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## PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): EMPLOYMENT-RELATED PROVISIONS

The PPACA and the companion Reconciliation Act significantly rework the rules governing employer-provided employee health benefits. Employers will need to change the way they provide employee health benefits. However, because the new rules phase in over a multi-year period, not everything needs to be done at once and there is time for considering options and planning. This article, which outlines the most significant PPACA changes affecting employers, begins with a timeline showing the staggered effective dates for these changes and then follows with a more detailed discussion of each provision.

### Timeline for PPACA Implementation

A summary of the PPACA implementation timeline can be found [here](#). For quick reference, the links below will take you to the PPACA changes by deadline year.

- [Changes for 2010](#)
- [Changes for 2011](#)
- [Changes for 2012](#)
- [Changes for 2013](#)
- [Changes for 2014](#)
- [Changes for 2015](#)
- [Changes for 2017](#)
- [Changes for 2018](#)

### Key Concepts

In this discussion of the PPACA, you need to understand several key concepts.

- **Group Health Plan:** This is an employee health plan that is maintained by an employer. It can be either insured or self-insured.
- **Insured Plan:** This is a plan whose health benefits are provided through insurance or HMO contracts that are purchased by the employer.
- **Self-Insured Plan:** This is a plan under which benefits are paid for out of the employer's general assets (usually funded with employer or employee contributions) or a voluntary employees' beneficiary association (VEBA) trust, often with a stop-loss insurance policy to protect the employer against losses for large claims.



- **Grandfathered Plan:** This is a group health plan that was in existence on March 23, 2010, the date of enactment of the PPACA. Insured grandfathered plans will lose their grandfathered status when the current contract expires. Self-insured grandfathered plans can retain their grandfathered status after the close of the current plan year; adding new dependents or new employees will not cause these plans to lose their grandfathered status. At this point, it is unclear what will cause a self-insured grandfathered plan to lose its grandfathered status.

## 2010

There is nothing that employers are affirmatively required to do to comply with the PPACA in 2010. Most of an employer's efforts in 2010 will be devoted to studying and taking steps to implement the changes that are required in 2011, including:

- A **temporary high-risk health insurance pool** is to be established by the U.S. Department of Health and Human Services (DHHS) no later than June 21, 2010 for use by those individuals with pre-existing conditions who are currently uninsured and unable to purchase insurance.
- Employers and health insurers are prohibited from **encouraging** or **providing any incentive** to any person to **dis-enroll** from the employer's plan in order to **shift coverage** to the temporary **governmental high risk sharing pool**. The penalty for a violation is reimbursement to the governmental pool of the medical expenses it incurs for such person.
- **Temporary large claim reinsurance assistance** is available for employers providing early retirement benefits to retirees age 55 – 64 under a retiree group health plan. The reinsurance reimbursement, up to a \$60,000 annual maximum per eligible retiree, is 80 percent of the costs incurred by the plan for an eligible retiree (and his/her dependents) in excess of the first \$15,000 of such costs. The costs that may be reimbursed include the portion paid by the retiree for deductibles, co-payments, and co-insurance. More details on the program will be forthcoming. This program will end on January 1, 2014.
- **Small employers with low-paid employees** are eligible for a **tax credit** for **purchasing health care for their employees**. The full credit is applicable for a business with no more than 10 full-time equivalent (FTE) employees who have average wages not exceeding \$25,000. The credit is phased out entirely if the business has 25 or more FTE employees or if the average wages of its employees is \$50,000 or more. For 2010 – 2013, the credit is 35 percent (25 percent for tax-exempt employers) of the employer's non-elective premium for qualified health insurance policies. Starting in 2014, the credit increases to 50 percent (35 percent for tax-exempt employers) but is available only if the health insurance



policy is purchased on a state health insurance exchange. Related employers are treated as a single employer.

- A **tax credit** is available for **adoption expenses** increases from \$10,000 to \$13,170 effective January 1, 2010.

## 2011

This is the year when most of the “insurance reform” provisions of the PPACA become effective. As noted below, some of the changes go into effect for plan years starting on or after September 23, 2010 (which for calendar year plans will be January 1, 2011) and others go into effect on January 1, 2011. Since many health plans use a calendar year plan year, we have simply reported them all as 2011 requirements, although employers with plan years that start on or after October 1 may have to start complying with some of these changes in late 2010 and others (e.g., as those with a July 1 year) may not have to start complying with all of the new requirements until after January 2011.

