Navigating National Health Care Reform: What Every Employer Should Know

President Obama recently signed into law two pieces of legislation, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (for purposes of this Alert, these Acts will be referred to collectively as "PPACA"), which, among other things, significantly alter employer responsibilities with respect to providing group health plan coverage to employees.

This Alert, which focuses on certain PPACA provisions which become effective before 2012, is the first in a series of Alerts that we expect to issue to describe various PPACA provisions of interest to employers. This Alert addresses new group health plan coverage and cost-sharing obligations (such as a ban on annual and lifetime benefit limits and pre-existing condition exclusions), new rules imposed on the administration of group health plans and new programs established under PPACA.

We anticipate that we will circulate one or more follow-up Alerts highlighting important PPACA provisions that become effective after 2011, and which will address topics such as:

- PPACA's "pay or play provisions," which will impose penalties on large employers who do not offer health coverage to full-time employees or whose coverage does not meet certain minimum standards, beginning on January 1, 2014;
- A penalty imposed on large employers when certain employees choose not to enroll in the employer-sponsored plan and instead receive a federal subsidy to enroll in certain other insurance coverage, beginning on January 1, 2014;
- "Free choice vouchers" that certain employers will be required to offer to certain lower income employees who choose not to participate in employer plans, generally effective in 2014; and
- The "Cadillac" tax that will be imposed where the cost of coverage exceeds certain specified levels, starting with taxable years beginning after December 31, 2017.

We note that this Alert does not describe all PPACA provisions that become effective before 2012, and that uncertainties exist regarding how some of the provisions described here will work in operation. We anticipate that guidance will be issued to resolve these issues and our understanding of PPACA's requirements will continue to evolve as guidance is issued.

I. Limited Exceptions From Obligations For Grandfathered Plans

Certain group health plans, known as "grandfathered plans," are not subject to some of the various PPACA provisions described in this Alert. Under PPACA, a grandfathered plan is any group health plan or health insurance coverage in which an individual was enrolled on the date of the Patient Protection and Affordable Care Act's enactment (i.e., March 23, 2010). A plan will not lose its grandfathered plan status merely because an individual enrolled on March 23, 2010 renews his or her participation and enrolls family members in the plan after such date. Further, enrolling new employees (and their family members) after March 23, 2010 will not adversely affect a plan's grandfathered status.

In addition to the above basis for attaining grandfathered plan status, health insurance coverage maintained pursuant to collective bargaining agreements that were in effect prior to March 23, 2010 will be grandfathered until the date on

which the last collective bargaining agreement relating to such coverage terminates. PPACA provides that any amendments to such coverage solely to conform to certain coverage and insurance market reforms under PPACA will not be treated as terminating the collective bargaining agreement.

PPACA does not address the key questions of how long a group health plan will be able to maintain its grandfathered plan status in light of changes in the facts and circumstances relating to the health plan, and what actions taken with respect to the plan will cause it to lose grandfathered status. Thus, for instance, it is currently unclear whether changes in insurance providers, or adding or significantly modifying insurance coverages or plan benefits would terminate a plan's grandfathered status. We expect, and must await, future regulations to offer guidance identifying those events that will cause a loss of grandfathered plan status.

This Alert generally indicates whether a grandfathered plan is subject to the particular PPACA provision described in this Alert. For ease of reference, the following chart briefly identifies whether grandfathered plans are subject to the PPACA provisions described in this Alert:

