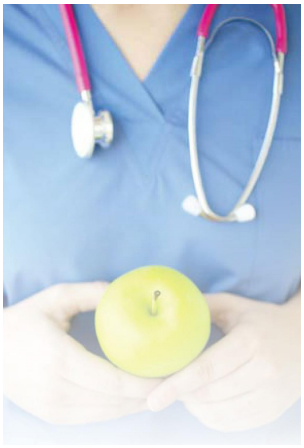
National Watermelon Association, Inc.

This special issue of our newsletter is completely dedicated to the new federal health care law that was passed a few months ago. Many "Thanks" to Matt McInerney and his team at Western Growers Association (WGA) for granting the NWA permission to republish this article, filled with details and advice. We appreciate WGA's support as we all look to how this law will effect our members.

After expending more lives than any cat, health care reform was finally passed in March on a strictly partisan vote and signed into law by President Barack Obama.

One would suspect that opponents, proponents and political pundits will be arguing well past this election cycle and throughout his term as to the merits and demerits of this effort. One Republican representative likened it to Armageddon (the end of time) while some Democratic counterparts were equally effusive on the other end of the spectrum, calling it the greatest piece of social legislation in more than 40 years. Some opponents called for repeal ignoring the political fact that the President would have to sign such legislation. Others ýled suit in court claiming that there is no way the government can force people to buy insurance. Constitutional scholars begged to differ stating that the government already forces people to buy auto insurance and that lack of freedom has been upheld by the courts.

As the dust is still settling, the fact is that universal health care insurance as an undeniable right is basically here, and it is going to be pretty hard to put the genie back in the bottle.



The Patient Protection and Affordable Care Act and its companion Health Care and Education Affordability Act are now the law with some provisions taking immediate effect and others being phased in over the next eight years. A signiýcant handful of provisions become law in the fall of this year while the majority of the provisions kick-in in 2014, and there are other points that don't phase-in until 2018.

The nuances of the law are many and every employer should analyze it very closely to determine just how it applies to his or her operation. The basic premise is that virtually all legal residents of the United States should be covered by a health insurance plan-either one provided through their employer or an individual plan available through insurance exchanges, which will be established in the coming years.

Employers of at least 50 fulltime employees (or Full Time Equivalents FTE) will be required to provide insurance for their employees by 2014 or pay a ýnancial penalty. Additionally, most legal residents of the United States will be required to purchase insurance through an exchange if it is not provided by an employer. Subsidies will be available for the poorest among us.

There are many regulations of these laws that must be written and of course, a new layer of bureaucracy will no doubt be established. Consequently exactly how this new law will operate is far from well developed. Over the coming months, Cathy Enright, Western Growers vice president of federal government affairs, said many interests will be weighing in on the development of the law and trying to craft

solutions to their advantage. She said the most important fact is probably a company's FTEs. Each company should determine at the outset if they are covered by the law or not.

Determining If an Employer Is Impacted

Enright said statistically, the average produce employer has only 18 full-time employees. At ýrst blush, this would seem to indicate that the average member will not be impacted. However, for the purpose of this act, the government has devised a formula to turn seasonal and part-time workers into FTEs. "If you are a grower with only 18 fulltime workers and you only have a bump in your workforce for a short time, you are probably in good shape and the law will not apply to you," she said. "But if you are a grower with year-round production and many seasonal workers, you most likely will qualify."

She explained that a seasonal workforce employed for 120 days or less in a year will not count toward a ýrm's FTE. A seasonal workforce however, that is employed for more than 120 days will be counted as full time employees. Hence a grower with a four-month harvest that employs more than 50 workers already is above the limit. Part time workers will be aggregated with every 30 hours of work per week counting as one FTE.

Employers with more than 50 employees will be required to provide health insurance or pay a ýne if any of his workers buying insurance through the exchange qualify for a federal subsidy. (Almost certainly an employer of more than 50 workers that chooses not to provide insurance will be paying the ýne.) Currently, the legislation calls for a $2,000 annual ýne per employee, excluding the ýrst 30 employees. Hence an employer with 100 employees will be assessed a penalty of $2,000 per employee for 70 employees or $140,000 annually. That is considerably less than what the employer would have to pay to cover those employees even under a bare-bones health insurance plan. Western Growers Association attorney and insurance expert Jon Alexander said presumably many employers will choose to go the penalty route. "The size of the penalty does appear to be a disincentive toward providing health insurance," he said. "Maybe the idea has to push as many people as possible into the exchanges." Simple economics tell you that the more people in the exchange pool, the greater the ability to spread the risk, which should result in lower rates (to a point). On the other hand, Alexander said the $2,000 ýgure may just be a placeholder that will be recalculated and changed by either regulation or a ýx-it law as its effective date of January 1, 2014, comes closer. Alexander said there also is an incentive in providing health insurance to employees as there is a signiýcant tax break. He said every company clearly should do a cost beneýt analysis on this issue once the law becomes fully effective.

