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FYI® In-Depth
For Your Information®

Volume 37 | Issue 23 | February 28, 2014

Health care reform — consequences of noncompliance for group health plans

With 2014 here, employers are by now familiar with the ACA's market reforms, mandates, and financing provisions that affect insured and self-funded group health plans. But what happens in the case of a compliance failure? The consequences of noncompliance can be severe, with the applicable penalty depending on which of the many and complex ACA provisions is violated and the nature and extent of the violation. Employers should keep these penalties in mind — outlined in the chart at the end of this article — as they work to ensure ACA compliance for their group health plans.

Background on ACA compliance

The Affordable Care Act (ACA) put in place new market reforms, employer and plan sponsor requirements, and financing provisions as part of comprehensive health care reform. (See our July 11, 2012 *For Your Information*.) In brief, these changes include the following:

- **Market reforms.** The ACA implements a number of insurance and market mandate reforms, such as the elimination of pre-existing condition exclusions, required coverage of adult children up to age 26, prohibitions on lifetime and annual dollar limits for essential health benefits, medical loss ratio requirements, and required coverage of specified preventative health services without cost sharing. Some of these reforms apply across the board, while others apply only to non-grandfathered plans.
- **New employer and plan sponsor requirements.** As of January 1, 2014, large employers generally must either provide affordable coverage to all full-time employees or pay an assessment. Additionally, the ACA imposes numerous new reporting and disclosure requirements on employers and plan sponsors. For example, plans must provide a summary of benefits and coverage (SBC) in connection with open enrollment and notify participants about choice-of-provider rules. Employers must report the aggregate value of employer-sponsored health coverage on the Form W-2.

- **Financing provisions.** The ACA imposes several fees and taxes on group health plan sponsors in order to help offset the cost of coverage expansion, including the patient-centered outcomes research fee (PCORI), the transitional reinsurance fee, and an excise tax on high-cost employer plans.

Consequences of noncompliance — penalties

The ACA amended several existing statutes, including the Internal Revenue Code (Code), ERISA, the Public Health Services Act (PHSA), and the Fair Labor Standards Act (FLSA). The consequences of noncompliance vary depending on which statute is in play. Below is a discussion of the applicable penalties for noncompliance with market reforms, new employer and plan sponsor requirements, and financing provisions.

Awareness of applicable penalties underscores the need for robust ACA compliance programs

Market reforms

In the accompanying chart, we list all ACA market reforms that affect group health plans, noting the effective date of each reform. In most cases, compliance failures will subject plans to one or more of the following penalties:

- **IRS excise tax (section 4980D penalties).** Code section 4980D generally assesses:
  - $100 per day per individual per violation
  - A minimum of $2,500 per individual affected by a violation where (1) the plan does not correct the compliance failure(s) before the IRS sends a notice of examination of income tax liability, and (2) the failures continued during the examination period
  - A minimum of $15,000 per individual if the compliance failure is more than *de minimis*

  The maximum penalty is the lesser of $500,000 or 10% of the aggregate amount paid or incurred by the employer (or, in the case of multiple employer plans, by the trust) during the previous taxable year. Employers must self-report section 4980D penalties on IRS Form 8928 within specified timeframes. Additional penalties and interest apply for an untimely-filed Form 8928.

  Code section 4980D penalties will not apply, however, if (1) the employer did not know, or exercising reasonable diligence would not have known, that a failure existed, or (2) the failure was due to reasonable cause (and not willful neglect) and the affected individual is made whole within 30 days. In addition, the IRS may waive part or all of the excise tax for a failure due to reasonable cause and not willful neglect.

  Buck comment. The IRS has not defined the terms “reasonable cause” or “willful neglect” in the context of ACA excise taxes. However, generally, reasonable cause can describe a scenario where a compliance failure occurs notwithstanding the exercise of ordinary business care and prudence — such as where an employer relies on the advice of a reputable attorney on a matter of law. Willful neglect, on the other hand, generally implies a conscious, intentional failure, or reckless indifference to the market reform at issue.

