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EMPLOYEE BENEFITS LAW

BULLETIN: HEALTH CARE REFORM LEGISLATION AFFECTING MULTIEMPLOYER PLANS

At the end of last month, President Obama signed into law sweeping health care reform legislation affecting multiemployer and single-employer health plans and sponsors, health insurance issuers, and individuals in myriad ways. The legislation consists of two separate acts: The Patient Protection and Affordable Care Act ("PPACA"), signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), enacted on March 30, 2010. This Bulletin refers to them collectively as "Health Care Reform" or the "Act." There are *many* unanswered questions regarding interpretation and implementation of the Act, and details will be fleshed out in the coming weeks and months in regulations and other guidance from federal agencies, and possibly further legislation making technical corrections. This Bulletin focuses on the impacts of the Act on existing multiemployer plans, and for context also includes major impacts on single-employer plans, employers, and the health insurance market generally.

This Bulletin is organized into three sections: (1) Changes Affecting Plan Design and Administration; (2) Universal Coverage Requirements; and (3) Other Changes Affecting Plans and Sponsors. The effective dates of changes vary considerably, and some are still subject to uncertainty. Many of the new rules are detailed and complex, and this Bulletin provides only a summary. Please call if you have specific questions or need advice on how a particular change applies to your situation. For ease of reference, a 2-page Highlights Chart accompanies this Bulletin.

1. CHANGES AFFECTING PLAN DESIGN AND ADMINISTRATION

Health Care Reform imposes many new benefit design and administrative requirements on multiemployer and single-employer group health plans ("health plans"). Health plans covered by the Act include both fully insured and self-insured plans; multiemployer, church, and governmental plans; and certain health FSAs and HRAs. (Issuers of group and individual health insurance coverage are generally subject to the same new benefit design and administrative requirements as health plans, plus many additional rules.)

Multiemployer and other collectively-bargained health plans in existence on March 23, 2010 have a delayed effective date for many of the new requirements, extending the deadline for compliance for some aspects of the Act at least until the expiration of all collective bargaining agreements related to the plan in effect on March 23, 2010.[1] (CBAs in effect on March 23, 2010 are described as "current CBAs" in this Bulletin and the accompanying Highlights summary.) Those extended dates are noted below. In addition, general "grandfathered plan" status under the Act, for plans in existence on March 23, 2010, is expected to apply to existing multiemployer plans and can make certain aspects of the law *never apply* – even after expiration of current CBAs – so long as that "grandfathered plan" status continues.[2]

Part A covers new benefit design and administrative requirements applicable to *all health plans*; Part B covers those that only apply to "non-grandfathered" plans (generally, new plans after March 23, 2010).

A. Requirements Applicable to All Health Plans, Including Multiemployer Plans

No Annual or Lifetime Limits. Health plans cannot establish lifetime or annual limits on the dollar value of benefits for any participant or beneficiary. However, annual or lifetime per beneficiary limits

on specific covered benefits that are not "essential health benefits"[3] are permitted. Also, for plan years beginning before 2014, "restricted annual limits" (to be defined by HHS) on essential health benefits are permitted to the extent otherwise allowed under applicable law. *Effective for plan years beginning after September 22, 2010 or, if later, at expiration of all current CBAs related to the plan.*

No Rescissions of Coverage. The Act provides that once a participant or dependent is enrolled, coverage cannot be rescinded except in cases of fraud or intentional misrepresentation of material fact prohibited under plan terms. This requirement seems primarily directed at insurers, and governmental guidance is needed regarding its scope as applied to health plans. *Effective for plan years beginning after September 22, 2010 or, if later, at expiration of all current CBAs related to the plan.*

Coverage for Children Until Age 26. Health plans that cover dependent children (to be defined by HHS) must continue to make the coverage available to such children until they turn age 26, even if married. Coverage for the child of a dependent child is not required. HHS appears to interpret this rule to require that coverage be offered through age 26 not just to those children that currently have coverage, but also to those children up to age 26 who do not already have coverage (including those who may have previously aged out of coverage).

