qualify for a subsidy for the exchange to 9.5 percent, and this same percentage should likely be the maximum percentage to qualify for a free choice voucher, HCERA did not change the maximum percentage specifically identified in the free choice voucher section. This appears to have been an oversight.

4. High-Cost Plan "Cadillac" Tax

Beginning in 2018, a nondeductible 40-percent excise tax imposed on the monthly value of high-cost coverage in excess of 1/12 of $10,200 for single coverage and 1/12 of $27,500 for family coverage. The annual limit for retirees between ages 55 and 64, individuals engaged in certain high-risk professions (e.g., law enforcement professionals, emergency medical technicians, construction workers, miners) and those employed to install electrical or telecommunication lines is increased to $11,850 for individual coverage and $30,950 for family coverage.

These amounts will be adjusted automatically if health costs increase by more than anticipated before 2018. The thresholds are increased by CPI-U + 1 in 2019, and by CPI-U thereafter. An employer may make an adjustment to reduce the cost of plans when calculating the tax if the employer's age and gender demographics are not representative of a national average. Additionally, the higher family threshold applies to both single and family coverage offered under a multiemployer plan.

"Coverage providers" are defined to include the following organizations:

- in the case of fully insured plans, the health insurer;
- in the case of HSA or medical savings accounts (MSA) contributions, the employer making the contributions; and
- in the case of a self-insured plan, the person who administers the plan (e.g., the third-party administrator).

In many cases, employer-sponsored coverage will include both fully insured and self-insured contributions (and

may also include HSA contributions). The coverage provider's applicable share of the tax will bear the same ratio to the total excess benefit as the cost of the coverage provider's coverage to the total value of employer-sponsored coverage. Although the coverage provider is responsible for paying the tax, the employer must calculate the tax, including each coverage provider's applicable share, and notify each coverage provider.

The coverage subject to this rule includes the following:

- The applicable premium (determined in accordance with COBRA rules) for all accident and health coverage provided by the employer, even if paid for with after-tax dollars by the employee. The value of certain excepted benefits (as defined by HIPAA) are not included, such as (i) non-integrated dental or vision, (ii) long-term care insurance, (iii) any coverage identified in IRC 9832(c)(1) other than onsite health care, (iv) hospital indemnity and/or specified disease coverage that is paid for with after-tax dollars—even if a group plan;
- Both non-elective and salary reduction contributions to a health flexible spending arrangement (FSA); and
- Employer contributions to an HRA and HSA (presumably including salary reductions to an HSA).

In addition, employers must include the value of all such coverage on the employee's Form W-2. The W-2 reporting requirement applies for all tax years beginning on or after January 1, 2011.

If you would like to receive future Executive Summaries regarding employee benefit related matters electronically, please forward your contact information including e-mail address to Info@BushnellCompany.com

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