



## MEMORANDUM

From: Bruce H. Wynn  
Date: August 16, 2010 (Updated – Version 2)  
RE: Health Care Reform – Employee Benefit Changes

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### 1 General Background Information

On March 23, 2010, the Patient Protection and Affordable Health Care Act (“**PPACA**”) became law, and on March 30, 2010, the Health Care and Education Reconciliation Act (“**HCERA**”) became law. These acts together form the new health care legislation (the “**Health Care Law**” or the “**Law**”). The purpose of this memorandum is to examine and generally outline provisions of the new Health Care Law impacting employers and their employee benefit arrangements, dividing the discussion of the provisions into the following four general areas:

- Impact of the Health Care Law on the FLSA & Employers
- Impact of the Health Care Law on Group Health Plans
- Impact of the Health Care Law on Taxes and Tax Reporting
- Impact of the Health Care Law on MEWAs

### 2 Impact of the Health Care Law on the FLSA & Employers

The purpose of this portion of this memorandum is to focus on how the new Law impacts the Fair Labor Standards Act and certain employers.

**2.1 Automatic Enrollment for Larger Employers.** Effective March 23, 2010, the Fair Labor Standards Act is amended so that employers with more than 200 full-time employees who offer enrollment in one or more group health plans will be required to automatically enroll new employees in one of the plans offered.<sup>1</sup>

**2.2 Reasonable Break Time for Nursing Mothers.** Effective March 23, 2010, the Fair Labor Standards Act is amended so that an employer must provide a reasonable break time for an employee to express breast milk for her nursing child for a period of up to one year after the child's birth.<sup>2</sup> An employer must also provide a place, other than a bathroom, that is shielded from view and free from intrusion, for an employee to use when expressing breast milk. An employer does *not* have to compensate an employee for such reasonable break time. If an employer employs less than 50 employees, they are not required to meet these new requirements *if* they would impose an undue hardship on the employer. State laws providing greater protections are *not* preempted.

### 3 Impact of the Health Care Law on Group Health Plans

The purpose of this portion of this memorandum is to focus on how the new Law impacts group health plans of employers.

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<sup>1</sup> New Section 18A of the Fair Labor Standards Act, added by Section 1511 of PPACA.

<sup>2</sup> New Section 7(r)(1)(A) of the Fair Labor Standards Act, added by Section 4207 of PPACA.

The provisions discussed below with respect to group health plans are enforced through the Code and ERISA. New Code §9815(a)(1) and new ERISA §715(a) provide that the provisions of Part A of title XXVII of the Public Health Service Act (the “**PHSA**”) (Sections 2701 through 2737) generally apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in subchapter B of Chapter 100 of the Code and Part 7 of title I of ERISA, except that the provisions of PHSA §2716 (prohibition on discrimination based on salary) and PHSA §2718 (bringing down the cost of health coverage) do **not** apply with respect to self-insured group health plans. Code §4980D provides for a \$100 per day of noncompliance excise tax for failures to comply with Chapter 100 of the Code (which would include the PHSA provisions of the new Law).

**3.1 PHSA §2711 - No Lifetime or Annual Benefit Limits.** Effective for plan years beginning on or after September 23, 2010, lifetime or annual benefits cannot be imposed by group health plans.<sup>3</sup> (For plan years beginning before January 1, 2014, group health plans *may* impose an *annual* limit on benefits per covered person only for “essential health benefits.” The Secretary of Health and Human Services (“**HHS**”) must determine what benefits are considered “essential health benefits.”) The lifetime and annual limitation prohibition does *not* prevent a group health plan from applying such a limitation to benefits that are *not* “essential health benefits.”

On June 28, 2010, the IRS (Treas. Reg. §54.9815-2711T), DOL (DOL Reg. §2590.715-2711) and the HHS published interim regulations regarding the prohibition on lifetime or annual limits. The interim regulations do provide some further guidance:

(a) The interim regulations clarify that the prohibition on establishing any annual limit on benefits does not apply to a health flexible spending arrangement.<sup>4</sup>

(b) The interim regulations clarify that a plan may exclude *all* benefits for a condition. However, if *any* benefits are provided for a condition, then the prohibition would apply.<sup>5</sup>

(c) The interim regulations do **not** define “essential health benefits” except by cross reference to the Health Care Law itself, but do provide that, until regulations defining “essential health benefits” are issued, the various government agencies involved “will take into account good faith efforts to comply with a reasonable interpretation of the term ‘essential health benefits.’”<sup>6</sup>

(d) The interim regulations provide for a three year phased approach for the prohibition on annual limits to mitigate the potential for premium increases:

(1) For plan years beginning on or after September 23, 2010, but before September 23, 2011, a plan may have an annual limitation of \$750,000 or more.

(2) For plan years beginning on or after September 23, 2011, but before September 23, 2012, a plan may have an annual limitation of \$1,250,000 or more.

(3) For plan years beginning on or after September 23, 2012, but before January 1, 2014, a plan may have an annual limitation of \$2,000,000 or more.

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<sup>3</sup> Section 2711 of the Public Health Service Act (“**PHSA**”), as amended by new Law.

<sup>4</sup> Treas. Reg. §54.9815-2711T(a)(2)(ii); DOL Reg. §2590.715-2711(a)(2)(ii).

<sup>5</sup> Treas. Reg. §54.9815-2711T(b)(2); DOL Reg. §2590.715-2711(b)(2).

<sup>6</sup> 75 F. R. 37191 (June 28, 2010).

These minimum annual limits apply on an individual-by-individual basis. Thus, any overall annual dollar limit applied to families may not operate to deny a covered individual the minimum annual benefits for the plan year.

(e) The interim regulations allow the Secretary of HHS to establish a program under which the annual limitation phase in provisions may be waived in certain situations.<sup>7</sup>

(f) The interim regulations require that individuals who reach a lifetime limit under a plan must be provided with a notice that the lifetime limit no longer applies and that the individual, if covered, is once again eligible for benefits under the plan.<sup>8</sup> Also, if the individual is not enrolled in the plan, the plan must also give such individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), and, if they enroll, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.<sup>9</sup>

As is noted and discussed further below, “grandfathered health plans” **are** subject to the prohibitions on *annual* and *lifetime* benefit limitations for plan years beginning on or after September 23, 2010, just as any other plan.

**3.2 PHSA §2712 - Prohibition on Rescissions.** Effective for plan years beginning on or after September 23, 2010, group health plans may not rescind coverage of an enrollee once the enrollee is covered, except where an individual has performed an act or practice constituting fraud or has made an intentional misrepresentation of material fact as prohibited under the terms of the plan, and, even then, prior notice to the enrollee must occur.<sup>10</sup>

On June 28, 2010, the IRS (Treas. Reg. §54.9815-2712T), DOL (DOL Reg. §2590.715-2712) and the HHS published interim regulations regarding the prohibition on coverage rescissions. The interim regulations do provide some further guidance:

(a) The interim regulations clarify that a plan must provide at least 30 days advance written notice to a participant who would be affected before coverage may be rescinded.<sup>11</sup>

(b) The interim regulations clarify that a “rescission” is “a cancellation or discontinuance of coverage that has retroactive effect.”<sup>12</sup> A cancellation or discontinuance is not considered a rescission if (1) the cancellation or discontinuance has only a prospective effect, or (2) the cancellation or discontinuance is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.<sup>13</sup>

As is noted and discussed further below, “grandfathered health plans” **are** subject to the prohibition on rescissions of coverage for plan years beginning on or after September 23, 2010, just as any other plan.

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<sup>7</sup> Treas. Reg. §54.9815-2711T(d)(3); DOL Reg. §2590.715-2711(d)(3).

<sup>8</sup> Treas. Reg. §54.9815-2711T(e)(2); DOL Reg. §2590.715-2711(e)(2).

