DAVISBROWN LAW FIRM

HEALTH CARE REFORM & EMPLOYERS

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The Patient Protection & Affordable Care Act ("PPACA") as amended on March 30, 2010 by the Health Care & Education Reconciliation Act of 2010 ("HCERA") is the most sweeping legislation to impact employee benefits in more than 35 years. While much of the details will be forthcoming, the following is an initial overview of provisions impacting employers and the group health plans they sponsor.

Employer Responsibility For Providing Health Insurance Coverage

PPACA does not require employers to provide health insurance to employees; however, it does penalize large employers who fail to provide affordable health insurance to their employees if these employees receive a subsidy from the federal government to purchase health insurance. Employers may receive a penalty for providing no coverage or a penalty for providing coverage that's not affordable.

Central to PPACA is the responsibility for every individual to obtain health insurance coverage that meets certain minimum requirements. To facilitate coverage of all Americans, PPACA provides subsidies to individuals who must spend more than a certain percentage of their income on health insurance premiums. If a large employer does not provide affordable coverage that meets minimum standards and an employee receives a subsidy from the federal government, the employer will be penalized.

> Who is a "large" employer? A "large employer" is defined as an employer having an average of 50 or more full-time employees during the prior calendar year. Full-time equivalents are included and are determined by adding the total number of hours worked in a month by non-full time employees and dividing by 120. Certain seasonal workers are excluded.

Who is a "Full-Time Employee."? A "full-time employee" is one who works 30 hours or more per week on average.

What Coverage Must an Employer Provide? To avoid a penalty, a large employer must provide "minimum essential coverage" and must pay at least 60% of the allowed costs. In addition, the employee must not have to pay more than 9.5% of his/her household income toward the premium.

When is an Employer Penalized? An employer is not penalized unless an employee enrolls in an insurance plan offered through an Exchange and qualifies for a subsidy to subsidize the cost of the insurance plan. Whether an employee qualifies for a subsidy is dependent on his/her household income.

What Individuals Qualify for a Subsidy? An individual qualifies for the subsidy if his/her household income is between 100 and 400% of the federal poverty line and they are either not eligible for employer-sponsored coverage or they are eligible for employer-sponsored coverage but the employer does not pay at least 60% of the allowed costs under the plan or the employee's required contribution for coverage is more than 9.5% of the employee's household income.

What is the Penalty? The penalty varies depending on whether the employer provides no insurance or provides insurance that is not affordable or does not meet minimum requirements.

> An employer who does not provide health insurance to full-time employees pays a monthly penalty equal to $2,000 divided by 12 ($166.67) multiplied by the number of full-time employees employed during the applicable month above 30. Only full-time employees are counted for purposes of this penalty and not full-time equivalents.
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> > Example: ABC Company does not provide health insurance to employees. ABC Company employs 100 full-time employees. At least one of ABC Company's employees qualifies for a subsidy. The monthly penalty ABC Company will pay is $11,666.90 (70 x 166.67).
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> An employer who provides health insurance to full-time employees that meets minimum essential coverage but who does not either pay 60% of the allowed costs or the employee must pay more than 9.5% of his/her household income toward the premium pays a monthly penalty equal to $3,000 divided by 12 ($250) multiplied by the number of employees who

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qualify for a subsidy during the month. The penalty is capped at the amount the employer would pay if he/she provided no coverage.

> Example: ABC Company does provide health insurance to employees; however, it contributes only 50% of the monthly premium. The employee portion of the premium exceeds 9.5% of the household income of 3 of ABC Company's employees. ABC Company's monthly penalty is $750.

The penalty provisions are effective January 1, 2014.

Free Choice Vouchers

Any employer (including small employers) who offers minimum essential coverage to employees through an employer sponsored group health plan and who pays any portion of the premium associated with the coverage is required to provide a free choice voucher to qualifying employees who opt out of the coverage. These vouchers may then be used by the employees to purchase health insurance through an Exchange and the premium paid by the employee under the Exchange is reduced by the amount of the voucher.

> What Employees Qualify for a Voucher? Only employees who are eligible for the employer-sponsored group health plan, whose household income does not exceed 400% of the federal poverty line, and who would be required to pay between 8% and 9.8% of their household income for the taxable year.
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> What is the Amount of the Voucher? The voucher is the monthly amount of the premium contribution the employer would have paid had the employee enrolled in the employer-sponsored group health plan. If the employee purchases self-only coverage in the Exchange, the voucher is the monthly amount the employer would have paid for individual coverage. If the employee purchases a family plan, the voucher is the monthly amount the employer would have paid for the family (or employee plus dependent or employee plus spouse) coverage.
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> Is the Employer Ultimately Responsible for the Amount of the Voucher? Yes. If a qualifying employee uses a voucher supplied by an employer and enrolls in coverage through the Exchange, the employer will need to pay the amount of the voucher to the Exchange.
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> What if the Voucher Exceeds the Cost of the Employee's Premium? If the employee's monthly premium is less than the amount of the voucher, the employee is entitled to keep the remaining amounts.

