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How Health Care Reform Impacts You

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Agenda

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2 – Foundation concepts

a. Employee

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3 – Current Issues

a. Legislative Update

b. Changes in place already

4 – Grandfather Plan Status

5 – Timeline of Changes 2010 - 2014

Overview

Health Care Reform represents a sweeping change to the nation's health care system. Most of the early provisions will be in the form of marketplace reform, which will be felt by employers but won't be employer-driven. As we approach 2014, employers will increasingly need to take action in implementing reforms.

How did we get here? In December 2009, the Senate passed the "Patient Protection & Affordable Care Act" (H.R. 3590). On March 18, 2010, the House Rules Committee released the "Health Care & Education Affordability Reconciliation Bill of 2010." ("Reconciliation measure") This bill, which was signed into law by the President on March 23, 2010, modifies provisions in the health care reform measure previously passed by the Senate. The combined package is now the law of the land.

Overview (continued)

This law is estimated to cost more than $940 billion ($940,000,000,000.00) over the next ten years. That cost is expected to be offset by $438 billion of new taxes plus $500 billion of anticipated decreases in healthcare spending (largely in Medicare). It is focused on insuring an estimated 32 million of the currently 54 million uninsured Americans.

Employee v. Independent Contractor

This is not a simple distinction, because each situation is based on the facts and circumstances. The more control a company has over how, when, where and by whom work is performed, the more likely workers are employees rather than independent contractors. According to the IRS, some factors to consider in defining the relationship include the following:

- Level of instruction
- Amount of training
- Degree of business integration
- Extent of personal services
- Control of assistants
- Continuity of relationship
- Flexibility of scheduling
- Demand for full-time work
- Need for on-site services
- Sequence of work
- Reporting requirements
- Method of payment
- Payment of business or travel expenses
- Provision of tools and materials
- Investment in facilities
- Realization of profit or loss
- Work for multiple companies
- Availability to the public
- Control over discharge
- Right of termination

Penalties or Taxes?

ERISA Penalties – All of the individual and group market reforms apply to group health plans, and to health insurance issuers providing health insurance coverage, as if the provisions were included in the Employee Retirement Income Security Act (ERISA). ERISA gives participants a private right of action, and allows for a penalty of $100 per day per violation to be imposed.

Non-qualified withdrawal penalty on Health Savings Accounts (HSA) raised from 10 percent to 20 percent effective 1/1/2011.

Medicare tax of 0.9 percent on earned income, and 3.8 percent tax on unearned income, both subject to minimum income thresholds effective 1/1/2013.

Employers subject to $2,000 per employee (first 30 employees excluded) effective 1/1/2014.

Failure to meet individual responsibility to participate in a plan results in a penalty up to $695 (or 2.5 percent of income) effective 1/1/2014.

Excise Tax on "Cadillac" Plans effective 1/1/2018

In Effect Now – Healthcare Related

Temporary High Risk Pool – The Act mandates establishment of a temporary insurance program that will exist from June 21, 2010 to January 1, 2014, for individuals who have preexisting conditions and who have not had group health plan coverage for at least six months. Employers are prohibited from doing anything to encourage employees from moving from employer-provided coverage to the high risk pool, and the penalty for doing so is being required to reimburse the program for the cost of coverage for the high-risk individual. People who already participate in high risk pools established by their state must drop their coverage for six months before being eligible for the federal plan.

In Effect Now – Healthcare Related?

Reasonable Break Time for Nursing Mothers -- Fair Labor Standards Act is amended to require employers to provide reasonable break time to allow an employee to express breast milk. Such breaks must be provided for up to one year after the birth of the child. The employer must provide a place for the employee to use for this purpose, other than a bathroom. The area must be shielded from view, and free from intrusion. A "reasonable" number of breaks is not defined in terms of frequency or length. Breaks are not required to be compensated. Employers with fewer than fifty employees may be exempt from the requirement, if they can show that providing such breaks or private area would cause an "undue hardship."

Nutrition Information -- Chain restaurants that have more than twenty locations must post nutrition information for the food items they serve. To assist the public in understanding, in the context of a total daily diet, the significance of the caloric information that is provided on the menu," such restaurants will be required to post a "succinct statement concerning suggested daily caloric intake."

