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Health Care Reform Timeline

On March 23, 2010, President Obama signed the health care reform bill, or Affordable Care Act (ACA), into law. The ACA makes sweeping changes to the U.S. health care system. The ACA's health care reforms, which are primarily focused on reducing the uninsured population and decreasing health care costs, will be implemented over the next several years.

This Legislative Brief provides a timeline of the implementation of key ACA reforms that affect employers and individuals. Please read below for more information and contact your Crane representative with any questions about how you can prepare for any of the health care reform requirements.

2010

EXPANDED INSURANCE COVERAGE

- ***Extended Coverage for Young Adults.*** Group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must make coverage available for adult children up to **age 26**. There is no requirement to cover the child or spouse of a dependent child. This requirement applies to grandfathered and non-grandfathered plans. However, grandfathered plans need not cover adult children who are eligible for other employer-sponsored coverage, such as coverage through their own employer, until 2014.

  The ACA also added a new tax provision related to health insurance coverage for these adult children. Effective March 30, 2010, amounts spent on medical care for an eligible adult child can generally be excluded from taxable income.

  Note: A "grandfathered plan" is one in which an individual was enrolled on March 23, 2010. A plan will retain its grandfathered status even if covered individuals renew their coverage after March 23, 2010, family members are added to coverage or new employees (and their families) enroll for coverage. A health plan will lose its grandfathered status if there are significant cuts to benefits or increases in participants' out-of-pocket spending. Grandfathered status is significant because many ACA reforms do not apply to grandfathered plans.

- ***Access to Insurance for Uninsured Individuals with Pre-existing Conditions.*** The health care reform law created a temporary high-risk health insurance pool program, called the Pre-existing Condition Insurance Plan (PCIP), to provide health insurance coverage to individuals who have been uninsured for at least six months because of a pre-existing condition. The program was scheduled to end in 2014, when the health insurance Exchanges are set to be operational.

  On Feb. 15, 2013, the Obama Administration issued a **nationwide suspension on enrollment in the PCIP program** due to limited funding. The enrollment suspension took effect immediately in 23 states where the federal government administers the program. However, state-based PCIPs may continue to accept enrollment applications **through March 2, 2013**. For more information, see https://www.pcip.gov/.

- ***Identifying Affordable Coverage.*** As required by the ACA, the Department of Health and Human Services (HHS) established an Internet website—www.healthcare.gov—through which residents of any state may identify affordable health insurance coverage options in their state. The website also includes information for

small businesses about available coverage options, reinsurance for early retirees, small business tax credits and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans are precluded from listing their policies on this website.

- ***Reinsurance for Covering Early Retirees.*** The ACA established a temporary reinsurance program to reimburse participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program was designed to end on Jan. 1, 2014, or earlier, if the $5 billion in funding was exhausted. Due to the program's popularity, it closed to new applications effective May 5, 2011. In early December 2011, HHS announced that, because the program had already provided more than $4.5 billion in reimbursements, it would not accept reimbursement requests for claims incurred after Dec. 31, 2011.

HEALTH INSURANCE REFORM

- ***Eliminating Pre-existing Condition Exclusions for Children.*** Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children **under age 19**. This provision applies to all employer plans and new plans in the individual market. This provision will also apply to adults in 2014.
- ***Coverage of Preventive Care Services.*** Group health plans and health insurance issuers offering group or individual health insurance coverage must provide coverage for certain preventive care services without cost-sharing (for example, deductibles, copayments or coinsurance). Grandfathered plans are exempt from this requirement.
- ***Prohibiting Rescissions.*** The health care reform law prohibits rescissions, or retroactive cancellations, of coverage, except in cases of fraud or intentional misrepresentation. Also, plans and issuers must provide at least 30 days' advance notice to the enrollee before coverage may be rescinded. This provision applies to all grandfathered and non-grandfathered plans.
- ***Lifetime and Annual Limits.*** Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement through HHS. The annual limit waiver program closed to applications effective Sept. 22, 2011. All annual limits will also be prohibited beginning in 2014.