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Does the Voucher Impact the Penalty an Employer Must Pay for Not Providing "Affordable" Coverage Discussed Above? Yes. Employees who receive a free choice voucher from an employer are not counted for purposes of determining the penalty the employer is required to pay for providing coverage that either does not pay for 60% of allowable costs or the employee's cost for such coverage exceeds 9.5% of the employee's household income.

> Example: ABC Company does provide health insurance to employees; however, it contributes only 50% of the monthly premium. The employee portion of the premium exceeds 9.5% of the household income of 3 of ABC Company's employees. ABC Company's monthly penalty is $750; however, ABC Company provides a free choice voucher to each of the three employees that they can utilize to purchase coverage through the Exchange. ABC Company incurs no penalty.

The free choice voucher provisions are effective January 1, 2014.

Auto-Enrollment

Large employers with 200 or more full time employees are required to automatically enroll new employees in a coverage option when they are first eligible. These employers are also required to continue elections from year to year. Employees must be given notice of the automatic enrollment and an opportunity to opt out.

The auto-enrollment provisions are effective January 1, 2014

Small Business Tax Credit

PPACA, as amended by HCERA, provides small employers with a temporary tax credit to help offset the cost of employer-provided health insurance coverage. The tax credit begins in 2010.

Who is a "small employer"? A small employer is one with fewer than 25 full-time equivalent employees and average annual wages of less than $50,000. For purposes of determining the number of employees, full-time equivalents are counted by adding the number of hours worked by employees during the taxable year divided by 2,080.

What is the tax credit available to small employers? In 2010 through 2013 a small employer can receive up to 35% of their contribution toward the

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employee's health insurance premium. In 2014 and beyond, small employers who purchase coverage through an Exchange may qualify for a tax credit for two years of up to 50% of their contribution. The tax credit is available on a sliding scale with the full amount of the tax credit available to employers who have 10 or fewer employees and average annual wages of less than $25,000. Tax exempt small employers are eligible for a reduced credit.

What type of coverage must the small employer offer? A small employer must provide employees with a "qualified health plan" and must contribute at least 50% of the premium. A "qualified health plan" starting in 2014 will be a health plan offered through the Exchange. It is unclear in the current legislation what constitutes a "qualified health plan" prior to 2014; however, further guidance on this issue is anticipated prior to implementation.

Reinsurance for Early Retirees

Five billion dollars is made available for reimbursing employers for health coverage provided to early retirees (ages 55-64) and their families. The benefit to the employer is 80% of the cost of coverage between $15,000 and $90,000. Health & Human Services is charged with developing the program and it must be established by June 21, 2010. Funds received by the federal government must be used to lower costs borne directly by participants and beneficiaries in the employer's group health plan.

The funds are available presumably on a first come first serve basis and they are limited. The program will end the earlier of (i) December 31, 2013, or (ii) when the $5 billion has been spent. Employers with early retirement benefits should apply as soon as they are able.

Health Plan Provisions- Applicable to All Group Health Plans

The PPACA, as amended by the HCERA, adopts many new design and administrative requirements for group health plans. Based on where these provisions were inserted in current law, it appears that they apply to medical benefits, including retiree medical, health reimbursement accounts, and employee assistance plans that fall within the definition of group health plan. They do not appear applicable to stand alone dental and vision benefits or health flexible spending accounts.

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Prohibition on Lifetime Limits.

Beginning with plan years starting on or after September 23, 2010, no group health plan may impose a lifetime limit on the dollar value of "essential health benefits". Essential health benefits are generally those offered by a typical employer-sponsored plan.

Limitations on Annual Limits

Beginning with plan years starting on or after September 23, 2010, group health plans may only impose annual limits on essential health benefits as determined by Health & Human Services. Beginning with plan years that start on or after January 1, 2014, no annual limits may be imposed on essential health benefits.

Expansion of Dependent Coverage

Beginning with plan years starting on or after September 23, 2010, group health plans that offer dependent coverage must offer coverage for adult children, even if they are married, up to the age of 26. Prior to January 1, 2014, coverage does not have to be offered to adult children who are eligible to enroll under another employer-sponsored health plan. Grandchildren are not included in the expanded definition.

Pre-Existing Condition Exclusions

Beginning with plan years starting on or after September 23, 2010, group health plans may not impose any pre-existing condition exclusions on children under the age of 19. The prohibition on pre-existing condition exclusions is extended to all participants, including adults, for plan years that begin on or after January 1, 2014.

Waiting Periods

For plan years beginning on or before January 1, 2014, group health plans may not impose a waiting period exceeding 90 days.