- *Effective for plan years beginning after September 22, 2010 or, if later, at expiration of all current CBAs related to the plan – required to cover children to age 26 but* ***only*** *if they do not have other health plan eligibility*
- *Effective for plan years beginning in 2014 and later or, if later, at expiration of all current CBAs related to the plan, coverage must be continued to age 26* ***regardless of*** *other eligibility.*

The Act makes a corresponding change to the Tax Code, expanding the tax exemption for employer-provided health coverage to include coverage for an employee's child through the end of the year he or she turns age 26 even if the child is not a tax dependent.

Pre-existing Condition Exclusions Prohibited. The Act prohibits health plans from imposing pre-existing condition exclusions. This rule applies in two phases:

- *Effective for plan years beginning after September 22, 2010 or, if later, at expiration of all current CBAs related to the plan*, health plans may not impose pre-existing condition exclusions with respect to "enrollees" under age 19. The term "enrollees" is not defined under the Act, but may include participants as well as dependents who are younger than 19.
- *Effective for plan years beginning in 2014 and later or, if later, at expiration of all current CBAs related to the plan*, health plans may not impose pre-existing condition exclusions on any persons covered under the plan.

New Notice Requirements. Employers will be required provide each employee with a notice regarding the Exchanges (discussed below), the eligibility conditions for premium tax credits (also discussed below), and related information. *Effective March 1, 2013.*

Reimbursement for Over-the-Counter Drugs. Costs for over-the-counter drugs that are not prescribed, other than insulin, are not reimbursable on a tax-free basis through an HRA, HSA or health FSA. It appears this rule applies to health plans generally. *Effective for tax years beginning in 2011 and later.*

Health FSA Contribution Limit. Employees may not elect to make more than $2,500 of salary deferral contributions per taxable year to a health FSA provided under a cafeteria plan, adjusted annually. *Effective for tax years beginning in 2013 and later.*

Obligation to report cost of employer-sponsored health coverage on Form W-2. The value of employer-provided health coverage must be reported on an employee's Form W-2, with the value of coverage determined in the same manner as COBRA continuation coverage premiums. No guidelines or requirements for implementation of this requirement in the multiemployer plan context have been issued. *Effective beginning with W-2s issued in 2012, reporting the value of coverage in 2011.*

Waiting Periods. Health plans cannot require individuals wait more than 90 days to be eligible to participate. Given typical multiemployer plan eligibility rules, relief from this requirement appears necessary; so far, however, no multiemployer guidance or exception has been issued. *Effective for plan years beginning in 2014 and later or, if later, at expiration of all current CBAs related to the plan.*

Uniform Summary of Benefits and Coverage; Notices of Changes. All group health plans will have to follow new, uniform requirements for communicating benefit and coverage information. These will supplement the current legal requirements (for example, the required summary plan description and notices of plan changes). The new rules will require that participants receive a "summary of benefits and coverage explanation" (Summary) that meets detailed standards related to:

- appearance (typeface and length requirements);
- language ("a culturally and linguistically appropriate" communication, understandable to the average participant); and
- content including, among other things (a) uniform definitions of standard insurance and medical terms; (b) a description of the coverage for each category of "essential health benefits" covered; (c) all cost-sharing provisions, including deductible, coinsurance, and co-payment obligations; (d) exceptions, reductions, and limitations on coverage; (e) renewability and continuation of coverage provisions; (f) whether the plan provides "minimal essential coverage" and covers at least 60% of total benefit costs; and (g) examples to illustrate common benefits scenarios.

