This article provides a health care reform timeline for multiemployer plans. Plans must be ready to act in the next year to comply with some provisions, while looking at cost and design implications of other provisions over the next five years. The author points out where more guidance is expected.
While regulatory guidance on many of the health care reform law’s provisions is limited, multiemployer health care plan trustees are advised to move ahead with planning and implementation and to be alert to new guidance as it is issued.

Significant cost pressures are anticipated, and plans that fail to comply with health care reform provisions can expect to incur substantial nondeductible excise taxes. Trustees and employers will need to continue to analyze their demographics, costs, risks and alternatives, and to make decisions regarding benefit structure and approach to compliance. This article includes important dates for multiemployer health plans, notes where guidance still is needed and describes factors that might increase costs.

This article was written before the November elections and presumes that the Patient Protection and Affordable Care Act (PPACA) will remain in place. Even if the law is repealed or revised, numerous aspects of health care reform already are effective (such as coverage of adult children until the age of 26, and preexisting-condition exclusion for children under the age of 19). Eliminating those benefits may be difficult at this point.

Following is a time line of the most pertinent requirements that are expected to become effective over the next several years.

**Late 2012 and 2013**

A number of provisions already are effective, and if grandfathered plans lose their grandfathered status, they will be required to comply with additional requirements. For example, nongrandfathered plans must provide certain benefits, such as preventive services, comply with emergency services payment rules and comply with internal and external review procedures. To maintain grandfathered status, plans must comply with disclosure requirements and ensure that any
takeaways >>

- Plan sponsors that fail to comply with health care reform provisions can expect to have to pay nondeductible excise taxes.
- Compliance is important for maintaining grandfathered status.
- For now, plan participants must be notified by March 2013 of the existence of a health insurance exchange—even though most states won’t yet have an exchange.
- W-2 reporting on the value of employer-sponsored health care coverage remains voluntary for employers contributing to multiemployer plans.
- Guidance is needed on many aspects of PPACA, including how and when employer excise taxes will be computed, paid and reconciled.
- Some health care practitioners believe the substantial Cadillac tax will hit many plans.

plan changes do not cause the loss of that status.⁴

Medical Loss Ratio Rebates

The administrator of an insured plan that receives a rebate because the issuer failed to provide value for premium payments must decide how to handle the rebate and participant communications in accordance with Department of Labor (DOL) guidance.⁵

Early Retiree Reinsurance Program

A plan that previously had received reimbursements under the Early Retiree Reinsurance Program must ensure that recordkeeping and use-of-money rules are followed,⁶ as audits are being conducted.

Summary of Benefits and Coverage

Plans that conduct open enrollment must provide the summary of benefits and coverage (SBC) with open enrollment materials during the first enrollment period that begins on or after September 23, 2012. Plans that do not conduct open enrollment are required to comply by the first day of the plan year beginning on or after September 23, 2012. Notice of a material modification of information contained in the most recent SBC must be provided 60 days before any such modification takes effect. This notice is required only for changes other than in connection with a renewal or reissuance of coverage.⁷

Patient-Centered Outcomes Institute Fee

Effective for plan years ending on or after October 1, 2012, health insurers and self-funded plans must report and pay with Form 720 a fee of $1 per covered life, increasing to $2 per covered life in 2014. This fee is intended to fund the Patient-Centered Outcomes Research Institute.⁸

Health Flexible Spending Account Contribution Limitation

Annual contributions to health care flexible spending accounts will be limited to $2,500.⁹ IRS Notice 2012-40 provides guidance, including a clarification that this requirement is effective for plan years beginning on or after January 1, 2013.

Explanation of Exchange

Employers are required to provide all employees with notice of the existence of an exchange by March 1, 2013, or at their subsequent date of hire.¹⁰ The notice will need to describe the services provided by the exchange and how an employee may contact the exchange. The notice also must explain that employees may be eligible for premium assistance and cost reductions through the exchange if the plan’s share of benefits is less than 60%, and that if the employee chooses exchange coverage, he will lose the employer’s contribution (if any), all or part of which may be excludable from taxable income for federal income tax purposes. PPACA requires HHS regulations implementing this provision, but regulations had not been issued at the time of this writing. Guidance is critical, given that the notice likely will be required before an exchange exists.

