Affordable Care Act – Where Are We Now?

Spring 2015

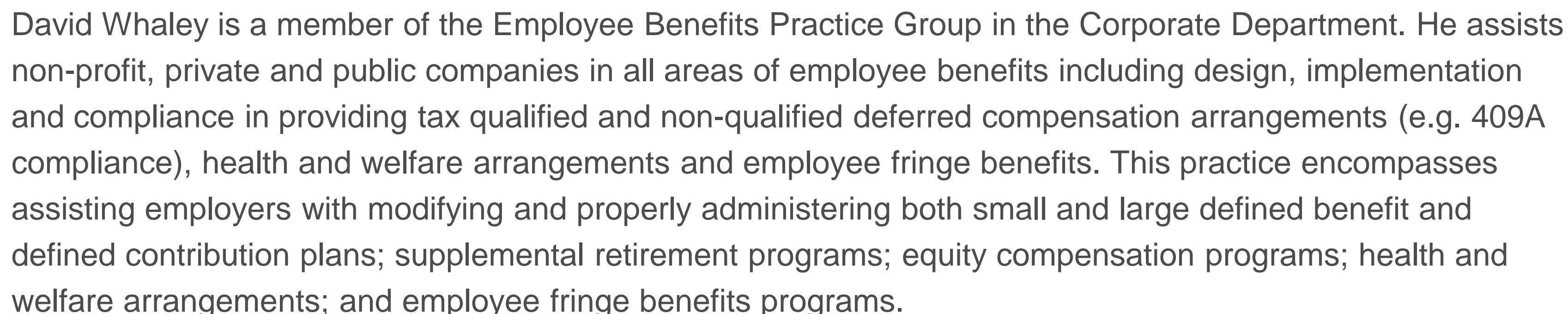
David A. Whaley, Esq.

Dinsmore & Shohl LLP

513.977.8554

david.whaley@dinsmore.com

Dinsmore



David Whaley is a member of the Employee Benefits Practice Group in the Corporate Department. He assists non-profit, private and public companies in all areas of employee benefits including design, implementation and compliance in providing tax qualified and non-qualified deferred compensation arrangements (e.g. 409A compliance), health and welfare arrangements and employee fringe benefits. This practice encompasses assisting employers with modifying and properly administering both small and large defined benefit and defined contribution plans; supplemental retirement programs; equity compensation programs; health and welfare arrangements; and employee fringe benefits programs.

David has extensive experience in the area of Employee Stock Ownership Plans (ESOPs). This experience has facilitated his membership in the Ohio/Kentucky Chapter of the ESOP Association and participation with both the Ohio Employee Ownership Center and with the Emerging Leaders Committee of the National ESOP Association.

In addition to his ESOP experience, David fills his practice by: assisting non-profit employers in drafting and administering qualified and non-qualified plans including 403(b), 457(b) and 457(f) plans; assisting professional employer organizations (PEOs) in offering employee benefit programs to their client organizations; and representing plan sponsors before the Department of Labor, the Internal Revenue Service and the Pension Benefit Guaranty Corporation in connection with audits of employee benefit plans.

Introduction:
Trends in Health Care Costs

Centers for Medicare and Medicaid Services, "National Health Expenditure Projections, 2013-23

- **"Health spending is projected to grow at an average rate of 5.7 percent for 2013-2023,1.1 percentage points faster than expected average annual growth in the Gross Domestic Product."**
- "Expected growth for 2014 is 5.6 percent, as 9 million Americans are projected to gain health insurance coverage, predominantly through Medicaid or the Health Insurance Marketplaces."

Source: ," "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy, *Health Affairs,* October 2014 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf)

Centers for Medicare and Medicaid Services, "National Health Expenditure Projections, 2013-23

- "Average annual projected growth of 6.0 percent per year is projected for 2015 through 2023, largely as a result of the continued implementation of the ACA coverage expansions, faster projected economic growth, and the aging of the population. While projected growth is faster compared to recent experience, it is still slower than the growth observed over the longer-term history."

Source: ," "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy, *Health Affairs,* October 2014 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf)

Centers for Medicare and Medicaid Services, "National Health Expenditure Projections, 2013-23

- "The government-sponsored share of health spending is projected to increase and account for 48 percent of national health expenditures by 2023, largely driven by Medicaid coverage expansions, Marketplace plan premium and cost-sharing subsidies, and an increasing gap between dedicated Medicare financing and program outlays."

Source: ," "National Health Expenditure Projections, 2013–23: Faster Growth Expected With Expanded Coverage And Improving Economy, *Health Affairs,* October 2014 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2013.pdf)

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2014

250%
200%
150%
100%
50%
0%

Health Insurance Premiums
Workers' Contribution to Premiums
Workers' Earnings
Overall Inflation

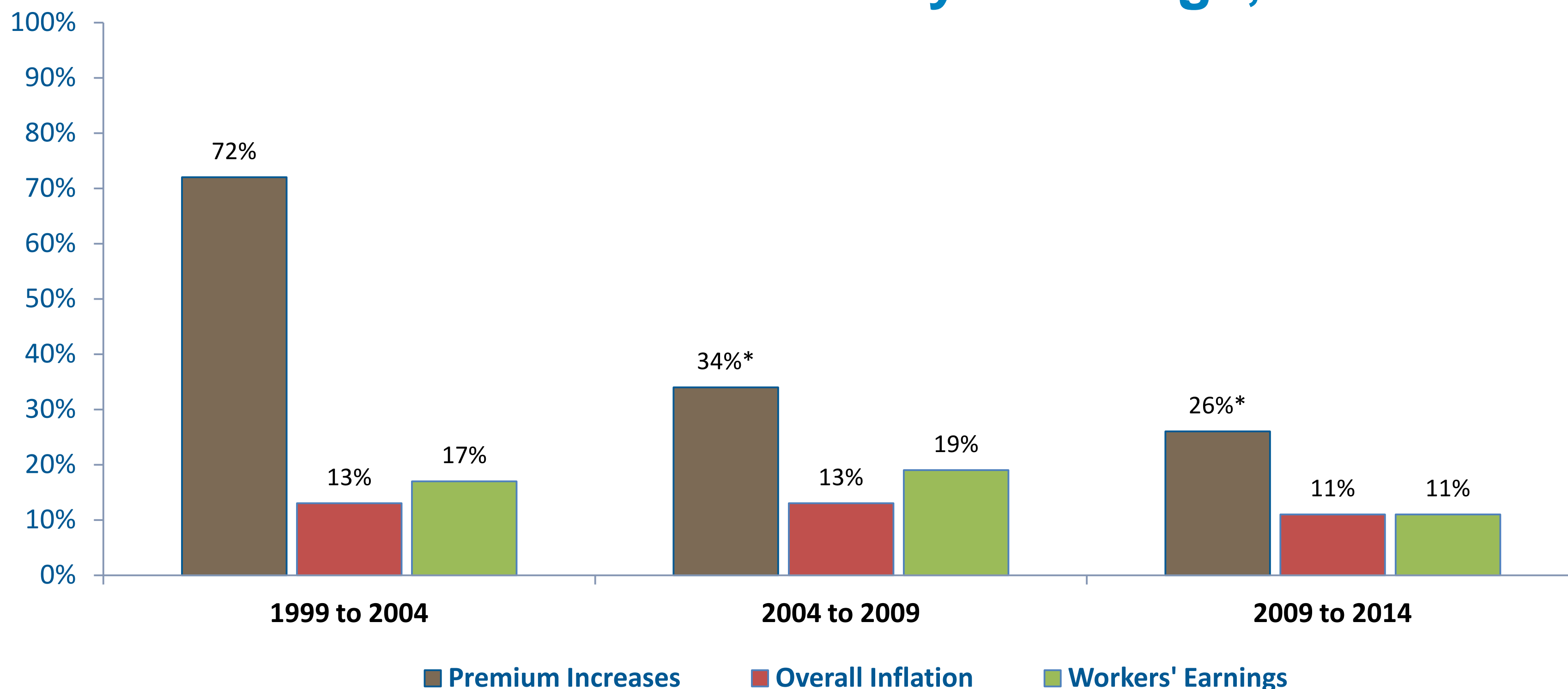
212%
191%
131%
127%
72%
54%
38%
17%
43%
28%
13%

1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2014 (April to April).

