
Health Care Reform: What You Need to Know *Right Now*



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Health Care Reform: What You Need to Know *Right Now*

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The sweeping health care reform law will affect the delivery and administration of group health plans for every employer and employee in the country. This report summarizes the provisions of the new law most pertinent to employers and the health plans they sponsor *in the near term*. It should be noted that substantial guidance will be needed from the U.S. Departments of Labor (DOL), Treasury and Health and Human Services (HHS) to fully implement health care reform. As such, certain issues under the new law simply cannot be answered at this time. Accordingly, it will be crucial for employers and their service providers to stay on top of, not just their new compliance responsibilities, but upcoming federal guidance under reform.



Background

In March 2010, Congress enacted and President Obama signed into law major health care reform legislation — the Patient Protection and Affordable Care Act (PPACA, Pub. L. 111-148), as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (HCERA, Pub. L. 111-152).

The new federal law includes hundreds of new requirements packed into hundreds of pages of new rules that affect the delivery and administration of employer-provided group health plans. The rules generally fall into one of four general categories, namely:

- 1) qualifying coverage mandates (aka “insurance reform measures”);
- 2) employer mandates (aka “play-or-pay provisions”);
- 3) revenue generating rules (taxes, fees, etc.); and
- 4) reporting requirements.

The effective date for each rule within these general categories varies. Additionally, certain of these rules do not apply or apply differently for group health plans that are “grandfathered” under the new law.

Grandfathering

The grandfathering relief exempts certain plans in effect on the enactment date of health care reform (that is, March 23, 2010) from applying many of the new reform rules. Nevertheless, some reform provisions do apply to grandfathered plans. Therefore, it is important not only to understand what makes a plan “grandfathered,” but also to distinguish between those provisions that are or are not applicable to grandfathered plans.

Generally, a “grandfathered health plan” is any group health plan or individual insurance coverage that was in effect on March 23, 2010, the date of the new law’s enactment. Even if an individual may reenroll in a grandfathered health plan or new employees (and their families) may be added to the plan after March 23, 2010, that does not destroy the plan’s grandfathered status. Likewise, an individual who was covered by a grandfathered health plan may add his or her dependents to the plan after March 23, 2010, without negating the plan’s grandfathered status as long as the plan allowed for dependent/family coverage on March 23, 2010. At this point, it is not clear whether any significant modifications of coverage under a plan design will alter a plan’s grandfathered status.

Separately, collectively bargained plans in effect on March 23, 2010, appear to be able to benefit from two grandfathering rules:

- 1) The first rule provides a general delayed effective date whereby collectively bargained health plans do not have to implement any reform requirement until after the last collective bargaining agreement (CBA) expires (CBAs that were ratified before March 23, 2010) relating to the coverage under such plan (the “CBA effective date”).¹
- 2) The second rule applies at the time of that CBA effective date and appears to then apply the general grandfathering rules otherwise applicable to non-bargained plans as discussed earlier.

However, at this early stage following the new law’s passage, a great deal of uncertainty remains about the scope and application of the CBA effective date. The following identifies and provides current views on some of those uncertainties:

- *Retention of grandfathered status.* A fair degree of ambiguity exists on whether a collectively bargained health plan will retain its grandfathered status upon reaching its CBA effective date. Some commentators have expressed the view that a collectively bargained health plan could lose its grandfathered status upon reaching its CBA effective date. This would mean that the plan will have to comply with all health care reform mandates at that point and lose any ability to be treated as a grandfathered plan. Other commentators believe that this interpretation will ultimately be rejected and, instead, the relevant provisions will be interpreted to mean that grandfathered collectively bargained plans retain that status beyond the CBA effective date — assuming they continue to satisfy the requirements for maintaining general grandfathered status. Of course, any new plans that are established through collective bargaining would not likely satisfy the grandfathering requirements.
- *Application to self-insured plans.* In a technical reading of the law’s delayed effective date for collectively bargained plans, an argument could be made that it only applies to insured plans and not self-insured plans. Although this technical point exists the way the law is drafted, it is anticipated that a technical correction or some other type of guidance may be issued to clarify that the delayed effective date for collectively bargained plans applies to self-insured as well as insured plans.