Lifetime Caps & Dependent Children Care

Probably the most immediate concern for most employers who currently offer health care insurance to their employees is what type of rate modiýcations will be justiýed because of some of the new requirements of these new laws. Provisions that will go into effect this year include elimination of lifetime beneýt caps, "reasonable" annual caps, inability to deny coverage to children because of pre-existing conditions and the expansion of continuing coverage for young adults on a parent's plan until the age of 26. Each of these provisions expands coverage and hence will logically make virtually any plan more expensive when these provisions kick-in by early fall. While many plans, especially those at the upper end of the spectrum, did not have lifetime caps, no plan covered adult children past the age of 23. Most likely employers will experience increased costs because of these provisions.

Self-Funded Programs

A signiýcant number of larger ýrms in the agricultural arena have established self-funded insurance plans. There is nothing in the new law that prevents these plans from continuing. Alexander said that like every plan, these self-funded plans must adhere to the provisions of the new law, once it becomes effective, such as eliminating life time beneýt caps as well as unreasonable annual caps. In addition, beneýts needed to be extended to affected classes as articulated above.

Eligibility to be an Exchange Provider

Enright said the legislation neither includes nor specifically excludes insurance providers which are organized under a special law and are called Multi Employer Welfare Association. Groups such as Western Growers Assurance Trust are not insurance companies per se but an association that provides insurance plans for their members. There is no doubt that MEWAs will be able to continue

to operate as private companies offering qualiýed plans under the new law to their members. What is not entirely clear is whether they will be able to be part of the exchanges competing for that book of business.

Enright said one part of the law makes it clear that the exchange providers must be "licensed insurance companies" but another part of the law says that these exchanges will be determined on a state by state basis and will be limited to licensed insurance providers in each state. Alexander said any reasonable interpretation of the law includes licensed MEWAs as part of the exchange.

Grandfathered In Plans

Plans that exist prior to the enactment date will be "Grandfathered In" with the exception of having to meet the new immediate and longer term coverage mandates but are not subject to all of the provisions of the new law. All employers that offer coverage (whether self-funded or fully insured) aſter the effective date will be required to offer coverage without: (1) lifetime limits; (2) pre-existing conditions for children under age 19; (3) unreasonable annual limits; (4) rescissions other than for fraud; and (5) exclusions for non-dependent children up to age 26 who do not have an offer of coverage f from their employer.

Aſter 2014, all employers that offer coverage (whether fully insured or self-insured) will also be required to offer plans without waiting periods for coverage greater than 90 days for employers with more than 200 full time employees. There will also be additional requirements on plans sold aſter the effective date of the law. Beginning in 2014, plans that did not exist before the effective date of the law must meet the requirements imposed by new beneýt standards, as described below.

"Grandfathered In" plans may keep their plans constituted the way they are today, save for the changes mentioned above. The Grandfathering provision of the Act is silent with respect to how plan changes aſter the law's enactment may affect Grandfathered status. Guidance regarding this provision is likely forthcoming. As mentioned, the new laws have many provisions that will be phased in over time. Following is a list of some of the more important points of new health care reform legislation and the effective date.

EFFECTIVE IN 2010

No Lifetime or Unreasonable Annual Limits:
A group health plan or health insurer offering group or individual health coverage may not establish lifetime limits or unreasonable annual limits. (What is "unreasonable" has not yet been determined.)

Prohibition on Rescissions Except in Cases of Fraud:
Insurance companies and group health plans cannot eliminate a participant's coverage because they get sick.

Extension of Dependent Coverage:
Group Health Plans and insurance companies offering group and individual plans will make coverage to an unmarried adult child until the child turns 26 years old. Plans and companies are not required to cover the child of a child receiving dependent coverage.

Prohibition of Discrimination Based Upon Salary:
Coverage rules governing eligibility may not be based upon hourly or annual salary. The coverage rules may not discriminate in favor of higher earners.

Prohibition of Preexisting Condition Exclusion or Other Discrimination Based on Health Status for Children under the age of 19:
These provisions limit the ability of insurance companies and self-funded plans to deny coverage because a child under the age of 19 is ill, or has been ill.

Prohibition on Policy Cancellation Except for Failure to Pay Premium or Fraud:
Insurance companies and plans cannot eliminate coverage because someone gets sick.

Coverage of Preventive Health Services:
Group Health Plans and insurance companies offering group or individual health insurance

coverage will provide, with no co-pay, evidence-based preventive services; including recommended immunizations and with respect to infants, children, and adolescents, evidence-informed preventative care and screenings.

EFFECTIVE IN 2011

Not later than 12 Months after Enactment
Development of uniform explanation of coverage documents. A number of reporting requirements become effective in 2011, including the reporting of the value of employer-provided health benefits on the employee's W-2 form.

