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SUMMARY OF THE MOST SIGNIFICANT HEALTH REFORM CHANGES AFFECTING HOSPITALS AND OTHER EMPLOYERS

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OVERVIEW

On March 23, 2010, President Obama signed into law H.R. 3590, the *Patient Protection and Affordable Care Act*. The following week, the President signed into law H.R. 4872, the *Health Care and Education Reconciliation Act of 2010*, which made modifications to H.R. 3590. Both bills are referred to as the “PPACA.”

The PPACA makes a number of changes affecting employers, including hospitals. The changes fall roughly into four areas:

- 1) changes requiring employers to amend their employer health plans or the way they operate or administer their plans;
- 2) changes affecting the availability and cost of health insurance;
- 3) the employer health insurance mandate; and
- 4) revenue provisions and other tax changes affecting employers.

The following is a summary of the most significant of these changes affecting employers:

- Some of the required plan amendments are quite significant and could change the cost of providing coverage. These include the ban on annual and lifetime benefit limits and pre-existing condition limitations for children under 19 and the requirement to provide an expansive list of preventive care benefits, including mental health and substance use benefits. Some of the required amendments, and other related changes, may require employers to **re-think their benefit plan designs**. These include new regulations banning executive-only health insurance arrangements, and the excise tax on “Cadillac” plans that will become effective in 2018. **Generally no distinction is drawn between insured and self-insured plans.**¹
- Some of the changes are designed to **make insurance easier for employers to obtain and afford**, but it is too soon to know how helpful most of them will be, and some are available only to small subsets of employers,

¹ In an insured plan, plan participants can claim benefits directly from the insurance company. In a self-insured plan, plan participants can claim benefits only from the employer or the plan. When an employer buys stop-loss insurance to limit its risk, or hires an insurance company to administer its health plan, this does not convert a self-insured plan into an insured plan, because participants cannot still claim benefits directly from the insurance company. *The Employee Retirement Income Security Act of 1974* (“ERISA”) allows states to regulate insurance policies that are sold to insured plans--requiring them to cover mandated benefits, etc.--but prohibits them from regulating either insured or self-insured plans directly, unless the plans are sponsored by governmental entities or by church-related entities that have not elected to be subject to ERISA. The PPACA does not change this regulatory scheme.

such as very small employers and employers that provide retiree health coverage.

- The new employer “mandate” will not actually require employers to provide coverage to all of their employees or provide any minimum level of coverage, but will **create financial incentives to provide coverage at least to lower-income full-time employees**. Each employer will have to decide how to react to these incentives, based on its own unique circumstances.
- Some of the revenue-raising provisions in the legislation also will **require time, effort and related expense on the part of the employer**, including the requirement to report the cost of all health coverage provided to an employee on the employee’s Form W-2, which will be used to help enforce the excise tax on “Cadillac” health plans.

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CHANGES REQUIRING PLAN AMENDMENTS OR CHANGES TO PLAN OPERATIONS

Insurance Market Reforms

Many of the changes requiring plan amendments are grouped together as “insurance market reforms,” and build on the “portability” provisions in the *Health Insurance Portability and Accountability Act of 1986* (HIPAA). Those provisions were added to the *Employee Retirement Income Security Act of 1974* (ERISA) and the Internal Revenue Code of 1986 (the Tax Code) as well as the *Public Health Service Act* (the PHSA). They will be enforced in the same way that the HIPAA portability provisions are enforced, *i.e.*, by giving participants rights to sue under ERISA to enforce their rights and by imposing a \$100 per participant per day excise tax on each violation.

The Departments of the Treasury (Treasury), Health and Human Services (HHS) and Labor (the Departments) generally share interpretive and enforcement authority over the new requirements, and are likely to coordinate any guidance they issue or issue it jointly.

Separate dental and vision plans, long-term care plans, and other limited-scope benefits, and plans that cover fewer than two active employees (for example separate retiree health plans), which are exempt from the HIPAA portability provisions, also appear to be exempt from the new requirements, although further clarification might be useful because of inconsistencies in the way the changes are worded. **Until guidance is issued by the Departments,**

employers should consult with counsel regarding how the changes apply to such plans.