¹It is noteworthy that the CBA effective date is the termination date of the last CBA and not the beginning of the following plan year. Thus, a plan that foregoes implementation of the new health reform requirements until required by law may have to implement changes in the middle of a plan year.

- *Impact of covering employees not subject to collective bargaining.* What does it mean to say that the delayed effective date applies to plans “maintained” pursuant to one or more CBAs? That is, it is not clear what the impact will be on the delayed effective date if a collectively bargained health plan covers non-bargained employees as well. Reasonable arguments can be advanced to support applying the delayed effective date at the plan level — regardless of whether the plan covers some participants who were not covered by CBAs. The exact limits of this rule are expected to be developed. In other benefits-related legislation, plans have been considered to be collectively bargained if at least 25 percent of plan participants are members of collective bargaining units for which benefit levels under the plan are specified under a CBA.

These questions are likely to remain unanswered until regulatory guidance is issued by government agencies. At this point, when plan decisions need to be made, the new law does not provide any relief for making “good faith” or “reasonable” efforts to comply when interpreting ambiguous issues for which no definitive guidance exists.

In considering grandfathering and delayed effective date issues, it is worth noting that collectively bargained health plans will not lose the delayed effective date protection merely because they are amended for only some of the new health care reform rules before they are otherwise required to do so. As noted earlier, collectively bargained health plans may wish to do so in any case to avoid the application of certain provisions in the middle of a plan year. In any event, it is important for all collectively bargained health plans to confirm as soon as practicable when the applicable longest running CBA (ratified before March 23, 2010) will terminate so that the appropriate parties can address and plan for the various mandated changes.

Qualifying Coverage Mandates

The new law contains various qualifying coverage mandates that are meant to increase health coverage access as well as improve the level of coverage provided under group health plans. In reviewing these mandates, it is important to focus on the specific effective dates for each. Some are effective with the first plan year that begins on or after Sept. 23, 2010 (for example, six months after the enactment of health care reform). That means Jan. 1, 2011, for calendar year plan years. Other provisions are effective for plan years beginning on or after Jan. 1, 2014. Additionally, as mentioned earlier, certain health care reform’s mandates do not apply to grandfathered plans at all, or have a delayed effective date. Below is a summary of some of the more significant qualifying coverage mandates under reform, categorized by whether or not the mandate applies to grandfathered plans, as well as the mandate’s general effective date.

Provisions Applicable to Grandfathered Plans

Provisions generally effective Jan. 1, 2011 for calendar-year grandfathered plans (technically effective for plan years beginning on or after Sept. 23, 2010)

- *Pre-existing conditions.* Elimination of pre-existing condition exclusions from group health plans for children under age 19.

- *Dependent coverage* (for plan years beginning on or after the date that is six months after enactment and before Jan. 1, 2014).² Requirement that group health plans provide coverage for adult dependent children up to age 26 only if the child is not eligible to enroll in other employer-provided coverage (other than in a grandfathered plan). As written, the new law does not require coverage of either the child of an adult dependent (that is, the participant's grandchild) or the adult dependent child's spouse.
- *Elimination of coverage rescissions*. Rescission refers to the practice of canceling coverage after someone has submitted medical claims. Rescission will still be permitted if an individual committed fraud or made an intentional misrepresentation of a material fact to the plan.
- *Requirement that group health plans eliminate lifetime maximum limits on coverage of essential benefits*.³ Annual limits on coverage of essential benefits will be restricted in accordance with regulations that are expected to be issued later this year. It should be noted that group health plans still can place limits on the amount covered for certain medical procedures.