Provision	Applicable to Grandfathered Plan?
Ban on Annual/ Lifetime Limits	Yes
Ban on Pre-Existing Condition Exclusions	Yes
Extended Coverage of Adult Children	Yes
Ban on Discriminating in Favor of Highly Compensated Individuals	No
Appeals Process Standards	No
Ban on Over the Counter Medication Reimbursement	Yes
Automatic Enrollment of Full-Time Employees by Large Employers	Yes
Advance Notice of Material Modifications	Yes
Penalties for Encouraging Employee Disenrollment	Yes
Premium Rebates for Plans with Low Medical-Loss Ratios	Yes
Temporary Reinsurance Program for Early Retirees	Yes
Ban on Cost-Sharing Requirements for Certain Preventative Health Services	No
Ban on Prior Authorization Requirements for Emergency Services	No
Limits on Ability to Rescind Coverage	Yes
Cost-Sharing Obligations for Out-of-Network Emergency Services	No
Participant Choice of Primary Care Physician/Pediatrician/Gynecologist	No
W-2 Health Coverage Cost Reporting Obligation	Yes

II. Group Health Plan Coverage And Cost-Sharing Obligations

The following section describes certain coverage and cost-sharing obligations PPACA imposes on group health plans that are currently effective, or will become effective in the near future, and identifies whether the "grandfathered plan" exception applies for certain PPACA provisions. One or more subsequent Alerts will describe important group health plan obligations which first become effective after 2011. Except as otherwise indicated, these new rules apply to group health plans, regardless of the employer's size. However, the new requirements generally do not apply to limited scope dental or vision benefits.

Effective for Plan Years Beginning On or After March 23, 2010

Advance Notice of Material Modification to Group Health Plan. PPACA generally requires a group health plan to provide advance notice of a material plan modification at least 60 days prior to the effective date of the change. This is a change to the current ERISA requirement, which does not require that notice of health plan changes be delivered in advance of such changes. Grandfathered plans are subject to this provision.

PPACA provides that this requirement is effective for *grandfathered plans* for plan years beginning on or after the March 23, 2010 enactment date, and is effective for new plans for plan years beginning on or after September 23, 2010.[1]

When renewing insurance policies, or considering whether to change insurers, employers will need to keep this advance notice requirement in mind. Specifically, employers should consider whether to begin negotiating insurance renewals, or seeking bids for changing insurers, earlier than in the past, so that any changes that are made to the plan in connection with the policy's renewal (or change to a new insurer) can be timely communicated to participants, in accordance with PPACA's 60-day advance notice requirement.

Effective For Plan Years Beginning On or After September 23, 2010

Except as specifically identified below, the following provisions are effective for plan years beginning on or after September 23, 2010. For calendar year plans, then, these provisions will become effective January 1, 2011.

Ban on Annual and Lifetime Limits. PPACA generally prohibits group health plans from imposing annual and lifetime limits on the dollar value of "essential" benefits available to plan participants and beneficiaries. Essential benefits include benefits such as hospitalization, prescription drugs and preventative and chronic disease management. However, with respect to plan years beginning prior to January 1, 2014, PPACA provides that a plan may still impose certain annual limits, and directs that more guidance be issued as to the permitted annual limits which may apply during this period. Such guidance is required to ensure (a) that any annual limits still permit access to needed services and (b) that access to needed services is made available with a minimal impact on premiums. The annual and lifetime limit bans apply to grandfathered plans.

1 PPACA provides that a notice of changes must only be provided if the change is not reflected in the most recently provided summary of benefits and coverage required under PPACA (which will be discussed in a following Client Alert). But because a group health plan has until March 23, 2012 to start providing the PPACA-required summary (and guidance must be issued as to the required content of such summary), it not entirely clear whether a plan must provide an advance notice of changes before the PPACA-required summary is required to be provided. In the absence of further guidance regarding the effective date of the advance notice of change requirement, however, we recommend that plans give advance notice of material changes in accordance with the schedule identified above for new plans or grandfathered plans, as applicable.

Because PPACA prohibits the imposition of a *dollar* limit on benefits, without further guidance clarifying this provision, it appears that PPACA may still allow a plan to impose limits on the number of visits or treatments, to the extent such limits are not otherwise restricted by applicable law. (For example, even if PPACA were to allow a plan to impose limits on the number of doctors visits covered, a group health plan must still comply with the Mental Health Parity and Addiction Equity Act of 2008's requirements prohibiting certain limits on the number of visits or treatments covered for mental health benefits.) However, further guidance may limit that possibility.

