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THE AFFORDABLE CARE ACT AT 2½— WHAT EMPLOYERS SHOULD EXPECT NOW

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I. INTRODUCTION

Almost two and a half years have passed since President Obama signed into law the Patient Protection and Affordable Care Act ("PPACA"; P.L. 111–148, 124 Stat. 119), and its companion amendment, the Health Care and Education Reconciliation Act of 2010 ("HCERA"; P.L. 111-152, 124 Stat. 1029), (collectively, the "Affordable Care Act" or "ACA"). The ACA makes a remarkable number of changes to the U.S. health care system, many of which directly affect employers in their role as sponsors of group health plans offered to current and former employees, and their dependents. The ACA also altered many other facets of the U.S. health care delivery and payment system, such as Medicare, Medicaid, and community health services.

Shortly after the ACA was enacted, various legal actions were filed challenging its constitutionality, focusing largely on the individual mandate and the statute's expansion of Medicaid coverage. These key issues were finally decided in the Supreme Court's controversial *National Federation of Independent Business* decision.[1] Additional legal challenges continue to be filed, but it is not expected they will be finally determined any time soon, or that their potential impact will be significant to the ACA overall.

Thus, in the absence of a major political shift in this November's elections, the ACA would appear to be here to stay. A good portion of the law gets implemented in 2014, and it is important for employers to understand the forthcoming rules and how they will affect their providing health benefits to current and former employees. This White Paper discusses them. To be sure, significant pieces of the reform architecture were left to the Departments of Treasury, Labor ("DOL"), and Health and Human Services ("HHS") to frame out in regulations and new disclosure forms, and a good deal of it has yet to be determined. Furthermore, presidential politics suggest that much of the needed regulatory pieces will not be issued until after the November election. Nonetheless, even with the current structural deficits, it is still sensible for employers to take stock of the ACA after two and a half years in operation, and to consider how to navigate its likely new rules in 2014.

1 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, Nos. 11-393, 11-398, 11-400 (U.S. June 28, 2012).

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II. THE LEGISLATIVE ELEMENTS DESIGNED TO INCREASE THE NUMBER OF INSURED AMERICANS

Perhaps the most important legislative purposes of the ACA are to increase the number of Americans with health insurance, and to ensure that such health insurance satisfies certain minimum thresholds of coverage. The ACA does so, effective January 1, 2014, by: (i) requiring most Americans to purchase health insurance coverage or pay what the ACA calls a "penalty," which the Supreme Court deemed to be a tax (the "Individual Mandate"), (ii) prohibiting insurance companies from denying coverage to those with preexisting conditions or health issues (i.e., guaranteed issue), (iii) prohibiting insurance companies from charging unhealthy individuals higher premiums than healthy individuals (i.e., community rating), and (iv) providing avenues for Americans to acquire health insurance that provides a minimum basic level of coverage. The avenues for acquiring coverage are: (i) for persons age 65 or over or disabled, through Medicare, (ii) for persons whose income is under 133 percent of the federal poverty line,[2] through Medicaid,[3] (iii) for individuals and small businesses by purchasing insured coverage through "American Health Benefit Exchanges" ("Exchanges"), and (iv) for "full-time" employees of "Large Employers" (i.e., generally employers with 50 or more employees) through their employer, to the extent their employer elects to "play" under the Large Employer mandates. Many individuals will be eligible for coverage under more than one of these avenues and will be able to choose what is the best value for them. In addition, individual and group health insurance will still be available outside of the Exchanges.

In order to help individuals purchase coverage, premium tax credits and cost-sharing subsidies will be available through Exchanges to persons with incomes below certain levels. These are discussed in more detail in Section II.E.2. below. In addition, certain small businesses that provide health coverage will be entitled to a small business tax credit, as discussed in Section V.C.

These new rules provide a crucial context to the many other rules that directly affect employers.

A. THE INDIVIDUAL MANDATE

Under the ACA, most Americans will be required to purchase health insurance coverage or pay a tax for each month for which they do not have minimum coverage. (Code § 5000A(b)). A taxpayer will be liable for the tax with respect to himself or herself, as well as with respect to his or her tax dependents, to the extent any of them are required, but fail, to obtain health insurance. The tax must be included with the taxpayer's annual income tax return.

The annual tax (which is prorated for each month a person is without coverage) equals the greater of (i) a "flat dollar amount" and (ii) a percentage of the taxpayer's household income in excess of that year's filing threshold (the filing threshold is the total of the standard deduction plus the personal exemptions; for the 2011 tax year, for example, a married couple with no dependents would have a filing threshold of $19,000). The annual flat dollar amount is $95 in 2014, $325 in 2015, and $695 in 2016, with the amount being indexed for inflation thereafter. While the flat dollar amount is multiplied by the number of people in the household who do not have coverage, the number of people counted is capped at three. In addition, the flat dollar amount for individuals who are under 18 is one-half of the amounts listed above. The percentage also phases in and is 1.0 percent in 2014, 2.0 percent in 2015, and 2.5 percent thereafter. (Code § 5000A(c)(2),(3)). The annual tax due from a taxpayer is capped by the national average premium for bronze level coverage (as defined in Section II.E.1. below) for the taxpayer's family size that is offered through Exchanges for the applicable tax year.

Certain individuals will not have to pay the tax. (Code § 5000A(e)). These include (i) individuals whose required contribution for self-only coverage through an employer-sponsored plan or whose required contribution, reduced by any premium tax credit, for bronze level coverage through an Exchange (as described in Section II.E. below) exceeds

2 The federal poverty line is set annually by HHS and varies by geographic location and household size. By way of example, the federal poverty line for 2012 for an individual living in the continental United States is $11,170; for a family of four, it is $23,050. The federal poverty line for individuals living in Alaska or Hawaii is slightly higher.

3 This avenue of coverage may not be available in all states, as discussed in more detail in Section II.D. below.

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8 percent (which percentage will be adjusted annually for premium inflation relative to income inflation) of his or her household income; (ii) individuals whose annual gross income is below the filing threshold (as defined in the immediately preceding paragraph); (iii) individuals who are members of an Indian tribe; and (iv) any individual who HHS determines has suffered a hardship. In addition, the penalty will not apply for the months in a gap in coverage of less than three months, provided this exception only applies once per calendar year.

While the tax is required to be paid in connection with the taxpayer's annual income tax return, the IRS is limited in its collection methods. (Code § 5000A(g)). The IRS may collect payment by sending an assessment or by automatically offsetting any refunds by the amounts of the tax owed. However, the ACA prohibits the IRS from filing any liens or levies to collect this unpaid tax and does not impose criminal fines or penalties for failure to pay this tax. (Code § 5000A(g)(2)).

B. GUARANTEED ISSUE

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), added provisions to the Public Health Service Act ("PHSA") requiring that insured coverage be available to certain individuals in every state, with no preexisting condition limitations. (PHSA § 2741). These individuals are ones that have at least 18 months of "creditable coverage," with the most recent prior "creditable coverage" being provided by an employer-sponsored group health plan. States have flexibility in how this coverage is provided, whether through private insurers or through a state-run high risk pool. There are, however, no limitations on the premiums for this coverage.

In addition, HIPAA requires that group health insurance for small groups (employers with two to 50 employees) be provided on a guaranteed issue basis. (PHSA § 2711). Some state insurance laws currently require broader guaranteed issue than that described above.

The ACA expands the guaranteed issue requirements under the PHSA. Specifically, for policy years beginning on or after January 1, 2014, with respect to nongrandfathered plans (as defined in Section IV.A.4. below), health insurance issuers are required to issue coverage to every employer and individual who applies for coverage. (PHSA § 2702). Enrollment may be restricted to certain open or special enrollment periods. However, the special enrollment periods must include events that are qualifying events for COBRA continuation coverage. In other words, an individual must be able to enroll in insured coverage at any time that they would be eligible for COBRA coverage. As discussed in Section IV.B.2. below, this coverage must be provided with no preexisting condition limitations.

Health insurance, whether sold through an Exchange (as described below) or sold outside the Exchange, is subject to the guaranteed issue requirement. There has been much speculation about whether the combination of guaranteed issue, the community rating requirement discussed in Section II.C. below, and the amount of the tax for not having coverage relative to the amount of likely premiums for obtaining coverage may cause many healthy people to choose the less expensive route of foregoing coverage and paying the tax. Yet such speculation fails to take into account the risk of not having coverage if one suddenly falls ill or is in an accident. We do not yet know the full parameters of any enrollment or waiting periods that may apply with respect to guaranteed issue coverage. However, it is questionable whether coverage would be issued on a retroactive basis to persons who had previously not had coverage. As such, an unexpected illness or injury may result in uninsured costs for obtaining treatment prior to the effective date of guaranteed coverage. Therefore, at least risk-averse individuals who can afford coverage will likely purchase it—if only to manage for the potential risk of expenses immediately following an unforeseen medical emergency.[4]

C. COMMUNITY RATING

In addition to the guaranteed issue requirement, the ACA sets community rating limits on insurance premiums, effective for policy years beginning on or after January 1, 2014. (PHSA § 2701). As with the guaranteed issue requirement, this requirement does not apply to grandfathered coverage. In addition, this requirement does not apply to large group

4 This appears to be the experience in Massachusetts relating to its Exchange. Under applicable Massachusetts law, the penalty for failing to obtain coverage is slightly less than the cost of a so-called "bronze" policy, and more than 94 percent of non-Medicare eligible adults now have health insurance. *Massachusetts Health Care Reform: Six Years Later*, Kaiser Family Foundation Focus on Health Reform (May 2012).

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(employers with more than 100 employees) coverage, unless that coverage is offered through an Exchange.

The community rating requirement places limits on the differences in rates that an insurer can set for the same coverage. Rates may only vary based on: (i) whether coverage is for an individual or a family, (ii) geographic location, (iii) age, and (iv) tobacco use. Rates may not vary for any other reason, including the health of the individual or group members. The geographic locations for which rates may vary will be set on a state-by-state basis, with at least one geographic location in each state. With respect to variations based on age, the variation may not be more than 3 to 1 for adults. In other words, the highest premium differential based on age may not be more than three times the lowest one. In addition, guidance will be issued defining the permissible age bands for rating purposes. Likewise, for variations based on tobacco use, the variation may not be more than 1.5 to 1. Until further guidance is issued, it will not be clear how this limitation on variations based on tobacco use will integrate with wellness program rewards (as discussed below at Section IV.F.1.) related to tobacco use. For family coverage, the permitted variations based on age and tobacco use must be applied based on the portion of the premium attributable to the applicable family member(s).

