

PPACA: Additional IRS and Treasury Guidance On Qualified Health Insurance Plans

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Introduction

The *Patient Protection and Affordable Care Act* (Affordable Care Act, P.L. 111-148), which became law on March 23, 2010, has many complex provisions. As a result many employers are uncertain as to what changes, if any, they must make to their employee health insurance plans to comply with the new law. According to a survey of more than 650 mid- to senior-level benefit professionals by Towers Watson, a benefit specialist firm, most employers anticipate that the health care reform legislation will increase health benefit costs and that these increased costs will be either passed on to employees, or the employer will reduce health benefits and programs (www.towerswatson.com/united-states/research/1935). Mercer Co., a benefit specialist firm, surveyed 791 employers about whether they expect the new act to increase premium costs. One-fourth of the respondents indicated that the new law will increase the cost of health insurance coverage between 3-5%, and another 41% indicated the increase would be less than 2% (www.mercer.com/referencecontent.htm?idContent=1380755).

This article discusses the salient points of Treasury and IRS guidance relating to the HI Tax Credit, Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Plan Rescissions, and Required Patient Protections. The new HI tax credit was explained in detail in the fall 2010 issue of NATP's *TAXPRO Journal*. As this article pointed out, the credit is available only for small employers. To briefly summarize how the credit works, for 2010 the maximum credit is 35% (25% for tax-exempt organizations), increasing to 50% (35% for tax-exempt organizations) in 2014. The credit is phased out when the employer has more than ten full-time equivalent employees or pays on average more than \$25,000 in qualifying annual wages. The employer must also satisfy numerous other requirements to obtain the HI credit.

Additional IRS Guidance on the HI Tax Credit

For employers who do qualify for the HI tax credit, the IRS and Treasury have provided additional guidance in Notice 2010-44, 2010-22 IRB, 5/17/2010, Notice 2010-38, 2010-20 IRB, 3/30/2010, Notice 2010-82, 2010-51 IRB, 12/3/2010, IR 2010-96, 9/7/2010, Revenue Ruling 2010-13, 2010-21 IRB, 5/3/2010, and in a list of Frequently Asked Questions (FAQs) posted on the IRS website (<http://www.irs.gov/newsroom/article/0,,id=220839,00.html>).

This guidance is summarized as follows:

- Only premiums paid by the employer are counted in calculating the HI credit (Notice 2010-44, 2010-22 IRB, 5/17/2010, II-F). Any premium paid under a salary reduction arrangement under a §125 cafeteria plan is not treated as paid by the employer. In determining the employer's deduction for health insurance premiums, the deduction is reduced by the amount of the credit (FAQ 20).
- Example: The employer pays 80% of the premium and the other 20% is paid through a qualified salary reduction plan. Only the 80% paid by the employer is taken into account

in calculating the credit. The deduction for the premiums paid by the employer must be reduced by the amount of the credit.

