2012 Health Care Reform Compliance Timeline—Quick Reference Guide

I.	Effective Immediately Following Enactment	a. Increased Adoption Assistance Exclusion
II.	Effective 90 Days Following Enactment	a. Early Retiree Reinsurance Program. New ERRP applications no longer being accepted after May 5, 2011. As of December 2, 2011 the ERRP had disbursed over $4.5B of the $5B that had been allotted to it. Accordingly, CMS will not accept claim lists that include any claims incurred after December 31, 2011.
III.	Effective Plan Years Beginning On or After September 23, 2010	a. No Lifetime Limits b. Restricted Annual Limits c. Adult Child Coverage to 26 (Federal)** d. No Rescissions e. No Pre-Existing Condition Exclusions for Participants Under Age 19 f. First Dollar Coverage for Preventive Care** g. Revised Appeals Process** h. Grandfathered Status Disclosure Notice i. Transparency Disclosures j. Nondiscrimination Rules Extended to Insured Plans*, ** k. Prohibition on ER Restrictions** l. Prohibition on PCP Restrictions**
IV.	January 1, 2011	a. No Reimbursement for Non-Prescription OTC Drugs b. Long-Term Care Program (October 14, 2011 HHS halts CLASS Act implementation) c. Increased Penalty for Non-Medical Withdrawals from an HSA or Archer MSA d. Simple Cafeteria Plans
V.	January 1, 2012	a. Corporate Service Provider Reporting Requirement b. Comparative Effectiveness Fee
VI.	September 23, 2012	a. Uniform Explanation of Coverage (Summary of Benefits and Coverage) b. 60-Day Notice of Material Modifications made other than in connection with a plan's renewal
VII.	January 1, 2013	a. Medicare Tax Increase for High-Earners b. No Deduction for Retiree Drug Subsidy c. Cap on Health FSA Contributions d. New Electronic Transaction Standards e. Form W-2 Reporting of Value of Benefits (for the 2012 tax year)
VIII.	March 1, 2013	a. Employer Notification Regarding Exchanges
IX.	January 1, 2014	a. State-Based Exchanges b. Free Rider Penalty c. No Pre-Existing Condition Exclusions d. Limit on Employee Out-of-Pocket Expenses** e. Employer Certification of Coverage f. Required Coverage for Clinical Trials for Life-Threatening Diseases** g. Individual Mandates h. No Annual Limits i. 90-Day Limit on Waiting Periods j. Increased Wellness Program Incentives k. Nondiscrimination Rules l. Community Rating m. Automatic Enrollment*
X.	2015 – 2018	2015-Electronic Claim Processing 2017-Exchange for Large Employers 2018-Cadillac Tax

**Effective Date Unclear* ***May contain certain exclusions for Grandfathered Plans*

Health Care Reform Employer Guide

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. Within a week, Congress passed the Health Care and Education Tax Credit Reconciliation Act of 2010 (HCERA). PPACA and HCERA (collectively referred to as "Health Care Reform") require all employer-sponsored plans – both self-insured and fully-insured group health plans – to comply with certain mandates over the next several years.

This Employer Guide highlights the changes that grandfathered and non-grandfathered plans will need to consider.

I. Effective Immediately Following Enactment

a. Increased Adoption Assistance Exclusion

Health Care Reform increases the tax credit under IRC §23 to $13,170 for all adoptions, including adoptions of children with special needs. It also increases the exclusion for employer-provided adoption assistance under section 137 to $13,170 for all adoptions, including adoptions of children with special needs. In addition, Health Care Reform allows for the credit and exclusion to be adjusted for inflation beginning January 1, 2011. That adjustment is made by multiplying the statutory limit by the cost of living adjustment for the calendar year in which the tax year begins. If the amount as increased is not a multiple of 10, the amount is rounded to the nearest multiple of 10.
[Tax years beginning on or after December 31, 2009]

II. Effective 90 Days Following Enactment

a. Early Retiree Reinsurance Program

Health Care Reform creates a temporary reinsurance program for employers providing benefits for retirees age 55 and older who are not eligible for Medicare. Employers can submit claims to the Secretary of HHS for reimbursement. The program reimburses up to 80% of expenses between $15,000 and $90,000 per retiree. Reinsurance payments must be used to lower the costs of the health plan and are excluded from employer's gross income. This program is financed by a $5 billion appropriation and ends at the earlier of the time the funding runs out or January 1, 2014.

