Where Are We Today?

An Update to ABA's *The Brief* Article Published in Winter 2013

I was asked to write an article regarding effective dates of the various provisions of the Patient Protection and Affordable Care Act ("PPACA" or "ACA" or "ObamaCare") to be published in the Winter 2013 edition of the American Bar Association's *The Brief*. A copy of the article as published is included in your materials. This supplement is designed to give you updates and additional details not included in the original article. Additionally, I will note certain planning opportunities for large employers.

UPDATES

1. Medicaid Expansion. As you are likely aware, Tennessee has not yet chosen to expand Medicaid. Governor Haslam has been to Washington several times to discuss his proposed "Tennessee Plan," which involves expanding our state's TennCare program. The proposed Tennessee Plan would use federal money to allow uninsured adults to buy private insurance on the federal health insurance exchanges. To date, Governor Haslam has not received approval of his proposal.

In September, CMS approved a similar plan, however, called the "Premium Assistance Model" or the "Arkansas Private Option Plan." The Arkansas Plan is very similar to the proposed Tennessee Plan, and there is much speculation that other states – including Tennessee, Michigan and Iowa – will alter their proposed plans to match the Arkansas Plan in order to expedite approval.

2. Nutritional Information. The FDA has stated that it will not enforce these provisions (on restaurants, retail food establishments, vending machine operators) until the final regulations are published, and likely not until some period of time following such publication (to give operators time to comply). Proposed regulations were published two years ago and final regulations were supposed to have been published a year ago, but publication was delayed. It was rumored that the final rules were going to be published in September 2013, but that did not happen.

3. Small Employer Tax Credit. Small nonprofit organizations may receive up to a 25% refundable credit. The Form 990-T, currently used by tax-exempt organizations to report and pay the tax on unrelated business income, has been revised to enable eligible tax-exempt organizations – even those that owe no tax on unrelated business income – to claim the small business health care tax credit by filing the form. A nonprofit can file IRS Form 990-T to claim the refund even if it does not otherwise need to file the IRS Form 990-T. The small employer credit can be claimed against three of the payroll taxes that nonprofits regularly send in to the IRS: the employer and employee share (combined total of 2.9%) of Medicare withholding, and the federal income taxes withheld by the employer on behalf of the employee. Employees will continue to get credit for their withheld income taxes payments.

4. **Wellness Program Rules.** The U.S. Department of Health and Human Services, Labor and Treasury issued their rules regarding wellness programs on May 29, 2013. The final rules will be effective for plan years beginning on or after January 1, 2014. The final rules ensure flexibility for employers by increasing the maximum reward that may be offered under appropriately designed wellness programs, including outcome-based programs. Specifically, the maximum rewards (or penalties) may total up to 30% of the total cost of coverage (including both employer and employee contributions), up from 20% under current law. In addition, the final regulation increases the maximum permissible reward (or penalty) to 50% for wellness program incentives designed to prevent or reduce tobacco use. The final rules also protect consumers by requiring that health-contingent wellness programs be reasonably designed, be uniformly available to all similarly situated individuals, and accommodate recommendations made at any time by an individual's physician based on medical appropriateness.

5. **Delays.**

a. **Employer Mandate.** The "employer shared responsibility" provision has been delayed until January 1, 2015. Although the law is technically still in place as of January 1, 2014, the IRS has stated that it will not enforce until January 1, 2015.

b. **Verification of Coverage.** Exchange/Marketplace will not verify applicants' coverage against employers' offering.

c. **Verification of Income.** Exchange/Marketplace will "scale back" verification of applicants' income. **[See discussion below related to changes in this area made by the recent budget resolution.]**

d. **Medicaid Electronic Notices.** Delayed until 2015.

e. **Large Employer Reporting.** The IRS has delayed compliance with the proposed regulations for one year under Notice 2013-45, 2013-31 I.R.B. 116. The reporting requirements are now effective for tax years beginning in 2015, with the first report due in 2016 for 2015 coverage. The IRS, however, encourages employers to voluntarily comply with the information reporting requirements for 2014. The proposed regulations were published in the Federal Register on September 9, 2013, with written comments to reduce or streamline reporting under the proposed rules due by November 8, 2013.

6. **Recent Government Shutdown resolution.** The only provision of the budget resolution that directly addresses the ACA requires the HHS Secretary to certify to Congress that the exchanges verify eligibility for premium tax credits and cost-sharing reduction payments consistently with the requirements of Section 1411 of the ACA. By January 1, 2014, HHS must submit a report to Congress as to how the exchanges are verifying eligibility, and by July 1, 2014, the HHS Office of Inspector General must submit a report to Congress as to the

effectiveness of the eligibility procedures and safeguards in place for preventing inaccuracies and fraud.

The referenced Section 1411, however, provides few specifics as to how financial eligibility is to be determined, and further provides, "The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant." In sum, HHS may for political reasons choose to enhance verification procedures, but there is nothing in the ACA or in the budget resolution that would require it to do so. In any event, HHS already requires far more to verify exchange eligibility than the IRS often requires to verify eligibility for other tax benefits, which in aggregate probably cost the U.S. Treasury far more money.

