Part III: Timeline for Implementation of Provisions: What Needs to Be Done and When

98. What are the major components of healthcare reform and when are they effective?

2010

* January 1, 2010
* Tax Credit. Beginning in 2010, small employers with low-paid employees are eligible for a tax credit for purchasing health care for their employees. The full credit applies to a business with no more than ten full-time equivalent (FTE) employees who have average wages not exceeding $25,000. The credit is phased out entirely if the business has twenty-five or more FTE employees or if the average wages of its employees is $50,000 or more. For 2010 through 2013, the credit is 35 percent (25 percent for tax-exempt employers) of the employer’s non-elective premium for qualified health insurance policies. Starting in 2014, the credit increases to 50 percent (35 percent for tax-exempt employers) but it is available only if the health insurance policy is purchased on a state health insurance exchange. Related employers are treated as a single employer.
* ERRP (Early Retiree Reinsurance Program.) Temporary large claim reinsurance assistance was available for employers providing early retirement benefits to retirees ages fifty-five to sixty-four under a retiree group health plan. The reinsurance reimbursement, up to a $60,000 annual maximum per eligible retiree, is 80 percent of the costs incurred by the plan for eligible retirees (and their dependents) in excess of the first $15,000 of such costs. The costs that may be reimbursed include the portion paid by the retiree for deductibles, copayments, and coinsurance. Medical expenses incurred after June 1, 2010, were eligible for reimbursement under this program. Up to $5 billion was allocated for the program, but the money was spent quickly, and HHS stopped taking claims on Dec. 31, 2011.[[1]](#footnote-1)
* March 23, 2010
* Grandfather Provision. Group plans in existence and with actual membership on and after March 23, 2010, have the right to maintain their existing coverage, except as otherwise provided.[[2]](#footnote-2) Family members of individuals enrolled in grandfathered plans and new employees can enroll in the plan if its provisions allow such enrollment without jeopardizing the plan’s “grandfathered” status.[[3]](#footnote-3)
* Reasonable Break Time for Nursing Mothers. Employers must provide reasonable break times to allow nursing mothers to express breast milk for a child up to age one.[[4]](#footnote-4)
* Nondiscrimination Rules for Health Program or Activity. An individual generally cannot be excluded from participation in, denied benefits of, or subjected to discrimination due to race, color, national origin, sex, age, or disability under any health program or activity that is receiving federal financial assistance on a ground that is prohibited under the following laws:
* Title VI of the Civil Rights Act of 1964;
* Education Amendments of 1972;
* Age Discrimination Act of 1975; or
* Section 504 of the Rehabilitation Act of 1973.[[5]](#footnote-5)
* Employee Whistleblower Protections. PPACA added the FLSA "Protections for Employees", which prohibits employers from taking adverse action against any employee because the employee:
* received a premium tax credit or subsidy for a health plan;
* provided information to the employer or the federal or state government concerning a violation, act or omission the employee reasonably believes to be a violation relating to Title I of the Act. (Title I of the Act, among other things, provides rules for the establishment and operation of the Exchange and imposes certain mandates on employers, including the provision of certain standards of benefits for health coverage, the automatic enrollment requirements described above and the elimination of certain restrictions in health coverage, such as pre-existing condition exclusions and lifetime and annual dollar limitations in coverage);
* testified or is about to testify in a proceeding concerning such violation;
* assisted or participated, or is about to assist or participate, in such a proceeding; or
* objected to, or refused to perform, any activity or assigned task the employee reasonably believes to be such a violation.[[6]](#footnote-6)

The procedures for handling retaliation complaints are at 29 CFR 1984.102 et seq.

