MEMORANDUM

From: Bruce H. Wynn

Date: May 10, 2010

RE: Health Care Reform – Employee Benefit Changes

---

1 General Background Information

On March 23, 2010, the Patient Protection and Affordable Health Care Act ("***PPACA***") became law, and on March 30, 2010, the Health Care and Education Reconciliation Act ("***HCERA***") became law. These acts together form the new health care legislation (the "***Health Care Law***" or the "***Law***"). The purpose of this memorandum is to examine and generally outline provisions of the new Health Care Law impacting employers and their employee benefit arrangements, dividing the discussion of the provisions into the following four general areas:

- Impact of the Health Care Law on the FLSA & Employers
- Impact of the Health Care Law on Group Health Plans
- Impact of the Health Care Law on Taxes and Tax Reporting
- Impact of the Health Care Law on MEWAs

2 Impact of the Health Care Law on the FLSA & Employers

The purpose of this portion of this memorandum is to focus on how the new Law impacts the Fair Labor Standards Act and certain employers.

2.1 *Automatic Enrollment for Larger Employers.* Effective March 23, 2010, the Fair Labor Standards Act is amended so that employers with more than 200 full-time employees who offer enrollment in one or more group health plans will be required to automatically enroll new employees in one of the plans offered.[1]

2.2 *Reasonable Break Time for Nursing Mothers.* Effective March 23, 2010, the Fair Labor Standards Act is amended so that an employer must provide a reasonable break time for an employee to express breast milk for her nursing child for a period of up to one year after the child's birth.[2] An employer must also provide a place, other than a bathroom, that is shielded from view and free from intrusion, for an employee to use when expressing breast milk. An employer does *not* have to compensate an employee for such reasonable break time. If an employer employs less than 50 employees, they are not required to meet these new requirements *if* they would impose an undue hardship on the employer. State laws providing greater protections are *not* preempted.

3 Impact of the Health Care Law on Group Health Plans

The purpose of this portion of this memorandum is to focus on how the new Law impacts group health plans of employers.

---

[1] New Section 18A of the Fair Labor Standards Act, added by Section 1511 of PPACA.

[2] New Section 7(r)(1)(A) of the Fair Labor Standards Act, added by Section 4207 of PPACA.

3.1 *No Lifetime or Annual Benefit Limits.* Effective for plan years beginning on or after September 23, 2010, lifetime or annual benefits cannot be imposed by group health plans.[3] (For plan years beginning before January 1, 2014, group health plans may impose an annual limit on benefits per covered person only for "essential health benefits." The Secretary of Health and Human Services ("***HHS***") must determine what benefits are considered "essential health benefits.") The lifetime and annual limitation prohibition does *not* prevent a group health plan from applying such a limitation to benefits that are *not* "essential health benefits."

3.2 *Prohibition on Rescissions.* Effective for plan years beginning on or after September 23, 2010, group health plans may not rescind coverage of an enrollee once the enrollee is covered, except where an individual has performed an act or practice constituting fraud or has made an intentional misrepresentation of material fact as prohibited under the terms of the plan, and, even then, prior notice to the enrollee must occur.[4]

3.3 *Coverage of Preventative Health Services.* Effective for plan years beginning on or after September 23, 2010, group health plans are required to cover, without any cost-sharing, preventative services and immunizations that are recommended by certain Federal agencies.[5]

3.4 *Extension of Dependent Coverage.* Effective for plan years beginning on or after September 23, 2010, group health plans *that provide dependent coverage of children* must continue to make available optional coverage for an adult child until the child turns 26 years old, regardless of their marital status.[6] Note that there is no requirement that a plan provide coverage for anyone, including dependents; however, if a plan does cover dependent children, then coverage for a child must continue until age 26. The extension of dependent coverage is not mandated with respect to children of dependent children.[7]

On May 13, 2010, the IRS (Treas. Reg. §54.9815-2714T), DOL (DOL Reg. §2590.715-2714) and the HHS published interim regulations regarding the extension of dependent coverage to children under age 26. The interim regulations do provide some further guidance:

(a) The interim regulations implement the statutory authority to define the dependents to which coverage shall be made available, and provide that "conditioning coverage on whether a child is a tax dependent or a student, or resides with or receives financial support from the parent, is no longer appropriate in light of the correlation between age and these factors."[8] Additionally, the interim regulations provide that a plan may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant, and provide that factors that cannot be used for defining dependent for purposes of eligibility include

---

[3] Section 2711 of the Public Health Service Act ("***PHSA***"), as amended by new Law. New Code §9815(a)(1) and new ERISA §715(a) provide that the provisions of Part A of title XXVII of the PHSA (Sections 2701 through 2737) generally apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in the Code and ERISA, except that the provisions of PHSA §2716 (prohibition on discrimination based on salary) and PHSA §2718 (bringing down the cost of health coverage) do ***not*** apply with respect to self-insured group health plans.

[4] PHSA §2712.

[5] PHSA §2713.

[6] PHSA §2714.

[7] *Id.*

[8] 75 F.R. 27124 (May 13, 2010).

financial dependency on the participant, residency with the participant, student status, employment, eligibility for other coverage, or any combination of these factors.[9]

(b) The interim regulations note that, for plan years beginning before January 1, 2014, a "grandfathered health plan" this is a group health plan may exclude an adult child who has not attained age 26 from coverage only if the child is eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. If an adult child is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent's employer.[10]

(c) For transition purposes, the interim regulations provide transitional relief for a child whose coverage ended or who was denied coverage or not eligible for coverage, because, under the terms of the plan, the availability of dependent coverage of children ended before the attainment of age 26. For these children, a plan must give the child an opportunity to enroll that continues for at least 30 days, and which must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. If the child does enroll, coverage must begin not later than the first day of the first plan year beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year.[11] The interim regulations allow the notice to be given to the employee on behalf of such employee's child, and allow the notice to be included with other enrollment materials *provided that the statement is "prominent."*[12]

Unfortunately, the interim regulations shed no light on the issues surrounding a "grandfathered health plan" such as how such a plan ceases to be a "grandfathered health plan." However, the interim regulations do provide that regulations "relating to grandfathered health plans under section 1251 of [PPACA] are expected to be published in the very near future" and further provide that it is anticipated that such regulations will "make clear that changes to plan or policy terms to comply with PHS Act section 2714 and these interim final regulations, including voluntary compliance before plan years … beginning on or after September 23, 2010, will not cause a plan or health insurance coverage to lose grandfathered health plan status for any purpose under [PPACA]."[13]

3.5 *Uniform Standards for Health Plan Summaries of Benefits & Coverage.* Within 12 months after March 23, 2010, the Secretary of HHS is to develop standards for use in communicating benefit summaries and coverage information by plans. Not later than 24 months after March 23, 2010, the standard benefits and coverage summary format is to be used by plans to communicate information to plan participants and beneficiaries. The summaries must be provided at the time of enrollment and at each time of reenrollment. The summaries must be no longer than 4 pages in length, must conform to a "uniform format," must have print that is not smaller than 12 point font, and must communicate in a "culturally and linguistically appropriate manner."[14] The summaries must include uniform definitions of standard insurance and medical terms, must describe any cost-sharing, exceptions, reductions, and

---

[9] Treas. Reg. §54.9815-2714T(b); DOL Reg. §2590.715-2714(b).

[10] Treas. Reg. §54.9815-2714T(g); DOL Reg. §2590.715-2714(g).

[11] Treas. Reg. §54.9815-2714T(f); DOL Reg. §2590.715-2714(f).

[12] Treas. Reg. §54.9815-2714T(f)(2)(ii); DOL Reg. §2590.715-2714(f)(2)(ii).

[13] 75 F.R. 27124 (May 13, 2010).