-AND-

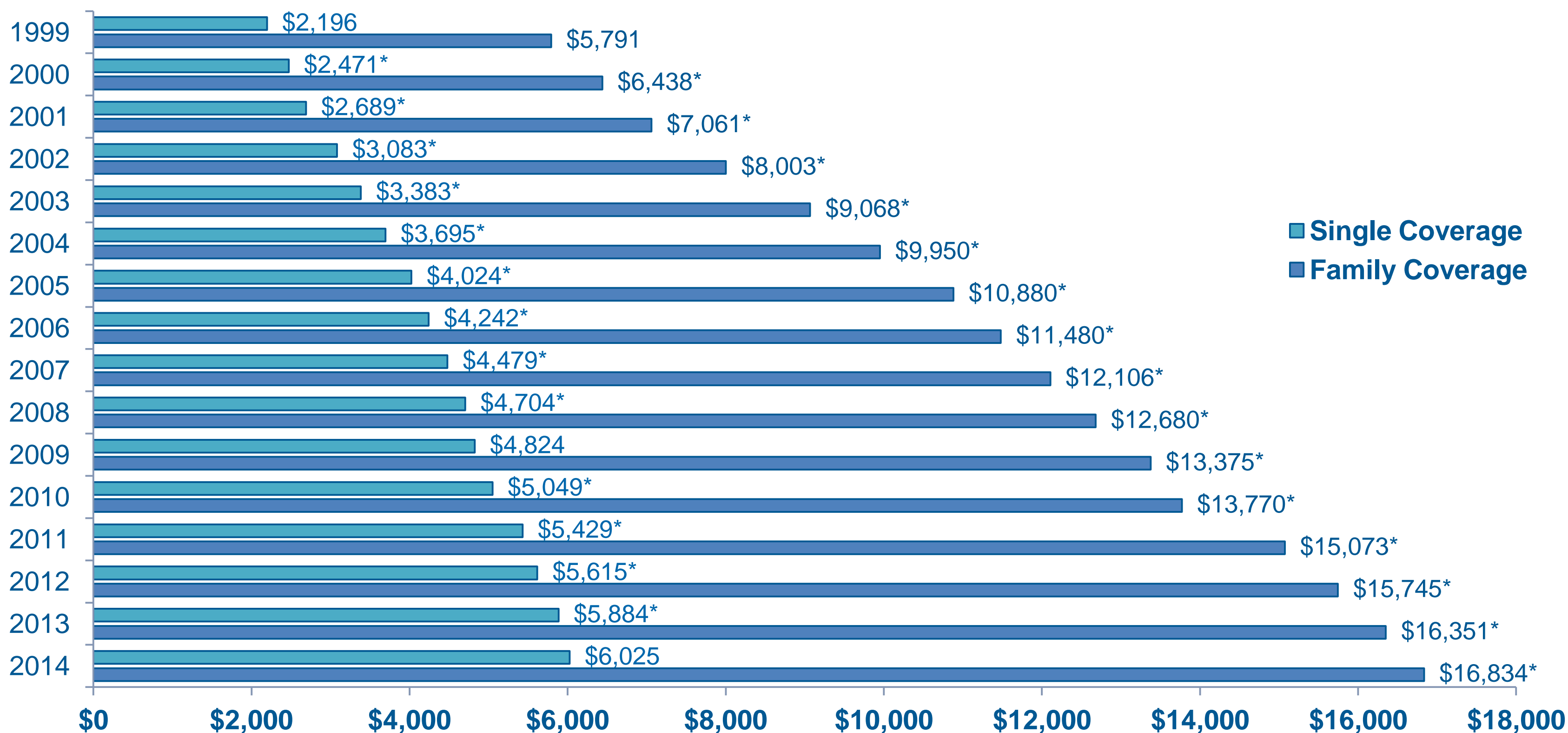
Average Premium Increases for Covered Workers with Family Coverage, 1999-2014



* Premium Change is statistically different from previous period shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2014 (April to April).

Average Annual Premiums for Single and Family Coverage, 1999-2014

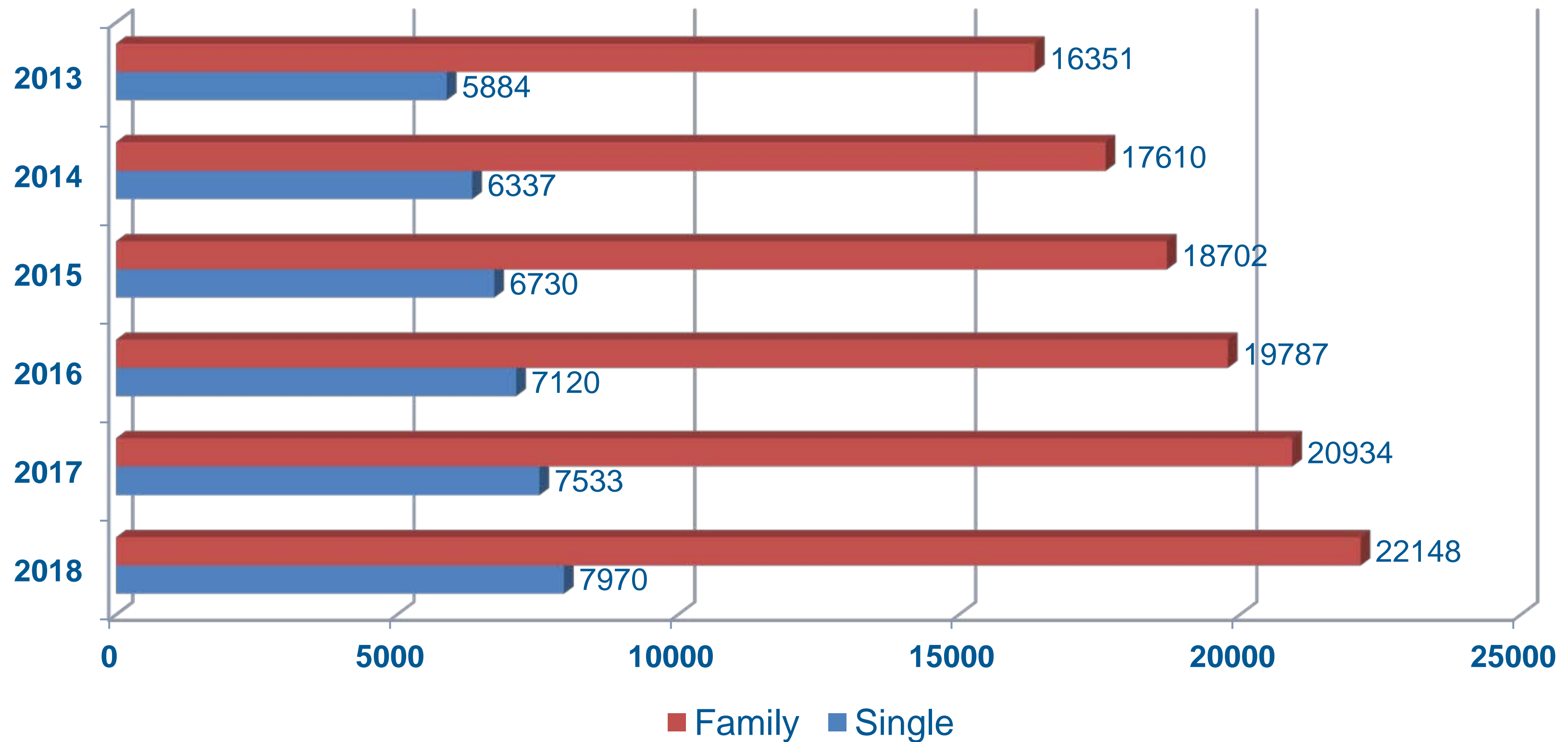


* Estimate is statistically different from estimate for the previous year shown (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014.