* June 21, 2010
* Temporary High-Risk Health Insurance Pool. Adults with pre-existing conditions can participate in a temporary high-risk pool, the Pre-Existing Condition Insurance Plan (PCIP) program. The program can be run by the states or by HHS, if a state elects. It will be superseded by the state healthcare exchanges in 2014. To qualify for coverage, applicants must have a pre-existing health condition and have been uninsured for at least the six months prior to enrolling in coverage. There is no age requirement to enroll. The program sets premiums as if for a standard population, and it allows premiums to vary by age, geographic area, and family composition. It also limits out-of-pocket spending to $5,950 for individuals and $11,900 for families, excluding premiums.[[7]](#footnote-7)
* Plan Years Beginning on or after September 23, 2010
* Annual and Lifetime Limits. Use of lifetime dollar limits on health benefits is prohibited. A group health plan may impose lifetime limits on non-essential health benefits for beneficiaries, but not participants. This applies to grandfathered plans. Use of unreasonable annual dollar limits for "essential health benefits" is prohibited. Starting in 2014, all annual dollar limits for non-essential health benefits are prohibited. Grandfathered plans are exempt from this rule.
* Pre-Existing Condition Exclusion for Children under Age Nineteen. Any pre-existing condition exclusion for children less than nineteen years of age is prohibited. This provision also applies to grandfathered plans.[[8]](#footnote-8)
* Adult Dependent Coverage. Group health plans that provide dependent coverage must provide coverage to their employees’ adult children (including those who are married) until age twenty-six, provided that, with respect to grandfathered plans, the child is not otherwise eligible for coverage under another employer-sponsored health plan.[[9]](#footnote-9)
* Preventive Care. Group health plans must provide first-dollar coverage for preventive care. Grandfathered plans are exempt from this requirement.[[10]](#footnote-10)
* Primary Care Physicians for Children and Women. Group health plans that use primary care provider gatekeepers must give participants the right to select any available primary care provider, including pediatricians for children. Women must have the right to see any participating OB/GYN physician without a primary care provider referral.[[11]](#footnote-11)
* Emergency Care. Group health plans must cover emergency care without a requirement for a primary care provider referral or imposition of any "out-of-network" penalty. Grandfathered plans are exempt.[[12]](#footnote-12)
* Policy Rescission Limited. Group health plans and health insurance issuers may not rescind coverage for reasons other than fraud or material misrepresentation by the plan participant or beneficiary. This provision also applies to grandfathered plans.[[13]](#footnote-13)
* Claims and Appeals Procedures. All plans, including grandfathered plans, must implement an “effective appeals process.” Church and government plans without ERISA-compliant claims procedures are required to adopt such procedures. External review must be conducted by one of the approved independent review organizations (IROs) with which the plan has contracted. Nongrandfathered, self-insured plans had an enforcement safe harbor that allowed them to contract with as few as two IROs. As of July 1, 2012, that was increased to at least three IROs for the safe harbor to apply. A grace period extended some of these requirements to July 1, 2011. The Employee Benefits Security Administration (EBSA) Technical Release 2011-01 extended the grace period for some of these rules to plan years beginning on or after January 1, 2012.[[14]](#footnote-14)
* Income Tax Nondiscrimination Requirements for Employer Provided Insured Health Plans Postponed. Originally to be effective for plan years beginning on or after September 23, 2010, but postponed by IRS Notice 2011-1 until regulations are issued. These nondiscrimination rules do not apply to grandfathered insured plans.[[15]](#footnote-15)
* January 1, 2011
* New SIMPLE Cafeteria Plan. For employers with 100 or fewer employees during either of the two prior years, and employers can increase the number of employees to 200. Simple cafeteria plans are exempt from the 25 percent concentration tests and deemed nondiscriminatory for purposes of the nondiscrimination requirements applicable to life insurance, dependent care plans, and other benefits if the employer provides:
* at least a 2 percent of pay contribution for participants, or
* a matching contribution for participants, which is the lesser of:
	+ 6 percent of pay, or
	+ two times each qualified employee’s pretax contribution.

A “qualified employee” is any employee who is not an HCE (as defined in Code section 414(q)) or a key employee (as defined in Code section 415(i)). Simple cafeteria plans must still comply with Code section 125 nondiscrimination requirements regarding eligibility and benefits. Simple Cafeteria Plans are discussed in more detail in Part V of this book.[[16]](#footnote-16)

* Reimbursement for Over-the-Counter Drugs. Reimbursement under flexible spending accounts (FSAs), health saving accounts (HSAs), medical savings accounts (MSAs), and health reimbursement accounts (HRAs) for over-the-counter drugs (except insulin) is no longer allowed unless the patient has a prescription for the drug.[[17]](#footnote-17)
* HSA/MSA Excise Tax. The excise tax for distributions from HSAs and MSAs for expenses that are not Code section 213 medical expenses increased to 20 percent from the current 10 percent and 15 percent respectively.[[18]](#footnote-18)
* Employer W-2 Reporting Postponed.
* Federal Long-Term Care. The Community Living Assistance Services and Support (CLASS) Act authorized a voluntary federal insurance program for employees to purchase long-term care insurance. Employers could elect to automatically enroll employees in the program, allowing employees to opt-out. The provision was intended to be effective January 1, 2011; however, HHS has announced that it will not implement this program because it could not function cost effectively.
* Medical Loss Ratio (MLR) Requirements. The required MLRs are 85 percent in the large group health insurance market and 80 percent in the small group and individual markets (or higher, based on state regulations). The remaining percentage of health insurance premiums can be spent by insurers on administrative costs. Insurers’ reports to policy holders for calendar year due by June 1 of following year; rebates by August 1 of following year. Health insurance companies must comply with medical loss ratio standards and are required to submit reports to HHS for each plan year relating to an accounting for costs, and are also required to provide rebates to policyholders under certain circumstances. Although the obligations to calculate the MLR and make rebates fall on insurers, in many cases the rebates will be paid to group health plans, and the plans will be required to determine how to use the rebates or refund them to plan participants.[[19]](#footnote-19)