- If the employer is entitled to a state tax credit or a premium subsidy that is paid directly to the employer, the premium payment is not reduced by the credit or subsidy for purposes of determining whether the employer has satisfied the requirement to pay at least 50% of the premium cost. Note, however, that the HI credit can only be taken for the actual premium paid by the employer (Notice 2010-44, 2010-22 IRB, 5/17/2010, III-D). Example: The state subsidizes 40% of the premium payments and the employer and employee each pay 30%. The 50% premium requirement is met since the 40% state subsidy is deemed to be paid by the employer. However, the HI credit is based upon the 30% of the premium actually paid by the employer.
- In an area that has higher premium rates than those allowed by the state small group market, the HHS may provide additional average premium rates for the small group market, but has not yet done so. In no case will additional sub-state rates be lower than the applicable state rate (Rev. Rul. 2010-13, 2010-21 IRS, 5/3/2010). Although premiums may vary depending upon the age of the employee, the HHS has not indicated that it will set more than one rate per state using age as a factor.
- Any group health plan or health insurance issuer offering coverage of dependent children must continue to make dependent coverage available until the child turns 26 years of age (*2010 Health Care Act* §1001(f) as amended by *2010 Reconciliation Act* §2301b). Example: An employee's child turns 26 on October 19, 2011. The employer's health insurance plan must cover the child through October 2011.
- The exclusion from gross income for reimbursements for medical care expenses under an employer-provided accident or health plan is extended to a participant's child who is under the age of 27 as of the end of the tax year, whether or not that child is the participant's dependent for tax purposes. An adult child who has not turned 27 years of age need not meet the dependency tests for a qualifying child under IRC §152(c)(1) (Notice 2010-38, 2010-20 IRB).
 - Example: An employee's child turns 26 on August 5, 2011. The employee may be reimbursed for out-of-pocket health care costs (but not health insurance premiums) relating to the child through December 31, 2011.
- The HI credit can be used to determine the amount of estimated tax payments to be made for the year in which the credit applies. The credit can also be used to offset the AMT liability for the year (Notice 2010-44, 2010-22 IRB, 5/17/2010, IV). For 2010, the unused credit can be carried forward 20 years as a general business credit. For 2011, the unused credit can be carried back to 2010, the first year that the credit was in effect. Any unused credit can then be carried forward to 2012 and later years (FAQ 16).
- Tax-exempt organizations are ineligible for the HI credit if they are not both described in IRC §501(c) and 501(a). Eligible wages must meet the definition of wages as defined under IRC 3121(a) for purposes of the *Federal Insurance Contributions Act* (FICA) but

determined without regard to the wage base limitation under IRC §3121(a)(1). Because the compensation of a minister is not subject to Social Security or Medicare tax under the act, a minister has no wages for purposes of computing the employer's eligible wages.

IRS Guidance on Grandfathered Plans

Grandfathered health plan coverage is coverage provided by a group health plan, or a health insurance issuer, in which at least one individual was enrolled on March 23, 2010. A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010, cease to be covered, provided that the plan or group health insurance coverage has continuously covered at least one person, not necessarily the same person, but at all times at least one person since March 23, 2010. A grandfathered plan may enroll family members of employees as long as family enrollment was allowed as of March 23, 2010. The plan must offer coverage for dependent children through the month in which the child reaches age 26, and it is prohibited from excluding enrollees from coverage for pre-existing conditions.

An employer with a group health plan may find it beneficial to be in a grandfathered plan if the current plan includes provisions that would not be permitted under the PPACA. The PPACA has new nondiscrimination rules that are effective for plan years beginning on or after September 23, 2010. The PPACA requires that insured plans must satisfy the substantive requirements of IRC §105(h) and pass both an eligibility and benefits test that requires coverage of at least 70% of all employees and at least 80% of those eligible, and requires that benefits provided to any highly compensated individual also be provided to all participants.

- **EXAMPLE:** A group plan that offers different benefits to different classes of employees would want to meet the requirements to be a grandfathered plan to continue these differential benefits. However, if changes are made to the plan and it ceases to be a grandfathered plan, then these differential benefits could no longer be offered. On the other hand, if the employer views some portion of the current plan as being cost prohibitive, the employer may decide to not maintain its grandfathered status so that the plan would have to be modified to meet the new, presumably less expensive, rules.

The regulations address how a grandfathered plan maintains its status and also provide examples that illustrate when a plan will lose its grandfathered status. Under Reg. §2590.712-1251(a) the plan must include a statement in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of §1251 of the *Patient Protection and Affordable Care Act* and must provide contact information for questions and complaints. Model language that can be used to satisfy this disclosure requirement is provided in the Regulations. In addition, the plan must also maintain records documenting the terms of the plan and make them available upon request.

A group health plan ceases to be a grandfathered health plan if:

- (A) Employees are transferred into the plan from a plan under which the employees were covered on March 23, 2010 (the transferor plan);
- (B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status; and
- (C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.

