

March 2011

Legislative update



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Health reimbursement arrangements to comply with the new Medicare Secondary Payer Rule disclosure requirements

As discussed in prior Legislative Updates, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) mandates that certain group health plans (GHPs) meet certain Medicare Secondary Payer (MSP) reporting requirements. The requirements are intended to assist the Centers for Medicare & Medicaid Services (CMS) monitor whether group plans are properly paying as primary for Medicare beneficiaries.

Section 111 requires that medical plans report certain enrollee information to CMS, including Social Security numbers, to identify the primary payer (GHP or Medicare). That burden generally falls on carriers for insured plans, and third party administrators (TPAs) for self-insured major medical plans. However, employers have been encouraged to cooperate with carriers and TPAs in gathering this information. Note that this requirement does not extend to health flexible spending accounts (health FSAs), health savings accounts (HSAs), or dental or vision plans. Please refer to the table below for additional information.

Type of plan	Reporting to CMS required?	Party responsible for reporting to CMS
Group medical insurance policy (fully insured plan)	Yes	Insurance carrier
Health maintenance organization contract (HMO)	Yes	Health maintenance organization (HMO)
Self-insured group medical plan	Yes	Employer or third-party administrator
Healthcare flexible spending account	No	Not applicable
Health reimbursement arrangement (HRA), stand-alone or offered as part of a medical plan (embedded)	Yes (unless annual benefit amount is less than \$1,000 per year)	Employer, if HRA offered on stand-alone basis by employer. Insurance carrier or TPA, if offered as part of an underlying medical plan
Health savings account	No	Not applicable
Stand-alone mental healthcare services	No	Not applicable
Stand-alone dental plan	No	Not applicable
Stand-alone vision care plan	No	Not applicable

As described in our October 2008, [March 2010](#), and [June 2010](#) Legislative Updates, CMS initially delayed the applicability of the disclosure requirement for health reimbursement arrangements (HRAs) until late 2010 and then indicated that the disclosure requirement applied only to stand-alone HRAs. Subsequent to the release of our June 2010 Legislative Update, CMS issued an updated GHP User Guide, which made some subtle changes to the preceding User Guide. Most significantly, it reflected a change in position by CMS whereby “embedded” HRAs were not exempt from Section 111 reporting. In other words, it extended the mandatory reporting rule to all HRAs. Thus, while most TPAs that administer HRAs should be familiar with their obligations under Section 111, customers who self-administer their HRAs will need to familiarize themselves with this new obligation and comply with the reporting requirements.

Note, however, there are two exceptions from complying with the new MSP reporting requirements applicable to all HRAs, regardless of who administers them:

- HRAs with an annual benefit amount of less than \$1,000 are exempt from reporting.
- Employers with less than 20 employees (full- or part-time) do not have to report covered individuals, unless a covered individual has end-stage renal disease (ESRD) and is receiving dialysis or has had a kidney transplant.

Obligations of employers self-administering an HRA

Employers who self-administer (the employer pays claims directly to participants) their HRAs will be required to:

1. Register with CMS as a “responsible reporting entity”
2. Work with an Electronic Data Interchange (EDI) representative at CMS to understand the reporting process and prepare for the initial report submission and subsequent quarterly updates

Employers must register with CMS by visiting the CMS website at <https://www.cms.gov/MandatoryInsRep/>. Forwarding of data generally begins in the first quarter of 2011, and reporting must be submitted to the CMS Benefits Contractor (COBC) quarterly from that point forward. Note that, upon registering, an employer is assigned a personal COBC EDI Representative.

Information to be reported

The key information CMS requires on certain enrollees in an HRA plan, includes:

- Medicare Health Insurance Claim Number (HICN) or Social Security number
- Name
- Date of birth

- Gender
- If a dependent, identifying information on the employee and the employee's coverage election

This information need only be provided for the following individuals:

1. All covered individuals age 45 and above
2. Covered individuals with ESRD receiving kidney dialysis or who have received a kidney transplant
3. Covered individuals under 45 who are known to be entitled to Medicare (note "entitled to" Medicare means actually enrolled in Medicare)

Given that this data is very basic, employers may be able to extract the information from an internal or payroll system without having to rely on a third party (such as a carrier or TPA) to obtain the information. With respect to identifying those individuals described in items 2 and 3 above, an employer that self-administers its HRA that is embedded in an underlying group medical plan may be able to obtain assistance from the carrier or TPA of such underlying plan. However, in the event that the carrier or TPA is uncooperative, or the employer prefers to not pursue that option, the employer can make a "query only" filing with the COBC by providing data on all enrollees. The COBC will respond with a listing of the enrollees identified as Medicare beneficiaries. The employer can then use that information in making its basic report.