Ban on Pre-Existing Condition Exclusion. Group health plans are prohibited from imposing a pre-existing condition exclusion with respect to enrollees who are under age 19. In a March 29, 2010 letter to America's Health Insurance Plans, Secretary of Health and Human Services Kathleen Sebelius indicated that this provision prohibits both the denial of coverage and the denial of treatment due to an individual's condition. This prohibition will apply to *all* enrollees (including those age 19 or older) starting with plan years beginning on or after January 1, 2014. This prohibition applies to grandfathered plans.

Extended Coverage of Adult Children. PPACA requires group health plans to continue to make coverage available to adult children until age 26, regardless of whether a child is married. Regulations will be issued regarding which adult children can be considered "dependents" for purposes of this extended coverage. A plan will not, however, be required to cover the children of a covered adult child (i.e., the grandchildren of the group health plan participant) or the spouse of a covered child.

Grandfathered plans are subject to this provision. However, for plan years starting prior to January 1, 2014, grandfathered group health plans need not extend coverage to an otherwise eligible adult child if such child is eligible to enroll in an employer-sponsored health plan (other than the grandfathered plan).

It should be noted that some states have already mandated extended coverage for adult children. To the extent that a state requires coverage of children for a period longer than the period specified under PPACA, a group health plan subject to that state law must continue to comply with the state law.

Under PPACA, an employer's provision of health coverage for an adult child will be excluded from the employee-parent's income for all calendar years ending prior to the year the covered child turns age 27. This change is effective as of March 30, 2010, and the IRS recently announced that cafeteria plans would immediately be permitted to allow employees to make pre-tax contributions to pay for this the adult child's health coverage in the group health plan, even if the cafeteria plan has not yet been amended to provide for this pre-tax contribution. Cafeteria plan administrators will have until the end of 2010 to amend their plan language accordingly. The IRS also clarified that the cafeteria plan regulations will be amended retroactively to include change in status events (which are required in order for participants to change their elections under the plan mid-year) involving non-dependent children under age 27. These change in status events would include becoming newly eligible for health plan coverage or eligible for a longer period than previously anticipated. Plan administrators will be permitted to rely on an employee's representation of the adult child's date of birth.

Although it initially seems incongruous that continued coverage is required only until a child's 26th *birthday*, but the tax exclusion continues through the *end of the calendar year* in which the child attains age 26, this timing can work in favor of plan sponsors and employees. Specifically, PPACA does not require a group health plan to terminate a child's health coverage on the date he or she attains age 26. Plan sponsors may choose to allow coverage through the end of the calendar year in which the child attains age 26

because it is administratively easier than terminating coverage immediately upon a child's reaching his or her 26th birthday. By extending the tax exclusion until the end of the calendar year in which the child attains age 26 (and beyond PPACA's required coverage period), in the case where a group health plan chooses to continue the child's coverage until the end of such year, the extended health benefits will not be taxable to the employee.

There are several uncertainties about the nature of the extended coverage requirement. First, it is not clear whether a plan is required to permit the re-enrollment of a covered employee's child, who had previously been excluded from a health plan due to age but who is under the age of 26 as of the effective date of this provision. It is likely, however, that as there is no specific exclusion of such individuals, dependent children under the age of 26 should be permitted to re-enroll, even if they had been excluded prior to the law change. In addition, it is unclear whether an employer would be allowed to charge an employee a separate premium rate for an adult child's enrollment in the coverage or to provide a different level of coverage for that adult child. We are hopeful that future guidance will resolve these uncertainties.

Advance Notice of Material Modification to Group Health Plan. This requirement is described above. Non-grandfathered plans are subject to this requirement starting with plan years commencing on or after September 23, 2010. (In contrast, grandfathered plans are subject to this requirement beginning with plan years beginning on or after March 23, 2010.)