D. MEDICAID EXPANSION

Medicaid, first enacted in 1965, is a partnership between the federal government and the various states to provide health coverage to certain low-income individuals. States that participate in the Medicaid program receive federal dollars as long as the state's Medicaid program meets certain requirements. Because these requirements give a great deal of flexibility to states, eligibility for Medicaid coverage varies greatly from state to state. In general, Medicaid coverage is currently available to: (i) pregnant women and children under age 6 with family incomes at or below 133 percent of the federal poverty line (as defined at footnote 2 above), (ii) children age 6 through 18 with family incomes at or below 100 percent of the federal poverty line, (iii) parents and child caretaker relatives who meet certain financial eligibility requirements, and (iv) elderly and disabled individuals who qualify for Supplemental Security Income benefits based on low income and resources. Some states have additional eligibility categories; however, coverage is generally not available for childless adults.

The ACA includes provisions to expand the Medicaid program to cover all individuals under age 65 with incomes below 133 percent of the federal poverty line. (42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). This Medicaid expansion is estimated to result in 16 million to 22 million additional individuals enrolling in Medicaid coverage nationwide.[5] Individuals who are eligible for Medicaid under this new category must receive a benefit package that meets certain minimum coverage requirements. Initially, the federal government will pay 100 percent of the costs of medical coverage for these newly eligible individuals. However, beginning in 2017, the federal payment will decrease over four years, to a permanent (at least under current law) minimum of 90 percent beginning in 2020.

The ACA further provides that if a state does not elect to participate in this Medicaid expansion, it will not receive either the additional federal dollars earmarked for the expansion or any other federal dollars related to the Medicaid program. In other words, the ACA provided states with a choice of agreeing to the expansion or losing all of their federal Medicaid funding. This was of great concern to several state governments because, even though the federal contribution for the Medicaid expansion would be substantial, it would decrease from 100 percent of the cost of coverage to 90 percent by 2020, leaving states with the obligation to pay for 10 percent of the expanded coverage, and the additional cost burden of increasing their respective Medicaid regulatory agencies so as to administer the significant expansion in the Medicaid rolls. For many states, the Medicaid expansion will involve the addition of a huge number of people to coverage. For example, Texas' Medicaid rolls are estimated to increase by at least 1,798,314, Florida's by at least 951,622, and California's by at least 2,008,796.[6] Ten percent of the cost of coverage of this volume of new enrollees is not insignificant.

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5 John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, 12-13 (May 2010).

6 *Id.*

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In *National Federation of Independent Business*, the Supreme Court addressed a challenge by 26 states to these Medicaid expansion provisions. The states asserted that the ACA's provision to eliminate all federal Medicaid funding if a state opted not to expand Medicaid eligibility was so onerous as to be "coercive," making that condition on funds an unconstitutional exercise of federal power beyond the scope of the Spending Clause. The Court agreed 7–2. Although there was no opinion for the Court, the Court's judgment was that the constitutional violation could be remedied by limiting the power of the Secretary of HHS to withhold Medicaid funds to just withholding the new Medicaid funds from states that do not participate in the Medicaid expansion, rather than withholding all Medicaid funds from such states.

In essence, the Supreme Court's decision means that the Medicaid expansion is optional for the states. A number of states have indicated that they will not participate in the Medicaid expansion for the reasons described above. However, because the Medicaid expansion is not effective until 2014, it remains to be seen whether a compromise will be reached. To the extent that states do not elect to participate in the Medicaid expansion, the ACA's public policy objective of near universal health coverage will not be achieved. Further, many hospitals located in states that do not participate in the Medicaid expansion, yet serve substantial numbers of individuals near the federal poverty line, will be harmed by the loss of Medicaid revenue.

If a state does not participate in the Medicaid expansion, the number of individuals in that state who take advantage of the premium tax credits to acquire coverage on an Exchange may increase significantly. Were a state to elect not to expand Medicaid as described in the ACA, individuals in such state whose household income is greater than 100 percent but less than 133 percent of the federal poverty line would be eligible for premium tax credit assistance if they acquire an Exchange-provided insurance policy. (*See* discussion below at II.E.) Because an employer's liability for the Large Employer mandates (and related penalties) is contingent on a full-time employee accepting a premium tax credit, the increase in the working poor obtaining the premium tax credit could increase the potential tax liability for employers that opt out of providing group health insurance. (*See* discussion below at III.A. and B.) Employers with lower-paid workers in states that do not participate in the Medicaid expansion will want to pay careful attention to the potential for Large Employer mandate penalties.

E. INSURANCE EXCHANGES

The ACA requires each state to create and operate an Exchange where individuals and small employers can purchase health insurance coverage. (PPACA § 1311(b)). The guidance refers to the Exchange for small employers as the SHOP ("Small Business Health Options Program") Exchange. States can choose to have separate Exchanges for these two different categories or combine them in one Exchange. In addition, states can choose to enter into a partnership with HHS, where the Exchange is partially run by the state and partially run by HHS. If a state fails to create and have operational an Exchange by January 1, 2014, or to comply with HHS regulations respecting the design of the Exchanges, the ACA requires HHS to establish and operate an Exchange for such state. These are known as "federally facilitated exchanges" ("FFEs"). In this regard, states are required to submit a blueprint to HHS documenting their plan for establishing an Exchange no later than November 16, 2012 for the 2014 plan year. HHS must approve or conditionally approve state-based Exchanges no later than January 1, 2013. If a state does not have a state-run Exchange for the 2014 plan year, it has the opportunity to assume all or part of the Exchange functions in future years through a similar application process with HHS.

For purposes of the SHOP Exchange, a "small employer" is an employer that employed no more than 100 employees on average during the prior calendar year. (PPACA § 1304(b)(2)). However, for plan years beginning before January 1, 2016, states can elect to substitute a 50-employee limit for the 100-employee limit. In addition, beginning in 2017, states may choose whether to allow employers with more than 100 employees to offer coverage for their employees through an Exchange. Participation by individuals and employers in coverage through an Exchange will be completely voluntary, and employers may continue to offer (and individuals to accept) coverage through non-Exchange health insurance arrangements.

It is not yet clear how many states will establish Exchanges on their own. All states, except Alaska, have received initial Exchange planning grants from the federal government. The majority of states have also received additional grant money

to help them establish an Exchange. However, even those states may not have moved far enough along by the deadline for HHS approval in order to have a state-established Exchange in 2014.

1. Qualified Health Plans

In order to ensure that the health insurance offered through an Exchange satisfies a minimum threshold of coverage, a "health plan" offered through an Exchange must be certified by the Exchange, pursuant to HHS regulations, as a "qualified health plan." (PPACA § 1311(c)-(e)). For these purposes, a "health plan" needs to be offered by a licensed insurer; it cannot be a self-insured plan sponsored by an employer or a Taft-Hartley plan and exempt from state regulation under ERISA's preemption rules. (PPACA § 1301(b)(1)). In addition, a "qualified health plan" will need to satisfy three categories of requirements.

First, it will need to provide coverage that includes "essential health benefits." In general, essential health benefits will include coverage for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse care, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, and pediatric care (including pediatric oral and vision care). (PPACA § 1302(b)). HHS has adopted an approach that would let each state choose from a number of "benchmark" plans in order to define in more detail what constitutes essential health benefits for insured coverage (both individual and small group) issued in that state. States could choose a "benchmark" plan from among the following health insurance plans: the largest insured plan by enrollment in any of the three largest small group insurance products in the state's small group market, any of the largest three employee health benefit plans for state employees by enrollment, any of the largest three national FEHBP (Federal Employees Health Benefits Program) plan options by enrollment, or the largest insured commercial non-Medicaid HMO operating in the state.

Second, a health plan must also satisfy limits on cost-sharing and deductibles. (PPACA § 1302(c)). Specifically, the annual cost-sharing—i.e., the sum of the annual deductible, coinsurance, and copayments—for a health plan cannot exceed the limits applicable to a so-called high deductible plan under Code section 223(c)(2)(A)(ii) for the 2014 tax year, with such amount being adjusted annually thereafter. By way of reference, the limits in place for 2012 are $6,050 for self-only coverage and $12,100 for multiperson coverage. In addition, the deductible cannot exceed $2,000 for self-only coverage and $4,000 for multiperson coverage (with such limits allowed to be increased by amounts "readily available" for reimbursement under a flexible spending account). Such amounts will be adjusted for inflation annually after 2014.

Third, the level of coverage that a "qualified health plan" must provide needs to satisfy one of five actuarial thresholds: (i) "platinum level" (providing coverage equal to 90 percent of actuarial value), (ii) "gold level" (providing coverage equal to 80 percent of actuarial value), (iii) "silver level" (providing coverage equal to 70 percent of actuarial value, (iv) "bronze level" (providing coverage equal to 60 percent of actuarial value), or (v) catastrophic. (PPACA § 1302(d), (e)). The catastrophic plan coverage level is available only to persons under the age of 30 (at the beginning of the plan year) or those otherwise exempt from the individual mandate tax due to the fact that they cannot afford coverage or suffered a hardship.

2. Premium Tax Credits and Cost-Sharing Subsidies

In order to help individuals purchase coverage, premium tax credits and cost-sharing subsidies will be available through Exchanges to persons with incomes below certain levels (Code § 36B (premium tax credit); PPACA § 1402 (cost-sharing subsidy)). These subsidies are available at least in Exchanges run by a state.[7] As discussed further below in Part III.C., there is a substantial question whether they are properly available in Exchanges run by the federal government.

Premium tax credits are available to individuals with household income of at least 100 percent but not more than 400 percent of the federal poverty line (as defined at footnote 2 above) and to resident aliens with household income of less than 100 percent of the federal poverty line. In order to qualify for the credit, spouses must file a joint return.

7 The ACA provides that the credit is available for any month in which the individual, the individual's spouse, or the individual's dependents were enrolled in a qualified health plan "through an Exchange established by the State under [PPACA section] 1311." (Code § 36B(b)(2)(A)). The Department of Treasury has taken the position that the premium tax credit will be available with respect to any coverage purchased through an Exchange, whether it is established by a state, the federal government, or some combination thereof. *See* T.D. 9590, 77 Fed. Reg. 30377, 30378 (preamble to final regulations).

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Individuals who are claimed as a dependent on another person's tax return are not separately eligible for the credit; persons not lawfully present in the United States are also not eligible for the credit. In addition, the credit is not available for individuals who are enrolled in an employer-sponsored plan or who are eligible for coverage under an employer-sponsored plan that meets the affordability and minimum value requirements described in Section III.B. below. (Code § 36B(c)(2)(B), (C)).

The premium tax credit is determined based on the individual's household income and the premium for the second-lowest-cost "silver level plan" available under the Exchange. The premium tax credit is set so that if an individual selects the second-lowest-cost silver level plan, the individual would pay no more than a certain percentage of his household income for the premium. This percentage starts at 2.0 percent for individuals with a household income up to 133 percent of the federal poverty line and gradually increases to 9.5 percent for individuals with a household income over 300 percent of the federal poverty line. The premium tax credit, while set based on the cost of a silver level plan, may nonetheless be applied toward the premium of any coverage purchased through an Exchange, but cannot, in any event, exceed the actual premium paid. In addition, advance payments can be paid directly to the insurer, with a reconciliation of any overpayment or underpayment being made on the individual's annual income tax return.

