The Reform Act & Sweeping Changes
Consequences Of Key Provisions Regarding Tax And Employee Benefits

Healthcare Fraud Enforcement
Statutes That Could Increase Potential Fraud Exposure
Dear Client:

The greatest certainty in healthcare reform seems to be the tremendous amount of uncertainty, whether related to specific provisions or to the outcome of broader legal challenges to the legislation as a whole. But, assuming reform is here to stay, the impact a number of its provisions will have on the pharmaceutical, medical device, and healthcare industries — as well as on businesses more broadly — is known already. We are devoting this issue to ways in which the 2010 Healthcare Reform Act, in conjunction with the 2010 Health Care and Education Reconciliation Act, will affect you and your business as well as to the legal challenges already in motion that seek to avoid some of those affects.

**Tax and Employee Benefit Consequences of Healthcare Reform**
gives a non-technical nuts and bolts outline of how healthcare reform will impact most businesses, yours included. It contains a chronological summary of the changes that will take place in each of the next four years and should serve as a handy reference tool.

Governmental action against both companies and individuals alleging fraud in the healthcare area have been on the rise for some time. **Turning Up the H.E.A.T. in Healthcare Fraud Enforcement** tells you how healthcare reform will ratchet up that effort even more.

**Lawsuits Challenging the 2010 Healthcare Reform Legislation**
outlines the principal arguments in the lawsuits challenging healthcare reform and contains a summary of the status of these cases.

Our goal in *Pro Te: Solutio* is to help educate and inform about issues that confront you every day. We hope this issue will help you prepare for some of the challenges coming to all of us through healthcare reform.

*Christy D. Jones*
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Co-Chair — Business and Corporate Healthcare

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**PRO TE: Solutio**

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**Sharing Solutions**

It’s human nature to share problems. But how often is someone willing to share solutions? Butler Snow wants to do just that — provide scenarios and the solutions that turned a client’s anxiety into relief and even triumph. That’s why we created this magazine, *Pro Te: Solutio*, which explores how real-life legal problems have been successfully solved.

That’s also why we at Butler Snow redesigned and expanded our unique health-oriented industry group, now comprised of two major sections that handle business and litigation. The Pharmaceutical, Medical Device, and Healthcare Industry Group has more than 50 multi-disciplinary attorneys who provide creative solutions for the complex issues of the healthcare industry. This group includes product liability and commercial litigators; corporate, commercial, and transaction attorneys; labor and employment attorneys; intellectual property attorneys; and those experienced in government investigations.

*Pro Te: Solutio* is a quarterly magazine available only to the clients of Butler Snow. If you have questions or comments about its articles, you’re invited to contact Christy Jones and Charles Johnson, as well as any of the attorneys listed on the last page of this publication.
Every healthcare provider involved in billing federal healthcare programs knows healthcare reform is a reality. The Patient Protection and Affordable Care Act (PPACA) and the Healthcare and Education Reconciliation Act of 2010 (HCERA) were signed into law by President Obama in March 2010. What providers may not be fully aware of is the number of significant fraud changes included in both statutes that will increase potential fraud exposure for them in the months and years ahead. This article summarizes some of the most significant fraud changes included in these reform statutes.

A. Increased Funding for Fraud and Enforcement Efforts

The Omnibus Appropriations Act of 2009 provided for a one-time, $198 million enhancement in fraud enforcement-related spending. The 2010 federal budget adds another $311 million in funding over a two-year period, amounting to a 50% increase over the FY09 funding level. The proposed 2011 budget would add another $250 million for the DOJ/HHS joint enforcement effort known as the Health Care Fraud and Prevention Enforcement Action Team (or “HEAT”). The HEAT program was announced in May 2009 as a Cabinet-level effort by DOJ, HHS-OIG, and the Centers for Medicare and Medicaid Services (CMS) designed specifically to combat Medicare fraud. The program created strike forces across the country in cities identified as high-volume fraud locales. By the end of 2009, those strike forces had generated some 222 cases. In addition to the extra funding for the HEAT program, PPACA increases funding to the Health Care Fraud and Abuse Control Program (HCFAC) for FY11 through FY20 by $10 million per year. The HCFAC Program is a funding mechanism for federal healthcare fraud enforcement efforts through dedicated healthcare fraud agent positions and attorney positions. Along with the PPACA increases, HCERA adds another $250 million to HCFAC between 2011 and 2016. Thus, the proposed overall additional spending amounts devoted to fraud and abuse enforcement efforts, if they make their way into each of the budgets in future years, could total almost $1 billion over the next 10 years.