Generally speaking, **these new requirements apply to both insured and self-insured employer health plans**, although there are a few exceptions, noted below.

Effective Dates and Grandfathering

The new requirements begin to go into effect in plan years beginning on or after September 23, 2010, which is six months after the date of enactment. **For calendar year plans, this means January 1, 2011.** Insurance companies might choose to implement some or all of the changes earlier, to avoid having different effective dates for different group insurance policies. Of course, this would not affect self-insured plans.

Existing employer health plans (called “grandfathered plans”) are exempt from many, but not all, of the new requirements. The grandfather rule generally applies to new enrollees as well as current enrollees, although there is some uncertainty over exactly which new enrollees are covered. It also is not clear when, if ever, a non-union plan loses its grandfather protection.

Changes effective for plans years beginning on or after September 23, 2010 and DO NOT EXEMPT grandfathered plans:

- **Ban on lifetime benefit limits:** An employer health plan may not impose any **lifetime** limit on the dollar value of benefits it chooses to provide that are “essential health benefits.” Currently many employer health plans impose limits of \$1-2 million per person on aggregate benefits. Because a large percentage of the cost of health benefits is attributable to a small number of individuals who need expensive treatments, this ban on lifetime limits, and the ban on annual limits listed below, could increase employer costs.

Lifetime limits on specific benefits are still allowed if the benefits are not “essential health benefits.” HHS will issue regulations defining “essential health benefits,” but the definition must include at least: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, maternity and newborn care, (4) mental health and substance use disorder services, (5) prescription drugs, (6) rehabilitative services and devices, (7) laboratory services, (8) preventive and wellness services and chronic disease management, and (9) pediatric services, including oral and vision care.

- **Ban on annual benefit limits:** An employer health plan may not impose any **annual** limit on the dollar value of its benefits that are “essential health benefits.” This restriction is less stringent before 2014, although exactly what will be permitted is not yet clear and will require regulations to be issued by

HHS. As with lifetime limits, annual limits on specific benefits are still allowed if the benefits are not “essential health benefits.”

- **Limit on rescission and cancellation of coverage:** An employer health plan may not rescind coverage unless an individual has committed fraud or made an intentional misrepresentation. It is not yet clear how this will apply if, for example, an individual receives coverage by mistake and is not even eligible to participate in the plan. Perhaps “rescission” will be limited to actions taken in response to a claim for benefits only.

The regulation appears to allow a plan to cancel a participant’s coverage only if it gives advance notice and generally only if the plan is terminated or the participant fails to pay premiums or moves outside the service area. It is not clear whether this regulation was intended to apply to employer health plans or only to insurance coverage offered by an insurance company.

- **Requirement to cover older children:** An employer health plan that provides dependent coverage must continue to make that coverage available to a child until the child turns 26. Before 2014, the change **applies to a grandfathered employer health plan only if the child is not eligible to enroll in another employer’s health plan**. Because of changes elsewhere in the PPACA, the value of this coverage is not taxed to the employee, even if the child is not the employee’s tax dependent. It is not clear at this time whether employees may be charged a different (higher) rate for this coverage.

Because these older children tend to be healthy, this change is unlikely to increase employer costs significantly. A number of health insurance companies already have announced plans to implement this change immediately for the plans they insure. Employers with self-insured plans might consider doing the same thing.

- **Ban on pre-existing condition limitations for children under 19:** An employer health plan may not impose any pre-existing condition limitation on individuals under age 19. (As noted below, this ban kicks in later for older enrollees.) According to HHS, this ban both prohibits insurers from denying an uninsured child **coverage** because of a pre-existing condition and from denying an insured child **treatments** for a pre-existing condition.