- Use of **lifetime dollar limits** on health benefits is **prohibited**. A group health plan may impose lifetime limits on non-essential health benefits for beneficiaries, but not participants. This applies to grandfathered plans (effective for plan years beginning on or after September 23, 2010).
- Use of unreasonable **annual dollar limits** for "essential health benefits" is **prohibited**. Essential health benefits are ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health, prescription drugs, rehabilitation services, laboratory services, preventative and wellness, and pediatric services. Starting in 2014, all annual dollar limits for non-essential health benefits are prohibited. Grandfathered plans are exempt from this rule (effective for plan years beginning on or after September 23, 2010).
- **Pre-existing condition** exclusion for children **under 19 years of age is prohibited**. This applies to grandfathered plans (effective for plan years beginning on or after September 23, 2010).
- Group health plans that provide **dependent coverage** must provide coverage to **adult children (including those who are married) until age 26**, provided that with respect to grandfathered plans, the child is not otherwise eligible for coverage under another employer-sponsored health plan. This applies to grandfathered plans (effective for plan years beginning on or after September 23, 2010).
- Group health plans must provide **first dollar coverage** for **preventative care**. Grandfathered plans are exempt from this requirement (effective for plan years beginning on or after September 23, 2010).



- Group health plans that use **primary care provider** gatekeepers must give participants the right to select any available primary care provider and see any participating **Ob/Gyn physician** without a primary care provider referral. Group health plans must cover **emergency care** without requirement for primary care provider referral or imposition of any "out-of-network" penalty. grandfathered plans are exempt from this requirement (effective for plan years beginning on or after September 23, 2010).
- Reimbursement under FSA, HSA, MSA, and HRA for **over-the-counter drugs is no longer allowed**; reimbursement is now limited to prescription drugs or insulin (effective January 1, 2011 for the 2011 tax year).
- Code Section **105(h)** currently taxes the benefits received by highly compensated employees (**HCE**) under **discriminatory** self-funded health plans. The PPACA has extended these non-discrimination rules to **insured plans**. It is unclear whether this change imposes tax penalties or is a substantive requirement. Employers with discriminatory insured arrangements, however, will need to consider changing them. Grandfathered plans are exempt from this rule (effective for plan years beginning on or after September 23, 2010).
- Group health plans and health insurance issuers may not **rescind coverage** for reasons other than **fraud or material misrepresentation**. This applies to grandfathered plans (effective for plan years beginning on or after September 23, 2010).
- Plans must implement an "**effective appeals processes.**" Initially, this will mean following U.S. Department of Labor (DOL) claims procedure rules (for self-funded and insured plans) and current state law procedures (for insured plans) as updated by the DOL or DHHS, respectively. ERISA plans should already be in compliance, but church and government plans that do not presently have ERISA-compliant claims procedures will need to adopt such procedures. This applies to grandfathered plans (effective for plan years beginning on or after September 23, 2010).
- The cost of employer-sponsored medical coverage provided to an employee must be reported on the employee's Form W-2 by the employer. The value of HSA, MSA, and FSA contributions need not be included because they are already separately reported on the Form W-2 (effective January 1, 2011 for the 2011 tax year, applicable to W-2s issued in January 2012).
- **Excise tax** for distributions from **HSA** and **MSA** for expenses that are not Code § 213 medical expenses **increases to 20 percent** from the current 10 percent and 15 percent respectively (effective January 1, 2011).