 2012

* January 1, 2012
* Expanded 1099 Reporting. Repealed.
* March 23, 2012
* Quality of Care Reporting. Health care reform requires group health plans and health insurance issuers to submit an annual report to the Secretary of HHS addressing plan or coverage benefits and provider “reimbursement structures” that may affect the quality of care in certain specified ways. The reporting requirements are to be developed in consultation with health care quality experts and “stakeholders” (e.g., representatives of care providers, care recipients, insurers, and employers) and may be enforced by “appropriate penalties” developed by the Secretary. Copies of the report must be made available to enrollees during each open enrollment period. HHS was required to “develop” the reporting requirements no later than March 23, 2012, and to issue regulations that provide criteria for determining whether a “reimbursement structure” is subject to the reporting rule. HHS guidance under this provision remains outstanding.[[20]](#footnote-20)
* August 1, 2012
* Medical Loss Ratio Reports and Rebates. Health plans must have procedures in place to handle any rebates received from the insurer in accordance with the rules for distribution, including the rules requiring ERISA plans to determine the extent to which rebates are plan assets. Rebates need to be apportioned if premiums are paid with both employer and employee contributions. (Effective Aug. 1, 2012.)[[21]](#footnote-21)
* Preventive Health Services for Women. Nongrandfathered group health plans must provide recommended preventive health services without cost sharing and must adjust the services covered in accordance with changes to recommended preventive services guidelines.
* September 23, 2012
* SBC Disclosures. HHS prescribed uniform summary of benefits that a group health plan sponsor or insurance issuer will need to distribute to plan participants and potential enrollees. This disclosure is in addition to the ERISA summary plan description. If any material modification is made after such summary is provided, then a notice of material modifications must be provided to participants at least sixty days prior to the modification’s (Effective date: Must be distributed during open enrollment periods for plan years beginning or after September 23, 2012, or, for other enrollments (such as new hires), beginning on the first day of the first plan year that begins on or after September 23, 2012. (Effective Sept. 23, 2012; originally to be effective March 23, 2012.)[[22]](#footnote-22)

2013

* January 1, 2013
* W-2 Reporting**.** W-2s must be issued showing employer and employee payments for certain health care items in 2012. This does not change the employer’s deduction or cause employees to be taxed. IRS announced an exemption for employers that did not file at least 250 W-2s in preceding year, but this exemption can be eliminated in the future by IRS notice.[[23]](#footnote-23)
* Health FSAs. A $2,500 annual limit will be imposed on health FSA deferrals; currently there is no such limit. Dependent care and adoption FSAs will not be limited.[[24]](#footnote-24)
* Individual Deduction Threshold Increased. The current 7.5 percent of adjusted gross income (AGI) floor on income-tax deductions for healthcare expenses is raised to 10 percent of AGI. ; However, the floor is waived during 2013, 2014, 2015, and 2016 for individuals who turn age sixty-five before the end of those years.[[25]](#footnote-25)
* Employer Deduction for Government-Subsidized Employer Drug Benefits Eliminated. The employer deduction for the portion of healthcare expenses that are reimbursed to the employer through the Medicare Part D subsidy program is eliminated.
* Administrative Simplification. The health reform law will affect relationships between payers and providers (hospitals, physicians, and allied care practitioners), as well as claims clearinghouses and banks that perform intermediary functions. HHS prescribes new “operating rules” that will govern the exchange of health data transactions, including eligibility, claim status, electronic funds transfers, electronic remittance advices, and other transactions. Group health plans must comply with "administrative simplification" rules for electronic exchange health information and electronic fund transfers, and they also must file a certification with the federal government that the plans are in compliance. This provision also applies to grandfathered plans. Systems must be compliant, and employers must certify compliance by December 31, 2013.[[26]](#footnote-26)
* Medicare Tax Increases. The FICA Medicare tax rate will be increased by 0.9 percent for wages/earnings over $200,000 for individuals ($250,000 for married couples filing jointly). This will result in a combined 2.35 percent on wages over $200,000 ($250,000 for joint filers). The employer is required to collect the employee’s share in the case of wages. The employer’s share of FICA Medicare tax remains 1.45 percent. A new Medicare tax on investment income of 3.8 percent will apply to individuals who earn more than $200,000 a year ($250,000 for married couples filing jointly). Effective for tax years beginning January 1, 2013.
* July 31, 2013
* Comparative Clinical Effectiveness Research Fee. First temporary fees imposed on self-insured health plan sponsors[[27]](#footnote-27) and insurers for insured plans.[[28]](#footnote-28) (Effective July 21, 2013, for plan years ending prior to that date.)
* Patient Centered Outcomes Research Institute (PCORI) Health Plan Fees. Health insurance issuers and self-funded health plans will be required to pay an annual fee of $2.00, ($1.00 during first year) indexed for inflation starting in 2014, times the average number of covered lives under the health insurance policy or self-insured health plan. (Effective for plan years ending after September 3, 2012; scheduled to end for plan years ending after September 3, 2019.) The first payments are required July 31, 2013, and each July 31 thereafter through 2020.[[29]](#footnote-29) The tax and return is due July 31 following the calendar year in which the plan year ends. For calendar year plans, the first return is due July 31, 2013. For a PYE 3/31/13, the calendar year ends in 2013 and the tax and return would be due 7/31/14. (See Q 404 through Q 412.)
* October 1, 2013
* Employer Health Insurance Exchange Notice. Employers, regardless of size and whether or not they have a health plan, must provide notice to employees of the upcoming existence of state insurance exchanges, which are to be established by all the states in 2014 or by HHS if a state fails to do so. Notice must be in the form specified in DOL guidance. (Original effective date of March 1, 2013, delayed until October 1, 2013.)
* December 31, 2013
* Plan Communications with Providers. Health plans must certify and document compliance with HHS rules for electronic transactions between providers and health plans.