Additional Medicare Hospital Insurance Tax

The Medicare hospital insurance tax rate increases by .9% (from 1.45% to 2.35%) on wages exceeding $200,000 for single filers or $250,000 for joint filers, effective for tax years beginning on or after January 1, 2013.¹¹ IRS has issued frequently asked questions (FAQs) explaining the withholding requirements that apply regardless of whether the tax is actually owed. Employers are not required to match the additional tax.¹²

Form W-2 Reporting

Form W-2 must report the value of employer-sponsored coverage.¹³ IRS modified the form accordingly and issued guidance that made reporting voluntary at first.¹⁴ The 2012 Forms W-2 (due by January 31, 2013) generally must indicate the value of employer-sponsored coverage, though reporting remains voluntary for employers contributing to multiemployer plans and health reimbursement arrangements.
Given the variations in how this figure may be computed, the information may not be too meaningful. It may, however, open a dialogue between employers and employees regarding the value and future of health care benefits.

**Medicare Part D Retiree Subsidy**

Employers that provide prescription drug coverage to Medicare-eligible retirees no longer will be eligible for a tax deduction for the amount for which they receive a federal subsidy.\(^{15}\)

**Enforcement Date to Be Determined**

**Nondiscrimination Requirements**

The *nondiscrimination* requirement for insured plans\(^ {16} \) is a critical new provision. Under this provision, an employer sponsoring an insured plan is prohibited from discriminating in favor of highly compensated individuals. The Code already prohibits such discrimination in self-funded plans, but most practitioners agree that the guidance is outdated and ambiguous and that the prohibition has not been rigorously enforced. Many questions exist about how the guidance will be applied, in both insured and self-funded plans. Given this uncertainty, IRS has announced it will not enforce this new provision until after it issues guidance.\(^ {17}\) To the extent that employees covered by a collective bargaining agreement are excluded from this analysis, an employer’s “pay or play” decision, discussed below, can differ for this group.

**Automatic Enrollment**

Employers that are subject to the Fair Labor Standards Act, have more than 200 full-time employees, and provide health care coverage must enroll new full-time employees in their health plan automatically.\(^ {18}\) New full-time employees must be notified that they can opt out of coverage. DOL apparently does not anticipate issuing guidance and enforcing this requirement by 2014, given the need to coordinate with other health care reform and tax requirements (e.g., 90-day waiting period, employer penalties and cafeteria plan rules prohibiting changes in elections except for specified circumstances).\(^ {19}\)

**Other Administrative Requirements and Developments**

After guidance is issued, plans will be required to comply with requirements regarding providing data, certifying compliance with the Health Insurance Portability and Accountability Act, and transferring electronic funds.\(^ {20}\)

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**Plan or Policy Year Beginning on or After January 1, 2014**

**Exchange Implementation**

PPACA provides that effective January 1, 2014, individuals and small employers will be able to buy health care insurance that provides essential health coverage through a state exchange.\(^ {21}\) An individual who is not eligible for Medicaid and has income up to 400% of the federal poverty level might be eligible for a premium tax credit to reduce required monthly premium contributions and cost reductions.\(^ {22}\) HHS must certify to the exchange whether the individual appears to be eligible for the credit, either because his employer does not provide coverage or because it appears that the employer provides coverage that either fails to provide *minimum value* (i.e., plan pays 60%, on average, of covered health care expenses) or is *unaffordable*. Coverage is unaffordable if the “required contribution” exceeds 9.5% of household modified adjusted gross income for the tax year.\(^ {23}\) Individuals who do not have *minimum essential coverage* (e.g., through an exchange, Medicaid or similar program, or an employer-sponsored plan) will be subject to penalties.\(^ {24}\)

**Employer Shared Responsibility: Pay or Play, or Employer Mandate to Provide Minimum Essential Coverage, at Minimum Value**

Commencing in 2014, applicable large employers are required to “pay or play.”\(^ {25}\) For this purpose, a *large employer* means any employer having an average of at least 50 full-time-equivalent employees on business days during the preceding calendar year. *Full-time* is 30 hours per week, and employees working fewer hours are combined to create full-time equivalents on a monthly basis when determining if the 50 full-time employee threshold is reached. The *employer* is defined under the Code-controlled group rules (i.e., certain related companies are required to be combined).