- DHHS will develop **uniform summary of benefits** no later than March 23, 2011 that a group health plan sponsor or insurance issuer will need to distribute to plan participants and potential enrollees no later than March 23, 2012. This disclosure is required in addition to the ERISA summary plan description. Also, if any **material modification** is made after such summary is provided, then a **notice of material modifications** must be provided to participants at least 60 days prior to the modification's effective date. (DHHS is to have developed a standard summary of benefits by March 23, 2011; the sponsoring employer or insurer to distribute summary of benefits no later than March 23, 2012.)
- **Simple cafeteria plans** will be made available for employers with 100 or fewer employees during either of the two prior years. Simple cafeteria plans are deemed nondiscriminatory for purposes of the nondiscrimination requirements applicable to life insurance, self-funded plans, and dependent care plans, if the employer provides at least a two percent of pay contribution for participants, and the plan satisfies minimum eligibility and participation requirements. Employees who have completed at least 1,000 hours during the prior year must be able to participate. Employees younger than 21 years of age with less than one year of service can be excluded. Minimum contribution requirement also can be satisfied if employer contribution for all participants (even those who do not make pretax contributions to the cafeteria plan) is the lesser of (i) six percent of pay, or (ii) two times each qualified employee's pretax contribution. A "qualified employee" is any employee who is not an HCE (as defined in IRC § 414(q)) or a key employee (as defined in IRC § 415(i)). Simple cafeteria plans must still comply with Code § 125 nondiscrimination requirements regarding eligibility and benefits.

## 2012

- Health insurance issuers and self-funded health plans will be required to pay an **annual fee of \$2.00**, (\$1.00 during first year the provision is applicable) indexed for inflation starting in 2014, **times the average number of covered lives** under the health insurance policy or self-insured health plan. (Effective for plan years ending after September 3, 2012; scheduled to end for plan years ending after September 3, 2019.)

## 2013

This is the year that the financial/revenue raising provisions of the PPACA start to become effective.

- A **\$2,500 annual limit** will be imposed on **health FSA** deferrals; currently there is no such limit (effective January 1, 2013).



- The current 7.5 percent of AGI floor on income-tax deductions for health care expenses is raised to 10 percent of AGI (effective January 1, 2013; however, new floor is waived during 2013, 2014, 2015, and 2016 for individuals who turn age 65 before the close of those years).
- The deduction for the portion of health care expenses that are reimbursed to the employer through the Medicare Part D subsidy program is eliminated (effective January 1, 2013).
- Group health plans must comply with "administrative simplification" rules (to be published) for **electronic exchange health information** and **electronic fund transfers** and file a certification with the federal government that the plans are in compliance. In addition, the employer must ensure that service providers also comply with the transaction and certification requirements. The penalty for non-compliance is \$1.00 per covered life per day of non-compliance up to a maximum of \$20.00 per covered life per year, but a double penalty applies in the case of any employer misrepresentation. This applies to grandfathered plans. Systems must be effective starting January 1, 2013, and employers must certify compliance by December 31, 2013.
- The **FICA Medicare tax** rate is **increased 0.9 percent** for wages/earnings **over \$200,000** (\$250,000 for married couples filing jointly); i.e., a combined 2.35 percent on wages over \$200,000 (\$250,000 for joint filers). An employer is required to collect the employee's share in the case of wages. However, the law does not increase the employer's share of FICA Medicare tax (effective for tax years beginning January 1, 2013).
- Employers must provide **notice to employees** of the upcoming existence of **state insurance exchanges**, which are to be established by all the states in 2014. Notice must be in the form specified in upcoming DOL guidance (effective March 1, 2013 or such later date as set forth in future DOL guidance).

## 2014

This is the year that the main mandated health insurance coverage provisions of the PPACA become effective.

- Each state must establish a **health insurance exchange** for use by the uninsured and small employers with 100 or fewer employees (although states may set the cap at 50 employees). The exchanges will offer fully insured contracts that provide essential health benefits at different levels of coverage (i.e., bronze, silver, gold, and platinum). Employees of small employers who offer health insurance coverage through an exchange may pay their employee premiums for such coverage on a pre-tax basis through the employer's cafeteria plan (effective January 1, 2014).