2014

* January 1, 2014
* Cafeteria Plans with Fiscal Plan Year Beginning in 2013 Can Be Amended to Allow Employees to Change Election to Purchase Health Insurance or to Terminate Election to Purchase Insurance. Employees may want to terminate their election to purchase health insurance through the employer’s cafeteria plan and go to the exchange if they are eligible for health insurance exchange tax credits. Other employees may want to elect to purchase health insurance effective January 1, 2014, to avoid the individual mandate penalty. If the cafeteria plan year is a fiscal year, employees wanting exchange insurance on January 1, 2014, would have to terminate or change their elections midyear. However, under current cafeteria plan regulations, these two elections are not a change in status allowing an election change midyear. The proposed regulations allow an applicable large employer with a fiscal year cafeteria plan, at its election, to amend the plan any time during the year on a retroactive basis (by December 31, 2014, retroactive to beginning of 2013 plan year) to permit either or both of the following changes in salary reduction elections:[[30]](#footnote-30)

(1) An employee who elected to salary reduce through the fiscal year cafeteria plan for accident and health plan coverage beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once, during that plan year, without regard to whether the employee experienced a change in status event described in Reg. §1.125-4; and

(2) An employee who failed to make a salary reduction election through his or her employer's fiscal year cafeteria plan beginning in 2013 for accident and health plan coverage before the deadline in proposed §1.125-2 for making elections is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the cafeteria plan without regard to whether the employee experienced a change in status event described in Reg. §1.125-4.

Some provisions of the transition relief refer to “applicable large employer members” (i.e., employers that are subject to healthcare reform’s employer mandate), raising questions as to whether the relief is available for all non-calendar-year cafeteria plans or only those that are sponsored by applicable large employer members.

* State Health Insurance Exchanges. Each state must establish a health insurance exchange (or HHS will do so) for use by the uninsured and small employers with 100 or fewer employees (although states may set the cap at 50 employees). The exchanges will offer fully insured insurance contracts that provide essential health benefits at different levels of coverage (bronze, silver, gold, and platinum).[[31]](#footnote-31) Employees of small employers who offer health insurance coverage through an exchange may pay their employee premiums for such coverage on a pre-tax basis through the employer’s cafeteria plan.[[32]](#footnote-32)
* State Health Insurance Exchange Tax Subsidies. Individuals who do not have affordable minimum essential coverage from their employer will be eligible for tax credit subsidies for their health insurance purchase on a state exchange if their income is below 400 percent of federal poverty level.
* Individual Mandate Tax Penalty. Individuals are required to obtain minimum essential health coverage for themselves and their dependents or pay a monthly penalty tax for each month without coverage. The monthly penalty tax is one-twelfth of the greater of the dollar penalty or gross income penalty amounts. The dollar penalty is an amount per individual of:
* $95 for 2014 (capped at $285 per family),
* $325 for 2015 (capped at $975 per family), and
* $695 for 2016 (capped at $2085 per family).

These dollar penalties will be indexed for inflation starting in 2017.

The gross income penalty is a percentage of household income in excess of a specified filing threshold of:

* 1 percent for 2014,
* 2 percent for 2015, and
* 2.5 percent for 2016 and later years.

In no event will the maximum penalty amount exceed the national average premium for bronze-level exchange plans for families of the same size.

Minimum essential coverage includes Medicare, Medicaid, CHIP, TRICARE, individual insurance, grandfathered plans, and eligible employer-sponsored plans. Workers compensation and limited-scope dental or vision benefits are not considered minimum essential health coverage.[[33]](#footnote-33)

* Employer Free Choice Vouchers. Repealed.
* Health Reform’ Out-Of-Pocket Limits – Generally Effective In 2014 – One Delayed Effective Date.
* Healthcare reform’s requirement that health insurance individual and small group plans cap how much consumers must pay out-of-pocket each year for medical care will take effect as scheduled in 2014 for some and 2015 for others.