HEALTH PLAN ADMINISTRATION

- ***Improved Claims and Appeals Process.*** Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective process for benefit claims and appeals of coverage determinations. A plan's or issuer's internal claims and appeals process must comply with the claims procedure regulation issued by the Department of Labor (DOL) in 2001. In addition, the ACA requires plans and issuers to:
    - Have an internal claims and appeals process in effect that provides claimants with a full and fair review;
    - Provide information to claimants in a culturally and linguistically appropriate manner in some situations;
    - Comply with additional content requirements for denial notices; and
    - Continue to provide coverage to a claimant pending the outcome of the appeals process.

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A grace period for some of the ACA's additional claims and appeals requirements was provided until plan years beginning on or after Jan. 1, 2012. Plans and issuers must also implement an external review process that meets applicable state or federal requirements.

- ***Nondiscrimination Rules for Fully Insured Plans.*** Fully insured group health plans will have to satisfy nondiscrimination rules regarding eligibility to participate in the plan and eligibility for benefits. These rules prohibit discrimination in favor of highly compensated individuals. This reform does not apply to grandfathered plans. This requirement was set to take effect for plan years beginning on or after Sept. 23, 2010. However, it has been **delayed indefinitely** pending the issuance of regulations. The regulations will specify the new effective date.

MEDICARE/MEDICAID

- ***Rebates for the Medicare Part D "Donut Hole."*** Currently, there is a coverage gap, or "donut hole," in most Medicare Part D plans. Once the plan and participant have paid $2,930 in total drug costs ($2,970 for 2013), the participant is in the coverage gap. The coverage gap ends when the participant has spent $4,700 ($4,750 for 2013) out of pocket for drug costs in a calendar year. For 2010, the ACA provided a $250 rebate check for all Medicare Part D enrollees who entered the donut hole. Starting in 2011, the health care reform law provides discounts on brand-name drugs and generic drug coverage in the donut hole. The donut hole gap will be filled by 2020.

- ***Medicaid Flexibility for States.*** States are given an option under the health care reform law to cover additional individuals under Medicaid. States will be able to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL).

FEES AND TAXES

- ***Small Business Tax Credit.*** The first phase of the small business tax credit for qualified small employers began in 2010. Eligible employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small tax-exempt organizations. When the health insurance exchanges are operational, the tax credits will increase, up to 50 percent of premiums.

- ***Indoor Tanning Services Tax.*** An additional tax imposed by the health care reform law is a 10 percent tax on amounts paid for indoor sun tanning services.

2011

EXPANDED INSURANCE COVERAGE

- ***Community Living Assistance Services and Supports Program (CLASS Act).*** The ACA created a voluntary, long-term care insurance program for disabled adults. Although the program was technically effective Jan. 1, 2011, significant portions were not required to be established until 2012. On Oct. 14, 2011, the CLASS Act's implementation was suspended due to concerns about the program's fiscal sustainability and affordability. On Jan. 2, 2013, the CLASS Act was repealed by legislation approved by Congress and signed by President Obama to avoid the "fiscal cliff."

HEALTH PLAN ADMINISTRATION

- ***Improving Medical Loss Ratios.*** Health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans) must annually report on the share of premium dollars spent on health care and provide consumer rebates for excessive medical loss ratios.

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- ***Standardizing the Definition of Qualified Medical Expenses.*** The ACA changed the definition of "qualified medical expenses" for health savings accounts (HSAs), health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) to the definition used for the itemized tax deduction. This means that expenses for over-the-counter (OTC) medicines and drugs may not be reimbursed by these plans unless they are accompanied by a prescription. There is an exception for insulin. Also, OTC medical supplies and devices may continue to be reimbursed without a prescription.
- ***Cafeteria Plan Changes.*** The ACA created a simple cafeteria plan to provide a vehicle through which small businesses can provide tax free benefits to their employees. This plan is designed to ease the small employer's administrative burden of sponsoring a cafeteria plan. The provision also exempts employers who make contributions for employees under a simple cafeteria plan from certain nondiscrimination requirements applicable to highly compensated and key employees.

