Timeline of Key Provisions

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Prohibits rescissions of coverage
Restricts annual coverage limits
Establishes temporary high risk pool
Requires coverage for dependent children up to 26 years of age
Provides tax credit for small employers
Creates temporary reinsurance program for early retirees
Prohibits discrimination in favor of highly compensated employees

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Increases excise tax on HSAs and Archer MSAs for nonqualified distributions
Initiates simple cafeteria plans
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Begins notice and reporting requirements
Imposes annual limits of $2,500 on contributions to health FSAs
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Imposes additional Medicare Part A tax of .9% (and an additional 3.8% tax on certain income)

2014

Requires States to establish Exchanges
Requires individuals to carry health coverage unless exempted
Requires employers to provide insurance coverage or pay a fee
Prohibits limits on pre-existing conditions
Prohibits waiting periods in excess of 90 days
Prohibits annual coverage limits

2016

Provides for sale of insurance through qualified health plans in all participating states

2017

Permit states to expand coverage through Exchanges to large employers

2018

Imposes excise tax on high cost employer-sponsored health coverage

On December 24, 2009, the Senate passed the Patient Protection and Affordable Care Act (the "PPACA"). On March 21, 2010, the House of Representatives approved the PPACA and, on the same day, passed the Health Care and Education Reconciliation Act of 2010 (the "Reconciliation Act"), which modified certain tax, revenue and Medicare and Medicaid provisions of the PPACA. On March 23, 2010, President Obama signed into law the PPACA and the amendments in the Reconciliation Act were sent to the Senate for passage. On March 25, 2010, the Senate adopted the Reconciliation Act with additional amendments and returned the legislation to the House for approval. Late in the evening on March 25, 2010, the House passed the Senate amendments and the amended Reconciliation Act was signed by President Obama on March 30, 2010.

In this summary, both the PPACA and the Reconciliation Act are referred to collectively as the "Health Reform Legislation." Date of enactment means March 23, 2010 for the PPACA and March 30, 2010 for the provisions affected by the Reconciliation Act.

The following is a summary of those provisions of the Health Reform Legislation that impact employers and their self-funded or fully insured health care benefit programs. Other provisions not addressed in this summary may impact employers indirectly by impacting the cost of health insurance and Medicare benefits.

1. **Are employers required to provide health insurance coverage to all of their employees?**

Employers are not required to provide health insurance coverage for their employees but certain employers will be assessed a fee if they do not provide coverage or if the coverage they provide is inadequate or unaffordable for their low paid employees.
Effective January 1, 2014, an employer with an average of at least 50 full-time employees during the preceding calendar year ("FTEs") that <u>does not</u> offer health insurance coverage, will be required to pay a fee of $2,000 per FTE if at least one of its FTEs receives a premium tax credit through an Exchange (as described below). The first 30 FTEs are excluded from the calculation of the assessed fee (for example, an employer with 51 FTEs would pay a fee of 21 times $2,000).

Effective January 1, 2014, an employer with an average of 50 FTEs during the preceding calendar year that does offer health insurance coverage but offers coverage that is considered unaffordable, would be assessed a fee of $3,000 for each FTE who receives a premium tax credit through an Exchange. The employer's fee would be capped at an amount equal to $2,000 for each FTE.

The Health Reform Legislation specifically defines FTE, how the number of FTEs should be calculated, how the 30 FTE exclusion is applied and how related employers are impacted. An employer is prohibited from discriminating or retaliating against any employee for receiving premium tax credit assistance or for providing information to the Secretary of the Department of Health and Human Services ("HHS") relating to employer violations under the Health Reform Legislation.

2. **What is a free choice voucher?**

Effective January 1, 2014, any employer that offers group health coverage to its employees must provide a free choice voucher to employees with incomes less than 400% of the federal poverty level if the employee's share of the premium exceeds 8% (but is less than 9.8%) of his or her income and if the employee chooses to purchase a health insurance plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan. An employer that provides free choice vouchers will not be required to pay the fees described in question 1 above.