B. Expansion of the Recovery Audit Contractor Program

Providers may be familiar already with the Recovery Audit Contractor Program (or “RAC program”) which was included initially in the Medicare Modernization Act of 2003 as a demonstration project for New York, California, and Florida — and later, South Carolina, Massachusetts, and Arizona. The demonstration project lasted three years and used private recovery firms on contingent fee contracts to conduct post-payment reviews/audits. Between March 2005 and March 2008, the contractors identified some $1.03 billion in overpayments and
collected over $980 million from provid-
ers. The Tax Relief and Healthcare Act of 2006 authorized the expansion of the RAC program nationwide by January 2010. To accomplish that goal, CMS divided the country into four RAC regions and awarded contracts to four companies to implement and manage the RAC program. 

The healthcare reform legislation expands the RAC program to cover Medicare Parts C and D (the existing program only covered Medicare Parts A and B); Medicare Part C is the HMO/PPO version or option of Medi-
care, and Medicare Part D is the prescrip-
tion drug program. The reform statutes also expand coverage of the program to include Medicaid. These sweeping changes in the healthcare environment have been in place no later than December 31, 2010. While the majority of RAC recov-
eries have been from inpatient hospitals, this expanded coverage will broaden significantly the circle of healthcare providers subject to the RAC audit process.

The majority of False Claims Act cases originate from whistleblowers, or relators, who bring actions on behalf of the govern-
ment and then encourage the government to intervene in those actions. For many years, a qui tam relator or whistleblower plaintiff had to meet a two-part test under 31 U.S.C. § 3730(e) (4): (1) a qui tam plaintiff must have provided information which has not been publicly disclosed; and (2) if the in-
formation had been publicly disclosed, then the qui tam plaintiff/relator must have been an “original source” of the information. A number of False Claims Act cases have been dismissed in prior years under both the public disclosure bar and the original source doctrine. PPACA significantly amends both these prongs of the False Claims Act in ways which will benefit relators, expand the potential pool of qui tam plaintiffs, and likely increase the number of qui tam cases filed.

Before these amendments, the failure of a qui tam plaintiff to meet the statutory re-
quirements of the public disclosure bar and original source doctrine deprived the court of juris-
diction. PPACA changes the rules in two crucial aspects: (1) Failure to meet the pub-
dic disclosure language will no longer serve as a jurisdictional bar to bringing a lawsuit, and (2) even if the qui tam relator completely fails to meet the public disclosure language of the statute, dismissal may be opposed by the government, in which case the False Claims Act case may proceed. Similarly, if the rela-
tor’s lawsuit is based upon publicly disclosed information of which the relator is not an original source, the relator may still qualify to participate in a False Claims Act matter if he/she shares with the government “knowledge that is independent of and materially adds to the publicly disclosed allegations . . . .” Students of False Claims Act jurisprudence know the courts have been struggling for years with the notion of materiality. No one can pre-
dict how the courts will interpret the phrase “materially adds to the publicly disclosed allegations,” but the relator/plaintiff’s bar unquestionably now has a much lighter bur-
den for initiating a False Claims Act lawsuit.

Given the enhanced fraud and abuse en-
fforcement efforts under these various amend-
ments, it should come as no surprise that PPACA also introduced mandatory compliance programs. While the law prior to PPACA did not require providers to adopt formal compliance programs, healthcare law-
yers have been encouraging and advising their clients for years to adopt voluntary compli-
ance programs. Section 6004 of PPACA pro-
vides that the Secretary of HHS may now require in a compliance program as a condition precedent to enrollment. No specific provid-
ers are listed in the language of the statute; rather, the Secretary of HHS is directed to establish a timeline, in consultation with HHS-OIG, for implementing mandatory compliance programs within a particular healthcare industry or supplier category.