[14] Given that many employers have gotten into the habit of issuing plan documents to participants and letting such documents constitute the summary plan description with respect to their plan, it will be most interesting to see how plans will be condensed into a 4 page 12 point font document. Also, given the case law regarding the binding nature of summary plan descriptions, it will be interesting to see how cases develop regarding rights asserted under these new summary documents.

limitations on coverage, and must use examples to illustrate common benefits scenarios.[15] The summary requirement will preempt any state law standards that would provide less information than that required by the summary requirement. There is a $1,000 fine for any *willful* violation of the summary requirement with respect to an individual. Also, the new Law requires that if a material modification is made to the terms of, or coverage involved with, a group health plan, and such modification is not reflected in the most recently provided summary of benefits and coverage, the plan must provide notice of such modification no later than 60 days *prior* to the date on which such modification will become effective.[16] *In essence, HHS will now prescribe the format and content (to some extent) of summary plan descriptions for group health plans under this provision of the new Law. Or perhaps these summaries will become "summaries" of the summary plan descriptions. Additionally, there is the "prior" notification required now for material modifications.*

3.6 *Prohibition on Discrimination in Favor of Highly Compensated Individuals.* Effective for plan years beginning on or after September 23, 2010, group health plans are prohibited from discriminating in favor of highly compensated individuals with respect to eligibility or benefits.[17] This effectively means that the non-discrimination requirements under Code §105(h) that previously only applied to self-funded medical reimbursement plans *will now apply to fully insured plans*. Employers will need to carefully consider this in structuring any post-termination coverage for former employees, as well as in other situations where discrimination in favor of highly compensated individuals might occur.

3.7 *Quality Reporting Requirements.* No later than March 23, 2013, HHS is required to develop quality reporting requirements for group health plans. Then, on an annual basis, plans will be required to provide plan participants and the HHS with a report detailing whether the coverage under the plan satisfies these reporting requirements. HHS is given authority to develop penalties for non-compliance with the reporting requirements.[18]

3.8 *Appeals Process.* Effective for plan years beginning on or after September 23, 2010, group health plans must establish and implement an effective process for appeals of coverage determinations and claims, which must include, at a minimum, an established internal claims appeal process, notification to participants of available internal and external appeals processes, and provisions allowing a claimant to review their file and to present evidence and testimony as part of the appeals process, and to receive continued coverage during the appeals process.[19] Until the DOL[20] issues standards under the new provision, the current DOL regulations dealing with ERISA claims procedure requirements will be the standard for the appeals process. For external reviews, group health plans may comply with state external review requirements that are binding and, at a minimum, include certain model consumer protections, or implement an external review process meeting standards set up by HHS.

3.9 *Patient Protections.* Effective for plan years beginning on or after September 23, 2010, group health plans must allow covered individuals to select, when the plan requires it, any primary care provider that participates in the plan's network. Group health plans must allow parents or legal guardians of a covered child to designate a physician who specializes in pediatric care as the child's primary care

---

[15] PHSA §2715.
[16] PHSA §2715(d)(4).
[17] PHSA §2716.
[18] PHSA §2717.
[19] PHSA §2719.
[20] United States Department of Labor.

physician if that physician participates in the plan's network. Group health plans must allow covered females to obtain OB/GYN specialist services without seeking a primary care physician referral. Also, when services are provided in an emergency services department of a hospital, those services must be covered without any required prior authorization, regardless of whether or not the provider participates in the plan's network, and non-participating provider services must be covered without any limitations and with the same cost-sharing requirements as coverage for emergency services from a participating provider.[21]

3.10 *Preexisting Condition Exclusions.* Effective for plan years beginning on or after January 1, 2014, group health plans may not impose any preexisting condition exclusion with respect to such plan. But for individuals under the age of 19, group health plans may not impose any preexisting condition exclusion effective for plan years beginning on or after September 23, 2010.[22]

The following changes are not as imminent as the foregoing, but are worth mentioning:

3.11 *Prohibiting Discrimination Based on Health Status.* Effective for plan years beginning on or after January 1, 2014, group health plans may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on the health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or other health status-related factor of such individual or a dependent of such individual.[23]

3.12 *Prohibition on Length of Waiting Period.* Effective for plan years beginning on or after January 1, 2014, group health plans may not impose any waiting period exceeding 90 days before individuals may enroll in the plan.[24]

3.13 *Coverage in Approved Clinical Trials.* Effective for plan years beginning on or after January 1, 2014, group health plans must pay for typically covered items and services provided under an approved clinical trial, and a plan may require that a qualified individual participate in a clinical trial in which a network provider is involved as long as the provider will accept the patient.[25]