Grandfathered Plans – Changes

A "grandfathered" plan is any plan in which an individual is enrolled – either directly or through any group plan – on the date of enactment, **March 23, 2010**.

For group plans, new beneficiaries can be added to the plans without affecting the "grandfather" status.

As a general matter, grandfathered plans are exempt from all of the market reforms included in the bill. However, there are some notable exceptions. **"Grandfathered" plans will be subject to the following new requirements** for plan years beginning six months after enactment, which is March 23, 2010. This includes existing self-insured plans unless an exception is noted.

- No lifetime coverage limits for essential benefits
- No annual coverage limits on essential benefits except as may be permitted by the department of Health and Human Services
- **See this list continued on the next slide**

Grandfathered Plans – Changes (continued)

List continued:

- No pre-existing conditions exclusions for children up to the age of 19
- Extension of dependent coverage until the dependent turns 26 years old (Until 2014, grandfathered group coverage need not be extended to a dependent that is directly eligible for employer-provided coverage.)
- New coverage disclosure rules
- The medical loss ratio/rebating-related informational filing requirements (does not apply to self-insured plans)
- A ban on policy rescissions except in cases of fraud
- In 2014 – No pre-existing conditions exclusions for anyone
- In 2014 – A ban on imposing waiting periods on plan participation in excess of 90 days

Non-Grandfathered Plans

Non-grandfathered plans must comply with the following additional new requirements:

- Mandated offering of free preventive services (2010)
- Mandatory appeals process rights/notice (2010)
- Primary care physician designation right for plan participants (2010)
- Section 105(h) non-discrimination rules (2010)
- **See this list continued on the next slide**

Non-Grandfathered Plans (continued)

List continued:

- Premium increase reviews (does not apply to self-insured plans) (2011)
- Plan quality reporting obligation to enrollees/HHS (2012)
- Out-of-pocket limitations (equal to the out-of-pocket limits for high deductible health plans for Health Savings Accounts) (2014)
- Clinical trial participation right (2014)
- And all non-grandfathered small group (<100) and individual plans also must comply with the following new requirements:
    - Provide "essential benefits" package and 60 percent minimum plan value (2014)
    - Community rating/no medical underwriting (2014)

Grandfathered Plans – Loss of Status

Interim final regulations: These interim final regulations provide that a group health plan or health insurance coverage no longer will be considered a Grandfathered health plan if a plan sponsor or an issuer:

- Changes insurance carriers-not applicable to self-funded plans changing TPA
- For a group health plan or group health insurance coverage, an employer or employee organization decreases its contribution rate by more than five percentage points below the contribution rate on March 23, 2010; or
- With respect to annual limits, a group health plan or group or individual health insurance coverage, that, on March 23, 2010:
    1. did not impose an overall annual or lifetime limit on the dollar value of all benefits imposes an overall annual limit on the dollar value of benefits;
    2. imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010; or
    3. imposed an overall annual limit on the dollar value of all benefits decreases the dollar value of the annual limit

Grandfathered Plans – Loss of Status (con't)

Interim final regulations: These interim final regulations provide that a group health plan or health insurance coverage no longer will be considered a Grandfathered health plan if a plan sponsor or an issuer:

- Increases fixed-amount cost-sharing requirements other than copayments, such as a $500 deductible or a $2,500 out- of-pocket limit, by a total percentage measured from March 23, 2010 that is more than the sum of medical inflation and 15 percentage points
- Increases copayments by an amount that exceeds the greater of: a total percentage measured from March 23, 2010 that is more than the sum of medical inflation plus 15 percentage points, or $5 increased by medical inflation measured from March 23, 2010
- Increases a percentage cost-sharing requirement (such as coinsurance) above the level at which it was on March 23, 2010
- Eliminates all or substantially all benefits to diagnose or treat a particular condition. The elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition

Grandfathered Plans - Clarifications

Additional Clarifications:

- The requirement that employers extend coverage to employees' adult children up to age 26 does not apply to Grandfathered plans until Jan. 1, 2014 in cases where the adult child is eligible for coverage through his or her own employer.