In addition, if not already included in a Summary, a notice of material modifications to the plan must be provided to participants at least 60 days *prior* to the effective date of the change. (Current law requires, at most, notice within 60 days *after* the effective date of the change. *Effective beginning March 23, 2011, when HHS is required to issue guidance detailing these standards; the first uniform-format Summaries are to be issued by March 23, 2012 or, if later, at expiration of all current CBAs related to the plan. Updated Summaries will probably be required thereafter, on a regular basis, although the Act is not clear on this point.*

Annual Fee on Health Insurance Issuers and Self-Insured Plans. The Act imposes an annual fee on health insurance issuers and self-insured plans. The fee is $1.00 per covered life for the first year and $2.00 per covered life for subsequent years (subject to a potential adjustment). *Effective for plan years ending after September 30, 2012 and before October 1, 2019.*

Electronic Transaction Standards. To simplify plan and health insurance administration, the Act directs HHS to adopt a single set of standards and operating rules for the electronic exchange of administrative information and electronic funds transfers. By no later than specified deadlines, health plans must file statements with HHS certifying that their systems comply with the applicable standards. Also, health plans must ensure that their business associates and other agents comply with the standards and certifications required by HHS. The Act gives HHS authority to conduct compliance audits of health plans, and beginning April 1, 2014, HHS has authority to assess a penalty of $1 per plan participant for each day that a plan's data system is out of compliance. *Effective dates are staggered; first applicable deadline is January 1, 2013.*

Automatic Enrollment Requirements. Plans maintained by employers with over 200 full-time employees must include automatic enrollment provisions and continue enrollment elections year-after-year unless the employee opts out. *The effective date of this requirement is not clear, but it appears it will be established in regulations.*

B. Requirements Applicable Only to New and "Non-Grandfathered" Plans

The following requirements appear to apply *only* to new plans established after March 23, 2010, or to plans in existence on March 23, 2010 but which lose "grandfathered" status (which may be possible in the case of significant plan design changes – an area of uncertainty under the Act). If any of these provisions apply to existing multiemployer plans due to a loss of "grandfathered plan" status, they should only apply *upon expiration of all current CBAs related to the plan*.

Required Preventive Health Services. New and non-grandfathered health plans must provide coverage, with no deductibles or other cost-sharing, for the following types of "preventive health services":

- Preventive care rated A or B by the U.S. Preventive Services Task Force;
- Immunizations recommended by the CDC; and
- Preventive care for infants, children, adolescents, and women, as provided in certain HHS guidelines.

Generally, plans will have at least a year from issuance of a preventive care guideline to cover that care, but some preventive care guidelines may become effective as early as the fall of 2010. *Effective for plan years beginning after September 22, 2010.*

Nondiscrimination Requirements for Insured Plans. New and non-grandfathered fully insured health plans are subject to nondiscrimination tests under Section 105(h) of the Tax Code similar to those that now apply to self-insured plans – i.e., barring discrimination in favor of highly compensated individuals as to eligibility or benefits. *Effective for plan years beginning after September 22, 2010.*

Patient Protections. New and non-grandfathered health plans that require individuals designate a participating primary care provider must allow the individual to choose any available provider. For covered pediatric and ob/gyn care, plans must allow a participating physician in that specialty to be designated as a primary care provider. Generally, prior authorizations and similar limits cannot be imposed on ob/gyn or emergency care. *Effective for plan years beginning after September 22, 2010.*

New Standards for Claim Determinations and Appeals. New and non-grandfathered health plans must satisfy certain procedural standards with respect to coverage and benefit determinations and appeals. The new rules address both (a) internal claim and appeal processes, and (b) external reviews. For internal claim and appeal processes, the Act incorporates the DOL's existing claims review regulations as the required standard. With respect to external reviews, it appears there will be different standards for insured and self-insured plans, with insured plans subject to any applicable State external review processes (including the consumer protections provided under the Uniform External Review Model Act published by the National Association of Insurance Commissioners (NAIC)), and self-insured plans subject to standards to be established by HHS. Plans will be required to notify enrollees of their internal and external appeals processes and of any applicable assistance they can receive from State agencies. *Effective for plan years beginning after September 22, 2010.*