New ERRP applications no longer being accepted after May 5, 2011. As of December 2, 2011 the ERRP had disbursed over $4.5B of the $5B that had been allotted to it. Accordingly, CMS will not accept claim lists that include any claims incurred after December 31, 2011. Even if only one post-12/31 claim is included on a claim list, together with allowable claims, CMS will reject the entire list.

III. Effective Plan Years Beginning On or After September 23, 2010

a. No Lifetime Limits

Group health plans are prohibited from placing lifetime dollar limits on "essential health benefits." For the 2011 plan year, group health plans will need to provide a 30 day special enrollment period for those individuals who have met their lifetime limit but are still eligible for coverage, which may run concurrent with the open enrollment period.

b. Restricted Annual Limits

Health Care Reform restricts annual limits on "essential health benefits." The restricted annual limits are based on plan years until 2014 when annual limits on essential health benefits are prohibited.

For example:

- $750,000 for plan years beginning on or after September 23, 2010 but before September 23, 2011
- $1,250,000 for plan years beginning on or after September 23, 2011 but before September 23, 2012
- $2,000,000 for plan years beginning on or after September 23, 2012 but before January 1, 2014

c. Child Coverage to Age 26

Health Care Reform allows children under age 26 to remain covered under their parents' medical insurance coverage. Under the federal law, group health plans that provide dependent coverage are required to extend eligibility for dependents to age 26. Employers are not required to offer coverage to an adult child's spouse or children. Health Care Reform extends the exclusion from gross income for coverage of adult children. In order for an older age child to be eligible for coverage, the child may be married or unmarried and must:

- be the child of the employee as defined under IRC §152(f)(1)
- have not yet reached their 26th birthday
- not be eligible for other employer coverage (this exclusion is available only to grandfathered plans, and then only for plan years starting on or before January 1, 2014)

d. No Rescissions

Group health plans may not retroactively cancel coverage after enrolling a participant, except in the event of fraud or intentional misrepresentation of material fact. A discontinuance of coverage is not a rescission if it has only a prospective effect, or is retroactive only to the extent it is attributable to a failure to pay required contributions. Note that 30 days advance written notice must be provided to each participant who would be affected by a rescission.

e. No Pre-Existing Condition Exclusions for Children Under Age 19

Group health plans are required to eliminate pre-existing condition exclusions for children under the age of 19. *[Provision applies to children under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]*

f. First Dollar Coverage for Preventive Care

Non-grandfathered group health plans may not impose cost sharing for certain preventive services. This means that the group health plan must pay the full cost of evidence-based preventive care, as recommended by the U.S. Preventive Services Task Force, immunizations recommended by the ACIP of the CDC, breast cancer screenings and other preventive services identified in HRSA guidelines.

In addition, in August 2011, HHS issued additional guidelines regarding women's health care services that group health plans and health insurance policies must cover without cost-sharing. The new guidelines apply to the first plan year that begins on or after August 1, 2012, which means that for calendar year plans the guidelines will be effective beginning January 1, 2013. The release and effective date were specifically intended to ensure that plans covering college students, which commonly begin new policy years in August, are subject to the guidelines for the 2012-2013 school year.