Changes effective for plan years beginning on or after September 23, 2010 and EXEMPT grandfathered plans:

- **Requirement to provide preventive care:** An employer health plan must provide certain preventive care benefits, certain immunizations, and screenings for infants, children and women, and may not impose any cost-sharing requirements on that care.

- **Executive nondiscrimination requirement extended to insured plans:** Employers may not discriminate in favor of highly compensated individuals with respect to coverage or benefits under an insured health plan. The Tax Code already imposes the same requirement on self-insured plans. This will prohibit employers from providing special health insurance coverage to their executives, at least on a pre-tax basis. Since this requirement is packaged with the other insurance market reforms, it appears that it will be enforced by the \$100/day excise tax rather than by subjecting the discriminatory coverage to tax.
- **Requirement to provide appeals process:** An employer health plan must provide an appeals process that goes somewhat beyond what is required currently for claims procedures under ERISA. In particular, it requires the plan to include an outside review process. The regulations for the external review process will be supplied by HHS in the case of self-insured employer health plans that are not subject to state regulation, and otherwise by the relevant state.
- **Other patient protections:** An employer health plan must provide a number of other patient protections relating, among other things, to a participant's right to designate a primary care provider for regular and pediatric care and access to emergency and obstetrical and gynecological care. For example, emergency care must be covered without any prior authorization requirement.

Changes effective for plan years beginning on or after March 23, 2012 and DO NOT EXEMPT grandfathered plans:

- **Requirement to provide a plain-English plan summary:** The plan sponsor or administrator (in the case of a self-insured health plan) or the insurance company (in the case of an insured plan) must provide a plain-English explanation of the plan that is somewhat more elaborate than the summary plan descriptions (SPDs) currently required under ERISA but is limited to four pages using at least 12-point font. The exact requirements will be explained in regulations to be issued by HHS.
- **Requirement to give advance notice of plan changes:** Participants must be notified 60 days before any "material modification" of the plan. Current law requires notice within 60 days after any material reduction in covered services or benefits.

Changes effective for plan years beginning on or after January 1, 2014 and DO NOT EXEMPT grandfathered plans:

- **Ban on pre-existing condition limitations:** An employer health plan may not impose any pre-existing condition limitations. Current law generally allows pre-existing condition limitations to be applied for up to 12 months,

subject to reduction for periods of prior creditable coverage. (As noted above, this ban kicks in earlier for enrollees under age 19.)

- **Waiting periods may not exceed 90 days:** An employer health plan may not apply a waiting period that exceeds 90 days.

Changes effective for plan years beginning on or after January 1, 2014 and EXEMPT grandfathered plans:

- **Expanded ban on discrimination on basis of health conditions:** Current law already prohibits employer health plans from discriminating on the basis of a health condition with respect to eligibility and premiums. This regulation expands the prohibition to cover discrimination with respect to benefits, and allows HHS to designate other health status-related factors with respect to which discrimination will be prohibited.
- **Limits on cost-sharing:** An employer health plan must satisfy the cost-sharing requirements for plans offered on an exchange. Exchanges are arrangements, described further below, that are established by states to facilitate the purchase of health insurance, mostly by individuals and small employers. Plans sold on an exchange must meet certain requirements, including cost-sharing requirements. In 2014, these cost-sharing requirements prohibit: (1) cost-sharing that exceeds the individual and family limits for high-deductible health plans in effect at that time (currently \$5,950 and \$11,900); and (2) deductibles in excess of \$2,000 in the case of individual coverage and \$4,000 in the case of family coverage. After 2014, the dollar limits are indexed to the rate of increase in health insurance premiums. For more on exchanges, see the AHA's April 19 [Legislative Advisory](#) on the PPACA.
- **Any-willing-provider requirement:** An employer health plan may not exclude any health care provider who wants to join its provider network and is willing to abide by the terms and conditions for participation. This requirement appears to apply even if the plan is self-insured and the plan merely contracts with an insurance company for access to its provider network.
- **Limits on charging different premiums (small insured plans only):** In the case of an insured employer health plan offered by a small employer (generally 50 or fewer employees), the insurance company may not charge different premiums to different participants, except based on age, premium rating area, family enrollment, or tobacco use, and even then only within limits (no more than 3:1 for adults based on age, and no more than 1.5:1 based on tobacco use). Although this requirement applies to insurance companies, as a practical matter, insured employer health plans must comply with it as well.