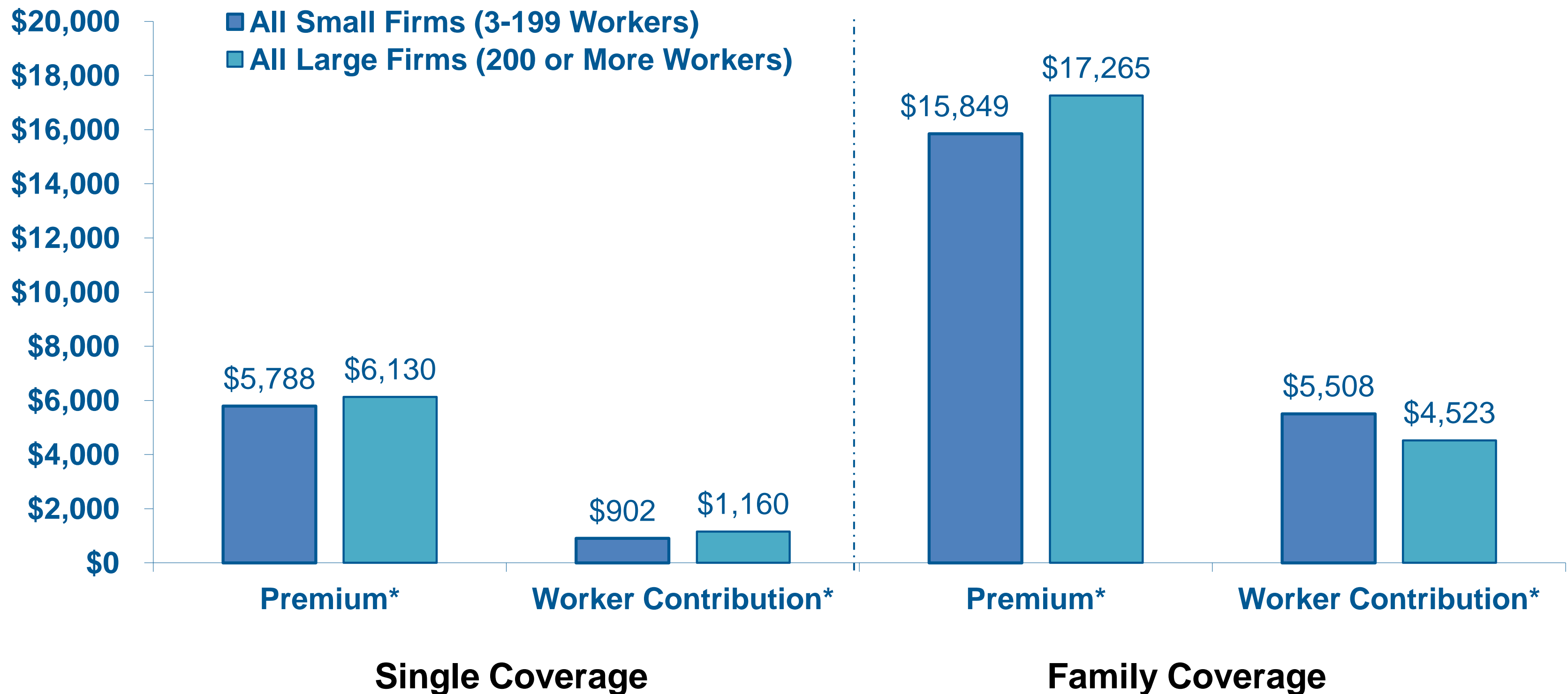
THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Based on Projected National Health Care Cost Increases, What are Costs Likely to Cost in 2018, On Average, For All Employers Throughout the US?



Source: National Health Expenditure Projections 2012-2022, Centers for Medicare and Medicaid Services, 2012

Average Annual Worker Premium Contributions and Total Premiums for Covered Workers, Single and Family Coverage, by Firm Size, 2014



* Estimates are statistically different between All Small Firms and All Large Firms (p<.05).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014.

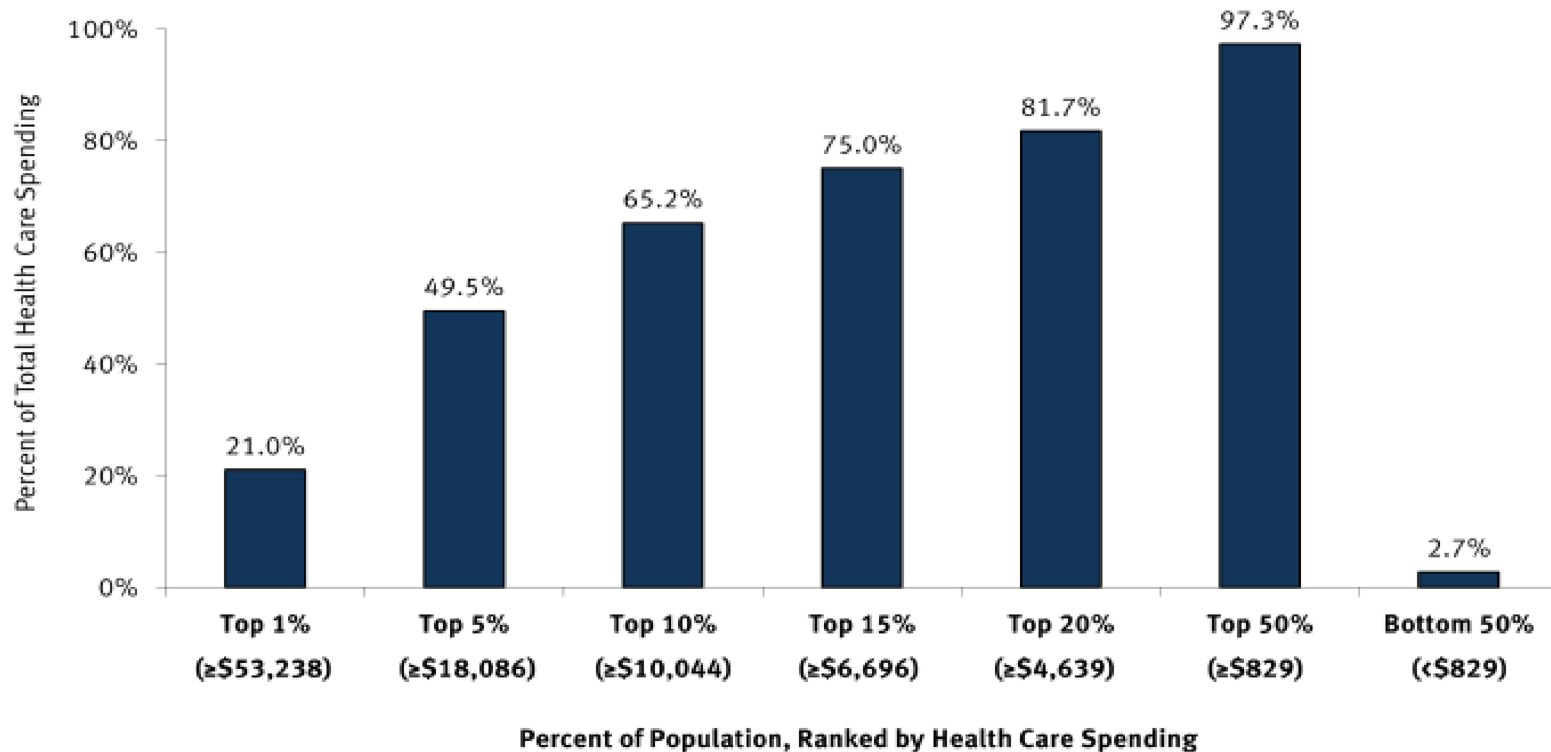
How to Use This Information to Glean
Practical Advice for Businesses

How to Use This Information to Glean Practical Advice for Businesses

- Use this information to benchmark the business's current group health plan premiums for single and family coverage
  - Well above peers? Well below peers?
- Use this information to gauge competitiveness of employee out of pocket obligations
- Use this information to determine whether a business that does not currently sponsor a group health benefit plan (and will be too small in 2015 to be exposed to the IRC § 4980H employer "pay or play" "shared responsibility" excise taxes) should consider adopting a plan to gain or retain its competitiveness for desirable employees.