Provisions generally effective Jan. 1, 2014, for calendar-year grandfathered plans

- *Dependent coverage*. Requirement that group health plans provide coverage for adult dependent children up to age 26.
- *Excessive waiting periods*. Elimination of enrollment waiting periods in excess of 90 days.
- *Pre-existing conditions*. Elimination of pre-existing condition exclusions entirely.
- *Coverage limits*. Elimination of annual limits on coverage of essential benefits. It should be noted that group health plans still can place limits on the amount covered for certain medical procedures.

Provisions Not Applicable to Grandfathered Plans

Although grandfathered health plans cannot avoid application of certain qualifying coverage mandates. They are still exempt from some key requirements, however. Those provisions, generally effective the first day of the plan year after Sept. 23, 2010 (that is, Jan. 1, 2011, for calendar year plans), are summarized below.

- *The application of Internal Revenue Code Section 105(h) to insured group health plans*. Code Section 105(h) prohibits discrimination in favor of highly compensated employees regarding eligibility to participate in, and the benefits provided under, self-insured health plans.
- *Claims appeals*. Group health plans must establish an internal claims appeals process that includes a requirement that claimants continue receiving coverage during the appeals process. Additionally, plans must establish an external review process that

²The new federal law is silent on whether a plan may charge for this benefit. It would appear to run contrary to the intent of health care reform to allow a plan to charge a flat fee unrelated to the actual cost to the plan in providing the new benefit. However, it would seem reasonable to adjust the cost of a coverage option that includes this benefit (for example, family coverage) to the extent the adjustment relates to the actual cost to the plan in providing the benefit.

³"Essential benefits" generally include: ambulatory patient services; emergency services; hospitalization maternity and newborn care; mental health and substance abuse prescription drugs; rehabilitative and devices; laboratory services preventive and wellness services; and pediatric services, including oral and vision care. Further guidance is anticipated that will refine the definition of "essential benefits" for purposes of health care reform.

HIPAA Transaction Standards Augmented

The health reform law includes amendments to HIPAA's electronic data interchange (EDI) provisions that require greater uniformity of HIPAA standard transactions, including governmental adoption of "operating rules." The HIPAA changes in Section 1104 of PPACA also add an "electronic funds transfer" (EFT) transaction.

In addition, this section seeks to jumpstart HHS' long delayed rules on unique health plan identifiers, which HHS is directed to finalize by Oct. 1, 2012, and standard claims attachments, which are now due Jan. 1, 2016. The EFT rules must be issued by Jan. 1, 2014.

Health plans must certify and document their compliance with the transaction standards and operating rules by Dec. 31, 2013, or Dec. 31, 2015 (depending on the standard), or pay a "penalty fee" of \$1 per covered life (\$2 for misrepresentation).

Health care providers and others involved with health care transactions have long complained that a profusion of health plan-specific implementation guides has undermined the uniformity goals of HIPAA's EDI rules.

The health plan-led coalition CAQH has developed voluntary standard operating rules for certain transactions.

PPACA Section 1104(b)(2) adds lengthy new requirements to Section 1173 of the Social Security Act (42 U.S.C. §1320d-2). New subsection (g) calls for HHS to adopt a single set of operating rules for each of HIPAA's standard transactions, with the advice of a "qualified nonprofit entity" and the National Committee on Vital and Health Statistics.

Operating rules for health plan eligibility and claim status transactions are to be adopted by July 1, 2011, and take effect by Jan. 1, 2013. Operating rules for the EFT, health care payment and remittance advice transactions are to follow one year thereafter, and the remaining standards two years after that.

HIPAA's transaction standards are detailed in the *Employer's Guide to HIPAA* and the *Employer's Guide to HIPAA Privacy Requirements*, published by Thompson Publishing Group.

meets at least the consumer protections in the Uniform External Review Model Act developed by the National Association of Insurance Commissioners (NAIC) or, in the case of self-insured plans, meets similar requirements as provided by the HHS Secretary.