- **Mandated benefits (small insured plans only):** In the case of an insured employer health plan offered by a small employer (generally 50 or fewer employees), the insurance company must cover in its insurance policy at least the “essential health benefits” described above. Although this requirement applies to insurance companies, as a practical matter insured employer health plans must comply with it as well.

Changes effective for plan years beginning on or after January 1, 2014:

- **Fair premium rating:** Premiums in the individual and small group markets can vary only by family size, geography, actuarial value of the benefit, tobacco use and age (limited to a ratio of 3:1). The state will establish the rating areas within the state subject to the HHS Secretary’s review and approval. In consultation with the National Association of Insurance Commissioners (NAIC), the Secretary will define the permissible age bands for premium rating purposes. These new requirements apply solely to premiums charged by health insurance issuers in the individual and small group markets (i.e., not the large group market). Self-insured group health plans will not be affected by these new premium rating requirements. These requirements do not apply technically to grandfathered plans, but there is language in the PPACA that requires states to apply premium rating requirements uniformly to all insurers in the individual, small group and large group markets. Further clarification is needed to determine whether the premium rating requirements apply to grandfathered plans.

Changes Affecting Wellness Programs

The PPACA makes a number of changes that favor wellness programs, including codifying the existing safe harbor under HIPAA for wellness programs that provide incentives based on meeting health standards, and increasing the incentive permitted under the safe harbor from 20 to 30 percent of the cost of coverage, and including “wellness services and chronic disease management” among the essential health benefits that are required for small insured plans and plans offered on an exchange. However, it does not remove all of the impediments to such programs that exist currently, in particular under the *Americans with Disabilities Act (ADA)* and the *Genetic Information Nondiscrimination Act (GINA)*.

Changes Required by Revenue Provisions

A few of the changes requiring plan amendments are found in the tax provisions of the PPACA. They will be administered solely by the IRS. There are no exceptions under these regulations for “grandfathered plans.”

Changes effective in 2011:

- **Non-prescription drugs do not qualify as medical expenses:** The cost of a medicine and drug cannot be reimbursed under a health spending account (HSA), Archer Medical Savings Account (MSA), health flexible spending account (FSA) or health reimbursement account (HRA) unless the medicine or drug is insulin or is prescribed by a doctor. Note that a medicine or drug can be prescribed by a doctor, and thus reimbursed, even if it is an over-the-counter drug.

For health FSAs and HRAs, the change applies to **costs incurred** in 2011 or later. Thus, a health FSA can reimburse an employee for the cost of nonprescription drugs purchased in 2010 even if the reimbursements are paid in 2011. On the other hand, if the FSA allows the employee's unused balance from 2010 to be used to reimburse expenses incurred during the first two-and-a-half months of 2011, those expenses may not include nonprescription drugs other than insulin.

Changes effective in 2013:

- **\$2,500 limit on salary reduction contributions to health FSAs:** Salary reduction contributions to a health FSA must be limited to \$2,500 per year. The limit is adjusted for inflation after 2013.
- **Small employers may adopt “simple” cafeteria plans with fewer requirements:** If a cafeteria plan sponsored by a small employer (generally 100 or fewer employees) meets certain minimum coverage and minimum employer contribution requirements, the plan will be deemed to satisfy the nondiscrimination requirements that apply to cafeteria plans, and the nondiscrimination requirements that apply to benefits provided through the plan.

PROVISIONS AFFECTING THE COST OF HEALTH INSURANCE

Insurance Market Reforms

Some of the insurance market reforms are designed to make insurance easier for employers to obtain and afford, rather than impose new requirements on employer health plans, and might benefit employers with insured plans. All of these changes apply solely to **insurance companies** and thus are of interest solely to employers with insured health plans.