Reg. §2590.712-1251(a) and (b) includes the following examples:

- **EXAMPLE:** A group health plan not maintained pursuant to a collective bargaining agreement provides coverage through a group health insurance policy from Issuer X on March 23, 2010. For the plan year beginning January 1, 2012, the plan enters into a new policy with Issuer Z. For the plan year beginning January 1, 2012, the group health insurance coverage issued by Z is not a grandfathered health plan under the rules of paragraph (a)(1)(ii) because the policy issued by Z did not provide coverage on March 23, 2010.
- **EXAMPLE:** A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan replaces the issuer for Option H with a new issuer. The coverage under Option H is not grandfathered health plan coverage as of July 1, 2013. If the plan enters into a new policy, certificate, or contract of insurance for Option G, its status as a grandfathered health plan would cease.
- **EXAMPLE:** A group health plan offers two benefit packages on March 23, 2010, Options F and G. During a subsequent open enrollment period, some of the employees enrolled in Option F on March 23, 2010, switch to Option G. The group health coverage provided under Option G remains a grandfathered health plan because employees previously enrolled in Option F are allowed to enroll in Option G as new employees.
- **EXAMPLE:** Same facts as above except that the plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. The plan did not have a bona fide employment-based reason to transfer employees from Option F to Option G and ceases to be a grandfathered health plan with respect to all employees. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, then Option F would cease to be a grandfathered health plan.
- **EXAMPLE:** A group health plan offers two benefit packages on March 23, 2010, Options H and I. On March 23, 2010, Option H provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and the employees are moved to another plant. The employer eliminates Option H and the employees are transferred to Option I. The plan has a bona fide employment-based reason to transfer employees from Option H to Option I. Therefore, Option I does not cease to be a grandfathered health plan. If instead of transferring employees from Option H to Option I, Option H was amended to match the terms of Option I, then Option H would cease to be a grandfathered health plan.

The following changes will cause a group health plan or health insurance coverage to cease to be a grandfathered health plan:

- The elimination of all or substantially all benefits to diagnose or treat a particular condition.
- Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement).
- Any increase in a fixed-amount cost-sharing requirement other than a copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010, exceeds the maximum percentage increase defined as the medical inflation amount plus 15 percentage points.
- Any increase in a fixed-amount copayment, determined as of the effective date of the increase, if the total increase in the copayment measured from March 23, 2010, exceeds the greater of:
 - An amount equal to \$5 increased by medical inflation; or
 - The maximum percentage increase determined by expressing the total increase in the copayment as a percentage.
- If the employer or employee organization decreases its contribution rate based on cost of coverage by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.
- If the employer decreases its contribution rate based on a formula towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

Reg. §2590.712-1251(g) includes the following examples:

- **EXAMPLE:** On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%. The increase in the coinsurance requirement causes the plan to cease to be a grandfathered health plan.
- **EXAMPLE:** Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling. The plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition. The plan is considered to have eliminated substantially all benefits for the treatment of the condition.
- **EXAMPLE:** On March 23, 2010, a grandfathered health plan has a copayment requirement of \$30 per office visit. The plan is subsequently amended to increase the copayment requirement to \$40. Within the 12-month period before the \$40 copayment takes effect, the greatest value of the overall medical care component of the CPI-U (unadjusted) is 475. The increase in the copayment from \$30 to \$40, expressed as a percentage, is 33.33% ($40 - 30 = 10$) \div 30. Medical inflation from March 2010 is 0.2269 ($475 - 387.142 = 87.858$) \div 387.142. The maximum percentage increase permitted is 37.69% (22.69% + 15%). Because 33.33% does not exceed 37.69%, the change in the

copayment requirement time does not cause the plan to cease to be a grandfathered health plan.