MEDICARE/MEDICAID

- ***Medicare Part D Discounts.*** In order to make prescription drug coverage more affordable for Medicare enrollees, the ACA provided a 50 percent discount on all brand-name drugs and biologics in the "donut hole." It also began phasing in additional discounts on brand-name and generic drugs to completely fill the donut hole by 2020 for all Part D enrollees.
- ***Additional Preventive Care Services.*** The ACA provided a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminated cost-sharing for preventive care services beginning in 2011.

FEES AND TAXES

- ***Increased Tax on Withdrawals from HSAs and Archer MSAs.*** The health care reform law increased the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses also increased from 15 to 20 percent.

2012

HEALTH INSURANCE REFORM

- ***Additional Preventive Care Services for Women.*** Beginning in 2010, non-grandfathered group health plans and health insurance issuers offering group or individual non-grandfathered health insurance coverage were required to provide coverage for preventive care services without cost-sharing requirements. Effective for **plan years beginning on or after Aug. 1, 2012**, the required preventive care services include specific services for women, including contraceptives and contraceptive counseling. Exceptions to the contraceptive coverage requirement apply to religious employers.

EXPANDED INSURANCE COVERAGE

- ***Community Living Assistance Services and Supports Program (CLASS Act).*** As noted above, the CLASS Act, which would have created a voluntary long-term care insurance program for disabled adults, was technically effective Jan. 1, 2011. However, significant aspects of the program, such as enrollment and premium payment rules, were to be established in 2012. Implementation of the CLASS Act was suspended on Oct. 14, 2011 due to concerns on fiscal sustainability and affordability.

HEALTH PLAN ADMINISTRATION

- ***Uniform Summary of Benefits and Coverage.*** All non-grandfathered and grandfathered health plans must provide a uniform summary of the plan's benefits and coverage to participants. The summary must be written

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in easily understood language and is limited to four double-sided pages. Any mid-year changes to the information contained in the summary must be provided to participants 60 days in advance. The ACA indicated that plans would be required to start providing the summary by March 23, 2012, but this deadline was pushed back.

Plans and issuers must start providing the summary by the following deadlines:

- Issuers must provide the summary to health plans effective **Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants and beneficiaries who enroll or re-enroll during an open enrollment period starting with the first day of the first **open enrollment period that begins on or after Sept. 23, 2012**;
- Plans and issuers must provide the summary to participants who enroll for coverage other than through an open enrollment period (for example, newly eligible individuals and special enrollees) starting with the first day of the first **plan year that begins on or after Sept. 23, 2012**.

- ***Reporting Health Coverage Costs on Form W-2.*** The ACA requires employers to disclose the value of the health coverage provided by the employer to each employee on the employee's annual Form W-2. This requirement was effective, but optional, for the 2011 tax year and is mandatory for later years for most employers. This requirement is optional for small employers (those filing fewer than 250 Form W-2s) at least for the 2012 tax year and will remain optional until further guidance is issued. Employers that file at least 250 Forms W-2 must comply with this reporting requirement for 2012 (for W-2 Forms that must be issued by the end of January 2013) and future years.
- ***Medical Loss Ratio Rebates.*** Sponsors of fully insured plans may qualify for a rebate from their health insurance issuers due to the medical loss ratio (MLR) rules. The MLR rules require insurance companies to spend a certain percentage of premium dollars on medical care and health care quality improvement, rather than administrative costs. Any portion of a rebate that is a plan asset must be used for the exclusive benefit of the plan's participants and beneficiaries. This may include, for example, reducing participants' premium payments.

FEES AND TAXES

- ***Patient-centered Outcomes Research Institute (PCORI) Fees.*** Effective for **plan years ending on or after Oct. 1, 2012**, issuers and sponsors of self-insured health plans must pay PCORI fees to fund health care research. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. Thus, for calendar year plans, the PCORI fees will be effective for the 2012 through 2018 plan years. For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee is **$1** multiplied by the average number of lives covered under the plan. The fee goes up to **$2** for plan years ending on or after Oct. 1, 2013 and before Oct. 1, 2014, and will be indexed for future years. PCORI fees must be reported and paid by July 31 of each year, and will generally cover plan years that end during the preceding calendar year. The first due date for paying PCORI fees was **July 31, 2013**.

