

Summary of Changes Affecting Large Employers under the PPACA

	Summary of Change	Effective Date	Citation / Comments
Health Insurance Exchange / Co-ops	(a) Individual Policies Across State Lines. States can form “health care choice compacts” to allow purchase of individual policies across state lines.	(a) No earlier than 1/1/2016 ¹	(a) Sec. 1333
	(b) State Exchanges. Establishes state exchange for individual and small employer market.	(b) No later than 1/1/2014	(b) Sec. 1311
	(c) Employers Eligible for Exchange. Employers with at least 100 employees allowed into exchange in 2017. If employer starts as a small employer and grows above 100 employees, it may still be treated as small employer.	(c) “Beginning in 2017”	(c) Secs. 1304(b) and 1312(f)
	(d) Co-ops Created. Non-profit co-ops created for individual and small employer market.	(d) Awards and grants provided by 7/1/2013	(d) Sec. 1322
Employer Requirements	(a) Large Employers Must Provide Minimum Essential Coverage. Assess employers with more than 50 employees that do not offer “minimum essential coverage” a \$750 annual fee (determined on a month-to-month basis) for each employee who receives a tax credit for health insurance through an exchange. This “assessable payment” can be avoided if the employer provides a “free choice voucher,” as noted below.	(a) 1/1/2014	(a) Sec. 1513 Michael Best Note: This provision is targeted for adjustment in reconciliation. Specifically, the \$750 annual fee is proposed to be raised to \$2,000.
	(b) Stricter Requirements for Construction Industry. 50-employee limit changed to 5 employees (if annual payroll exceeds \$250,000) for construction industry employers.	(b) 1/1/2014	(b) Sec. 10106

¹ HHS instructed to release regulations governing such compacts no later than 7/1/2013.



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Employer Requirements	(c) Penalty for Waiting Periods. If large employer has a waiting period which exceeds 60 days to enroll in “minimum essential coverage,” a tax of \$600 per full-time employee subject to the waiting period is imposed.	(c) 1/1/2014	(c) Sec. 10106 Michael Best Note: This provision is targeted for deletion in reconciliation.
	(d) Automatic Health Plan Enrollment. Require employers with 200 or more employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.	(d) Unclear ²	(d) Sec. 1511
	(e) Employer Tax for Employees Failing to Enroll. If large employer offers minimum essential coverage but a full-time employee enrolls in a “qualified health plan” eligible for a premium tax credit or cost-sharing reduction, tax of \$3,000 per each such employee.	(e) 1/1/2014	(e) Sec. 1513(c) Michael Best Note: This provision is targeted for adjustment in reconciliation. Specifically, this tax is proposed to be determined on a monthly basis.
	(f) Reports to Government on Plan Coverage. Employers with 50 or more employees and any employer who: (i) offers minimum essential coverage to employees through an eligible employer-sponsored plan; (ii) who pays any portion of the costs of such plan; and (iii) where the employee’s share of the cost of such coverage exceeds 8% of the employee’s wages, must report to federal government on health coverage (including certification of whether it offers full-time employees and dependents minimum essential coverage, the name of each employee and dependent covered by plan, the number of full-time employees, the length of any waiting period (in the case of an employer with 50 or more employees), the monthly premium of lowest cost option, and the employer’s share of cost).	(f) 1/1/2014	(f) Secs. 1514, 10106, and 10108

² Notice requirements to employees take effect beginning on March 1, 2013. See page 348 (Sec. 1512).



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Employer Requirements	<p>(g) Summary Report to Employees. Summary of information provided to federal government in (f), above, must be provided to each full-time employee.</p>	(g) 1/1/2014	(g) Sec. 1514
	<p>(h) Free Choice Vouchers to Qualified Employees. If employer offers “minimum essential coverage” to employees and pays any portion of plan’s cost, employer must offer “free choice vouchers” to “qualified employees.” “Qualified employee” status based on employee contribution being between 8% and 9.8% of “household income,” for a tax year not being greater than 400% of federal poverty level for such tax year and not participating in employer plan. Amount of voucher equals amount employer would have paid for self-only coverage (or family if elected by employee). Plan’s “cost” is a defined term under federal law (may not be actual “cost” of employer plus employee contributions). Employee can credit voucher towards cost of exchange-provided coverage (employer must pay amounts to exchange). Excess is paid to employee (not employer). Voucher value is not taxable to employee but is deductible by employer.</p>	(h) 1/1/2014	<p>(h) Sec. 10108 Michael Best Note: It may be very difficult for an employer to know this information (an employer may not know an employee’s total “household income” or poverty level status). It is also unclear how the employer would determine whether a “qualified employee” would elect family coverage when the definition of a qualified employee requires that the employee not participate in the employer’s plan.</p>
	<p>(i) Provide Notice of Exchange. Employers must provide notice of exchange to employees and, if employer’s share of cost is less than 60%, that employee may be eligible for premium tax credit / cost sharing reduction if employee purchases a qualified health plan through exchange.</p>	(i) 3/1/2013	(i) Secs. 1512 and 10108