How Do "We" Spend Our Health Care Dollars? And Why Should We Care?

Concentration of Health Care Spending in the U.S. Population, 2010



NOTE: Dollar amounts in parentheses are the annual expenses per person in each percentile. Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

SOURCE: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), Household Component, 2010.

THE HENRY J. KAISER FAMILY FOUNDATION

How Do "We" Spend Our Health Care Dollars?

- A small proportion of the U.S. Population accounts for half of all U.S. health care spending
- The 5% of the population with higher health care expenses (>$16,336 annually) was responsible for nearly half (47.5%) of total health care spending, while the 50% of the population with the lowest expenses (<$825) accounted for only 3.1% of total spending.
- Much of these claims are for treatment of chronic conditions.

How Do “We” Spend Our Health Care Dollars?

- Our national spending proclivity is equally discouraging:
  - We do a poor job spending health care dollars wisely
  - The systems we use to compensate health care providers reward volume provided by each provider– not effectiveness or even coordination to minimize overtreatment or less than optimal treatment
  - We talk proudly about “consumer-driven health care” – and then fail to provide consumers with the tools necessary to effectively manage how and when they receive care so as to maximize quality and minimize cost

"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America" (Smith et. al., Institute of Medicine, November 2012)

TABLE S-1 Estimated Sources of Excess Costs in Health Care (2009)

Category	Sources	Estimate of Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion
Inefficiently Delivered Services	• Mistakes—errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion
Prices That Are Too High	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion
Fraud	• All sources—payers, clinicians, patients	$75 billion

SOURCE: Adapted with permission from IOM, 2010.

Total: $750 billion-$765 billion

“Best Care at Lower Cost: The Path to Continuously Learning Health Care in America” (Smith et. al., Institute of Medicine, November 2012)

“Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:

- If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
- If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.

“Best Care at Lower Cost: The Path to Continuously Learning Health Care in America” (Smith et. al., Institute of Medicine, November 2012)

- “If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.”

"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America" (Smith et. al., Institute of Medicine, November 2012)

"The point is not that health care can or should function in precisely the same way as all other sectors of people's lives – each is very different from the others, and every industry has room for improvement. Yet if some of the transferrable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities and personal services were adopted as standard best practices in health care, the nation could see patient care in which

- Records were immediately updated and available for use by patients;
- Care delivery was care proven reliable at the core and tailored at the margins;
- All ream members were fully transparent to all participants;

"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America" (Smith et. al., Institute of Medicine, November 2012)

"The point is not that health care can or should function in precisely the same way as all other sectors of people's lives – each is very different from the others, and every industry has room for improvement. Yet if some of the transferrable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities and personal services were adopted as standard best practices in health care, the nation could see patient care in which

- records were immediately updated and available for use by patients;
- care delivery was care proven reliable at the core and tailored at the margins;
- all team members were fully informed in real time about each other's activities;
- prices and total costs were fully transparent to all participants;

“Best Care at Lower Cost: The Path to Continuously Learning Health Care in America” (Smith et. al., Institute of Medicine, November 2012)

- “payment incentives were structured to reward outcomes and value, not volume;
- errors were promptly identified and corrected; and
- results were routinely captured and used for continuous improvement.

“Unfortunately, these are not features that would describe much of health care in America today. Health care can lag behind many other sectors with respect to its ability to meet patients’ specific needs, to offer choice, to adapt, to become more affordable, to improve – in short, to learn. Americans should be served by a health care system that consistently delivers reliable performance and constantly improves, systematically and seamlessly, with each care experience and transaction.”

Which Employers Are Exposed to The
Employer Mandate Penalties? An
"Applicable Large Employer"

Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- An Employer is an "Applicable Large Employer" for a calendar year if the employer employed at least 50 "full-time employees" during the preceding calendar year
  - "Full-time employees": working 30 or more hours per week.
  - Seasonal Exception. The number of full-time employees excludes those full-time seasonal employees who work for less than 120 days during the year.
    - If employer's work force is > 50 full-time + full-time equivalent employees for 120 days or less during a calendar year, and if the employees > 50 who were employed for not more than 120 were seasonal employees, the employer is NOT an "applicable large employer"
    - Regulations : Good faith interpretation of "seasonal worker" is permitted

Which Employers Are Exposed to The Employer Mandate Penalties? An "Applicable Large Employer"

- 2015 Transition Rule
  - 50 Full-time Equivalents Becomes 100 for the purposes of 2015 alone
    - Requirements:
      - Cannot reduce workforces in 2014
      - Requires no reduction to the benefits that were being offered from February 9, 2014
  - Result – Not subject to "Pay or Play" for 2015 and, if a non-calendar year plan, the portion of 2016 consisting of the 2015 plan year
    - Note – Deductible year and plan year can differ

The Two Employer Pay or Play
Mandate Penalties

The Two Employer Pay or Play Mandate Penalties

- Penalty #1: Penalty on the applicable large employer that **does not offer group health benefit plan coverage to all of its full time employees**
- Penalty #2: Penalty on the applicable large employer that offers coverage – but the coverage is
  - **Not affordable** --The employee's share of the premium > 9.5% of household income

    OR
  - The plan's share of covered health benefit costs (the "actuarial value") does not offer **minimum value** – it is less than 60%

The Two Employer Pay or Play Mandate Penalties

- **ONLY IF** - Applicable Large Employers face these two different penalties only if at least **one bona fide full time employee (> 30 hours per week)** is eligible for and received the new premium tax credit
  - One of the two penalties is calculated by reference to the number of **bona fide full time employees** – so, being able to identify who they are will be important

“Pay or Play” Requirement Penalty #1- Offer Coverage to all Bona Fide Full Time Employees

"Pay or Play" Requirement Penalty #1-Offer Coverage to all 30+ Hour Full Time Employees

- What Triggers This First Penalty?
  - Do not offer group health benefit plan coverage to bona fide full-time employees (and their dependents) AND at least one of those full time employees enrolls in an exchange plan AND receives the premium tax subsidy (i.e., family income < 400% of FPL)
- How Much is This First Penalty?
  - In 2015, the annual penalty is equal to: the total number of full-time employees minus 30, multiplied by $2,000.
  - After 2015, the penalty payment amount will be indexed by a premium adjustment percentage for the calendar year.
- 2015 Transition Relief – "30" becomes "80" for the purpose of applying limitations under this rule

"Pay or Play" Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value

"Pay or Play" Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value (the "B" Penalty or "Tacking" Penalty

- What Does it Take to Fall Prey to This Penalty?
  - Employee's share of the premium is not affordable: at least 9.5% of household income

    OR
  - plan's share of covered health benefit costs (plan-paid benefits ÷ sum of plan-paid benefits plus copayments/deductibles) does not offer minimum value – it is less than 60%

    AND
  - At least one bona fide full time employee enrolls in an exchange plan AND receives the premium tax subsidy

“Pay or Play” Requirement Penalty #2- Fail to Offer a Plan That is Affordable and Which Offers Minimum Value

- How Much is This Penalty?
  - In 2015, the annual penalty is equal to:
    - the number of full-time employees who receive the tax subsidy when enrolling in an exchange plan, multiplied by $3,000.
      - but in any event not more than (total # of FTEs – 30) x $2,000
  - After 2015, the penalty payment amount will be indexed by a premium adjustment percentage for the calendar year.

