Patient Protection and Affordable Care Act:

Timeline of Important Dates for Employers

November 15, 2011

C.M. SMITH AGENCY, INC.

Proskauer

Benefit Advisors Network

Introduction:

The Timeline of Important Dates for Employers is intended to briefly summarize certain provisions of the Patient Protection and Affordable Care Act and should by no means be considered as an exhaustive list of all of the provisions. This document was written by our Compliance Director, Peter J. Marathas, Jr., Esq., with the law firm of Proskauer Rose under the direction of the Benefit Advisors Network Compliance Committee. This document was last modified November 15, 2011.

Immediate: Grandfathered Health Plans	• Individual policies and group health plans in effect on March 23, 2010 are "grandfathered" (i.e., not subject to many of health care reform's new rules) • Insured collectively-bargained multi-employer and single employer plans in effect on March 23, 2010 do not need to determine whether there has been a loss of grandfathered status until the date on which the last collective bargaining agreement relating to the coverage terminates. At that time, changes made since March 23, 2010, are evaluated to determine whether there will be a loss of grandfathered status. • A grandfathered plan does not lose grandfathered status if new employees are added or if dependents of current participants are added/deleted

Immediate: Taxable Years Beginning On or After January 1, 2010	**Small Employer Tax Credits**
	• Available to employers with:
	    • less than 25 employees; and
	    • Average annual wages < $50,000
	• Maximum credit available for:
	    • Employers with ≤ 10 employees
	    • Average annual wages of < $25,000
	• Average wage threshold for determining the phase-out credits will be adjusted for inflation after 2013
	• Maximum credit equal to 35% of premiums paid by the employer is available for each year during the period 2010-2013
	• Maximum credit equal to 50% of premiums paid by the employer is available for 2 years only beginning in the first year that an employer offers health coverage to its employees through an Exchange, if employer contributes at least 50% of total premium cost
	• Credit would phase out entirely for employers with:
	    • 25 or more employees; or
	    • Average annual salaries equal or exceed $50,000
	• Certain individuals are not counted as "employees," either for claiming the credit or determined headcount:
	    • Defined "seasonal workers"
	    • Self-employed individuals or their family members
	    • 2% shareholders of an S corporation (as defined by section 1372(b)) or their family members
	    • 5% owners (as defined by section 416(i)(1)(B)(I)of a small business or their family members
	• Leased employees ARE counted
	• Employers receiving credits will be denied any deduction for health insurance costs equal to the credit amount

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<table>
<tr><td>Immediate
Applies to Taxable Years Beginning After December 31, 2010</td><td>Elimination of employer deductibility of subsidy under Medicare Part D
• FAS 109 requires employers to take charge against current earnings to:
    • Reflect the higher anticipated tax costs; and
    • Higher FAS 106 liability
• ASC 740 states that expense or benefit related to adjusting deferred tax liabilities and assets:
    • Must be recognized in income from continuing operations for the period that includes the enactment day
• Expense from this change will be recognized in the first quarter of 2010, even though change in law may not be effective until later years</td></tr>
<tr><td>June 23, 2010</td><td>• Coverage for individual market consumers with pre-existing conditions (high-risk pool)
• Can utilize existing state high-risk pools
• Will end on January 1, 2014 once:
    • Exchanges become operational; and
    • Pre-existing condition and guaranteed issue provision take effect
• Employers prohibited from putting individuals into the high-risk pool with associated fines
• Create a temporary reinsurance program for employers providing retiree benefits for retirees age 55 and older who are not eligible for Medicare
    • Pays up to 80% of retiree health care costs between $15,000 - $90,000
    • Ends on January 1, 2014 and financed by a $5 billion appropriation
    • CMS announced that it will no longer be accepting applications for the program after May 5, 2011, consistent with PPACA's provisions regarding the availability of funding
    • Reinsurance payments must be used to lower the costs of the health plan and are excluded from employer's gross income</td></tr>
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First Plan Year Beginning On or After September 23, 2010	Coverage mandates for employer plans:
	• Cover dependent children to age 26
	    • Through 2013, grandfathered plans only need to cover dependent children who are not eligible for coverage under another employer's plan
	• Eliminates lifetime caps for "essential health benefits"
	• Modifies and restricts annual limits on "essential health benefits"
	• Emergency services covered without prior authorization and at in-network level regardless of provider*
	• Allows enrollees to designate any in-network doctor as their PCP (including OB/GYN and pediatrician)*
	• Eliminates the rescission right absent fraud or intentional misrepresentation
	• Requires coverage for certain preventive services without cost sharing*
	    • Evidence-based items or services with a rating "A" or "B" in the current USPSTF recommendations (except the 11/09 mammogram recommendation is disregarded)
	    • Immunizations recommended by the ACIP of the CDC
	    • For infants, children and adolescents, evidence-informed preventive care and screenings identified in HRSA guidelines
	    • For women, additional preventive care and screenings identified in to-be-issued HRSA guidelines
	• Imposes prohibitions on benefit discrimination for fully-insured plans: must comply with IRC § 105(h) rules that prohibit discrimination in favor of highly compensated employees (delayed until further guidance is issued)*
	• Eliminates pre-existing condition exclusions for participants under age 19
	• Requires plans to have claims and appeals process (currently exists under ERISA) and external review process*
	* Does not apply to grandfathered plans