Notwithstanding the effective dates mentioned above, individuals who are enrolled in a group health plan as of March 23, 2010, may not be required to terminate that coverage, and such plan is considered a "***grandfathered health plan***." Grandfathered group health plans are generally *not* subject to above provisions, except for items 3.1, 3.2, 3.4, 3.5, 3.10, and 3.12 above, and, (1) with respect to item 3.1 above, such provision (pertaining to lifetime and annual benefit limits) shall, with respect to the prohibition on annual limits, not apply to a grandfathered plan for plan years beginning before January 1, 2014, and (2) with respect to item 3.4 above, such provision (pertaining to extensions of dependent child coverage) shall apply to a grandfathered plan for plan years beginning before January 1, 2014, only with respect to adult children who are not eligible to enroll in some other employer sponsored group health plan. A "grandfathered plan" apparently may retain such status even if employees reenroll in the plan or new family members of current employee participants or new employees join the plan. However, it is not clear whether a "grandfathered plan" may lose such status, and when such a loss of "grandfathered status"

---

[21] PHSA §2719A.
[22] PHSA §2704.
[23] PHSA §2705.
[24] PHSA §2708.
[25] PHSA §2709.

would, if ever, occur. (*See* the last paragraph of item 3.4 above.) For collectively bargained plans, different effective dates may apply than those set forth above.

These provisions with respect to group health plans are enforced through the Code and ERISA. As noted in a footnote above, new Code §9815(a)(1) and new ERISA §715(a) provide that the provisions of Part A of title XXVII of the PHSA (Sections 2701 through 2737) generally apply to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in subchapter B of Chapter 100 of the Code and Part 7 of title I of ERISA, except that the provisions of PHSA §2716 (prohibition on discrimination based on salary) and PHSA §2718 (bringing down the cost of health coverage) do ***not*** apply with respect to self-insured group health plans. Code §4980D provides for a $100 per day of noncompliance excise tax for failures to comply with Chapter 100 of the Code (which would include the PHSA provisions of the new Law).

4 Impact of the Health Care Law on Taxes & Tax Reporting

The purpose of this portion of this memorandum is to focus on how the new Law impacts taxes imposed on employees and employers.

4.1 *Code §45R - Small Employer Tax Credit.* Effective for amounts paid for tax years beginning after December 31, 2009, under new Code §45R, a small employer (generally, an employer that has 25 or fewer "full-time equivalent employees" for a tax year *and* that has average annual wages of its employees that does not exceed $50,000 (adjusted)) may apply for a tax credit if they offer a "qualified health care arrangement" and they pay at least 50% of the cost of such health coverage. The number of "full-time equivalent employees" that an employer has for a tax year is determined by taking the total number of hours for which employees were paid wages by such employer for the tax year and dividing by 2,080, rounding the result down to the nearest whole number. The amount of the credit phases out as the number of "full-time equivalent employees" exceeds 10, and as the average annual compensation paid to the employees exceeds $25,000 (as adjusted). The IRS is to issue regulations preventing the use of multiple entities to obtain the credit. The credit is generally 35% of employer paid amounts for the years 2010 through 2013, and increases to 50% of employer paid amounts for years 2014 and thereafter; however, the credit is only available for the first two years that the employer offers a qualified health care arrangement.[26]

4.2 *Code §6051(a)(14) – Cost of Health Coverage Reporting.* Beginning in 2011, employers are required to disclose the aggregate cost of "applicable employer sponsored coverage" provided to employees annually on the employee's Form W-2, regardless of whether the employer or the employee pays for the coverage.[27]

4.3 *Code §§6055 & 6056 - Health Care Coverage Reporting.* Beginning in 2011, employers that provide minimum essential health care coverage to an individual during a calendar year will be required to file a return reporting such coverage with the IRS, and will also be required to furnish a written statement to the individual with respect to the information reported. The required return must show the dates of coverage with minimum essential coverage, and other information that the IRS may require.[28] *This is a different requirement than the requirement to provide a report of health care coverage costs under Code §6051(a)(14) above.*

---

[26] Code §45R.

[27] Code §6051(a)(14) added by PPACA Section 9002.

[28] Code §6055.

