

If you have any questions about health care reform, please contact [Robert W. Patterson](mailto:rpatterson@jaeckle.com) at 716.843.3910 or [rpatterson@jaeckle.com](mailto:rpatterson@jaeckle.com), or [Michele O. Heffernan](mailto:mheffernan@jaeckle.com) at 716.843.3850 or [mheffernan@jaeckle.com](mailto:mheffernan@jaeckle.com).

### Important Dates For Employers Under Health Care Reform - Updated 2011

Except where otherwise indicated, each changes is effective for plan years beginning on or after the stated date.

## 2010

Health Care Reform Requirement	Effective Date	Employer Action
<p><b>Small Business Tax Credits:</b> Beginning with the 2010 tax year, businesses with fewer than 25 employees and average wages of \$50,000 or less could qualify for a tax credit of up to 35 percent (50 percent beginning in 2014) of the cost of their group health plan premiums. See our Alert at: <a href="http://jaeckle.com/Small_Employer_Tax_Credit.pdf">http://jaeckle.com/Small_Employer_Tax_Credit.pdf</a>.</p>	January 1, 2010	<p>Determine if employer is qualified for full or partial tax credit.</p> <p>Claim credit on IRS Form 8941.</p> <p><b>Note:</b> The IRS has issued guidance (including Notice 2010-82) and Instructions for Form 8941, which is used by eligible small employers to claim the tax credit.</p>
<p><b>Grandfathered Health Plans:</b> A group health plan or health insurance coverage in effect on March 23, 2010 is grandfathered with respect to some (though not all) requirements under the Affordable Care Act. Certain plan changes will cause the loss of grandfathered status. See our Alert at <a href="http://jaeckle.com/Grandfathered_Plans.pdf">http://jaeckle.com/Grandfathered_Plans.pdf</a>.</p>	March 23, 2010	<p>Determine if the employer's health plan is grandfathered.</p> <p>Be aware of rules under which plan changes can cause the loss of grandfathered status.</p> <p><b>Note:</b> Grandfathered plans must include a statement that the plan is grandfathered in all benefit summaries provided to participants and beneficiaries.</p> <p><b>Note:</b> Insured plans can now change insurers without losing grandfathered status.</p> <p><b>Note:</b> The DOL has published additional guidance on various issues relating to grandfathered status.</p>

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Health Care Reform Requirement	Effective Date	Employer Action
<p><b>Retiree Health Plans:</b> A temporary re-insurance program for employer group health plans that provide coverage for early retirees (ages 55-64) goes into effect. Under the program, employers that sponsor qualifying retiree plans could receive tax-free subsidies from the federal government to help offset the cost of providing retiree coverage. See our Alerts at: <a href="http://jaeckle.com/Retiree_Reinsurance_Application.pdf">http://jaeckle.com/Retiree_Reinsurance_Application.pdf</a> and <a href="http://jaeckle.com/Retiree_Reinsurance_Program.pdf">http://jaeckle.com/Retiree_Reinsurance_Program.pdf</a>.</p>	<p>June 1, 2010 (For grandfathered and non-grandfathered plans)</p>	<p><b>Note:</b> This program was closed effective May 5, 2011. Under the Affordable Care Act, the program was to be continued only as long the program's limited funding was available.</p>
<p><b>Dependent Coverage to Age 26:</b> Health plans and health insurance policies must permit a dependent child to continue coverage under their parent's plan until the child turns 26 years of age. See our Alert at: <a href="http://jaeckle.com/Dependent_Coverage_to_Age_26.pdf">http://jaeckle.com/Dependent_Coverage_to_Age_26.pdf</a>.</p>	<p>September 23, 2010 (For grandfathered<sup>1</sup> and non-grandfathered plans)</p>	<p>Determine if health plan complies with new dependent coverage requirements and amend plan or policy if necessary. <b>Note:</b> The definition of "children" who are covered by the mandate has been clarified with reference to the Internal Revenue Code definition.</p>
<p><b>Lifetime Limits:</b> A group health plan and a health insurance issuer cannot impose lifetime limits on the dollar value of benefits. <b>Annual Limits:</b> A group health plan can only impose annual limits on benefits that are "essential health benefits" and only in accordance with HHS guidance. Limits on benefits that aren't "essential health benefit" may be permissible.</p>	<p>September 23, 2010 (For grandfathered and non-grandfathered plans)</p>	<p>Determine if health plan complies with new restrictions on annual and lifetime limits and amend plan or policy if necessary. <b>Note:</b> HRAs were exempted from the prohibition on annual limits through 2014, and no longer have to apply for a waiver with respect to this requirement.</p>

<sup>1</sup> For grandfathered plans, until January 1, 2014 such continued coverage is required only if the adult child is not eligible for coverage under an employer-sponsored health plan, other than a plan of either parent.