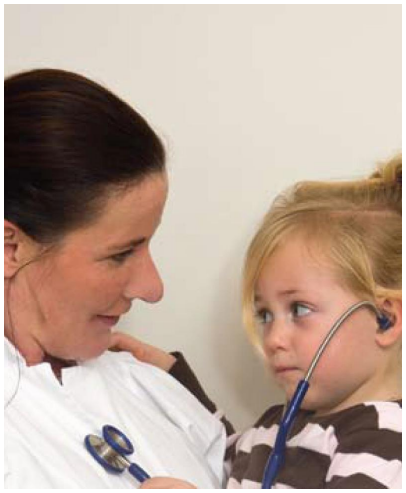
EFFECTIVE 2014

Employer "Pay or Play" Mandate:
Beginning January 1, 2014, the following "pay-or-play" mandates apply: Employers with more than 50 full time employees will be required to offer health care coverage to employees or pay a penalty. The penalty for failure to provide coverage - applicable only if at least one full-time employee receives government- subsidized Exchange coverage - is $2,000, prorated, per the total number of full-time employees minus 30. (The "Exchange" is a state-based program through which individuals and small businesses with 100 or fewer full time employees can buy health coverage that includes subsidies for those with income that is 133%-400% of the federal poverty level.)

Unaffordable Insurance:
Also beginning in 2014, an employer may be subject to ýne even if he or she provides insurance in the event the insurance is deemed unaffordable. This occurs where an employee is required to pay more than 9.8% of his or her income, indexed over time, for coverage or the employer contributes less than 60% of the value of the plan. If either event occurs, employees may apply for a federal subsidy and coverage through an Exchange. The penalty is assessed only if the employee seeks and receives the subsidy. (If an employer with more than 50 employees experiences either event, it will be required to pay $250 per month per full time employee (or $3000 per year) times the number of employees getting a federal subsidy. Employers would be able to subtract the ýrst thirty (30) employees from this assessment, as described above.)

Eligibility for Premium and Cost Sharing Subsidies:
Premium credits and cost-sharing subsidies through Exchanges are available to citizens and legal immigrants. Employees who are offered employer based coverage are not eligible for these subsidies or credits unless (1) the employer plan does not have an actuarial value of at least 60%; or (2) the employee share of the premium exceeds 9.8% of his or her income.

Reporting Requirements:
Larger employers with more than 100 employees will be required to report to the Secretary of Health and Human Services whether they offer coverage to their employees, the types of coverage, and the social security numbers and names of full-time employees that are receiving coverage.



Automatic Enrollment:
In 2014, employers may have waiting periods of 90 days before they offer health coverage to their new employees. Aſter 90 days, employers with more than 200 employees will be required to automatically enroll their employees in their health beneýt plan. However, employees will be given the opportunity to opt out.

New Benefit Standards:

Beginning in 2014 all new health policies including those offered through newly created state based exchanges and those offered outside the exchanges must comply with one of four (4) beneýt categories (bronze, silver, gold, and platinum). The new beneýts standards will be comprised of a comprehensive set of services that cover at least 60 percent of the actuarial value of the covered beneýts. "Grandfathered In" plans do not have to meet the new beneýt standards. The essential beneýts package will be deýned and updated annually by the Government through a transparent and public process.

State Based Exchanges:
States are required to create health insurance exchanges offering the essential beneýts packages discussed above beginning in 2014. The Exchanges will initially be open to individuals and small employers with 100 or fewer employees; unless a State wants to limit this number further (e.g. 50 employees). States may allow employers with more than 100 employees to participate in the exchange beginning in 2017. Funding will be made available to States to set up exchanges within one year of enactment and until January 1, 2015. Eligibility to purchase coverage through an Exchange is restricted to U.S. Citizens and legal immigrants who are not incarcerated.

Excise Taxation of "Cadillac" Plans:
To help fund health care reform the Act imposes, beginning in 2018, an excise tax upon insurers of employer sponsored health plans and upon employers that self-insure. A 40% excise tax will be imposed on employment based plans whose premium exceeds $10,200 for individuals, $27,500 for family plans, $11,850 for retirees, and $30,950 for employees in high risk occupations, indexed for inþation. The tax could be on the amount that exceeds the limits above and would be paid for by insurers or the case of a self-insured plan, by the employer. The tax combines the value of the health plan and includes reimbursements under a þexible spending account ("FSA") for medical expenses, or health reimbursement arrangement ("HRA"), employer contributions to a health savings account ("HSA"), and coverage for supplementary health insurance coverage. However, dental and vision costs are not included for excise tax purposes. The threshold amounts, above, may be adjusted upward if health care costs rise more than anticipated by 2018.

Medical Loss Ratio:
Medical loss ratio is the percentage of health insurance premium dollars that are required to be spent on clinical services and quality health care activities. This ratio is important because the Act imposes new medical loss ratios on health insurers. Beginning in 2011, large fully-insured group health plans, including "Grandfathered In" plans that spend less than 85% of premium dollars on clinical services and activities that improve health care quality must rebate the difference to enrollees.

CONCLUSION

The Act is sweeping and wide ranging in its impact and will impose many new requirements on Employers and Individuals. As the 20-state lawsuit against this federal law develops, and new information comes available, the NWA will endeavor to work with our partners such as Western Growers Association to keep you informed. There will be more to come as the weeks, months and years for full enactment of this law take effect. Our goal is to enhance your profitability and keep you alert to federal mandates. Let us know how we can help.

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