2013

HEALTH PLAN ADMINISTRATION

- ***Administrative Simplification.*** Beginning in 2013, health plans must adopt and implement uniform standards and operating rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs. For example, effective Jan. 1, 2013, health plans must comply with HHS's operating rules for electronic health care transactions regarding eligibility for health plan coverage and health care claim status.

Health Care Reform Timeline

- ***Limiting Health Flexible Savings Account Contributions.*** Effective for plan years beginning after Dec. 31, 2012, the ACA limits the amount of salary reduction contributions to health FSAs to **$2,500 per year**. On Oct. 31, 2013, the IRS announced that the health FSA limit will remain unchanged at $2,500 for the taxable years beginning in 2014. However, the $2,500 limit potentially will be indexed for cost-of-living adjustments for later years.

- ***Employee Notice of Exchanges.*** Employers must provide a notice to employees regarding the availability of the health care reform insurance exchanges. The original deadline was March 1, 2013, but that deadline was delayed pending additional guidance from the DOL. On May 8, 2013, the DOL issued Technical Release 2013-02 to provide temporary guidance on the exchange notice requirement. Employers will need to provide the exchange notice to current employees by **Oct. 1, 2013**. They will also need to start providing it to new employees on this date. The DOL issued model language for employers that do not offer a health plan and model language for employers who offer a health plan to some or all employees.

  On Sept. 11, 2013, the DOL issued an FAQ on the penalties for failing to provide an Exchange Notice. In this FAQ, the DOL stated that **there is no fine or penalty under the ACA for failing to provide the notice**. This means that employers cannot be fined for failing to provide employees with notice about the ACA's new Exchanges.

- ***HIPAA Certification***. By **Dec. 31, 2013**, group health plans must certify that they comply with certain HIPAA rules on electronic transactions. HHS intends to issue more guidance on this requirement in the future.

FEES AND TAXES

- ***Eliminating Deduction for Medicare Part D Subsidy.*** In the past, employers that received the Medicare Part D retiree drug subsidy were permitted to take a tax deduction for their prescription drug costs, including costs attributable to the subsidy. The deduction for the retiree drug subsidy was eliminated in 2013.

- ***Increased Threshold for Medical Expense Deductions.*** The ACA increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 percent of income to 10 percent. However, individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

- ***Additional Medicare Tax for High Wage Workers.*** The ACA increases the Medicare hospital insurance tax rate by 0.9 percentage points on wages over $200,000 for an individual ($250,000 for married couples filing jointly). The tax is also expanded 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).

- ***Medical Device Excise Tax.*** The ACA establishes a 2.3 percent excise tax on the first sale for use of a medical device. Eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use are exempted from the tax.

- ***PCORI Fees.*** For plan years ending on and after Oct. 1, 2012 and before Oct. 1, 2019, self-insured plans and issuers must pay fees per covered life. The initial fee is $1 per covered life, increasing to $2 per covered life for plan years ending on or after Oct. 1, 2013 (and adjusted annually for later plan years). The first possible payments were due on **July 31, 2013**.

2014

COVERAGE MANDATES

- ***Individual Coverage Mandate.*** The ACA requires most individuals to obtain acceptable health insurance coverage or pay a penalty, beginning in 2014. The penalty will start at $95 per person for 2014 and increase each year. The penalty amount increases to $325 in 2015 and to $695 (or up to 2.5 percent of income) in

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2016, up to a cap of the national average bronze plan premium. After 2016, dollar amounts are indexed. Families will pay half the penalty amount for children, up to a cap of three times the adult penalty for that year. Individuals may be eligible for an exemption from the penalty if they cannot obtain affordable coverage.

  - Legal challenges to the health care reform law have focused on whether Congress had the constitutional authority to enact the individual coverage mandate. On June 28, 2012, the U.S. Supreme Court addressed these legal challenges and upheld the individual coverage mandate as constitutional. This means that the mandate will go into effect in 2014 as planned, unless it is repealed by Congress.

- ***Employer Coverage Mandate.*** See the 2015 section below. The employer mandate provisions were set to take effect on Jan. 1, 2014, but have been delayed for one year, until 2015.