Ban on Discriminating in Favor of Highly Compensated Individuals. PPACA prohibits an *insured* group health plan from discriminating as to eligibility to participate or as to benefit levels in favor of highly compensated individuals. Under the new law, rules similar to those that currently apply under the Internal Revenue Code regarding discrimination under self-insured health plans will also apply to insured arrangements. This prohibition does not apply to grandfathered plans.

For these purposes, highly compensated individuals will generally include the 5 highest paid officers of an employer, shareholders owning more than 10% of the stock of an employer, and the highest paid 25% of all employees of the employer. For purposes of determining whether a plan is discriminatory with respect to eligibility to participate, the plan can exclude certain non-participating employees with less than 3 years of service, who have not attained age 25, who are part-time or seasonal employees, who are non-resident aliens without US-source income, or certain collectively-bargained employees.

There are a number of elements of the new rule that are not clear. One uncertainty relates to the penalty for non-compliance. It appears (although it is not clear) that in contrast to the current impact of the nondiscrimination rules on self-insured arrangements, which can result in taxable income related to the benefits paid to a highly compensated individual or retiree under a discriminatory plan, the penalties here may be on the employer itself. A discussion of the potential penalties for non-compliance is found in the following Section. The scope of the grandfathered plan exception provision is also unclear, and may be particularly important where a promise of discriminatory insured coverage for an employee or a retiree has previously been made in an employment agreement. We also do not yet know to what extent there may be any exceptions for discriminatory coverage provided under an insured group health plan where the premium is paid by the employee, rather than by the employer. We are hopeful that regulatory guidance will answer some of those questions.

Appeals Process. PPACA requires group health plans to establish claims appeals processes which appear to be generally similar to the claims procedures required by ERISA. However, the statute requires that a plan's appeals process include an external review process, which is not currently an ERISA requirement (although certain states do currently require insured plans to use an external appeals procedure). PPACA also provides that a plan's internal claims procedure must allow an enrollee to receive continued coverage pending the outcome of the appeals process, although clarification is needed regarding how this requirement is intended to work with respect to claims which are ultimately denied. Standards for this external review process are to be established for self-insured plans and insured plans operating in states which have not established requirements for an external review process. Grandfathered plans are not subject to this appeals process requirement.

Other Notable PPACA Group Health Plan Responsibilities. Other notable coverage and cost-sharing obligations which become effective for plan years beginning on or after September 23, 2010, include a ban on cost-sharing requirements for certain preventative health services, such as immunizations and a ban on prior authorization requirements for emergency services. In addition, PPACA limits a group health plan's ability to rescind coverage to instances of fraud or material misrepresentation, requires that the cost-sharing obligations for out-of-network emergency services be the same as the obligations for in-network emergency services and requires that participants be allowed to choose their primary care physicians and pediatricians, and not be required to obtain a referral in order for gynecologist visits to be covered.

Effective in 2011

Limitation on Over-the-Counter Medications. Health flexible spending arrangements, health savings accounts, health reimbursement arrangements and Archer MSAs may not reimburse participants for medication unless the medication is a prescribed drug or insulin. Therefore, these arrangements will generally not be permitted to reimburse for costs of over-the-counter medications unless the purchase is pursuant to a doctor's prescription. This provision applies to grandfathered plans.

We understand that this limitation is first effective for expenses incurred during 2011, regardless of whether a plan is a non-calendar year plan. For example, if a health flexible spending account plan has a July 1 plan year, a participant may not be reimbursed for over-the-counter medications the individual purchases on January 30, 2011, even though the individual based his or her elections for the July 1, 2010-June 30, 2011 plan year on the ability to use his or her flexible spending account to purchase over the counter medications. Similarly, it appears that an individual cannot be reimbursed from his or her flexible spending account for over-the-counter medications purchased during a 2011 grace period, which is with respect to a 2010 calendar year plan. For example, if a calendar year plan has a grace period through March 15, 2011, a participant cannot be reimbursed for the February 8, 2011 purchase of over-the-counter medication, even if the claim relates to 2010 health flexible spending account contributions.