- **EXAMPLE:** On March 23, 2010, a self-insured group health plan provides two tiers of coverage — self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage. The decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.
- **EXAMPLE:** On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of \$5000 for self-only coverage and \$12,000 for family coverage. The required employee contribution for the coverage is \$1000 for self-only coverage and \$4000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% $(5000 - 1000)/5000$ for self-only coverage and 67% $(12,000 - 4000)/12,000$ for family coverage. For a subsequent plan year, the COBRA premium is \$6000 for self-only coverage and \$15,000 for family coverage. The employee contributions for that plan year are \$1200 for self only coverage and \$5000 for family coverage. The contribution rate based on cost of coverage is 80% $(6000 - 1200)/6000$ for self-only coverage and 67% $(15,000 - 5000)/15,000$ for family coverage. Because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under IRC § 125.

IRS Guidance Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections.

The Treasury Department issued temporary regulations on June 28, 2010, relating to preexisting condition exclusions, lifetime and annual limits, rescissions and patient protections. These regulations are substantially similar to interim final regulations issued by the Department of Health and Human Services. A group health plan, or a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion for policy years beginning on or after January 1, 2014 (Reg. § 54.9815-2704T(a)). This date is September 23, 2010, for children who are under 19 years of age.

The following examples illustrate the definition of a preexisting condition exclusion.

- **EXAMPLE:** A group health plan provides benefits solely through an insurance policy offered by Issuer P. The plan switches coverage to a policy offered by Issuer N and excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy. The exclusion of benefits for the oral surgery described in the facts is a preexisting condition exclusion.
- **EXAMPLE:** Individual C applies for individual health insurance coverage with Issuer M who denies C's application for coverage because a pre-enrollment physical revealed that C has type 2 diabetes. M's denial of C's application for coverage is a preexisting condition exclusion.

- **EXAMPLE:** Individual F commences employment and enrolls F and F's 16 year-old-child in a group health plan maintained by F's employer with a first day of coverage of October 15, 2010. F's child had a significant break in coverage because of a lapse of more than 63 days without creditable coverage immediately prior to enrolling in the plan. F's child was treated for asthma within the prior six-month period and the plan has a 12-month preexisting condition exclusion for coverage of asthma. The next plan year begins on January 1, 2011. Because the child is under 19 years of age on January 1, 2011, the plan cannot impose a preexisting condition exclusion with respect to the child's asthma.
- **EXAMPLE:** Individual G applies for a policy for family coverage in the individual market for G, G's spouse, and G's 13-year-old child. The issuer denies the application for coverage on March 1, 2011, because G's child has autism. Because the child is under 19 years of age and the denial of coverage was after September 23, 2010, the issuer is prohibited from imposing a preexisting condition exclusion with respect to the child.

A group health plan, or a health insurance issuer offering group or individual health insurance coverage may not establish any lifetime limit on the dollar amount of benefits for any individual unless the benefits are not essential benefits or unless the limits are specifically provided for in the regulations [Reg. § 54.9815-2711T(d)]. The removal of the limit on essential benefits is phased-in for plan years beginning before September 23 for each of the following years:

Year	Limit
2011	\$750,000
2012-13	\$1,250,000
2014	\$2,000,000

In limited cases, a waiver to the higher limits may be granted if it would result in a significant decrease in access to benefits or would significantly increase premiums. The regulations require employers, group health plans, and health insurance issuers providing group health insurance coverage to (Reg. §54.9815-2711T(a)):

- Notify individuals otherwise eligible for coverage who have previously reached a lifetime limit that this limit no longer applies and that the individual has the right to enroll in the health plan;
- Notify individuals 30 days in advance that the plan or issuer intends to rescind coverage; and
- Notify individuals of their rights to choose any primary care provider in the plan's network who is available to accept the individual, to designate a pediatrician in the network for a child, and to receive obstetrical and gynecological services without a referral

The following examples illustrate the rules applicable to the lifetime limit caps:

- **EXAMPLE:** Employer Y maintains a single benefit group health plan with a calendar plan year. The plan has a lifetime limit on the dollar value of all benefits, which Employee B reached at the end of the 2008 plan year. Before January 1, 2011, Y's group health plan

notified B in writing that the lifetime limit on the dollar value of all benefits no longer applies and that B is eligible to enroll in the plan through February 1, 2011, with enrollment retroactive to January 1, 2011. The plan has complied with the notification requirements because B was provided a timely written notice and enrollment opportunity that lasts at least 30 days.