The 95% Exception – Cover 95% of Your Full-Time Employees and Escape the “A” Penalty

- If you cover 95% of your bona fide full-time employees, you escape application of the “A” Penalty
  - Still subject to the “B” or “tacking” penalty
  - Application on an “entity” by “entity” basis
- The 95% becomes 70% for 2015

Addressing the Act's Health Plan Design and Underwriting Requirements

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

- The Affordable Care Act includes health plan **design requirements** that effectively apply to ALL employer sponsored group health plans:
  - Coverage of preventive services with no participant out of pocket costs
  - Nondiscrimination in eligibility and benefits - DELAYED
  - Prohibition on annual and lifetime benefit caps
  - Limits on deductibles and out of pocket costs

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

- The Affordable Care Act includes **underwriting requirements** that all fully insured group health plans in the "small group market" must use – whether coverage is purchased through the Small Business Health Options Program (SHOP) on an Exchange Marketplace or outside the Exchange Marketplace
  - Community rating, using the rating area in which the employer is located
  - The only permitted variations:
    - Age – 1:3 range from 21-65
    - Tobacco use

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

- What is the "small group market"?
  - For 2014 and 2015, under 50 "full-time employees" as declared under state insurance regulations
  - In 2016, this will increase to 100 """full-time employees" as declared under state insurance regulations"

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

- Practical strategy
  - Employers that have more than 50 full time employees (are an applicable large employer) but fewer than 100 employees
    - Consider a self-insured arrangement?
      - Escapes the underwriting requirements
      - Favorable for employers with young, healthy employee workforce
      - Will IRS sanction small group market self-insured arrangements if risk-sharing is constrained?
        - State Laws Applicable to Stop-Loss Coverage – Not preempted

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

- Practical strategy
  - Beware – LASER Claims in the Stop-Loss Market
    - Broker Involvement in Negotiating Claims
    - Claim Management Systems

Practical Advice for Employers: Dealing with the Act's Health Plan Design and Underwriting Requirements

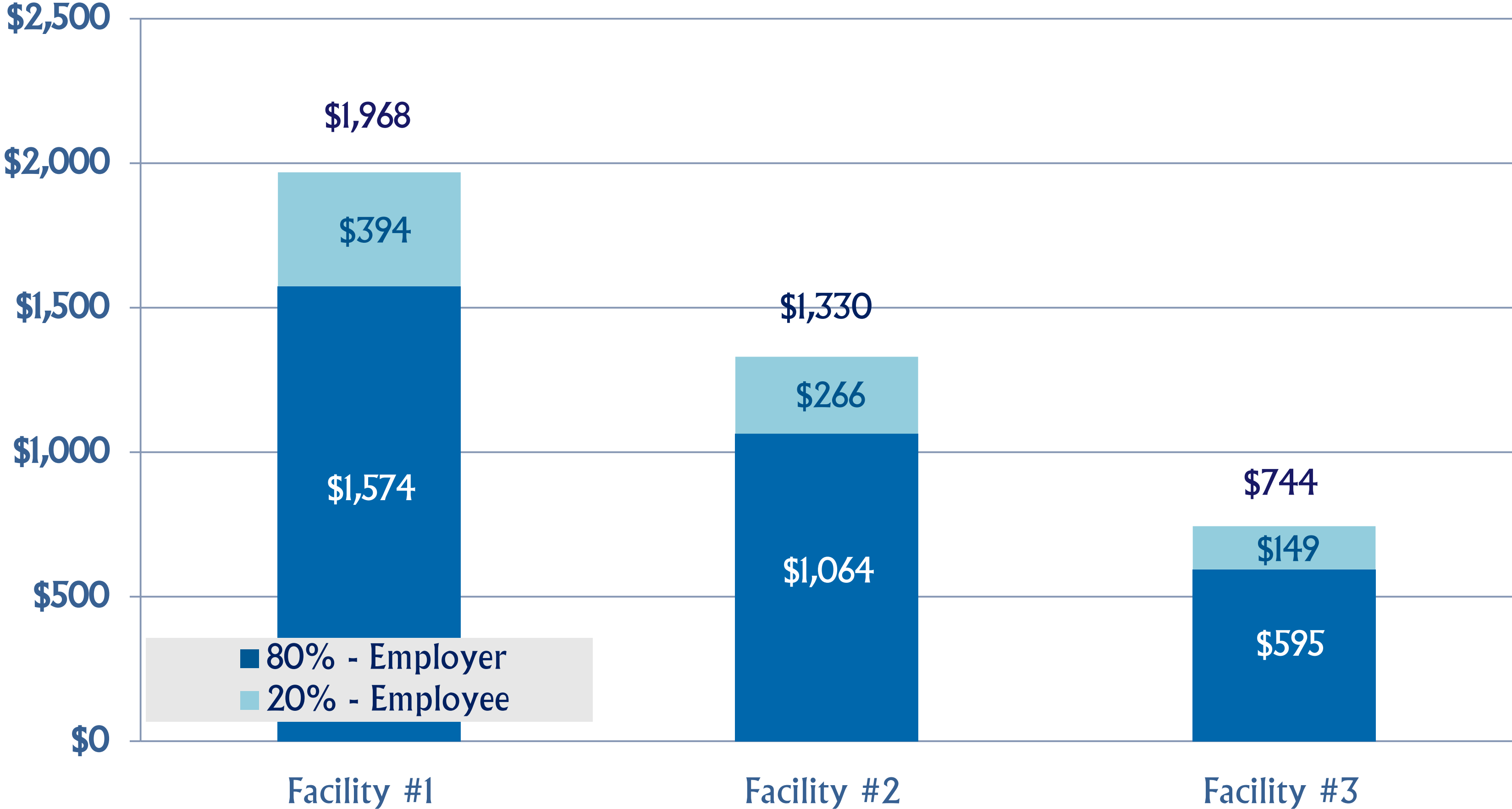
- Practical strategy
  - Employers that have more than 100 employees
    - The design features apply – but the underwriting requirements do not

Other Solutions?

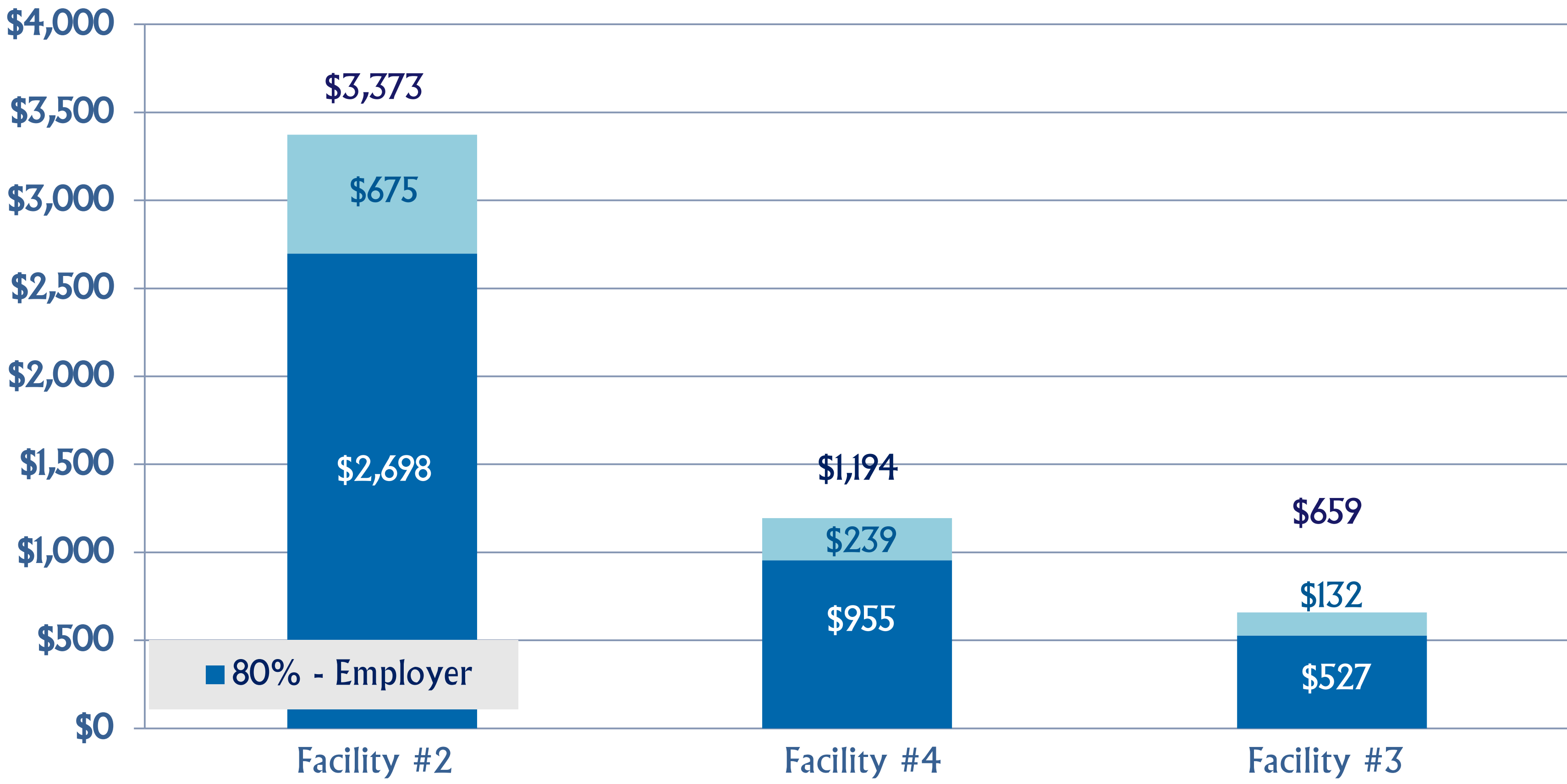
- Reference pricing
  - Definition: Policies that include least costly alternative determinations, under which a single payment is set for clinically comparable services