IRS issues new guidance on the tax treatment of breast pumps

On February 8, 2011, the Internal Revenue Service (IRS) concluded that breast pumps and other supplies that assist lactation are for medical care under Section 213(d) of the Internal Revenue Code because they are for the purpose of affecting a structure or function of the body. Therefore, these expenses can now be reimbursed on a tax favored basis from health flexible spending arrangements (health FSAs), health reimbursement arrangements (HRAs), or health savings accounts (HSAs). This is a change from the IRS' prior position, which stated that breast pumps did not qualify for tax favored reimbursement unless they were being used to treat a specific medical condition (as opposed to being used for convenience, scheduling, or other personal reasons). Plan sponsors should review their plan documents and summary plan descriptions (SPDs) to determine if their plan should be amended to provide for the reimbursement of breast pumps and other supplies that assist lactation.

HHS clarifies that student health insurance is subject to certain ACA mandates

On February 11, 2011, the Department of Health and Human Services (HHS) published draft regulations addressing the way the Patient Protection and Affordable Care Act (ACA) applies to student health insurance coverage. This guidance is effective for policy years beginning on or after January 1, 2012.

The draft regulations define "student health insurance" as a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education and a health insurance issuer and provided to students enrolled in that institution and to their dependents. The definition specifically excludes self-funded student health plans as beyond the scope of HHS' regulatory authority under the ACA. Also, in order to meet the definition of student health insurance, the coverage cannot condition enrollment in the plan on any health status-related factor of a student or dependent. This effectively extends the ACA prohibition that plans and insurers impose any pre-existing condition exclusions on individuals enrolled in the plan who are under 19 years of age. Otherwise, the regulations exempt student health insurance from complying with the ACA's guaranteed renewability and guaranteed availability mandates, reasoning that these mandates are incompatible with plans that, by definition, are of a limited duration and restricted to individuals enrolled as students.

HHS confirmed that the mandate to cover preventive care services without cost sharing applies to student health insurance, but clarified that the student fee for enrollment would not constitute cost sharing or otherwise violate the ACA.

Under the proposed regulation, the prohibition on lifetime limits under the ACA would be applicable to student health insurance coverage. With respect to the ACA's restricted annual limits, the draft regulations provide transitional relief. For policy years beginning before September 23, 2012, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than \$100,000. For policy years beginning on or after September 23, 2012, all student health insurance coverage must comply with the annual dollar limits requirements applicable to all plans under the ACA. See our [June 23, 2010 Legislative Alert](#) for a discussion of these limits.

HHS' [Fact Sheet](#) and [News Release](#) on the draft regulations also confirm that the prohibition on rescinding coverage applies to student health insurance.

Students covered by these types of plans must receive a notice informing them that not all of the ACA mandates apply to their coverage. Model language is provided in the draft regulations,

which are available in full at <http://edocket.access.gpo.gov/2011/pdf/2011-3109.pdf>.

Finally, HHS requested comments on how the ACA's mandate requiring plans to allow participants to select any available participating primary care provider could apply to student health insurance and how the new Medical Loss Ratio requirements (80 percent of premiums in the small and individual markets and 85 percent of premiums in the large group market must be spent on clinical services or activities to improve healthcare quality) could be modified to apply to student policies.

HHS issues proposed regulations establishing a rate review program

The Patient Protection and Affordable Care Act (ACA) requires the Department of Health and Human Services (HHS) to establish a process for the disclosure and review of unreasonable rate increases by health insurance issuers. HHS recently released proposed regulations that establish this rate review program. The regulations and new process will apply to rate increases filed in a state on or after July 1, 2011, or increases effective on or after July 1, 2011, in a state that does not require rate increases to be filed.

The proposed regulations apply only to the individual and small group markets as defined under state law and do not apply to grandfathered benefit options. Moreover, the process set forth by HHS does not preempt an effective state rate review process already in place. If a state has an "effective" rate review process, as determined by HHS under standards set out in the regulations, HHS will adopt the state's determination on rate increases. Forty-three states already have some form of rate review process in place.