We recommend that employers immediately inform participants of this new limitation so that participants will understand the new restriction on reimbursement for the purchase of over-the-counter drugs and when it is effective.

Unclear Effective Date

Automatic Enrollment. PPACA requires that an employer subject to the Fair Labor Standards Act that employs more than 200 full-time employees and offers health plan coverage must automatically enroll new full-time employees in the plan (subject to any allowed waiting period). The employer must provide the employee with notice of the automatic enrollment program, and the opportunity to opt-out of such health coverage. In addition, employers must automatically continue plan enrollment of current employees (subject to their right to opt out of coverage). This provision applies to grandfathered plans.

PPACA does not include a specific effective date for this provision. Because PPACA provides that the automatic enrollment requirement is imposed in accordance with still-to-be-issued regulations, we are hopeful that this provision will not be treated as effective until guidance is issued.

III. Penalties/Disincentives

A. Penalties for Non-Compliance with Coverage and Cost-Sharing Obligations.

PPACA does not incorporate independent penalties for non-compliance with respect to the group health plan coverage and cost-sharing obligations described above; instead, the penalty provisions generally derive from existing provisions in the Internal Revenue Code and the Public Health Service Act. While the penalties are not clear, it appears that if a group health plan fails to satisfy certain of the obligations described above, the group health plan (or, in many cases, the employer sponsoring the plan), may be subject to (a) an excise tax, under the Internal Revenue Code, which could be as much as $100 per day *for each individual* with respect to whom a failure occurred (but subject to certain limitations) and possibly (b) an additional penalty on group health plans, under the Public Health Service Act, of up to $100 per day *for each individual* with respect to whom a failure occurred (but subject to certain limitations).

B. Penalties for Encouraging Employee Disenrollment.

Effective immediately, PPACA authorizes sanctions be imposed against an employment-based health plan in the event an employer encourages an employee to disenroll from the health plan, based on the individual's health status, in consideration for money or other financial consideration. By way of background, the statute establishes a temporary high risk health insurance pool program (which ends on January 1, 2014) to provide health insurance coverage to uninsured individuals with pre-existing conditions. PPACA provides that an employment-based plan that encourages disenrollment could be responsible for reimbursing the program for the medical expenses incurred by the program for the enrolled individual. But it also provides that this penalty should not be construed as the exclusive sanction for violating PPACA's provisions and encouraging employee disenrollment. This provision applies to grandfathered plans.

It should be noted that the law speaks in terms of *disenrolling* employees previously covered. We are hopeful that PPACA will not be interpreted to disallow, or otherwise restrict, choices regarding health coverage under Section 125 flexible benefit plans, where cash may be paid in lieu of coverage, or employer policies that provide for small cash payments to employees who never enroll in coverage. The extent to which either arrangement will be impacted by the new law, however, will not be known until guidance is issued.

C. Premium Rebates for Group Health Plans with Low Medical-Loss Ratios.

Beginning no later than January 1, 2011, PPACA requires health insurance issuers to provide an annual rebate to each enrollee (on a pro-rata basis) in the event that expenses the issuer incurs in insuring a group health plan for medical claims and services do not meet a certain threshold percentage of the premium revenue it is collecting from the plan, known as the "medical-loss ratio." This provision applies to grandfathered plans. It appears from PPACA that this provision applies to grandfathered plans starting with plan years beginning on or after March 23, 2010 and to non-grandfathered plans starting with plan years beginning on or after September 23, 2010, but more guidance is necessary to clarify the effective date provisions. (In addition, in accordance with this effective date schedule, a health insurance issuer will be required to submit a report on the ratio of certain of its expenses to its "earned" premiums.)