- **EXAMPLE:** Employer Z maintains a single and family benefit group health plan with a plan year beginning October 1. The plan has a lifetime limit on the dollar value of all benefits which Employee D reached at the end of the 2009 plan year because of a claim for benefits for Individual E, who is D's child. D dropped family coverage but remains an employee of Z. No later than October 1, 2010 Z's group health plan must notify D in writing that D has 30 days to enroll in the family coverage plan with enrollment effective not later than October 1, 2010.
- **EXAMPLE:** Employer Q maintains a group health plan with a plan year beginning October 1 which has an annual dollar value limit on all benefits of \$500,000. Q must increase the annual limit to at least \$750,000 for the plan year beginning October 1, 2010, to \$1.25 million for the plan year beginning October 1, 2011, and to at least \$2 million for the plan year beginning October 1, 2012. Beginning on October 1, 2014, Q may not impose a dollar cap on benefits. However, if the cap maintained by Q were \$1 million, the cap may be lowered to \$750,000 for the plan year beginning October 1, 2010. Also, if the cap were a lifetime limit on the dollar value of all benefits of \$1 million, Q may apply an annual cap of \$1 million through 2013.

A group health plan or a health insurance issuer offering group or individual health insurance coverage must not rescind coverage with respect to a covered individual unless the individual performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. The plan must provide at least 30 days advance written notice before coverage may be rescinded regardless of whether the coverage is insured or self-insured or whether the rescission applies to an entire group or only to an individual within the group [Reg. §54.9815-2712T(a)].

The following examples illustrate these rules:

- **EXAMPLE:** Individual A seeks enrollment in an insured group health plan, which permits rescission of coverage with respect to an individual who engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a question regarding A's prior medical history. A inadvertently fails to list that A visited a psychologist on two occasions six years ago. A is later diagnosed with breast cancer and seeks benefits under the plan. The plan cannot rescind A's coverage because of A's failure to disclose the visits to the psychologist since it was not an intentional misrepresentation of a material fact.
- **EXAMPLE:** An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position which means that B is no longer eligible coverage. However, the plan mistakenly continues to provide health coverage and collects premiums and pays claims submitted by B. The plan later discovers that B does not work 30 hours per week and rescinds B's coverage from the date that B changed from full-time to part-time employment. The plan cannot rescind B's coverage

because there was no fraud or intentional misrepresentation of a material fact. However, the plan may cancel coverage for B prospectively.

The plan or issuer must permit each participant, beneficiary, or enrollee to designate any available participating primary care provider. The plan must permit designation of a pediatrician as the primary care provider for children, and if the plan provides coverage for obstetric or gynecological care, it must not require prior authorization for females seeking access to obstetrical or gynecological care. The regulations include model language that can be used to satisfy the requirement that all participants are notified of their rights [Reg. §54.9815-2719AT(a)].

The following examples illustrate these requirements:

- **EXAMPLE:** A group health plan requires individuals covered under a plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual. If the individual has not designated a primary care provider, the plan designates one until one has been designated by the individual. The plan has satisfied the requirements.
- **EXAMPLE:** Participant A has a child with severe shellfish allergies. A takes the child to B for treatment. B wishes to refer the child to an allergist for treatment. A's group health plan's HMO does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network and therefore refuses to authorize the referral. The HMO has not violated the requirements because the exclusion of treatment for food allergies is in accordance with the terms of A's coverage.
- **EXAMPLE:** A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam. The group health plan has violated the requirements because of the plan's prior authorization requirement. If the health care plan only requires B to inform A's designated primary care physician of treatment decisions, the plan would not violate the requirements. Note that if A instead sought gynecological services from C, an out-of-network provider, the group health plan would not violate the requirement for requiring prior authorization because C is not a participating health care provider.