3. **What happens to an employer's existing health insurance coverage?**

The Health Reform Legislation does not require an individual to terminate the insurance coverage he or she has under a group health plan or through an insurance policy on the date of enactment. This existing coverage is grandfathered for existing employees, new employees and for individuals who renew their existing coverage and, with certain exceptions, is not subject to the new requirements of the Health Reform Legislation.

The exceptions to grandfathering include:

a. For plan years beginning six months on or after enactment, all plans and insurance policies must comply with the prohibition on lifetime coverage limits, the prohibition on rescission of coverage, the restriction permitting only reasonable annual coverage limits (as determined by the Secretary of HHS), the requirement to provide coverage for dependent adult children up to age 26 years of age (as described below), the prohibition on imposing pre-existing condition limitations for children, and the uniform summary of benefits disclosure and insurer reporting requirements.1
b. Beginning in 2014, a group health plan may not exclude any pre-existing conditions for adults, may not impose excessive waiting periods and is prohibited from imposing any annual coverage limits.

4. **What additional limitations are placed on insurance coverage?**

a. <u>Lifetime Maximums</u> – Effective for plan years beginning on or after the date that is six months after enactment of the PPACA, health insurance policies in the individual and group markets may not include lifetime maximums.
b. <u>Annual Limits</u> – Beginning January 1, 2014, group health plans may not impose annual limits on the dollar value of coverage.2
c. <u>Rescission and Cancellation</u> – Effective for plan years beginning on or after the date that is six months after enactment of the PPACA, a group health plan or a health insurance issuer that offers group or individual health insurance coverage may not rescind coverage for an enrollee (once covered), except in cases of fraud. In addition, a group health plan and health insurance issuer may not cancel health insurance coverage without prior notice to the enrollee and then only for those reasons specifically permitted by the Public Health Service Act (e.g., for nonpayment of premiums, termination of the plan, relocation outside the area, etc.).
d. <u>Guarantee Access and Renewability</u> – Effective for plan years on or after January 1, 2014, all health insurance issuers that offer health insurance coverage in the

individual or group markets are subject to the "guarantee access and renewability" rules (originally established under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and must accept every employer and individual in the State that applies for coverage.

e. Pre-Existing Condition Limitation – Beginning six months after enactment, all health insurance policies in the individual and group markets and group health plans are prohibited from imposing pre-existing condition limitations for children. The prohibition is expanded to adults beginning in 2014.
f. High-Risk Pool – Beginning ninety days after enactment of the PPACA, the Secretary of HHS will establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. If an employer or health insurance issuer offers an incentive to an individual to disenroll from his or her current coverage and the individual disenrolls and enrolls in the temporary highrisk pool, the employer or health insurance issuer will be required to reimburse any expense incurred under the high-risk pool.
g. Waiting Periods – Effective for plan years beginning on and after January 1, 2014, group health plans and health insurance issuers in individual or group markets may not impose waiting periods in excess of ninety days.
h. Automatic Enrollment – An employer that is subject to the Fair Labor Standards Act, has more than 200 FTEs, and offers its employees one or more health benefit plans is required to automatically enroll all new FTEs in one of the plans offered and to continue the enrollment of current employees in an employer offered health benefit plan. The employer must provide adequate notice to employees of the automatic enrollment and give employees the opportunity to opt out of any coverage in which the employee was automatically enrolled.

5. **What additional benefits are group health plans and insurance carriers required to offer?**

a. Coverage for Adult Dependents – A group health plan or a health insurance issuer that offers group or individual insurance coverage that provides dependent coverage must continue to make such coverage available for an adult child until the child turns 26 years of age. This change is generally effective beginning six months after enactment except that prior to 2014, this requirement is applicable only for adult children who have no other employer coverage available to them. Employees may qualify for an income tax exclusion for the coverage of adult children under the employer's group health plan.
b. Comprehensive Health Insurance Coverage – Effective for plan years beginning on or after January 1, 2014, unless the plan is considered a grandfathered plan, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure that such coverage includes the "essential health benefits package." A group health plan must ensure that any annual cost-sharing (e.g. copayment, deductible) imposed under the plan does not exceed the limitations provided for in the "essential health benefits package."

c. Preventive Health Services – Effective for plan years beginning six months after enactment of the PPACA, a group health plan or a health insurance issuer in the individual and group markets must provide coverage for certain preventive health services (as defined in the PPACA) with no cost sharing to the participant.