For 2014 and thereafter, the health reform law requires that private insurance plans offered in the individual and small group markets[[34]](#footnote-34) limit how much in cost-sharing charges — deductibles, copayments, and coinsurance — that people enrolled in a plan must pay each year for covered benefits provided by the plan’s network of health care providers. The requirement does not apply to “grandfathered” plans or to self-insured employer plans, large group employer plans, or large group market insurers.[[35]](#footnote-35) In 2014, the maximum out-of-pocket limit will be $6,350 for an individual and $12,700 for a family (the same as for HSA compatible high deductible plans), and will apply in 2014 to health insurance offered in the individual, nongroup, market.[[36]](#footnote-36) The deductible cannot exceed $2,000 for a plan covering a single individual or $4,000 for any other plan.[[37]](#footnote-37)

* The agencies interpret the annual deductible limit as applying only to employers and insurers in the individual and small group markets for non-grandfathered plans.[[38]](#footnote-38) In the case of a plan using a network of providers, cost sharing paid by, or on behalf of, an individual for benefits provided outside of such network does not count toward the annual limitation on cost sharing or the annual limitation on deductibles.[[39]](#footnote-39)

**One Delay until 2015**. However, employer plans that have “separately administered” benefits, such as a primary package of health benefits and a different insurer or administrator for other benefits, such as prescription drugs, need not comply until 2015.[[40]](#footnote-40) Employer plans with separately administered benefits that qualify for the delay must apply some out-of-pocket limits in 2014. These plans must ensure that their primary package of health benefits has an out-of-pocket limit of no more than $6,350 for individuals and $12,700 for families. A separately administered benefit, such as prescription drugs, that already has an existing limit on out-of-pocket costs must also comply with the limits of $6,350 for individuals and $12,700 for families in 2014.[[41]](#footnote-41)

* Pre-Existing Condition Exclusion Practices Eliminated. Pre-existing condition exclusions no longer will be allowed in group health plans or individual insurance policies, not even the limited exclusions previously allowed under HIPAA. This also applies to grandfathered plans.[[42]](#footnote-42) Effective for plan years beginning on or after January 1, 2014.
* Ninety-Day Maximum Waiting Period. Group health plans and health insurance issuers may not impose waiting periods of more than ninety days before coverage becomes effective. This also applies to grandfathered plans.[[43]](#footnote-43)
* Cost-Sharing Limits. Group health plans, including grandfathered plans, may not impose cost-sharing amounts (i.e., copays or deductibles) that are more than the maximum allowed for high-deductible health plans (currently these limits are $5,000 for an individual and $10,000 for a family coverage). After 2014, these amounts will be adjusted for health insurance premium inflation.[[44]](#footnote-44)
* Annual or Lifetime Limits. Group health plans, including grandfathered plans, may no longer include more than restricted annual or any lifetime dollar limits on essential health benefits for participants. Limits may exist in and after 2014 for non-essential benefits.[[45]](#footnote-45)
* Wellness Program Health Plan Discount. The maximum premium discount an employer can offer under its health plan for participation in a wellness program is 30 percent. This is an increase from the prior 20 percent maximum premium discount. Regulatory agencies can increase this maximum discount to 50 percent in the future.
* Coverage for Those in Clinical Trials. Insurers and health plans, unless grandfathered, may not discriminate against an individual for participating in a clinical trial. If a plan covers a qualified individual, it may not deny or impose additional conditions for participation in a clinical trial.[[46]](#footnote-46)
* Medicaid Expansion. Supreme Court in effect ruled that the requirement for states to offer Medicaid benefits to all persons with incomes at or below 133 percent of federal poverty level is optional with each state. States that participate will receive full reimbursement of additional costs from federal government until 2017, at which point reimbursement will gradually decline to 90 percent of extra costs in 2020 and thereafter.

2015

* Health Insurance Income Tax Nondiscrimination Requirements**.** Code section 105(h) currently taxes the benefits received by highly compensated employees (HCEs) under discriminatory self-funded health plans. Healthcare reformed extends these nondiscrimination rules to insured plans, but only after the IRS issue regulations, which has not yet occurred. Employers with discriminatory insured arrangements, however, will need to consider changing them or face a $100 per day ($36,500 per year) per affected participant penalty once the rules go into effect. Grandfathered insured plans, however, are exempt from this rule. (This new requirement for insured plans was postponed in 2010 until IRS publishes regulations, which have not yet been issued; originally to be effective for plan years beginning on or after September 23, 2010. May not be effective in 2015.)[[47]](#footnote-47)
* Automatic Enrollment. Employers with more than 200 employees who maintain one or more health plans must automatically enroll new full-time employees in a health plan. The employer must give affected employees notice of this automatic enrollment procedure and an opportunity to opt out. State wage withholding laws are preempted to the extent that they prevent an employer from instituting this automatic enrollment program. The final effective date will be established by DOL regulations.[[48]](#footnote-48)
* Employer Mandate (Play or Pay) Tax Penalties. Employers with one hundred or more full-time equivalent (FTE) employees will be required to offer their full-time employees (FTEs) minimum essential health coverage or pay a fine of up to $2,000 per year for each FTE in excess of thirty FTEs if any employee receives a premium tax credit on a state health insurance exchange. If an employer provides minimum essential health coverage to its FTEs, but fails to pay at least 60 percent of its actuarial value or the coverage is considered unaffordable (costs more than 9.5 percent of household income), then the employer must pay a penalty of up to $3,000 per year for each FTE who receives the premium credit on an exchange, but not more than would be owed for the $2,000 per year penalty. An FTE is defined as an employee who is employed for thirty or more hours per week, calculated on a forty-hour work week. This provision also applies to grandfathered plans.[[49]](#footnote-49) (Originally effective January 1, 2014, but delayed until January 1, 2015.)