- *Preventive care, the requirement that certain preventive care benefits be provided under group health plans without cost sharing.* Example of such benefits include: immunizations; preventive care and screening for infants, children and adolescents; preventive care for women including annual to biennial mammograms for all women starting at age 40, cervical cancer screening (pap smears) at least every three years, genetic counseling for certain women with increased risk of breast cancer, promotion and support of breastfeeding, and routine screening for osteoporosis in women age 65 and older.

In addition to the mandates described earlier, health care reform places a limit on deductibles under non-grandfathered health plans. Generally effective Jan. 1, 2014,

Law Calls for National COB Standard

Currently, coordination-of benefit (COB) rules are based on a model regulation developed by the NAIC that is adapted, in whole or part under state insurance law or by self-insured plans. One disadvantage of this approach is that COB rules differ from state to state, and from plan to plan.

To help remedy this problem the health care reform law calls for a national standard. Specifically, Section 136 of the Reconciliation Act provides that a “health choices commissioner” to be appointed by the President from HHS “shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.”

As COB expert Jack B. Helitzer Esq., explains, “This could present an opportunity to simplify the administration of COB and subrogation and reimbursement to make it much easier for insurers, claim administrators and plan participants to deal with those issues.”

In the *COB Handbook* published by Thompson Publishing Group, Helitzer provides more details in how COB and third-party recovery administration could be improved under reform.

deductible limits of \$2,000 per individual/\$4,000 per family annual limit will apply to non-grandfathered health plans.

Other Health Benefit-related Rules

The new federal law contains provisions impacting other health care-related benefits. Two primary provisions are summarized below.

- *Unpaid breastfeeding breaks.* Effective immediately, employers covered by the Fair Labor Standards Act must provide “reasonable” unpaid breaks to mothers to express milk for their infants who are up to one year old. The law also mandates that employers provide a private location, other than a restroom, where mothers may express milk. This provision does not apply to employers with fewer than 50 employees if its requirements would “impose an undue hardship by causing the employer significant difficulty or expense.” If the employer is operating in a state that has rules more favorable to the employee regarding the employee’s right to breast pump in the workplace, then the employer must operate under the state’s rules.
- *Wellness program changes.* Effective plan years beginning on or after Jan. 1, 2014, the new federal law codifies HIPAA wellness rules and increases the 20-percent incentive cap to 30 percent with the HHS Secretary’s discretion to increase the incentive cap to 50 percent.

Employer Mandates

In addition to the qualifying coverage mandates outlined earlier, the new federal law contains employer mandates that require an employer to pay certain penalties and/or fees based on the level of health benefits the employer provides to its employees.

Penalty for Providing No Coverage or Coverage That Is ‘Not Affordable’

Effective Jan. 1, 2014, the law assesses a fee of \$2,000 per full-time employee (30+ hours per week) on employers with more than 50 employees that:

- 1) do not offer health coverage; and
- 2) have at least one full-time employee who receives a premium tax credit.

Wellness Programs Promoted Under Reform Law

The health reform law includes provisions intended to boost employer-provided wellness programs and make them a more widespread way to help increase the overall health of the population. They are intended to encourage employers to offer wellness programs, provide employers with support in doing so and make it possible for them to offer employees a financial incentive to participate in programs that promote greater health and healthier lifestyles.

The law calls on the HHS Secretary to make federal grants available to state and local governments, national networks of community-based organizations, state and local non-profits and Indian tribes that include funds for assessing and implementing worksite wellness programming and incentives.

The law also makes federal grants available to small businesses to enable them to provide employees access to comprehensive workplace wellness programs. These programs include: health awareness initiatives, such as health education, screenings and health risk assessments; initiatives to change unhealthy behavior, such as counseling, seminars, online programs and self-help materials; and supportive environment efforts, such as workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity and improved mental health. The law authorizes the government to appropriate \$200 million for fiscal years 2011-2015 for these grants.

The law also directs the HHS secretary to develop reporting requirements for group health plans concerning their coverage and reimbursement structures for the following wellness and prevention programs:

- 1) smoking cessation;
- 2) weight management;
- 3) stress management;
- 4) physical fitness;
- 5) nutrition;
- 6) heart disease prevention;
- 7) healthy lifestyle support; and
- 8) diabetes prevention.