For 2011, HHS sets a general 10 percent threshold for determining which rate increases will be subject to review. In future years, HHS will establish state-specific thresholds based on local variations in rates, costs, and healthcare trends. With respect to whether an increase is unreasonable, HHS will consider the effect of the rate increase on Medical Loss Ratios in the applicable market, the evidence and assumptions on which the increase is based, and whether the increase would result in premium differences between insureds with similar risk categories that do not correspond to differences in expected costs.

If HHS determines that a rate increase is unreasonable, the insurer can choose to implement a reduced rate increase or implement the original rate increase that was found to be unreasonable. If the insurer implements the unreasonable rate increase, it must submit final justifications for the increase and make information about the review process publicly available

on its website. HHS will also post all final justifications for unreasonable rate increases on its website.

Department of Justice will not defend the constitutionality of the Defense of Marriage Act

On February 23, 2011, the Attorney General and the Department of Justice stated that they would no longer defend the constitutionality of the Defense of Marriage Act (DOMA) in the Second Circuit or any other circuit where the constitutionality of Section 3 (definition of marriage) of DOMA was challenged. The Attorney General made the announcement based on a directive from President Obama, who considers DOMA to be unconstitutional.

DOMA is a public law passed by President Clinton in 1996 that defines marriage as a legal union between a man and a woman. All federal laws must follow DOMA when defining marriage, including, but not limited to, the federal tax code, ERISA, COBRA, HIPAA, USERRA, and the ACA. If DOMA is deemed to be unconstitutional, or if it is repealed by Congress, employers would be required to provide the same rights and benefits available at a federal level to same sex spouses that are currently available to opposite sex spouses, most notably extending federal tax free benefits to same sex spouses covered under an employer's group health plan.

We will continue to monitor the case in the Second Circuit that challenges the constitutionality of DOMA and comment in a future Legislative Update.

California introduces AB 36 to extend tax free benefits to adult children

The state of California introduced AB 36, a bill that intends to amend the California Tax Code retroactively to March 30, 2010, to conform with the ACA changes that extend tax free benefits to children up to the age of 26 regardless of their tax dependent status. AB 36 has passed the Assembly's Committees for Revenue and Taxation and Appropriations, but has not been submitted for the General Assembly's consideration. Assuming AB 36 passes the Assembly, the bill will have to be introduced in the Senate for its review and consideration. If the bill passes the Senate, it will return to the Assembly for final review and consideration and then be submitted to Governor Brown for signature.

Until AB 36 is enacted into law, employers with employees in the state of California are required to tax the fair market value of coverage provided to children over the age of 19 that are

not tax qualified dependents of the employee. On February 28, 2011, the California Employment Development Department (EDD) posted on its website new guidance for calculating the fair market value of coverage provided to an adult child. The EDD concluded in its new guidance that the “fair market value of the healthcare coverage is set at the discretion of the employer.” This allows employers to use a formula other than the incremental value formula, if they were using a different method in calculating the fair market value of coverage provided to an adult child.

To view the new guidance, please visit the EDD website at http://www.edd.ca.gov/Payroll_Taxes/Updated_Information_Related_to_Adult_Child_Health_Care_Premiums.htm.

We will continue to monitor the progress of AB 36 and comment on its status in future Legislative Updates.

Question of the month

Question

How often must I distribute a HIPAA Privacy Notice to covered participants?

Answer

HIPAA Privacy Notices must be distributed every three years unless there is a material revision in the notice as required by law or in the covered entity’s privacy policies. If you sponsor a large group health plan (\$5 million or more in claims or premiums) you are required to distribute the notice no later than April 14, 2012, as the first notification requirement was effective on April 14, 2003. If you are a small group health plan (less than \$5 million in claims or premiums) you are not required to distribute the notice until April 14, 2013. You can either distribute the notice or you can inform participants via e-mail or mail where they can retrieve a full copy of the Privacy Notice.

This material is provided for informational purposes only based on our understanding of applicable guidance in effect at the time of publication, and should not be construed as being legal advice or as establishing a privileged attorney-client relationship. Customers and other interested parties must consult and rely solely upon their own independent professional advisors regarding their particular situation and the concepts presented here. Although care has been taken in preparing and presenting this material accurately (based on the laws and regulations, and judicial and administrative interpretations thereof, as of the date set forth above), Wells Fargo Insurance Services disclaims any express or implied warranty as to the accuracy of any material contained herein and any liability with respect to it, and any responsibility to update this material for subsequent developments.