If employer has on average 100 or more Full-Time (including full-time equivalents) Employees:

* If an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not having been offered coverage during the entire month. For January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.
* Employers With Fiscal Year Health Plans. The employer mandate retains it’s effective of January 1, 2015. However, employers with non-calendar (fiscal) year plans can be subject to the mandate based on the start of their 2015 plan year rather than on January 1, 2015, and other transition relief where certain conditions are met, as follows:

(a) Pre-2015 Fiscal Year Plan Eligibility Transition Relief. Pre-2015 eligibility transition relief applies to employees, whenever hired, who are:

* Eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of February 9, 2014 (whether or not they elected coverage); and
* Offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year.

Where these two conditions are satisfied, the employer will not be subject to a potential employer shared responsibility payment until the first day of the 2015 plan year. This relief applies only to employees to whom coverage was previously offered by the employer. Thus, penalties may still be imposed for the months in 2015 that are part of the plan year commencing in 2014 for employees to whom coverage was not previously offered.

(b) Significant Percentage Fiscal Year Plan Transition Relief (All Employees). No employer mandate penalty applies for any month before the first day of the plan year beginning in 2015 for employees who are offered affordable coverage that provides minimum value by the first day of the 2015 plan year if as of any date in the 12 months ending on February 9, 2014, an employer:

* Covers at least one-quarter of its employees (full-time and part-time) under its non-calendar year plan; or
* Offered coverage under the plan to one-third or more of its employees during the open enrollment period that ended most recently before February 9, 2014.

To qualify for this relief, the employee must not have been eligible for coverage as of February 9, 2014 under any group health plan maintained by his or her employer that has a calendar year plan year.

Unlike the pre-2015 eligibility transition relief discussed above, an employer that qualifies for this relief and who offers affordable, minimum value coverage commencing with the 2015 plan year has no Code § 4980H exposure for periods before the 2015 plan year. Relief under this and the next transition rule applies for the period before the first day of the first non-calendar year plan year beginning in 2015 but only for employers that maintained non-calendar year plans as of December 27, 2012, and only if the plan year was not modified after December 27, 2012, to begin at a later calendar date.

* 70% Offer In 2015. For 2015 (and for any calendar months during a non-calendar year plan year beginning in 2015 that fall in 2016), the 95% offer of coverage threshold is lowered to 70%. Thus, in 2015, an employer will be in compliance if employer offers coverage to at least 70% of full-time employees and dependents in 2015 ((unless the employer qualifies for the 2015 dependent coverage transition relief, discussed below), although an employer will owe penalty if at least one of the full-time employees receives a premium tax credit for coverage in the public marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered was either unaffordable or did not provide minimum value.
* Dependent Coverage. In order to avoid exposure for the employer mandate penalty, an employer must offer coverage not only to full-time employees but also their dependents (but not spouses). The final regulations provide transition relief to plan years that begin in 2015 if the employer takes steps during the 2015 plan year toward satisfying this requirement.in 2016. The transition relief applies to employers for the 2015 plan year for plans under which (i) dependent coverage is not offered, (ii) dependent coverage that does not constitute minimum essential coverage is offered, or (iii) dependent coverage is offered for some, but not all, dependents. This relief is not available, however, if the employer had offered dependent coverage during either the plan year that begins in 2013 or the 2014 plan year and subsequently eliminated that offer of coverage.
* Employer Minimum Essential Coverage Reporting. All employers providing minimum essential coverage must file information with the IRS and plan participants.[[50]](#footnote-50) (Effective for calendar years beginning on and after Jan. 1, 2015, after one-year delay.)
* Large Employer Health Information Reporting. Large employers and employers with at least fifty full-time equivalent employees must submit annual health insurance coverage returns to the FTEs and the IRS. The returns must certify whether the employer offers healthcare insurance to its employees and, if so, describe the details regarding plan participation, applicable waiting periods, coverage availability, the lowest cost premium option under the plan in each enrollment category, and other information.[[51]](#footnote-51) (Effective January 1, 2015, after one-year delay.)
* December 31, 2015
* Group health plans must use electronic systems for processing health claims, enrollment, and premium payments and certify to the federal government that their systems comply. This also applies to grandfathered plans (plans must certify compliance by December 31, 2015).

 2016

* January 1, 2016

If employer has on average between 50 and 99 Full-Time (including full-time equivalents) Employees:

* Employer has a one-year delay in the employer mandate, until January 1, 2016 (and for non-calendar-year plans, any calendar months during the plan year beginning in 2015 that fall in 2016) if:
* Employer certifies it did not lay off employees during the period beginning on February 9, 2014 and ending on Dec. 31, 2014 to fall below the 100 employee threshold and that employer did not reduce any coverage you were already offering, and
* During the period beginning on February 9, 2014 and ending on Dec. 31, 2014, employer does not eliminate or materially reduce the health coverage, if any, offered as of February 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if, for each employee who is eligible for coverage on February 9, 2014:

(a) The employer offers to make a contribution toward the cost of employee-only coverage that is either (i) at least 95 percent of the dollar amount of the contribution the employer was making toward the coverage in effect as of February 9, 2014, or (ii) at least the same percentage of the cost of coverage that the employer offered to contribute toward coverage in effect as of February 9, 2014;

(b) Benefits offered as of February 9, 2014 at the employee-only coverage level does not change, or, if it does, the coverage after the change provides minimum value; and

(c) Eligibility under the employer’s group health plans is not amended to narrow or reduce the class or classes of employees (or the employees’ dependents) to whom coverage under those plans was offered as of February 9, 2014.