More information on wellness programs can be found in *Wellness Programs: Employer Strategies and ROI*, and the *Employer’s Handbook: Complying With IRS Employee Benefits Rules*, both published by Thompson Publishing Group.

The first 30 employees are excluded for purposes of determining the aggregate assessed fee amount. Employers are not assessed any payments if they require a waiting period before any employee can enroll in the health coverage, but the amount of any waiting period must be limited to 90 days.

For purposes of determining whether an employer employees 50 or more individuals, part-time employees are added together on a full-time equivalent basis. For example, two half-time employees would equal one full-time employee for purposes of the 50-employee head-count.

Employers that do provide coverage, but the coverage is deemed “not affordable” to employees will be assessed \$250 per month (\$3,000 per annum) for each full-time employee who obtains an income-based health insurance premium tax credit or other support in an insurance exchange. For this purpose, an employee is eligible for a credit if his/her required premium for employer insurance exceeds 9.5 percent of the individual’s household income or the employer’s share of premium is less than 60 percent.

Automatic Enrollment

The new federal law requires employers with 200 or more employees to automatically enroll employees into health plans unless an employee demonstrates that he or she has coverage from another source. The law does not contain an express effective date for implementation of automatic enrollment. However, it does state that implementation is subject to future regulations. Thus, either a technical correction will be required by Congress to clarify the effective date for implementing the automatic enrollment requirement or regulations will be promulgated to set such date.

Revenue Raisers

Several tax code provisions affecting health benefits were amended as a way to raise revenue for the new reform requirements.

High-cost Plan Excise Tax

Effective Jan. 1, 2018, employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and high-risk professionals) will have to pay an excise tax equal to 40 percent of the excess benefit. Free-standing dental and vision benefits will not be required to be counted as taxable benefits for excise tax purposes. The tax will be owed by insurers of insured plans and the employer or administrator in the case of self-insured plans. The thresholds will be indexed to inflation.

Taxation of Retiree Drug Subsidies (Medicare Part D)

Effective Jan. 1, 2013, employers will be taxed on the Medicare Part D subsidies they receive for maintaining retiree drug coverage for their Medicare-eligible retirees. Because this provision requires employers to treat the subsidies as taxable income, it is thought by some that the provision will be a deterrent to the continued maintenance of employer-sponsored retiree drug coverage.

Flexible Spending Accounts

Effective Jan. 1, 2011, the new law excludes non-prescribed over-the-counter (OTC) drugs as an expense that is reimbursable under flexible spending accounts (FSAs).

Effective Jan. 1, 2013, the law also limits contributions to health FSAs to \$2,500 per year, indexed to the Consumer Price Index. Such a limit will raise health care costs for employees with unreimbursed health care expenses in excess of \$2,500 to the extent the employee currently has an FSA that permits contributions in excess of \$2,500.

Excise Tax on Non-qualified Distributions

The excise tax imposed on non-qualified distributions from health savings accounts (HSAs) and Archer medical savings accounts (MSAs) will increase to 20 percent for distributions after Dec. 31, 2010.

Medicare Tax

Effective Jan. 1, 2013, the employee's share of the Medicare (hospital insurance) tax rate on wages will increase by an additional 0.9 percent (in addition to the existing 1.45 percent)

Health Care Reform's Impact on Flexible Benefits

Flexible benefits will need to be just that — flexible — according to Rich Glass, chief compliance officer for Infinisource, Inc., because of changes made by the new health care reform law. As noted elsewhere in this report, among other things the new law limits contributions to health FSAs to \$2,500 per year, indexed to the Consumer Price Index and will change the reimbursement rules regarding OTC medicines or drugs.