6. **What is the Health Insurance Exchange?**

Each State is required to create a State or regional-based American Health Benefit Exchange or a Small Business Health Options Program Exchange for the purchase of health insurance. The purpose of the Exchanges is to permit individuals and small employers (with 100 or fewer employees) to purchase "qualified health insurance coverage."

If a State creates an Exchange within one year of enactment, the State may receive federal grant funding to assist it to establish the Exchange. The federal grant funding is available until January 1, 2015, after which the Exchanges must be self-sustaining.

The Exchanges must meet the following requirements:

a. Only "qualified health plans," as defined in the PPACA, may participate in the Exchanges;
b. The plan must offer five benefit categories: bronze, silver, gold, platinum and a separate catastrophic plan option. Each benefit category must, at a minimum, provide the "essential health benefits package," defined in the PPACA, with packages in the silver, gold and platinum levels offering additional levels of benefits. The catastrophic plan is intended to cover individuals up to age 30 or individuals who are otherwise exempt from the individual mandates and it provides coverage only for catastrophic conditions. The catastrophic coverage is not available to employers.
c. Only "qualified individuals," as defined in the PPACA, and small groups may purchase insurance through an Exchange. In addition, certain "qualified individuals" may be eligible to receive premium tax credits and costsharing subsidies. Employees who are offered coverage by an employer are not eligible for premium tax credits unless the employer plan does not provide the coverage equivalent to the "essential health benefits package."

7. **Which employers qualify for the premium tax credit?**

For tax years 2010 through 2013, an employer that employs no more than 25 FTEs for the tax year, has average annual wages that do not exceed $50,000 (as adjusted for cost of living in 2014 and subsequent years), and provides health insurance coverage for its employees, may be eligible to receive a tax credit. The tax credit will be equal to a percentage of the employer's contribution toward each employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The amount of the tax credit is capped at 35% of the employer's contribution and the full amount of the tax credit is available only to employers with ten or fewer FTEs and average annual wages of $25,000 or less. Tax-exempt small employers meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.

For tax years 2014 and later, an eligible small employer that purchases coverage through the Exchange will be entitled to a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The tax credit will be available for two years. The full credit will be available to employers with ten or fewer full-time employees and average annual wages of less than $25,000. Tax-exempt small employers meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

The tax credit may be claimed by an eligible small employer as a general business tax credit on its tax return; no deduction will be allowed for that portion of the premium paid by an employer that is equal to the amount of the tax credit claimed by such small employer.

8. **Are there other provisions that could impact employers?**

a. Notice to Employees – Beginning March 1, 2013 (and thereafter, for new hires), employers are required to notify their employees about the Exchange, the potential for premium tax credits for eligible employees, the cost-sharing subsidies that may be available to purchase coverage through the Exchange and the potential loss of coverage and employer contribution if the employee decides to purchase insurance through an Exchange.
b. Uniform Summary of Benefits – The Secretary of HHS will develop, for use by group health plans and health insurers that offer group or individual health insurance coverage, standards for benefit summaries and coverage explanations utilizing a uniform format with standardized definitions. Beginning not later than twenty-four months after enactment of the PPACA, a health insurance issuer (or the plan sponsor, in the case of a self-funded group health plan) must furnish the summary of benefits and coverage explanation to enrollees to an applicant, at the time of application; to an enrollee, prior to the time of enrollment or reenrollment; and to a policyholder, at the time of issuance of the policy. If material modifications are made in any of the terms of the plan or coverage that are not reflected in the most recently issued summary of benefits, the plan or issuer must also provide notice of such modifications no later than 60 days prior to the date on which such modification is to become effective. Failure to provide information can result in a penalty of not more than $1,000 for each failure.
c. Reporting Requirements – Group health plans and health insurance issuers that offer group or individual health insurance coverage also will need to comply with certain quality reporting requirements established by the Secretary of HHS. For calendar years beginning after 2013, each person that provides minimum essential coverage to an individual must report to the Secretary of HHS information about the covered individual and coverage levels and must provide a copy of such information to the covered individual.
d. Prohibition of Discrimination in Favor of Highly Compensated Individuals – Effective for plan years beginning on or after the date that is six months after enactment of the PPACA, the plan sponsor of a group health plan (other than a self-insured plan) must satisfy the requirements of IRC Section 105(h)(2), which prohibit a plan from discriminating in favor of highly compensated individuals as to eligibility