Do We Face Price Disparities? Yes, We Do

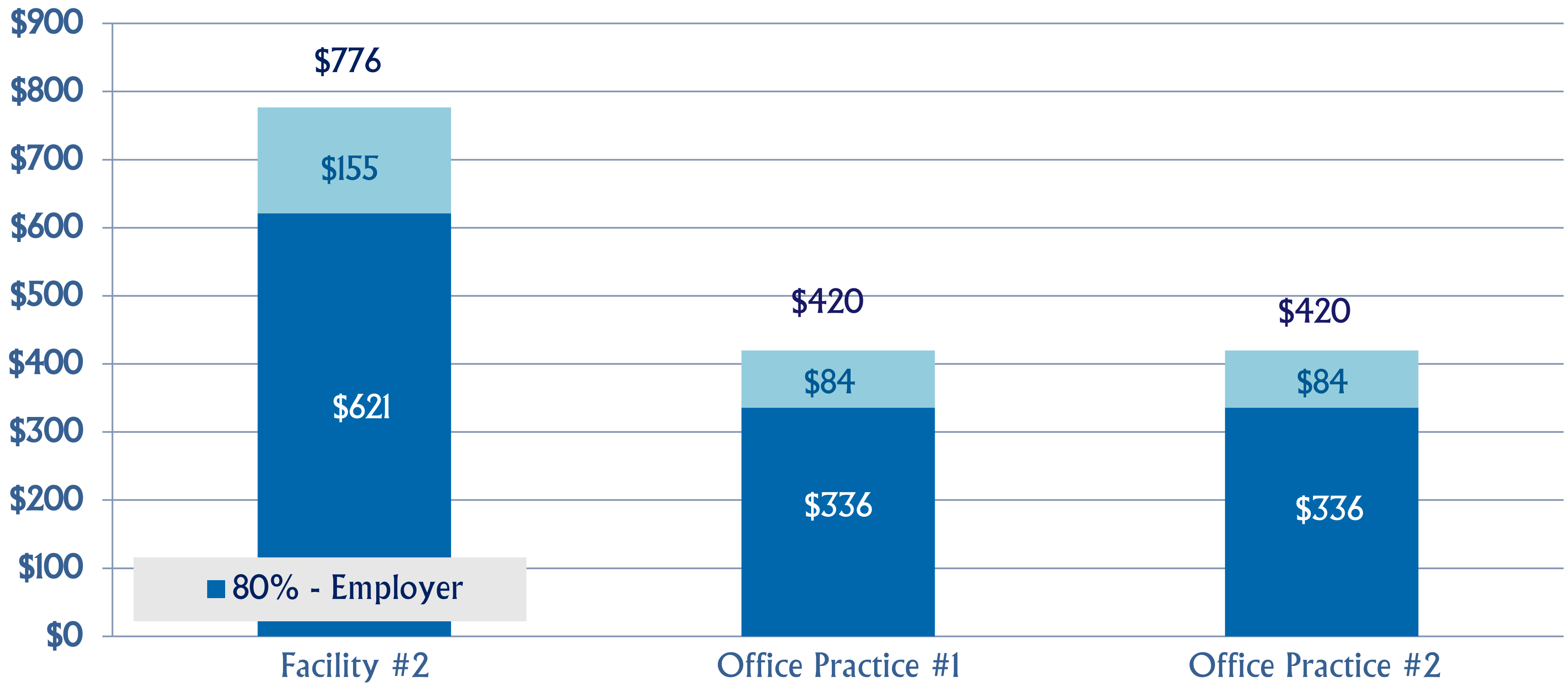
Cost of CAT Scan of Head and Neck



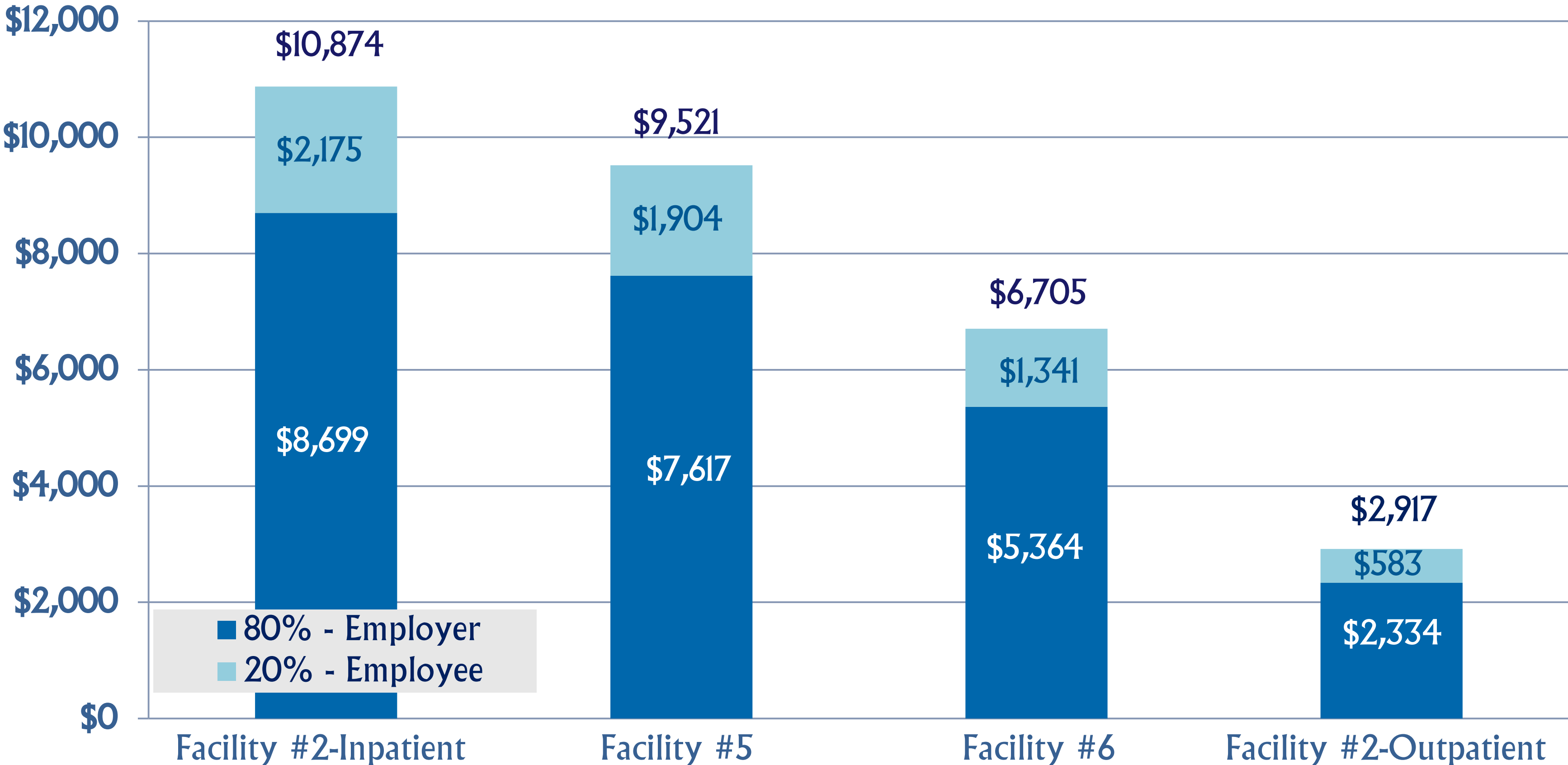
Cost of Scan of Abdomen



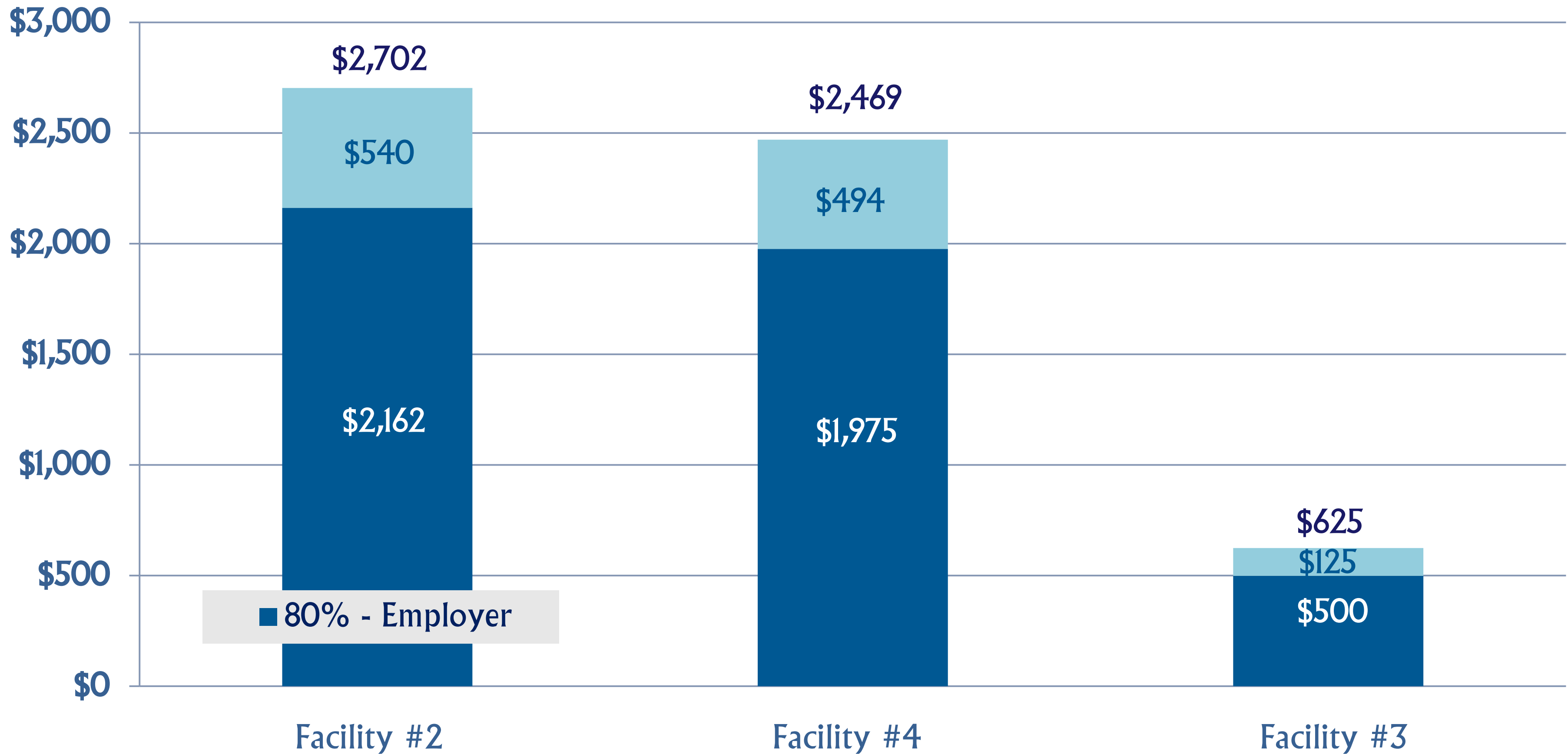
Cost of Ultrasound for Pregnancy



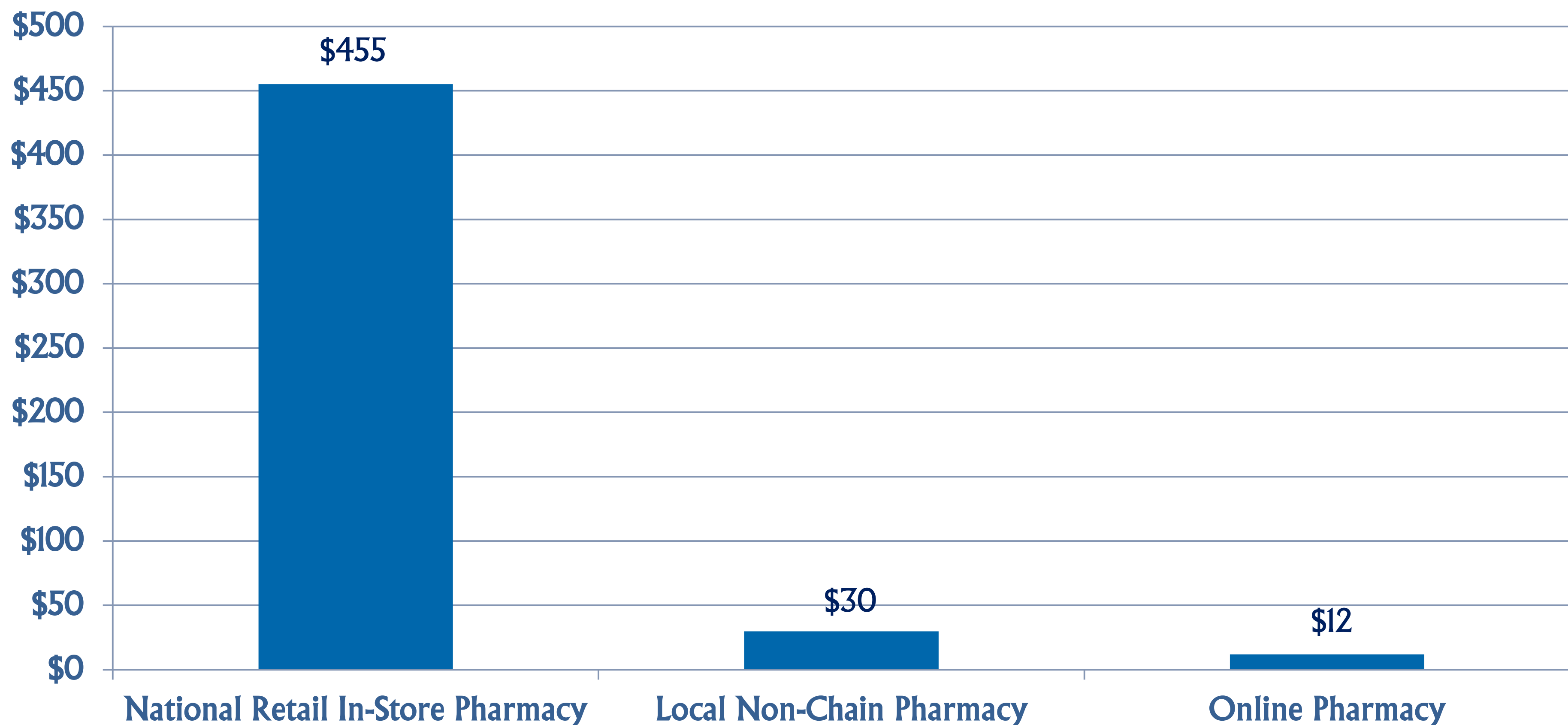
Cost of Gall Bladder Removal



Cost of Colonoscopy



Letrozole (30 day supply) Generic of Femara



Reference Pricing

- Reference Pricing
  - Remember the Affordable Care Act's prohibition on annual or lifetime benefit limits? Does reference pricing violate that prohibition?
  - ACA Implementation FAQs Part XVIII, Q4, available at www.dol.gov/ebsa/faqs/faq-aca18.html and www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html: a group health benefit plan may limit its coverage for out-of-network services without running afoul of the prohibition on annual or lifetime limits.

- Reference Pricing
  - Remember the Affordable Care Act's prohibition on annual or lifetime benefit limits? Does reference pricing violate that prohibition?
  - ACA Implementation FAQs Part XXI, available at http://www.dol.gov/ebsa/faqs/faq-aca21.html: Agencies issue guidance. See Planning for Small Employers in Category #3, below, for details.

- Narrow network plans
    - These plans have begun to sprout among plans offered on the Marketplace Exchanges.
    - They frequently provide for no out-of-network coverage.
    - Warning: read the fine print. These arrangements save money by allowing the most specialized hospitals in the area to participate as in-network providers only for the most sophisticated procedures that are not offered at other area hospitals. Everything else: out of network.

- The “Somewhere in the Middle” Option
  - Can we sponsor a plan that covers less in the way of benefits – for example, could we only cover preventive services and office-based care, but eliminate coverage for inpatient and outpatient services? These “skinny” plans reduce costs and premiums.

- Employee Impact
  - If an employee who is otherwise eligible to go to the Exchange and receive premium tax credits toward the purchase of an Exchange policy instead opts to participate in the employer’s skinny plan, that employee loses eligibility for premium tax credits.
  - Result: employee forfeits Marketplace, extensive coverage, at a price net of tax credits that could be less than the cost the employee pays for the employer’s “skinny” plan.

Health Reimbursement Arrangements and the Like

- Can we:
  - Offer employees a pre-tax reimbursement if they secure health care coverage through the Exchange (or through a plan offered outside the Exchange or through a plan offered at their spouse's place of employment)? That way, we only incur expenses for employees willing to buy coverage – and we look as if we're providing an employer-sponsored plan with the accompanying pre-tax treatment of the reimbursement.
  - Continue to sponsor our traditional plan, but approach high health care cost enrollees and offer to pay them a pre-tax reimbursement (or even an after-tax bonus) if they seek coverage elsewhere?

Health Reimbursement Arrangements and the Like

- Answer: No, we cannot.
  - See: IRS Notice 2013-54 (identical to DOL Technical Release No. 2013-13), “Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements; IRS 5-13-14 Newsroom FAQ Amplifying IRS Notice 2013-54 Prohibition of Employer Payment Plan Pre-Tax Reimbursement of Individual Insurance Premiums and Sanctioning After-Tax Reimbursement; and ACA Implementation FAQs Part XXII, “Compliance of Premium Reimbursement Arrangements”

- Notice 2013-54 and the IRS Newsroom FAQ amplifying IRS Notice 2013-54
    - Arrangements in which the employer characterized its reimbursement arrangement either as a Code §105 medical reimbursement plan – a group health benefit plan – or as a health reimbursement arrangement, and attempts to characterize the reimbursement as a pre-tax expense.

Health Reimbursement Arrangements and the Like

- Notice 2013-54 and the IRS Newsroom FAQ amplifying IRS Notice 2013-54
  - In either case, the Departments said that this arrangement, if maintained on a stand-alone basis, constitutes a group health plan for Affordable Care Act market reform purposes, and violates at least two of the Act's market reforms and in all likelihood three of the reforms: (1) individual policies as well as group health plans may not have any annual limits on benefits; (2) individual policies as well as group health plans may not have any lifetime limits on benefits; (3) nongrandfathered individual policies as well as group health plans may not have any limits on preventive services. Since the employer's obligation is limited to the amount of the premium, all three requirements are violated.

Planning for Small Employers in Categories #1 and #2

- Three Options for Small Employers in Categories #1 and #2: The "Somewhere in the Middle" Option
  - **Notice 2013-54 and the IRS Newsroom FAQ amplifying IRS Notice 2013-54**
  - The Departments permitted one exception. Health reimbursement arrangements that are integrated with a traditional employer-sponsored group health plan that does meet the market reforms and only covers individuals who participate in the traditional employer-sponsored group health plan are OK.
  - **Result:** Stand-alone attempts to reimburse employees for health care premiums on a pre-tax basis won't work.