If an individual who is eligible for the premium tax credit enrolls in a silver level of coverage through an Exchange, that individual will also be eligible for a reduced out-of-pocket maximum, with the reduction being greater for individuals with a lower household income. (PPACA § 1402). Additional cost-sharing (i.e., deductibles, co-insurance, and copayments) reductions will be provided to individuals with a household income no greater than 250 percent of the federal poverty line.

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III. THE MANDATES FOR LARGE EMPLOYERS

A. "PLAY OR PAY" MANDATE

Effective January 1, 2014, the ACA will generally require all employers who employed an average of at least 50 "full-time equivalent" employees during the prior calendar year (which the ACA defines for this purpose as a "Large Employer") to either offer health insurance coverage constituting "minimum essential coverage" to full-time employees and their dependents[8] or potentially be subject to a tax equal to $2,000 annually ($166.67 per month) for each full-time employee of the employer in excess of 30 employees. (Code § 4980H(a), (c)(1)). For these purposes, an employer is defined by the controlled group rules of Code section 414. The term "minimum essential coverage" does not require the employer to provide certain types of coverage or maintain certain cost-sharing limits, such as would apply to an "essential health benefits" plan eligible for certification by an Exchange as a "qualified health plan." Minimum essential coverage merely needs to be a group health plan (as defined in Section IV.A.1. below) offered by an employer. (Code § 5000A(f) (defining "minimum essential coverage")). That being said, there are numerous requirements that independently apply to such coverage. The ones added by the ACA are described in Section IV below.

The term "full-time employee" is defined as an employee working on average 30 hours or more each week. For determining the number of "full-time equivalent" employees the employer has in a month, the hours of part-time employees for the month are aggregated and divided by 120. (Code § 4980H(c)(2)(E)). An employer will not be subject to the "play or pay" rule if, in the prior year, the employer's workforce exceeded 50 full-time employees for only 120 or fewer days, and the employees in excess of 50 during that maximum 120-day period were seasonal workers. (Code § 4980H(c)(2)(B)). The Department of Treasury has issued preliminary proposals to use a "look back/stability period safe harbor" method to determine who constitutes a full-time employee for these purposes. (IRS Notice 2011-36). These preliminary proposals have also discussed but not yet provided rules for determining full-time status for new employees and employees who move into full-time status mid-year, as well as how the Large Employer mandates will interact with the automatic enrollment requirement and the 90-day limitation on waiting periods (discussed at Sections IV.E.1. and IV.E.3. below).

In order for the $2,000 per full-time employee annual tax to apply, at least one of the employer's full-time employees must enroll in a health plan offered by an Exchange and also qualify for a premium tax credit or cost-sharing subsidy (discussed above at Section II.E.2.). If no full-time employee receives such a credit or subsidy, then the tax does not apply. Because the credits and subsidies are available only to individuals with household incomes less than 400 percent of the federal poverty line, employers who pay relatively high wages to their full-time employees may not be at risk for the "play or pay" tax, even if they don't provide any coverage.

B. AFFORDABILITY AND MINIMUM VALUE MANDATE

In addition to providing "minimum essential coverage," effective January 1, 2014, a Large Employer also is required by the ACA to provide coverage to its full-time employees (defined in the same manner as for the "play or pay" mandate) and their dependents that is "affordable" and provides "minimum value." If a Large Employer does not do so, a tax penalty may apply, as described below.

The affordability and minimum value requirements technically apply only to full-time employees with a household income that is less than 400 percent of the federal poverty line. Coverage is affordable for such employees if the employee's share of the cost of coverage does not exceed 9.5 percent of the employee's household income. Coverage has minimum value for such employees if the plan's share of the actuarial value of covered benefits (i.e., the amount that the plan would pay toward the actuarially projected cost of covered services) is at least 60 percent (i.e., it is at least the actuarial value of "bronze level coverage" under an Exchange). The Department of Treasury has issued a preliminary proposal to use the self-only premium for the lowest-cost coverage and an employee's Form W-2 wages (instead of household income) in determining whether coverage is affordable. (IRS

8 Guidance has not yet been issued defining which dependents must be eligible for coverage.

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Notice 2011-73). In addition, the Department of Treasury has issued preliminary proposals regarding whether coverage has minimum value, including an actuarial value calculator and design-based safe harbors. (IRS Notice 2012-31). As with the "play or pay" mandate, until final guidance is issued, employers will have difficulty designing their benefits for 2014 in a manner that clearly will avoid the tax.

If the employer-offered coverage fails to meet either of these requirements with respect to a full-time employee, and such full-time employee (despite the employer-offered coverage) enrolls in a qualified health plan through an Exchange and is eligible for a premium tax credit or cost-sharing subsidy, the employer would be subject to a tax of $3,000 annually ($250 per month) for each such employee. (Code § 4980H(b)(1)). The total monthly tax on an employer for any such month would, however, be capped at the amount that the employer would otherwise be taxed (as described in Section III.A. above) if it did not offer any health coverage. (Code § 4980H(b)(2)). Note that the $3,000 tax applies only with respect to full-time employees. Part-time employees who are eligible to enroll in the employer's plan and who eschew coverage and opt to enroll in an Exchange plan will not be aggregated and counted for purposes of calculating the $3,000 annual tax.

C. QUESTIONABLE APPLICABILITY OF MANDATES IN STATES WITH FEDERALLY RUN EXCHANGES

As mentioned above at footnote 7, the language in Code section 36B would seem to indicate that premium tax credits are available only for coverage purchased through Exchanges established by states and not through federally facilitated Exchanges. Because the trigger for the imposition of the tax under both of the mandates for Large Employers described above is that at least one of its employees receives a premium tax credit or subsidy, this raises the question of whether such a tax can be imposed on a Large Employer in those states in which the federal government imposes a federally facilitated Exchange or runs an Exchange in partnership with the state. To wit, there is an argument that in any state in which a federally facilitated Exchange or partially federally run Exchange operates, the premium tax credit is unavailable. If such tax credit is unavailable, then a legal requisite for imposition of these taxes will never be satisfied, thus freeing employers to eschew providing minimum essential coverage or coverage that meets the affordability and minimum value thresholds without imposition of a tax. Indeed, the operative language in Code section 36B is that premium tax credits are available for coverage "through Exchanges *established by the State* under [section] 1311 [of the ACA]," (emphasis added), and section 1311, in turn, addresses only state creation of Exchanges and does not include the rules governing federally facilitated Exchanges or partially federally run Exchanges. Thus, there appears to be at least a plain-meaning-based argument that in such states, the premium tax credit is unavailable. To be sure, the Treasury Department has determined that premium tax credits will be available irrespective of what entity establishes the Exchange, and a court could grant deference to the Treasury Department's interpretation. Nonetheless, the issues of whether premium tax credits are available in a state that eschews creating its own Exchange, and whether the employer tax can be lawfully imposed, are bona-fide, and are likely to be resolved by the courts.

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IV. HEALTH BENEFIT-RELATED MANDATES

The ACA imposes a variety of requirements on both "group health plans" and "health insurance issuers." These new requirements include rules governing who must be afforded coverage by such plans and insurers, what types of services must be covered, cost-sharing rules governing such coverage, and what coverage limitations can be imposed. Some of the new requirements build on an existing regulatory scheme first established under HIPAA. Others are added separately. The various requirements apply to different health coverages and have different penalties. Below is a discussion of the rules for certain of the requirements, which are mandates added by the ACA to the HIPAA scheme (herein, the "ACA Coverage Mandates"), followed by a list of the various requirements in chronological order by effective date.

A. ACA COVERAGE MANDATES

The HIPAA regulatory scheme is found in the Public Health Service Act ("PHSA"), ERISA, and the Code. Some of the new requirements are added to the PHSA and are incorporated into ERISA and the Code by reference through ERISA section 715 and Code section 9815. It is important to understand the forms of employer-provided arrangements to which these mandates apply.

1. Health Benefits Subject to the ACA Coverage Mandates

The term "group health plan" is not defined in the ACA, but it is defined under the earlier HIPAA rules that are incorporated in ERISA, the Code, and the PHSA, and accordingly such definition will govern for ACA purposes. A group health plan is defined to mean "an employee welfare benefit plan … to the extent that the plan provides medical care … to employees or their dependents … directly or through insurance, reimbursement or otherwise." (PHSA § 2791(a)). An employee welfare benefit plan, in turn, means an insured or self-insured health arrangement sponsored or maintained by an employer or union (or both) for employees. (ERISA 3(1)). As such, by imposing new requirements on "group health plans," the ACA effectively imposes them on virtually all employer-provided health benefit arrangements for employees. Furthermore, the term "health insurance issuer" is defined to mean an "insurance company, insurance service, or insurance organization … licensed to engage in the business of insurance in a State and which is subject to State law …." (PHSA § 2791(b)). Thus, the ACA, by also imposing its coverage mandates on health insurance issuers, has effectively imposed mandates on virtually all individual and group insurance market policies.

2. "Excepted Benefits" and Retiree-Only Plans

Note, however, that the ACA Coverage Mandates do not apply to certain "excepted benefits," such as (i) limited-scope dental or vision benefits that are provided under a separate policy or are not otherwise an integral part of the group health plan, (ii) on-site medical clinics, and (iii) separate coverage for specific diseases or fixed indemnity coverage that is not coordinated with group health plan coverage. (PHSA §§ 2763, 2791(c); ERISA §§ 732(b) & (c), 733(c); Code §§ 9831(b) & (c), 9832(c)). Excepted benefits also include health flexible spending arrangements and health reimbursement accounts if other employer-sponsored group health coverage is available to the same class of participants, and the maximum benefit payable does not exceed the greater of (i) two times the participant's salary reduction election or (ii) $500 plus the participant's salary reduction election. (ERISA Reg. § 2590.732(c)(3); Treas. Reg. § 54-9831-1(c)(3)).

In addition, the ACA Coverage Mandates do not apply to any group health plan (or insurance offered in connection with a group health plan) "for any plan year, if, on the first day of such plan year, such plan has less than 2 participants who are current employees." (ERISA § 732(a); Code § 9831(a)(2)). This exception is commonly known as the "retiree-only plan" exception. It should be noted that the ACA could be read to have eliminated the retiree-only plan exception. However, federal agency guidance indicates that it still exists for group health plans. For more information, please see our *Commentary* on the subject at www.jonesday.com/retiree_only_plan_exception/.

3. Penalties for Violating the ACA Coverage Mandates

Violations of the ACA Coverage Mandates are subject to a tax under Code section 4980D. Under section 4980D, employers that sponsor or maintain group health plans are required to pay a tax of $100 per day during the noncompliance period with respect to each individual to whom a violation relates (although the tax is limited in cases of unintentional failure, and small employers (at least two but no more than 50 employees) are exempt to the extent they provide coverage through a health insurance issuer and the failure is solely due to the health insurance coverage offered by such issuer).

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This tax must be self-reported annually on Form 8928 no later than the deadline for filing the entity's federal income tax return, with no extensions.