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Health Care Reform Requirement	Effective Date	Employer Action
<p><u>Rescissions</u>: A group health plan and a health insurance issuer cannot rescind coverage once an enrollee is covered, except where the covered individual commits an act of fraud or intentional misrepresentation.</p>	<p>September 23, 2010  (For grandfathered and non-grandfathered plans)</p>	<p>Determine if health plan complies with new restrictions on rescissions and amend plan or policy if necessary.  <u>Note</u>: Regulations and other agency guidance have clarified that only retroactive terminations of coverage for reasons other than non-payment of premiums are prohibited, and that certain retroactive coverage terminations (e.g. of a divorced spouse) are not prohibited.</p>
<p><u>Children's Pre-Existing Conditions</u>: A group health plan cannot deny coverage to a child under age 19 on the basis of a pre-existing medical condition.</p>	<p>September 23, 2010  (For grandfathered and non-grandfathered plans)</p>	<p>Determine if health plan complies with new restrictions on pre-existing condition exclusions and amend plan or policy if necessary.  <u>Note</u>: Temporary high risk pool for eligible individuals with pre-existing conditions has been established, and is administered in New York by GHI (New York Bridge Plan).</p>
<p><u>Appeals Process and External Review</u>: Appeals process (including (includes internal appeals and external review) required to allow for appeals of coverage determinations and claims.</p>	<p>September 23, 2010  For non-grandfathered plans)</p>	<p><u>Note</u>: "Enforcement grace period" applied to some new requirements. New internal appeals rules are fully effective for plan years beginning on or after January 1, 2012.</p>

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Health Care Reform Requirement	Effective Date	Employer Action
<p><u>Misc. Requirements for Non-grandfathered Plans:</u></p> <ul style="list-style-type: none"> <li>Plans must cover emergency services without prior authorization and in-network.</li> <li>Plans must allow designation of OB/GYN and Pediatrician as Primary Care Provider.</li> <li>Plans must cover preventive care without cost sharing</li> </ul>	<p>September 23, 2010 (For non-grandfathered plans only)</p>	<p>If plan is not grandfathered, or loses grandfathered status, determine if health plan complies with new requirements and amend plan or policy if necessary.</p>

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## 2011

Health Care Reform Requirement	Effective Date	Employer Action
<u>Over the Counter Medicines:</u> The cost of over-the-counter drugs not prescribed by a physician may no longer be reimbursed through a health flexible spending account (FSA), a health reimbursement arrangement (HRA) or a health savings account (HSA).	January 1, 2011 (For grandfathered and non-grandfathered plans)	If employer sponsors HRA, FSA or HSA, determine if plan requires prescription for reimbursable drug costs and if it does not, amend plan as necessary.  <u>Note:</u> Retroactive amendments to cafeteria plans were permitted until June 30, 2011.
<u>Non-Qualified HSA and MSA Distributions:</u> The excise tax on distributions from health savings accounts (HSAs) and Archer medical savings accounts (MSAs) not used to pay qualifying medical expenses is increased to 20 percent (from 10 percent).	January 1, 2011 (For grandfathered and non-grandfathered plans)	Consider notifying employees who participate in HSA or MSA of increased tax.

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## 2012

Health Care Reform Requirement	Effective Date	Employer Action
<u>Appeals Process and External Review</u> : Appeals process (including (includes internal appeals and external review) required to allow for appeals of coverage determinations and claims.	January 1, 2012	Some requirements were effective September 23, 2010 (see last item under 2010 requirements). The new rules are fully effective January 1, 2012.
<u>Reporting the Cost of Employer Coverage</u> : Beginning with the 2012 tax year, every employer must report the cost of employer-sponsored health coverage on employees' W-2s. (So the first reports will likely be due in January 2013.)	January 1, 2012 <sup>2</sup> (For grandfathered and non-grandfathered plans)	Work with payroll department or vendor to ensure compliance with new reporting requirement.  <u>Note</u> : The IRS has issued guidance on how to compute the aggregate cost and what coverages are counted.
<u>Coverage Summaries</u> : Insurers and sponsors of self-insured plans must provide summaries of benefits and coverage to all participants, based on a uniform format to be developed by HHS.	March 23, 2012 (For grandfathered and non-grandfathered plans)	Sponsors of insured plans should work with the insurer to make sure the required coverage summary is provided. Sponsors of self-insured plans must themselves ensure compliance.  <u>Note</u> : HHS has issued model summaries and templates.
<u>Prior Notice of Plan Changes</u> : Group health plans must provide 60 days advance notice of any material change to the plan or insurance coverage.	March 23, 2012 (For grandfathered and non-grandfathered plans)	If covered by this rule, provide 60 days advance notice of any material plan amendment.  <u>Note</u> : Under agency guidance, only certain mid-year changes require prior notice.

<sup>2</sup> The Affordable Care Act states that the W-2 reporting requirement is effective beginning January 1, 2011; however, the IRS announced that reporting will not be required earlier than 2012.