	Summary of Change	Effective Date	Citation / Comments
	(j) Report Cost on W-2. The aggregate cost of employer-sponsored coverage must be reported on an employee's W-2.	(j) Tax years beginning after 12/31/2010	(j) Sec. 9002
Health Plan Mandates	(a) New Appeals Process Required. A new health plan appeals process must be followed. New rules require external review in some situations.	(a) Plan years beginning 6 months after enactment	(a) Sec. 10101 A "grandfathered" plan ³ does not appear to be subject to this requirement. Secs. 1251 and 10103
	(b) Any Available Doctor as Primary Doctor. Plan must permit enrollee to designate any available doctor as a participating primary care doctor. Similar rules for pediatric care.	(b) Plan years beginning 6 months after enactment	(b) Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103
	(c) Coverage of Emergency Services. Emergency services must be covered without prior authorization and as though services were in-network.	(c) Plan years beginning 6 months after enactment	(c) Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103
	(d) No Authorization for Ob/Gyn Care. For female enrollees, cannot require authorization for Ob/Gyn care for designated participating primary care provider.	(d) Plan years beginning 6 months after enactment	(d) Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Sec. 1251 and 10103
	(e) No Discrimination Based on Clinical Trials. Cannot deny participation or routine patient costs to an individual due to participating in clinical trial for treatment of cancer or other life-threatening disease or condition.	(e) Plan years beginning on or after 1/1/2014	(e) Sec. 10101 (Sec. 1253 for effective date) A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103

³ PPACA provides that many of its changes do not apply to a "grandfathered" plan. Sec. 1251(e). This protection clearly applies where there is "no change to existing coverage." Sec. 1251(a) (heading). A plan will retain its grandfathered status even if it allows family members or new employees to join the plan. Sec. 1251(b), (c). However, it is not clear if any other common changes would cause the plan to lose its grandfathered status—e.g., change in benefit terms (increasing or decreasing co-payments or deductibles), changes in type of funding (fully-insured versus self-funded), changes due to a corporate merger / acquisition, change in plan numbers or "wrapping" previously separate plans into a single plan. Further guidance would be helpful.



	Summary of Change	Effective Date	Citation / Comments
	(f) Limits on Waiting Periods. Plan cannot impose any waiting period that exceeds 90 days.	(f) Plan years beginning on or after 1/1/2014	(f) Sec. 1201 A grandfathered plan does not appear to be subject to this requirement. Michael Best Note: The reconciliation bill would apply this rule to a grandfathered plan. (Recon. Sec. 2301)
	(g) Limits on Preexisting Condition Exclusions. Plan cannot impose any preexisting condition exclusion with respect to plan coverage.	(g) Generally plan years beginning on or after 1/1/2014. However, as it relates to preexisting condition exclusions against children under 19, plan years beginning 6 months after date of enactment.	(g) Secs. 1201, 10103
Cafeteria Plans	(a) Safe Harbor from Nondiscrimination Rules. Safe harbor from nondiscrimination rules for certain small employers (under 100 employees) provided minimum employer contributions are given. If employer starts as a small employer and grows above 100 employees, can remain in safe harbor in certain situations.	(a) 1/1/2011	(a) Sec. 9022
	(b) Pre-Tax Payments for Exchange Individuals. Plan can allow pre-tax premium payments for exchange-eligible individuals only if employer is a "qualified employer."	(b) 1/1/2014	(b) Sec. 1515
	(c) Cap on Health FSA Contributions. Health FSA contributions limited to \$2,500. Amount is inflation-adjusted beginning 1/1/2012.	(c) Tax years beginning after 12/31/2010	(c) Secs. 9005 and 10902 Michael Best Note: The reconciliation bill would change the effective date to 12/31/2012. (Recon. Sec. 1403)