7. **Employers Cannot Ignore other ACA Provisions.** Even with the delay in the employer mandate and reporting requirements, employers cannot ignore other provisions of the ACA that have become effective already or will become effective in 2014. These include the following:

a. **90-Day Waiting Periods Limit**: Effective for plan years beginning on or after January 1, 2014, a group health plan or health insurance issuer cannot impose any waiting period that exceeds 90 days.

b. **Maximum Out-of-Pocket Limitation**: Effective for plan years beginning on or after January 1, 2014, a group health plan must comply with a new maximum out-of-pocket limitation, which is $6,350 for employee-only coverage and $12,700 for family coverage. This requirement applies to both self-funded and insured plans.

c. **Patient-Centered Outcomes Research Institute (PCORI) Fee:** Health insurance issuers and sponsors of self-funded plans must pay a fee to fund the patient-centered outcomes and research institute based on the average numbers of lives covered. The PCORI fee is $2 ($1 in the case of a policy or plan year ending before October 1, 2013, and $2 for subsequent years). The fee expires in 2019.

d. **Transitional Reinsurance Fee**: Insured and self-funded plans must pay a per enrollee fee of $63. The number of enrollees must be reported by November 15, 2014. The first fee must be paid in early 2015.

e. **Preexisting Condition Exclusions:** Effective for plan years beginning on or after January 1, 2014, the prohibition on preexisting condition exclusions (currently applicable only with respect to individual under age 19) is extended to individuals of all ages.

f. **Elimination of Annual Limits:** Effective for plan years beginning on or after January 1, 2014, annual limits on the dollar amount of essential health benefits are prohibited.

ADDITIONAL DETAILS

8. Reporting Requirements for 2013 and 2014.

a. W-2 Reporting. Employers must report aggregate cost of health insurance on each employee's Form W-2 effective for 2012 tax year (i.e., W-2s issued in January 2013). This is only applicable to employers that file 250 or more Form W-2s.

b. Summary of Benefits and Coverages. This is effective on all plans renewing after October 1, 2012. Employer must provide to all employees a uniform, concise, easy-to-read four page summary of benefits and coverage. (Originally meant to be four pages total, now can do four pages front and back.) This summary must be provided at initial enrollment, open enrollment and upon request.

c. Notice of Exchange. Employers are required to notify **all** employees regarding the availability of subsidized health insurance exchange coverage. A model notice is available at www.dol.gov. This notice was required to be given as of October 1, 2013.

9. Penalty for Failure to Offer "Minimum Essential" Health Coverage. Applicable large employers (i.e., more than 50 FTEs) that fail to offer "minimum essential" health coverage to at least 95% of their full-time employees (and their children) will pay a penalty *if any full-time employee receives a federal subsidy to purchase insurance through a health exchange*. This "no-coverage" penalty under 4980H(a) will be $2,000 per year multiplied by the number of FTEs in excess of 30.

10. Penalty for Offering "Minimum Essential" Coverage that is not "Minimum Value" or not "Affordable". Employers that offer "minimum essential" coverage, but fail to provide "minimum value" or provide coverage deemed "unaffordable," will pay a penalty under 4980H(b) that is the *lesser* of $2,000 per year multiplied by the number of full-time employee (minus 30) or $3,000 multiplied by the *number of full-time employees who receive a premium tax credit to purchase coverage through a health insurance exchange*. The tax credit is generally available to those employees who cannot buy "affordable" or "minimum value" coverage and whose family income is below 400% of the Federal Poverty Level.

a. **"Minimum Value."** "Minimum Value" means that the plan's share of the total allowed costs of benefits provided under the plan is not at least 60% of those costs. The Department of Health and Human Services has provided a

"minimum value" calculator to determine if the plan is deemed to pay for at least 60% of the benefits. Alternatively, the regulators are also supposed to publish safe harbor plan designs that are deemed to provide minimum value. Plans with nonstandard features may use a certified actuary

b. **"Affordable."** Employers may take advantage of one of three safe harbors to determine whether their plan is "affordable." A plan is deemed affordable if the employee's required contribution for the calendar year for the employer's lowest cost, self-only coverage that provides minimum value during the entire calendar year (excluding COBRA or other continuation coverage) does not exceed 9.5% of: (1) the employee's W-2 wages from the employer for the calendar year, (2) the employee's rate of pay, or (3) the federal poverty level.

11. Planning opportunities for Large Employers.

a. If the employer has a small (or borderline) number of full-time employees, but many part-time employees, employers should consider capping part-time employees' hours at twenty-eight (28) per week to avoid an "accidental" classification as full-time (and thus possibly bumping the employer into the "large employer" classification).

b. Depending on the cost of coverage, of course, it may be less expensive to pay the penalty than to provide coverage. Remember, however, to factor in the fact that the penalty is not tax deductible when doing the calculation to make this determination.

c. If the employer is currently paying for or contributing substantially to spousal coverage, the employer may deny coverage for spouses who are eligible for coverage through their own employers. Alternatively, employers may require a substantial surcharge to be paid for spousal coverage. Of course, the difficulty is in determining which spouses are eligible for coverage through their own employers.

d. Employers may consider providing a so-called "skinny" plan to their employees to minimize, but not avoid, penalties under 4980H. Such a "skinny" plan, which would provide little beyond required preventive care services, would serve to provide "minimum essential coverage," but likely would not provide "minimum value." This means that the employer may avoid paying the no-coverage penalty under 4980H(a), which is $2,000 multiplied by the number of FTEs in excess of 30. Instead, the employer would pay the penalty under 4980H(b), which is the lesser of the 4980H(a) penalty or $3,000 multiplied by the number of FTEs who receive a federal premium tax credit only. Some employees who would otherwise be eligible for the tax credit may

prefer the employer's skinny plan to exchange coverage, which would reduce the amount of the employer penalty.