These new recommended preventive services for women include: well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies, and counseling; and domestic violence screening and counseling.

g. Revised Appeals Process

Non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage must provide an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process that meets minimum standards or the plan is self-insured, the plan or issuer shall implement an external review process that meets standards established by the Federal government. The group health plan must continue coverage until appeals process is resolved.

h. Grandfathered Status Disclosure Notice

To maintain status as a grandfathered health plan, employers must include a statement, in **any and all** plan materials provided to a participant or beneficiary describing the benefits provided under the group health plan, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints. Plans must maintain records documenting the terms of the plan that were in effect on March 23, 2010 and any

other document necessary to support that the plan has maintained grandfather status. Plans are required to make these records available for examination by participants or the agencies on request.

The following model language can be used to satisfy this disclosure requirement:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
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> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

i. Transparency Disclosures

Group health plans must submit to the Secretary of HHS, and make available to the public, information regarding claims payment policies, enrollment information, information on cost sharing and rating policies, information on out-of-network coverage and information on participant rights. The Secretary of HHS may require additional information as well but has not yet issued guidance on this disclosure.

j. Nondiscrimination Rules Extended to Non-grandfathered Insured Plans (Indefinitely Delayed)

Non-grandfathered fully insured group health plans must comply with IRC §105(h) rules that prohibit discrimination in favor of "highly-compensated individuals." Similar non-discrimination requirements applied to self-insured group health plans prior to Health Care Reform (and continue to apply to self-insured plans).

k. Prohibition on Emergency Room Restrictions

Non-grandfathered group health plans may not require prior authorization for emergency room services received in-network or out-of-network and may not include administrative requirements or limitations of benefits for out-of-network emergency services that are more restrictive than those applying to emergency services received in-network. Cost sharing for out-of-network emergency services may not be greater than if the services were provided in-network. Any other cost-sharing requirements (such as a deductible or out-of-pocket maximums) can only be imposed for emergency services if the requirement applies generally to out-of-network benefits.

l. Prohibition on Primary Care Physician Restrictions

Non-grandfathered group health plans that require the employees to select an in-network primary care physician must allow the participants to designate any available participating network primary care provider and see any participating OB/GYN and pediatrician without a primary care provider referral. Summary plan descriptions and other similar descriptions of benefits must include a notice to individuals of these rights.

IV. January 1, 2011

a. No Reimbursement for Non-Prescription OTC Drugs

Employees may no longer purchase non-prescription over-the-counter drugs on a pre-tax basis through health FSAs, HSAs, Archer MSAs or HRAs. This change will not affect insulin or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays, and deductibles.

b. Long-Term Care Program (<u>October 14, 2011 HHS halts CLASS Act implementation</u>)
The Community Living Assistance Services and Support (CLASS) Act is a voluntary, federal program for long-term care insurance. Employee participation is voluntary, and employers who choose to implement the program may automatically enroll employees unless they opt out. Employees pay a monthly premium through payroll deduction. After five years of contributing, the employee becomes eligible to receive assisted living funding in the event the employee is no longer able to perform normal daily activities. Only active workers are eligible to participate.

c. Increased Penalty for Non-Medical Withdrawals from an HSA or Archer MSA
Health Care Reform increases the penalty tax on non-medical withdrawals to 20% from an HSA (currently 10%) or an Archer MSAs (currently 15%).

d. Simple Cafeteria Plans
Employers with 100 or fewer employees during either of the two prior years will be permitted to adopt "simple cafeteria plans." These plans are deemed non-discriminatory for purposes of the non-discrimination requirements applicable to life insurance, self-insured plans and dependent care plans, if the employer provides a minimum of 2% of pay contribution for participants and the plan satisfies minimum eligibility and participation requirements. Employees who have completed at least 1,000 hours during the prior year must be allowed to participate. Employees younger than 21 years old with less than one year of service can be excluded. The minimum contribution requirement can be satisfied if the employer contribution for all participants is the lesser of (a) 6% of pay or (b) two times each employee's pre-tax contribution.