4.4 *Code §106 – Taxable Reimbursement of Over-The-Counter Medicines.* Effective for tax years beginning after December 31, 2010, for purposes of reimbursements from health flexible spending arrangements or health reimbursement arrangements, the definition of qualified medical expenses is modified to include amounts paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.

4.5 *Code §§220(f)(4)(A) and 223(f)(4)(A) – Additional Tax on HAS and Archer MSA Distributions.* Effective for tax years beginning after December 31, 2010, the additional tax on distributions made from HSAs not used for qualified medical expenses is increased from 10% to 20%, and the additional tax on distributions made from Archer MSAs not used for qualified medical expenses is increased from 15% to 20%.[29]

4.6 *Code §6041(h) – Corporate Payment Reporting Requirements.* Effective for tax years beginning after December 31, 2011, the exception to the information reporting requirements (Forms W-2 or 1099) for payments over $600 for corporations is eliminated (other than for tax-exempt corporations).[30]

4.7 *Code §501(r) – Additional Requirements for Charitable Hospitals.* Effective for tax years beginning after March 23, 2010, four new requirements are imposed upon Code §501(c)(3) tax-exempt entities that operate at least one hospital facility (a facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital, and any other facility or organization that the IRS determines has the provision of hospital care as its principal purpose).[31] Those four new requirements are:

(a) The hospital facility must conduct a community health needs assessment a least once every three tax years and adopt an implementation strategy to meet the community needs identified.

(b) The hospital facility must adopt, implement, and widely publicize a written financial assistance policy, indicating the eligibility criteria for financial assistance and whether such assistance includes free or discounted care.

(c) The hospital facility must bill patients who qualify for financial assistance no more than the amount generally billed to insured patients, and may not use gross charges for billing individuals who qualify for financial assistance.

(d) The hospital facility must not undertake certain extraordinary collection actions against a patient without first making reasonable efforts to inform the patient about the hospital's financial assistance policy and determining whether the patient is eligible for assistance under the policy.

Failure to meet these four new requirements can result in a loss of tax-exempt status, but, also, can result in a new excise tax.[32] The excise tax is $50,000 for any applicable tax year.

4.8 *Code §162(m)(6) - Health Insurer Compensation Deduction Limitation.* Effective for tax years beginning after December 31, 2009, "applicable individual" remuneration for services performed will not be deductible above $500,000.00 for any tax year in which the employer is a "covered health insurance provider."[33] An "applicable individual" is an officer, director, or employee of a covered health insurance

---

[29] Code §§220(f) and 223(f) added by PPACA §9004.

[30] Code §6041(h), added by PPACA §9006.

[31] Code §501(r), added by PPACA §9007.

[32] Code §4959.

[33] Code 162(m)(6), as amended by PPACA §9014.

provider (an employer which is a health insurance issuer, and, for tax years beginning after December 31, 2012, which also receives gross premiums from providing such coverage such that not less than 25% of those gross premiums is from essential health benefits coverage). For remuneration for services that an applicable individual performs during a tax year but that isn't deductible until a later year because the remuneration is deferred, any unused portion of the $500,000 limit for the year is carried forward until the year in which the remuneration is otherwise deductible, and the remaining unused limit is then applied to the remuneration.

4.9 *Code §5000B – Excise Tax on Indoor Tanning Services.* Effective as of July 1, 2010, a 10% excise tax is imposed on each individual for whom indoor tanning services are performed. While the tax is imposed on the patron of the services, the performer of the indoor tanning services is required to collect and remit the tax on a quarterly basis.[34]

4.10 *Code §125(j) – New Simple Cafeteria Plans for Small Employers.* Effective for tax years beginning after December 31, 2010, an employer employing an average of 100 or fewer employees during the preceding 2 calendar years (or who expects to employ an average of 100 or fewer employees during the current calendar year if the employer hasn't been in existence for a complete calendar year) may establish a "simple" cafeteria plan if certain contribution, eligibility and participation requirements are met, and under such a plan, the non-discrimination requirements generally applicable to cafeteria plans are deemed satisfied.[35] For the contribution requirement, the employer must make a contribution to the plan in an amount equal to (1) at least 2% of each employee's compensation for the year, or (2) the lesser of (A) 6% of each employee's compensation for the year, or (B) 2 times the amount of salary reduction contributions of each employee. For the eligibility and participation requirements, all employees who had at least 1,000 hours of service during the preceding plan year must be eligible to participant, and each employee eligible to participate may elect any benefit available under the plan.