D. Jurisdictional Changes to the False Claims Act That Benefit Relators

E. New Grounds for Imposing Civil Monetary Penalties

Civil monetary penalties have been an arrow in the government’s fraud enforcement quiver for some time. PPACA adds new grounds for imposition of civil monetary penalties. These new grounds include:

(a) knowingly making false statements in an application, bid, or contract to partici-

(b) failing to report or return a known overpayment;

c) ordering or prescribing items or ser-

(d) failing to grant HHS-OIG timely access for audits, investigations, evaluations, and the like;

e) making false statements material to a false or fraudulent claim for payment for an item or service furnished under a federal healthcare program.

These new grounds for imposing civil monetary penalties “ratchet up” the risks involved in doing business under any fed-

F. Mandatory Compliance Programs

eral healthcare program.

While the law prior to PPACA did not require providers to adopt formal compliance programs, healthcare lawyers have been encouraging and advising their clients for years to adopt voluntary compli-
ance programs.
CIVIL MONETARY PENALTIES HAVE BEEN AN ARROW IN THE GOVERNMENT’S FRAUD ENFORCEMENT QUVER FOR SOME TIME.

PPACA ADDS NEW GROUNDS FOR IMPOSITION OF CIVIL MONETARY PENALTIES.

As these guidelines are developed in future months and years, healthcare providers will be well advised to made known to the Sec- retary of HHS and to the Inspector General the terms and conditions providers believe are appropriate and necessary.

G. CHANGES TO THE STARK LAW AND THE NEW SELF-REFERRAL DISCLOSURE PROTOCOL

1. New Freedom of Choice Rules for In-Office Ancillary Services

Subject to various exceptions or safe harbors, the Stark Law prohibits a physician from referring a Medicare or Medicaid ben- efactor to an entity in which the referring physician, or members of his/her immediate family, have a financial relationship.6 Unlike the Anti-Kickback Statute, which applies to anyone providing services or supplies under a federal healthcare program, the Stark Law is addressed to physicians only.

The so-called In-Office Ancillary Services (or “IOAS”) exception is one of the major exceptions to the Stark Law. It allows in- divisional physicians in solo practice and in physician practice groups to self-refer patients to physicians in solo practice and in physician practice groups to self-refer patients to individuals residing in a rural area. Section 6001 of PPACA essentially prevents the formation of new physician-owned hospitals, and not in merely a distinct part or depart- ment of the hospital. Stark also permits phys- ician referrals to “rural” hospitals where substantially all of the designated health services furnished by the entity are furnished to individuals residing in a rural area. Section 6001 of PPACA essentially prevents the formation of new physician-owned hospitals, and freezes the amount

3. A New Stark Self-Referral Disclosure Protocol

In 2009, HHS-OIG announced that its Self-Disclosure Protocol used by providers to report technical (and, often, unintentional) violations of various federal healthcare fraud and abuse laws was not available for use in disclosing Stark Law violations. This gap left providers with potential Stark issues in a quandary about how to approach the govern- ment in these circumstances, since Stark has some of the harshest penalties provisions — imposing a requirement that all payments for designated health services paid in violation of Stark are to be refunded to the government in addition to an $15,000 civil monetary penalty for each designated health service provided in violation of Stark.

In response to provider concerns, Congress added § 6409 to PPACA, which obligated the Secretary of HHS to develop and implement a disclosure protocol for actual and potential Stark violations within six months of the enactment of PPACA. CMS was instructed to publish the new Self-Referral Disclosure Protocol on its website within six months, with instructions to providers on how to access and use it. Right on schedule, the new Protocol was announced and appeared on the CMS website on September 23, 2010. The Protocol makes clear, as set forth in § 6409(a)(2) of PPACA, that it is separate and distinct from the existing CMS advisory opinion process used to determine whether a Stark violation exists.