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Legislative Alert

Summary of Federal Healthcare Reform Law

Updated as of February 4, 2011



The Patient Protection and Affordable Care Act (H.R. 3590) was signed into law by President Obama on March 23, 2010. The companion bill, the Healthcare and Education Reconciliation Act (H.R. 4872), was signed into law on March 30, 2010. Together, these two bills constitute what is now commonly referred to as the “Affordable Care Act” or “ACA.” Set forth below is a brief summary of some of the key changes that will affect employers and employees under the ACA.

Important notes

- **Fully-insured vs. self-insured group health plans.** Except as otherwise noted, all of the items below that are applicable to group health plans apply to both fully-insured and self-insured group health plans.
- **Grandfathered plans vs. non-grandfathered plans.** Group health plans existing on March 23, 2010, are “grandfathered” under the ACA. Grandfathered plans are deemed to be “minimum essential coverage,” have special effective date rules for certain health reform changes, and are completely exempt from certain other changes (as noted in the chart below). A grandfathered plan is allowed to enroll new employees (both newly hired and newly enrolled) and their families without losing its grandfathered status. In regulations issued on June 14, 2010 and subsequent amendment to the regulations issued on November 15, 2010, federal regulators provided that grandfathered status would be lost if various actions were taken with respect to the plan (such as changing insurance carriers prior to November 15, 2010, eliminating benefits, raising percentage cost-sharing requirements, significantly raising fixed-amount

cost-sharing or co-payment requirements, significantly lowering employer contributions, imposing new or decreased annual dollar limits, etc.).

- **Collectively-bargained plans.** For insured group health plans maintained under one or more collective bargaining agreements ratified before March 23, 2010, there is a provision in the ACA that grants grandfathered status to such plans until the termination date of the last collective bargaining agreement relating to the plan. This special collectively-bargained grandfathered status will allow insured collectively-bargained plans (but not self-insured plans) to take certain actions (as noted above) that would otherwise result in loss of grandfathered plan status. Nevertheless, like any other group health plan there are some market reform changes (such as limits on lifetime and annual dollar limits, extension of dependent coverage to adult children up to age 26, phase-out of pre-existing condition limitations, prohibition on rescissions, etc.) that will apply to every insured or self-insured collectively-bargained plan regardless of whether the plan is considered grandfathered or not.