Quality of Care Reporting. The Act directs HHS, no later than March 23, 2012, to develop reporting requirements for new and non-grandfathered health plans (and insurers) on initiatives and activities that improve health outcomes, prevent hospital readmission, improve patient safety, and promote wellness. Once the guidance is issued, plans and insurers must report annually to HHS on such statistics, and make such reports available to enrollees in the plan during open enrollment periods. Wellness and health promotion activities are prohibited from requiring disclosures relating to an individual's lawful ownership, use, possession, or storage of a firearm or ammunition. *Effective for plan years beginning after September 22, 2010.*

Clinical trial participation. Generally, new and non-grandfathered health plans may not discriminate against covered individuals for participating in a clinical trial that relates to cancer or another life-threatening condition and meets certain requirements under the Act. *Effective for plan years beginning in 2014 and later.*

Wellness programs. The Act generally codifies the current regulations that prohibit discrimination based on health status, but permit certain employer-provided wellness programs. However, the Act raises the incentive limit for standard-based wellness programs from 20% to 30% of the cost of coverage. The DOL, HHS, and IRS have the discretion to raise the limit further (up to 50% of the cost of coverage). Small employers (generally, those who employ fewer than 100 employees working at least 25 hours per week) may be eligible for grants for establishing new workplace wellness programs for all employees. *Effective for plan years beginning in 2014 and later. It may be oversight that this provision does not apply to existing plans; this may be corrected in further legislation or regulations.*

Cost-sharing limitations. New and non-grandfathered health plans are subject to annual cost-sharing limits equal to the maximum out-of-pocket expense limits for self-only or family high-deductible health plan ("HDHP") coverage (currently, in 2010, $5,950 for self-only coverage and $11,900 for family coverage). In general, "cost-sharing" includes deductibles, coinsurance, copayments, and similar charges, but does not include premiums, balance billing amounts for non-covered providers, or spending for non-covered services. In addition, health plans in the small group market cannot impose deductibles over $2,000 for self-only coverage and $4,000 for family coverage, increased by the maximum reimbursable amount available to the participant under a health FSA (determined without regard to participant salary reduction contributions), subject to annual adjustments. *Effective for plan years beginning in 2014 and later.*

Disclosure and Transparency Requirements. New and non-grandfathered health plans must submit to HHS and state insurance commissioners (and make available to the public) certain information, including claims payment policies and practices, financial disclosures, data on enrollment and disenrollment, and information on cost sharing and payments for out-of-network coverage. Plans must also make cost-sharing information regarding specific items and services available in a timely manner (including through use of the internet). The Act directs the DOL to update plan disclosure requirements to integrate these new requirements. *Effective January 1, 2014.*

2. UNIVERSAL COVERAGE REQUIREMENTS

The Act tackles the goal of universal health care coverage in three general ways: (A) insurance market reforms, (B) individual mandates, and (C) employer mandates. These changes are all effective beginning in 2014 except as otherwise noted below.

A. Insurance Market Reforms

Health Insurance Exchanges. Each State must establish a health insurance exchange system ("Exchange") in which individuals and small businesses (generally those with 100 or fewer employees[4]) can purchase health insurance. Insurance offered through an Exchange must provide "essential health benefits" and must meet certain cost-sharing requirements (for example, maximum out-of pocket limits). In general, Exchanges will offer insurance at four different levels that vary based on the percentage of benefit costs covered (determined on an actuarial basis): Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%). Exchanges will also offer a Catastrophic Plan for individuals younger than 30 or who are exempt from the individual mandate provisions of the law. After 2017, states will have the option of permitting larger employers (those with more than 100 employees) to purchase insurance through an Exchange. At least two multi-state plans will also be offered through the Exchange in each state. Eligible employers who purchase insurance through an exchange may allow employees to pay premiums on a pre-tax basis through a cafeteria plan.