<sup>9</sup> *Id.*

<sup>10</sup> PHSA §2712.

<sup>11</sup> Treas. Reg. §54.9815-2712T(a)(1); DOL Reg. §2590.715-2712(a)(1).

<sup>12</sup> Treas. Reg. §54.9815-2712T(a)(2); DOL Reg. §2590.715-2712(a)(2).

<sup>13</sup> *Id.*

**3.3 PHSA §2713 - Coverage of Preventative Health Services.** Effective for plan years beginning on or after September 23, 2010, group health plans are required to cover, without any cost-sharing, preventative services and immunizations that are recommended by certain Federal agencies.<sup>14</sup>

On July 19, 2010, the IRS (Treas. Reg. §54.9815-2713T), DOL (DOL Reg. §2590.715-2713) and the HHS published interim regulations regarding the coverage of preventive health services. The interim regulations do provide some further guidance:

(a) The interim regulations provide clarity as to which preventative services and immunizations are required, looking at guidance provided by the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.<sup>15</sup> The complete listing may be found at <http://www.HealthCare.gov/center/regulations/prevention.html>.<sup>16</sup>

(b) The interim regulations clarify that no cost-sharing requirements may be imposed with respect to an office visit if the preventive action is not billed separately from such office visit and the primary purpose of the visit was for the preventive action; however, if the office visit is separately billed or if the primary purpose of the visit was not for the preventive action, then cost-sharing requirements may be imposed with respect to the office visit.<sup>17</sup>

(c) Apparently cost-sharing requirements may also be imposed if preventive action is provided by out-of-network providers as well.<sup>18</sup>

(d) If not specified in the applicable governmental agency guideline, reasonable medical management techniques may be used to determine the frequency, method, treatment or setting for preventive actions.<sup>19</sup>

(e) Coverage for preventive actions is required for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.<sup>20</sup>

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the preventative health service requirements unlike other plans.

**3.4 PHSA §2714 - Extension of Dependent Coverage.** Effective for plan years beginning on or after September 23, 2010, group health plans *that provide dependent coverage of children* must continue to make available optional coverage for an adult child until the child turns 26 years old, regardless of their marital status.<sup>21</sup> Note that there is no requirement that a plan provide coverage for anyone, including dependents; however, if a plan does cover dependent children, then coverage for a child must continue

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<sup>14</sup> PHSA §2713.

<sup>15</sup> Treas. Reg. §54.9815-2713T(a)(1); DOL Reg. §2590.715-2713(a)(1).

<sup>16</sup> 75 F.R. 41728 (July 19, 2010).

<sup>17</sup> Treas. Reg. §54.9815-2713T(a)(2); DOL Reg. §2590.715-2713(a)(2).

<sup>18</sup> Treas. Reg. §54.9815-2713T(a)(3); DOL Reg. §2590.715-2713(a)(3).

<sup>19</sup> Treas. Reg. §54.9815-2713T(a)(4); DOL Reg. §2590.715-2713(a)(4).

<sup>20</sup> Treas. Reg. §54.9815-2713T(b)(1); DOL Reg. §2590.715-2713(b)(1).

<sup>21</sup> PHSA §2714.

until age 26. The extension of dependent coverage is not mandated with respect to children of dependent children.<sup>22</sup>

On May 13, 2010, the IRS (Treas. Reg. §54.9815-2714T), DOL (DOL Reg. §2590.715-2714) and the HHS published interim regulations regarding the extension of dependent coverage to children under age 26. The interim regulations do provide some further guidance:

(a) The interim regulations implement the statutory authority to define the dependents to which coverage shall be made available, and provide that “conditioning coverage on whether a child is a tax dependent or a student, or resides with or receives financial support from the parent, is no longer appropriate in light of the correlation between age and these factors.”<sup>23</sup>

(b) The interim regulations provide that a plan may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant, and provide that factors that cannot be used for defining dependent for purposes of eligibility include financial dependency on the participant, residency with the participant, student status, employment, eligibility for other coverage, or any combination of these factors.<sup>24</sup>

(c) For transition purposes, the interim regulations provide transitional relief for a child whose coverage ended or who was denied coverage or not eligible for coverage, because, under the terms of the plan, the availability of dependent coverage of children ended before the attainment of age 26. For these children, a plan must give the child an opportunity to enroll that continues for at least 30 days, and which must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. If the child does enroll, coverage must begin not later than the first day of the first plan year beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year.<sup>25</sup> The interim regulations allow the notice to be given to the employee on behalf of such employee’s child, and allow the notice to be included with other enrollment materials *provided that the statement is “prominent.”*<sup>26</sup>

As is noted and discussed further below, “grandfathered health plans” generally **are** subject to the required extension of dependent coverage for plan years beginning on or after September 23, 2010, just as any other plan; *however*, for plan years beginning before January 1, 2014, a “grandfathered health plan” may exclude an adult child who has not attained age 26 from coverage **if** the child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. If an adult child is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent’s employer.<sup>27</sup>

### **3.5 PHSA §2715 - Uniform Standards for Health Plan Summaries of Benefits & Coverage.**

Within 12 months after March 23, 2010, the Secretary of HHS is to develop standards for use in communicating benefit summaries and coverage information by plans. Not later than 24 months after March 23, 2010, the standard benefits and coverage summary format is to be used by plans to

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<sup>22</sup> *Id.*

<sup>23</sup> 75 F.R. 27124 (May 13, 2010).

<sup>24</sup> Treas. Reg. §54.9815-2714T(b); DOL Reg. §2590.715-2714(b).

<sup>25</sup> Treas. Reg. §54.9815-2714T(f); DOL Reg. §2590.715-2714(f).

<sup>26</sup> Treas. Reg. §54.9815-2714T(f)(2)(ii); DOL Reg. §2590.715-2714(f)(2)(ii).

<sup>27</sup> Treas. Reg. §54.9815-2714T(g); DOL Reg. §2590.715-2714(g).

communicate information to plan participants and beneficiaries. The summaries must be provided at the time of enrollment and at each time of reenrollment. The summaries must be no longer than 4 pages in length, must conform to a “uniform format,” must have print that is not smaller than 12 point font, and must communicate in a “culturally and linguistically appropriate manner.”<sup>28</sup> The summaries must include uniform definitions of standard insurance and medical terms, must describe any cost-sharing, exceptions, reductions, and limitations on coverage, and must use examples to illustrate common benefits scenarios.<sup>29</sup> The summary requirement will preempt any state law standards that would provide less information than that required by the summary requirement. There is a \$1,000 fine for any *willful* violation of the summary requirement with respect to an individual. Also, the new Law requires that if a material modification is made to the terms of, or coverage involved with, a group health plan, and such modification is not reflected in the most recently provided summary of benefits and coverage, the plan must provide notice of such modification no later than 60 days *prior* to the date on which such modification will become effective.<sup>30</sup> *In essence, HHS will now prescribe the format and content (to some extent) of summary plan descriptions for group health plans under this provision of the new Law. Or perhaps these summaries will become “summaries” of the summary plan descriptions. Additionally, there is the “prior” notification required now for material modifications.*

As is noted and discussed further below, “grandfathered health plans” **are** subject to the uniform standards for plan summaries of benefits and coverage, just as any other plan.

**3.6 PHSA §2716 - Prohibition on Discrimination in Favor of Highly Compensated Individuals.** Effective for plan years beginning on or after September 23, 2010, group health plans are prohibited from discriminating in favor of highly compensated individuals with respect to eligibility or benefits.<sup>31</sup> This effectively means that the non-discrimination requirements under Code §105(h) that previously only applied to self-funded medical reimbursement plans *will now apply to fully insured plans*. Employers will need to carefully consider this in structuring any post-termination coverage for former employees, as well as in other situations where discrimination in favor of highly compensated individuals might occur.