- Plans that have already made changes that would cause them to lose grandfathered status will have a chance to revoke those changes so that they can preserve grandfathered status.

- Retiree-only health plans are automatically exempt from health care reform requirements. Dental-only and vision-only plans do not have to comply with market reforms.

2010

Insurance Market Reforms	Provisions Impacting Employers	Employer Action Items	When
• Eliminates pre-existing condition exclusions for children. • Bans lifetime and annual coverage limits as determined by HHS. • Extends eligible dependent coverage to age 26. • Requires first dollar coverage for preventative health care. • Eliminates health care coverage cancellation based on health status. • Establishes medical loss ratios for insurance carriers. For plan years beginning six months after enactment, which is March 23, 2010, carriers below the medical loss ratio will be required to rebate the amount to members (80 percent for small group plans and 85 percent for large group plans. Self-insured plans are excluded). • Fosters wellness initiatives. • Adds disclosures for rate increases.	**Coverage Provisions** No lifetime maximums; no "restrictive" annual maximums; adult children covered to age 26 (if not eligible for other employer plan); no pre-existing condition exclusions for children under age 19.	• Conduct actuarial valuations. • Update administrative system and procedures • Communicate plan design changes before and during 2011 open enrollment. • Update SPDs, Plan Documents and HIPAA certificates.	Upon renewal, beginning with plan years renewing 9/23/10 or later
	Retiree Drug Plan Adjust FAS 106/FAS 109 liability for impact of change to tax status of Retiree Drug Subsidy effective Jan. 1, 2013.	• Employers must conduct actuarial estimates	2010/ first quarter financial statements
	Early Retiree Reinsurance Program Reimbursement of 80 percent of claims between $15,000 and $90,000 for retirees age 55-64. Funds are only available until 2014 or whenever the funding is exhausted. The plan must have cost management programs in place.	• 90 days after health care reform is enacted, employers should reevaluate their current retiree medical plan to determine whether its currently eligible / determine if plan design changes are needed. • Apply for claim reimbursement through HHS. • Communicate plan design changes.	Beginning 2010
	Appeals Process Internal and external claim appeals processes are mandatory, subject to regulatory guidance, for plan years beginning six months after enactment, which is March 23, 2010.	• Update materials including SPDs and Plan Documents. • Update current procedures.	Upon renewal, beginning with plan years renewing 9/23/10 or later

Subsidies for Small Employers

Phase I – 2010

Phase I of the Small Business Tax Credit: For tax years 2010 through 2013, this provides a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost or 50 percent of a benchmark premium. In this provision, a small employer is an employer with no more than 25 employees and average annual wages of less than $50,000 that purchases health insurance for employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000.

*For tax-exempt organizations the credit from 2010 through 2013 is 25 percent and can be used to reduce the federal withholding or Medicare taxes remitted.

Subsidies for Small Employers (continued)

Phase II – 2014 and later for only two years

Phase II of the Small Business Tax Credit would provide a tax credit of up to 50 percent of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the total premium cost. The credit will be available for two years. In this provision, a small employer is an employer with no more than 25 employees and average annual wages of less than $50,000 that purchases health insurance for employees. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000.

*For tax-exempt organizations the credit for 2014 and later years is 35 percent and can be used to reduce the federal withholding or Medicare taxes remitted.

Subsidies for Small Employers (continued)

- Exclusions from all of the components of the calculations include the following:
  - Self employed individuals such as partners, sole proprietors, 2 percent (or more) shareholders in S-corporations, and 5 percent (or more) owners of the employer
  - Family members of the owners
  - Seasonal employees (work less than 120 days per calendar year)
- Computation of number of employees:
  - Include hours from everyone other than the excluded employees listed above
  - Maximum of 2,080 hours for any single employee
  - Divide the total by 2,080 hours
- Use Form 8941 to claim the credit – currently in draft form only