Applicable large employers will be required to provide health care coverage that is affordable (as described above) and that provides *minimum value* to their full-time employees (and their dependents), or they potentially will owe penalties.\(^ {26}\) The agencies are working to define mechanisms for measuring minimum value.\(^ {27}\)

A large employer that does not provide coverage will be subject to a nondeductible excise tax if even one full-time
employee receives a premium credit. The monthly tax is the number of full-time employees minus 30, times one-twelfth of $2,000, with the tax indexed after 2014.26

A large employer that does provide coverage will be subject to a nondeductible excise tax for each full-time employee who receives a premium credit.29 The monthly tax is one-twelfth of $3,000 for each employee who receives a premium, limited to the total number of full-time employees of the employer minus 30, times one-twelfth of $2,000.30

Reporting Requirements and Determination of Excise Taxes

Many questions remain regarding how and when employer excise taxes will be computed, paid and reconciled. IRS Notice 2011-36 requested comments regarding employer shared responsibility and made some assumptions about how employees would be counted. The examples use 2014 data to determine whether an employer is a large employer in 2015. It appears, however, that an employer that wants to avoid being treated as an applicable large employer may need to start documenting its full-time employee and full-time-equivalent employee counts as early as January 1, 2013.31

PPACA contemplates a procedure for an employer to dispute an individual’s assertion that the employer does not provide affordable coverage, but this occurs at initial application (e.g., fall 2013, for coverage commencing January 1, 2014).32 Whether an individual who receives a premium credit actually would be eligible for that credit (and the employer thus would owe excise taxes) will not be known until much later. Health insurance issuers, employers that sponsor self-funded plans, and other persons that provide minimum essential coverage to an individual are required to report specified information about the past year to IRS, and to the individuals, by January 31 (e.g., by January 31, 2015 for 2014).33 Individuals are required to provide certain information, including a reconciliation relating to any premium credit, with their tax returns (e.g., assuming no extensions, by April 15, 2015 for 2014).

PPACA allows the Treasury to require penalties on an annual, monthly or periodic basis. The act also requires the Treasury to establish rules for the repayment of payments later determined to be inaccurate.34 This suggests that an employer might make payments in advance, based on initial assumptions.

To determine whether an employee actually was eligible for a premium credit, and to compute the amount of any excise taxes an employer is required to pay, someone will have to assemble extensive amounts of data from many sources and do numerous computations. Typically, that would be done by the person liable for the tax (e.g., the employer), but PPACA provides for this information to flow to the Treasury and seemingly prohibits the employer from obtaining the necessary information.35 That suggests a substantial amount of work for the Treasury, which has not yet indicated that it is gearing up for work of this magnitude.

PPACA directs the Secretary of HHS to consult with the Secretary of Treasury and report, by January 1, 2013, what procedures and/or law changes are necessary to protect both the individual taxpayers’ privacy rights and the employers’ rights to adequate due process. It will be interesting to see how the agencies propose resolving these issues, given that due process seemingly requires that a taxpayer have access to information necessary to challenge the accuracy of a penalty assessed and an opportunity to make this challenge.

No Preexisting-Condition Exclusions

The preexisting-condition exclusions that have been in effect for minors for plan years beginning on or after September 23, 2010 will be extended to all individuals in 2014.36

Complete Prohibition on Annual and Lifetime Limits on “Essential Health Benefits”

Plans no longer will be able to put lifetime limits on essential health benefits. The phaseout of limits began with plan years beginning on or after September 23, 2010.37 Under that phaseout, the applicable lifetime limit for 2012 calendar-year plans is $1.25 million and the applicable lifetime limit for 2013 calendar-year plans is $2 million.