American Bar Association

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Effective Dates Are Lurking
Health Care REFORM

Also in this issue:

Effective Dates Are Lurking
WHAT YOU SHOULD KNOW ABOUT HEALTH CARE REFORM

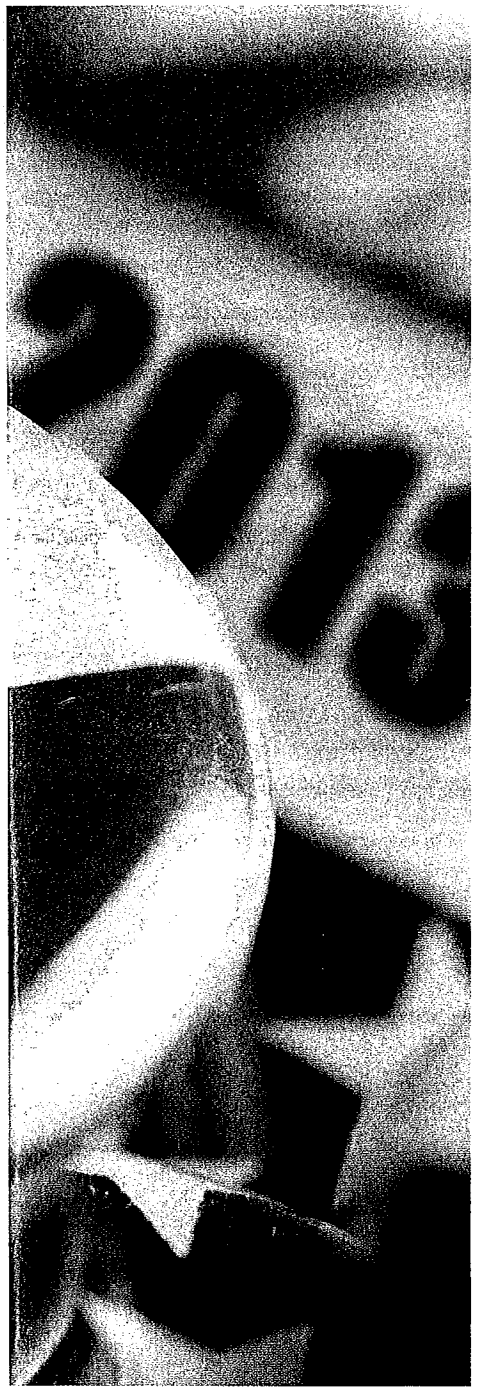
By Shannon Coleman Egle

Health care lawyers throughout the United States have been experiencing a higher than normal call volume recently. Interestingly, many of the calls are coming from colleagues who are in management positions at their own law firms, as well as from colleagues who routinely advise clients in corporate and employment matters. All of the callers are after the same information—a summary of the recent Supreme Court decision on health care reform and what that decision means for them.

The Supreme Court Case

The Patient Protection and Affordable Care Act (PPACA) was enacted on March 23, 2010.[1] Soon to follow were numerous federal court cases challenging various aspects of the PPACA.[2] In late 2011, the U.S. Supreme Court agreed to hear arguments related to the constitutionality of certain provisions of the PPACA by accepting an appeal of two Eleventh Circuit Court of Appeals cases that struck down the individual mandate but upheld the Medicaid expansion.

Individual mandate. The commonly called "individual mandate" provision of the PPACA requires most individuals to obtain minimum levels of health insurance coverage for themselves and their dependents beginning in 2014, or else pay a penalty for failure to do so.[3] This penalty is calculated based on a percentage of the individual's household income (with



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a floor and a cap), is reported on the individual's federal tax return, and, accordingly, is assessed and collected by the Internal Revenue Service (IRS).[4]

Three of the issues before the Supreme Court related to the individual mandate: (1) is the individual mandate constitutional under the commerce clause, the necessary and proper clause, and/or the taxing power; (2) if it is unconstitutional, is the mandate severable; and (3) does the Anti-Injunction Act (AIA) prevent courts from deciding lawsuits about the PPACA until after the individual has paid the financial penalty for failure to comply with the individual mandate?

The controlling opinion, written by Chief Justice John Roberts, upholds the individual mandate as constitutional under the taxing power,[5] but not under the commerce clause or the necessary and proper clause. Not surprisingly, Justices Ginsberg, Breyer, Sotomayor, and Kagan joined in the outcome, but also joined in a secondary opinion saying that they would have upheld the individual mandate under the commerce clause as well. Justices Scalia, Kennedy, Thomas, and Alito dissented. Because the individual mandate was upheld, the Court did not find it necessary to determine whether the individual mandate provisions were severable from the remainder of the PPACA.