Any cost-sharing requirement expressed as a copayment amount or coinsurance rate with respect to out-of-network emergency services cannot exceed the cost-sharing requirement imposed if the services were provided in-network. The plan may require payment of the excess amount of out-of-network provider charges (Reg. §54.9815-2719AT(b)). A group health plan or health insurance issuer complies with this requirement if it provides benefits with respect to an emergency service in an amount equal to the greatest of:

- The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the

participant or beneficiary. If more than one amount has been negotiated with the in-network providers, the median amount is used.

- The amount for emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services. If the plan generally pays 70% of the usual, customary and reasonable amount for out-of-network services, the total amount not reduced by the 30% coinsurance amount is used.
- The amount paid under Medicare Part A or B for the emergency service before excluding any in-network copayment or coinsurance.

Any cost-sharing requirement other than a copayment or coinsurance requirement may be imposed with respect to emergency services provided out-of-network. A deductible may be imposed only as part of a deductible that generally applies to out-of-network benefits.

The following examples illustrate these requirements:

- **EXAMPLE:** A group health plan imposes a 20% coinsurance requirement on individuals who are furnished emergency services provided whether provided in-network or out-of-network. If a covered individual notifies the plan within two business days after the day the treatment was received, the coinsurance rate is 15%. The notification requirement does not violate the requirement that the plan cover emergency services without the need for any prior authorization.
- **EXAMPLE:** A group health plan imposes a \$60 copayment for emergency services without preauthorization, whether provided in network or out of network. If the emergency services are preauthorized the copayment is waived even if it was later determines the medical condition was not an emergency medical condition. This plan violates the prior authorization requirement restriction. If the plan merely requires that it be notified to have the copayment waived, then the plan would not violate the requirement.
- **EXAMPLE:** An individual covered by the plan receives emergency service from an out-of-network provider who charges \$125. The plan normally reimburses covered individuals 80% for in-network services and 50% for out-of-network services of the reasonable amount charged for medical services. The reasonable amount calculated by the provider based upon charges within a zip-code area is \$116. The median amount is \$115 and the Medicare amount is \$80. The plan is responsible for paying \$92.80, which is the highest amount [\$92.80 (\$116 x 80%), \$92.00 (\$115 x 80%), \$80].
- **EXAMPLE:** The group health plan imposes a \$250 deductible for in-network health care and a \$500 deductible for out-of-network health care. The individual has submitted \$260 of covered claims prior to receiving out-of-network emergency services. The plan is not responsible for paying anything to the out-of-network provider until the \$500 deductible has been met.

In complying with the new law, it's important to understand the time line in which benefit and tax law changes not discussed above take effect.

2011

- Each employee's annual Form W-2 must disclose the value of employer provided health insurance [IRC §6051(a)(14)]. However, this requirement has been deferred to 2012 (IR-

2010-103; Notice 2010-69). The IRS determined that relief from the requirement for 2011 is appropriate to provide employers with additional time to make any necessary changes to their payroll systems or procedures in preparation for compliance with the reporting requirement. The draft Form W-2 for 2011 has been released indicating that the cost of employer-sponsored health coverage will be reported in Box 12, using Code DD. The instructions reiterate that any amount reported with Code DD is *not* taxable.

- Distributions from a Health Savings Account that are not used for qualified medical expenses will be subject to a 20% (formerly 10%) excise tax [IRC §223(f)(4)(A)].
- The cost of over-the-counter medicines cannot be reimbursed from a flexible spending arrangement (FSA), health reimbursement account (HRA) or a health savings account (HSA) unless prescribed by a doctor.
- Employers with 100 or fewer employees may offer a “simple cafeteria plan” [IRC §125(j)]. These plans will have a safe harbor from the nondiscrimination requirements of a regular cafeteria plan and may offer qualified benefits including group term life insurance, a self-insured medical expense reimbursement plan, and a dependent care assistance program.