- **ERISA-based penalties.** The DOL and affected participants and beneficiaries can file lawsuits under ERISA to compel compliance with the ACA's market reforms and/or obtain monetary damages in connection with noncompliance.

  Buck comment. Non-federal governmental plans and church plans are governed by the PHSA (see below), not ERISA, and, therefore, not subject to ERISA-based lawsuits. There is no individual right to sue under the PHSA.

- **HHS penalties.** In the case of non-federal governmental plans, pursuant to the PHSA, the Department of Health & Human Services (HHS) may require either the plan or its sponsoring employer to pay civil monetary penalties of up to $100 per day for each failure to comply with ACA market reforms.

New employer and plan sponsor requirements

The following penalties apply to the new responsibilities that the ACA places on employers and plan sponsors. (Refer to the chart at the end of this article for more details.) Many of these penalties are the same as those associated with market reform noncompliance, as discussed above.

- **Monetary penalties for failure to comply with ACA reporting, notice, and disclosure requirements.**

  - **Notice of patient protections.** Plans must notify participants of their right to choose a primary care provider or pediatrician from any available participating provider, obtain obstetrics, gynecological, or emergency services without a referral or prior authorization, and be charged in-network rates for out-of-network emergency care. Failure to provide this notice subjects an ERISA plan sponsor to section 4980D penalties and a nonfederal governmental plan sponsor to a similar penalty under the PHSA. (See our July 2, 2010 *For Your Information*.)

  - **Notice of expanded claims appeal procedures.** Plans must provide participants with a notice of available processes for appeals of coverage and claim determinations. Failure to provide this notice subjects an ERISA plan sponsor to section 4980D penalties and a nonfederal governmental plan sponsor to a similar penalty under the PHSA. (See our August 4, 2011 *For Your Information*.)

  - **Summary of benefits and coverage (SBC).** The SBC is a four-page "uniform explanation" of the group health plan's benefits and coverage that uses standard definitions and common terms. (See our May 10, 2013 *For Your Information.)* Willful failure to provide an SBC triggers a $1,000 penalty for each incident.

    Buck comment. Until December 31, 2014, group health plans working "diligently and in good faith" to comply with SBC-related regulations are not liable for penalties. Starting in 2015, however, section 4980D penalties apply generally.

Marketplace notice

The ACA also requires employers to provide a marketplace (exchange) notice with information on the availability of marketplaces. DOL has confirmed, however, that there is no penalty for an employer's failure to provide this notice. (See our September 30, 2013 *For Your Information*.)

- **Notice of material modifications.** Plans must provide a notice of material modification to any plan terms or coverage not reflected in the most recently provided SBC at least 60 days before the modification's effective date. Willful failure to provide this notice will result in a penalty of up to $1,000 per failure, and section 4980D penalties also may apply generally. (See our March 1, 2012 *For Your Information.)*

- **Form W-2 reporting of aggregate cost of group health plan coverage.** Employers that issue more than 250 Form W-2s must report the aggregate cost of employer-sponsored group health plan coverage on their employees' W-2 forms. Penalties for failure to do so start at $30 per Form W-2 up to a maximum of $1.5 million per calendar year, depending on the number of failures and when they are corrected. (See our January 11, 2012 *For Your Information*.)

- **Reporting compliance with employer shared responsibility.** Beginning in 2016 in connection with the 2015 year, employers subject to the shared responsibility requirement (discussed below) must provide the IRS and each full-time employee with information regarding compliance during the preceding year. Employers that fail to do so face penalties under Code sections 6721 and 6722 of $100 per tax return associated with the failure up to a maximum of $1.5 million, in addition to penalties under Code section 6723 of $50 per failure up to a maximum of $100,000. Some relief is provided if the failure is due to reasonable cause and not willful neglect (See our July 22, 2013 *For Your Information.)*