HEALTH INSURANCE EXCHANGES

The ACA provides for **health insurance Exchanges** to be established in each state in 2014. Individuals and small employers will be able to shop for insurance through the Exchanges. Small employers are those with no more than 100 employees. If a small employer later grows above 100 employees, it may still be treated as a small employer. However, states may limit employers' participation in the Exchanges to businesses with up to 50 employees until 2016. Large employers with over 100 employees are to be allowed to participate in the Exchanges in 2017.

States have three main options with respect to their Exchange. They can (1) establish and run a state-based Exchange, (2) have HHS establish a federally-facilitated Exchange (FFE) for their residents or (3) partner with HHS so that some FFE functions can be performed by the state. In addition, a state may elect to partner with HHS so that the state runs the Exchange's small business health options program (SHOP) and HHS runs the Exchange's individual market component.

The health care reform legislation provided that workers who qualified for an affordability exemption to the coverage mandate, but did not qualify for tax credits, could use their employer contribution to enroll in an Exchange plan. This requirement is known as the "free choice voucher" provision. The federal appropriations bill signed by President Obama on April 15, 2011, eliminated the free choice voucher provision from health care reform.

On March 11, 2013, HHS proposed a transition policy for SHOP Exchanges to delay implementation of the employee choice model as a requirement for all SHOPs until 2015 plan years. For plan years beginning on or after Jan. 1, 2014, and before Jan. 1, 2015: (1) state SHOPs would not have to allow employers to offer their employees a choice of QHPs at a single level of coverage, and (2) FF-SHOPs would not allow qualified employers to offer their employees a choice of QHPs at a single level of coverage.

HEALTH INSURANCE REFORM

Additional health insurance reform measures will be implemented beginning in 2014.

- ***Guaranteed Issue and Renewability***. Health insurance issuers offering health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue to enforce the coverage at the option of the plan sponsor or the individual.

- ***Pre-existing Condition Exclusions***. Effective Jan. 1, 2014, group health plans and health insurance issuers may not impose pre-existing condition exclusions on any covered individual, regardless of the individual's age.

- ***Insurance Premium Restrictions***. Health insurance issuers in the individual and small group markets will not be permitted to charge higher rates due to heath status, gender or other factors. Premiums will be able to vary based only on age (no more than 3:1), geography, family size and tobacco use. The rating limitations will not apply to health insurance issuers that offer coverage in the large group market unless the state elects to

offer large group coverage through the state exchange (beginning on or after 2017). Also, these restrictions do not apply to grandfathered coverage.

- ***Nondiscrimination Based on Health Status***. Group health plans and health insurance issuers offering group or individual health insurance coverage (except grandfathered plans) may not establish rules for eligibility or continued eligibility based on health status-related factors.
- ***Nondiscrimination in Health Care***. Group health plans and health insurance issuers offering group or individual insurance coverage may not discriminate against any provider operating within their scope of practice. However, this provision does not require a plan to contract with any willing provider or prevent tiered networks. It also does not apply to grandfathered plans. Plans and issuers also may not discriminate against individuals based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.
- ***Annual Limits***. Restricted annual limits will be permitted until 2014. However, in 2014, the plans and issuers may not impose annual limits on the coverage of essential health benefits.
- ***Excessive Waiting Periods***. Group health plans and health insurance issuers offering group or individual health insurance coverage will not be able to require a waiting period of more than 90 days.
- ***Coverage for Clinical Trial Participants***. Non-grandfathered group health plans and insurance policies will not be able to terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases or deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.
- ***Comprehensive Benefits Coverage***. Health insurance issuers that offer health insurance coverage in the individual or small group market will be required to provide the essential benefits package required of plans sold in the health insurance exchanges. This requirement does not apply to grandfathered plans.
- ***Limits on Cost-sharing***. Non-grandfathered group health plans will be subject to limits on cost-sharing or out-of-pocket costs. Out-of-pocket expenses may not exceed the amount applicable to coverage related to HSAs and deductibles may not exceed $2,000 (single coverage) or $4,000 (family coverage). These amounts are indexed for subsequent years. Final guidance from HHS provides that the deductible requirement will apply only to plans in the insured small group market, while the out-of-pocket cost limit will apply to all non-grandfathered health plans. Also, the final guidance provides that a health plan's annual deductible may exceed the ACA limit if a plan could not reasonably reach the actuarial value of a given level of coverage (that is, a metal tier - bronze, silver, gold or platinum) without exceeding the limit.
- ***Risk-spreading Mechanisms***. The health care reform law includes reforms related to the allocation of insurance risk through reinsurance, risk corridors and risk adjustment. The purpose of these reforms, which become effective in 2014, is to protect against risk selection and market uncertainty as insurance changes and the health insurance exchanges are implemented. Under reinsurance program, which will operate from 2014 through 2016, health insurance issuers and third party administrators (TPAs) will be required to make contributions based on a federal contribution rate established by HHS. States may collect additional contributions on top of the federal contribution rate.