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Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Premium tax credit for small employers	The government provides a 35 percent premium tax credit to small employers (up to 25 employees with average annual wages of less than \$50,000) that contribute toward health insurance premiums for employees; generally increases to 50 percent in 2014 (available for only two years) but only if employer offers coverage through an insurance exchange (see “Insurance exchanges,” below)	2010	2010	Apply for tax credit, if applicable
Medicare Part D	Provides a \$250 rebate to Medicare Part D participants who reached the “donut hole” in 2010; also, the coinsurance rate is effectively phased down from 100 percent to 25 percent by 2020	2010	2010	If offering coverage to retirees, notify them of changes to Medicare Part D benefit
Temporary government high-risk pool	A national high-risk insurance program for uninsured individuals previously denied coverage due to a pre-existing condition and who have been uninsured for at least 6 months; rules prevent employers and insurance companies from shifting risk to high-risk program by discouraging individuals from remaining enrolled in their prior coverage based on individual’s health status	No later than June 21, 2010; the program ends on the earlier of \$5 billion in funding being exhausted or December 31, 2013	No later than June 21, 2010; the program ends on the earlier of \$5 billion in funding being exhausted or December 31, 2013	Communicate availability of program to any ineligible employee
Temporary government subsidies for early retiree plans	For employers with early retiree medical plans, the government will reimburse eligible employers for 80 percent of the cost of medical benefits (between \$15,000 and \$90,000) for retirees age 55 to 64 and their dependents; subsidy must be applied only as permitted	June 1, 2010; the program ends on the earlier of \$5 billion in funding being exhausted or December 31, 2013	June 1, 2010; the program ends on the earlier of \$5 billion in funding being exhausted or December 31, 2013	Apply for and seek reimbursement, if applicable
Lifetime dollar limits on plan benefits	Group plans may not place lifetime dollar limits on essential health benefits	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Annual dollar limits on plan benefits	Group plans may only place “restricted” annual dollar limits (not less than \$750,000, phasing up to not less than \$2 million for 2013 plan years) on essential health benefits as defined by the Secretary of Health and Human Services (HHS), with all annual dollar limits on essential health benefits prohibited starting in 2014 plan year; HHS may grant limited waivers from pre-2014 limitations in certain situations	Requirement for government-set limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Requirement for government-set limits is effective with first plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Amend plan documentation
Rescinding coverage	Plans cannot rescind coverage of an enrollee, except in cases of enrollee fraud or material misrepresentation	First plan year beginning after September 23, 2010	First plan year beginning after September 23, 2010	Amend plan documentation
Pre-existing condition limits on plan benefits	Group plans may not impose a pre-existing condition exclusion with respect to children under age 19, with pre-existing condition exclusions eliminated for all participants starting in 2014 plan year	First plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	First plan year beginning after September 23, 2010; full prohibition is effective with first plan year beginning in 2014	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Adult child coverage	<ul style="list-style-type: none"> • All group health plans must extend eligibility to children of the covered employee until the child turns 26 years of age (grandfathered plans can exclude an “adult child,” if the child is eligible for coverage under another employer-sponsored group health plan, although this exception is eliminated in 2014) • Coverage must be extended regardless of marital status, student status, level of support provided, or residency of adult child; but does not need to extend to children of an adult child (that is, grandchildren of the employee) • Terms of group health plan providing dependent coverage cannot vary based on age up to age 26 (for example, no surcharges allowed for adult child coverage) • Healthcare benefits for adult children are excludible from taxable income through the end of the calendar year in which the adult child turns age 26, effective as of March 30, 2010 • State laws extending insured coverage for dependents past the age of 26 are still enforceable 	<p>First plan year beginning after September 23, 2010, but plans can exclude an adult child eligible to enroll in another employer-sponsored health plan (not including a parent’s plan)</p> <p>Effective with first plan year beginning in 2014, coverage must be extended to all children up to the age of 26</p> <p>Tax exclusion effective March 30, 2010</p>	<p>First plan year beginning after September 23, 2010</p> <p>Tax exclusion effective March 30, 2010</p>	Amend plan documentation
Preventive care coverage	Employer plans must provide coverage, without cost-sharing, for preventive services rated A or B by the U.S. Preventive Services Task Force; recommended immunizations; preventive care for infants, children, and adolescents; and preventive care and screenings for women	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation
Appeals procedures	All group plans must have both internal and external claims review procedures that are generally expanded beyond current requirements; federal grants available to states to strengthen assistance programs for individual claimants	Not applicable, except that federal grants for state government assistance programs effective with 2010 fiscal year	First plan year beginning after September 23, 2010, except federal grants for state government assistance programs effective with 2010 fiscal year	Amend plan documentation

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Nondiscrimination requirements	Insured health plans will now be required to comply with Internal Revenue Code § 105(h)(2) nondiscrimination rules that previously only applied to self-insured health plans	Not applicable	Effective date delayed until further guidance issued, pursuant to IRS Notice 2011-1	Conduct testing, if applicable
Access to certain healthcare providers	Plans that require designation of a primary care provider must allow the designation of any available participating primary care provider, including pediatricians for children; plans cannot require authorization or referral prior to seeking OB-GYN services; plans cannot require prior authorization for emergency services or set more restrictive cost-sharing requirements when emergency services are provided out of network	Not applicable	First plan year beginning after September 23, 2010	Amend plan documentation
Disclosure of plan information	<p>In “plain language,” plans must disclose to the Secretary of HHS and the relevant state insurance commissioner (and make available to the public) specified information, including:</p> <ul style="list-style-type: none"> • claims payment policies and practices; • periodic financial disclosures; • data on enrollment, disenrollment, number of claims denied, and rating practices; • information on cost-sharing and payments with respect to any out-of-network coverage; • information on enrollee and participant rights under the Healthcare Law; and • other information as determined appropriate by the Secretary of HHS 	Not applicable	First plan year beginning after September 23, 2010, but some uncertainty remains	Monitor government data disclosure requirements
Automatic enrollment	Large employers (those with more than 200 full-time employees) that offer coverage must automatically enroll all new full-time employees in the employer’s health plan; employees may opt out of coverage	Uncertain; but likely soon after regulations issued	Uncertain; but likely soon after regulations issued	Amend plan documentation, if applicable