Temporary High Risk Health Insurance Pool. Within 90 days after enactment, HHS will establish a temporary high risk health insurance pool program to make health insurance immediately accessible to uninsured individuals with pre-existing conditions. The program will last until 2014, when the Exchanges are created. The program will be administered either directly by the federal government or through contracts with states and non-profit entities.

Consumer Information Websites. No later than July 1, 2010, HHS (in consultation with individual States) must establish a website that allows residents and small businesses in any state to identify affordable health insurance coverage options.

B. Individual Mandates

Requirement to Maintain Minimum Essential Coverage. All U.S. citizens and legal residents will be required to maintain "minimum essential coverage" or face a tax penalty assessed when they file their federal income tax returns. Minimum essential coverage includes coverage under eligible employer-sponsored plans, governmental sponsored programs (such as Medicare or Medicaid), and coverage purchased in the individual insurance market (such as through an Exchange). In general, the penalty for failing to have coverage is the greater of (a) $695 per uninsured adult in the household (less for uninsured minors and capped at $2,085 per family), or (b) 2.5% of household income in excess of the tax return filing threshold.[5] The penalty is assessed on a monthly basis – i.e., 1/12 of the annual penalty amount described above is assessed for each month an individual is uninsured. The maximum annual penalty is capped at the national average premium for Bronze health plans offered through Exchanges for the family size involved. Individuals with income below certain levels are exempt.[6] There are also exemptions for individuals residing outside of the U.S., those who qualify for religious exemptions, individuals who are incarcerated, members of Native American Tribes, and gaps in coverage of less than three months.

Governmental Assistance to Low Income Individuals. The following governmental assistance will be provided to lower-income individuals to help make health care coverage more affordable:

- *Premium Assistance Credit.* A refundable tax credit (called a "premium assistance credit") will be provided to eligible individuals to subsidize their purchase of health insurance coverage through an Exchange. To qualify, an individual's household income must be between 100% and 400% of the Federal Poverty Level ("FPL"). (For context, 400% of the current FPL for residents of the lower 48 states is $43,320 for an individual and $88,200 for a family of four.) In

general, an individual who receives coverage through an employer (or spouse's employer) is not eligible for the premium assistance credit. There is an exception if the employee's share of premiums exceeds 9.5% of household income or if the coverage is deemed inadequate (i.e., it covers less than 60% of allowed benefit costs). Generally, the credit is the amount needed to keep the individual's premium cost[7] below a specific percentage of household income, ranging from 2% up to 9.5% for individuals at 400% of the FPL. The government will pay the assistance amount directly to insurers, with the individual responsible for paying the remainder of the premium. Any difference between the amount of assistance advanced and the amount the individual is actually entitled to (based on income for the year) will be reconciled on the individual's tax return.

- *Cost Sharing Subsidy.* Individuals with household income between 100% and 400% of the FPL who purchase coverage through an Exchange will also be eligible for a cost-sharing subsidy to reduce their out-of-pocket costs. The subsidy is only available for months an individual is eligible for a premium assistance credit.

- *Expansion of Medicaid Eligibility; Potential Expansion of State Basic Health Programs.* In addition, the Act extends Medicaid eligibility to include individuals with household income at or below 133% of the FPL, and it gives States the option to create or expand basic health plans to cover uninsured individuals with incomes between 133% and 200% of the FPL.

C. Employer Mandates

Pay or Play Requirements. "Large employers" will be subject to tax penalties unless they provide health coverage meeting certain requirements to all "full-time employees" and their dependents. The control group rules of Code § 414 are used in applying these requirements.

- *Large Employer:* An employer is a "large employer" if it employed an average of at least 50 full-time employees during the previous calendar year. There is a limited exception related to employers of seasonal employees.[8] For purposes of determining employer size, part-time employees are counted on a pro-rated basis (determined by dividing the aggregate number of hours of service by such employees for the month by 120).