* Such employer must report coverage of employer’s employees for 2015.

2017

* January 1, 2017
* Employers Purchasing Insurance on Exchange Can Be Increased. States can allow larger employers (those with more than 100 employees) to purchase health insurance for their employees on the state health insurance exchanges.
* Medicaid Expansion. Federal reimbursement will be reduced from 100 percent of the cost of expansion gradually to 90 percent in 2020.

Employer Mandate (Play or Pay) Tax Penalties. Employers with fifty or more full-time equivalent (FTE) employees will be required to offer their full-time employees (FTEs) minimum essential health coverage or pay a fine of up to $2,000 per year for each FTE in excess of thirty FTEs if any employee receives a premium tax credit on a state health insurance exchange. If an employer provides minimum essential health coverage to its FTEs, but fails to pay at least 60 percent of its actuarial value or the coverage is considered unaffordable (costs more than 9.5 percent of household income), then the employer must pay a penalty of up to $3,000 per year for each FTE who receives the premium credit on an exchange, but not more than would be owed for the $2,000 per year penalty. An FTE is defined as an employee who is employed for thirty or more hours per week, calculated on a forty-hour work week. This provision also applies to grandfathered plans.[[52]](#footnote-52)

2018

* January 1, 2018
* Cadillac Health Plan Tax. An excise tax of 40 percent, called the "Cadillac health plan" tax, will be imposed on “coverage providers” (i.e., health insurer for fully insured plans, the employer with respect to HSA or MSA contributions, and in all other cases, the “person that administers the plan”) that provide high-cost healthcare coverage to the employer’s employees. The excise tax will be imposed on the “excess benefit” provided to the employees.[[53]](#footnote-53)

**98.02 If an employer offers an HRA and a group health plan but there is limited participation, will the HRA pass Code section 105(h)?**

An employer offers a group health plan and an HRA to those employees participating in the group health plan (or a spouse’s employer’s group health plan). The employer has ten eligible employees, but only two employees participate in the group health plan and thus in the HRA, and one of them is the employer’s only highly compensated employee. Is there any way that the HRA can pass the nondiscrimination rules of Code §105(h), which apply to self-funded (uninsured) employer health plans?

The answer is not definitive but is probably yes. In order to avoid “excess reimbursements,” which are not excludible from taxable income, a plan must meet either one of two numerical tests or a general nondiscriminatory classification test set forth in Code §105(h)(3). The numerical test is satisfied if the plan covers either (a) at least 70 percent of all employees or (b) at least 80 percent of all employees who are eligible to benefit under the plan if at least 70 percent of all employees are eligible to benefit. If these tests are not met, 105(h) is nevertheless met if such employees as qualify under a classification established by the employer and found by the IRS not to discriminate in favor of highly compensated employees.[[54]](#footnote-54) The nondiscriminatory classification test is met if the plan benefits a classification of employees set up by the employer which is found by the IRS not to be discriminatory in favor of highly compensated employees. In general, this determination is made based upon the facts and circumstances of each case.[[55]](#footnote-55) It seems reasonable to assume that while the Code uses the word “cover,” since the Code has a separate coverage nondiscrimination test, if the general nondiscriminatory classification test is used, it is passed if the employee classification is reasonable and the plan, as here, is offered to all eligible employees.

On this basis, the employer could treat the group health plan and the HRA as a single plan (even if they have separate plan documents) and test them on eligibility, not actual participation. An employer may “designate” two or more plans as one plan for purposes of the nondiscrimination requirements.[[56]](#footnote-56)

Additionally, a determination that the combination of plans so designated does not satisfy such requirements does not preclude a determination that one or more of such plans, considered separately, satisfies such requirements. A single plan document may be utilized by an employer for two or more separate plans provided that the employer designates the plans that are to be considered separately and the applicable provisions of each separate plan.[[57]](#footnote-57)

See also Q 76.