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Community living assistance services and supports (CLASS) program	Employers may agree to participate in a national, voluntary long-term care program that, after a five-year vesting period, will provide individuals with functional limitations a cash benefit of not less than \$50 per day to purchase non-medical services and supports to maintain community residence; participating employers must automatically enroll employees, who have an opt-out right	2011	2011	Evaluate whether to offer program
Temporary wellness program grants for small employers	Small employers (those with less than 100 employees who work 25 hours or more per week) that did not have a workplace wellness program in place on March 23, 2010, may apply for government grants to help subsidize workplace wellness programs that satisfy certain criteria	2011; the program ends on the earlier of \$200 million in funding being exhausted or December 31, 2015	2011; the program ends on the earlier of \$200 million in funding being exhausted or December 31, 2015	Monitor governmental grant submission requirements, and apply for grant if program applicable
Over-the-counter drugs	Except for insulin, over-the-counter drugs without a prescription are not reimbursable from a healthcare flexible spending account (FSA) or health reimbursement account (HRA), and are not a tax-free reimbursement from a health savings account (HSA)	2011	2011	Amend plan documentation
Health savings accounts (HSAs)	Penalty on non-medical HSA distributions raised from 10 percent to 20 percent	2011	2011	Amend plan documentation, and notify HSA participants of new excise tax
Medicare Parts B and D	Freezes the threshold for imposing higher premiums for Medicare Part B coverage for 2011 through 2019; individuals also pay a greater share of the cost of Medicare Part D coverage if they have income above \$85,000 (\$170,000 if filing jointly)	2011	2011	None

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Simple cafeteria plans for small employers	<p>Internal Revenue Code § 125 cafeteria plans maintained by small employers (with an average of 100 or fewer employees during either of the two preceding years) are deemed to be nondiscriminatory if all employees with at least 1,000 hours of service in the preceding year are eligible to participate; certain nondiscrimination standards are met; and employer contribution are either</p> <ul style="list-style-type: none"> • a uniform percentage (at least two percent) of employee compensation, or • not less than six percent of employee compensation (or, if less, two times the employee contribution amount) 	2011	2011	Consider adopting a simple cafeteria plan, if applicable
Medical loss ratio for insurance policies	Insurance carriers must provide a rebate to consumers if the amount spent on clinical services and quality is less than 85 percent of the premium cost (80 percent for plans in the individual market and small group market, which generally covers employers having an average of 100 or fewer employees in the previous calendar year, though states can set at 50 or fewer for plan years beginning prior to 2016)	2011	2011	None
Form W-2 reporting to employees	Although not taxable, the aggregate value (using rules similar to COBRA) of employer-provided health coverage provided to each employee must be disclosed on Form W-2	For 2012 tax year	For 2012 tax year	Develop reporting mechanism
Temporary tax on insured and self-insured group health plans to fund patient-centered outcomes research trust fund	Establishes a tax of \$2 times the average number of lives covered (\$1 times the average number of lives covered for plan years ending in 2013)	Plan years ending after September 30, 2012; terminates for plan years ending after September 30, 2019	Plan years ending after September 30, 2012; terminates for plan years ending after September 30, 2019	Monitor government payment procedures

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Distribute uniform explanation of coverage document	Employers will be required to distribute to enrolled employees a summary of benefits with an explanation of coverage (in addition to a summary plan description) that accurately describes the benefits and coverage levels offered under the employer’s plans according to uniform standards; employers also must notify enrollees if they intend to make any material modifications not reflected in the most recent summary within 60 days prior to the effective date of the modifications; each compliance failure can result in a \$1,000 penalty	March 23, 2012 (possibly sooner)	March 23, 2012 (possibly sooner)	Monitor release of HHS guidance, and prepare compliant benefits summaries for distribution to new and existing employees
Healthcare flexible spending account (FSA) plans	Employee pre-tax contributions to a healthcare FSA are limited to \$2,500 per year	2013	2013	Amend plan documentation, if applicable
Medicare payroll tax increase	<ul style="list-style-type: none"> • Employees pay 2.35 percent (not 1.45 percent) on earnings greater than \$200,000 (\$250,000 if filing jointly) • Increase is not matched by employers and employers only withhold an additional 0.90 percent on wages above \$200,000 • Taxpayers with an income of at least \$200,000 (\$250,000 if filing jointly) will also pay a 3.8 percent tax on investment income 	2013	2013	Develop payroll tax mechanism
Itemized deduction for medical expenses	Threshold for tax deduction is 10 percent (not 7.5 percent) of adjusted gross income; threshold remains at 7.5 percent until 2017, if the taxpayer or spouse is age 65 or older	2013	2013	None