Planning for Small Employers in Categories #1 and #2

- Three Options for Small Employers in Categories #1 and #2: The "Somewhere in the Middle" Option
  - **ACA Implementation FAQs Part XXII, "Compliance of Premium Reimbursement Arrangements"**
  - What if the employer treats the reimbursement as an after-tax reimbursement rather than as a pre-tax reimbursement, but only offers the reimbursement to individuals who purchase individual health policies? FAQs Part XXII: *that arrangement also constitutes a noncompliant group health plan.*
  - What if the employer approaches high risk employees and offers them cash if they opt out of the employer's group health plan and go to the Marketplace Exchange instead? FAQs Part XXII: *No, that doesn't work: the arrangement is treated as a noncompliant group health plan.*

Health Reimbursement Arrangements and the Like

- Three Options for Small Employers in Categories #1 and #2: The "Somewhere in the Middle" Option
  - Where does that leave us?
  - If an employer does not wish to sponsor a group health plan but does wish to offer employees cash to defray all or a portion of the employees' premium obligations for individual policies, the employer must offer all employees a choice of taxable additional cash wages or reimbursement of their premium expenses (which will also be treated as additional taxable cash wages). That way, every employee gets the additional taxable cash benefit – not just employees who elect health insurance.

Health Reimbursement Arrangements and the Like

- Notice 2015-17
  - Recently, the IRS issued a non-enforcement notice for 2015:
    - HRAs of non-ALEs
    - HRAs for Medicare reimbursement (but, careful with Medicare Secondary Payor Rules)
    - HRAs for 2% S-Corp. Shareholders
  - Specifically permits after-tax payments “non-conditional” bonuses
  - But, prohibits, “conditional” after-tax payments

Health Reimbursement Arrangements and the Like

- Three Options for Small Employers in Categories #1 and #2: The "Somewhere in the Middle" Option (contd.)
  - Medical reimbursement plans that reimburse discrete health care expenses other than health insurance premiums may continue, too, and on a pre-tax basis. But, they, too must either –
    - exist side by side with a traditional, employer-sponsored group health plan; or
    - must be operated as the flexible spending account under a cafeteria plan (subject to the Affordable Care Act's new limits on the amount that may be deferred to a flexible spending account -- $2,500 for 2014 and $2,550 for 2015).

David A. Whaley
Dinsmore & Shohl LLP
513.977.8554
david.whaley@dinsmore.com