Change effective immediately:

- **Review of premium increases:** HHS, in conjunction with the states, is required to establish a process for reviewing increases in health insurance

premiums. The process will require a health insurance issuer to submit, to HHS and the relevant state “a justification for an unreasonable premium increase prior to the implementation of the increase.” On April 14, HHS issued a request for public comments on how to implement this provision.

Change effective for plan years beginning on or after September 23, 2010:

- **Insurers required to pay premium rebates:** A health insurance company must pay rebates to its customers if its medical loss ratio (MLR) (generally the ratio of actual health care expenditures to premiums) for a product falls below 85 percent (80 percent in the small group market), averaged over three years. HHS is responsible for issuing regulations implementing this regulation, in consultation with the NAIC. On April 14, HHS issued a request for public comments on how to implement this provision.

Change effective for plan years beginning on or after January 1, 2014:

- **Guaranteed availability for large employers:** The guaranteed availability requirement that currently applies to health insurance issuers in the small group health market is extended to health insurance issuers in the large group market as well. Thus, insurance companies must accept every employer in states in which they operate, even larger employers, and may not turn down employers with older or sicker workforces. It is not clear what “plan year” means in the effective date here, as this provision applies solely to health insurance companies.

Temporary Insurance Programs

The PPACA also creates two temporary insurance programs that will exist from **June 21, 2010**, which is 90 days after the date of enactment of the PPACA, until January 1, 2014, when exchanges first become available. The reinsurance program for retirees could be beneficial to employers that still provide retiree health coverage.

Temporary reinsurance program for early retirees. HHS must establish a temporary insurance program “to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees” and their spouses and dependents. Federal funding for the program is capped at \$5 billion. HHS released initial guidance on qualifying for the program on May 4, 2010. According to this guidance, the program will exist from June 1, 2010 until January 1, 2014 when the exchanges first become available. Therefore, interested employers will need to act quickly once applications to participate in the program become available from HHS. Application forms are expected in June.

Temporary high-risk insurance program for those with pre-existing conditions.

The second program is a temporary insurance program for individuals who have pre-existing conditions and have not had group health plan coverage for at least six months. Because the program is available solely to individuals without group health coverage, the only part of this program that is relevant to employers is a requirement that the Secretary establish criteria for determining whether insurers or employer-sponsored health plans are dumping enrollees into the high-risk pool based on the enrollees' health status.

Tax Credits

The PPACA provides tax credits to small employers and (as noted below) lower-income employees to help them purchase health insurance. The tax credit for small employers is likely to benefit only a small percentage of employers.

Tax credit for small employers. **Effective immediately**, small employers (no more than 25 full-time equivalent employees) may be eligible for a tax credit equal to as much as 50 percent of the portion of the premiums they pay under their health plans. The Internal Revenue Service (IRS) already has provided guidance on this credit on its website, www.irs.gov.

THE EMPLOYER HEALTH INSURANCE 'MANDATE'

Creation of Exchanges

By January 1, 2014, each state must establish an exchange through which individuals and certain employers may purchase coverage under "qualified health plans." If a state fails to establish an exchange, HHS will do so. The exchanges, known as American Health Benefit Exchanges (exchanges), may be governmental or non-profit entities. Federal start-up money will be available beginning in 2011 through 2015, at which time exchanges must be self-sustaining. HHS is required to consult with the NAIC and other stakeholders to develop regulations for the exchanges.

States may establish more than one exchange within their borders as long as distinct geographic areas are served. They also have the option of forming a regional exchange with other states, and creating a Small Business Health Options Program (SHOP) within an exchange to assist qualified small employers in the enrollment of their employees. After 2017, a state that agrees to establish an acceptable alternative system may request an exemption from the requirement to establish an exchange and from certain other exchange-related requirements, including the individual and employer mandates. There is no provision allowing states to apply for an ERISA waiver, as there was in some other versions of the legislation.