- *Full-Time Employee:* A "full-time employee" is an employee who is employed an average of at least 30 hours of service per week. The Act requires HHS (in consultation with the DOL) to issue regulations or other guidance on determining an employee's hours of service (including rules for employees who are not compensated on an hourly basis).

The "pay or play" penalties work as follows:

- *Penalty for Failing to Provide Coverage.* If a large employer fails to provide "minimum essential coverage"[9] to all full-time employees and their dependents, it is subject to a penalty equal to $2,000 times the employer's number of full-time employees, excluding the first 30 employees. This penalty is triggered only if one or more full-time employees purchases health insurance coverage through an Exchange and qualifies for premium assistance credits or cost-sharing subsidies. The law is unclear on several issues, including the impact of a permissible (i.e., 90 days or less) waiting period; rules regarding dependent coverage; and the applicable penalty if an employer provides minimum essential coverage for some but not all of its full-time employees (whether through plan design or operational error).

- *Penalty for Providing Inadequate or Unaffordable Coverage.* If a large employer does provide "minimum essential coverage," but the coverage is deemed "inadequate" or is "unaffordable" such that some employees can qualify for premium tax credits or cost sharing subsidies (see

above), a penalty tax can still apply. The penalty in this situation equals $3,000 for each full-time employee who purchases health insurance coverage through an Exchange and qualifies for a premium tax credit (not to exceed the penalty amount for failure to provide coverage).

The above figures reflect annual penalty amounts, which are indexed for inflation after 2014. However, penalties are assessed on a monthly basis. These tax penalties are not deductible.

Free Choice Vouchers. Any employer (regardless of size) offering minimum essential coverage and paying for a portion of it must provide "qualified employees" with a "free choice voucher" for the purchase of health insurance through an Exchange. A "qualified employee" is an employee who meets the following tests: (1) the employee's household income is less than 400% of the FPL; (2) the employee's share of the premium for employer-sponsored coverage is more than 8% but less than 9.8% of their household income; and (3) the employee purchases insurance through an Exchange in lieu of employer-sponsored coverage. Notably, part-time employees can qualify for vouchers. The value of the voucher equals the cost of the employer-sponsored coverage the employer would have paid for the employee. (Cost is generally determined in the same manner as COBRA rates.) The value of the voucher is not taxable to the employee and is deductible by the employer. If the voucher exceeds the employee's premiums for insurance purchased through an Exchange, the excess is paid to the employee as taxable income. Employees who use vouchers are ineligible for the premium tax credit.

New Reporting Requirements Related to Universal Coverage Rules. Any entity that provides minimum essential coverage to individuals during a year must file an annual report with the IRS containing certain information regarding the individuals covered, the coverage provided, and the portion of premiums paid by the employer (if applicable). It appears this obligation will fall on insurers in the case of insured plans. In the case of self-insured plans, it is unclear whether this obligation will fall on employers or the plan administrator. In addition, large employers (50 or more full-time employees) must file an annual report with the IRS with information related to the penalty tax provisions (for example, whether minimum essential coverage is offered, the plan's share of the total cost of benefits, and employees' share of premiums). It is anticipated that these two annual reporting requirements will be consolidated in some fashion. Copies of these reports must also be provided to participants.

3. OTHER CHANGES AFFECTING HEALTH PLANS AND SPONSORS

Temporary Subsidy Program for Plans Providing Health Coverage to Early Retirees. The Act creates a temporary subsidy program for qualifying employer-sponsored health plans covering retirees age 55 or older but not yet eligible for Medicare ("early retirees"). To qualify, a plan must apply to HHS and be certified to have implemented cost-savings programs or procedures for chronic and high-cost conditions (to be identified by HHS). This program will reimburse participating plans for a portion of their cost of providing health insurance coverage to early retirees during the period beginning on the date the program is established by HHS (no later than June 21, 2010) and ending on January 1, 2014 (or when its $5 billion in funding runs out, if earlier). Claims must be based on actual amounts expended in providing health benefits to an early retiree (or spouse, surviving spouse, or dependent) during a year, and are limited to amounts from $15,000 to $90,000 (as indexed). The program reimburses the plan for 80% of approved costs within these limits. The subsidies *must* be used to lower the costs of the plan – such as reductions in premium costs, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants – not as general revenue.