October 1, 2010	• Creates grants for small businesses to provide workplace wellness programs
	    • Appropriates $200 million in funding from fiscal years 2011-2015
	    • To date, no application process exists for these grants.

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<td>Taxable Years Beginning After December 31, 2010</td>
<td>Cost of OTC medications (other than insulin) that do not have a doctor's prescription may no longer be reimbursed under an:

FSA
HRA
HSA
Archer MSA

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<td>January 1, 2011</td>
<td>

Provide rebate to policyholders if an insurer's medical loss ratio is not at least 85% (80% for individual and small group market)
Increases to 20% the penalty tax on distribution from an HSA or Archer MSA that are not used to pay qualified medical expenses (current penalty tax is 10% for HSAs and 15% for Archer MSAs)
Employers with ≤ 100 employees will be allowed to adopt new "simple cafeteria plans"

Must satisfy minimum participation and contribution requirements
Plans treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan and underlying benefits

CLASS Act – creates a new public long-term care program and permits participating employers to auto-enroll employees (unless employee opts out) and collect payroll deductions (not effective until implementing regulations are issued)
In October 2011, HHS Secretary Sebelius released a recommendation to halt implementation of the CLASS Act due to design and financial problems

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<td>January 1, 2012 for W-2s produced for calendar year 2012 in January 2013</td>
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Requires reporting on W-2s of the aggregate cost of employer-sponsored health benefits

If employee is covered under multiple plans (e.g., medical, EAP), employer must disclose the aggregate value of all plans
Includes any portion paid by employee
Excludes:

Stand-alone dental and vision plans
Health Reimbursement Arrangements
All contributions to HSAs and Archer MSAs
Salary reduction contributions to FSAs

Effective for payments made after 2011, persons engaged in a trade or business (including non-exempt corporations) must report on Form 1099 all payments in excess of $600 made to any payee (including non-exempt corporations) NOTE: This provision has been repealed.
Expands payments subject to reporting to include the amount of gross proceeds paid in consideration for property or services to non-exempt corporations

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March 23, 2012	Health plans (insured and self-funded, including grandfathered) must begin providing new enrollees and re-enrollees with a summary of benefits and coverage explanation
	• Must provide a summary of benefits and a coverage explanation to:
	  • All applicants at the time of application
	  • To all enrollees prior to the time of enrollment or re-enrollment
	  • All policyholders or certificate holders at the time of issuance of the policy/certificate
	• Must include specific information determined by the Secretary of DHHS in consultation with the National Association of Insurance Commissioners
	• Must notify all of the above if any material modifications in coverage are made
	  • Notice must be provided at least 60 days prior to the effective date of the modification (except for notifications made in connection with the plan's renewal)
	• If the plan and the insurance carrier fail to provide summary of benefits and coverage explanation or notice of material modification, plan can be fined up to $1,000 for each failure
	• These notification requirements are in addition to ERISA-required summary plan description

Taxable Years Beginning On or After January 1, 2013	• Increase Medicare payroll tax by 0.9% (no indexing of inflation, for a total of 2.35%) on wages in excess of:
	  • $200,000 – single filers
	  • $250,000 – married filing jointly
	  • Employers must withhold on wages paid to any employee in excess of $200,000, regardless of the employee's filing status or spouse's income
	• Impose a new Medicare tax on individuals equal to 3.8% (no indexing for inflation) on the lesser of (i) net investment income (including interest, dividends, royalties, rents and passive income) or (ii) the excess of modified gross income over the threshold amount ($250,000 for married filing jointly; $200,000 for single filers)
	• Limit the amount of salary reduction contributions to a health FSA offered through a cafeteria plan to $2,500 (subject to indexing)
	• Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments

March 1, 2013	Give notice to existing employees and all new employees on their hire date regarding:
	  • Existence of Exchanges
	  • Availability of subsidies if employee purchases coverage through the Exchange (if plan's actuarial value is less than 60% and premiums exceed 9.5% of W-2 wages (provided that all full-time employees are eligible to participate))
	  • Loss of employer contribution toward the cost of coverage if employee purchases coverage through the Exchange

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January 1, 2014	• Requires U.S. citizens to have "minimum essential coverage"
	    • Imposes a tax for noncompliance of the greater of $695/person (up to $2,085 for family) or 2.5 % of household income per year
	    • Tax implemented on a sliding scale commencing in 2014 (exceptions apply); rates noted above apply beginning in 2016
	• Employers with 50 or more employees that <u>do not</u> provide health coverage would be assessed 1/12th of $2,000 per month for each full-time employee in its workforce
	    • Tax applies only if at least 1 full-time employee receives coverage through the Exchange and that employee receives a subsidy for that coverage
	    • First 30 employees are disregarded, so an employer with 51 employees that does not offer coverage would pay each month: 1/12th of $2,000 ($166.67) x 21
	• Employers that <u>do</u> provide coverage, but the coverage is deemed <u>not affordable</u> to employees would be assessed $250 per month ($3,000 per year) for each full-time employee who obtains coverage through the Exchange and who receives a subsidy
	    • Tax is capped at the amount that would apply if employer did not provide coverage – see above
	    • Additional insurance market reforms:
	        • Guaranteed issue
	        • Rating restrictions (see below)
	        • Essential level of plan benefits
	    • Additional mandates for employer plans (including grandfathered plans):
	        • Elimination of all pre-existing condition exclusions
	        • Elimination of annual limits for essential health benefits
	        • Elimination of coverage waiting periods in excess of 90 days

January 1, 2014	• Individuals meeting income guidelines and who do not have employer-based coverage are eligible for premium credits and cost sharing subsidies with respect to Exchange-based coverage
	• Requires employers with > 200 full-time employees that offer one or more health plans to automatically enroll new full-time employees into one of its plans (employees can opt out; notice must be provided). NOTE: the effective date of this provision is unclear.
	• Health insurance issuers providing individual or small group policies (covering ≤ 100 individuals) must abide by strict community rating rules with premium variations allowed only for:
	    • Age (3:1);
	    • Tobacco use (1.5:1);
	    • Whether single or family coverage is provided; and
	    • Geographic rating area (regions to be defined by the states).
	    • Experience rating would be prohibited
	    • The rating restrictions also apply to insurers (but not self-funded group health plans) that offer large group policies through the Exchange
	• Coverage in the Exchange will be offered on a pre-tax basis only if it is purchased through an employer's cafeteria plan (there are some restrictions)
	• Employer-sponsored plans do not have to provide essential benefits coverage (but must provide affordable minimum essential coverage or pay penalties – see above)

January 1, 2014	• [State will offer premium assistance and Medicaid wraparound benefits to Medicaid beneficiaries who are offered employer-sponsored coverage if cost-effective to do so] [Note: we are unfamiliar with this provision and cannot provide support for it in the law.]
	• Employers must report annually on health coverage information to both covered individuals and the IRS
	• Codifies and improves upon the HIPAA wellness program rules:
	    • Increases the value of workplace wellness incentives from 20% to 30% of premiums
	    • Agency discretion to increase the cap on incentives to 50% of premiums

January 1, 2018	**Cadillac Tax** • Imposes a nondeductible excise tax of 40% for any plan valued above $10,200 for single coverage and $27,500 for family coverage • Thresholds are indexed and are increased for retirees and employees in high-risk professions • Tax imposed on insurers of insured plans and the employer or administrator of self-insured plans • Allow plans to take into account age, gender and certain other factors that impact premium costs • 40% tax would apply to the amount of the plan value in excess of the threshold • Stand-alone vision and dental plans are not counted as taxable benefits for purposes of the excise tax

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