- **Reporting compliance with the "individual mandate."** Beginning January 31, 2015, employers must provide the IRS and each "primary" insured with an individualized written statement regarding the prior year's coverage. Employers that fail to do so face penalties under Code sections 6721 and 6722 of $100 per tax return associated with the failure up to a maximum of $1.5 million, in addition to penalties under Code section 6723 of $50 per failure up to a maximum of $100,000. Some relief is provided if the failure is due to reasonable cause or is timely corrected. (See our July 22, 2013 *For Your Information.)*

Buck comment. The ACA modified the Fair Labor Standards Act (FLSA) to require employers with at least 200 employees must automatically enroll full-time employees into one of their health plans following the completion of any applicable waiting period. There are no statutory penalties specified for noncompliance with this FLSA provision. DOL guidance is forthcoming. (See our March 1, 2012 *For Your Information.)*

- **Non-monetary penalties for failure to comply with ACA reporting, notice, and disclosure requirements.**

  - **Disclosure of grandfathered status.** Plans must provide participants and beneficiaries with notice of their belief that coverage is grandfathered, and therefore exempt from certain market mandates. Failure to provide this notice results in loss of grandfathered status. (See our November 2, 2010 *For Your Information*.)

- **Rescission of coverage notice.** Plans must notify participants in instances where the plan has retroactively cancelled coverage due to fraud or misrepresentation of material fact. Failure to provide this notice renders the purported rescission of coverage ineffective. (See our July 2, 2010 *For Your Information*.)

- **Preventative health services — contraceptive services.** Plans maintained by nonprofit organizations must notify participants of the plan's eligibility for a one-year enforcement safe harbor, relieving the plan from the obligation to cover contraceptive services. Failure to provide this notice results in a loss of safe harbor protection. (See our October 18, 2013 *For Your Information*.)

- **Failure to provide medical loss ratio rebates**. The ACA requires health insurers to spend at least 85% of large group premium dollars on medical care claims rather than administrative expenses, and insurers must provide plans with rebates for any administrative expenses exceeding the 15% threshold. An insured group health plan that fails to distribute these rebates to participants within 90 days may be sued for breach of its ERISA fiduciary duties and/or face section 4980D penalties. (See our August 7, 2012 *For Your Information*.)

- **Permitting salary reduction contributions to a health FSA to exceed $2,500 per participant.** Salary reduction contributions to a participant's health FSA for a given plan year may not exceed $2,500 (indexed annually). If the employer permits salary reduction contributions to exceed this limit, the health FSA will not be considered a qualified benefit, and the cafeteria plan will lose its tax-advantaged status. IRS guidance provides some relief for reasonable mistakes that an employer timely corrects. (See our June 8, 2012 *For Your Information*.)

- **Employer shared responsibility.** Generally, large employers must either offer full-time employees (and their dependents) health coverage that is affordable and provides minimum value, or make an "assessable payment" to the IRS if at least one full-time employee enrolls in marketplace coverage and receives a premium subsidy. (See our February 11, 2014 *For Your Information.*)

  - **Employers that do not offer coverage.** If at least one full-time employee obtains a low-income premium subsidy through the marketplace for a calendar month, the employer must make a monthly assessable payment of $167 (1/12 of $2,000) with respect to each of its full-time employees during that month (over an 80-employee threshold in 2015 and 30-employee threshold thereafter). The maximum non-deductible payment per full-time employee is $2,000 (indexed annually).

  - **Employers that fail to offer "affordable" or minimum value coverage.** Generally, an employer offering coverage must make a monthly assessable payment of $250 (1/12 of $3,000) with respect to each of its full-time employees who, during that month, receives a low-income premium subsidy through the marketplace and for whom the employer's coverage fails to meets either affordability or minimum value requirements. The maximum nondeductible payment per full-time employee receiving a premium subsidy is $3,000 (indexed annually).

    Buck comment. Although commonly referred to as such, this assessment is not a "penalty." An employer can comply with the ACA by choosing to pay the assessment rather than offering coverage.