4. Grandfathered Status

The ACA also contains certain grandfathering rules. It effectively provides that group health plans or health insurance coverage do not need to comply with certain of the new ACA Coverage Mandates if the plan or coverage had at least one individual enrolled on March 23, 2010. Such plans are defined as "grandfathered health plans." (PPACA §§ 1251(e), 10103(d); HCERA § 2301). In order to maintain status as a "grandfathered health plan," a plan must (i) include a statement in any plan materials that the plan is a "grandfathered health plan" within the meaning of section 1251 of PPACA and (ii) maintain records necessary to substantiate the terms of the plan in effect on March 23, 2010 and verify its status as a "grandfathered health plan" for as long as it maintains that it is entitled to grandfathered status. The grandfathered health plan status extends to new enrollees in an otherwise grandfathered health plan, including family members of current enrollees, new employees, and family members of new employees. In the discussion of the mandates that follows, we identify which new rules may be avoided by "grandfathered health plans."

There are a number of ways that a grandfathered health plan may lose its grandfathered status. First, a plan will lose its grandfathered status if one of the following occurs:

- A business restructuring (i.e., merger, acquisition, or similar restructuring) occurs for the principal purpose of covering new individuals under such plan; or
- Without a bona fide, employment-based reason, employees are transferred into a grandfathered health plan from other coverage, if the amendment of such other coverage to match the terms of the grandfathered health plan would violate one of the rules below.

Second, a grandfathered health plan will lose its status if any of the following changes are made to the coverage:

- Elimination of all or substantially all benefits to diagnose or treat a condition;
- Any increase in a percentage cost-sharing requirement (e.g., coinsurance) measured from March 23, 2010;
- An increase in a fixed-amount cost-sharing requirement other than a copayment (e.g., a deductible or out-of-pocket limit) if the total percentage increase, as measured from March 23, 2010, exceeds a percentage reflecting medical inflation, as defined in the regulations, plus 15 percentage points;
- An increase in a fixed-amount copayment if the total increase, as measured from March 23, 2010, exceeds the greater of: (i) $5, with such amount being increased by medical inflation (as defined in the regulations) from time to time, or (ii) a percentage reflecting medical inflation, as defined in the regulations, plus 15 percentage points;
- A decrease in the employer's contribution rate toward the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate in place during the coverage period that includes March 23, 2010; or
- Adopting an overall annual limit on the dollar value of benefits if (i) the plan did not have an overall annual or lifetime dollar limit on March 23, 2010, (ii) the plan had an overall lifetime dollar limit (but no overall annual dollar limit) on March 23, 2010 and the new overall annual limit is lower than the lifetime limit, or (iii) the plan had an overall annual dollar limit on March 23, 2010 and the new overall annual limit is less than the prior limit.

Changes that are not effective until after March 23, 2010, but were made pursuant to a legally binding contract or filing that was effective, or written amendments to a plan that were adopted, prior to or on March 23, 2010 will not affect the plan's grandfathered status. Health insurance coverage maintained pursuant to a collective bargaining agreement that was ratified prior to March 23, 2010 will continue to be a grandfathered health plan at least "until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates." (26 CFR § 54.9815-1251T(f); 29 CFR § 2590.715-1251(f); 45 CFR § 47.140(f)). Upon termination of such last collective bargaining agreement, a determination as to whether the plan continues to be a grandfathered health plan is made under the terms described above.

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B. CURRENTLY EFFECTIVE MANDATES THAT APPLY GENERALLY TO HEALTH BENEFITS

1. Coverage of Children to Age 26

Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers that offer coverage for children are required to continue to make such coverage uniformly available (i.e., cannot vary based on age) for a child until such child turns 26 years of age, whether or not such child is married; meets the financial dependency, residency, student status, or employment requirements; or is eligible for other coverage. (PHSA § 2714). With one temporary exception, eligibility distinctions may only be based on (i) the age of the child, for children over age 26, or (ii) the relationship of the child to the employee (for example, a plan could provide no coverage for stepchildren because that is a relationship-based distinction). For plan years beginning before January 1, 2014, grandfathered plans do not need to extend coverage to children who are eligible to enroll in another plan other than one sponsored by the employer of the parent(s).

A conforming change was made to Code section 105(b), providing beneficial tax treatment for dependent health coverage until the end of the year in which the child attains age 26. Although PHSA section 2714 requires coverage only "until" the child turns age 26, because the new language in Code section 105(b) extends the tax exclusion until the end of the taxable year in which the child attains age 26, tax-free coverage could be provided until the end of the month or even until the end of the year in which the child "ages out" of the plan. The income tax exclusion rules also apply to other health benefits, such as dental plans, health care flexible spending arrangements ("HFSAs"), and health reimbursement arrangements ("HRAs"). Of course, because the age 26 mandate does not apply to these plans, extension of coverage under these plans is discretionary. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

2. No Preexisting Condition Exclusions for Children

Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers are prohibited from excluding individuals under the age of 19 from coverage "on the basis of any preexisting condition exclusion." (PHSA § 2704(a)). For individuals age 19 and over, the prohibition will apply for plan years beginning on or after January 1, 2014. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

To be sure, as a consequence of the HIPAA rules of 1996, even prior to the ACA, there were restrictions on the ability of insurers or group health plans to impose preexisting condition exclusions. (PHSA § 2701; ERISA § 701; Code § 9801). The ACA, however, effectively created a blanket prohibition on preexisting condition exclusions for all individual insurance policies and employer plans. Further, as a consequence of the HIPAA rules, the term "preexisting condition exclusion" is already defined in the PHSA, ERISA, and the Code (*see*, e.g., PHSA § 2701(b)(1)), and HHS, DOL, and Treasury promulgated final regulations in 2004 that interpret and apply the term "preexisting condition exclusion." (45 C.F.R. §§ 144.103, 146.111-119; 29 C.F.R. §§ 2590.701-1–2590.701-7; 26 C.F.R. §§ 9801-1–9801-6). Presumably this existing regulatory definition of the term "preexisting condition exclusion" will continue to govern for purposes of the ACA's blanket prohibition on such exclusions, but it is unclear.

Moreover, the current legal requirement to provide certificates of creditable coverage was not removed from the law, which is temporarily sensible given that the ACA's elimination of preexisting condition exclusions will not apply until 2014 for adults. Presumably, regulatory action will be forthcoming to eliminate the burden of creditable coverage certificates going forward after 2014.

3. No Lifetime or Annual Dollar Limits on Essential Health Benefits

Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers are prohibited from providing coverage that contains a lifetime limit on the dollar value of "essential health benefits." Similarly, subject to certain exceptions described below, group health plans and health insurance issuers are prohibited from imposing annual limitations on the dollar value of "essential health benefits." (PHSA § 2711(a)(1)). Group health plans and insurance carriers are free to impose either lifetime or annual limits on benefits that do not constitute "essential health benefits." A 30-day special enrollment period for persons who had previously reached a lifetime limit was required to be provided in connection with the

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first plan year beginning on or after September 23, 2010. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

As discussed in Section II.E.1. above, the term "essential health benefits" refers to categories of benefits that must be provided in coverage sold through an Exchange. However, given that this term is being defined for Exchange coverage purposes on a state-by-state basis, it is not clear whether the same definition will apply in the context of the annual and lifetime dollar limit prohibition. No guidance has yet been issued on this point.[9]

With respect to plan years beginning prior to January 1, 2014, a group health plan is free to establish a "restricted annual limit" on the dollar value of an individual's benefits that are "essential health benefits" provided that the limit is:

PLAN YEARS	AMOUNT
Beginning on or after September 23, 2010 but before September 23, 2011	No less than $750,000
Beginning on or after September 23, 2011 but before September 23, 2012	No less than $1,250,000
Beginning on or after September 23, 2012 but before January 1, 2014	No less than $2,000,000

HHS established a program to provide for temporary waivers to the annual limit requirement for plan years prior to January 1, 2014, for plans for which compliance with the limit would result in a significant decrease in access to benefits under or a significant increase in premiums for the plan or health insurance coverage. However, HHS stopped accepting waiver applications on September 22, 2011. For coverage that received a waiver, the group health plan or health insurance issuer must retain records supporting its application and annually notify participants or subscribers that the plan has received a waiver from the annual limits requirement and therefore the annual limits have not been met.

4. No Rescissions

Effective for plan years beginning on or after September 23, 2010, group health plans and health insurance issuers are generally prohibited from rescinding coverage with respect to an enrollee once such enrollee is covered. (PHSA § 2712). Rescission means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance is not a rescission if it (i) only has a prospective effect or (ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. Rescissions are permitted for fraud or the intentional misrepresentation of a material fact by the enrollee, if permitted under the terms of the coverage. The plan or issuer must provide at least 30 days' advance notice to an affected participant before coverage may be rescinded. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

5. Over-the-Counter Drug Coverage

Effective for expenses incurred after December 31, 2010, over-the-counter drugs (other than insulin) purchased without a prescription can no longer be reimbursed by an HRA or an HFSA. If the cost of such drugs is paid or reimbursed from an HSA or an Archer MSA, the amount will be included in gross income and subject to a 20 percent additional tax. (Code §§ 223(d)(2), 220(d)(2), 106(f)). For this purpose, a "prescription" means "a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state." (IRS Notice 2010-59). Because current debit card systems cannot confirm whether over-the-counter drugs were prescribed, HFSA and HRA debit cards cannot be used to purchase such drugs, and only claims for reimbursement are permitted. This change applies

9 Health flexible spending arrangements, HSAs, Archer MSAs, retiree-only HRAs, HRAs that are integrated with other group health coverage, and HRAs that are "excepted benefits" (as defined in Section IV.A.2. above) are not subject to the prohibition on annual limits. Stand-alone HRAs that are not otherwise exempt from this rule and that were in effect before September 23, 2010 are covered by a temporary class exemption from the annual limit prohibition as long as they meet the record retention and annual notice requirements that apply generally to coverage allowed under a waiver. (CCIIO Supplemental Guidance (CCIIO – 1E): Exemption for Health Reimbursement Arrangements that are subject to PHS Act section 2711 (Aug. 19, 2011)). The temporary class exemption expires for the first plan year that begins on or after January 1, 2014. As such, and barring further guidance, these non-excepted HRAs will need to be modified or eliminated at such time.

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to over-the-counter drugs but not to over-the-counter devices, such as crutches, bandages, and blood sugar test kits.

6. Increase in Penalty on Certain HSA and Archer MSA Distributions

Effective for distributions made after December 31, 2010, the "penalty" for distributions from an HSA or Archer MSA that are used for purposes other than to pay "qualified medical expenses" increases to 20 percent, from the existing 10 percent for HSAs and 15 percent for Archer MSAs. (PPACA § 9004). These distributions continue to be included in the recipient's gross income.