Excise Tax on "Cadillac Plans." Beginning in 2018, a 40% excise tax will apply to any "excess benefits" provided under high-cost, employer-sponsored health insurance coverage. The excess benefit is the value (or "cost") of the benefit (generally determined in the same manner as COBRA continuation

coverage premiums) in excess of a specified dollar threshold: generally $10,200 for self-only coverage and $27,500 for family coverage or multiemployer plans ($11,850 and $30,950, respectively, for early retirees and plans covering certain high risk professions). These thresholds may increase if healthcare costs increase more than expected prior to 2018, and are indexed for inflation after 2020. There is also an adjustment for workforce age and gender characteristics. Stand-alone vision and dental policies and certain other types of coverage are disregarded. For insured plans, the tax is imposed on the insurer.

Small Business Tax Credit for Health Insurance Premiums. Effective for tax years beginning after 2009, businesses (determined on a control group basis) that have 25 or fewer "full-time equivalent employees" (FTEs) may be eligible for a tax credit for a portion of their expenses to provide health insurance coverage to employees. The number of FTEs is determined by dividing the total number of hours of service for which wages were paid by the employer during the year (not to exceed 2,080 per single employee) by 2,080. To qualify, the average annual wages paid by the employer may not exceed $50,000 (determined by dividing aggregate wages paid by the number of FTEs). In addition, the employer must pay at least 50% of the premium cost for health coverage. The credit equals 35% of premium costs for employers with less than 10 FTEs and average annual wages below $25,000, and it gradually phases out as these figures approach the 25 FTE/$50,000 average wage maximums. The hours and wages of seasonal employees (as defined in DOL regulations) are disregarded if they work less than 120 days during the year, and self-employed individuals are excluded. Beginning in 2014, the maximum credit available increases to 50% of premium costs, but employers will only be eligible for up to two years of credits (disregarding years before 2014). There are special rules for small tax-exempt employers, which can apply the credit against their payroll tax obligations. The IRS has already posted information regarding the credit on its website, www.irs.gov/newsroom/.

"Simple Cafeteria Plans" for Small Businesses (Nondiscrimination Testing Safe Harbor). Beginning in 2011, a new nondiscrimination testing safe harbor[10] (called a "simple cafeteria plan") is available for small employers (generally defined as those averaging 100 or fewer employees in either of the two preceding years). To qualify as a simple cafeteria plan, all employees (other than certain excludable employees) must be eligible to participate, and must be able to elect any benefit available under the plan. In addition, the employer must provide a minimum contribution for each non-highly compensated employee.[11] IRS guidance is needed to fill in details regarding this new rule.

Increase in Employee Payroll Taxes. Beginning in 2013, the *employee share* of the Medicare Part A hospital insurance (HI) tax is increased by 0.9% on wages over a dollar threshold ($250,000 for married individuals filing a joint return and $200,000 for single individuals). In addition, a new annual *employee* HI tax of 3.8% will apply to the lesser of: (a) the taxpayer's net investment income, or (b) modified adjusted gross income exceeding the dollar threshold above.

Voluntary Public Long-Term Care Insurance Program. The Act creates a voluntary public long-term care insurance program (called the "CLASS" program). While the provisions of the Class program are technically effective January 1, 2011, current thought is that the program won't actually become operational until 2013, after HHS regulations and other guidance is issued. Eligibility for benefits will require, among other things, that participants pay into the program for at least 60 months. Premium amounts are to be established based on actuarial soundness at a later date, together with details on benefits, enrollment, claims, and other matters. The Act envisions that employers will automatically enroll employees (unless they opt out) and channel premiums to the government through payroll deductions. However, employers may elect not to participate in the program.