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Rescission of Group Health Plan Coverage

Effective on the first day of the plan year that starts on or after September 23, 2010, an insurance company providing insurance to an employer sponsored group health plan or a self-insured group health plan may not rescind a policy except in cases of intentional misrepresentation of a material fact or fraud. Furthermore, a policy can not be cancelled for failure to pay premiums or termination of the plan without providing the participant/beneficiary with prior notice.

Report Amount of Premium Revenues

Starting with plan years that begin on or after September 23, 2010, with respect to fully-insured health plans, the health insurance issuer must report the percentage of revenue used for (i) reimbursing providers for clinical services provided to participants/beneficiaries, (ii) quality improvement activities, and (ii) non-claim costs (excluding taxes and licensing/regulatory fees). A health insurance issuer who spends more than 20% of premium revenue on non-claim costs must provide a rebate to participants.

Uniform Explanation of Coverage Documents

On or before March 23, 2012, insurance companies providing insurance to an employer sponsored group health plan or the plan sponsors or administrators of self-insured plans must provide summaries of the benefits and coverage offered to plan participants/beneficiaries utilizing the uniform terms and format published by HHS.

Health Plan Provisions- Applicable to Group Health Plans that Are Not Grandfathered Plans

The following provisions are only applicable to group health plans not considered to be "grandfathered plans." A group health plan is a grandfathered plan if it was in effect on March 23, 2010. It is currently unclear whether a group health plan that merges with another plan or is substantially modified retains its grandfathered status.

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Cost Sharing Limitations

Beginning with the first plan year on or after January 1, 2014, group health plans can not impose cost-sharing provisions (deductible/out of pocket maximum) that exceed the limits for high deductible health plans.

Appeals Process

Beginning with plan years on or after September 23, 2010, group health plans must have an internal and external appeals process. The internal appeals process must initially follow the Department of Labor's claim procedure regulations. The

external review process must include the consumer protection requirements under the Uniform External Review Model Act.

Patient Protections Relating to Participating Provider Panels

Beginning with plan years on or after September 23, 2010, group health plans can not limit the participating primary care provider a participant chooses and cannot require advance authorization for emergency services and must cover emergency expenses without regard to whether the provider is a participating provider.

Preventative Health Services

Beginning with plan years on or after September 23, 2010, group health plans must cover certain preventative health services without any cost-sharing, including certain immunizations, well-child screenings, breast cancer screenings, and mammograms.

Nondiscrimination Provisions

Beginning with plan years on or after September 23, 2010, a fully-insured group health plan may not discriminate in favor of highly compensated or key employees and must follow the same rules self-insured groups are currently subject to.

Beginning with the first plan year on or after January 1, 2014, no group health plan can discriminate against an employee based on a health status factor. This is currently prohibited by regulations promulgated under HIPAA.

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Medicare Retiree Drug Subsidy

Beginning January 1, 2013, the deduction for the subsidy for employers who provide retiree prescription drug plans to retirees eligible for Medicare Part D is eliminated.

Wellness Programs

PPACA raises the limits on rewards and rebates offered through a wellness program that require satisfying a health status related standard from 20% to 30%. The percentage may be raised to 50% if approved by the Department of Labor, Health & Human Services and the Internal Revenue Service.

Reporting of Health Coverage

Beginning January 1, 2011, employers are required to report the cost and value of employer-sponsored coverage on Form W-2. Beginning on January 1, 2014, health insurance issuers and group health plans providing minimum essential coverage, must report the coverage to the Internal Revenue Service. Large employers (50 or more full time employees) and employers required to provide free choice vouchers are subject to expanded reporting requirements.

Over the Counter Drugs

Beginning January 1, 2011, over the counter drugs may no longer be reimbursed from a health flexible spending account, health savings account, Archer medical savings account or health reimbursement arrangement.

Health Flexible Spending Accounts

Beginning January 1, 2013, the amount an employee can contribute to a health flexible spending account is capped at $2500.

Health Savings Accounts

The penalty for using amounts contributed to a health savings account on non-medical expenses is increased from 10% to 20%.

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"Cadillac Plans"

Effective January 1, 2018, "Cadillac plans" will be taxed on excess health coverage.

What plans are subject to the tax? A plan is considered to be a high cost or "Cadillac" plan if the total cost of the coverage exceeds $10,200 for individual coverage or $27,500 for non-individual coverage (family, employee plus child, employee plus spouse). These amounts will be adjusted for inflation annually and immediately adjusted if the standard benefit option under the Federal Employees Health Benefits Plan exceeds these thresholds. The thresholds are increased for certain high risk professions.

What is the applicable tax? A high cost plan is taxed at 40% of the cost above the designated limit.

> Example: Susan elects self-only coverage through her employer which costs $12,000 annually. The applicable tax is 40% of $1800 ($12,000 - $10,200).

Who pays the tax? The tax is imposed on health insurance issuers for fully-insured plans and plan administrators of self-insured plans. Nothing, however, prevents the insurance company or plan administrator from passing the tax on to the consumer.

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