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the prohibition on discrimination in favor of highly compensated individuals unlike other plans.

**3.7 PHSA §2717 - Quality Reporting Requirements.** No later than March 23, 2013, HHS is required to develop quality reporting requirements for group health plans. Then, on an annual basis, plans will be required to provide plan participants and the HHS with a report detailing whether the coverage under the plan satisfies these reporting requirements. HHS is given authority to develop penalties for non-compliance with the reporting requirements.<sup>32</sup>

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the quality reporting requirements unlike other plans.

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<sup>28</sup> Given that many employers have gotten into the habit of issuing plan documents to participants and letting such documents constitute the summary plan description with respect to their plan, it will be most interesting to see how plans will be condensed into a 4 page 12 point font document. Also, given the case law regarding the binding nature of summary plan descriptions, it will be interesting to see how cases develop regarding rights asserted under these new summary documents.

<sup>29</sup> PHSA §2715.

<sup>30</sup> PHSA §2715(d)(4).

<sup>31</sup> PHSA §2716.

<sup>32</sup> PHSA §2717.

**3.8 PHS §2719 - Appeals Process.** Effective for plan years beginning on or after September 23, 2010, group health plans must establish and implement an effective process for appeals of coverage determinations and claims, which must include, at a minimum, an established internal claims appeal process, notification to participants of available internal and external appeals processes, and provisions allowing a claimant to review their file and to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.<sup>33</sup> Until the DOL<sup>34</sup> issues standards under the new provision, the current DOL regulations dealing with ERISA claims procedure requirements will be the standard for the appeals process. For external reviews, group health plans may comply with state external review requirements that are binding and, at a minimum, include certain model consumer protections, or implement an external review process meeting standards set up by HHS.

On July 23, 2010, 2010, the IRS (Treas. Reg. §54.9815-2719T), DOL (DOL Reg. §2590.715-2719) and the HHS published interim regulations regarding the requirements for internal claims and appeals and external review processes. The interim regulations do provide some further guidance:

(a) Notices of adverse benefit determinations must be provided in a “culturally and linguistically appropriate manner.”<sup>35</sup> For plans with under 100 participants at the beginning of a plan year, if at least 25% of the participants are literate in a non-English language, notices would have to be available in that language, and for plans with 100 or more participants at the beginning of a plan year, if at least 500 participants or 10% of the participants are literate in a non-English language, notices would have to be available in that language.<sup>36</sup>

(b) The interim regulations add six (6) new requirements to those already in the DOL claims procedure regulation:<sup>37</sup>

(1) Adverse benefit determinations now include any rescission of coverage.<sup>38</sup>

(2) Adverse benefit determinations with respect to urgent care claims require notification as soon as possible, but no later than 24 hours after the receipt of the claim.<sup>39</sup>

(3) Plans must provide claimants with any new or additional evidence considered, relied upon, or generated by the plan in connection with the claim and with the rationale for the determination in advance to give the claimant an opportunity to respond prior to a determination.<sup>40</sup>

(4) The interim regulations require that a plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision; therefore, decisions regarding the hiring, compensation,

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<sup>33</sup> PHS §2719.

<sup>34</sup> United States Department of Labor.

<sup>35</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(E); DOL Reg. §2590.715-2719(b)(2)(ii)(E).

<sup>36</sup> 75 F.R. 43337 (July 23, 2010); Treas. Reg. §54.9815-2719T(e); DOL Reg. §2590.715-2719(e).

<sup>37</sup> See DOL Reg. (29 CFR) §2560.503-1 for the current DOL claims procedure regulations.

<sup>38</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(A); DOL Reg. §2590.715-2719(b)(2)(ii)(A).

<sup>39</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(B); DOL Reg. §2590.715-2719(b)(2)(ii)(B).

<sup>40</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(C); DOL Reg. §2590.715-2719(b)(2)(ii)(C).

termination, promotion, or other similar matters, with respect to a claims adjudicator must not be made based upon the likelihood that the individual will support a denial of benefits.<sup>41</sup>

(5) Notices regarding claims must provide more information, such as information sufficient to identify the claim involved, and information regarding the availability of internal appeals and external review, and information regarding any applicable office of health insurance consumer assistance or ombudsman established under PHSA §2793 to assist covered individuals with claims.<sup>42</sup>

(6) Any failure of a plan to comply with the new claims and appeals standards results in the claimant's immediate ability to initiate an external review and pursue any available remedies under applicable law.<sup>43</sup>

(c) The interim regulations provide that plans must comply with either a state or Federal external review process. If a state process is binding upon an insurer paying benefits under the plan, and such process includes the consumer protections in the NAIC Uniform Model Act in place on July 23, 2010, then the insurer must comply with the applicable state process. If a plan (or its insurer) is not subject to a state external review process, or where the state process does not meet the consumer protection requirements in the NAIC Uniform Model Act, then the Federal external review process will apply.<sup>44</sup> To allow states time to amend their laws to meet or go beyond the minimum consumer protections of the NAIC Act, for plan years beginning before July 1, 2011, existing state external review processes will be treated as meeting the minimum standards.<sup>45</sup>

As is noted and discussed further below, "grandfathered health plans" are **not** subject to the claims, appeals and external review process requirements, unlike other plans.

**3.9 PHSA §2719A - Patient Protections.** Effective for plan years beginning on or after September 23, 2010, group health plans must allow covered individuals to select, when the plan requires it, any primary care provider that participates in the plan's network. Group health plans must allow parents or legal guardians of a covered child to designate a physician who specializes in pediatric care as the child's primary care physician if that physician participates in the plan's network. Group health plans must allow covered females to obtain OB/GYN specialist services without seeking a primary care physician referral. Also, when services are provided in an emergency services department of a hospital, those services must be covered without any required prior authorization, regardless of whether or not the provider participates in the plan's network, and non-participating provider services must be covered without any limitations and with the same cost-sharing requirements as coverage for emergency services from a participating provider.<sup>46</sup>

On June 28, 2010, the IRS (Treas. Reg. §54.9815-2719AT), DOL (DOL Reg. §2590.715-2719A) and the HHS published interim regulations regarding the prohibition on coverage rescissions. The interim regulations do provide some further guidance:

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<sup>41</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(D); DOL Reg. §2590.715-2719(b)(2)(ii)(D).

<sup>42</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(E)(4); DOL Reg. §2590.715-2719(b)(2)(ii)(E)(4).

<sup>43</sup> Treas. Reg. §54.9815-2719T(b)(2)(ii)(F); DOL Reg. §2590.715-2719(b)(2)(ii)(F).

<sup>44</sup> Treas. Reg. §54.9815-2719T(c) and (d); DOL Reg. §2590.715-2719(c) and (d).

<sup>45</sup> Treas. Reg. §54.9815-2719T(c)(3); DOL Reg. §2590.715-2719(c)(3).

<sup>46</sup> PHSA §2719A.

(a) The interim regulations specify that if a plan requires the designation by a participant or beneficiary of a primary care provider, the plan must provide a notice informing each participant of the terms of the plan regarding such designation, and of the rights to select any participating primary care provider who is available, to select any pediatric primary care provider for a child, and to have treatment from an obstetrical or gynecological care provider without the need for a referral. Model language is provided in the regulations for this purpose:<sup>47</sup>

[Name of group health plan] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participate in our network and who is available to accept you or your family members. [If the plan designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan] designates one for you.] For information on who to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator] at [insert contact information].