With regard to the applicability of the AIA, the Court held that the financial penalty is not a "tax" for purposes of the AIA, but instead is a "penalty" for purposes of the AIA. In other words, it is a "tax" for purposes of the Constitution, but not a "tax" for purposes of the AIA. Confused? The Court explains that the PPACA uses the label "penalty" when discussing the "shared responsibility payment" and uses the label "tax" when describing many other exactions it creates. The Court further explains that where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acted intentionally; however, Congress cannot change whether an exaction is a tax or a penalty for *constitutional* purposes simply by labeling it as one or the other.[6]

Medicaid expansion. States' participation in the Medicaid program is voluntary. However, if a state chooses to participate in the Medicaid program, it obtains some funding from the federal government if the state follows certain federal rules. One such rule defines the group of people who must be covered by the state's Medicaid program—currently, pregnant women and children under age six with family incomes at or below 133 percent of the federal poverty level, children ages six to 18 with family incomes at or below 100 percent of the federal poverty level, and people who qualify for Supplemental Security Income (SSI) benefits due to low income and disability status.[7]

The PPACA contains provisions that would expand the group of people who must be covered by the state's Medicaid program to nearly all people under age 65 with household incomes at or below 133 percent of the federal property level.[8] Funding of this expansion would start with the federal government paying 100 percent of a state's cost of this expansion in 2014, gradually decreasing to 90 percent by 2020.[9] One of the issues before the Supreme Court was whether the Medicaid expansion provisions of the PPACA are constitutional.

With regard to the Medicaid expansion provisions, the Court said that the federal government may not threaten to decrease or eliminate states' current Medicaid funding for failure to participate in the Medicaid expansion provided in the PPACA. As Chief Justice Roberts explains:

> As for the Medicaid expansion, that portion of the [PPACA] violates the Constitution by threatening existing Medicaid funding. Congress has no authority to order the States to regulate according to its instructions. Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer. The States are given no such choice in this case: They must either accept a basic change in the nature of Medicaid, or risk losing all Medicaid

TIP
The Affordable Care Act contains a variety of effective dates. Watch for information related to delays (or statements of nonenforcement) until the required regulations are promulgated by federal agencies.

> funding. The remedy for that constitutional violation is to preclude the Federal Government from imposing such a sanction.[10]

In other words, for now, states' participation in the PPACA's Medicaid expansion is optional.

PPACA Provisions That May Affect You as an Individual or Employer

Now that the Supreme Court has issued an opinion that the majority of the PPACA is constitutional, what does this mean for you? If you have not already done so, it means that you need to make certain you are compliant with any and all provisions of the PPACA that are already effective and that are applicable to you. Additionally, it means that you need to start preparing to comply with the provisions of the PPACA that are applicable to you and that have future effective dates. To get you started, below are summaries of some of the provisions of the PPACA with applicability to a large number of individuals or companies.

Discrimination (effective March 23, 2010). Employers are prohibited from discharging or in any manner discriminating against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee: (A) has received a credit under Section 36B of the Internal Revenue Code of 1986 (I.R.C.) or a subsidy under PPACA § 1402 (credits and subsidies are discussed in more detail below); (B) has provided, has caused to be provided, or is about to provide or cause to be provided to the employer, the federal government, or the attorney general of a state information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of the PPACA; (C) has testified or is about to testify in a proceeding concerning such violation; (D) has assisted or participated, or is about to assist or participate, in such a proceeding; or (E) has objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of the PPACA, or any order, rule, regulation, standard, or ban under the PPACA.[11]

Nutritional information (effective March 23, 2010). Restaurants and other retail food establishments that are part of a chain (i.e., 20 or more locations doing business under the same name and offering substantially the same menu items) are required to disclose adjacent to the item on the menu (and the menu board) the number of calories in such menu item as it is usually prepared and offered for sale, as well as a succinct statement concerning suggested daily caloric intake designed to enable the public to understand the significance of the caloric information provided on the menu. Likewise, with regard to self-service food and food on display (i.e., salad bars, buffet lines, cafeteria lines, etc.), such restaurants and other retail food establishments must place a sign adjacent to each food offered that lists the calories per food item or per serving. Restaurants and other retail food establishments are not required to display caloric or nutritional information on items not listed on the menu (such as condiments), temporary menu items appearing on the menu less than 60 days per calendar year, or menu items that are part of a customary market test appearing on the menu for less than 90 days.[12] (Note that although these provisions of the PPACA were technically effective upon enactment of the PPACA, the Food and Drug Administration has yet to adopt final regulations regarding these provisions and has stated on its website that it will not enforce the rule until final regulations are adopted, and likely not until six months after the final regulations are adopted.)

Small employer tax credit (effective March 23, 2010). Small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for their employees will receive a tax credit.[13]

- 2010–2013: Tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost (or 50 percent of the benchmark premium cost). The full credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit is phased out as employer size and average annual wages increase.
- 2014 and beyond: Tax credit of up to 50 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of

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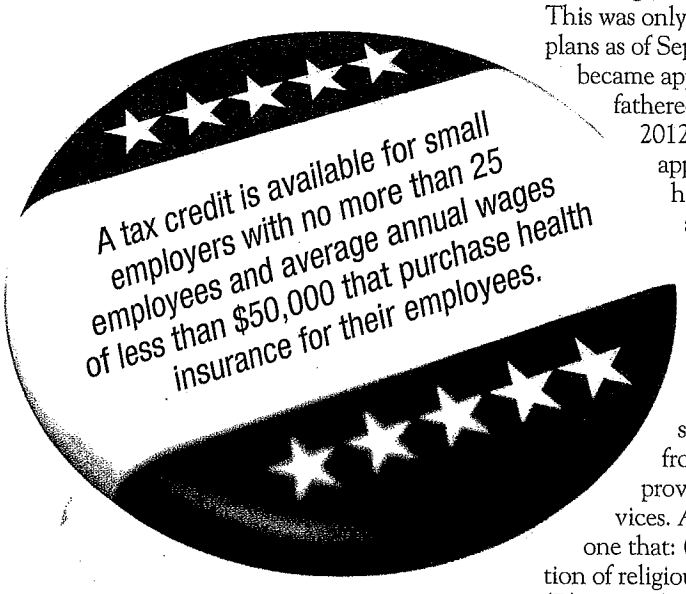
the total premium cost. The credit is available for two years. The full credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit is phased out as employer size and average annual wages increase.