In addition, the law notes that the Code Section 125 nondiscrimination rules do not apply for cafeteria plans (and some plans offered through a cafeteria plan, such as group term life insurance, self-insured medical and dependent care assistance) if certain requirements are met. Glass explains that while this is being hailed as a "SIMPLE" cafeteria plan, it requires more than seven pages of rules. For example, all non-excludable employees must be eligible to participate, and the employer must make a minimum level of contribution. Eligible employers must have 100 or fewer employees during either of the two preceding years (provided it is a full year).

Glass further notes that many questions remain to be answered, including:

- When does the \$2,500 health FSA limit take effect for non-calendar plan years?
- What form of documentation will be required for a doctor-recommended OTC drug to be viewed as a prescribed drug, and therefore reimbursable?
- What will happen to the Inventory Information Approval System, which was set up to auto-adjudicate OTC drugs, medicines and other items when an authorized debit card is used?
- What additional guidance will there be on the SIMPLE cafeteria plan?

In the *Flex Plan Handbook*, published by Thompson Publishing Group, Glass explains the other health care reform changes that will indirectly affect flexible benefits, like the calculation of the so-called Cadillac Plan tax.

What Does Reform Mean for COBRA Compliance?

Because of the health reform law's scope, it is fair to ask, "What does this mean from a COBRA continuation coverage perspective?" The answer, according to COBRA expert Paul M. Hamburger, Esq., is not much.

Although the new law establishes hundreds of new requirements, it still leaves the basic structure of employer-provided health coverage in place. Nevertheless, there are some issues that will arise from a COBRA perspective and that are important to consider.

- 1) *Do we need COBRA coverage any more?* A key component of health care reform is that by 2014, everyone will be required to obtain health coverage (the "individual mandate") and that comprehensive coverage will be available either through employment-based coverage or through health insurance exchanges. Therefore, if everyone has to have coverage and coverage is otherwise available, will there be a need for COBRA coverage? The short answer is "yes," because reform did not eliminate the employer-based system of health coverage. So plan variations will continue to exist, and coverage available on an individual basis, even through the insurance exchanges, will likely be expensive and not as comprehensive as employer-provided group coverage.
- 2) *Form W-2 reporting on the value of group health plan coverage.* As noted earlier in this report, employers will have to report the cost of group health coverage on each employee's Form W-2 each year. For this purpose, the "cost" is supposed to be determined in the same manner as under the COBRA rules. This provision does not have a direct impact on COBRA coverage. However, it does signal the growing need for the IRS to issue regulations governing the calculation of COBRA cost and premiums.
- 3) *Pre-existing conditions.* The elimination of pre-existing condition exclusions affects the circumstances under which COBRA coverage could be terminated. Under COBRA, if a qualified beneficiary elects COBRA coverage, that coverage may be terminated when he or she first becomes, after the date of the COBRA election, covered by another group health plan. However, if that other group health plan excludes coverage for the qualified beneficiary's pre-existing conditions (and the HIPAA rules do not eliminate that rule's application), then the other coverage does not terminate COBRA coverage. Once health care reform eliminates the application of pre-existing condition exclusions, this COBRA "other coverage" rule will apply to terminate COBRA coverage in more circumstances than was previously the case.
- 4) *Mandate for dependent coverage through age 26.* This new requirement will raise several administrative questions for COBRA purposes. For example, what if a child who lost dependent child status due to an age lower than age 26 is currently on COBRA coverage and paying 102 percent of the applicable premium? How will the plan administrator notify the affected individual and let that child back on to coverage as a permitted dependent? How will dependent children who "aged out" under the plan rule that was lower than age 26 and did not elect COBRA coverage be addressed?

Because of the many unanswered questions reform raises regarding COBRA administration, future federal guidance is likely. Hamburger will explain the implications of such guidance in *Mandated Health Benefits — The COBRA Guide*, published by Thompson Publishing Group.

for individuals with a modified adjusted gross income (AGI) of \$200,000, or \$250,000 in the case of married couples filing jointly.