The Protocol is not as clearly written as it might have been, and it appears to be lim- ited solely to Stark issues, adhering specifi- cally to the statutory language that mandated it. This means the new Protocol cannot be used for Anti-Kickback Statute issues or for other voluntary disclosures to the government. Too, while earlier volun- tary disclosures might have generated a discounted fine for Stark violations, this new Protocol merely provides that CMS “may consider” reducing the amounts “oth- erwise owed” based upon five factors: (1) the nature and extent of the improper or illegal practice; (2) the timeliness of the self- disclosure; (3) the cooperation in providing additional information related to the disclo- sure; (4) the litigation risk associated with the matter disclosed; and (5) the financial position of the disclosing party.

H. CRIMINAL ENHANCEMENTS INCLUDED IN THE REFORM STATUTES

When Congress enacted the original HIPAA statute in 2003, it gave DOJ signifi- cantly enhanced criminal authority in combat- ing healthcare fraud (including the new healthcare fraud statute at 18 U.S.C. § 1347 and the ability to issue administrative sub- poenas known as authorized investigative demands under 18 U.S.C. § 3486). PPACA adds even more criminal healthcare fraud tools for DOJ to use, including:

(1) The U.S. Sentencing Commission is directed to update the Sentencing Guidelines to increase offense levels by 20-50% for crimes involving losses of more than $1 million;

(2) The definition of “healthcare fraud offense” under 18 U.S.C. § 24 is broadened to include Anti-Kickback Statue violations; Food, Drug and Cosmetic Act violations, and even certain ERISA reporting violations;

(3) PPACA provides DOJ with subpoena authority for investigations conducted pur- suant to the Civil Rights of Institutional-
Less than one year after passage, the Patient Protection and Affordable Care Act ("PPACA," "Act")—part of the Obama Administration’s healthcare reform legislation signed into law on March 23, 2010—already is the subject of numerous legal challenges. The following is a summary of the pending cases.

As of this writing, twenty-four lawsuits have been filed challenging the constitutionality of the PPACA. With some variation, the lawsuits generally challenge the Act on one or more of the following bases: (i) the Act is an unlawful expansion of Congress’s power to regulate interstate commerce in violation of the Commerce Clause, Art. I, § 8; (ii) the individual health insurance mandate is an unconstitutional direct tax on the people, in violation of the Direct Tax prohibition, Art. I, § 9; (iii) the Act takes private property for public use and deprives individuals of property without due process of law, in violation of the Fifth Amendment; (iv) the Act is an unconstitutional exercise of power in violation of the Tenth Amendment; (viii) the Act is an unconstitutional expansion of Congress’s power, and the Act is not a valid exercise of Congress’s Commerce Clause power; (ix) the Act violates the First, Third, Fourth, Fifth, and Ninth Amendments by requiring individuals to purchase a good or service.

The Cases

Florida v. United States Department of Health & Human Services, pending in the Northern District of Florida, Cause No. 3:10cv00891, before Judge Roger Vinson. Among the Plaintiffs are the Attorneys General of 26 states.

Allegation: The Act’s individual mandate and penalty provisions exceed the federal government’s power, and the Act is not a valid exercise of Congress’s Commerce Clause power.

Status: On December 13, 2010, the court granted the Commonwealth’s summary judgment motion, holding that the individual insurance mandate is unconstitutional.

Virginia v. Sebelius, pending in the Eastern District of Virginia, Cause No. 1:10cv00188, before Judge Henry E. Hudson.

Allegation: The Act favors one religion over another and violates the Constitution’s guarantee of a republican form of government. The suit also challenges the Act’s use of public funds for abortions.

Status: The Defendants’ motion to dismiss was granted on November 30, 2010. The Plaintiffs have appealed that ruling to the Fourth Circuit Court of Appeals.

La Salle v. Obama, pending in the California District of Columbia, Cause No. 1:10cv00697, before Judge David Colker. Allegation: The Act’s individual insurance mandate provides for the payment of indirect taxes, in violation of the Eleventh Amendment.

Status: The Act’s requirement for individuals to purchase health insurance violates individual religious beliefs and is a violation of the Religious Freedom Restoration Act of 1993.

Allegation: Both a motion to dismiss and a motion for summary judgment are pending.