The medical-loss ratio threshold an insurer must satisfy depends on the size of the plan. The medical-loss ratio for an insured group health plan in the large group market can be no less than 85%, and the medical loss ratio for an insured group health plan in the small group market can be no less than 80%. In each instance, PPACA allows states to establish higher thresholds.

The amount of the rebate is the product of (a) the amount by which the minimum threshold percentage exceeds the actual medical-loss percentage and (b) the total amount of premium revenue collected by the issuer for the plan year, subject to certain exclusions (such as federal and state taxes). While the statute contemplates that the rebate is to be paid to enrollees, further guidance is necessary in connection with how such rebate is to be paid with respect to group health plans.

IV. New Programs And Possible Payments To, Or Tax Credits For, Employers

A. Temporary Reinsurance Reimbursement Program for Early Retirees.

PPACA includes a temporary reimbursement program to reimburse employment-based plans for a portion of the cost involved in providing certain health coverage to early retirees (including their spouses, surviving spouses and other dependents). An "early retiree" is an individual who is at least 55 years old but is not yet eligible for Medicare and who is no longer an active employee of an employer maintaining or contributing to the plan or that has made substantial contributions to the plan.

The program contemplates reimbursement of a plan for 80% of the portion of a claim that exceeds $15,000 (adjusted for inflation). To be eligible for the reimbursement, however, a plan must implement a certified program to generate cost-savings with respect to participants with chronic and high-cost conditions. In addition, the plan must submit an application for the reimbursement which includes documentation of the actual cost of the items and services for which each claim is submitted. A submitted claim must be for at least $15,000 and may not exceed $90,000 (adjusted for inflation). The reimbursement will not be considered income to the sponsoring entity, but must be used to lower costs for the plan, including reducing premiums or deductibles.

Although the program is due to end on January 1, 2014, PPACA has allocated a fixed amount of $5 billion to the program – which is available without fiscal year limitation. Moreover, the statute indicates that, based on availability of funds, a decision may be made to stop taking applications for the reimbursement. Therefore, once the application process begins, it would be advisable to submit applications, if eligible,

as soon as possible. However, fundamental questions about this program (including the mechanics of participation where coverage is fully insured, with claims paid by an insurer rather than an employer or plan) will need to be answered in the guidance to come.

B. Small Employer Subsidy.

The PPACA introduces a new tax credit for certain small employers, including certain small tax-exempt employers, that provide health care coverage to their employees. This new tax credit is available beginning with the 2010 taxable year.

To be eligible for the tax credit, an employer must (i) have no more than 25 "full-time equivalent employees" (as defined below) for the applicable taxable year, and (ii) pay average annual wages to its employees that do not exceed $50,000 (adjusted for cost of living after the 2013 taxable year) per full-time equivalent employee per year. In addition, the employer must pay a uniform percentage of at least 50 percent of the cost of single coverage in a health plan. (Beginning with the 2014 taxable year, it appears that the health plan coverage must be in a qualified health plan offered through a state or federal government-established "exchange" to be established under PPACA.) Because the limit is 25 "full-time equivalent employees," an employer with more than 25 employees may be able to qualify for the credit if some employees are part-time.

For tax years beginning in 2010 through 2013, the maximum credit available is 35 percent (25 percent for eligible tax-exempt organizations) of the premiums paid by an employer for health insurance coverage (generally health insurance coverage purchased from an insurance company licensed under state law). Beginning with the 2014 tax year, the maximum credit available will increase to 50 percent (35 percent for eligible tax-exempt organizations) of premiums paid by an employer only for a qualified health plan it offers to its employees through a state or federal government-established exchange (or, if less, the premiums it would have made, had each employee enrolled in such plan), and is only available for a maximum coverage period of two consecutive taxable years (beginning with the first year after 2013 in which the employer or any predecessor first offers one or more qualified plans to its employees through a government-established exchange) (so, a qualified small employer could potentially qualify for the tax credit for six consecutive taxable years—2010 through 2013 and then 2014 and 2015). If an eligible employer has in excess of 10 full-time equivalent employees and/or average annual wages in excess of $25,000, the credit will be proportionately reduced.