- Employers with 50 or more employees **will be required** to offer their **FTEs minimum essential coverage** under a group health plan or pay a fine of up to \$2,000/year for each FTE, in excess of 30 FTEs. If an employer does provide minimum essential health coverage to its FTEs, but at terms that are ungenerous enough for the FTE to receive a premium credit on the state health insurance exchange, then the employer must pay a penalty of up to \$3,000/year for each FTE who receives the premium credit on an exchange, but not more than would be owed with the \$2,000/year penalty by itself. An FTE is defined as an employee who is employed for 30 or more hours per week (effective January 1, 2014).
- Individuals are required to obtain minimum essential health coverage for themselves and their dependents or pay a monthly penalty tax for each month without coverage. The monthly penalty tax is 1/12 of the greater of the dollar penalty or gross income penalty amounts. The dollar penalty is an amount per individual of \$95 for 2014 (capped at \$285 per family), \$325 for 2015 (capped at \$975 per family), and \$695 for 2016 (capped at \$2085 per family). These dollar penalties will be indexed for inflation starting in 2017. The gross income penalty is a percentage of household income in excess of a specified filing threshold of one percent for 2014, two percent for 2015, and 2.5 percent for 2016 and later years. In no event will the maximum penalty amount exceed the national average premium for bronze-level exchange plans for families of the same size. Minimum essential coverage includes Medicare, Medicaid, CHIP, TRICARE, individual insurance, grandfathered plans, and eligible employer-sponsored plans; workers compensation and limited scope dental or vision benefits are not considered minimum essential health coverage (effective January 1, 2014).
- An employer that offers minimum essential health coverage to its employees generally must each FTE **a free choice voucher** that can be used to purchase health insurance on the state exchange, if the FTE's employee share premium is more than eight percent but less than 9.8 percent of the employee's household income, the employee's household income is less than 400 percent of the federal poverty line for a family of the size involved and the employee is not covered under the employer's plan. The free choice voucher will be in the amount the employer would have paid for coverage for the employee and his/her dependents, if applicable. If the amount of the voucher is more than is needed for the employee to purchase insurance on a state insurance exchange, the employer must pay the difference to the employee as wages. The portion of the free choice voucher that is used to buy insurance on an exchange is not included in the employee's income. An employer will not have to pay the \$3,000 "failure to cover" penalty tax for an employee who receives a free choice voucher (effective January 1, 2014).



- Employers with more than 200 employees who maintain one or more health **plans must automatically enroll new FTEs in a health plan**. The employer must give affected employees notice of this automatic enrollment procedure and an opportunity to opt out. State wage withholding laws are preempted to the extent that it prevents an employer from instituting this automatic enrollment program (effective date will be as provided in regulations Congress has directed the secretary of DOL to prepare).
- Pre-existing condition exclusions are no longer allowed in group health plans or individual insurance policies, not even the limited exclusions previously allowed under HIPAA. This applies to grandfathered plans (effective for plan years beginning on or after January 1, 2014).
- Group health plans and health insurance issuers **may not impose waiting periods in excess of 90 days**. This applies to grandfathered plans (effective for plan years beginning on or after January 1, 2014).
- Group health plans **may not impose cost sharing amounts** (i.e., co-pays, deductibles) that are more than the maximum allowed for high-deductible health plans (currently these limits are \$5,000 for an individual and \$10,000 for a family coverage). After 2014, these amounts will be adjusted for health insurance premium inflation. This applies to grandfathered plans (effective for plan years beginning on or after January 1, 2014).
- Group health plans **may no longer include annual limits** on essential health benefits for participants, but may continue to do so for beneficiaries (effective for plan years beginning on or after January 1, 2014).
- The maximum **premium discount** an employer can offer under its health plan for participation in a wellness program is **30 percent**; this is an increase from the current maximum premium discount of 20 percent. Regulatory agencies can increase this maximum discount to 50 percent in the future (effective January 1, 2014).
- Employers with at least 50 FTEs must submit **annual health insurance coverage returns to the IRS** and annual individual health insurance coverage statements to FTEs. The IRS will issue guidance and forms for this purpose (effective January 1, 2014).
- States must implement a **CHIPRA premium assistance** subsidy for individuals under age 19 and/or their parents for premiums paid for employer-sponsored health coverage and **extend such assistance to all individuals** who **qualify** for medical assistance **under Medicaid** or a state medical assistance program **regardless of age**. The state will pay the employee cost of coverage and any cost-sharing expenses (e.g., co-pays, deductibles, and so forth) that otherwise would be covered by the state



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program. Eligible employees can opt out of the employer's health plan (effective January 1, 2014).

## 2015

- Group health plans must use **electronic systems for processing health claims, enrollment, and premium payments** and certify to the federal government that their systems comply. This applies to grandfathered plans (plans must certify compliance by December 31, 2015).