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## 2013

Health Care Reform Requirement	Effective Date	Employer Action
<u>FSA</u> s: Contributions to health FSAs are limited to \$2,500 per year beginning with the 2013 tax year. The limit will be adjusted for inflation in subsequent years.	January 1, 2013 (For grandfathered and non-grandfathered plans)	Amend health FSA plan document as necessary and administer plan in accordance with new limit.
<u>FICA Tax Increase</u> : The hospital insurance portion of FICA tax will increase by 0.9 percentage points on wages over \$200,000 for an individual, or \$250,000 for married couples filing jointly. In addition, the tax to include a 3.8 percent tax on net investment income in the case of taxpayers earning over \$200,000 (\$250,000 for joint returns).	January 1, 2013	Consider impact on various employee benefit plans, including deferred compensation plans.
<u>Notification to Employees</u> : Employers must provide written notice to all employees about health insurance Exchanges, eligibility for premium tax credits and the effect of purchasing coverage under an Exchange plan.	March 1, 2013	Provide required notices on a timely basis.

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## 2014

Health Care Reform Requirement	Effective Date	Employer Action
<u>Health Insurance Exchanges</u> : Health insurance exchanges are to be established, which (among many other requirements) will offer health plans in standardized coverage levels (bronze, silver, gold and platinum, plus a catastrophic coverage option for individuals under age 30).	January 1, 2014	
<u>Premium Tax Credits</u> : Premium tax credits will be available to help low income individuals (household income above Medicaid level but below 400% of Federal poverty level <sup>3</sup> (FPL) purchase health insurance.	January 1, 2014	
<u>Individual Mandate</u> Most U.S. citizens who do not have acceptable health coverage will be subject to a penalty tax. The tax will be phased in during 2014 and 2015, and when fully effective as of in 2016, the tax will be as high as \$695 per individual and \$2,085 for a family.	January 1, 2014	
<u>Employer Mandate/ "Pay or Play"</u> : Any employer with 50 or more full-time employees that does not provide health coverage for full-time employees, or who provides coverage that is inadequate or not affordable for lower paid employees, could be subject to a penalty tax. If the employer does not offer any coverage and at least one employee receives a premium tax credit (see above), the penalty is \$2,000 for each full-time employee over the first 30. If the employer offers coverage but it is unaffordable or its value is less than 60% of expected plan costs, and at least one employee receives a premium tax credit, the	January 1, 2014  (For grandfathered and non-grandfathered plans)	Before 2014, determine effect of mandate, including (1) whether the employer's plan would meet requirements as to actuarial value and affordability, (2) what employees could be eligible for Exchange credit, (3) what the total mandate penalty (if any) might be, and (4) what plan design changes would be required to avoid the penalty.

<sup>3</sup> Currently, the federal poverty level is \$10,830 for one person and \$22,050 for a family of four. 400% of the FPL would be \$43,320.

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Health Care Reform Requirement	Effective Date	Employer Action
penalty is \$3,000 for each employee who receives a premium tax credit to purchase coverage on an Exchange.		
<u>Automatic Enrollment:</u> Employers with more than 200 employees who offer health coverage must automatically enroll new full-time employees in one of their plans. Employees can opt out of the employer plan.	When DOL regulations are issued; these are expected sometime in 2014.	When this requirement become effective, establish automatic enrollment and opt-out mechanisms.
<u>Discrimination Rules for Insured Health Plans.</u> Insured group health plans cannot discriminate in favor of highly compensated individuals.	Some time after regulations are issued - probably not until 2014.	
<u>Essential Health Benefits:</u> All non-grandfathered plans in the individual and small group (employers with 100 or fewer employees) insurance markets must include all “essential health benefits”, and no annual or lifetime limits can apply to such benefits. The exact scope of this term will be defined by HHS, but the Act provides that such benefits will include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services.	January 1, 2014 (For non-grandfathered plans in the individual and small group markets)	For employers subject to the small group insurance market rules, ensure that plan provides essential health benefits.
<u>Waiting Periods:</u> A group health plan and a health insurance issuer cannot impose a waiting period of longer than 90 days.	January 1, 2014 (For grandfathered and non-grandfathered plans)	Amend health plan if necessary to comply with new limit on waiting periods.

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<u>Pre-existing Condition Exclusions</u> : All plans are prohibited from imposing pre-existing condition exclusions with respect to new coverages.	January 1, 2014 (For grandfathered and non-grandfathered plans)	Determine if health plan complies with restrictions on pre-existing condition exclusions and amend plan or policy if necessary.
<u>Cost Sharing Limits</u> : A group health plan in the small group market may not require participant deductibles and overall cost sharing beyond the limits prescribed under the Act and the Internal Revenue Code (\$2,000 single, \$4,000 family, both figures to be indexed for inflation after 2014).	January 1, 2014 (For non-grandfathered plans)	Determine if health plan complies with restrictions on deductibles and cost sharing and amend plan if necessary.
<u>Wellness Programs</u> : The maximum reward for participating in a qualifying wellness program is increased from 20% to 30% of the employee's premium.	January 1, 2014	Consider using increased reward for participation in a wellness program.

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## 2018

<p><b>Excise Tax on High Cost Plans:</b> An excise tax on high cost health plans - the so called “Cadillac plan tax” - takes effect. The tax will be equal to 40% of the premium cost in excess of defined threshold amounts, and will be payable by the insurer with respect to an insured plan, or by the employer sponsor of a self-insured plan.</p>	<p>January 1, 2018</p>	<p>When this provision is effective, employers must determine whether their plans could be subject to the tax and consider whether to amend the plan of benefits accordingly.</p>
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