Kinder v. Department of Treasury, pending in the Eastern District of Missouri, Cause No. 1:10cv00101, before Judge Rodney Sippel.

Allegation: The Act violates the First, Fifth, Tenth, and Fourteenth Amendments and is an unconstitutional exercise of Congress’s Commerce Clause powers.

Status: The Defendant’s answer is due by January 11, 2011.

Shreve v. Obama, pending in the Eastern District of Tennessee, Cause No. 1:10cv00116, before Judge Curtis Collier.

Allegation: The Act is an unconstitutional exercise of power in violation of the Tenth Amendment.

Status: The court granted the Defendants’ motion to dismiss, finding the 29,000 plus Plaintiffs lacking standing. The Plaintiffs plan to re-file in another court.

Gundy-Bachman v. United States Department of Health & Human Services, pending in the Middle District of Pennsylvania, Cause No. 1:10cv00763, before Judge Chris Conner.

Allegation: The Act is an unconstitutional expansion of Congress’s power, and the Act is not a valid exercise of Congress’s Commerce Clause power.

Status: The Act’s requirement for individuals to purchase health insurance violates individual religious beliefs and is a violation of the Religious Freedom Restoration Act of 1993.

Allegation: Both a motion to dismiss and a motion for summary judgment are pending.


Allegation: This class action lawsuit challenges almost every aspect of the PPACA and includes a Thirteenth Amendment challenge alleging that the Act constitutes involuntary servitude.

Status: No answer has been filed.

Purpura v. Sebelius, pending in the District of New Jersey, Cause No. 3:10cv04814, before Judge Freda Wolfson.

Allegation: The bill was illegally signed, and the Act itself illegally expands government.

Status: A motion for a temporary restraining order and preliminary injunction was denied. An answer is due to be filed soon.


2 Id.

3 The inevitable delay in the printing of this article may have caused some information to become outdated. Please contact us if you would like more up-to-date information on these lawsuits.


5 Written by John Doolabhidi.
I. Tax Changes

The tax changes found in the new legislation focus on the universal health insurance coverage mandate and revenue raisers, some health-related and others not. Certain changes are expected to have the greatest impact.

A. Beginning in 2011

Beginning in 2011, a fee will be levied against drug manufacturers and importers based on market share. The total fee assessed for 2011 will be $2.5 billion and will gradually increase until it peaks in 2018 at $4.1 billion. In 2019, the fee will decrease to $2.8 billion and will remain constant thereafter.

B. Beginning in 2013

1. Federal Sales Tax on Sales of “Medical Devices”

Manufacturers and importers of medical devices will be taxed 2.3% of the sales price of any “taxable medical device” intended for human use such as eyeglasses, contact lenses, and hearing aids. This tax will not apply to medical devices the IRS determines are of a type “generally purchased by the general public at retail for individual use” such as eyeglasses, contact lenses, and hearing aids.

2. Loss of Deduction for Retiree Prescription Drug Plans

The Reform Act not only imposes additional fees and taxes but also reduces or eliminates certain deductions. Currently, employers are entitled to an income tax deduction for the cost of providing a prescription drug plan to retirees even though they receive a tax-free Medicare Part D subsidy from the federal government. Under the new legislation, the amount allowed as a deduction for retiree prescription drug expenses will be reduced by the amount of the tax-free subsidy payments received.

3. Surtax on Investment Income of High-Income Taxpayers

As a revenue raiser, a surtax will be imposed on the investment income of high-income taxpayers. This tax will be a 3.8% Medicare contribution tax and will be imposed on the net investment income of certain individuals, estates, and trusts with income above specified thresholds. For individuals, the tax is 3.8% multiplied by the lesser of either net investment income or adjusted gross income in excess of $200,000 for single filers or $250,000 for joint filers. Net investment income includes interest, dividends, royalties, rents, and net gain from the disposition of investment assets. The surtax is subject to individual estimated income tax payment requirements and is not deductible for income tax purposes.