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Fees and taxes

Finally, the following penalties (see full details in accompanying chart) attach when an employer or plan fails to pay the following fees and taxes:

- **Patient-centered outcomes research fees.** Group health plans are assessed a PCORI fee designed to fund health care-related research. (See our January 23, 2013 *For Your Information.*) Under the Code, the penalty for failing to pay the PCORI fee is the full amount of the fee itself, possibly coupled with IRS excise taxes ranging from .5 to 25% of the fee.

  Buck comment. If a group health plan is insured, the health insurer is responsible for calculating and paying the PCORI fee.

- **Transitional reinsurance fee.** From 2014 through 2016, health insurance issuers and self-funded group health plans must pay a per-covered-life fee designed to offset costs of non-grandfathered coverage in the individual market. (See our December 11, 2013 *For Your Information*.) Failure to pay the fee may result in HHS penalties of $100 a day per affected person.

  Buck comment. While this fee was enacted as a stand-alone provision of the ACA and was not expressly included in the PHSA, an HHS penalty of $100 a day may apply.

- **Excise tax on high-cost employer plans ("Cadillac tax").** Beginning in 2018, an excise tax will be imposed on the aggregate value of employer-sponsored health coverage that exceeds certain thresholds. Generally, the nondeductible tax will equal 40% of the aggregate value in excess of $10,200 for individual coverage and $27,500 for family coverage (subject to certain adjustments). Regulations related to the assessment of the tax have not yet been issued. The penalty for underpayment of this tax is 100% of any underpayment, plus interest calculated at the IRS tax unemployment rate. (See our April 21, 2010 *For Your Information*.)

  However, the excise tax will not attach if:

  – The employer/plan sponsor neither knew, nor by exercising reasonable diligence could have known, that an underpayment existed

  – The underpayment was due to reasonable cause and not willful neglect and is corrected within 30 days of the employer learning about it

  – The IRS deems the penalty excessive and inequitable

In closing

Awareness of applicable penalties underscores the need for robust ACA compliance programs. Use the chart accompanying this *In-depth* as a quick reference guide for the types of penalties that compliance failures may trigger. Initially, the agencies will be looking to help group health plans advance their compliance efforts and may develop voluntary corrections programs in the future, but compliance failures, in addition to being costly, nevertheless can cause negative public and press attention.

Market reforms applicable to grandfathered and non-grandfathered plans

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Adult child coverage to age 26	Plans offering dependent coverage must allow employees to cover their adult children until they reach age 26	September 22, 2010 May 13, 2010	Plan years beginning on or after September 23, 2010	IRC section 4980D penalties (section 4980D penalties): • $100 per day/individual affected by the violation • minimum of $2,500/individual affected by the violation where plan does not correct compliance failure(s) before receiving a notice of examination of income tax liability from IRS, and failures continue during the examination period • $15,000 if the failure to comply with mandates is determined to be more than *de minimis* Maximum penalty is lesser of $500,000 or 10% of aggregate amount paid or incurred by the employer (or, in the case of multiple employer plans, the trust) during the previous taxable year Code section 4980D penalties do not apply, however, where: • IRS determines that no one liable for the tax knew, or exercising reasonable diligence would have known, that a compliance failure existed, or • failure was due to reasonable cause (and not willful neglect) and failure was corrected (affected individual made whole) within 30 days of the date anyone liable for the tax knew, or exercising reasonable diligence, should have known, that failure existed ERISA penalties: For plans governed by ERISA, DOL and affected participants can file a lawsuit to compel compliance with market reforms and/or seek monetary damages in connection with compliance failure HHS penalties: Non-federal governmental plans and church plans are not governed by ERISA, and so are not subject to ERISA-based lawsuits. For plans governed by the PHSA, HHS may file a lawsuit to compel compliance or obtain civil monetary penalties for compliance failures on the part of non-federal governmental and church plans (Together, referred to as Code section 4980D penalties, ERISA penalties, and HHS penalties)
No rescission of coverage	Once an individual is covered under a group health plan, the plan may not rescind that individual's coverage except in cases of fraud or intentional misrepresentation	July 2, 2010	Plan years beginning on or after September 23, 2010	
No annual or lifetime dollar limits	Plans may not impose lifetime or annual dollar limits on essential health benefits This restriction does not apply to FSAs, HSAs, and integrated HRAs	February 27, 2013 October 22, 2012 March 1, 2012 December 22, 2011	Plan years beginning on or after January 1, 2014 (annual limits phased in for 2010-2013)	
No pre-existing condition exclusions	Plans may not impose any pre-existing condition exclusions on coverage	July 2, 2010	Plan years beginning on or after January 1, 2014	
No waiting periods in excess of 90 days	Plans may not require otherwise eligible employees to wait more than 90 days after hire to be eligible for coverage	April 9, 2013 September 10, 2012 March 1, 2012	Plan years beginning on or after January 1, 2014	
No health status-related discrimination	Wellness plans, provided under the group health plan, may not discriminate on the basis of a health status-related factor in determining eligibility or coverage	July 16, 2013	Plan years beginning on or after January 1, 2014	