(b) The interim regulations provide more specifics on the cost-sharing requirements applicable to emergency services. Copayment amounts or coinsurance rates imposed for out-of-network emergency services cannot exceed the copayment amounts or coinsurance rates imposed for in-network benefits, but the covered individual may be required to pay the excess of the amount the out-of-network provider charges over the greater of (1) the amount negotiated with in-network providers, (2) the amount calculated using the same methods the plan usually would use for out-of-network services, but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions, or (3) the amount that would be paid under Medicare.<sup>48</sup>

(c) The interim regulations define the terms “emergency medical condition,” “emergency services” and “stabilize” generally in conformity with the Emergency Medical Treatment and Labor Act which is part of the Social Security Act; however, rather than using a standard of care of qualified hospital medical personnel, a prudent layperson possessing an average knowledge of health and medicine standard of care is used.<sup>49</sup>

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the patient protections, unlike other plans.

**3.10 PHSA §2704 - Preexisting Condition Exclusions.** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose any preexisting condition exclusion with respect to such plan. However, there is an earlier effective date for individuals under the age of 19; for these individuals, group health plans may not impose any preexisting condition exclusion effective for plan years beginning on or after September 23, 2010.<sup>50</sup> Interim regulations issued on June 28, 2010 provide that the term “preexisting condition exclusion” is defined in the same manner as it is currently defined under HIPAA regulations.<sup>51</sup>

As is noted and discussed further below, “grandfathered health plans” generally **are** subject to the prohibition on pre-existing condition exclusions for plan years beginning on or after January 1, 2014, and the earlier effective prohibition applied to individuals under the age of 19 for plan years beginning on or after September 23, 2010, just as any other plan.

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<sup>47</sup> Treas. Reg. §54.9815-2719AT(a)(4); DOL Reg. §2590.715-2719A(a)(4).

<sup>48</sup> Treas. Reg. §54.9815-2719AT(b)(3); DOL Reg. §2590.715-2719A(b)(3).

<sup>49</sup> Treas. Reg. §54.9815-2719AT(b)(4); DOL Reg. §2590.715-2719A(b)(4).

<sup>50</sup> PHSA §2704.

<sup>51</sup> Treas. Reg. §54.9815-2704T(a)(1); DOL Reg. §2590.715-2704(a)(1). See Treas. Reg. 54.9801-2 and DOL Reg. §2590.701-2.

**3.11 PHSA §2705 - Prohibiting Discrimination Based on Health Status.** Effective for plan years beginning on or after January 1, 2014, group health plans may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on the health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or other health status-related factor of such individual or a dependent of such individual.<sup>52</sup>

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the prohibition on discrimination based on health status, unlike other plans.

**3.12 PHSA §2708 - Prohibition on Length of Waiting Period.** Effective for plan years beginning on or after January 1, 2014, group health plans may not impose any waiting period exceeding 90 days before individuals may enroll in the plan.<sup>53</sup>

As is noted and discussed further below, “grandfathered health plans” generally **are** subject to the prohibition on pre-existing condition exclusions for plan years beginning on or after January 1, 2014, just as any other plan.

**3.13 PHSA §2709 - Coverage in Approved Clinical Trials.** Effective for plan years beginning on or after January 1, 2014, group health plans must pay for typically covered items and services provided under an approved clinical trial, and a plan may require that a qualified individual participate in a clinical trial in which a network provider is involved as long as the provider will accept the patient.<sup>54</sup>

As is noted and discussed further below, “grandfathered health plans” are **not** subject to the coverage requirement for approved clinical trials, unlike other plans.

**3.14 Grandfathered Health Plans.** Notwithstanding the effective dates mentioned above in this Section 3, individuals who are enrolled in a group health plan as of March 23, 2010, may not be required to terminate that coverage, and such plan is considered a “**grandfathered health plan.**” Grandfathered group health plans are generally **not** subject to above provisions, except for items 3.1, 3.2, 3.4, 3.5, 3.10, and 3.12 above, and, with respect to item 3.4 above, such provision (pertaining to extensions of dependent child coverage) shall apply to a grandfathered plan for plan years beginning before January 1, 2014, only with respect to adult children who are not eligible to enroll in some other employer sponsored group health plan. For collectively bargained plans, different effective dates may apply than those set forth above.

Generally, a “grandfathered plan” may retain such status even if employees reenroll in the plan or new family members of current employee participants or new employees join the plan; *provided, however*, if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a “grandfathered health plan,” the plan ceases to be a “grandfathered health plan.”<sup>55</sup> Also, individuals are transferred into a plan from a previous plan, and treating the terms of the plan as if it were an amendment to the previous plan would cause the loss of “grandfathered health plan” status, then, if

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<sup>52</sup> PHSA §2705.

<sup>53</sup> PHSA §2708.

<sup>54</sup> PHSA §2709.

<sup>55</sup> Treas. Reg. 54.9815-1251T(b); DOL Reg. §2590.715-1251(b).

there was no *bona fide* employment-based reason to transfer the employees into the plan, then the plan will cease to be a “grandfathered health plan.”<sup>56</sup>

On June 17, 2010, the IRS (Treas. Reg. §54.9815-1251T), DOL (DOL Reg. §2590.715-1251) and the HHS published interim regulations regarding “grandfathered health plans” and the continuation of their status. The interim regulations do provide some further guidance:

(a) The interim regulations clarify that either a fully insured plan or a self-insured plan may be a “grandfathered health plan”.

(b) The term “grandfathered health plan” refers to a plan which provides “grandfathered health plan coverage,” which is coverage provided by a group health plan or a health insurance issuer in which an individual was enrolled on March 23, 2010.

(c) A “grandfathered health plan” may remain such even if all individuals who were enrolled in the plan on March 23, 2010, cease to be covered under the plan so long as the plan continues to cover someone.

(d) There are many various ways that a “grandfathered health plan” may lose its status as such:

(1) If the sponsoring employer or union enters into a new policy, certificate or contract of insurance after March 23, 2010.<sup>57</sup>

(2) The failure to include a statement, in any plan materials provided to participants or beneficiaries describing benefits provided under the plan, that the plan believes it is a “grandfathered health plan” within the meaning of Section 1251 of PPACA, and providing contact information for questions and complaints.<sup>58</sup> (Model language is provided for this purpose in the interim regulations and attached hereto as **EXHIBIT A.**)

(3) The failure to maintain records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify the plan’s status as a “grandfathered health plan.”<sup>59</sup>

(4) The elimination of all or substantially all benefits to diagnose or treat a particular condition.<sup>60</sup>

(5) Increasing (measured from March 23, 2010) a percentage cost-sharing requirement (such as a co-insurance requirement).<sup>61</sup>

(6) Increasing a fixed-amount cost-sharing requirement other than a copayment (for example, an out-of-pocket limit) beyond the “maximum percentage increase” (*i.e.*, medical inflation plus 15 percentage points).<sup>62</sup>

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<sup>56</sup> Treas. Reg. §54.9815-1251T(b)(2)(ii); DOL Reg. §2590.715-1251(b)(2)(ii). Changing the terms or cost of coverage is not a *bona fide* employment-based reason for this purpose. *Id.*

<sup>57</sup> Treas. Reg. §54.9815-1251T(a)(1); DOL Reg. §2590.715-1251(a)(1).

<sup>58</sup> Treas. Reg. §54.9815-1251T(a)(2); DOL Reg. §2590.715-1251(a)(2).

<sup>59</sup> Treas. Reg. §54.9815-1251T(a)(3); DOL Reg. §2590.715-1251(a)(3).

<sup>60</sup> Treas. Reg. §54.9815-1251T(g)(1)(i); DOL Reg. §2590.715-1251(g)(1)(i).

<sup>61</sup> Treas. Reg. §54.9815-1251T(g)(1)(ii); DOL Reg. §2590.715-1251(g)(1)(ii).

<sup>62</sup> Treas. Reg. §54.9815-1251T(g)(1)(iii); DOL Reg. §2590.715-1251(g)(1)(iii).