1. . PPACA §§1102, 10102. [↑](#footnote-ref-1)
2. . PPACA §1251. [↑](#footnote-ref-2)
3. . PPACA §1251(b) & (c). [↑](#footnote-ref-3)
4. . PPACA §4207; FLSA §(r). [↑](#footnote-ref-4)
5. . PPACA §1557. [↑](#footnote-ref-5)
6. . PPACA §1558; FLSA §18C. [↑](#footnote-ref-6)
7. . PPACA §1201: PHSA §2704. [↑](#footnote-ref-7)
8. . PHSA §2704; PPACA §§1201 1255, 10103. [↑](#footnote-ref-8)
9. . PHSA §2714. [↑](#footnote-ref-9)
10. . PPACA §§1001, 10101; PHSA §2713. [↑](#footnote-ref-10)
11. . PPACA §§1001, 10101; PHSA §2719A(c) & (d). [↑](#footnote-ref-11)
12. . PPACA §§1001, 10101, PHSA §2719A. [↑](#footnote-ref-12)
13. . PPACA§1001; PHSA §2712. [↑](#footnote-ref-13)
14. . PPACA §10101; PHSA §2719. [↑](#footnote-ref-14)
15. . PHSA §2716. [↑](#footnote-ref-15)
16. . IRC Sec. 125(j). [↑](#footnote-ref-16)
17. . IRC Secs. 106(f), 223(d)(2), 220(d)(2). [↑](#footnote-ref-17)
18. . IRC Secs. 223(f)(4)(A), 220(f)(4)(A). [↑](#footnote-ref-18)
19. . PHSA §2718. [↑](#footnote-ref-19)
20. . PPACA §1251, adopting PHSA §2717. [↑](#footnote-ref-20)
21. . PHSA §2718. [↑](#footnote-ref-21)
22. . PHSA §2715. [↑](#footnote-ref-22)
23. . IRC Sec. 6051(a). [↑](#footnote-ref-23)
24. . IRC Sec. 125(i). [↑](#footnote-ref-24)
25. . IRC Sec. 213(a). [↑](#footnote-ref-25)
26. . PPACA §1104. [↑](#footnote-ref-26)
27. . IRC Sec. 4376. [↑](#footnote-ref-27)
28. . IRC Sec. 4375. [↑](#footnote-ref-28)
29. . PPACA §6301; IRC Secs. 4375, 4376. [↑](#footnote-ref-29)
30. . Preamble to Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 217, 237 (Jan. 2, 2013). [↑](#footnote-ref-30)
31. . See Q 63, Part 1, for more information about the levels. [↑](#footnote-ref-31)
32. . PPACA §1557. [↑](#footnote-ref-32)
33. . PPACA §§1501, 10106; IRC Sec. 5000A. [↑](#footnote-ref-33)
34. A group health plan shall ensure that any annual cost sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section PPACA §1302(c). [↑](#footnote-ref-34)
35. Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 45 CFR Parts 147, 155, and 156, 78 Fed. Reg. 12834, 12837 (Feb. 25, 2013); FAQs About the Affordable Care Act Implementation Part XII, Q/A-1 at <http://www.dol.gov/ebsa/faqs/faq-aca12.html>. [↑](#footnote-ref-35)
36. PPACA § 1302(c)(1)(A) IRC § 223(c)(2)(A)(ii). [↑](#footnote-ref-36)
37. PPACA § 1302(c)(2)(A). [↑](#footnote-ref-37)
38. HHS Reg. § 156.130(b); Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 45 CFR Parts 147, 155, and 156, 78 Fed. Reg. 12834, 12837 (Feb. 25, 2013). [↑](#footnote-ref-38)
39. HHS Reg. § 156.130(c). [↑](#footnote-ref-39)
40. FAQs About the Affordable Care Act Implementation Part XII, Q/A-2 at [http://www.dol.gov/ebsa/faqs/faq- aca12.html](http://www.dol.gov/ebsa/faqs/faq-%20aca12.html). [↑](#footnote-ref-40)
41. Id. [↑](#footnote-ref-41)
42. . PHSA §2704 & §2705. [↑](#footnote-ref-42)
43. . PHSA §2708. [↑](#footnote-ref-43)
44. . PPACA §1302(c); PHSA §2707(b). [↑](#footnote-ref-44)
45. . PHSA §2711. [↑](#footnote-ref-45)
46. . PHSA §2709. [↑](#footnote-ref-46)
47. . PPACA §1201; PHSA §2716. [↑](#footnote-ref-47)
48. . PPACA §1511; FLSA §18A. [↑](#footnote-ref-48)
49. . IRC Sec. 4980H. See Q 26, Part 1, for an explanation of how the penalties are calculated. [↑](#footnote-ref-49)
50. . PPACA §1502; IRC Sec. 6055. [↑](#footnote-ref-50)
51. . PPACA §§1311(e)(3), 10104; PHSA §2715A; IRC Sec. 5056 [↑](#footnote-ref-51)
52. . IRC Sec. 4980H. See Q 26, Part 1, for an explanation of how the penalties are calculated. [↑](#footnote-ref-52)
53. . See Part VIII of this book for more information on Cadillac plans. IRC Sec. 4980I. [↑](#footnote-ref-53)
54. IRC Sec. 105(h)(3)(A). [↑](#footnote-ref-54)
55. Reg. §1.105-11(c)(2)(ii). [↑](#footnote-ref-55)
56. Reg. §1.105-11(c)(4)(i). [↑](#footnote-ref-56)
57. Reg. §1.105-11(c)(4)(i). [↑](#footnote-ref-57)