Generally any individual who is a citizen or legal resident of the state and is not incarcerated may purchase health insurance through an exchange. Before 2017, only small employers (generally 100 or fewer employees) may use an exchange to purchase health insurance for their employees. Beginning in 2017, a state may (but is not required to) open an exchange up to larger employers. Thus, the regulations relating to exchanges will not be directly relevant to many larger employers. However, they will be important in determining when a larger employer is subject to the employer mandate penalties described in the next section.

The functions of the state exchanges are largely to facilitate and manage enrollment, including the use of web-based resources. The exchanges also will be responsible for managing the tax-based premium subsidies, including eligibility determinations. The exchanges will enroll eligible individuals in Medicaid, CHIP or other available public programs. Exchanges will share with Treasury appropriate information including an individual's qualification for an exemption from the individual mandate or an individual's eligibility for public subsidies.

Requirements for Plans Offered on Exchanges

To be a qualified health plan that can be offered on an exchange, a health plan must, among other things: (1) be offered by a licensed health insurance issuer; and (2) provide the essential health benefits package. The essential health benefits package is one that provides the "essential health benefits" described above under "Ban on lifetime benefit limits," satisfies the cost-sharing limits described above under "Limits on cost-sharing," and pays at least 60 percent of the cost of benefits covered by the plan. A plan's share of the cost of benefits may be higher, of course. Depending on the percentage, the plan will be designated as providing either bronze (60 percent), silver (70 percent), gold (80 percent), or platinum (90 percent) coverage.

HHS is required to establish criteria for certifying qualified health plans, develop a rating system for the health plans, establish criteria for open enrollment periods and maintain the internet portal that makes information on health plans available to the public.

Individual "Mandate"

Beginning in 2014, an individual who does not have health insurance coverage, or who has a family member who does not have health insurance coverage, generally is subject to a tax, collected by the IRS, of \$695 per year for each individual with respect to whom the violation occurs (or, if greater, 1 percent of household income in 2014 and 2 percent thereafter). Generally any employer health plan will qualify as minimum health insurance coverage for purposes of the individual mandate, although further clarification of this point might be useful because of the confusing way the provision is worded.

Lower-income individuals who are not eligible for Medicaid may qualify for a refundable tax credit that can be used for coverage purchased on an exchange. Generally an individual does not qualify for the credit if he or she is eligible to participate in, *i.e.*, not necessarily covered, an employer health plan. However, he or she will qualify if coverage under the employer health plan is unaffordable, *i.e.*, premiums cost more than 9.5 percent of his or her household income, or if the plan does not provide minimum value, *i.e.*, pays less than 60 percent of the cost of benefits covered by the plan.

After 2014, the 9.5 percent affordability threshold is indexed to the excess of the rate of premium growth over the rate of income growth. The credit also is not available with respect to an individual who has a free choice voucher (described below), or for coverage under a low-cost catastrophic coverage policy.

Individuals who qualify for the premium tax credit may also qualify for cost-sharing reductions under the plans they purchase on an exchange.

Employer “Mandate”

The employer mandate has several elements. The penalty provisions become effective beginning in 2014, but other provisions become effective sooner. None of the provisions actually requires an employer to provide any health benefits to its employees, much less to provide any particular level of benefits. However, as explained below, the penalty provisions create financial incentives for employers to provide health benefits at least to their full-time employees. **No distinction is drawn between insured and self-insured plans.**

Requirement effective as soon as regulations are issued:

- **Automatic enrollment requirement:** An employer that has at least 200 full-time employees generally must enroll each new full-time employee automatically in one of the plans that it offers (subject to any waiting period), unless the employee affirmatively opts out or elects a different option.

Requirement effective March 1, 2013:

- **Notice requirement:** An employer generally must notify each new employee at the time of hire and each current employee (by March 1, 2013) that the employee can obtain coverage through an exchange, that the employee might be eligible for a premium tax credit and a cost sharing reduction if the employee obtains coverage through an exchange, but that if the employee does so the employee might lose the right to a pre-tax employer contribution towards the coverage.