(7) Increasing a fixed-amount copayment if the total increase in the copayment exceeds the greater of (i) an amount equal to \$5 increased by medical inflation, or (ii) the “maximum percentage increase.”<sup>63</sup>

(8) If the sponsoring employer or union decreases its contribution rate based on the cost of coverage or based on a formula by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.<sup>64</sup>

(9) The imposition of an overall annual limit on the dollar value of benefits in the plan if the plan, on March 23, 2010, did not impose an overall annual or lifetime limit on benefits.<sup>65</sup>

(10) The imposition of an overall annual limit on the dollar value of benefits in the plan if the plan, on March 23, 2010, had a lifetime limit on the dollar value of benefits but no overall annual limit on benefits as of March 23, 2010.<sup>66</sup>

(11) The decrease in an overall annual limit on the dollar value of benefits in the plan from the overall annual limit on the dollar value of benefits in the plan in effect on March 23, 2010.<sup>67</sup>

Generally, the above provisions are designed to reflect a policy that different standards should apply with respect to coinsurance and fixed-amount costs sharing. Coinsurance (percentage amount a patient is required to pay) automatically rises with medical inflation and, therefore, coinsurance changes would significantly alter the level of benefit provided. However, fixed-amount cost-sharing requirements (such as copayments and deductibles) do not take into account medical inflation and, therefore, changes to fixed-amount cost-sharing requirements may be reasonable to keep up with the rising cost of medical items and services.

(e) Additionally, there are some transitional rules provided in the interim regulations:

(1) Changes effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010, are considered part of the plan’s terms as of March 23, 2010, and don’t cause the plan to lose “grandfathered health plan” status.<sup>68</sup>

(2) Changes effective after March 23, 2010, pursuant to a filing with a state insurance department on or before March 23, 2010, are considered part of the plan’s terms as of March 23, 2010, and don’t cause the plan to lose “grandfathered health plan” status.<sup>69</sup>

(3) Changes effective after March 23, 2010, pursuant to written amendments to a plan adopted on or before March 23, 2010, are considered part of the plan’s terms as of March 23, 2010, and don’t cause the plan to lose “grandfathered health plan” status.<sup>70</sup>

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<sup>63</sup> Treas. Reg. §54.9815-1251T(g)(1)(iv); DOL Reg. §2590.715-1251(g)(1)(iv).

<sup>64</sup> Treas. Reg. §54.9815-1251T(g)(1)(v); DOL Reg. §2590.715-1251(g)(1)(v).

<sup>65</sup> Treas. Reg. §54.9815-1251T(g)(1)(vi)(A); DOL Reg. §2590.715-1251(g)(1)(vi)(A).

<sup>66</sup> Treas. Reg. §54.9815-1251T(g)(1)(vi)(B); DOL Reg. §2590.715-1251(g)(1)(vi)(B).

<sup>67</sup> Treas. Reg. §54.9815-1251T(g)(1)(vi)(C); DOL Reg. §2590.715-1251(g)(1)(vi)(C).

<sup>68</sup> Treas. Reg. §54.9815-1251T(g)(2)(i)(A); DOL Reg. §2590.715-1251(g)(2)(i)(A).

<sup>69</sup> Treas. Reg. §54.9815-1251T(g)(2)(i)(B); DOL Reg. §2590.715-1251(g)(2)(i)(B).

<sup>70</sup> Treas. Reg. §54.9815-1251T(g)(2)(i)(C); DOL Reg. §2590.715-1251(g)(2)(i)(C).

(4) Changes made after March 23, 2010 but adopted prior to June 14, 2010, may be revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and won't cause the plan to lose "grandfathered health plan" status.<sup>71</sup>

In addition, the interim regulations provide an excellent chart that summarizes the various provisions of Sections 2701 through 2719A of the Public Health Service Act (as modified by the Health Care Law), and the applicability of such provisions to "grandfathered health plans." That chart is attached hereto as **EXHIBIT B**.

## **4 Impact of the Health Care Law on Taxes & Tax Reporting**

The purpose of this portion of this memorandum is to focus on how the new Law impacts taxes imposed on employees and employers.

**4.1 Code §45R - Small Employer Tax Credit.** Effective for amounts paid for tax years beginning after December 31, 2009, under new Code §45R, a small employer (generally, an employer that has 25 or fewer "full-time equivalent employees" for a tax year *and* that has average annual wages of its employees that does not exceed \$50,000 (adjusted)) may apply for a tax credit if they offer a "qualified health care arrangement" and they pay at least 50% of the cost of such health coverage. The number of "full-time equivalent employees" that an employer has for a tax year is determined by taking the total number of hours for which employees were paid wages by such employer for the tax year and dividing by 2,080, rounding the result down to the nearest whole number. The amount of the credit phases out as the number of "full-time equivalent employees" exceeds 10, and as the average annual compensation paid to the employees exceeds \$25,000 (as adjusted). The IRS is to issue regulations preventing the use of multiple entities to obtain the credit. The credit is generally 35% of employer paid amounts for the years 2010 through 2013, and increases to 50% of employer paid amounts for years 2014 and thereafter; however, the credit is only available for the first two years that the employer offers a qualified health care arrangement.<sup>72</sup>

**4.2 Code §6051(a)(14) – Cost of Health Coverage Reporting.** Beginning in 2011, employers are required to disclose the aggregate cost of "applicable employer sponsored coverage" provided to employees annually on the employee's Form W-2, regardless of whether the employer or the employee pays for the coverage.<sup>73</sup>

**4.3 Code §§6055 & 6056 - Health Care Coverage Reporting.** Beginning in 2011, employers that provide minimum essential health care coverage to an individual during a calendar year will be required to file a return reporting such coverage with the IRS, and will also be required to furnish a written statement to the individual with respect to the information reported. The required return must show the dates of coverage with minimum essential coverage, and other information that the IRS may require.<sup>74</sup> *This is a different requirement than the requirement to provide a report of health care coverage costs under Code §6051(a)(14) above.*

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<sup>71</sup> Treas. Reg. §54.9815-1251T(g)(2)(ii); DOL Reg. §2590.715-1251(g)(2)(ii). For this purpose, "adopted prior to June 14, 2010" includes becoming effective before June 14, 2010, effective on or after June 14, 2010, if required by a legally binding contract entered into before that date or written amendments made before that date or a filing with a state insurance department before that date.

<sup>72</sup> Code §45R.

<sup>73</sup> Code §6051(a)(14) added by PPACA Section 9002.

<sup>74</sup> Code §6055.

**4.4 Code §106 – Taxable Reimbursement of Over-The-Counter Medicines.** Effective for tax years beginning after December 31, 2010, for purposes of reimbursements from health flexible spending arrangements or health reimbursement arrangements, the definition of qualified medical expenses is modified to include amounts paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.

**4.5 Code §§220(f)(4)(A) and 223(f)(4)(A) – Additional Tax on HAS and Archer MSA Distributions.** Effective for tax years beginning after December 31, 2010, the additional tax on distributions made from HSAs not used for qualified medical expenses is increased from 10% to 20%, and the additional tax on distributions made from Archer MSAs not used for qualified medical expenses is increased from 15% to 20%.<sup>75</sup>

**4.6 Code §6041(h) – Corporate Payment Reporting Requirements.** Effective for tax years beginning after December 31, 2011, the exception to the information reporting requirements (Forms W-2 or 1099) for payments over \$600 to corporations is eliminated (other than for tax-exempt corporations).<sup>76</sup> Thus, payments to corporations will no longer be automatically exempt from reporting requirements by virtue of the payee's corporate status. Also, under PPACA §9906, the types of payments that can trigger the reporting requirement are expanded to include amounts paid in consideration of property and other gross proceeds.

**4.7 Code §501(r) – Additional Requirements for Charitable Hospitals.** Effective for tax years beginning after March 23, 2010, four new requirements are imposed upon Code §501(c)(3) tax-exempt entities that operate at least one hospital facility (a facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital, and any other facility or organization that the IRS determines has the provision of hospital care as its principal purpose).<sup>77</sup> Those four new requirements are:

(a) The hospital facility must conduct a community health needs assessment at least once every three tax years and adopt an implementation strategy to meet the community needs identified.