V. January 1, 2012

a. Corporate Service Provider Reporting Requirement (<u>Repealed</u>)
Employers must issue Form 1099s reflecting any payment over $600 to corporate service providers.

b. Comparative Effectiveness Fee
Employers sponsoring group health plans will be required to pay $1.00 per participant in 2012. The annual fee increases to $2.00 per participant in 2013 and is indexed for inflation beginning in 2014. The comparative effectiveness fee phases out in 2019. Revenue from this fee will fund research to determine the effectiveness of various forms of medical treatment. The fee applies to insured and self-insured medical plans regardless of grandfathered status, including retiree-only plans and most HRAs, but excluding HIPAA-excepted benefits such as stand-alone dental or vision plans and most health FSAs. Insurers and plan sponsors must report and pay the fee annually on IRS Form 720, which will be due by July 31 of each year, with the first due date being July 31, 2013, which will cover policy or plan years that end during 2012. Form 720 may be filed electronically, although the IRS has not yet updated Form 720 to reflect the reporting of these fees. With respect to insured plans, the carrier is responsible for paying the fee. With respect to self-insured plans, the plan sponsor is responsible for paying the fee. Various methods exist for counting members; consult with qualified benefits counsel for assistance.
[Plan years ending after September 2012]

VI. September 23, 2012

a. Uniform Explanation of Coverage
Employers must provide a uniform summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment.

For disclosures to participants and beneficiaries who enroll or re-enroll in group health plan coverage at open enrollment, the SBC must be provided no later than the first day of each open enrollment that begins on or after September 23, 2012. For participants enrolling other than through open enrollment (including newly eligible participants or those subject to a special enrollment opportunity), the SBC must be provided starting on the first day of the plan year beginning on or after September 23, 2012.

The summary may not be longer than four double-sided pages and not include print that is smaller than a 12 point font. The summary must be written in a "linguistically" and "culturally" appropriate manner so it is easy

for the participant to understand. The summary must contain information regarding cost sharing, continuation of coverage, limitations on coverage and details on where participants can obtain more information. This summary is required in addition to the ERISA summary plan description. The Secretary of HHS will develop this summary no later than March 23, 2011. Failure to comply will result in a $1,000 fine per occurrence. Unless the plan has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).

b. 60-Day Notice of Material Modifications
Employers must provide notice of any material modification in coverage at least 60 days prior to the effective date of the modification (other than a material modification made in connection with the plan's renewal). This requirement is part of the Uniform Explanation of Coverage and is in addition to the ERISA summary plan description. Failure to comply will result in a $1,000 fine per occurrence.

VII. January 1, 2013

a. Medicare Tax Increase for High-Earners
Health Care Reform increases the 1.45% Medicare payroll tax on workers' wages to 2.35% (0.9% increase) on earnings that exceed $200,000 for an individual filer or $250,000 for a married couple filing jointly. The portion of the Medicare payroll tax paid by the employer would remain at 1.45%. Health Care Reform will also impose a new Medicare tax of 3.8% on the lesser of (a) net investment income (including interest, dividends, royalties, rents and other passive income) or (b) the excess of modified gross income that exceeds that threshold ($200,000 for single filers or $250,000 for married couples filing jointly).

***b.* Form W-2 Reporting of Value of Benefits**
Employers are responsible for reporting the total costs incurred for providing health care to employees. Specifically, W-2s for the 2012 tax year must include the "aggregate cost" of employer-sponsored group health insurance coverage, excluding any salary reductions deferred to a flexible spending account and all contributions to an HSA or Archer MSA. "Aggregate cost" is the annual cost of the insurance and includes any portion paid by the employee. Employers may use COBRA rates (without the 2% administrative fee) to determine the value of benefits.
[Tax years beginning on or after January 1, 2012, with the cost of coverage to be first reported on January 2013 Form W-2s]

c. No Deduction for Retiree Drug Subsidy
Although Health Care Reform retains the Retiree Drug Subsidy, it eliminates an employer's ability to deduct the amount of that subsidy. This change increases an employer's income tax liability, in effect increasing the employer's cost of providing prescription drug coverage to retirees. The amount by which an employer's tax liability will increase depends on the total amount of the subsidy and the employer's applicable corporate tax rate, which currently ranges from 15 percent for income below $50,000 to 35 percent for income over $10 million. Although employers will not face the higher tax liability until 2013, under financial accounting rules, employers must now include the present value of the future taxes as a current liability charged against earnings.