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Administrative simplification	Health insurance administrators must comply with standards and associated operating rules to be adopted by the Secretary of HHS (including certification and documentation requirements) with respect to the following:			Monitor government developments
	• Eligibility verification and claims status;	2013	2013	
	• Electronic funds transfers and healthcare payments; and	2014	2014	
	• Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization.	2016	2016	
Employer notice to employees of coverage options	A penalty of \$1 per covered life per day will be assessed for noncompliance	2014	2014	
Employer notice to employees of coverage options	Notice must be provided to existing employees and new hires of the existence of and information regarding an insurance exchange (see “Insurance exchanges,” below), the availability of a government subsidy (if applicable), and the consequences if the employee waives coverage under the employer plan in favor of obtaining coverage through the exchange	March 1, 2013	March 1, 2013	Develop reporting mechanism

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Individual mandate	<p>U.S. citizens and legal residents are required to have "minimum essential coverage" which may include an eligible employer-sponsored plan, a grandfathered plan, certain individual coverage available through an exchange, and most government plans (for example, Medicare, Medicaid, TRICARE)</p> <p>The tax penalty for noncompliance is the greater of the applicable dollar amount per year per person (up to a maximum of 300 percent of applicable dollar amount per family), or the designated percentage of household income that exceeds tax filing threshold (for example, \$9,350 for individuals and \$18,700 for those filing jointly for 2010)</p> <ul style="list-style-type: none"> • The applicable dollar amount is \$95 in 2014, \$325 in 2015, \$695 in 2016, and adjusted for inflation thereafter • The designated percentage is 1 percent in 2014, 2 percent in 2015, and 2.5 percent in 2016 and thereafter <p>Various exceptions apply, such as for individuals with financial hardships or religious objections; Native Americans; individuals without coverage for less than three continuous months; whenever the lowest cost plan option costs more than 8 percent of income; or whenever the individual's income is below the tax filing threshold</p>	2014	2014	None

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Insurance exchanges	<p>Individuals (U.S. citizens and legal immigrants) and small employers (those having an average of 100 or fewer employees in the previous calendar year, although states can set the number at 50 or fewer for plan years beginning prior to 2016) may purchase insurance from state-run exchanges beginning in 2014; if the state agrees, large employers (having an average of at least 101 employees in the previous calendar year) also may purchase from the exchange beginning in 2017</p> <p>Five tiers of coverage are offered through the exchange:</p> <ul style="list-style-type: none"> • Bronze—provides essential health benefits, covers at least 60 percent of actuarial value of covered benefits, with out-of-pocket limit equal to current limits on HSAs (\$5,950 for individuals and \$11,900 for families, in 2010); • Silver—provides essential health benefits, covers at least 70 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Gold—provides essential health benefits, covers at least 80 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Platinum—provides essential health benefits, covers at least 90 percent of actuarial value of covered benefits, with HSA out-of-pocket limits; • Catastrophic—similar to high-deductible health plan, except available only to individuals up to age 30 in the individual market (not through an exchange) <p>Reduced out-of-pocket limits apply to individuals with incomes up to 400 percent of the federal poverty level</p>	2014	2014	Monitor government developments

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Employer “play or pay” mandate	<p>Employers with more than 50 full-time employees in the preceding calendar year (working an average of at least 30 hours per week) can “play” by offering “minimum essential coverage” to all of its full-time employees and their dependents; solely for purposes of determining whether the employer has more than 50 full-time employees, part-time workers are converted to full-time equivalents by adding all hours worked by part-timers during the month and dividing by 120; special rules apply with respect to seasonal employees working for employers close to satisfying the more-than-50 full-time employee standard</p> <p>Employers with more than 50 full-time employees that do not offer “minimum essential coverage” must pay an excise tax of \$2,000 times the total number of full-time employees of the employer (excluding the first 30 employees) if at least one full-time employee receives government-subsidized coverage through an insurance exchange (discussed below)</p> <p>Even if the employer offers “minimum essential coverage,” but still has at least one full-time employee who receives government-subsidized coverage through an insurance exchange, the employer must pay an excise tax equal to \$3,000 for each employee receiving subsidized exchange coverage (but this assessment cannot exceed the assessment for not providing minimum essential coverage at all); employees receiving vouchers (discussed below) are not counted in calculating assessments</p> <p>Note that in either penalty situation, these nondeductible excise taxes are calculated and assessed on a monthly basis</p>	2014	2014	Evaluate “play or pay” strategy; monitor government developments