(b) The hospital facility must adopt, implement, and widely publicize a written financial assistance policy, indicating the eligibility criteria for financial assistance and whether such assistance includes free or discounted care.

(c) The hospital facility must bill patients who qualify for financial assistance no more than the amount generally billed to insured patients, and may not use gross charges for billing individuals who qualify for financial assistance.

(d) The hospital facility must not undertake certain extraordinary collection actions against a patient without first making reasonable efforts to inform the patient about the hospital's financial assistance policy and determining whether the patient is eligible for assistance under the policy.

Failure to meet these four new requirements can result in a loss of tax-exempt status, but, also, can result in a new excise tax.<sup>78</sup> The excise tax is \$50,000 for any applicable tax year.

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<sup>75</sup> Code §§220(f) and 223(f) added by PPACA §9004.

<sup>76</sup> Code §6041(h), added by PPACA §9006.

<sup>77</sup> Code §501(r), added by PPACA §9007.

<sup>78</sup> Code §4959.

**4.8 Code §162(m)(6) - Health Insurer Compensation Deduction Limitation.** Effective for tax years beginning after December 31, 2009, “applicable individual” remuneration for services performed will not be deductible above \$500,000.00 for any tax year in which the employer is a “covered health insurance provider.”<sup>79</sup> An “applicable individual” is an officer, director, or employee of a covered health insurance provider (an employer which is a health insurance issuer, and, for tax years beginning after December 31, 2012, which also receives gross premiums from providing such coverage such that not less than 25% of those gross premiums is from essential health benefits coverage). For remuneration for services that an applicable individual performs during a tax year but that isn’t deductible until a later year because the remuneration is deferred, any unused portion of the \$500,000 limit for the year is carried forward until the year in which the remuneration is otherwise deductible, and the remaining unused limit is then applied to the remuneration.

**4.9 Code §5000B – Excise Tax on Indoor Tanning Services.** Effective as of July 1, 2010, a 10% excise tax is imposed on each individual for whom indoor tanning services are performed. While the tax is imposed on the patron of the services, the performer of the indoor tanning services is required to collect and remit the tax on a quarterly basis.<sup>80</sup> Final regulations on this were issued on June 15, 2010, as Treas. Reg. §49.5000B-1T.<sup>81</sup>

**4.10 Code §125(j) – New Simple Cafeteria Plans for Small Employers.** Effective for tax years beginning after December 31, 2010, an employer employing an average of 100 or fewer employees during the preceding 2 calendar years (or who expects to employ an average of 100 or fewer employees during the current calendar year if the employer hasn’t been in existence for a complete calendar year) may establish a “simple” cafeteria plan if certain contribution, eligibility and participation requirements are met, and under such a plan, the non-discrimination requirements generally applicable to cafeteria plans are deemed satisfied.<sup>82</sup> For the contribution requirement, the employer must make a contribution to the plan in an amount equal to (1) at least 2% of each employee’s compensation for the year, or (2) the lesser of (A) 6% of each employee’s compensation for the year, or (B) 2 times the amount of salary reduction contributions of each employee. For the eligibility and participation requirements, all employees who had at least 1,000 hours of service during the preceding plan year must be eligible to participate, and each employee eligible to participate may elect any benefit available under the plan.

**4.11 Code §36C and 137Adoption Benefits Expanded.** Effective for 2010 and 2011, the dollar limitation for the adoption credit and income exclusion for employer-paid or employer-reimbursed adoption expenses through a qualified adoption assistance program is increased by \$1,000 to \$13,170.<sup>83</sup> This dollar amount is indexed for inflation for 2011. In addition, the adoption credit is now refundable.

**4.12 Code §§105, 162(l), 401(h), and 501(c)(9) - Taxation of Medical Benefits for Children under Age 27.** A child who is under the age of 27 will be considered a dependent of a taxpayer for purposes of the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan, the self-employed health insurance deduction, the provisions allowing a tax-qualified plan to provide benefits for sickness, accident, hospitalization and medical expenses to

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<sup>79</sup> Code 162(m)(6), as amended by PPACA §9014.

<sup>80</sup> Code §5000B, as added by PPACA §10907.

<sup>81</sup> 75 F.R. 33683-33688 (June 15, 2010).

<sup>82</sup> Code §125(j), as added by PPACA §9022.

<sup>83</sup> Code §§36C and 137(b)(1), as amended by PPACA §10909.

retired employees, and the VEBA rules.<sup>84</sup> Accordingly, it is no longer necessary for a child to be a “dependent” in order for the tax exclusion to apply; the exclusion may apply to a child age 26 or less at the end of a tax year even if the child provides their own support. In Notice 2010-38, the IRS addressed several issues raised by the fact that the tax exclusion here relates to *children age 26 or less at the end of a tax year*, while the required expansion of coverage (see item 0 above in “Impact of the Health Care Law on Group Health Plans”) for dependents in group health plans is *only until the child attains age 26*:

(a) Under the Notice, an employer may assume that an employee’s taxable year is the calendar year, and employers may rely on an employee’s representation as to a child’s date of birth.<sup>85</sup>

(b) While PPACA addressed tax exclusions relative to benefits received or reimbursements received under Code §105, there were no corresponding changes to the taxability of premiums or coverage payments under Code §106. However, in Notice 2010-38, the IRS acknowledges that “the exclusion for employer-provided accident or health plan coverage under §106 paralleled the exclusion for reimbursements under §105” before PPACA, and “there is no indication that Congress intended to provide a broader exclusion in §105 than in §106.” Accordingly, the IRS announced that it intends to amend Code §106 regulations retroactive to March 30, 2010, to provide that coverage for an employee’s child under age 27 is excluded from gross income, to match the expansion of coverage for dependents (see item 0 above in “Impact of the Health Care Law on Group Health Plans”).<sup>86</sup>

(c) In the Notice, the IRS announced that it intends to amend Code §125 regulations retroactively to March 30, 2010, to include change of status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.<sup>87</sup>

(d) Cafeteria plans generally need to be amended to include employees’ children who have not attained age 27 as of the end of the taxable year, and current proposed cafeteria plan regulations provide that cafeteria plan amendments may be effective only prospectively. However, in Notice 2010-38, the IRS announced that “as of March 30, 2010, employers may permit employees to immediately make pre-tax salary reduction contributions for benefits under a cafeteria plan for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals,” but the IRS also provided that “a retroactive amendment to a cafeteria plan to cover children under age 27 must be made no later than December 31, 2010, and must be effective retroactively to the first day in 2010 when employees are permitted to make pre-tax salary reduction contributions to cover children under age 27....”<sup>88</sup>

**4.13 Code §7701(o) - Codification of Economic Substance Doctrine.** Courts have traditionally used the “economic substance doctrine” to enforce the Code and prevent taxpayers from subverting the legislative intent by engaging in transactions that are fictitious or lack economic reality simply to reap a tax benefit. Under the doctrine, a transaction must have economic significance apart from the tax benefits achieved from the transaction in order for the tax benefits to apply. Under new Code §7701(o),

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<sup>84</sup> Code §§105(b), 162(l), 401(h) and 501(c)(9), as amended by HCERA §1004.

<sup>85</sup> Notice 2010-38, Section II.

<sup>86</sup> Notice 2010-38, Section III.

<sup>87</sup> Notice 2010-38, Section IV.

<sup>88</sup> Notice 2010-38, Section VII.

tax benefits should not be allowed for transactions lacking economic substance or a business purpose.<sup>89</sup> The new codified economic substance doctrine will apply to transactions entered into after March 30, 2010.