2012

- Businesses that pay any amount greater than \$600 during the year to a non-tax-exempt corporate provider of property and services must file an information report (Form 1099) [IRC §6041(h)].

2013

- An additional 0.9% hospital insurance tax applies to wages from employment and self-employment income in excess of \$250,000 for joint returns and \$200,000 for single/head of household filers [IRC §6051(a)(14)].
- For individuals, estates and trusts, an unearned income Medicare contribution tax of 3.8% applies on income equal to the lesser of net investment income or modified adjusted gross income in excess of \$250,000 for joint return filers or \$200,000 for single/head of household filers.
- Unreimbursed medical expenses are subject to a 10% of AGI floor for taxpayers under the age of 65 [IRC §213(a)]. (Applies to taxpayers 65 or over in 2017.)
- The maximum contribution to a medical expense reimbursement plan cannot exceed \$2,500 per year.

2014

- Premium rates based upon age cannot be greater than 3:1.
- A new refundable tax credit (the premium assistance credit) will be offered to low-income taxpayers who enroll in a qualified health plan through a state-established American Health Benefit Exchange. Individuals not carrying health insurance will be subject to a penalty based on the greater of a flat dollar amount of \$95 or 1% percent of income. (Note: These amounts are scheduled to increase to \$325 or 2% of income in 2015 and \$695 or 2.5% of income in 2016.)
 - Example: Individual D has income of \$20,000 and did not enroll in a health benefit exchange. For 2014, D must pay a penalty of \$200 (1% of income). For 2015 the penalty will be \$400 (2% of income), and for 2016 the penalty will be \$695 since this amount is greater than \$500 (2.5% of income).

- Example: Same as example 1 only Individual D has a non-income earning spouse. For 2014, D must pay a penalty of \$200 (1% of income) and the spouse would pay a penalty of \$95. For 2015 the penalty will be \$400 (2% of income) for D and \$325 for the spouse, and for 2016 the penalty will be \$1,390 (\$695 each). (Query: What would the result be if D lives in a community property state?)

2018

- 40% excise tax on high-cost health plans where coverage is in excess of \$72,500 (family coverage) and \$10,200 (single coverage). The dollar thresholds will be indexed for inflation and higher costs associated with age or gender demographics or with employees in high-risk professions may have higher limits.

Conclusion

Employers offering health insurance coverage may want to consider the costs and benefits of maintaining their current plans by complying with the restrictions on grandfathered plans. In some geographic areas, the plan costs and premiums may be less for non-grandfathered plans. The IT departments of employers will face new demands from the W-2 and Form 1099 reporting requirements. Beginning in 2014 employers must decide whether to offer coverage that meets the minimum standards or pay the excise penalty. In some cases it may be more beneficial to employers to offer vouchers to their employees to purchase health insurance through the state exchanges. Small firms will want to decide whether to continue offering health insurance once the HI tax credit expires.

Upper-income individuals must begin to plan for the tax increases on wage (.9%) and unearned (3.8%) income that take effect in 2013. In 2014, all individuals will face a federal mandate to purchase health insurance if they are self-employed or their employer does not offer health insurance. This controversial requirement is currently being challenged in the U.S. District Courts as exceeding the authority of the Commerce Clause of the U.S. Constitution. To date, the Eastern District of Virginia Court has ruled in favor of the plaintiff. A decision in the Northern District of Florida Court is expected in early 2011. Both sides will likely appeal the decisions, and it will not be until sometime in 2012 when the suits make their way to the U.S. Supreme Court. Should the plaintiffs' suits ultimately succeed, one of the key components of financing the cost of changes mandated by the PPACA will be eliminated, requiring the Congress to either find new sources of paying for expanded health care coverage or to scale back the mandate that all individuals, irrespective of pre-existing conditions, be offered health insurance coverage.

Employers and individuals must consider the sweeping nature of the changes mandated by the PPACA and begin to rethink the way they plan to pay for health care.