Employee pre-tax contributions to the cost of coverage are not included in the premium calculation for determining an employer's credit. In addition, the amount of the employer's premium payments that are taken into account for purposes of the credit may not exceed the following:

- the average premium cost for the small group market in the state (or area within the state) in which the employer offers coverage (a state-by-state average premium list is expected to be published by the IRS); and
- for tax-exempt organizations, the organization's total amount of payroll taxes (i.e., amounts required to be withheld from employees for income and Medicare taxes, and the organization's share of Medicare taxes on employees' wages).

For purposes of the credit, the number of "full-time equivalent employees" is calculated by dividing the total number of hours for which the employer pays wages to employees during the taxable year (up to a

maximum of 2,080 hours for any employee) by 2,080 (rounded down if not a whole number). In making this determination the following rules apply: (i) the number of hours worked by and wages paid to a seasonal worker shall not be taken into account unless the worker works more than 120 days during the year; (ii) leased employees are included; (iii) self-employed individuals, 2 percent shareholders of an S corporation, 5 percent owners, and certain relatives of these individuals are excluded (as are their wages). It also appears that an employee of a self-employed individual is not an employee for purposes of the credit if the employee is not performing services in the trade or business of the employer (for example, the credit does not appear to be available for a domestic employee of a sole proprietor or business). It is expected that the government will provide guidance instructing how to count hours for these purposes, including rules for the application to employees who are not compensated on an hourly basis. Average wages for a year is generally calculated as total wages divided by the number of full-time equivalent employees so considered (rounded down to the nearest $1,000 paid to employees considered in the calculation).

Members of a controlled group are treated as a single employer for purposes of the credit. Accordingly, all employees of the controlled group, and all wages page to employees by the controlled group are counted in determining whether any member of the controlled group is eligible for the credit.

Eligible employers can claim this new tax credit on their annual income tax return starting with the 2010 income tax return they file in 2011. For tax-exempt employers, the Internal Revenue Service is expected to provide additional information on how to claim the credit.

The Internal Revenue Service has indicated that it intends to issue guidance that will provide transition relief for tax years beginning in 2010 to make it easier for eligible employers to meet the requirements and qualify for the tax credit. It is anticipated that for tax years beginning in 2010, the following transition relief will apply with respect to the requirements for providing certain health plan coverage: (i) an employer can still qualify for the credit (if it otherwise satisfies the eligibility requirements, such as paying at least half of the premium for each employee enrolled in coverage) even if the percentage of the premium it pays is not uniform for all employees; (ii) if an employee is receiving coverage that is more expensive than single coverage (i.e., family or employee plus one coverage), the employer satisfies the 50 percent requirement with respect to the employee if the amount that the employer pays for such coverage is at least 50 percent of the premium for single coverage for that employee (even if it is less than 50 percent of the premium for the coverage the employee is actually receiving).

C. Simple Cafeteria Plans.

PPACA establishes a "simple cafeteria" program to help small businesses maintain cafeteria plans providing for choices of certain non-taxable and taxable benefits. If a small business (as defined below) establishes a simple cafeteria plan, it will be treated as meeting the nondiscrimination requirements that would otherwise apply to the plan. In addition, the simple cafeteria plan rules may provide some design alternatives for cafeteria plans that are generally not thought to be available under generally applicable cafeteria plan rules.