C. Beginning in 2014

1. Industry-wide Fee on Health Insurance Providers

An industry-wide fee will be levied against health insurance providers with net premium income from health insurance of more than $25 million. For purposes of this fee, health
insurance does not include coverage for a specified disease or illness only, hospital indemnity or other fixed indemnity insurance, insurance for long-term care, or Medicare supplemental health insurance. This fee, which will be apportioned based on net premiums received during the preceding year, will be $8 billion in 2014. The fee gradually increases to $14.3 billion in 2018. Thereafter, the fee will be indexed for premium growth.12

2. Employer Group Health Insurance Mandate

A “pay-or-play” tax will be imposed on employers that fail to provide affordable coverage to employees. (See section I.E.1.) This provision applies to employers with an average of fifty full-time employees during the preceding calendar year and who are not offering “minimum essential coverage.” For purposes of determining whether an employer has fifty employees, business entities under common control must aggregate employees. “Minimum essential coverage” is a plan where the employer covers at least 60% of the costs under the plan and employee costs do not exceed 9.5% of household income. The monthly penalty is one-twelfth of $2,000 multiplied by the number of employees in excess of thirty.2

D. Beginning in 2018

A 40% excise tax will be imposed on “coverage providers” for the cost of the employer-sponsored health coverage to employees that exceeds $10,200 for single coverage and $27,500 for family coverage. These plans are often referred to as “Cadillac” plans. For purposes of this tax, “coverage providers” include the health insurer for fully-insured plans, employers making the contributions for health savings accounts (HSA) or Archer medical savings accounts (MSA) contributions, and the person administering the plan for self-insured plans or flexible spending accounts (FSA).31

II. New Employer-Sponsored Group Health Plan Requirements

A. Beginning in 2010

1. Automatic Enrollment

The Reform Act requires that employers with more than two hundred employees automatically enroll eligible employees in their GHP unless an employee opts out pursuant to a required opt-out notice.35 Since this requirement has not stated effective date, the effective date is the date of enactment. However, compliance is being delayed by the Agencies until regulations are issued.36

The following provisions are effective for GHPs with plan years beginning after September 23, 2010.

2. Annual & Lifetime Limits

No annual limits or annual limits on “essential health benefits” are allowed.37 “Essential health benefits” is to be defined by Department of Health and Human Services regulations.

3. Retroactive Rescissions

Retroactive cancellation of coverage is prohibited except for fraud or intentional misrepresentation of material facts, and then only with prior written notice.38

4. Pre-Existing Condition Exclusions

Through 2013, there are to be no pre-existing condition exclusions for employees under age 19 or dependents under age 19.39 Beginning January 1, 2014, there are to be no pre-existing condition exclusions for any employees or dependents irrespective of age.40

5. Coverage of Children to Age 26 (Limited GPE)

GHPs offering dependent coverage must also permit coverage of children until their twenty-sixth birthdays. The child does not have to be a student or a tax-dependent of the employee and can be married. The child can be included on the parent’s plan even if the GPE is available are designated with the parenthetical “(GPE).”41

A HIPAA special enrollment period is required for any such children who have already ceased to be covered but are now re-eligible.42 GHPs are not required to cover the child’s spouse or children.43 If the covered child has not reached the age of twenty-seven before the end of the year, the value of coverage is excluded from the employee’s income for the entire year for tax purposes, and benefits are excluded from the child’s income for tax purposes.44

6. Preventive Care — First-Dollar Coverage (GPE)

GHPs are to provide first-dollar coverage, i.e. no cost-sharing, for certain types of preventative care including certain well-child, adolescent, and female care, as well as certain immunizations.45

7. Nondiscriminatory Insured Plans (GPE)

There also can be no discrimination in favor of highly-compensated employees by insured GHPs, similar to the previously existing nondiscrimination rules for self-insured GHPs.46 The IRS, though, has announced delayed enforcement of this requirement until after implementing regulations are issued.47

8. Claims Appeals/External Review

New benefit appeals procedures allow claimants to present evidence and oral testimony as part of the appeal and require continued coverage during the appeals process.48 GHPs will have to provide an external review process as part of the review procedures for denied claims.49 Written notice of these new rights must be provided.50