Requirements effective in 2014:

- **Penalties for failure to provide adequate coverage:** Beginning in 2014, a large employer (at least 50 full-time employees in the prior year, determined

on a full-time equivalent basis) is subject to a penalty if it does not provide adequate health coverage to all of its full-time employees and their dependents, and some of its full-time employees opt to purchase coverage on an exchange and qualify for a premium tax credit or cost-sharing reduction to enable them to do so. A full-time employee for this purpose generally means one who works on average at least 30 hours per week.

Specifically, if a large employer does not offer a health plan to **all** of its full-time employees and their dependents for a month, and if even one full-time employee obtains a premium tax credit or a cost sharing reduction for coverage purchased on an exchange, the employer is subject to a tax of \$2,000 per year multiplied by the total number of full-time employees (disregarding the first 30 full-time employees).

Also, if a large employer offers a health plan to all of its full-time employees and their dependents, and if one or more full-time employees **opt out** and obtain premium tax credits or cost sharing reductions for coverage purchased on an exchange, the employer is subject to a tax of \$3,000 per year per full-time employee who opts out. This penalty cannot exceed the penalty that would have applied if the employer had not provided **any** coverage.

The upshot of these penalty regulations, when the requirements to obtain premium tax credits or cost sharing reductions for coverage on an exchange are taken into account, is that an employer could be subject to penalties triggered by its **lower-wage full time** employees opting to purchase coverage on an exchange if they: (1) **are not offered any health plan** at all (in which case the penalties generally are larger); or (2) are offered a health plan but their **premiums cost more than 9.5 percent of their household incomes**; or (3) are offered a health plan but **the plan pays less than 60 percent of the cost of benefits**.

Whether an employer is likely to pay more by: (a) improving coverage and/or reducing the employee share of premiums enough to avoid any risk of penalties; or (b) paying the penalties will depend on each employer's facts. Which is more expensive might be difficult to determine without the help of an actuary or other expert consultant. In addition, because the 9.5 percent affordability requirement is based on household income, which takes some deductions (as well as other family members' incomes) into account and might not even be known until the end of the year, this determination will always involve a certain amount of guesswork. Finally, employers with grandfathered plans must consider whether any plan changes will raise issues under the grandfather regulation and, if any individuals lose coverage as a result of the changes, whether the new regulations on rescissions and cancellations apply.

- **Free choice vouchers:** If an employer offers a health plan to an employee whose household income is below 400 percent of the poverty line, and

premiums cost more than 8 percent but less than 9.8 percent of his or her household income, the employer also must give the employee a “free choice voucher” equal to the portion of the cost of the plan that the employer would have paid on his or her behalf if he or she had participated in the plan, to enable him or her to purchase less expensive insurance on an exchange. The law says this calculation is based on what the employer would pay for self-only coverage unless the employee “elects family coverage,” in which case it is based on what the employer would pay for family coverage, but it is not clear how to determine whether the employee has elected family coverage since the employee has not elected anything at all.

Unlike earlier versions of the legislation, employees are free to buy insurance on an exchange even if their employer or their spouse’s employer already provides an adequate insurance plan. This, combined with free choice vouchers, might destabilize employer plans. Qualified health plans offered on exchanges are specifically prohibited from imposing penalties on individuals who drop coverage because they become eligible for an adequate employer plan. It is not clear at this time whether an employer can try to limit switching by, for example, excluding employees who purchase insurance on an exchange for less than some minimum period of time.

- **Nondiscrimination requirements:** An employer may not discriminate against (e.g., fire), an individual because the individual has received a premium tax credit or a cost-sharing reduction.

REVENUE PROVISIONS AND OTHER TAX CHANGES

The PPACA amends the Tax Code in a number of ways that will affect employers. The most significant are described below, in order of their effective dates.