	Summary of Change	Effective Date	Citation / Comments
Taxes on TPAs and Insurers	(a) Reinsurance Fees for TPAs. Third party administrators of group health plans and insurers contribute to a reinsurance program for individual policies administered by a non-profit for high risk cases in state.	(a) No later than 1/1/2014 (apparent sunset 1/1/2017)	(a) Sec. 1341
	(b) Fees on Certain Plans/Insurers. Annual fee on a “covered entity” that provides health insurance. Excludes self-funded employer but does not specifically exclude fully-insured plan.	(b) First payment due no later than September 30, 2011	(b) Secs. 9010 and 10905 Michael Best Note: Practical effect likely is to increase fees insurers and TPAs will charge to employers. Unclear if “group health plans” includes only major medical or also FSAs, HRAs and HSAs. The reconciliation bill would change the effective date to 2013. Also, some VEBAs would be excepted. (Recon. Sec. 1406)
Retiree Health Subsidy	Federal government to reimburse eligible plans (including multiemployer plans or VEBAs) 80% of “early retiree” (age 55+ but not eligible for Medicare) health claims between \$15,000 - \$90,000. Program ceases by 1/1/2014 (could be earlier if \$5B funding is exhausted). Plan must satisfy various application and submission rules to qualify.	Within 90 days of Act’s enactment	Sec. 1102
Health Care Tax Credits	(a) Individual Credits. Individuals can receive premium assistance credits if income between 100% and 400% of federal poverty level.	(a) 1/1/2014	(a) Sec. 1401 Michael Best Note: The reconciliation bill would make some changes – e.g., the phase-out is slightly decreased. (Recon. Sec. 1001)
	(b) Credits to Small Employers. Limited tax credit to small employers to purchase health coverage.	(b) Tax years beginning after 12/31/2009	(b) Secs. 1421 and 10105 Michael Best Note: The tax credit calculation changes for tax years beginning after 12/31/2013.



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Individual Requirement	(a) Individuals Must Have Minimum Essential Coverage. Starting in 2014, all U.S. citizens would need to have "minimum essential coverage" through individual market or employer or certain other coverage (e.g., Medicare or CHIP).	(a) 1/1/2014	(a) Secs. 1501 and 10106
	(b) Coverage Cannot Be Only Excepted Benefits. Employer group health plan coverage is "minimum essential coverage" but not if coverage is only excepted benefits.	(b) 1/1/2014	(b) Sec. 1501
	(c) Penalties on Individuals. Individual noncompliance penalties start at \$95 in 2014, phase to \$750 per adult in 2017 (1/2 for child); various exceptions, e.g., Native American, religious, 8% of gross income.	(c) 1/1/2014	(c) Secs. 1501 and 10106 Michael Best Note: The reconciliation bill would decrease some penalties – e.g., the \$750 penalty decreases to \$695. (Recon. Sec. 1002)
Native Americans	Certain Indian Health Service or other Tribal health benefits would not be considered gross income.	Upon enactment	Sec. 9021 Michael Best Note: It is unclear what Congress meant to do with this term; there is a numbering issue with the Senate bill and the Manager's Amendment.
HIPAA Wellness Changes	(a) Codification of Regulations. Codifies many existing regulations.	(a) Apparently plan years beginning on or after 1/1/2014	(a) Sec. 1201 A grandfathered plan does not appear to be subject to this requirement as codified, but it appears that the plan would still be required to comply with HIPAA's regulations. Secs. 1251 and 10103
	(b) Wellness "Carrot/Stick" Limits Raised. Raises current 20% cap on wellness discounts to 30% of employee-only coverage and allows HHS, IRS and DOL to increase amount to 50%.	(b) Apparently plan years beginning on or after 1/1/2014	(b) Sec. 1201 A grandfathered plan does not appear to be subject to this requirement. Secs. 1201, 1251 and 10103



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	(c) No Questions on Firearms. Information on lawful firearm or ammunition ownership, storage, or use may not be required to be provided.	(c) Plan years beginning 6 months after enactment	(c) Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103
Pharmacy Benefit Manager (PBM) Disclosures	PBMs must share information about rebates, discounts and other items with HHS and plans the PBMs contract with through Medicare Part D or the exchanges.	Unclear	Sec. 6005
HIPAA Standard Transaction Rules Changes	(a) Plans Must Certify Compliance. By Dec. 31, 2013, health plans must certify with HHS that their data and information systems comply with, and have tested, current standards and operating rules for certain Standard Transactions.	(a) Upon enactment	(a) Secs. 1104 and 10109
	(b) New Transactions. New Standard Transactions include unique health plan identifier (by 10/1/2012), electronic funds transfer (by 1/1/2014) and health claims attachments (by 1/1/2016).	(b) Upon enactment	(b) Sec. 1104
Excise Taxes / Other Revenue Raisers	(a) Additional Payroll Taxes. Additional FICA and SECA payroll tax of 0.9% for individual wages over \$200,000 (\$250,000 for couples filing jointly).	(a) 1/1/2013	(a) Secs. 9015 and 10906
	(b) "Cadillac Tax" on Certain Plans. 40% excise tax on excess benefit of high cost employer-sponsored health insurance (so-called "Cadillac tax"). Limit based on \$8,500 annual limit for individuals and \$23,000 annual limit for other than individual coverage. Numerous exceptions based on states and job classifications. Third party administrator may have liability to pay tax.	(b) Tax years beginning 1/1/2013	(b) Sec. 9001 Michael Best Note: Certain employer-provided coverage is disregarded (modified in Sec. 10901). The reconciliation bill would change the annual limit amounts to \$10,200 and \$27,500, respectively, and delay the effective date until 2018.