**4.14 Code §6662 - Penalty for Underpayment Attributable to Lack of Economic Substance.** For transactions entered into after March 30, 2010, a 20% penalty may be applied to underpayments of tax attributable to disallowance of claimed tax benefits relating to a transaction that lacks economic substance, as defined in new Code §7701(o).<sup>90</sup> The penalty is increased to 40% if the non-economic substance transaction is not disclosed on the taxpayer's return.<sup>91</sup>

The following changes are not as imminent as the foregoing, but are worth mentioning:

**4.15 Code §4980H - Assessable Penalties on Large Employers if No Coverage Provided.** Effective for months beginning after December 31, 2013, an applicable large employer (*i.e.*, generally, an employer who employed an average of at least 50 full-time employees during the preceding calendar year) who fails to offer its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" must pay an "assessable payment" of about \$166 per full-time employee per month. Such employers may also be required to pay an "assessable payment" of about \$250 per full-time employee per month if they offer "minimum essential coverage" but they have full-time employees who enroll in state exchange offered plans.<sup>92</sup>

**4.16 Code §5000A - Individual Shared Responsibility Payments.** Beginning in 2014, under new Code §5000A, a penalty is imposed upon "applicable individuals" (generally, almost everyone except undocumented aliens and certain religious individuals) for each month that they fail to have minimum essential health coverage for themselves and their dependents. Applicable individuals may be exempt from the penalty if they don't file Federal income tax returns, if they cannot afford coverage, if they are reside outside the United States or in U.S. territories, or if they have incurred a hardship. The penalty amount is generally 1/12 of the greater of \$695, or 2.5% of income, for each failure month. The dollar amount and income percentage are phased in during 2014 and 2015, and the dollar amount is indexed for inflation thereafter.<sup>93</sup>

**4.17 Code §4980I – Excise Tax on "Cadillac" Health Plans.** Beginning in 2018, a 40% excise tax will be imposed on the plan administrator of a self-funded group health plan or on the health insurer of a fully-insured group health plan for "excess benefits" provided by such plan.<sup>94</sup> The excess benefit taxable is sum of the monthly excess amounts for the year, with the monthly excess amounts being the excess of the aggregate cost of the applicable employer-sponsored coverage of an employee for the month over an amount equal to 1/12 of the annual limitation for such year. The annual limitations will be \$10,200 for employee-only coverage, and \$27,500 for employee and other coverage, and such amounts are adjusted for increases in health costs occurring up until 2018. Other adjustments to these annual limitations are also possible due to higher age demographics of an employer, individuals over the age of 55, and high risk professions.

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<sup>89</sup> Code §7701(o), as added by HCERA §1409.

<sup>90</sup> Code §6662(b)(6), as added by HCERA §1409.

<sup>91</sup> Code §6662(i), as added by HCERA §1409.

<sup>92</sup> Code §4980H.

<sup>93</sup> Code §5000A.

<sup>94</sup> Code §4980I added by PPACA §9001(a).

**4.18 Code §125(i) – Health FSA Limitation.** Effective for tax years beginning after December 31, 2013, a health flexible spending arrangement will not be considered a qualified benefit under a cafeteria plan unless the plan provides for a \$2,500 maximum annual salary reduction contribution to the health flexible spending arrangement.<sup>95</sup>

**4.19 Code §4191 - Excise Tax on Medical Devices.** Effective for sales occurring after December 31, 2012, a new 2.3% excise tax is imposed on any manufacturer, producer or importer of certain medical devices based on the price for which the medical device is sold.

**4.20 Code §213 - Medical Expense Deduction Threshold Increased.** Effective for tax years beginning after December 31, 2012, the threshold to claim an itemized deduction for unreimbursed medical expenses is increased from 7.5% of adjusted gross income to 10% of adjusted gross income for regular income tax purposes.<sup>96</sup>

**4.21 Code §3101(b)(2) - Additional Medicare Tax.** Effective for tax years beginning after December 31, 2012, in addition to the 1.45% employee portion of the hospital insurance Medicare tax on wages, a 0.90% additional employee portion Medicare tax is imposed on every taxpayer who receives wages with respect to employment during any tax year in excess of \$200,000 (\$250,000 in the case of a joint return, and \$125,000 in the case of a married taxpayer filing separately).<sup>97</sup> The obligation to withhold is only imposed upon an employer if the employee receives wages from that employer in excess of \$200,000, and an employer is permitted to disregard the amount of wages received by a taxpayer's spouse. If the additional tax is not withheld by the employer, the employee is responsible for paying such tax. For self-employed individuals, there is a corresponding new 0.90% Medicare tax on self-employment income in excess of the amounts noted above.<sup>98</sup> *If an employer employs both a husband and a wife, may the employer still disregard one spouse's wages in withholding on the other spouse? Also, if an employee is over-withheld due to the employer withholding based on \$200,000, when the correct amount for the married employee is \$250,000, is there any way for the married employee to get back the over-withheld amount?*

**4.22 Code §1411 - Unearned Income Medicare Contribution.** Effective for tax years beginning after December 31, 2012, in addition to traditional Medicare taxes, there is a new 3.8% "unearned income Medicare contribution" tax imposed on individuals.<sup>99</sup> The tax is 3.8% of the lesser of (A) net investment income or (B) the excess of modified adjusted gross income over an applicable threshold amount (\$250,000 in the case of joint returns or surviving spouses, and \$200,000 in other cases). For this purpose, "net investment income" is gross income from interest, dividends, annuities, royalties and rents, and other gross income from a trade or business, and net gain attributable to the disposition of property other than property held in a trade or business, less any allowable deductions properly allocable to such gross income or net gain. The Medicare "contribution" tax will apply to a trade or business if it is a passive activity of the taxpayer.

**4.23 Code §6655 - Estimated Tax Payment Increase.** Estimated tax payments in July, August and September of 2014 that are required of "large" corporations (those with assets of \$1 billion or more) have been increased to 173.50% of the amount otherwise due.

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<sup>95</sup> Code §125(i), added by PPACA §9005.

<sup>96</sup> Code §213(a), amended by PPACA §9013.

<sup>97</sup> Code §3101(b)(2), as added by PPACA §9015.

<sup>98</sup> Code §1401(b)(2), as added by PPACA §9015.

<sup>99</sup> Code §1411, as added by HCERA §1402.

## 5 Impact of the Group Health Care Law on MEWA's

The purpose of this portion of this memorandum is to focus on how the new Law impacts multiple employer welfare arrangements.

**5.1 ERISA §519 – Prohibition on False Statements Regarding MEWA.** Effective on March 23, 2010, under new ERISA §519, no person is allowed to make a knowingly false statement or representation of fact as to a MEWA's financial condition or solvency, the benefits provided by the MEWA, the regulatory status of the MEWA under federal or state laws, or the exemption of a MEWA from state laws under ERISA. A person found guilty of violating this criminal prohibition is subject to fine and/or imprisonment for up to 10 years.<sup>100</sup>

**5.2 ERISA §520 – Application of State Laws to MEWAs by DOL.** Effective on March 23, 2010, the Department of Labor ("**DOL**") is given the authority to adopt regulatory standards establishing, and given the authority to issue an order relating to a specific person establishing, that an entity engaged in the business of providing insurance through a MEWA is subject to the laws of the states in which the entity operates.<sup>101</sup> Even if the state law is preempted by ERISA, the DOL will have the authority to require compliance with the state law in order to prevent the preemption provisions of ERISA from being used as a basis for evading responsibility in state court.

**5.3 ERISA §521 –Cease & Desist Orders.** Effective on March 23, 2010, the DOL is given the authority to issue cease and desist orders against a MEWA if the DOL determines that the MEWA's conduct is fraudulent or causes an imminent danger to the public welfare.<sup>102</sup> A party adversely affected may request a hearing. The DOL may also issue a seizure order if the MEWA is financially distressed. The DOL is authorized to issue regulations or other guidance to effectuate these new powers.