d. Cap on Health FSA Contributions
Employee contributions to employer-sponsored health flexible spending account are limited to $2,500 in a calendar year. This limit is indexed to inflation starting in 2014.
[Effective for plan years beginning on or after January 1, 2013]

e. New Electronic Transaction Standards
Group health plans must file a certification with the Secretary of HHS that their plan is in compliance with "administrative simplification" rules (to be published) for electronic fund transfer, health claim status and health care payment. The penalty for non-compliance is $1.00 per covered life per day of non-compliance, to a maximum of $20.00 per covered life per year. A double penalty applies in the case of a misrepresentation by the employer.
[Systems must be effective starting January 1, 2013 and employers must certify compliance by December 31, 2013]

VIII. March 1, 2013

a. Employer Notification Regarding Exchanges

Employers must provide existing employees and new employees on their hire date with information about the existence of state insurance Exchanges, including information on employee eligibility for an Exchange if the actuarial value of the health plan is less than 60% and the employee's contribution towards the cost of employee-only coverage exceeds 9.5% of his/her household income, and the loss of employer contribution toward the value of coverage if the employee purchases coverage through the Exchange.

IX. January 1, 2014

a. Automatic Enrollment

Employers with more than 200 employees who maintain one or more group health plans must automatically enroll all full-time employees (defined as employees who work more than 30 hours per week) as soon as they are eligible for coverage. The employer must give affected employees notice of this automatic enrollment procedure and an opportunity to opt out.
[Effective date unclear; the Department of Labor has concluded that its automatic enrollment guidance will not be ready to take effect by 2014]

b. State-Based Exchanges

Every state must establish a health insurance Exchange for use by the uninsured and small employers with 100 or fewer employees (although states may set the cap at 50 employees). The exchanges will offer fully insured contracts that provide essential health benefits at different levels of coverage (i.e. platinum, gold, silver and bronze). Employees may pay for the Exchange premiums on a pre-tax basis only if it is purchased through an employer's cafeteria plan.

c. Free Rider Penalty

Employers with 50 or more employees will be required to offer "minimum essential coverage" to all full-time employees (working 30+ hours) through a group health plan. If an employer does not provide coverage and at least one full-time employee receives coverage through an Exchange, the employer will be assessed a penalty of $2,000 per year for each full-time employee. If an employer provides coverage but the coverage is deemed unaffordable, the employer will be assessed a penalty of the lesser of $3,000 per year for each full-time employee receiving the premium credit on an Exchange or $2,000 per year for each full-time employee. An employee who is offered coverage will only be eligible for the premium credit if the employee's contribution exceeds 9.5% of the employee's household income or if the plan's share of the total allowed cost of benefits is less than 60%. The first 30 employees are disregarded when calculating the $2,000 per employee penalty.

d. No Pre-Existing Condition Exclusions

Group health plans and individual insurance policies are required to eliminate pre-existing condition exclusions completely.
[Provision applies to individuals under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]

e. Limit on Employee Out-of-Pocket Expenses

Group health plans must limit out-of-pocket costs to $5,950 for single coverage and $11,900 for family coverage, and deductibles can be no greater than $2,000 for single coverage or $4,000 for family coverage.
[Additional regulatory guidance expected to clarify the scope of this requirement]

f. Employer Certification of Coverage

Employers offering group health coverage must fulfill two new IRS reporting requirements. Employers that self insure their group coverage must identify those employees and dependents that were offered health coverage and specify the dates of coverage (if the policy is fully insured, the report must be filed by the insurer.) Employers with 50 or more full-time employees must certify whether all full-time employees and their dependents were offered health care coverage. The certification must include the length of the waiting period under the plan, the time period during which coverage was available, the premium charged and the employer's

share of the cost. A statement containing this information must also be provided to all full-time employees. The Secretary will use the certification to enforce the individual mandate.