4.11 *Code §36C and 137Adoption Benefits Expanded.* Effective for 2010 and 2011, the dollar limitation for the adoption credit and income exclusion for employer-paid or employer-reimbursed adoption expenses through a qualified adoption assistance program is increased by $1,000 to $13,170.[36] This dollar amount is indexed for inflation for 2011. In addition, the adoption credit is now refundable.

4.12 *Code §§105, 162(l), 401(h), and 501(c)(9) - Taxation of Medical Benefits for Children under Age 27.* A child who is under the age of 27 will be considered a dependent of a taxpayer for purposes of the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan, the self-employed health insurance deduction, the provisions allowing a tax-qualified plan to provide benefits for sickness, accident, hospitalization and medical expenses to retired employees, and the VEBA rules.[37] Accordingly, it is no longer necessary for a child to be a "dependent" in order for the tax exclusion to apply; the exclusion may apply to a child age 26 or less at the end of a tax year even if the child provides their own support. In Notice 2010-38, the IRS addressed several issues raised by the fact that the tax exclusion here relates to *children age 26 or less at the end of a tax year*, while the required expansion of coverage (see item 3.4 above in "Impact of the Health Care Law on Group Health Plans") for dependents in group health plans is *only until the child attains age 26*:

---

[34] Code §5000B, as added by PPACA §10907.

[35] Code §125(j), as added by PPACA §9022.

[36] Code §§36C and 137(b)(1), as amended by PPACA §10909.

[37] Code §§105(b), 162(l), 401(h) and 501(c)(9), as amended by HCERA §1004.

(a) Under the Notice, an employer may assume that an employee's taxable year is the calendar year, and employers may rely on an employee's representation as to a child's date of birth.[38]

(b) While PPACA addressed tax exclusions relative to benefits received or reimbursements received under Code §105, there were no corresponding changes to the taxability of premiums or coverage payments under Code §106. However, in Notice 2010-38, the IRS acknowledges that "the exclusion for employer-provided accident or health plan coverage under §106 paralleled the exclusion for reimbursements under §105" before PPACA, and "there is no indication that Congress intended to provide a broader exclusion in §105 than in §106." Accordingly, the IRS announced that it intends to amend Code §106 regulations retroactive to March 30, 2010, to provide that coverage for an employee's child under age 27 is excluded from gross income, to match the expansion of coverage for dependents (see item 3.4 above in "Impact of the Health Care Law on Group Health Plans").[39]

(c) In the Notice, the IRS announced that it intends to amend Code §125 regulations retroactively to March 30, 2010, to include change of status events affecting nondependent children under age 27, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.[40]

(d) Cafeteria plans generally need to be amended to include employees' children who have not attained age 27 as of the end of the taxable year, and current proposed cafeteria plan regulations provide that cafeteria plan amendments may be effective only prospectively. However, in Notice 2010-38, the IRS announced that "as of March 30, 2010, employers may permit employees to immediately make pre-tax salary reduction contributions for benefits under a cafeteria plan for children under age 27, even if the cafeteria plan has not yet been amended to cover these individuals," but the IRS also provided that "a retroactive amendment to a cafeteria plan to cover children under age 27 must be made no later than December 31, 2010, and must be effective retroactively to the first day in 2010 when employees are permitted to make pre-tax salary reduction contributions to cover children under age 27…."[41]

4.13 *Code §7701(o) - Codification of Economic Substance Doctrine.* Courts have traditionally used the "economic substance doctrine" to enforce the Code and prevent taxpayers from subverting the legislative intent by engaging in transactions that are fictitious or lack economic reality simply to reap a tax benefit. Under the doctrine, a transaction must have economic significance apart from the tax benefits achieved from the transaction in order for the tax benefits to apply. Under new Code §7701(o), tax benefits should not be allowed for transactions lacking economic substance or a business purpose.[42] The new codified economic substance doctrine will apply to transactions entered into after March 30, 2010.