Effective immediately:

- **Tax exclusion for coverage of adult children:** Health coverage provided under an employer health plan to an employee’s children who have not reached age 27 by the end of the year is not subject to tax, even if they are **not** the employee’s tax dependents. The IRS provided guidance on this provision in Notice 2010-38, including guidance on amending cafeteria plans to permit these individuals to be covered.

Effective in 2011:

- **Increased penalty on nonqualified distributions from HSAs:** The tax penalty for nonqualified (*i.e.*, nonmedical) distributions from HSAs and Archer MSAs increases from 10 to 20 percent.

- **Reporting the cost of health coverage on Form W-2:** The aggregate cost of health insurance coverage provided by an employer must be reported on the employee's Form W-2. The cost of coverage generally means the same thing it does for purposes of the excise tax on "Cadillac" coverage described below (even though the excise tax itself is not effective until 2018), except that it generally does *not* include contributions to health FSAs, HSAs or Archer MSAs. **Complying with this requirement is likely to be time-consuming and require expert advice** on how to value the different kinds of coverage provided to employees. Employers should begin this process as soon as possible.

Effective in 2012:

- **Form 1099s required in more situations:** The exception from information reporting on Form 1099 under current law for **payments to a corporation** is repealed, except for payments to a tax-exempt corporation, which continue to be exempt as under current law. In addition, reporting on Form 1099 will be required for **gross proceeds** and amounts paid for **property** (currently not subject to information reporting because the taxable amount is not fixed or determinable). Tax-exempt payers have to comply with these regulations to the same extent as taxable payers.
- **Fees to fund patient-centered outcomes research trust fund:** An annual fee, collected by the IRS, is imposed on health insurance policies and self-insured employer health plans. The fee is generally \$2 multiplied by the average number of lives covered under the plan.

Effective in 2013:

- **Tax on Medicare Part D subsidy:** If an employer provides retiree drug coverage and receives a subsidy under Medicare Part D, the cost of the prescription drugs that are taken into account in determining the subsidy will no longer be deductible. In addition to the tax cost, for many companies receiving the subsidy this change will require a reduction of their "deferred tax assets," resulting in a **significant, immediate accounting charge**.
- **\$500,000 limit on deductible compensation:** A health insurance company or HMO generally may not deduct compensation paid to any officer, director, employee or independent contractor to the extent it exceeds \$500,000. The limit is applied each year, to compensation earned in that year. Any portion of the \$500,000 allowance that is not used up deducting current compensation for a year can be applied to deferred compensation earned in the same year but paid in a later year. The limit applies to compensation **earned** in 2010 or a later year and **deducted** in 2013 or a later year. This regulation closely resembles the regulation applicable employers in the troubled assets relief program (TARP). Like that regulation, there is **no exception for performance-based compensation**.

The regulation applies on a controlled-group basis, meaning that it could apply to an entity that is not itself an insurance company or HMO if there is an insurance company or HMO in its controlled group.

Effective in 2018:

- **Excise tax on “Cadillac” plans:** A nondeductible 40 percent excise tax is imposed on health coverage to the extent the cost exceeds \$10,200 (in the case of individual coverage) or \$27,500 (in the case of family coverage). The limits are adjusted for age and gender (but not geographic area) and are increased (by \$1,650 for individual coverage and \$3,450 for family coverage) for retirees and for plans that cover mostly employees in high-risk professions or employees who repair or install electrical or telecommunications lines. The limits are indexed under a complex formula. The tax is imposed on the employer in the case of a self-insured plan and on the issuer in the case of an insured plan. **All coverage provided to an employee and his or her family by or through an employer must be aggregated for this purpose (other than a very limited list of limited-scope benefits and benefits under separate dental and vision policies), including employee-paid coverage and other taxable coverage.** The employer (or the plan in the case of a multiemployer plan) is responsible for determining the excess and allocating it among different providers (if there is more than one), and can be responsible for any shortfall if this is not done correctly.

The cost of coverage will be determined actuarially, in roughly the same way as COBRA premiums are determined when an employee terminates employment. Currently there is no guidance explaining how that is done, but the IRS is actively working on regulations on this issue.