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Market reforms applicable to non-grandfathered plans only

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Preventative care coverage	Plans must cover specified in-network preventive health services at 100%, without cost sharing	March 15, 2013 August 28, 2012 August 11, 2011 July 20, 2010	Plan years beginning on or after September 23, 2010	Section 4980D penalties, ERISA penalties, and HHS penalties apply
Patient protections	Plans must allow enrollees to select their primary care provider or pediatrician from any available participating provider No preauthorization or referrals are permitted for obstetrical, gynecological, and emergency services Out-of-network emergency care must be charged in accordance with in-network benefit terms	July 2, 2010	Plan years beginning on or after September 23, 2010	Section 4980D penalties, ERISA penalties, and HHS penalties apply
Claims appeals process requirements	Plans must implement internal appeals and external review processes	August 4, 2011 September 1, 2010 August 11, 2010	Plan years beginning on or after September 23, 2010	Section 4980D penalties, ERISA penalties, and HHS penalties apply
Nondiscrimination for insured plans	Insured plans may not discriminate in favor of highly compensated employees	January 5, 2011	Plan years beginning on or after September 23, 2010 – but enforcement is delayed until guidance is released	Section 4980D penalties, ERISA penalties, and HHS penalties apply
Women's preventive services	Plans must provide first-dollar coverage for "women's preventive services" provided in-network Plans sponsored by certain religious employers are exempt from this requirement, and there is a one-year enforcement safe harbor in 2014 for plans that do not currently cover contraceptives due to their sponsors' religious beliefs	August 11, 2011	Plan years beginning on or after August 1, 2012	Section 4980D penalties, ERISA penalties, and HHS penalties
Coverage for approved clinical trials	Plans must cover routine patient costs incurred in connection with approved clinical trials	May 21, 2013	Plan years beginning on or after January 1, 2014	Section 4980D penalties, ERISA penalties, and HHS penalties

Market reforms applicable to non-grandfathered plans only

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Maximum deductibles and out-of-pocket maximums	Maximum deductible limit of $2,000/individual and $4,000/family (indexed) applicable to insured and small group plans only The in-network out-of-pocket maximum for essential health benefits for 2014 is $6,350/individual and $12,700/family	February 27, 2013	Plan years beginning on or after January 1, 2014	Section 4980D penalties, ERISA penalties, and HHS penalties
Provider nondiscrimination	No discrimination against a provider who is acting within the scope of license when service is covered under the plan	May 21, 2013	Plan years beginning on or after January 1, 2014	Section 4980D penalties, ERISA penalties, and HHS penalties

New employer and/or plan sponsor requirements – reporting, notice, and disclosure requirements