To satisfy the simple cafeteria plan rules, an employer must make a contribution equal to: (a) a uniform percentage of an employee's compensation, which may not be less than 2%; or (b) an amount which at least the lesser of: (i) 6% of the employee's compensation or (ii) twice the amount of the salary reduction contributions of each employee who is neither a highly compensated or key employee. If an employer chooses to satisfy the simple cafeteria requirements through method (b), the rate of employer

contributions with respect to highly compensated or key employee salary contributions may not be greater than that with respect to the salary reduction contributions of any employee who is not a highly compensated or key employee. In addition to the employer contribution requirements, PPACA imposes the following eligibility requirements: (a) all employees who had at least 1,000 hours of service in the preceding plan year must be eligible to participate, and (b) each employee eligible to participate in the plan must, subject to the terms and conditions applicable to all participants, be eligible to elect any benefit available under the plan. Nevertheless, PPACA allows an employee to exclude the following employees from simple cafeteria plan participation: (a) employees who have not attained age 21 before the close of the plan year, (b) employees who have less than 1 year of service with the employer, (c) employees who are covered by a collective bargaining agreement, and (d) nonresident aliens without U.S. source income.

An employer is considered a "small" employer eligible to establish a simple cafeteria plan if the employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. If an employer was not in existence throughout the preceding year, this determination is instead based on the average number of employees it is reasonably expected the employer will employ in the current year. If an employer establishes a small cafeteria plan, but then grows larger, the employer will generally still be considered a "small" employer in the next following year. However, if the employer employs an average of 200 or more employees during any preceding year, it will no longer be considered a small employer and will not be eligible to continue to offer a simple cafeteria plan. In that circumstance, its cafeteria plan will be required to comply with the generally applicable Code Section 125 cafeteria plan nondiscrimination requirements.

V. Employer Obligations

A. W-2 Reporting.

PPACA generally requires employers to report the aggregate cost of employer-sponsored health coverage on an employee's W-2. The calculation of this cost should be done in a manner similar to the method determining the applicable COBRA premium. The aggregate cost of coverage may not, however, include the amount of an employee's salary reduction contribution to a flexible spending arrangement. A literal reading of the statute indicates that employer-sponsored coverage does not include, moreover, coverage such as stand-alone dental and vision coverage, certain specified disease coverage, long-term care and accident and disability insurance. Finally, this reporting requirement does not apply to the amount contributed to an Archer MSA of an employee or his or her spouse or the amount contributed to a health savings account of an employee or an employee's spouse.[2]

This information will first be reported on W-2s issued in 2012 with respect to the 2011 tax year. This provision applies to grandfathered plans.

B. Reasonable Break Time for Nursing Mothers.

PPACA requires that employers provide a "reasonable" break time for an employee to express breast milk for her child each time the employee has the need to express milk. An employee is entitled to this break

2 We note that the Joint Committee on Taxation Technical Explanation of PPACA, in disagreement with PPACA's literal terms, suggests that an employer must disclose the aggregate value of all health coverage other than the value of a health flexible spending arrangement. We hope that future guidance will clarify this issue.

time for the 1 year period following the child's birth. As part of its obligations, the employer must provide a place other than the bathroom for employees to express milk – and this area must be free from intrusion. While the law does not specify what constitutes a "reasonable" break time, it does provide that an employer is not required to compensate an employee for the break time she takes in connection with this provision.

While the law is generally applicable to employers subject to the Fair Labor Standards Act, it provides an exception for certain smaller employers. An employer that employs fewer than 50 employees will not be subject to these requirements if satisfying these requirements would cause undue difficulty or expense, when considered in relation to the size, financial resources, nature or structure of the employer's business.

It should be noted that PPACA provides that this provision does not preempt State law. Therefore, to the extent that a State has a more rigorous obligation, the employer must follow the State's requirements.

PPACA did not indicate a specific effective date for this obligation. Accordingly, it appears that employers must immediately begin to comply with this new rule.

VI. Conclusion

As is apparent from this Alert, PPACA substantially changes the rules regarding the delivery of health care benefits through the employer provider system. Though many changes have delayed effective dates, employers are advised to begin to carefully study the implications of PPACA now to determine the impact on their medical plans, employees and related costs.

Please stay tuned, as we will be issuing one or more follow-up Alerts highlighting important PPACA provisions which become effective after 2011. ◆

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