Additionally, effective Jan. 1, 2013, investment income will be included in the Medicare tax base — which would be taxed at 3.8 percent — for individuals who file jointly with a modified AGI of \$250,000, or \$200,000 in the case of a single return. For this purpose, net investment income includes gross income from interest, dividends, annuities, royalties, rents, and disposition of properties and excludes (among other items), distributions from qualified retirement plans and IRAs.

Economic Substance Doctrine

As a revenue-raiser, the new federal law codifies the “economic substance” doctrine: This judicial doctrine denies tax benefits when the transaction generating the benefits lacks economic substance. Under the codification of this doctrine, a taxpayer must demonstrate that the transaction changes in a meaningful way (apart from tax effects) the taxpayer’s economic position, and that the taxpayer has a substantial non-tax purpose for entering into the transaction.

New Reporting and Disclosure Requirements

The law also establishes several new reporting and disclosure requirements.

Form W-2 Reporting on the Value of Group Health Plan Coverage

Effective for tax years beginning after Dec. 31, 2010, the new law requires employers to report on Form W-2 the aggregate cost of health coverage (determined on a basis similar to that under COBRA) received by an employee under the employer’s health plan. For this purpose, FSAs, HRAs, and Archer MSAs are excluded from the cost analysis.

Reporting of Payments to Corporations and for Goods

Effective for payments made beginning in 2013, the new law expands the current Form 1099 information reporting requirement for compensation paid for services to individuals and partnerships to payments made to corporations, and to payments made for goods as well as services.

General Reporting

Effective Jan. 1, 2014, employers will be required to report to the Treasury Secretary each year, certifying:

- whether coverage is offered to full-time employees;
- the waiting period for any such coverage;
- the number of full-time employees during each month; and
- the name, address and TIN of each full-time employee and the months during which they were covered under the plan.

Future guidance is anticipated on how an employer may meet this reporting requirement.

New Explanation of Coverage Document

Effective March 23, 2012, plan administrators (of self-insured plans) or insurance carriers (of fully insured plans) must give a coverage summary to all applicants and enrollees, at initial enrollment and open enrollment. This is in addition to the summary plan description. This requirement is for both grandfathered and non-grandfathered plans. HHS is to provide standards by March 23, 2011.

Conclusion

As noted earlier, the new reform law runs hundreds of pages, and includes hundreds of new requirements affecting affect group health plans delivery and administration. In addition, it is anticipated that the first round of guidance expounding upon the law's requirements will be released within the next two months, with further guidance to follow in the summer. Until then, employers should begin developing a general strategy for complying with the new federal law to position themselves for quick implementation of the new rules once guidance is released.

Are Audits to Find Fault With Self-insured Plans?

Under reform, the governing departments will inspect and audit employer health plans — including self-funded plans — to ensure performance, solvency and compliance with the law's benefits and cost-sharing rules.

Within one year of enactment (March 23, 2010), HHS is charged with submitting to Congress reports on the large group market — including self-funded plans — that explore:

- the risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent;
- the extent to which rating rules are likely to cause adverse selection in the large group market or to encourage small and mid-size employers to self-insure;
- whether self-insured group plans can offer less costly coverage and if so, if that is due to efficiency or to claims denials and limited benefit packages;
- claim denial rates and plan benefit fluctuations, to see whether plans scale back benefits in hard economic times; and
- whether conflicts of interest cause self-insured plans to improperly deny claims or service customers.

In addition, the law requires the DOL Secretary to prepare an annual report, using information obtained from submitted Form 5500s, on various aspects of self-insured, group health plans, including: plan type, number of participants, benefits offered, funding arrangements, benefit arrangements and data from the financial filings.

Furthermore, effective in 2013, the law will require the plan sponsor of a self-insured plan to pay \$2 multiplied by the average number of covered lives. From 2013-2019 the previous year's fee will be multiplied by projected per-capita amount of National Health Expenditures. Plans will not be required to pay fees beyond 2019.

Benefits attorney Terry Humo explains the strategic implications of health care reform for self-insured plans in the *Employer's Guide to Self-Insuring Health Benefits*, published by Thompson Publishing Group.

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