4.14 *Code §6662 - Penalty for Underpayment Attributable to Lack of Economic Substance.* For transactions entered into after March 30, 2010, a 20% penalty may be applied to underpayments of tax attributable to disallowance of claimed tax benefits relating to a transaction that lacks economic

---

[38] Notice 2010-38, Section II.

[39] Notice 2010-38, Section III.

[40] Notice 2010-38, Section IV.

[41] Notice 2010-38, Section VII.

[42] Code §7701(o), as added by HCERA §1409.

substance, as defined in new Code §7701(o).[43] The penalty is increased to 40% if the non-economic substance transaction is not disclosed on the taxpayer's return.[44]

The following changes are not as imminent as the foregoing, but are worth mentioning:

4.15 *Code §4980H - Assessable Penalties on Large Employers if No Coverage Provided.* Effective for months beginning after December 31, 2013, an applicable large employer (*i.e.*, generally, an employer who employed an average of at least 50 full-time employees during the preceding calendar year) who fails to offer its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" must pay an "assessable payment" of about $166 per full-time employee per month. Such employers may also be required to pay an "assessable payment" of about $250 per full-time employee per month if they offer "minimum essential coverage" but they have full-time employees who enroll in state exchange offered plans.[45]

4.16 *Code §5000A - Individual Shared Responsibility Payments.* Beginning in 2014, under new Code §5000A, a penalty is imposed upon "applicable individuals" (generally, almost everyone except undocumented aliens and certain religious individuals) for each month that they fail to have minimum essential health coverage for themselves and their dependents. Applicable individuals may be exempt from the penalty if they don't file Federal income tax returns, if they cannot afford coverage, if they are reside outside the United States or in U.S. territories, or if they have incurred a hardship. The penalty amount is generally 1/12 of the greater of $695, or 2.5% of income, for each failure month. The dollar amount and income percentage are phased in during 2014 and 2015, and the dollar amount is indexed for inflation thereafter.[46]

4.17 *Code §4980I – Excise Tax on "Cadillac" Health Plans.* Beginning in 2018, a 40% excise tax will be imposed on the plan administrator of a self-funded group health plan or on the health insurer of a fully-insured group health plan for "excess benefits" provided by such plan.[47] The excess benefit taxable is sum of the monthly excess amounts for the year, with the monthly excess amounts being the excess of the aggregate cost of the applicable employer-sponsored coverage of an employee for the month over an amount equal to 1/12 of the annual limitation for such year. The annual limitations will be $10,200 for employee-only coverage, and $27,500 for employee and other coverage, and such amounts are adjusted for increases in health costs occurring up until 2018. Other adjustments to these annual limitations are also possible due to higher age demographics of an employer, individuals over the age of 55, and high risk professions.

4.18 *Code §125(i) – Health FSA Limitation.* Effective for tax years beginning after December 31, 2013, a health flexible spending arrangement will not be considered a qualified benefit under a cafeteria plan unless the plan provides for a $2,500 maximum annual salary reduction contribution to the health flexible spending arrangement.[48]

---

[43] Code §6662(b)(6), as added by HCERA §1409.

[44] Code §6662(i), as added by HCERA §1409.

[45] Code §4980H.

[46] Code §5000A.

[47] Code §4980I added by PPACA §9001(a).

[48] Code §125(i), added by PPACA §9005.

4.19 *Code §4191 - Excise Tax on Medical Devices.* Effective for sales occurring after December 31, 2012, a new 2.3% excise tax is imposed on any manufacturer, producer or importer of certain medical devices based on the price for which the medical device is sold.