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Disclosure of grandfathered status	Plans must provide participants and beneficiaries with notice that coverage is grandfathered and therefore exempt from certain market mandates	November 2, 2010	Plan years beginning on/after September 23, 2010	Loss of grandfathered status
Rescission of coverage notice	Plans retroactively cancelling coverage due to fraud or intentional misrepresentation must provide notice to affected participants and beneficiaries	July 2, 2010	Plan years beginning on/after September 23, 2010	Rescission ineffective

New employer and/or plan sponsor requirements – reporting, notice, and disclosure requirements

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Notice of patient protections	Plans must notify participants about their right to select their primary care provider or pediatrician from any available participating provider, obtain obstetric, gynecological, and emergency services without a referral or prior authorization, and be charged for out-of-network emergency care with in-network benefit terms	July 2, 2010	Plan years beginning on/after September 23, 2010	Section 4980D penalties and HHS penalties apply
Notice of expanded claims appeals procedures	Plans must provide participants with a notice of available processes for appeals and coverage and claims determinations In the case of insured plans, the requirement applies to health insurance issuer	August 4, 2011	Plan years beginning on/after September 23, 2010, but subject to enforcement grace period	Section 4980D penalties and HHS penalties apply
Summary of benefits and coverage (SBC)	Plans must provide participants and beneficiaries with a summary of benefits that accurately describes benefits and coverage and is limited in length to four double-sided pages	May 10, 2013	Open enrollment periods and plan years beginning on/after September 23, 2012	Willful failure to provide an SBC triggers a $1,000 penalty for each failure Plans working "diligently and in good faith" to comply with SBC-related regulations generally not liable for penalties through December 31, 2014. Starting in 2015, however, Code section 4980D penalties apply generally
Notice of material modifications	Plans must provide notice of any material modification to a plan term or coverage not reflected in the most recently issued SBC at least 60 days before the modification's effective date In the case of insured plans, the requirement applies to health insurance issuer	March 1, 2012	Plan years beginning on/after September 23, 2012	Willful failure to provide notice of material modifications triggers a $1,000 penalty for each failure Section 4980D penalties may also apply generally

New employer and/or plan sponsor requirements – reporting, notice, and disclosure requirements

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Notice of preventative health services – contraceptive services	Plans maintained by nonprofit organizations with religious objections to providing contraceptive coverage must notify participants of the plan's eligibility for a one-year enforcement safe harbor with respect to covering contractively services	October 18, 2013	Plan year beginning on/after August 1, 2012	Failure to provide notice results in loss of safe harbor protection
Form W-2 reporting	Employers that issue 250 or more W-2 forms must report on their employees' W-2 forms the aggregate cost of employer-sponsored group health coverage, including employer contributions to HRAs and health FSAs	January 11, 2012	Reporting first required in 2013 for coverage provided in 2012	From $30/Form W-2 up to maximum of $1,500,000/calendar year, depending on the number of failures and when the failures are corrected
Marketplace (Exchange) notice	Employers must provide employees with information concerning the availability of marketplaces	September 30, 2013	October 1, 2013	No penalty provided
Reporting compliance with employer shared responsibility mandate	Employers subject to the employer shared responsibility mandate must provide the IRS and each full-time employee with information regarding the employer's compliance during the preceding year	July 22, 2013	Reporting first required in 2016 for the 2015 year	$100/per tax return associated with the failure, up to maximum of $1.5 million $50/failure up to a maximum of $100,000. Some relief provided if failure is due to reasonable cause and not willful neglect
Reporting compliance with the "individual mandate"	Employers must provide the IRS and each "primary" insured with an individualized written statement regarding the prior year's coverage	July 22, 2013	January 31, 2015	$100/per tax return associated with the failure, up to maximum of $1.5 million $50/failure up to a maximum of $100,000. Some relief provided if failure is due to reasonable cause or is timely corrected
Auto-enrollment of full-time employees	Employers with at least 200 employees must automatically enroll full-time employees into one of their health plans following the completion of any applicable waiting period DOL has indicated that regulations are forthcoming	July 11, 2012 April 21, 2010	Unknown – awaiting regulations	No statutory penalties specified. DOL guidance forthcoming