g. Required Coverage for Clinical Trials for Life-Threatening Diseases
Group health plans may not deny individual participation, discriminate an individual on the basis of participation or deny coverage of routine patient costs for items and services rendered in a clinical trial for a life-threatening disease.

h. Individual Mandates
Health Care Reform requires individuals to obtain "minimum essential coverage" (i.e. Medicare, Medicaid, CHIP, individual insurance and eligible employer sponsored plans) for themselves and their dependents or pay a monthly penalty tax for each month without coverage. The monthly penalty is 1/12 of the greater of the dollar penalty or the gross income penalty amounts. The dollar penalty in 2014 is $95.00 per individual to a maximum of $285 per family. The dollar penalty in 2015 is $325 per individual to a maximum of $975 per family. The dollar penalty in 2016 is $695 per individual to a maximum of $2,085 per family. In 2017 the dollar penalties will be indexed for inflation. The gross income penalty in 2014 is 1% of household income in excess of a specified filing threshold, 2% in 2015 and 2 ½% in 2016 and beyond. Waivers are allowed for specified individuals and circumstances.

i. Free Choice Vouchers (<u>Repealed</u>)
If any employee's cost of coverage exceeds 8% of household income but does not exceed 9.5% of household income, and the employee's household income is less than or equal to 400% of the federal poverty level, employers must provide that employee a tax-exempt "free choice voucher" to be used to purchase coverage through a state-based Exchange. The amount of the voucher will be equal to the cost the employer would have paid to cover the employee under the most generous option in the employer's plan, based on the level of coverage (single or family coverage) that the employee obtains through the Exchange. The employer pays the amount directly to the Exchange, with the employee retaining the excess amount if the cost of coverage in the Exchange is less than the cost of the employer's coverage. If an employer provides a voucher and the employee purchases coverage through an Exchange, the employer will not be subject to the "free rider" penalty as a result of that employee's purchase.

j. No Annual Limits
Group health plans may no longer include annual limits on "essential health benefits" for participants, but may continue to do so for beneficiaries.

k. 90-Day Limit on Waiting Periods
Group health plans may not impose a waiting period longer than 90 days for health care coverage.

l. Increased Wellness Program Incentives
Health Care Reform increases the wellness program incentive cap from 20% of the total cost of coverage to 30%.

m. Nondiscrimination Rule
Health Care Reform will adopt HIPAA's rules whereby group health plans may not discriminate as to benefits or coverage based on health status.

n. Community Rating
Health insurance issuers providing individual or small group policies covering 100 or fewer individuals must abide by strict community rating rules with premium variations allowed only for age (3:1), tobacco use (1.5:1), level of coverage (single or family) and geographic rating area (regions to be defined by the states). Experience rating will be prohibited. These rating restrictions will also apply to insurers offering large group policies through the Exchange.

X. 2015 – 2018

2015 – Electronic Records
Group health plans must certify to the Secretary of HHS that they are using electronic systems for processing health claims, enrollment and premium payments and that their systems are in compliance.
[Group health plans must certify compliance by December 31, 2015]

2017 – Exchange for Large Employers
States are able to allow large employers with more than 100 employees to purchase health insurance for their employees through the exchanges.