2011

Insurance Market Reforms	Provisions Impacting Employers	Employer Action Items	When
• Standardized definition of qualified medical expense for HSA, FSA, HRA (non-prescribed OTC drugs will be eliminated). Increased tax on Non-Qualified medical expense distributions from HSA and MSA from 10 percent to 20 percent.	**CLASS Act** The voluntary, federal long-term care plan for employees is introduced.	• Employers decide whether they wish to participate. If yes, update administrative and payroll systems and procedures. • Remit enrollment information and premiums to trust fund. • Communicate financial reality of long-term care and opportunity to employees.	1/1/11
	Health-Related Accounts OTC drugs require a prescription to be reimbursed through FSA, HRA and HSA. For HSAs, the non-qualified withdrawal penalty is raised to 20 percent (from 10 percent).	• Communicate new rules before and during open enrollment, and change administrative procedures. • Update materials including SPDs and Plan Documents.	1/1/11
	Reporting Value of medical plan benefits to be disclosed annually on W-2. (FSAs, stand-alone dental and vision are excluded). **See next slide.**	• Calculate and report value of health benefits to payroll and help employees interpret and understand the new information they are receiving.	The reporting deadline is for the 2011 Form W-2, which is generally Jan. 31, 2012.
	Auto Enrollment Employers with more than 200 employees would be required to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. The effective date of this provision requires clarification from regulators.	• Update administrative procedures and systems. • Revise new hire enrollment materials; provide adequate notice about opting out. • Update materials including SPDs and Plan Documents.	It is likely to take effect after the Secretary of Labor issues implementation rules, which may occur in 2010.

2011 Reporting Updates

- W-2 – The new reporting requirement has been made optional for the calendar year 2011 per Notice 2010-69. However, employers will be required to comply with this for 2012 Form W-2, which are generally due January 31, 2013.

- 1099 – Effective for calendar year 2011, two primary exclusions to the 1099 reporting rules were repealed.

  - First, the exclusion for recipients who are corporations is repealed.

  - Second, the exclusion for recipients who were paid for products and goods is repealed.

  - Effectively, businesses are now required to provide 1099's to any person or business that is paid more than $600 for anything (other than wages, which are reported on Form W-2).