to participate as well as to benefits offered under the plan. This provision will prohibit the common practice among employers of purchasing fully-insured supplemental plans for key or highly paid employees only.

e. Appeal Process – Effective for plan years beginning on or after the date that is six months after enactment of the PPACA, a group health plan or health insurance issuer that offers group or individual health insurance coverage must comply with enhanced appeal process requirements, including making available internal and external claims processes and notifying enrollees of such rights. The plan and issuer must also inform enrollees of the availability of the to be created office of health insurance consumer assistance to assist them with appeals.

f. Fair Premium Rating – Effective for plan years beginning on or after January 1, 2014, a health insurance issuer for health insurance coverage offered in the individual or small group market may vary the premium rate with respect to a particular plan or coverage involved based only on single/family coverage tiers, premium rating areas, certain age bands, and certain tobacco use. These rating restrictions also will apply to any insurance offered in the Exchange in the large group market.

g. Reporting of Cost of Employer-Sponsored Health Coverage – Effective for tax years beginning after January 1, 2011, employers are required to disclose the value of an employee's medical, dental, vision, prescription drug, and health savings accounts benefits (but excluding pre-tax salary contributions to a flexible spending account) on IRS Form W-2.

9. **Are there new reinsurance requirements for early retirees?**

Beginning ninety days after enactment of the PPACA, the Health Reform Legislation creates a temporary reinsurance program for participating employment-based plans. A participating employment-based plan is a group health plan that: (i) is maintained by one or more current or former employers (including States and local governments and political subdivisions thereof), an employee organization, a VEBA, a committee or board of individuals appointed to administer such plan or a multiemployer plan; (ii) provides health benefits (including self-funded or fully insured medical, surgical, hospital, prescription drug benefits4) to early retirees,5 (iii) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions and provides documentation of the actual cost of medical claims to HHS, and (iv) is certified by the HHS.

The participating employment-based plan will be reimbursed for 80% of the retiree claims between $15,000 and $90,000. Payments to a participating employer-based plan must be used to lower the premium costs of the employer or to reduce premium contributions, copayments, deductibles, coinsurance or other out-of-pocket costs for plan participants. Payments received under the reinsurance programs by employers will not be treated as income to the employer.

Congress has appropriated $5 billion to finance this reinsurance program for early retirees. The Secretary of HHS has the authority to stop taking applications in the program based on the availability of funds.

10. **What changes are made that impact an employer's wellness plans?**

a. Wellness Grants – Beginning in 2011, small employers may receive grants to establish wellness programs for up to five years.

b. HIPAA Non-Discrimination – Effective January 1, 2014, the Health Reform Legislation expands the HIPAA non-discrimination rules to apply to all group health plans and health insurance issuers in individual or group markets and in the Federal Employee Health Plan. The Health Reform Legislation also codifies the wellness regulations under the HIPAA nondiscrimination rules and increases the amount that a plan may give to a participant for achieving certain wellness targets. The Secretaries of HHS and Treasury are directed to establish ten state pilot programs by July, 2014 in order to develop wellness programs in the individual market and, if proven effective, to expand wellness initiatives in 2017. The Secretaries are required to submit a report to Congress on the effectiveness of wellness programs within three years following enactment.