Tax on indoor tanning (effective July 1, 2010). With the exception of phototherapy services provided by licensed medical professionals, any person who performs a service employing any electronic product designed to incorporate one or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning, must collect and remit to the Secretary of Health and Human Services (HHS) a tax equal to 10 percent of the amount paid by the individual on whom the service is performed.[14]



No lifetime limits (effective September 23, 2010). Health insurance companies and group health plans may not impose lifetime limits on the dollar value of benefits for any participant.[15]

Prohibition on rescissions (effective September 23, 2010). Health insurance companies and group health plans may not rescind coverage with respect to an enrollee once the enrollee is covered, except in the instance of fraud by the enrollee.[16] This means that health insurance companies and group health plans may not drop coverage if an insured gets sick.

Preventive health services (effective September 23, 2010). Health insurance companies and group health plans must provide coverage for, and may not impose a cost-sharing requirement (i.e., copay or deductible) for, immunizations and certain preventive care and screenings, such as mammograms.[17] This was only applicable to new plans as of September 23, 2010, but became applicable to nongrandfathered plans on August 1, 2012, and will become applicable to all existing health plans as of January 1, 2018. Note that group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to provide contraceptive services. A religious employer is one that: (A) has the inculcation of religious values as its purpose; (B) primarily employs persons who share its religious tenets; (C) primarily serves persons who share its religious tenets; and (D) is a nonprofit organization under I.R.C. §§ 6033(a)(1) and 6603(a)(3)(A)(i) or (iii).[18]

Dependent coverage (effective September 23, 2010). Health insurance companies and group health plans that provide dependent coverage of children must continue to make such coverage available for unmarried adult children up to age 26.[19]

Prohibition of discrimination based on salary (effective September 23, 2010). A plan sponsor of a group health plan may not establish rules related to eligibility of any full-time employee based on the total hourly or annual salary of the employee (or otherwise establish eligibility rules that have the effect of discriminating in favor of highly compensated employees).[20] The IRS issued a notice, however, that compliance with this section, and sanctions for noncompliance, will not apply until after regulations or other administrative guidance is issued.[21]

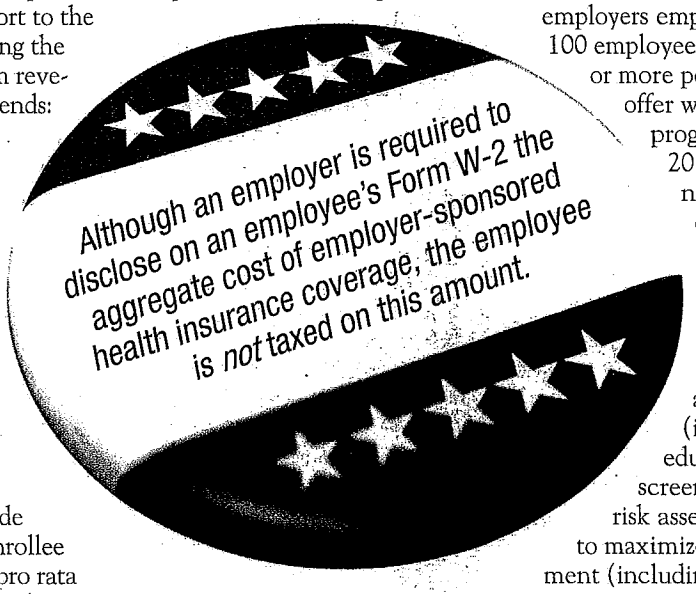
Reporting on quality of care (effective September 23, 2010). Health insurance companies and group health plans must annually submit to the Secretary of HHS and participants a report on whether the benefits under the plan or coverage: (A) improve health outcomes through the implementation of certain activities; (B) implement certain activities to prevent hospital readmissions; (C) implement certain activities to improve safety and reduce medical errors; and (D) implement wellness and health promotion activities. For purposes of (D), wellness and health promotion activities may include personalized wellness and prevention services as well as the following wellness and prevention efforts: (1) smoking cessation; (2) weight management; (3) stress management; (4) physical fitness; (5) nutrition; (6) heart disease prevention; (7) health lifestyle support; and (8) diabetes prevention.[22]

Appeals (effective September 23, 2010). Health insurance companies and group health plans must implement an "effective" appeals process for appeals of coverage determinations and claims. At a minimum, health insurance companies and group health plans must: (A) have an internal claims appeal process; (B) provide a plain language notice of internal and

external claims appeal processes and the availability of any applicable office of health insurance consumer assistance; (C) allow an enrollee to review his file, to present evidence and testimony, and to receive continued coverage pending the outcome of the appeals process; and (D) provide an external review process that meets certain standards.[23]