	Summary of Change	Effective Date	Citation / Comments
	(c) Medicare Part D Subsidy Deductions. Deduction for Medicare Part D subsidy eliminated.	(c) Tax years beginning 1/1/2011	(c) Sec. 9012 Michael Best Note: The reconciliation bill would change the effective date from 2011 to 2013.
Over the Counter Medicines	Cost of over-the-counter medicine (other than doctor prescribed) may not be reimbursed through health FSA, HRA, HSA or Archer MSA.	Tax years beginning 1/1/2011	Sec. 9003
HSA Excise Tax	Effective January 1, 2011, 10% excise tax on HSA distributions for non-medical purposes is increased to 20%.	Distributions beginning 1/1/2011	Sec. 9004
No Lifetime Limits; Restricted Annual Limits	Lifetime limits under health plans for “essential health benefits” are eliminated. Annual limits prior to 1/1/2014 are subject to a “restricted annual limit.” Benefits that are not “essential” may have lifetime or annual limits.	Plan years beginning 6 months after enactment	Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103 Michael Best Note: The reconciliation bill would subject grandfathered plans to these requirements. (Recon. Sec. 2301)
Fully Insured Plans Subject to Nondiscrimination Rules	Fully-insured group health plans must now satisfy the nondiscrimination rules of Code Section 105(h)(2) (eligibility to participate and eligibility for benefits).	Plan years beginning 6 months after enactment	Sec. 10101 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103 Michael Best Note: This could be a significant change, especially for “executive-only” policies.
No Rescission	A plan cannot rescind coverage once person is enrolled unless fraud or intentional misrepresentation of material fact and plan’s term prohibit such fraud / misrepresentation.	Plan years beginning 6 months after enactment	Sec. 1001 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103 Michael Best Note: The reconciliation bill would apply this requirement to a grandfathered plan. (Recon. Sec. 2301)



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Preventive Health Coverage	Plan must cover, without cost-sharing, certain preventive services (e.g., immunizations and infant screenings).	Plan years beginning 6 months after enactment	Sec. 1001 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103
Coverage of Older Dependents	If plan covers dependents, unmarried adult child must be allowed coverage until age 26. No requirement to cover child of such a dependent child.	Plan years beginning 6 months after enactment	Sec. 1001 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103 Michael Best Note: The reconciliation bill provides that coverage must be available even if the dependent is married. It also would remove the grandfathered plan exception. However, “before” plan years beginning 1/1/2014, the grandfathered plan must allow enrollment only if such dependent is not eligible for any other employer-sponsored coverage. Recon. Sec. 2301(b). It is not clear if the word “before” would cause change to be immediately effective.
Standardized Plan Summary	Secretary to develop standards for plans to compile and provide to applicants, enrollees, and policy or certificate holders a summary of benefits and coverage explanation. Cannot exceed 4 pages with 12-point font. Various contents required (e.g., description of cost sharing and coverage).	Standards developed no later than 12 months after enactment. Plan to distribute no later than 24 months after enactment.	Secs. 1001 and 10101
Quality of Care Reporting	Secretary to develop reporting requirements related to various quality of care items (e.g., effective case management, preventing hospital readmissions). Plan must then annually submit to Secretary and enrollees a report on these elements.	Standards developed within 24 months after enactment. Unclear when plans must report.	Sec. 1001 A grandfathered plan does not appear to be subject to this requirement. Secs. 1251 and 10103



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EGTRRA Extension	The Economic Growth and Tax Relief Reconciliation Act of 2001 had a “sunset” provision of 12/31/2010. The sunset provision is extended by one year, to 12/31/2011. This change principally affects retirement plans, not health plans.	Tax years beginning 1/1/2010	Sec. 10909

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