C. CURRENTLY EFFECTIVE MANDATES THAT ONLY APPLY TO NON-GRANDFATHERED COVERAGE

1. Mandatory Coverage of Certain Preventive Services with No Cost Sharing

It is common for employer-provided health insurance to impose copayments or co-insurance in connection with nearly all categories of covered services, including many preventive services. But *effective for plan years beginning on or after September 23, 2010*, group health plans and health insurers are required, with respect to non-grandfathered coverage, to cover certain preventive medicine services—including, but not limited to, certain immunizations and certain screenings for infants, children, adolescents, and women—and prohibit imposition of any cost-sharing requirements for such preventive services. (PHSA § 2713). Cost-sharing includes copayments, co-insurance, or deductibles. If a plan uses a network, this requirement can be limited to in-network coverage. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

The preventive services to which this requirement applies are:

- Care recommended with an "A" or "B" rating by the United States Preventive Services Task Force (except that the 2002 recommendations regarding breast cancer screenings are considered the most current because the November 2009 recommendations are disregarded),
- Immunizations recommended by the Centers for Disease Control, and
- Certain preventive care and screenings for infants, children, adolescents, and women recommended by the Health Resources and Services Administration.

Updates to the lists are effective for the first plan year that begins a year after the change is effective, but they can be implemented sooner, if desired. The lists can be found at the following site: www.healthcare.gov/law/resources/regulations/prevention/recommendations.html.

The prohibition on imposing cost-sharing requirements depends on whether the preventive service is billed separately from the office visit and whether the preventive service is the primary purpose of the office visit. For instance, if the preventive service is not billed separately from the office visit, group health plans and insurers (i) may not impose cost-sharing requirements if the primary purpose of the office visit is to deliver the preventive service and (ii) may impose cost-sharing requirements if the primary purpose of the office visit is not to deliver the preventive service. On the other hand, if the preventive service is billed separately from the office visit, the plan may impose cost-sharing requirements on the office visit. There is no guidance on how to determine the primary purpose of an office visit.

2. Designation of Primary Care Provider

Effective for plan years beginning on or after September 23, 2010, a group health plan or health insurance issuer that, with respect to non-grandfathered coverage, requires or provides for the designation of a participating primary care provider must allow participants to choose any such provider who is available and participates in the network (including the choice of a pediatric specialist as the primary care provider for a child). Notice of this requirement must be included in the summary plan description or other similar description of benefits. Model language is provided in the regulations. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

3. No Pre-Authorization for Obstetrical and Gynecological Care

Effective for plan years beginning on or after September 23, 2010, a group health plan or health insurance issuer, with respect to non-grandfathered coverage, may not require

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pre-authorization or a referral before a female participant or beneficiary seeks obstetrical or gynecological care from a professional specializing in such care. However, a plan or issuer may require that the obstetrical or gynecological provider provide the primary care physician, plan, or issuer with a notice of treatment decisions. Notice of this requirement must be included in the summary plan description or other similar description of benefits. Model language is provided in the regulations. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

4. Coverage of Emergency Room Services

Effective for plan years beginning on or after September 23, 2010, a group health plan or health insurance issuer that, with respect to non-grandfathered coverage, covers emergency room services is required to cover such services when provided by an out-of-network provider without the need for prior authorization and without regard to any term or condition of the coverage (other than (i) a permitted waiting period or (ii) applicable cost-sharing requirements). Administrative requirements or limitations on coverage for out-of-network emergency room services may be no more restrictive than the requirements that apply to in-network services. Furthermore, cost-sharing cannot exceed the cost-sharing that would apply if the services were received in-network. (PHSA § 2719A). This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

5. Benefit Claim Dispute Resolutions Rules

Effective for plan years beginning on and after September 23, 2010, group health plans and health insurance issuers must, with respect to non-grandfathered coverage, provide a claims appeal and review process that meets certain requirements. (PHSA § 2719). Coverage that is governed by ERISA has already been subject to various requirements governing the claims and appeal process. (ERISA § 503; 29 CFR § 2560.503-1). PHSA section 2719 makes the ERISA claims and appeals rules applicable to all group coverage, expands upon those rules for internal claims and appeals, and adds a nonjudicial external review requirement. Individual coverage is generally subject to the same rules, with certain modifications set forth in regulatory guidance. (45 CFR § 147.136(b)(3)). This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

The expanded rules make several changes to the ERISA claims and appeals process. (26 CFR § 54.9815-2719T(b); 29 CFR § 2590.715-2719(b); 45 CFR § 147.136(b)). In particular:

- The category of adverse benefit determinations that may be appealed is expanded to include rescissions (as defined at Section IV.B.4. above), whether or not such rescission has an adverse effect on any particular benefit.
- The plan or issuer must provide the claimant, free of charge, (i) with any new or additional evidence used in connection with the claim and (ii) if a final adverse benefit determination is based on a new or additional rationale, with the rationale, in both instances as soon as possible and sufficiently in advance of the deadline for providing the final decision to give the claimant a reasonable opportunity to respond.
- The plan or issuer must ensure that all claims and appeals are reviewed in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. In that regard, decisions regarding hiring, compensation, termination, promotion, or similar matters must not be made based on the likelihood of the person denying benefits.
- All notices of adverse benefit determinations must include certain information identifying the claim involved, the reason for the denial, how to initiate any applicable appeal or external review, and contact information for any available office of health insurance consumer assistance or ombudsman.
- If the plan or issuer fails to strictly adhere to the required internal claims and appeals rules (except certain de minimis violations that do not cause and are not likely to cause prejudice or harm to the claimant), the internal claims and appeals process will be deemed exhausted and the claimant may initiate an external review and pursue any remedies in civil court that are available under ERISA section 502(a) or state law, as applicable.
- Plans and issuers are required to provide continued coverage pending the outcome of an appeal with respect to an ongoing course of treatment.

As mentioned above, group health plans and health insurance issuers must also provide an external review process, with respect to non-grandfathered coverage. (26 CFR § 54.9815-2719T(c), (d); 29 CFR § 2590.715-2719(c), (d); 45 CFR § 147.136(c), (d)). An external review is a de novo review of the claim by a trained reviewer affiliated with an accredited external organization. Because some states already require insured coverage to provide for an external review, the external review requirement can be fulfilled by the existing state process if the state process is approved by HHS and the external review, under state law, is binding on the plan or issuer. If there is no such state process, then the plan or issuer is required to contract with multiple accredited external review organizations to handle external reviews in compliance with federal guidelines.

Under current guidance, external reviews are available only for adverse benefit determinations that involve medical judgment (e.g., medical necessity, appropriateness, or whether a treatment is experimental or investigational) or a rescission of coverage. (26 CFR § 54.9815-2719T(c)(2)(i), (d)(1)(ii); 29 CFR § 2590.715-2719(c)(2)(i), (d)(1)(ii); 45 CFR § 147.136(c)(2)(i), (d)(1)(ii)). The determination of the external reviewer is binding on both the plan and the claimant, except to the extent that other remedies are available under state or federal law. (26 CFR § 54.9815-2719T(c)(2)(xi); 29 CFR § 2590.715-2719(c)(2)(xi); 45 CFR § 147.136(c)(2)(xi); DOL Technical Release 2010-01). If the decision is in favor of the claimant, the plan must immediately provide coverage or payment.

Finally, a group health plan or issuer with participants who reside in a county in which 10 percent or more of the population is literate only in the same non-English language must provide notices, upon request, and oral language services (e.g., a customer assistance hotline) in such non-English language to such participants. (26 CFR § 54.9815-2719T(e); 29 CFR § 2590.715-2719(e); 45 CFR § 147.136(e)). In addition, all English versions of notices distributed to residents of such counties must include a prominent statement in the applicable non-English language, describing the availability of such services. The applicable counties are published annually by the United States Census Bureau, and the languages for which this requirement currently applies (depending on the particularly county) are Spanish, Chinese, Tagalog, and Navajo. For 2012, there are affected counties in 24 states plus Puerto Rico.

For those plans to which these new rules will apply, the biggest change from existing federal requirements will be the imposition of an external appeal right (certain states currently mandate external appeals for insured plans). Such an additional dispute resolution layer obviously will increase the cost of claims administration, particularly if courts extend the judicially created ERISA exhaustion doctrine and require claimants to also exhaust this new external appeal right prior to gaining access to federal court.

6. No Discrimination in Favor of Highly Compensated Individuals in Fully Insured Plans

Currently, under Code section 105(h), the value of amounts that a discriminatory self-insured plan pays or covers for "highly compensated individuals" is taxable to such individuals. A "highly compensated individual" is (i) one of the five highest paid officers, (ii) a shareholder who owns (including by attribution) more than 10 percent in value of the stock of the employer, or (iii) an individual who is among the highest 25 percent of all employees (with certain exclusions allowed). Code section 105(h) prohibits discrimination both in connection with eligibility for benefits and benefits actually provided to highly compensated individuals.

Originally effective for plan years beginning on or after September 23, 2010 (but *currently in an agency non-enforcement period until final regulations are issued and become effective*), the prohibition on discrimination found in Code section 105(h) is extended to non-grandfathered group health plans that are not self insured (i.e., fully insured plans). (PHSA § 2716). This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above. The ACA does not amend Code section 105(h) to extend the provisions of subsection 105(h) to insured arrangements. Instead, PHSA section 2716 requires group health plans that are not self-insured to satisfy these nondiscrimination rules through new Code section 9815. As a consequence, the penalty for violation of PHSA section 2716 will be the penalty imposed on violations of the ACA Coverage Mandate, namely a tax on the employer under Code section 4980D. This is in contrast to Code section 105(h), which penalizes discrimination in favor of highly compensated individuals in self-insured plans by taxing the recipient of the discriminatory benefit. In addition, because new ERISA section 715 (discussed above at Section IV.A.) incorporates by reference the changes made to

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the PHSA by the ACA, there could be the prospect of private party litigation under ERISA brought by lower-paid employees alleging violations of PHSA section 2716 and seeking retroactive equal treatment in the form of the better benefits allegedly provided to "highly compensated individuals."

Under the grandfathered plan exception, it would appear that such plans could apply existing design provisions that might be deemed discriminatory to current, and even newly hired, "highly compensated employees" without running afoul of PHSA section 2716. It also is a fair reading of the grandfathered health plan rules to allow existing insured plans to be amended to provide new benefits exclusively to current or newly hired "highly compensated employees" without application of section 2716, but HHS regulations might say otherwise. If so, it is worth noting that while most of the mandates in the ACA apply to both group health plans and group health insurance issuers, PHSA section 2716 applies only to insured group health plans.

D. MANDATES TO BE EFFECTIVE IN 2012 AND 2013 THAT WILL APPLY GENERALLY TO HEALTH BENEFITS

1. Medical Loss Ratio Rebates

Effective beginning January 1, 2011, PHSA section 2718 requires health insurance issuers to spend a certain percentage of premium dollars on reimbursement for clinical services and health care quality improving activities. If these percentages (called "medical loss ratios") are not met, then sufficient premium dollars must be rebated to policy holders so that, taking into account the rebate, the percentage is met. Rebates will be determined and issued annually. If a rebate is issued with respect to an ERISA plan, it may be a plan asset and subject to the ERISA trust requirements and requirements regarding the use of plan assets. The Department of Labor has established a safe harbor exempting rebates from the trust requirement if they are distributed within three months of receipt. (DOL Tech. Release 2011-04). This release also provides guidelines for distribution of rebates in the absence of direction in the plan document itself.