Reducing the cost of health care coverage (effective January 1, 2011). Health insurance companies must submit annually a report to the Secretary of HHS concerning the percentage of total premium revenue that such coverage expends: (A) on reimbursement for clinical services provided to participants under such coverage; (B) for activities that improve health care quality; and (C) on all other nonclaim costs (excluding state taxes and licensing/regulatory fees). These reports will be available to the public on the Secretary's website. Additionally, health insurance companies must provide an annual rebate to each enrollee under such coverage (on a pro rata basis) in an amount equal to the amount premium revenue spent on (C) above exceeds a certain percentage of total premium revenue.[24]

HSAs, MSAs, HRAs, and FSAs (effective January 1, 2011). Likely the most important change in these areas comes in the definition of qualified medical expenses. For purposes of reimbursements from health flexible spending accounts (FSAs) or health reimbursement accounts (HRAs), and distributions from health savings accounts (HSAs) or Archer medical savings accounts (MSAs), the definition of "qualified medical expenses" has been modified to include amounts paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin (i.e., over-the-counter drugs no longer qualify).[25] Moreover, the additional tax on distributions made from HSAs not used for qualified medical expenses is increased from 10 percent to 20 percent of the amount includible in gross income. Similarly, the additional tax on distributions made from Archer MSAs not used for qualified medical expenses is increased from 15 percent to 20 percent of the amount includible in gross income.[26] Effective January 1, 2013, contributions to FSAs are limited to $2,500 (increased annually by the cost-of-living adjustment).[27]



Cafeteria plans (effective January 1, 2011). The PPACA includes some beneficial rules for small employers offering cafeteria plans. Specifically, if, during either of the two preceding years, an employer employed an average of 100 or fewer employees on business days, then the employer is eligible to establish a simple cafeteria plan, under which the applicable nondiscrimination requirements of a classic cafeteria plan are treated as satisfied. Through the establishment of a simple cafeteria plan, employers may retain potentially discriminatory benefits for highly compensated and key employees (subject to some restrictions relating to contributions), while allowing other employees to enjoy the benefits of a cafeteria plan without worrying about running afoul of the nondiscrimination requirements of a classic cafeteria plan.[28]

Wellness programs (effective 2011). Small employers (i.e., those employers employing fewer than 100 employees who work 25 hours or more per week that did not offer workplace wellness programs as of March 23, 2010) that offer wellness programs to all of their employees are eligible for grants for up to five years. The wellness program must include: (A) health awareness initiatives (including health education, preventive screenings, and health risk assessments); (B) efforts to maximize employee engagement (including mechanisms to encourage employee participation); (C) initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials); and (D) supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health). Employers are permitted to offer employees rewards for participating in the wellness program and meeting certain health-related standards.[29] Rewards may include premium discounts, waivers of cost-sharing requirements, or benefits that may not otherwise be included. Employers must offer an alternative standard for employees for whom it

is unreasonably difficult or inadvisable to meet the standard.

W-2 reporting (effective January 1, 2012). An employer is required to disclose the aggregate cost of employer-sponsored health insurance coverage provided to its employee on the employee's Form W-2 (although, contrary to claims made in current chain e-mails, the employee is *not* taxed on this amount).[30]

Uniform explanation of coverage documents (effective March 23, 2012). All health insurance companies (and plan sponsors and plan administrators of self-insured plans) must give a summary of benefits and coverage explanation that accurately describes the applicable benefits and coverage and that complies with the standards issued by the Secretary of HHS to: (A) an applicant at the time of application; (B) an enrollee prior to the time of enrollment or reenrollment; and (C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate. The document must comply with standards developed by the Secretary. The document must be no longer than four pages and must use at least 12 point font size. The documents must use plain language and uniform definitions of standard insurance and medical terms. Exceptions, reductions, and limitations on coverage along with cost-sharing provisions, including deductible, coinsurance, and copayments, must be clearly stated. The document must also contain: (A) the renewability and continuation of coverage provisions; (B) examples to illustrate common benefits scenarios (such as pregnancy and serious or chronic medical conditions) and related cost sharing; (C) a statement of whether the plan or coverage provides minimum essential coverage and whether the plan or coverage ensures that the coverage share of the total allowed costs of benefits provided is not less than 60 percent of such costs; (D) a statement that the document is a summary and that the policy itself should be consulted for determining contractual provisions; and (E) a contact number for the participant to call with additional questions and a web address where a copy of the policy or certificate of coverage can be reviewed and obtained. Failure to provide the information required will result in a fine of not more than $1,000 for each such failure. Such failure with respect to each participant constitutes a separate offense.[31]

Increase in Medicare Part A tax and tax on unearned income (effective January 1, 2013). Starting in 2013, there is a 0.9 percent increase in the Medicare Part A tax rate (from 1.45 percent to 2.35 percent) on earnings over $200,000 for individuals ($250,000 for married couples filing jointly), as well as a 3.8 percent tax on unearned income for higher-income tax payers.[32] However, unlike claims made in various chain e-mails currently circulating, the PPACA does *not* cause employees to be taxed on the value of health insurance provided by an employer; although beginning in 2018, there is a 40 percent excise tax on health coverage providers (i.e., employers, *not* employees) to the extent that the aggregate value of employer-sponsored health coverage for an employee exceeds a threshold amount.