New Cost-Sharing Limitations

PPACA limits cost-sharing provisions such as deductibles and maximum out-of-pocket expenses, at
least for nongrandfathered small-group coverage. It is unclear whether these limits apply to large-group insured plans and to self-funded plans. Guidance in this area will be critical as employers seek to limit health care costs and comply with potentially inconsistent mandates. For example, many employers have sought to control costs by shifting to high-deductible health plans with health savings accounts (HSAs).

Restrictions on Waiting Periods

Eligibility waiting periods for group health care plans (insured and self-funded, grandfathered and nongrandfathered) will be limited to 90 days. IRS Notice 2012-59 provides some initial guidance effective through at least the end of 2014. In the case of a plan that provides for eligibility on the first day of the month following 90 days of service, it appears the eligibility requirement will have to be revised. Questions remain regarding how this requirement will interact with other requirements. IRS and Treasury stated that upcoming guidance is expected to provide that the employer penalty for failure to provide coverage will not apply during the permitted waiting period.

Reinsurance Assessment

PPACA requires states to establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years the exchanges are operational. The program is funded through a reinsurance assessment. All health insurance issuers, and third-party administrators on behalf of self-funded plans, are required to make quarterly payments, generally on a per capita basis, to support a transitional reinsurance program to establish a high-risk pool for the individual insurance market. Given that the minimum amounts total $25 billion or more in three years, health care premiums can be anticipated to increase accordingly.

Annual Health Insurer Provider’s Fee

Issuers of individual and group health insurance coverage will be required to pay substantial amounts to help with health care reform. The aggregate fee will be $8 billion in 2014, increasing to $14.3 billion in 2018. After 2018, the fee will increase based on premium trends. Again, health care premiums can be anticipated to increase for this amount. Significantly, self-funded plans are exempt from this tax.

2018 Cadillac Tax

Effective January 1, 2018, a non-deductible 40% excise tax applies to multiemployer plans (including governmental plans) that offer health coverage valued at more than $27,500. Value is the actual premium for insured plans and is computed essentially the same way as a COBRA premium for a self-funded plan. Multiemployer plans can use the average cost of single and family coverage for this purpose. The dollar amount will be indexed to inflation and possibly increased due to health care cost escalation. The dollar amount will also be adjusted for retirees aged 55 and over who are ineligible for Medicare, and for employers where the majority of employees are in a high-risk profession. The amount will not be adjusted for areas that have the highest cost of health care. The tax is computed and paid by the plan administrator if self-funded, or by the insurer if the plan is insured. The tax is paid on the value in excess of the threshold. Contributions to a health savings account, flexible spending account or health reimbursement arrangement count toward value, which means that employers and employees may be surprised at a Cadillac tax applying to a plan that might not otherwise look like a Cadillac.

Given escalating health care costs and other provisions of PPACA, such as mandated benefits, the health insurance

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provider’s fee and cost-sharing limitations, some health care practitioners anticipate this substantial tax will hit many plans. This is likely to be an important issue in collective bargaining negotiations leading up to 2018. This tax, and the exchanges, may pose existential threats to multiemployer plans. Accordingly, multiemployer plan trustees need to carefully analyze alternative designs to try to minimize the impact of this tax, and they should be prepared to address the questions of employers and unions preparing for negotiations.

In summary, multiemployer plan trustees have a lot of work to do in the coming years and need to be attuned to developing guidance as health care reform is more fully implemented.

**Endnotes**

1. PPACA is codified in various statutes, including the Internal Revenue Code and Employee Retirement Income Security Act (ERISA). The Treasury, Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Health and Human Services (HHS) are required to collaborate on much of the guidance under PPACA, and much of the guidance is published in virtually identical form by two or three of the agencies. For consistency, this article primarily refers to the Internal Revenue Code (Code) and IRS guidance.

2. Significant excise taxes may apply with respect to any failure to comply. See Code Sections 4980B, 4980D, 4980E and 4980G.

3. PPACA Sections 2713, 2719A and 2719.

4. PPACA provisions that became effective in prior years, and special grandfather rules that apply in the context of multiemployer plans and collectively bargaining are presumed to have been addressed.

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