11. **How does the Health Reform Legislation impact cafeteria plans, HRAs and HSAs?**

a. Qualified Health Plans in the Exchange – An employer's IRC Section 125 – cafeteria plan may not allow employees to pay for "qualified health plan coverage" that is purchased through an Exchange on a pre-tax basis under the cafeteria plan. The only exception to this prohibition is for a small employer that is a "qualified employer" and that offers the employee the opportunity to enroll through the Exchange in a "qualified health plan" in a group market.
b. Annual Salary Reduction Limitation on Contributions to Health Care Flexible Spending Accounts – Effective January 1, 2013, a health care flexible spending account ("FSA") provided under an employer's IRC Section 125 – cafeteria plan must limit the employee's pre-tax salary reduction contributions to no more than $2,500 in a plan year (as adjusted annually for cost of living).
c. Simple Cafeteria Plans – Effective January 1, 2011, the IRS will develop a simple cafeteria plan for small employers. The plan automatically will be deemed to satisfy nondiscrimination requirements if the plan satisfies minimum eligibility, participation and uniform contribution requirements specified in the Health Reform Legislation.
d. Eligible Medical Expenses – Effective January 1, 2011, the costs for over-the-counter drugs that are not prescribed by a physician may not be reimbursed through a Health Reimbursement Account ("HRA") or an FSA and will not be reimbursed on a tax-free basis through a Health Savings Account ("HSA") or an Archer Medical Savings Account ("Archer MSA").
e. Increased Excise Tax for Nonqualified Distributions from HSA or Archer MSA – Effective January 1, 2011, if a HSA or an Archer MSA makes a distribution for expenses other than qualified medical expenses, then the accountholder will be subject to an excise tax of 20% of the disbursed amount.

12. **Are there changes to taxes applicable to employers?**

a. Excise Tax on High Cost Employer-Sponsored Health Coverage – Effective January 1, 2018, an excise tax will be imposed on any employer-sponsored health coverage that has an aggregate value6 (using principles similar to those used in calculating the applicable COBRA premium) that exceeds $10,200 for individual coverage and $27,500 for family coverage (or $11,850 for single and $30,950 for family in the case of retirees age 55 and older who are not eligible for Medicare or for employees

engaged in high-risk professions).7 The excise tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy or, in the case of a self-insured plan, the plan administrator (which in some cases will be the employer).

An employer must calculate the excess value of health insurance coverage and report it to the insurer and the IRS and is subject to a penalty for underreporting.

b. Increase in Medicare Part A (Hospital Insurance) Tax Rate – Effective January 1, 2013, the Medicare Part A tax rate is increased from 1.35% to 2.35% on earnings over $200,000 for individual taxpayers and over $250,000 for married couples filing jointly. An additional 3.8% tax is imposed on certain net investment income or modified adjusted gross income over a threshold amount on unearned income for higher-income taxpayers.

c. Medicare Part D – If an employer offers a retiree health plan that includes prescription drug coverage that is actuarially equivalent to Medicare Part D, the employer may receive a Retiree Drug Subsidy ("RDS") from the Centers for Medicare & Medicaid Services. Effective on January 1, 2013, the amount of deduction that the employer may claim for the health care expenses of employees/retirees must be offset by the amount of any RDS received by the employer.

13. Which provisions will impact dental coverage?

a. New annual fee being imposed on Health Insurance providers (beginning 2013). To help fund health care reform, health insurers will be subject to a new annual fee beginning in 2013. Each carrier's fee will be based on their specific 2013 market share – total insured premium for medical, dental and vision.

Potential impact: Pricing for dental benefits could increase to reflect the new annual fee that health insurers will be required to pay.

b. Pediatric dental coverage provision (beginning in 2014)
Health Insurers will be required to package pediatric dental and vision benefits with a medical plan as part of the "Essential Health Benefits Package" (EHBP) in the individual and Small Group market (100 or fewer employees). At this point, standalone dental plans sold through the state-sponsored insurance Exchanges (to be established in 2014) can be used to satisfy the pediatric dental requirement.

Potential impact: Details around this specific provision are still being clarified, but there is the potential that this provision will impact both the purchasing of standalone dental benefits, as well as administration of those plans. Guardian will go into more detail on this specific provision in a future Legislative Update.

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