2. W-2 Reporting

Effective for taxable years beginning after December 31, 2011, employers must include the aggregate value of certain employer-sponsored health coverage on an employee's Form W-2. (Code § 6051(a)(14)). The cost of coverage is determined in a manner similar to that used for determining cost for COBRA purposes. Reporting is required only with respect to individuals to whom the employer is otherwise issuing a W-2. Currently, reportable health plan coverage includes traditional medical plans; employer contributions to health FSAs; EAPs, on-site clinics, and wellness programs, if the employer charges a COBRA premium; and hospital or illness indemnity coverage if paid on a pre-tax basis or by the employer. Stand-alone dental or vision coverage, amounts contributed to an HRA or HSA, employee contributions to a health FSA, and coverage under a multiemployer plan or self-insured church plan are not required to be included. In addition, small employers that provide fewer than 250 Forms W-2 need not comply until further guidance is issued. The list of reportable coverage may change for future years.

This provision was technically effective for taxable years beginning after December 31, 2010, but IRS guidance delayed enforcement until the 2012 tax year. Therefore, employers should be prepared to include this information when preparing Forms W-2 issued in 2013 for the 2012 tax year.

3. Summary of Benefits and Coverage ("SBC")

Currently under ERISA, administrators of group health plans are required to provide enrollees with a summary plan description that explains the material terms of the plan and a summary of material modification when material changes are made to such plans. (ERISA § 104(b)). The ACA creates separate summary benefit disclosure obligations that, at the very least, overlap with the summary plan description rules of ERISA. Specifically, PHSA section 2715 and HHS guidance issued thereunder require group health plans and insurers to provide to each applicant and enrollee a four-page (double-sided) SBC and a uniform glossary of terms. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

An SBC must be prepared for each benefit package and must describe certain elements of the coverage under such benefit package, all in a very particular format prescribed under regulatory and other guidance. Templates and instructions as well as a number of FAQs have been issued,

describing in mind-numbing detail how SBCs must be prepared. For example, a particular header is required to appear on the first page of the SBC but is optional on all other pages; a particular footer is required to appear on both the first and last page and is likewise optional on the remaining pages.

Fortunately, in some respects, the uniform glossary of terms is a nonchangeable document. However, to the extent that any of the terms in the uniform glossary (which are used throughout the SBC) are different from terms used in the plan's summary plan description, it may create some confusion. In the long-term, it may make sense to revise the summary plan description to use the terms from the uniform glossary, to the extent appropriate.

In addition to preparing the SBC in English, plans and issuers with eligible individuals residing in counties where 10 percent or more of the population is literate only in a non-English language will have to make the SBC available, upon request, in the applicable non-English language. The potential languages are Spanish, Chinese, Tagalog, and Navajo. This requirement mirrors the requirement to provide claims communications in alternate languages, as described in Section IV.C.5. above.

For insured plans, the health insurer will be required to provide the SBC. For self-insured plans, the plan sponsor (i.e., the employer) or the plan administrator will need to provide the SBC. (PHSA § 2715(d)(2)). However, given the complex rules governing the format of SBCs, the plan sponsor or plan administrator may prefer to retain the third party administrator or a benefits communication vendor to prepare the document.

The SBC must be provided to an applicant for coverage at the time he or she applies for coverage, to an enrollee prior to the time of enrollment or reenrollment, and within seven days of request. (PHSA § 2715(d)(1)). *In particular, SBCs must be provided in connection with an open enrollment period starting on or after September 23, 2012 and to new hires and special enrollees for plan years starting on or after the same date*. Because many open enrollment periods occur in the fall and materials must be finalized in late summer, employers should be working diligently now to make sure that SBCs are ready in time.

Because this is a new requirement, the guidance that has been issued has created a number of potentially temporary rules to ease the administrative burden. In particular, SBCs can be delivered electronically in a number of instances, including in connection with an open enrollment that is conducted electronically. Further, for current enrollees, only the SBC for the benefit package in which the individual is already enrolled is required to be distributed, unless the individual requests SBCs for other benefit packages. Finally, the regulators have provided guidance to the effect that during the first year, no penalties will be imposed on plans and issuers "that are working diligently and in good faith to comply." (FAQs About Affordable Care Act Implementation (Part IX), Q&A 8 (May 11, 2012)).

Outside of the good faith compliance exception, failure to provide an SBC would subject the health insurance issuer or plan sponsor/administrator to a penalty of up to $1,000 for each such failure. (PHSA § 2715(f)). In addition, a violation of the SBC requirement will subject employers to the $100 per day, per individual tax under Code section 4980D. (See discussion above at Section IV.A.3.).

To the extent that employers (or insurers, in the case of insured health arrangements) have to provide both an SBC and a separate summary plan description as required by ERISA section 104, it will be crucial to ensure that the two documents are synchronized and do not contain conflicting rules.

4. Comparative Effectiveness Fee

The ACA imposes new fees on "specified health insurance policies" and applicable self-insured health plans, for the seven consecutive policy and plan years ending on or after October 1, 2012. (Code §§ 4375, 4376, and 4377). *The fee for the first such year will be due by July 31, 2013*. These fees will be deposited in a trust fund for the benefit of the newly established Patient-Centered Outcomes Research Institute (a nonprofit corporation), whose purpose is to advance the quality and relevance of evidence concerning the manner in which health conditions are effectively and appropriately prevented.

Employers (or insurers, for insured coverage) must pay a fee of $2 for each year ($1 for the year ending on or after October 1, 2012 and before October 1, 2013), multiplied by the average number of lives covered under the plan (i.e., all

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participants, including dependents). For plan years ending on or after October 1, 2014, the fee will be increased based on medical inflation.

Proposed regulations provide various alternatives to determine the average number of covered lives. For self-insured plans, these are: average of actual count throughout year; average of actual count on quarterly snapshot dates; average on quarterly snapshot dates, counting single coverage as 1 and non-single coverage as 2.35; average of total of covered lives reported on Form 5500 for beginning and end of year (times two if plan covers dependents). "Covered lives" for an HRA refers only to participants and not to covered dependents.

Under the proposed regulations, the fee applies to insured and self-insured health plans, including retiree plans and certain HRAs. Multiple self-insured plans with the same plan sponsor and the same plan year will be subject to a single fee. The fee does not apply to "excepted benefits" (as described in Section IV.A.2. above) including HFSAs with only employee contributions and stand-alone dental and vision plans. In addition, the fee does not apply to employee assistance programs, disease management programs, or wellness programs that do not provide significant medical care benefits.

The regulations are currently only proposed. Until final regulations are issued, we cannot be sure exactly how the fee will be imposed.

5. FICA Tax Increase

Effective for taxable years beginning after December 31, 2012, the rate of the "Hospital Insurance" tax (part of FICA) on wages for certain taxpayers is increased from 1.45 percent to 2.35 percent. (Code § 3101(b)). The increase applies only to the employee portion of the Hospital Insurance tax, not to the employer portion of the tax. A parallel increase applies to the self-employed under the provisions applicable to SECA taxes. (Code § 1401(b)). The increase applies to wages in excess of the following amounts: (i) for married taxpayers who file joint returns, $250,000; (ii) for married taxpayers who file separate returns, $125,000; and (iii) for all others who file returns, $200,000. Although this tax is imposed on employees, an employer is obligated to deduct and withhold for the hospital insurance tax from wages paid to employees in excess of $200,000. (Code § 3102(a)). If this results in an overpayment of tax by the employee (for example, when an employee earns $230,000 per year but is the sole breadwinner in the family and files jointly with a spouse), then the employee may request a refund on the employee's Form 1040.

6. Contribution Limit on Health Flexible Spending Arrangements

Effective for plan years beginning after December 31, 2012, salary reduction contributions to a HFSA are limited to $2,500 per year. (Code § 125(i)). This statutory maximum will be adjusted annually for inflation beginning in 2014. The maximum applies only to amounts for which the employee has a choice between the contribution or cash. In other words, it does not apply to employer contributions. In addition, the maximum does not apply to grace period carryovers. The maximum is applied on an individual basis and a separate plan basis. Therefore, a married couple could each make a $2,500 contribution through their respective employer's cafeteria plans, and an individual who is employed by two employers who each offer a health flexible spending arrangement could contribute the maximum under each employer's arrangement. As a result of the new maximum, the Department of Treasury has asked for comments on whether it is appropriate to relax, in whole or in part, the current "use it or lose it" rules that apply to HFSAs.

7. Written Notice Upon Hiring

Not later than March 1, 2013, employers must provide all current employees, and thereafter to all new employees, written notice apprising them of their health care coverage options. (New FLSA § 18B, 29 U.S.C. § 218B). This notice must include information regarding the available employer-sponsored coverage, as well as information about the Exchange and the employee's potential eligibility for a premium tax credit or cost-sharing subsidy. The DOL will issue regulations providing more guidance on the content and distribution of this notice.

E. MANDATES EFFECTIVE IN 2014 OR LATER THAT WILL APPLY GENERALLY TO HEALTH BENEFITS

1. Automatic Enrollment Rule for Employers with More Than 200 Employees

Employers who have more than 200 full-time employees, and provide one or more health benefits plans or options, will be required to automatically enroll full-time employees in one of

the employer's health benefits plans or options (subject to any authorized waiting periods) and to continue the enrollment of current employees in such plan or option. This new rule is an amendment to the Fair Labor Standards Act (FLSA § 18A, 29 U.S.C. § 218A). Under FLSA section 18A, employers also will be required to give adequate notice to employees of the automatic enrollment protocol and an opportunity to opt out of such coverage.

The Department of Labor has issued guidance indicating that the new rule will not be effective until final regulations are issued, which will not be by 2014. (FAQs About Affordable Care Act Implementation part V, Q&A 3 (Dec. 22, 2010); DOL Technical Release 2012-01 (Feb. 9, 2012)). In this guidance, the Department has indicated that it is working to make sure that the guidance concerning the automatic enrollment requirement, the 90-day limitation on waiting periods (described at Section IV.E.3. below), and the Large Employer mandates (described at Section III above) are coordinated.

Interestingly, for those employers that offer more than one health benefit plan or benefit option, the statutory language does not dictate the particular option or plan into which the employer is required to automatically enroll the new employee. On its face, the statute leaves that determination to the employer (although the forthcoming regulations may, contrary to the plain language of the statute, circumscribe the choice). Similarly, on its face, FLSA section 18A appears to require only that the full-time employee be automatically enrolled, and not his or her spouse or dependents. Furthermore, it does not provide a time frame by which the employer must enroll the new employee, although the new provision can be read to require the enrollment as of the first day on which the new employee is eligible for coverage. Presumably the forthcoming guidance will clarify these open issues.