9. Patient Protections (GPE)

GHPs must now include a number of new patient protection features. For instance, if enrollees are required by their GPE to designate a primary-care provider, certain types of enrollees may designate certain types of providers as their primary-care provider, i.e. pediatricians for children and OB/GYNs for women.43 In addition, there can be no preauthorization or increased cost-sharing required for emergency services, and no preauthorization or referral can be required for OB/GYN care.49

B. Beginning 2011

1. Reimbursement of OTC Drugs

Effective January 1, 2011, there can be no reimbursement for over-the-counter medication (except insulin) by an FSA, health...
1. Benefits Summary

2. Form W-2 Requirements

MSA without a prescription.

required to be published by March 23, 2012; reimbursement accounts (HRA), HSA, or the actual effective date could be earlier.

no more than four pages, separate from the beginning in 2014.

2. Notice of Material Modifications

A new notice of material modifications, sep

3. Quality Report (GPE)

The GHP must annually file a quality report with the Department of Health and Human Services, reporting any plan design changes intended to improve outcomes, reduce hospital readmissions, reduce medical error, implement wellness programs, etc.

The effective date for this reporting requirement is to be in accordance with regulations required to be published by March 23, 2012, the actual effective date could be earlier.

D. Beginning in 2013

1. FSA Limitations

Effective January 1, 2013, FSA salary reductions are limited to $2,500 per year.

This is to be indexed to the consumer price index beginning in 2014.

2. Exchange Notice (GPE)

Effective March 1, 2013, employers must provide written notice to their employees, at hiring, of the availability of state exchanges and of the employee’s right to purchase health coverage through such an exchange.

If the employee chooses to participate in the exchange, the employer pays the redeemed voucher amount to the exchange, which must be the amount the employer would have contributed to its GHP to the exchange.

4. Free Choice Vouchers

Employers that pay part of the GHP coverage cost must issue “free choice” vouchers for each employee who can purchase coverage through a new or different health plan.

These vouchers permit employees to purchase coverage through an exchange instead of their employer’s GHP. If the employee chooses to participate in the exchange, the employer pays the redeemed voucher amount to the exchange, which must be the amount the employer would have contributed to its GHP to the exchange.

5. Expiration of Limited Exclusions

Plan Years Beginning (PYB) after January 1, 2014, the limited GHE for many employees to cover a service or product that is not considered a “minimum essential coverage” in such plans.

Pay-or-Play Penalty

Employers are not required to offer any health coverage. If they do not offer “minimum essential coverage” the employer offered is “unaffordable,” though, they will be subject to the “pay-or-play” penalty, effective January 1, 2014. (See section I.C.2.)

3. Reporting Coverage

If an employer does not offer “minimum essential coverage” to full-time employees and their dependents, the employer must confirm that such coverage is not offered and file a variety of other information in order to permit the assessment of the “pay-or-play” penalty against the employer.

4. Cost-sharing Limits (GPE)

Effective for PYB after January 1, 2014, out-of-pocket expenses cannot exceed HSA coverage limits.

Cost-sharing limits for different amounts for different coverage options, the voucher amount must be the maximum employer contribution available to the employee. The exchange pays any excess to the employee.

These exchanges are generally designed to provide affordable health coverage to people not covered under a GHP sponsored by an employer.

The exchange pays any excess to the employee. The changes are expected to be consistent with the employee’s income to the extent they are used for healthcare and also are deductible by the employer.

Employers that pay part of the GHP coverage cost must offer “minimum essential coverage” in such plans.

Effective for PYB January 1, 2014, the government mandates that very few employers will be subject to the “pay-or-play” penalty.

The exchange pays any excess to the employee.

Thus, while many of these benefit mandates and notice and reporting requirements have already taken or will soon take effect, the country is still awaiting regulations to aid in the implementation not only of current requirements but also of many others soon to take effect.

5. HIPAA Wellness Program Incentives (GPE)

Under the HIPAA wellness program regulations, the permissible incentive for satisfaction of a health standard increases from 20% to 30% (or as much as 50% by regulation) effective January 1, 2014. However, exist

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