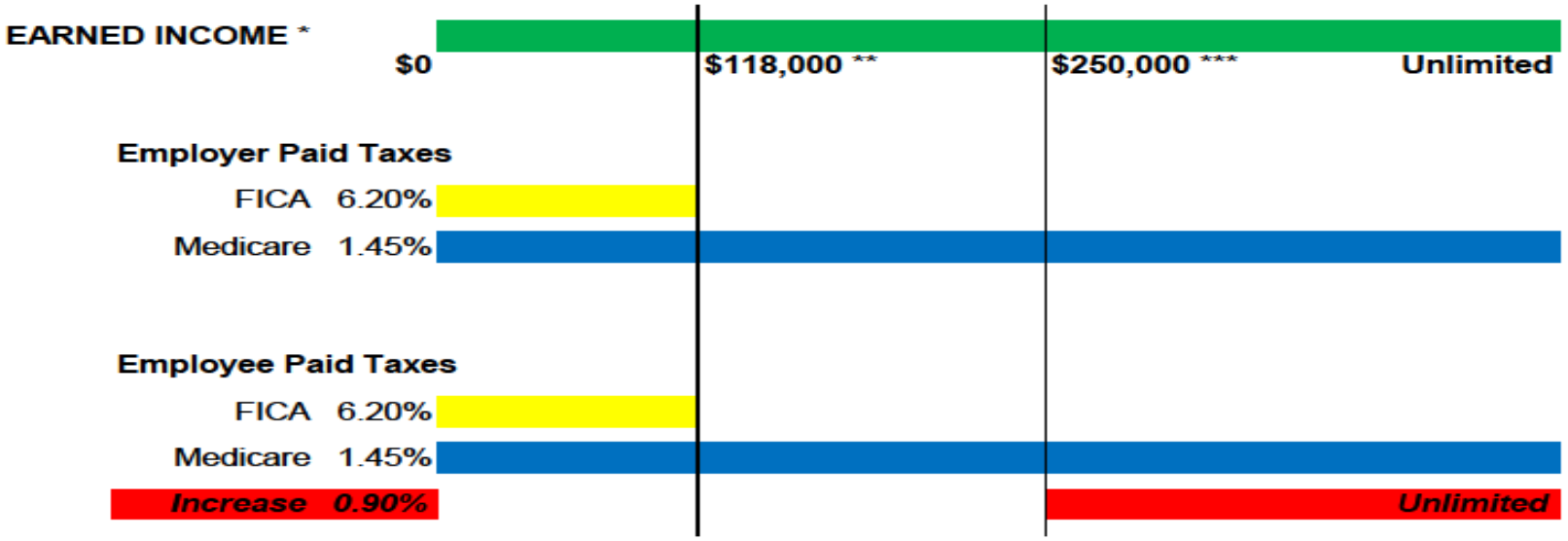
2012

Insurance Market Reforms	Provisions Impacting Employers	Action Items	When
None	**Reporting** Quality of care reports are required by HHS.	• Track measures required by HHS, develop a reporting format	1/1/12
	Summary of Benefits and Coverage Insurers of insured health plans and plan administrators of self-insured health plans are required to provide applicants and enrollees a "summary of benefits and coverage" before enrollment or re-enrollment. Summaries must be no longer than four pages and meet specific requirements for appearance (e.g., no print smaller than 12-point font), language (e.g., understandable by the average plan enrollee), and content (e.g., uniform definitions, co-payments and other cost-sharing provisions, etc.). Regulations will be issued to address these summaries no later than 12 months after the enactment date. Carriers will be charged with developing these summaries for fully insured plans.	• Develop / send out these summaries 60 days prior to renewal date	Upon renewal, beginning with plan years renewing 1/1/12
	Comparative Effectiveness Fee A fee of $1 per participant in the first year and $2 per participant thereafter must be paid by the employer. The fee ends in plan years after Sept. 30, 2019.	• Estimate fee and await guidance on payment	2012

2013

Insurance Market Reforms	Provisions Impacting Employers	Employer Action Items	When
• Co-ops are implemented: A $6 billion appropriation by July 1, 2013 fosters multi-state purchasing. • Revenue generation: Cap contribution on medical FSAs at $2,500 • Revenue generation: 0.9 percent increase in Medicare tax for high income individuals ($200,000 individual, $250,000 couples; The individual will bear the full impact; the 0.9 increase is not split employer / employee). • Revenue Generation: 3.8 percent Medicare tax on net investment income for individuals meeting those thresholds.	**FSA Requirements** $2,500 limit, indexed to CPI.	• Change administrative system • Communicate new rules for 2013 open enrollment • Update SPDs, Plan Documents and HIPAA certificates	Calendar year beginning 1/1/13
	Retiree Drug Plan The Retiree Drug Subsidy (RDS) becomes taxable.	• Reevaluate retiree drug strategy and consider alternatives • Adjust administrative procedures to accommodate any changes • Communicate changes and rationale to employees	Calendar year beginning 1/1/13
	Medicare Taxes Medicare taxes go into effect for high income individuals and couples.	• Update payroll to withhold at higher rates for employees only (may disregard spouses' income)	Calendar year beginning 1/1/13
	Notifications Notify all employees about Exchanges, eligibility and their services and contact information.	• Develop a process for notifying employees about Exchanges • Create a notice to send to employees (A model notice is anticipated via regulation)	On or before 3/2/13

0.9% Increase in Medicare Tax



* Earned Income includes wages and income subject to self employment tax such as active interests in partnerships or working interests in oil & gas.

** Estimated OASDI Maximum Base for 2013

*** $250,000 for Married Taxpayers Filing Jointly; $200,000 for Single filers

3.8% Tax on Unearned Income

The tax applies to individuals, trusts, and estates. It does NOT apply to "C" corporations.