**5.4 ERISA §101(g) – MEWA Plan Registration.** Effective on March 23, 2010, the DOL may issue regulations requiring MEWAs to register with the DOL before operating in any state.<sup>103</sup> The registration requirements appear to be an attempt to make sure that the MEWA has the financial capacity to satisfy claims.

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<sup>100</sup> ERISA §519 added by PPACA §6601(a).

<sup>101</sup> ERISA §520 added by PPACA §6604.

<sup>102</sup> ERISA §521 added by PPACA §6605.

<sup>103</sup> ERISA §101(g), as amended by PPACA §6606.



**EXHIBIT A**

**MODEL GRANDFATHERED HEALTH PLAN DISCLOSURE NOTICE**

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, 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.

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.

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](http://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](http://www.healthreform.gov).]

***EXHIBIT B***

**APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO  
GRANDFATHERED PLANS**

***Application of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act to Grandfathered Plans***

PHS Act Section	Summary of Provision	Application to Grandfathered plans
§2701 Fair health insurance premiums	Health insurance issuers may not charge discriminatory premium rates. The rate may vary only by whether such plan or coverage covers an individual or family, rating area, actuarial value, age, and tobacco use.	Not applicable; also does not apply to large group insurance market coverage in States that do not allow such coverage to be offered through the State exchanges.
§2702 Guaranteed availability of coverage	Health insurance issuers in both the individual and group markets must accept every employer and individual in the State that applies for coverage, but are permitted to limit enrollment to annual open and special enrollment periods for those with qualifying lifetime events.	Not applicable
§2703 Guaranteed renewability of coverage	Requires guaranteed renewability of coverage regardless of health status, utilization of health services, or any other related factor. Coverage can only be cancelled under specific, enumerated circumstances.	Not applicable
§2704 Prohibition of preexisting condition exclusion or other discrimination based on health status	Group health plans and health insurance issuers offering group or individual coverage may not impose a preexisting condition exclusion or discriminate based on health status.	Applicable to grandfathered group health plans and group health insurance coverage.  Not applicable to grandfathered individual health insurance coverage.
§2705 Prohibiting discrimination against individual participants and beneficiaries based on health status	Retains the HIPAA <sup>1</sup> nondiscrimination provisions for group health plans and group health insurance issuers. Specifically, plans and group health insurance issuers may not set eligibility rules based on factors such as health status and evidence of insurability – including acts of domestic violence or disability. Provides limits on the ability of plans and issuers to vary premiums and contributions based on health status.  The Affordable Care Act adds new provisions regarding wellness programs and extends all the nondiscrimination protections to the individual market.	The HIPAA nondiscrimination provisions are applicable to grandfathered group health plans and group health insurance issuers.  The new Affordable Care Act extensions are not applicable to grandfathered group health plans and group health insurance coverage.  Not applicable to grandfathered individual health insurance coverage.
§2706 Nondiscrimination in health care	Prohibits discrimination by group health plans and health insurance issuers against health care providers acting within the scope of their professional license and applicable State laws.	Not applicable
§2707 Comprehensive health insurance coverage	Requires health insurance issuers in the small group and individual markets (and large group markets in State exchanges) to include coverage which incorporates defined essential benefits, provides a specified actuarial value, and requires all policies to comply with limitations on allowable cost sharing.	Not applicable

<sup>1</sup> HIPAA is the Health Insurance Portability and Accountability Act of 1996.

§2708 Prohibition on excessive waiting periods	Prohibits any waiting periods that exceed 90 days for group health plans and group health insurance coverage.	Applicable
§2709 <sup>2</sup> Coverage for individuals participating in approved clinical trials	Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.	Not applicable
§2711 No lifetime or annual limits	Prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from establishing lifetime limits and annual limits on the dollar value of benefits. Prior to 2014, plans and issuers may establish certain restricted annual limits (as defined in regulations).	Prohibition on lifetime limits: Applicable  Prohibition and limits on annual limits: Applicable to grandfathered group health plans and group health insurance coverage; not applicable for grandfathered individual health insurance coverage.
§2712 Prohibition on rescissions	Group health plans and health insurance issuers may not rescind health coverage after coverage begins except in the case of fraud or intentional misrepresentation.	Applicable
§2713 Coverage of preventive health	Group health plans and health insurance issuers offering group or individual health insurance coverage must cover certain preventive services, immunizations, and screenings, without any cost sharing.	Not applicable
§2714 Extension of dependent coverage	Group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage must continue to make such coverage available to children until age 26.	Applicable <sup>3</sup>
§2715 Development and utilization of uniform explanation of coverage	Requires the Federal government to develop standards for use by group health plans and health insurance issuers in compiling and	Applicable

<sup>2</sup> After the amendments made by the Affordable Care Act, there are two PHS Act sections 2709. The first section 2709 was PHS Act section 2713 before the amendments made by the Affordable Care Act and was redesignated PHS Act section 2733 by section 1001(3) of the Affordable Care Act and then, as PHS Act section 2733, was again redesignated by section 1562(c)(10) of the Affordable Care Act as PHS Act section 2709. The second section 2709 was added by section 10103 of the Affordable Care Act and relates to coverage for individuals participating in approved clinical trials. Grandfathered health plans are subject to the first PHS Act section 2709 because as PHS Act section 2713 it was part of the PHS Act before the enactment of the Affordable Care Act. However, grandfathered health plans are not subject to the second PHS Act section 2709.

<sup>3</sup> For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before January 1, 2014, PHS Act section 2714 is applicable in the case of an adult child only if the adult child is not eligible for other employer-sponsored health plans coverage. The interim final regulations relating to PHS Act 2714, published in 75 FR 27122 (May 13, 2010), and these interim final regulations clarify that, in the case of an adult child who is eligible for coverage under the employer-sponsored plans of both parents, neither parent's plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the other parent's employer-sponsored plan.

documents and standardized definitions	providing an accurate summary of benefits and explanation of coverage for applicants, policyholders or certificate holders, and enrollees. The explanation of coverage must describe any cost sharing, exceptions, reductions, and limitations on coverage, and give examples to illustrate common benefits scenarios.	
§2715A Provision of additional information	Requires group health plans and health insurance issuers offering group or individual health insurance coverage to disclose, to the Federal government and the State insurance commissioner, certain enrollee information such as claims payment policies and practices and enrollee rights. Requires such plans and issuers to provide information to enrollees on the amount of cost-sharing for a specific item or service.	Not applicable
§2716 Prohibition on discrimination in favor of highly-compensated individuals	Prohibits fully-insured group health plans from discriminating in favor of highly compensated individuals with respect to eligibility and benefits.	Not applicable
§2717 Ensuring quality of care	Requires the Federal government to develop guidelines for use by health insurance issuers to report information on initiatives and programs that improve health outcomes. Prohibits a wellness program from requiring the disclosure or collection of any information relating to the presence or storage of a lawfully possessed firearm or ammunition in the residence or the lawful use, possession or storage of a firearm or ammunition by an individual.	Not applicable
§2718 Bringing down cost of health care coverage (medical loss ratio provisions)	Requires health insurance issuers offering group or individual health insurance coverage to submit annual reports to the Federal government on the percentages of premiums that the coverage spends on reimbursement for clinical services and activities that improve health care quality, and to provide rebates to enrollees if this spending does not meet minimum standards for a given plan year.	Applicable to insured grandfathered plans
§2719 Appeals process	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.	Not applicable
§2719A Patient protections	Group health plans and health insurance issuers offering group or individual health insurance coverage must permit an individual to select a participating primary care provider, or	Not applicable

	pediatrician in the case of a child. Provides direct access to obstetrical or gynecological care without a referral. Prohibits prior authorization or increased cost sharing for out-of-network emergency services.	
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