4.20 *Code §213 - Medical Expense Deduction Threshold Increased.* Effective for tax years beginning after December 31, 2012, the threshold to claim an itemized deduction for unreimbursed medical expenses is increased from 7.5% of adjusted gross income to 10% of adjusted gross income for regular income tax purposes.[49]

4.21 *Code §3101(b)(2) - Additional Medicare Tax.* Effective for tax years beginning after December 31, 2012, in addition to the 1.45% employee portion of the hospital insurance Medicare tax on wages, a 0.90% additional employee portion Medicare tax is imposed on every taxpayer who receives wages with respect to employment during any tax year in excess of $200,000 ($250,000 in the case of a joint return, and $125,000 in the case of a married taxpayer filing separately).[50] The obligation to withhold is only imposed upon an employer if the employee receives wages from that employer in excess of $200,000, and an employer is permitted to disregard the amount of wages received by a taxpayer's spouse. If the additional tax is not withheld by the employer, the employee is responsible for paying such tax. For self-employed individuals, there is a corresponding new 0.90% Medicare tax on self-employment income in excess of the amounts noted above.[51] *If an employer employs both a husband and a wife, may the employer still disregard one spouse's wages in withholding on the other spouse? Also, if an employee is over-withheld due to the employer withholding based on $200,000, when the correct amount for the married employee is $250,000, is there any way for the married employee to get back the over-withheld amount?*

4.22 *Code §1411 - Unearned Income Medicare Contribution.* Effective for tax years beginning after December 31, 2012, in addition to traditional Medicare taxes, there is a new 3.8% "unearned income Medicare contribution" tax imposed on individuals.[52] The tax is 3.8% of the lesser of (A) net investment income or (B) the excess of modified adjusted gross income over an applicable threshold amount ($250,000 in the case of joint returns or surviving spouses, and $200,000 in other cases). For this purpose, "net investment income" is gross income from interest, dividends, annuities, royalties and rents, and other gross income from a trade or business, and net gain attributable to the disposition of property other than property held in a trade or business, less any allowable deductions properly allocable to such gross income or net gain. The Medicare "contribution" tax will apply to a trade or business if it is a passive activity of the taxpayer.

4.23 *Code §6655 - Estimated Tax Payment Increase.* Estimated tax payments in July, August and September of 2014 that are required of "large" corporations (those with assets of $1 billion or more) have been increased to 173.50% of the amount otherwise due.

5 Impact of the Group Health Care Law on MEWA's

The purpose of this portion of this memorandum is to focus on how the new Law impacts multiple employer welfare arrangements.

---

[49] Code §213(a), amended by PPACA §9013.

[50] Code §3101(b)(2), as added by PPACA §9015.

[51] Code §1401(b)(2), as added by PPACA §9015.

[52] Code §1411, as added by HCERA §1402.

5.1 *ERISA §519 – Prohibition on False Statements Regarding MEWA.* Effective on March 23, 2010, under new ERISA §519, no person is allowed to make a knowingly false statement or representation of fact as to a MEWA's financial condition or solvency, the benefits provided by the MEWA, the regulatory status of the MEWA under federal or state laws, or the exemption of a MEWA from state laws under ERISA. A person found guilty of violating this criminal prohibition is subject to fine and/or imprisonment for up to 10 years.[53]

5.2 *ERISA §520 – Application of State Laws to MEWAs by DOL.* Effective on March 23, 2010, the Department of Labor ("***DOL***") is given the authority to adopt regulatory standards establishing, and given the authority to issue an order relating to a specific person establishing, that an entity engaged in the business of providing insurance through a MEWA is subject to the laws of the states in which the entity operates.[54] Even if the state law is preempted by ERISA, the DOL will have the authority to require compliance with the state law in order to prevent the preemption provisions of ERISA from being used as a basis for evading responsibility in state court.

5.3 *ERISA §521 –Cease & Desist Orders.* Effective on March 23, 2010, the DOL is given the authority to issue cease and desist orders against a MEWA if the DOL determines that the MEWA's conduct is fraudulent or causes an imminent danger to the public welfare.[55] A party adversely affected may request a hearing. The DOL may also issue a seizure order if the MEWA is financially distressed. The DOL is authorized to issue regulations or other guidance to effectuate these new powers.

5.4 *ERISA §101(g) – MEWA Plan Registration.* Effective on March 23, 2010, the DOL may issue regulations requiring MEWAs to register with the DOL before operating in any state.[56] The registration requirements appear to be an attempt to make sure that the MEWA has the financial capacity to satisfy claims.

---

[53] ERISA §519 added by PPACA §6601(a).

[54] ERISA §520 added by PPACA §6604.

[55] ERISA §521 added by PPACA §6605.

[56] ERISA §101(g), as amended by PPACA §6606.