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Government-subsidized coverage through insurance exchange for individuals	<p>A government subsidy is available to U.S. citizens and legal immigrants with incomes up to 400 percent of the federal poverty level to purchase coverage through an insurance exchange; however, an individual will <i>not</i> be eligible for a government subsidy if eligible for minimum essential coverage through an employer that is:</p> <ul style="list-style-type: none"> • “affordable” (the employee’s contributions do not exceed 9.5 percent of the employee’s household income) and • provides “minimum value” (the plan pays at least 60 percent of the allowed costs of benefits) <p>Employees receiving vouchers (discussed below) are not eligible for a government subsidy</p>	2014	2014	None
Employer free-choice vouchers	<p>Employers with more than 50 full-time employees that offer “minimum essential coverage” to employees must give certain eligible employees the option of receiving a voucher from the employer to purchase coverage from an insurance exchange (which is tax-free up to the purchase price of coverage purchased); employees receiving a voucher amount are not counted in calculating any employer “play or pay” penalty</p> <p>The employee is eligible for a voucher if:</p> <ul style="list-style-type: none"> • his or her share of the cost of the employer plan is between 8 percent and 9.8 percent of household income, • the employee’s household income does not exceed 400 percent of the federal poverty level, and • the employee does not participate in the employer plan <p>The dollar amount of the voucher equals the employer’s largest contribution for any employee-only coverage (or family coverage, if elected by the employee) under the employer plan, and is adjusted for age and category of enrollment; no voucher is required if the employer makes no contribution to the plan</p>	2014	2014	Monitor government developments; determine how many employees who waive coverage and do not have coverage elsewhere are eligible for vouchers

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Waiting periods	Waiting periods in excess of 90 days are prohibited	First plan year beginning in 2014	First plan year beginning in 2014	Amend plan documentation, if applicable
Approved clinical trials	Group plans cannot deny qualified individuals' participation in certain clinical trials, including coverage for routine patient costs that would typically be covered outside the clinical trials	Not applicable	First plan year beginning in 2014	Amend plan documentation
Employer reporting to government	Employers must report to the government whether they offer minimum essential coverage to full-time employees and dependents, the length of the waiting period, the lowest-cost option for coverage, the employer's share of coverage costs, and the total number and names of employees receiving coverage from the employer's plan	2014	2014	Monitor government reporting mechanism
Wellness programs	Employers may offer financial incentives to employees of up to 30 percent (not just 20 percent) of the cost of coverage to participate in a wellness program that satisfies the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination requirements; the government can increase the limit to 50 percent if deemed appropriate	2014	2014	Amend plan documentation, if applicable; monitor government developments
Medicaid eligibility	Eligibility is expanded to all individuals under age 65 with incomes up to 133 percent of the federal poverty level	2014	2014	None

Topic	Provisions of Affordable Care Act	Effective date for grandfathered plans	Effective date for non-grandfathered plans	Action items for employers
Excise tax on high-cost plans	<p>A 40 percent excise tax is imposed on insurers (for insured coverage) and employers (for self-insured coverage) to the extent that the aggregate annual value of an employee’s health coverage (including medical, prescription, HRA, healthcare FSA, and employer HSA contributions) exceeds \$10,200 (\$27,500 for more than employee-only coverage)</p> <p>Threshold values are indexed to changes in the consumer price index for urban consumers; thresholds are</p> <ul style="list-style-type: none"> • raised by \$1,650 for retirees age 55 to 64 (\$3,450 for family coverage), for persons in certain high-risk professions (including law enforcement, fire protection, and others), and certain utility workers; and • adjusted to reflect higher healthcare costs attributable to age or gender in the workforce. <p>The employer is responsible for calculating the value of excess coverage using COBRA rules, and making reports to insurers and the government</p>	2018	2018	Evaluate whether group health plan would be subject to excise tax

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