EMPLOYER WELLNESS PROGRAMS

Under health care reform, the rules for employer wellness programs will be changed slightly. Existing wellness regulations under HIPAA permit wellness incentives of up to 20 percent of the total premium, as long as the program meets certain conditions. Under health care reform, the potential incentive increases to 30 percent of the premium in 2014 for employee participation in the program or meeting certain health standards. In addition, the maximum permissible reward for health-contingent wellness programs designed to prevent or reduce tobacco use will increase to 50 percent of the cost of health coverage. Following a governmental study on wellness programs, the incentive may

be increased to as much as 50 percent. Employers must offer an alternative standard to those employees for whom it is unreasonably difficult or inadvisable to meet the standard.

FEES AND TAXES

- ***Individual Health Care Tax Credits***. The ACA makes premium tax credits available through the exchanges to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty level who are not eligible for or offered other acceptable coverage. The credits apply to both premiums and cost-sharing.
- ***Small Business Tax Credit***. The second phase of the small business tax credit for qualified small employers will be implemented in 2014. These employers can receive a credit for contributions to purchase health insurance for employees, up to 50 percent of premiums.
- ***Health Insurance Provider Fee***. The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2015

EMPLOYER COVERAGE MANDATE

Beginning in 2015, employers with 50 or more employees that do not offer coverage to their employees will be subject to penalties if any employee receives a government subsidy for health coverage. Employers will be required to report to the federal government on health coverage they provide.

The employer mandate provisions were set to take effect on Jan. 1, 2014. However, on July 2, 2013, the Treasury announced that the employer mandate penalties and related reporting requirements will be **delayed for one year, until 2015**. Therefore, these payments will not apply for 2014. No other provisions of the ACA are affected by the delay, including individuals' access to premium tax credits for Exchange coverage and the individual mandate.

On July 9, 2013, the Internal Revenue Service (IRS) issued Notice 2013-45 to provide more formal guidance on the delay, including questions and answers for employers, insurers and other health insurance providers. The Treasury issued additional proposed regulations on the reporting requirements on Sept. 5, 2013. It is unclear how the new deadline will impact guidance that has already been issued, such as the transition relief for non-calendar year plans and the optional safe harbor for determining full-time status. Future guidance may impact these rules.

In preparation for the application of the employer mandate provisions beginning in 2015, the IRS is encouraging employers and other affected entities to **voluntarily comply for 2014** with the information reporting provisions (once the information reporting rules have been issued) and to maintain or expand health coverage in 2014.

The penalty amount is up to $2,000 annually for each full-time employee, excluding the first 30 employees. Employers who offer coverage, but whose employees receive tax credits because the coverage is unaffordable or does not provide minimum value, will be subject to a fine of $3,000 for each worker receiving a tax credit, up to an aggregate cap of $2,000 per full-time employee (excluding the first 30 employees).

2018

HIGH COST PLAN EXCISE TAX

A 40 percent excise tax is to be imposed on the excess benefit of high cost employer-sponsored health insurance. This tax is also known as a "Cadillac tax." The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage. Responsibility for the tax is on the "coverage provider" which can be the insurer, the employer or a third-party administrator. There are a number of exceptions and special rules for high coverage cost states and different job classifications.

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