2. Coverage of Children to Age 26 for Grandfathered Plans

As mentioned above, *effective for plan years beginning on or after January 1, 2014*, the exclusion to the requirement to cover children to age 26 for grandfathered plans if such child is eligible to enroll in employer-sponsored coverage other than coverage provided by the employer of a parent, described at Section IV.B.1. above, is eliminated. (PPACA § 1251(a)(4)(B)(ii)).

3. No Excessive Waiting Periods

Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers will be prohibited from imposing more than a 90-day "waiting period," i.e., the period that a new employee and family members must wait before coverage is provided under a plan. (PHSA § 2708). While final guidance regarding this requirement has not been issued, there have been two pieces of preliminary guidance, designed to request comments about how this requirement would be coordinated with the automatic enrollment requirement and the Large Employer mandate (described at Sections IV.E.1. and III above) (IRS Notice 2011-73; DOL Technical Release 2012-01 (Feb. 9, 2012)). This guidance has indicated that a waiting period would begin when the employee is otherwise eligible for coverage under the terms of the plan and that eligibility conditions that are not designed to avoid compliance would be permitted. The guidance provides examples of permitted eligibility conditions, such as full-time status, a bona fide job category, receipt of a license, or meeting a specified cumulative number of hours of service (under certain conditions). It is important to remember, however, that the guidance release so far is preliminary and cannot be relied upon. Employers will need to wait for further guidance to fully understand how this provision may affect any existing waiting period. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

Presumably, this rule will not override the more aggressive requirement currently in the PHSA (and ERISA and the Code) respecting newborn and adopted children, but that is not clear. The existing rule requires that such children and their parents have a special right to enroll in group health plans as of the date of birth or placement for adoption, as long as enrollment is requested within 30 days from the birth or adoption placement date. (PHSA § 2701(f)(2(C); ERISA § 701(f)(2(C); Code § 9801(f)(2)(C)).

4. Individual Market Reinsurance Fee

For three plan years beginning with the plan year beginning on or after January 1, 2014, insurers and third-party administrators on behalf of group health plans will be required to make payments to an applicable reinsurance entity to

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support the individual insurance market. (PPACA § 1341(b)(3)). The fee will be imposed based on the number of enrollees receiving coverage through a contributing entity and will be designed so that the aggregate national annual required contribution is met. This aggregate national contribution is $12 billion for 2014, $8 billion for 2015, and $5 billion for 2016, plus amounts sufficient to cover the administrative costs of collection for each year. The fee does not apply to "excepted benefits" as described in Section IV.A.2. above. Under current guidance, all other health plans are subject to the fee, including EAPs, HRAs, and retiree plans. The fee for self-insured plans must be paid to HHS on a quarterly basis beginning January 15, 2014. For insured plans, the fee may be paid to HHS or the state, depending on the state.

5. No Preexisting Condition Exclusions for Adults

Effective for plan years beginning on or after January 1, 2014, the prohibition against preexisting condition exclusions discussed at Section IV.B.2. above is extended to all individuals. (PHSA § 2704(a)).

6. Reporting of Health Coverage

The ACA adds reporting requirements under Code sections 6055 and 6056, designed to collect information regarding compliance with the employer "play or pay" rules and the individual coverage mandate. Large employers subject to the "play or pay" rules will be required to file a return regarding their compliance. In addition, all entities that provide coverage at a sufficient level so as to enable an individual to satisfy the individual coverage mandate upon purchase of such coverage will be required to file a return. In both instances, the return will include specific information about the coverage, who was covered, and the dates of coverage. It may be feasible for the IRS to allow employers to satisfy some of these new reporting demands through a revised Form 5500 rather than new IRS form, but it is unclear at this time whether it will do so.

In connection with the filing of each of these returns, the employer will be required to provide a statement to each individual the employer lists in the filing that advises the individual of the information the employer has reported to the IRS with respect to him or her. This requirement appears to be similar to the current W-2 and 1099 processes. Because one of the goals is to determine whether the individual coverage mandate is met with respect to all individuals enrolled in the plan, group health plans and health insurance issuers will need to collect tax identification numbers (Social Security numbers) from all participants. Such a collection effort has begun for many group health plans to meet Medicare Secondary Payer Reporting requirements, but it will need to be expanded in order to comply with these reporting requirements. *These requirements will apply beginning with the 2014 calendar year, and the first information returns will be filed in 2015*. (IRS Notices 2012-32 and 2012-33).

7. Prohibition on Discrimination Against Employees Who Exercise PHSA Rights

The ACA amends the Fair Labor Standards Act to prohibit employers from discharging an employee or discriminating against an employee with respect to any of the terms of his or her employment merely because the employee has received a premium tax credit for use in paying for a "qualified health plan," obtained a cost-sharing subsidy, provided information about a violation of the PHSA provisions, testified or assisted (or is about to testify or assist) in a proceeding concerning such violation, or objected or refused to participate in any activity that the employee reasonably believed to be such a violation. (FLSA § 18C, 29 U.S.C. § 218C). *Effective for plan years beginning on or after January 1, 2014*, these provisions also apply to group health plans and health insurance issuers with respect to individuals. (PHSA § 2706(b)). The relief available to such employee or individual in the event of such a violation will be the same as that provided under the whistleblower protections of the Consumer Product Safety Improvement Act.

F. MANDATES EFFECTIVE IN 2014 OR LATER THAT WILL ONLY APPLY TO NON-GRANDFATHERED PLANS

1. Wellness Program Rewards

Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers may not, with respect to non-grandfathered coverage, establish eligibility rules based on certain enumerated health-status-related factors with respect to an individual or a dependent (e.g., health status, medical condition (physical or mental), claims experience, medical history). (PHSA § 2705(a)). This new section is almost identical to existing statutory language prohibiting discrimination based on health status factors applicable to employer-provided group health plans under

PHSA section 2702(a), ERISA section 702(a), and Code section 9802(a). Presumably, the existing regulations jointly promulgated by the DOL, HHS, and Treasury interpreting and applying existing law will apply to new PHSA section 2705.

A key change that the ACA makes, however, is in connection with wellness programs. Existing law allows employer-provided health plans to include wellness programs that have the effect of granting premium discounts, rebates, and other favorable terms for certain participants based on wellness considerations. (ERISA § 702(b)(2)(B); PHSA § 2702(b)(2)(B); Code § 9802(b)(2)(B)). DOL, HHS, and Treasury have promulgated joint regulations to allow various types of wellness arrangements. (45 C.F.R. § 146.121(f); 29 C.F.R. § 2590.702(f); 26 C.F.R. § 9802-1(f)). New PHSA section 2705(j) codifies as statutory law virtually all elements of the existing regulation, with some minor language changes and one important difference. Under existing regulations, the reward for successful participation in an otherwise lawful wellness program cannot exceed 20 percent of the total cost of the coverage (including both employee and employer contributions). If the reward is available only for employee participation, then the 20 percent is based on the cost of single coverage; but, if family members may participate, then the reward is based on the cost of the tier of coverage that includes those family members. PHSA section 2705(j)(3)(A) increases the maximum reward to 30 percent of the total cost of coverage under the plan and authorizes HHS, DOL, and Treasury to increase this percentage to 50 percent if appropriate. An example of how the wellness program reward is calculated is provided below. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above. While this provision, including the increased reward, does not apply to grandfathered coverage, grandfathered coverage, as such, will not lose its grandfathered status by voluntarily complying with some of the ACA Coverage Mandates. Therefore, it would appear that grandfathered coverage could elect to take advantage of the increased wellness program reward thresholds.

It is not clear how this increase in the potential wellness program reward will interplay with the Americans With Disabilities Act ("ADA"). The ADA prohibits an employer from requiring an employee to undertake a medical examination unless, inter alia, the exam is voluntary and part of an employee health program. (42 U.S.C. § 12112(d)(4)). The EEOC has informally interpreted the term "medical examination" broadly and has taken the position that wellness programs that penalize employees who do not participate will not be treated as voluntary. The ACA did not modify these ADA rules, and we have found nothing in the ACA that would indicate that it overrules existing ADA law. Therefore, the ability of employers to design wellness programs with incentives of up to 30 percent or 50 percent of the cost of coverage might be prohibited if the EEOC aggressively interprets these by ADA rules.

2. Nondiscrimination Against Health Care Providers

Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers may not, with respect to non-grandfathered coverage, discriminate against health care providers who are acting within the scope of their license or certification under applicable state law. (PHSA § 2706(a)). The statutory language indicates that this provision shall not require a plan or issuer to contract with any willing health care provider. The legislative history indicates that the provision is intended to benefit practitioners who may have been traditionally excluded from participation, such as alternative medicine practitioners, acupuncturists, and chiropractors. Until regulatory guidance is issued, it will not be clear how this provision will affect non-grandfathered coverage. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

3. Coverage for Individuals Participating in Approved Clinical Trials

Effective for plan years beginning on or after January 1, 2014, group health plans and health insurance issuers may not, with respect to non-grandfathered coverage, deny individuals with life-threatening diseases participation in approved clinical trials. (PHSA § 2709). In addition, plans and issuers may not discriminate against participants who enroll in clinical trials or deny, limit, or impose additional conditions on the coverage of routine patient costs for trial study participants. Routine patient costs do not include the drug, device, or service that is being tested in the trial. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

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4. Cost-Sharing Limitations

Effective for plan years beginning on or after January 1, 2014, all group health plans and health insurance issuers (for coverage in the individual and small group market) must, with respect to non-grandfathered coverage, ensure that (i) the annual deductible does not exceed $2,000 for self-coverage and $4,000 for family coverage, with each amount indexed annually beginning in 2015, and (ii) the annual out-of-pocket costs (including deductibles) do not exceed the limit that applies to a high deductible health plan under Code section 223, as it may be adjusted from year to year (this maximum is $6,050 for self-coverage and $12,100 for family coverage in 2012). (PHSA § 2707(a) & (b)). Such limits may be increased by amounts "readily available" for reimbursement under a flexible spending account. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

5. "Essential Health Benefits" Requirement for Insurance Sold to Small Groups

As noted in the "play or pay" discussion above at Section III.A., for purposes of the Code section 4980H tax on employers, the employer is not required to provide a group health plan that includes a certain minimum level of benefit. Yet as a practical matter, most employers with 100 or fewer employees provide health benefits through an insured product rather than self-insurance. Consequently, such employers' ability to shape the design of their health plans is at the mercy of the insurance market, which heretofore was regulated almost exclusively by the respective states. In many states, catastrophic-only or minimum benefit products have been made available to employers. PHSA section 2707(a), however, potentially alters that equation.

Effective for plan years beginning on or after January 1, 2014, that section provides that a health insurance issuer that offers health insurance in the "small group market" (i.e., for "small employers") must "ensure that such coverage, if it is not grandfathered, must include the essential health benefits package required" for "qualified health plans" under the Exchanges. For these purposes, a "small employer" is considered an employer that employed on average no more than 100 employees on business days during the prior calendar year and at least one employee on the first day of the plan year. (PPACA § 1304(b)(2)). As discussed above in Section II.E.1., an "essential health benefits" package must provide broad levels of coverage and must limit cost-sharing, and it may vary on a state-by-state basis.