New Requirements For Group and Individual Health Care Insurance Coverage. Group and individual health care insurance coverage is now subject to many new requirements. In addition to

the new benefit design and administration requirements described in Section 1, beginning in 2014 health care insurance (whether offered through an Exchange or otherwise) must cover benefits in prescribed categories (called "minimum essential benefits") and have an actuarial value of at least 60%, and insurers must meet new rules on rating practices and guaranteed availability and renewability of coverage. Insurance companies are also subject to new reporting and disclosure rules with varying effective dates.

New Fees and Taxes on Pharmaceutical and Medical Device Manufactures and Insurers. The Act imposes various new fees and taxes on pharmaceutical and medical device manufacturers and insurers. These fees and taxes have varying effective dates, and will presumably be passed through to employer plans.

Changes to Medicare Part D Program. The Act makes several changes to the Medicare Part D program. Most notably for employers, the deduction related to the Medicare Part D subsidy (for employers that offer Medicare Part D prescription drug coverage) is eliminated effective for tax years beginning after 2012. This change may have an immediate effect on employers' financial accounting obligations. In addition, the Act phases-out the Medicare Part D donut hole over a 10-year period, beginning with $250 rebates for Medicare beneficiaries who reach the donut hole in 2010. The phase-out is achieved in part by requiring drug manufacturers to discount brand name drugs in the donut hole.

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[1] The Act provides an extended deadline for "health insurance coverage" pursuant to CBAs in effect on March 23, 2010, but it is expected that this is actually intended to refer to *both* insured and self-insured plans. We are continuing to monitor this issue. If the government determines that the multiemployer plan delayed effective dates apply *only to insured* multiemployer plans, major changes to this Bulletin and the Highlights summary would be required.

[2] The Act is clear that "grandfathered plans" can add new participants or dependents and not lose their protected status. However, the Act does not indicate whether a "grandfathered plan" may lose protected status if the *benefits or features* of the plan are changed. Until there is further guidance from the federal government, Trustees will need to carefully consider whether changes to a health plan's benefit design may create a risk of losing grandfathered status.

[3] The term "essential health benefits" will be defined in regulations issued by the Department of Health and Human Services (HHS). However, it will generally include items and services in the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

[4] Prior to 2016, states have the option of excluding employers with more than 50 employees from purchasing insurance through an Exchange. There are transition rules for employers that increase in size.

[5] Lower penalty amounts apply in 2014 and 2015, as the penalty provisions are phased-in. The dollar figures are indexed to inflation for years after 2016.

[6] An exemption applies if an individual's household income is below the income tax return filing threshold, or if their required contribution for employer-sponsored coverage or the lowest cost plan in their local Exchange exceeds 8% of their household income.

[7] Individuals may purchase any level of coverage on the Exchange, but the premium assistance credit is based on premiums for the second lowest cost Silver plan.

[8] If an employer's workforce exceeds 50 full-time employees for 120 or fewer days and such excess is due solely to the employment of "seasonal workers" (as defined in DOL regulations), the employer is not a "large employer."

[9] Generally, "minimum essential coverage" includes any employer-provided coverage (whether or not grandfathered) that satisfies the benefit design and administrative requirements applicable to it under the Act. It need not meet the standards for health insurance coverage provided through an Exchange, such as coverage for all "essential health benefits," maximum out-of-pocket limits, and 60% or greater actuarial value.

[10] The safe harbor applies to the nondiscrimination tests applicable to cafeteria plans under Code § 125, self-insured medical plans (and now non-grandfathered insured plans) under Code § 105(h); group term life insurance under Code § 79(d), and DCAPs under Code § 129(d).

[11] There are two options: (1) a non-elective contribution of at least 2% of compensation; or (2) a matching contribution of 200% of the employee's salary reduction contributions up to 6% of compensation.