## 2017

- States can allow **larger employers** (more than 100 employees) to purchase health insurance for their employees on the state health insurance **exchanges**.

## 2018

- A "**Cadillac health plan**" **40 percent excise tax** will be imposed on "coverage providers" (i.e., health insurer for fully insured plans, the employer with respect to HSA or MSA contributions, and in all other cases, the "person that administers the plan") that provide high-cost health care coverage to the employer's employees. The excise tax is imposed on the "excess benefit" provided to the employees. Excess benefit is determined by comparing the cost of the actual coverage provided (calculated using rules similar to those for determining COBRA premiums) to set, annual limits. For 2018, the annual limit for employee-only coverage is \$10,200/year (as adjusted by a "health cost adjustment percentage" or HCAP) and \$27,500/year (as adjusted by the HCAP) for coverage other than employee-only. The HCAP takes into account year-to-year increases in the cost of health care coverage, including increases attributable to age and gender differences. The annual limits noted above are increased by \$1,650 and \$3,450, respectively, for employees in high-risk professions (e.g., law enforcement, EMT/paramedics, construction, mining, longshoremens, and so forth). Liability for the excise tax is determined on a monthly basis. Employers are required to calculate the amount of the excess benefit subject to the excise tax for each taxable period and to determine each coverage provider's "applicable share" of the excess benefit. A coverage provider's applicable share of an employee's excess benefit is determined by multiplying the aggregate excess benefit for the employee by the ratio obtained by comparing (i) the cost of the coverage provided to the employee by the coverage provider to (ii) the aggregate cost of all applicable coverage (effective January 1, 2018).

**Patient Protection and Affordable Care Act Implementation Timeline for Benefit Plans**

<b>2010</b>	<b>2011</b>	<b>2012-2013</b>	<b>2014</b>	<b>2015-2018</b>
Establishment of Federal government high risk pool.	No lifetime limits.	\$2/covered person tax for health plans. (Plan years ending after 9/3/2012)	State health insurance exchanges established. Midsize employers (50-100 employees) can use exchange as their health plan.	<b>2015:</b> Electronic claims processing, enrollment and premium payment mandatory.
Prohibition on incentives to dis-enroll from employer plan.	Annual benefit dollar limits restricted.	\$2500 health FSA limit. (1/1/13)	Large employers (50+ employees) must provide health plan or pay fine.	<b>2017:</b> States can allow larger (>100 employees) to use exchange for their health plan.
Retiree health reinsurance assistance.	No pre-existing condition exclusion for children under age 19.	Itemized medical expense deduction increased from 7.5 percent to 10 percent. (1/1/13)	Individuals must secure health coverage or pay penalty tax.	<b>2018:</b> Cadillac plan excise tax starts.
Small business employee health insurance tax credit.	Adult children covered thru age 26.	Medicare Part D subsidy deduction eliminated. (1/1/13)	Employers must provide free-choice vouchers to certain participants.	
Adoption assistance credit expanded.	First dollar coverage for preventative care.	Mandatory electronic funds transfer/eligibility systems. (1/1/13)	Automatic employee health plan enrollment required (200+ employees).	
	Participants choose primary care physician / Ob/Gyn.	FICA Medicare tax increased from .145 percent to .235 percent for wages over \$200,000 (\$250,000 married filing jointly). (1/1/13)	No pre-existing condition exclusion allowed.	
	No FSA reimbursements for over-the-counter drugs.	Employer must notify employees of new state health insurance exchange. (3/1/13)	Waiting periods limited to 90 days.	
	No HCE discrimination in insured health plans.		Cost-sharing amounts capped.	
	Rescission for fraud only.		Annual limits removed.	
	ERISA-like appeal procedures for church/government health plans.		Maximum health premium discount for wellness program participation increased from 20 percent to 30 percent.	
	W-2 reporting of health plan coverage.		Group health plan must report coverage by individual to IRS.	
	20 percent excise tax on non-qualified HSA & MSA expenditures.		CHIPRA premium assistance becomes mandatory for states.	
	Uniform explanation of coverage provided to participants.			
	Simple Cafeteria plans available for small employers (≤ 100 employees)			