Unreimbursed medical expenses (effective January 1, 2013). The threshold for itemized deduction for unreimbursed medical expenses is increased to 10 percent of adjusted gross income for regular tax purposes (from 7.5 percent).[33] Note that this increase in threshold is not applicable to individuals age 65 or older for tax years 2013–2016.

Medicare Part D drug subsidy recipients (effective January 1, 2013). Employers will no longer be able to take a tax deduction if they receive Medicare Part D retiree drug subsidy payments for retiree prescription drug benefits.[34]

Requirement to inform employees of coverage options (effective March 1, 2013). Employers are required to provide to each employee at the time of hiring written notice: (A) informing the employee of the existence of an Exchange (if applicable), including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance; (B) if the employer plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, that the employee may be eligible for a premium tax credit under I.R.C. § 36B and a cost-sharing reduction under PPACA § 1402 if the employee purchases a qualified health plan through the Exchange; and (C) if the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.[35] (The PPACA creates state-based health insurance exchanges, referred to in the PPACA as "Exchanges," to be administered by a governmental agency or nonprofit organization, in order to facilitate the purchase of quality health plans and through which small employers can purchase qualified plans. Each state must establish an Exchange no later than January 1, 2014. The requirements related to Exchanges are set forth in PPACA § 1311(d).)

"Preexisting conditions" (effective January 1, 2014). Health insurance companies and group plans are prohibited from denying coverage to individuals for any reason (including gender, preexisting conditions, or other health status).

A health insurance company that offers health insurance coverage in the individual or group market in any given state must accept every employer and individual in the state that applies for such coverage and must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable. Health insurance companies are allowed to vary premiums *only* based on the following: age, geographic area, tobacco use, and number of family members.[36]

Requirement to have insurance (effective January 1, 2014). Effective January 1, 2014, most U.S. citizens and legal residents are required to have health insurance. Those without coverage will pay a tax penalty of the greater of $695 per year (up to a maximum of $2,085 per family) or 2.5 percent of household income. The penalty is to be phased in as follows:

- 2014: $95 or 1.0 percent of taxable income.
- 2015: $325 or 2.0 percent of taxable income.
- 2016: $695 or 2.5 percent of taxable income.

Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions may be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of the individual's income, and those with incomes below the tax filing threshold.[37]

No annual limits (effective January 1, 2014). No annual dollar limits are allowed on most covered benefits beginning January 1, 2014.[38] However, plans may place an annual dollar limit on spending for health care services that are not considered "essential."

Penalty for failure to offer coverage, etc. (effective January 1, 2014). Effective January 1, 2014, an employer with 50 or more full-time employees that does not offer health insurance coverage and has at least one full-time employee who receives a premium tax credit will be assessed a monthly fee of 1/12 of $2,000 per full-time employee (excluding the first 30 employees from the assessment), while an employer with 50 or more full-time employees that offers coverage but has at least one full-time employee receiving a premium tax credit will be assessed a monthly fee equal to the lesser of (A) 1/12 of $3,000 for each employee receiving a premium credit, and (B) 1/12 of $2,000 for each full-time employee (excluding the first 30 employees from the assessment). Note that employers with fewer than 50 employees are exempt from these provisions.[39]

Premium and cost-sharing subsidies (effective January 1, 2014). The provisions related to premium and cost-sharing subsidies to individuals who purchase insurance through an Exchange are effective January 1, 2014.[40] Availability is limited to U.S. citizens and legal residents who meet income limits. Employees offered coverage through their employer are not eligible unless the employer plan does not have an actuarial value of at least 60 percent or if the employee's share of the premium exceeds 9.5 percent of income. Note that federal premium or cost-sharing subsidies are prohibited from being used to purchase coverage for abortions, except in cases of rape/incest and to save the life of the mother.

Reporting of health insurance coverage (effective January 1, 2014). Beginning in 2014, every person who provides minimum essential coverage to an individual during a calendar year must, at such time as the Secretary of HHS prescribes, make a return, in the form as the Secretary prescribes, that contains: (A) the name, address, and taxpayer identification number (TIN) of the primary insured and the name and TIN of each other individual obtaining coverage under the policy; (B) the dates during which such individual was covered under the minimum essential coverage during the calendar year; (C) in the case of minimum essential coverage that consists of health insurance coverage, information concerning whether or not the coverage is a qualified health plan offered through an Exchange, and in the case of a qualified health plan, the amount (if any) of advance payment under PPACA § 1412 of any cost-sharing reduction or premium tax credit with respect to such coverage; and (D) any other information the Secretary may require. Additionally, if minimum essential coverage provided consists of health insurance coverage of a health insurance issuer

provided through a group health plan of an employer, the return must also include: (1) the name, address, and employer identification number of the employer maintaining the plan; (2) the portion of the premium (if any) required to be paid by the employer; and (3) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under I.R.C. § 45R (relating to credit for employee health insurance expenses of small employers). Every person who is required to make such a return must furnish to each individual whose name is required to be set forth in such return a written statement showing the name and address of the person required to make such return and the phone number of the information contact for such person, as well as the information required to be shown on the return with respect to such individual. The report to the individual described in the immediately preceding sentence must be provided before January 31 of the year following the calendar year for which the report is required to be made.[41]