It is unclear whether the language of PHSA section 2707(a) effectively means that any and all insurance products offered to employers with fewer than 100 employees will contain the "essential health benefits" minimums, or whether at least one such product offered to such employers must contain such minimums. The statutory language, while susceptible to either reading, is likely to be interpreted to require that all insurance product offerings contain the minimums. If so (and HHS will advise by regulation), it would appear that the ability of a small employer to acquire a low-cost, catastrophic-only type product is eliminated by the ACA, and that may significantly increase the cost of coverage for small employers.

6. "Transparency" Disclosures

Effective after guidance is issued by HHS, group health plans and health insurance issuers will be required, with respect to non-grandfathered coverage, to make certain "transparency" disclosures to HHS (and to the applicable state insurance commissioner and to the public), including information on claims-payment policies and practices, number of claims denied, rating practices, enrollment (and disenrollment), and information on cost-sharing and payments with respect to out-of-network coverage. (PHSA § 2715A). To some degree, this new rule overlaps with the annual requirement to file Form 5500s and the disclosures required by the Form 5500, but it is conceivable that employers will be required to satisfy these new filing obligations through new forms rather than by amendment to the existing Form 5500 structure. The effective date will likely not be until 2014 because this requirement mirrors a requirement imposed on coverage offered through an Exchange. This mandate is subject to the excepted benefits exclusion, retiree-only exclusion, and Code section 4980D penalty, all described at Section IV.A. above.

V. OTHER HEALTH BENEFIT-RELATED REQUIREMENTS

A. KEY RETIREE HEALTH PROVISIONS IN THE ACA

1. Limits on Deductions for Certain Retiree Prescription Drug Expenses

Under pre-ACA Medicare Part D rules, plan sponsors of certain qualified, employment-based retiree health plans that cover prescription drug expenses are eligible for subsidy payments from HHS for a portion of each "qualifying covered retiree's" prescription drug costs. The Medicare Part D subsidy, as it is called, encourages plan sponsors to provide retiree prescription drug coverage that is at least equivalent to Part D coverage, and thus avoid the need for those retirees to join the Medicare Part D system. Under pre-ACA Medicare Part D rules, the subsidy is excludible from the plan sponsor's income, and such exclusion is not taken into account in determining whether the plan sponsor may claim a tax deduction for those covered retiree prescription drug expenses. (Code § 139A). *For taxable years beginning after December 31, 2012*, however, the ACA modifies this regime so that the plan sponsor cannot take a deduction for retiree prescription drug expenses for which subsidy payments are received, effectively making the Medicare Part D subsidy payments taxable to the recipient. (PPACA § 9012 (amending Code § 139A); HCERA § 1407).

At the time of its passage, this tax law change caused an accounting issue for large employers that receive the Medicare Part D subsidy. Under Financial Accounting Standard 109 ("FAS 109"), employers are required to show as an asset on their balance sheets the present value of future tax deductions relating to future Medicare Part D subsidy payments. The ACA change, however, had the effect of reducing the FAS 109 value of the tax asset and requiring employers to take a charge against earnings for the reduced value of this tax asset.

2. Early Retiree Reinsurance Program

Although the loss of tax deductibility for the Part D subsidy will harm employers that provide retiree health benefits, the ACA also provided potential financial reimbursement to employers if their retiree health arrangements cover early retirees. The ACA established a temporary program through which the government will reimburse eligible plans for a portion of the cost of providing coverage to early retirees and their spouses, surviving spouses, and dependents. (PPACA § 1102). The program began shortly after enactment (June 21, 2010) but already has sunset because the $5 billion funding limit has been exhausted.

Payments must be used to lower increased costs for the plan sponsor or to lower costs for participants. Any use must also be in accordance with the proposed use of funds in the program application. Thus, in situations in which the plan is funded by the employer, the statutory language is properly read to allow employers to use reimbursements to reduce increases in their cost of coverage over the baseline plan year. Reimbursements also may be used to reduce premium contributions, copayments, deductibles, co-insurance, or other out-of-pocket plan costs of plan participants. When used to benefit participants, reimbursements must be used to benefit all plan participants, not just early retirees or participants whose claims resulted in reimbursement. Payments received under the program are not included in the gross income of the recipient.

B. THE CADILLAC-PLAN TAX

For taxable years beginning after December 31, 2017, the ACA imposes an excise tax on "Cadillac Plans." (Code § 4980I). Cadillac Plans are plans with a total coverage cost that exceeds $10,200 for individual coverage and $27,500 for other than individual coverage, as such amounts are adjusted for medical inflation since 2010. The Cadillac Plan tax will equal 40 percent of the cost of the coverage on a monthly basis that exceeds the thresholds described above (the excess benefit). The threshold limits are higher for persons in high-risk professions set forth in the ACA, including emergency personnel, and persons in certain jobs related to construction, utilities, and agriculture. In addition, the ACA provides for adjustments to the thresholds for employers whose health care costs are higher because of the age and gender of their employees. Further, the threshold for all coverage under a multiemployer plan is $27,500. The Cadillac Plan tax is imposed on health insurance issuers for insured plans and on the plan administrator for self-insured plans. The Cadillac Plan tax is not discussed further in this analysis because of the distant effective date and the possibility that significant changes to the provision will occur between now and then.

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C. SMALL EMPLOYER TAX CREDIT

The ACA provides for a tax credit for small businesses and tax-exempt organizations that provide health care coverage for their employees for tax years beginning after December 31, 2009. (Code § 45R). To qualify for the credit, (i) the employer must have fewer than 25 full-time equivalent employees (based on a 40-hour work week), (ii) the average annual wages must be less than $50,000 per full-time equivalent employee (with such amount increasing for inflation beginning in 2014), and (iii) the employer must maintain a qualifying arrangement where the employer provides a uniform contribution of at least 50 percent of the premium cost of coverage. Because the qualification is based on full-time equivalent employees, an employer could have more than 25 employees and still qualify, if some of those employees work part-time. However, the credit is not available for an employer with exactly 25 full-time equivalent employees and exactly $50,000 in average annual wages.

For the 2010–2013 tax years, the maximum credit is 35 percent of employer-paid premiums (25 percent for tax-exempt organizations), with the premium amount used in this calculation capped by the average premium for the local small group market. Beginning with the 2014 tax year, the maximum credit increases to 50 percent (35 percent for tax-exempt organizations). For purposes of the credit, a tax-exempt organization is one described in Code section 501(c), which is exempt from taxation under Code section 501(a). Tax-exempt organizations that do not meet this definition are eligible to claim the credit as a taxable employer, if they otherwise meet the requirements.

An employer with 10 full-time equivalent employees and average annual wages per full-time equivalent employee of $25,000 would receive the maximum credit. The credit is subject to a gradual phaseout for employers with full-time equivalent employees in excess of 10 or average annual wages in excess of $25,000. In other words, the credit is targeted to smaller employers with lower-paid employees. In addition, for tax-exempt organizations, the total credit is capped by the total amount of the organization's employee income tax withholding and Medicare employment taxes for the year. Small businesses can claim the credit on their income tax return, and any unused credit can be carried back for one year and forward for 20 years. Tax-exempt organizations can claim the credit on Form 990-T, and the credit is a refundable credit, as long as it does not exceed the tax-exempt organizations total income tax withholdings and Medicare tax liability for the year. Furthermore, the amount of the premium that is equal to the Code section 45R credit cannot be allowed as a deduction for purposes of Code section 162.

The number of full-time equivalent employees employed for a calendar year equals the total hours of service of all employees, divided by 2,080, rounded to the next lowest number, but not below one. For this purpose, "employee" includes leased employees and employees of certain related companies (for example, companies that are owned by the same individual or company or by spouses). However, an employer cannot receive a credit for premiums paid by a leasing company. "Employee" does not include partners, sole proprietors, S corporation shareholders who own more than two percent of the corporation, individuals who own more than five percent of other businesses, and family members or dependents of any of the foregoing. In addition, "employee" does not include seasonal workers who work less than 121 days during the year. Total hours of service include each hour employees are paid or entitled to payment for performance of services or during periods where the employees were out of work due to vacation, holiday, illness, layoff, incapacity, jury duty, military duty, or leave of absence. However, if an employee is out of work for more than 160 hours during a single continuous period, the employer is only required to include 160 hours toward the total hours of service for that employee.

"Average annual wages" equals the total wages paid by an employer to its employees (using the definition of "employee" set forth above), divided by the number of full-time equivalent employees for the year, rounded down to the nearest $1,000. For this purpose, "wages" has the same meaning as for employment (FICA) tax but without the limitation on wages for Social Security tax.

Tax credits or premium subsidies that are paid under state programs (for example, Medicaid) to an employer are not taken into account when determining (i) whether the employer satisfies the qualified arrangement requirement or (ii) the amount of the employer's credit under Code section 45R. Such amounts, when paid directly to insurance companies, are treated as being paid on behalf of the employer. Even though these tax credits and premium subsidies do not

affect whether an employer is eligible for a Code section 45R credit, the Code section 45R credit cannot exceed the net premium paid by the employer (i.e., the actual premium less the state credit or subsidy). In other words, double dipping is not allowed.

D. EXPANDED REQUIREMENTS FOR ELECTRONIC STANDARD TRANSACTIONS

The ACA adds additional requirements regarding the performance of electronic standard transactions by health plans, health care providers, and health care clearinghouses under HIPAA. The goal of these additional requirements is to provide as much uniformity as possible in the performance of electronic standard transactions, reduce the number and complexity of forms and data entry required, and eliminate, to the extent possible, the need for paper or other non-electronic communications. The ACA provides a staggered schedule for the issuance of new guidance, with guidance on different topics being issued no later than July 1 of 2011, 2012, and 2014. The new guidance will be effective also on a staggered schedule with effective dates on January 1 of 2013, 2014, and 2016. Health plans will be required to certify and provide documentation showing that their data and information systems are in compliance with the applicable standards and rules. This requirement will have the largest impact on health insurance issuers and third-party administrators, as these are the entities that generally perform electronic standard transactions on behalf of health plans. The cost of compliance will undoubtedly increase the cost of providing health coverage in the short term. However, in the longer term, it may result in increased operating efficiencies and therefore decreased administrative costs.

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VI. CONCLUSION

While much regulatory guidance has been issued since the ACA was enacted, there still remain many uncertainties confronting employers and health care administrators regarding how to provide health benefits to their employees in compliance with the ACA's legal requirements. Further, the vast majority of guidance regarding the Large Employer mandates has yet to be issued. Because of these uncertainties and lack of guidance, employers are struggling to understand how to design coverage appropriately for 2014.

Jones Day will continue to provide guidance on how the provisions of the ACA, and the developing regulatory framework, affect employer-sponsored health plans and their sponsoring employers as developments occur

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