2018 – Cadillac Tax
Health Care Reform imposes a non-deductible excise tax of 40% on the value of health insurance benefits exceeding $10,200 for single coverage and $27,500 for family coverage (indexed to inflation). The thresholds are higher for qualified retirees and "high risk" professions ($11,850 for single and $30,950 for family.) The tax appears to include all employer and employee amounts paid for medical, including pre-tax employee premiums and contributions made to health FSAs, HRAs and HSAs. It does not include stand alone dental or vision coverage. The plan administrator is responsible for calculating the value of coverage and dividing the tax pro rata among insurers (including the employer, if self-insured). Plans are allowed to take into account age, gender and certain other factors that impact premium costs.
[Tax years beginning on or after January 1, 2018]

Additional Key Points on Health Care Reform

- Collectively-bargained, multi-employer and single employer plans in effect on March 23, 2010 do not have to evaluate the plans for loss of grandfathered status until the date on which the last collective bargaining agreement relating to the coverage terminates.

- A temporary, high-risk health insurance pool is to be established by the US Department of Health and Human Services (DHHS) no later than June 21, 2010 for use by those individuals with pre-existing conditions who are currently uninsured and unable to purchase insurance. This coverage will end in 2014 when exchanges become operational and the pre-existing condition provision takes effect.

- Employers and health insurers are prohibited from providing an incentive to any person to dis-enroll from the employer's plan in order to shift coverage to the temporary governmental high-risk sharing pool. The penalty for violation is reimbursement to the governmental pool of the medical expenses it incurs for such persons.

- Health Care Reform includes a small business health care tax credit designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. The credit is specifically targeted to help small businesses and tax-exempt organizations that primarily employ moderate- and lower-income workers. In 2010, the credit is generally available to employers with less than 25 full-time equivalent (FTE) employees and average annual wages of less than $50,000. Employers must contribute an amount equivalent to at least half the cost of single coverage. For tax years 2010 to 2013, the maximum credit is 35% of premiums paid by eligible small business employers and 25% of premiums paid by eligible employers that are tax-exempt organizations. Beginning in 2014, the maximum tax credit will go up to 50% of premiums paid by eligible small business employers and 35% of premiums paid by eligible, tax-exempt organizations for two years. The maximum credit goes to smaller employers with 10 or fewer FTE employees paying annual average wages of $25,000 or less. Because the eligibility rules are based in part on the number of FTE employees, and not simply the number of employees, businesses that use part-time help may qualify even if they employ more than 25 individuals. Seasonal workers, self-employed individuals (and family members), 2% shareholders of an S-corporation (and family members) and 5% owners (as defined by section 416(i)(1)(B)(I)) of a small business or family members, are not counted as 'employees'. Leased employees are counted. Any credits received offset deductions for health insurance costs to employer.

- Health Care Reform provides a $250 rebate for all Medicare Part D enrollees who enter the "donut hole" in 2010. The donut hole is created when a Medicare Part D beneficiary exceeds the prescription drug coverage limit but has not had costs that have reached the catastrophic coverage limit, so is personally responsible for the cost of prescription drugs in this gap. Health Care Reform increases discounts in subsequent years and completely closes the donut hole by 2020. This provision is significant for employers providing coverage for retirees to supplement Medicare Part D coverage. *[Phase out begins January 1, 2011]*

- Health Care Reform provides that a health insurance company cannot deduct compensation paid to an employee in excess of $500,000 per year.
  [Applies to current compensation beginning in 2013; applies immediately to compensation deferred in 2010 and paid on or after 2013]

- States must implement a CHIPRA premium assistance subsidy for individuals under age 19 and/or their parents for premiums paid for employer-sponsored health coverage and extend such assistance to all individuals who qualify for medical assistance under Medicaid or a state medical assistance program, regardless of age. The state will pay the employee cost of coverage and any cost-sharing expenses (i.e. copayments, deductibles, etc.) that otherwise would be covered by the state program. Eligible employees can opt out of the employer's health plan.
  [January 1, 2014]

- The current 7.5% of AGI floor on income-tax deductions for health care expenses is raised to 10% of AGI, effective January 1, 2013. The new floor is waived during 2013, 2014, 2015 and 2016 for individuals who turn 65 before the close of those years.