Reporting applicable to large employers (effective January 1, 2014). Applicable employers will have additional reporting requirements related to health insurance coverage offered to employees. Specifically, applicable employers will be required to report to the Secretary of HHS: (A) whether they offer full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan; (B) the length of any waiting period with respect to such coverage; (C) the months during the calendar year for which coverage under the plan was available; (D) the monthly premium for the lowest cost option in each of the enrollment categories under the plan; (E) the applicable employer's share of the total allowed costs of benefits provided under the plan; (F) the number of full-time employees for each month during the year; and (G) the name, address, and TIN of each full-time employee (and any dependents) who were covered under such plan. Additionally, each employer who is required to furnish the report to the IRS set forth above must also furnish to each full-time employee whose name is required to be set forth in such IRS report a written statement showing the name and address of the employer required to submit such IRS report, the phone number and contact information of such employer, and the information required to be shown on the return with respect to the individual. The report to the individual described in the immediately preceding sentence must be provided before January 31 of the year following the calendar year for which the report is required to be made.[42]

Automatic enrollment (after final regulations are issued—likely 2014 or later). An employer with more than 200 employees must automatically enroll employees into health insurance plans offered by the employer. (Note that employees may opt out of coverage.) Guidance on automatic enrollment will not be ready by 2014, and until final regulations under Section 18A of the Fair Labor Standards Act (FLSA) are listed and become applicable, employers are not required to comply with FLSA § 18A.[43]

"Essential health benefits." This term is used frequently in the PPACA. The PPACA states that the Secretary of HHS has the right to define this term, except that such benefits must include at least the following general categories:[44]

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

Conclusion

While we were in limbo from March 23, 2010, until June 28, 2012, we are in limbo no more. At least for the foreseeable future, the PPACA is here to stay, and compliance with the currently effective provisions is imperative. While this article discusses general legal issues of interest, it is not designed to give any specific legal advice pertaining to any specific circumstances. Accordingly,

Effective January 1, 2014, health insurance companies and group plans are prohibited from denying coverage to individuals for any reason, including preexisting conditions.

it is important that professional legal advice be obtained if you are in doubt as to your (or your client's) responsibilities under the PPACA. ■

Notes

1. Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of I.R.C. and 42 U.S.C.).
2. These included a lawsuit filed in Florida by the State of Florida, several individuals, and the National Federation of Independent Businesses and joined by the following states: Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. *See* Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011).
3. Patient Protection and Affordable Care Act (PPACA) of 2010 § 1501, 26 U.S.C. § 5000A.
4. *Id.*
5. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2598 (2012).
6. *Id.* at 2582–84.
7. 42 U.S.C. § 1396a(a)(10).
8. PPACA § 2001, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
9. PPACA § 2001, 42 U.S.C. § 1396d(y)(1).
10. *Sebelius*, 132 S. Ct. at 2608.
11. PPACA § 1558, 29 U.S.C. § 218c.
12. PPACA § 4205, 21 U.S.C. § 343(q)(5).
13. PPACA § 1421, 26 U.S.C. § 45R.
14. PPACA § 10907, 26 U.S.C. § 5000B.
15. PPACA § 1001, 42 U.S.C. § 300gg-11.
16. PPACA § 1001, 42 U.S.C. § 300gg-12.
17. PPACA § 1001, 42 U.S.C. § 300gg-13.
18. 45 C.F.R. § 147.130(a)(1)(iv)(B).
19. PPACA § 1001, 42 U.S.C. § 300gg-14.
20. PPACA § 1001, 42 U.S.C. § 300gg-16.
21. I.R.S. Notice 2011-1, 2011-2 I.R.B. 259.
22. PPACA § 1001, 42 U.S.C. § 300gg-17.
23. PPACA § 1001, 42 U.S.C. § 300gg-19.
24. PPACA § 1001, 42 U.S.C. § 300gg-18.
25. PPACA § 9003, 26 U.S.C. § 223(d)(2).
26. PPACA § 9004, 26 U.S.C. § 223(f)(4)(A).
27. PPACA § 9005, 26 U.S.C. § 125(i); I.R.S. Notice 2012-40, 2012-26 I.R.B. 1046.
28. PPACA § 9022, 26 U.S.C. § 125.
29. PPACA § 10408 (to be codified at 42 U.S.C. § 2801).
30. PPACA § 9002, 26 U.S.C. § 6051(a)(14); I.R.S. Notice 2010-69, 2010-44 I.R.B. 576.
31. PPACA § 1001, 42 U.S.C. § 300gg-15.
32. PPACA § 9015, 26 U.S.C. § 1401.
33. PPACA § 9013 (to be codified at 26 U.S.C. § 213(a)).
34. PPACA § 9012, 26 U.S.C. § 139A.
35. PPACA § 1512, 29 U.S.C. § 218b.
36. PPACA § 1201, 42 U.S.C. § 300gg-4.
37. PPACA § 1501, 26 U.S.C. § 5000A.
38. 29 C.F.R. § 2590.715-2711.
39. PPACA § 1513, 26 U.S.C. § 4980H.
40. PPACA §§ 1401–02, 26 U.S.C. § 36B.
41. PPACA § 1502, 26 U.S.C. § 6055.
42. PPACA § 1514, 26 U.S.C. § 6056.
43. I.R.S. Notice 2012-17, 2012-9 I.R.B. 430.
44. PPACA § 1302, 42 U.S.C. § 18022.