New employer and/or plan sponsor requirements – miscellaneous

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Failure to provide medical loss ratio rebates	Insurers must provide plans with rebates for any administrative expenses exceeding 15% threshold. Plans must distribute these rebates to participants within 90 days	August 7, 2012	January 1, 2012	Section 4890D penalties
Permitting annual salary reduction contributions to a health FSA in excess of $2,500 per participant	Employees may not contribute more than $2,500 to their health FSAs through salary reduction	June 8, 2012	Plan years beginning on or after January 1, 2013	Health FSA is not considered a qualified benefit and the cafeteria plan loses its tax-advantaged status, potentially rendering all benefits under the plan taxable. IRS guidance provides some relief for reasonable mistakes that an employer timely corrects
Employer shared responsibility	Generally, large employers must either offer full-time employees (and their dependents) health coverage that is affordable and provides minimum value, or make an "assessable payment" to the IRS if at least one full-time employee enrolls in marketplace coverage and receives a premium subsidy	February 11, 2014 June 22, 2013 January 30, 2013	Generally, penalties first imposed in 2016 in connection with 2015 failures. Final regulations provide compliance transition rules for large employers with fewer than 100 employees and certain other large employers	Failure to offer coverage: If at least one full-time employee obtains a low-income premium subsidy through the marketplace for a calendar month, the employer must make a monthly assessable payment of $167 (1/12 of $2,000)/each of its full-time employees during that month (over an 80-employee threshold in 2015 and 30-employee threshold thereafter). Maximum non-deductible payment/full-time employee is $2,000 (indexed annually) Failure to offer "affordable" or minimum value coverage: Generally, an employer offering coverage must make a monthly assessable payment of $250 (1/12 of $3,000)/each of its full-time employees who, during that month, receives a low-income premium subsidy through the marketplace and for whom the employer's coverage fails to meets either affordability or minimum value requirements. Maximum nondeductible payment per full-time employee receiving a premium subsidy is $3,000 (indexed annually)

Financing provisions

ACA provision	Purpose	Relevant *For Your Information* publication(s)	Effective date	Consequences of noncompliance
Patient-centered outcomes research institute (PCORI) fee	Fee assessed on self-funded plans (and insurers) to fund research to evaluate and compare the health outcomes and clinical effectiveness, risks, and benefits of medical treatments, services, procedures, and drugs	January 23, 2013	Plan/policy years beginning on or after October 1, 2012 through plan years ending on or after September 30, 2019	Full amount of the fee itself, plus excise taxes ranging from .5 to 25% of the fee, depending on when fee is paid Excise taxes will not apply, however, if the plan or insurer establishes that it failed to file or pay on time because of reasonable cause and not due to willful neglect
Transitional reinsurance fee	Fee designed to stabilize premiums for coverage in the individual market between 2014-2016 that is assessed on self-funded plans (and insurers)	December 11, 2013 November 12, 2013 December 6, 2012	2014-2016	Possible fee of $100/day/affected person
Excise tax on high-cost (Cadillac) employer plans	Excise tax on the aggregate value of employer-sponsored health coverage that exceeds certain thresholds Generally, tax will equal 40% of the aggregate value in excess of $10,200 for individual coverage and $27,500 for family coverage	July 11, 2012 April 21, 2010	2018	Penalty for underpayment is 100% of any underpayment, plus interest calculated at the IRS tax unemployment rate However, the tax will not apply if: • the employer/plan sponsor neither knew, nor by exercising reasonable diligence could have known, that an underpayment existed • the underpayment was due to reasonable cause and not willful neglect, and is corrected within 30 days of the employer learning about it • the IRS deems the penalty excessive and inequitable

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Authors
Julia Zuckerman, JD
Sharon Cohen, JD

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