The tax applies to the lesser of unearned income or the excess of Modified Adjusted Gross Income above defined threshold amounts for taxpayers of each filing status:

$250,000 Married Filing Jointly

$200,000 Single

$125,000 Married Filing Separately

$11,000 Trusts and Estates

3.8% Tax on Unearned Income (continued)

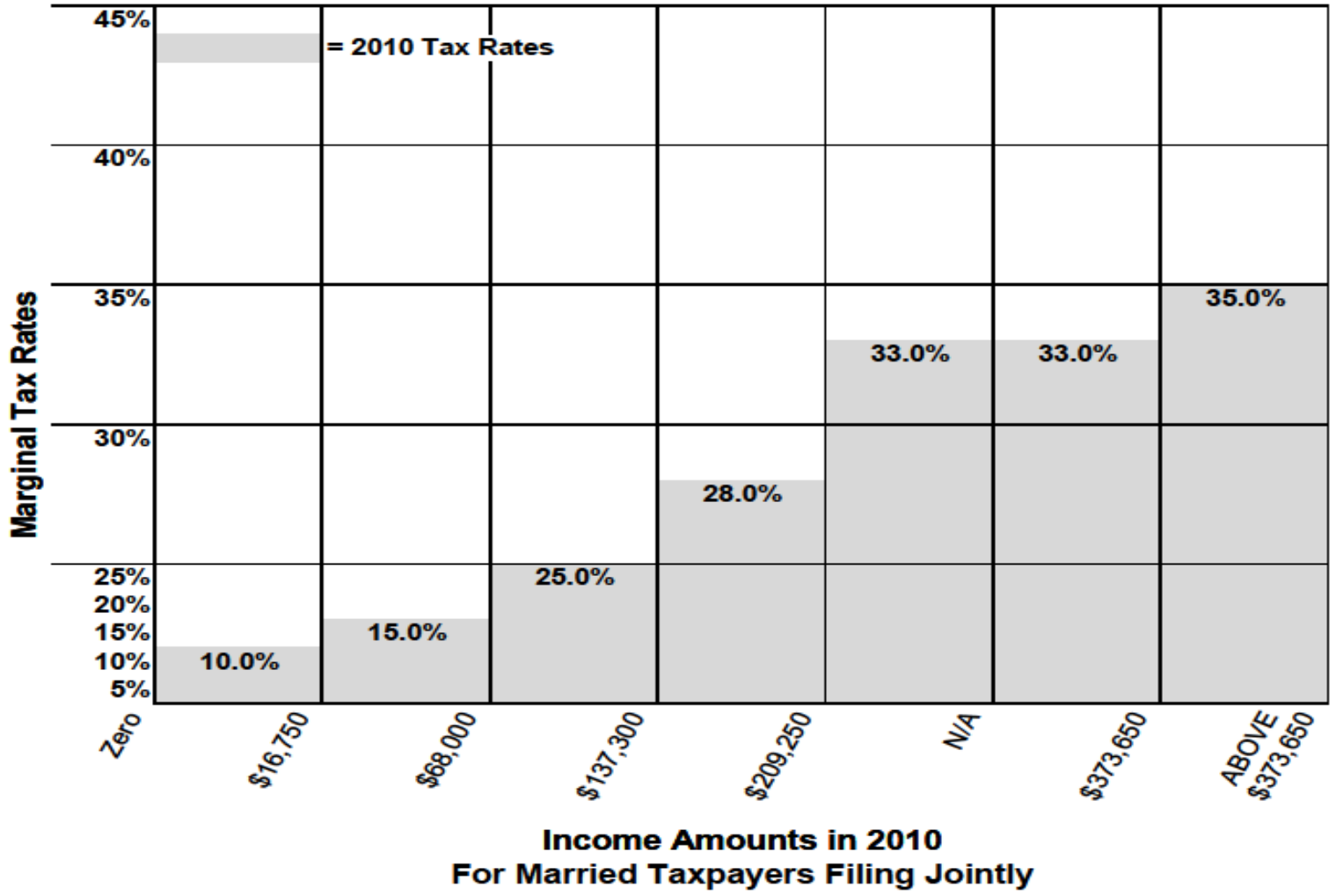
Unearned Income INCLUDES the following:

- Interest
- Dividends
- Capital Gains
- Rents (unless active trade or business of rental activities)
- Royalties
- Passive Income from partnerships and s-corporations

Unearned Income EXCLUDES the following:

- Municipal Bond Interest
- Income from partnerships and s-corporations in which the taxpayer actively participates
- IRA and other qualified retirement plan distributions
- Other income on which self employment taxes are paid

3.8% Tax on Unearned Income (continued)



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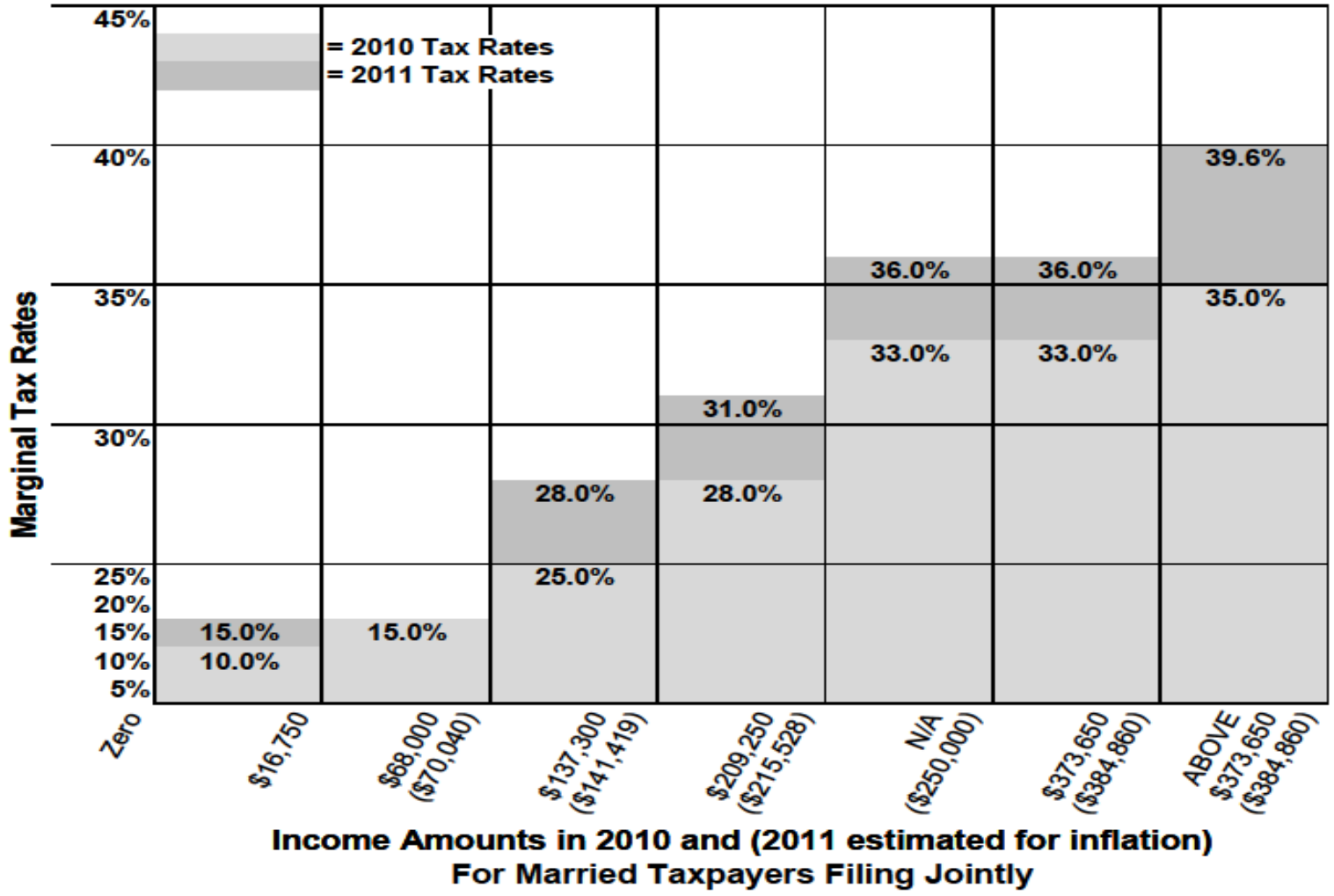
3.8% Tax on Unearned Income (continued)



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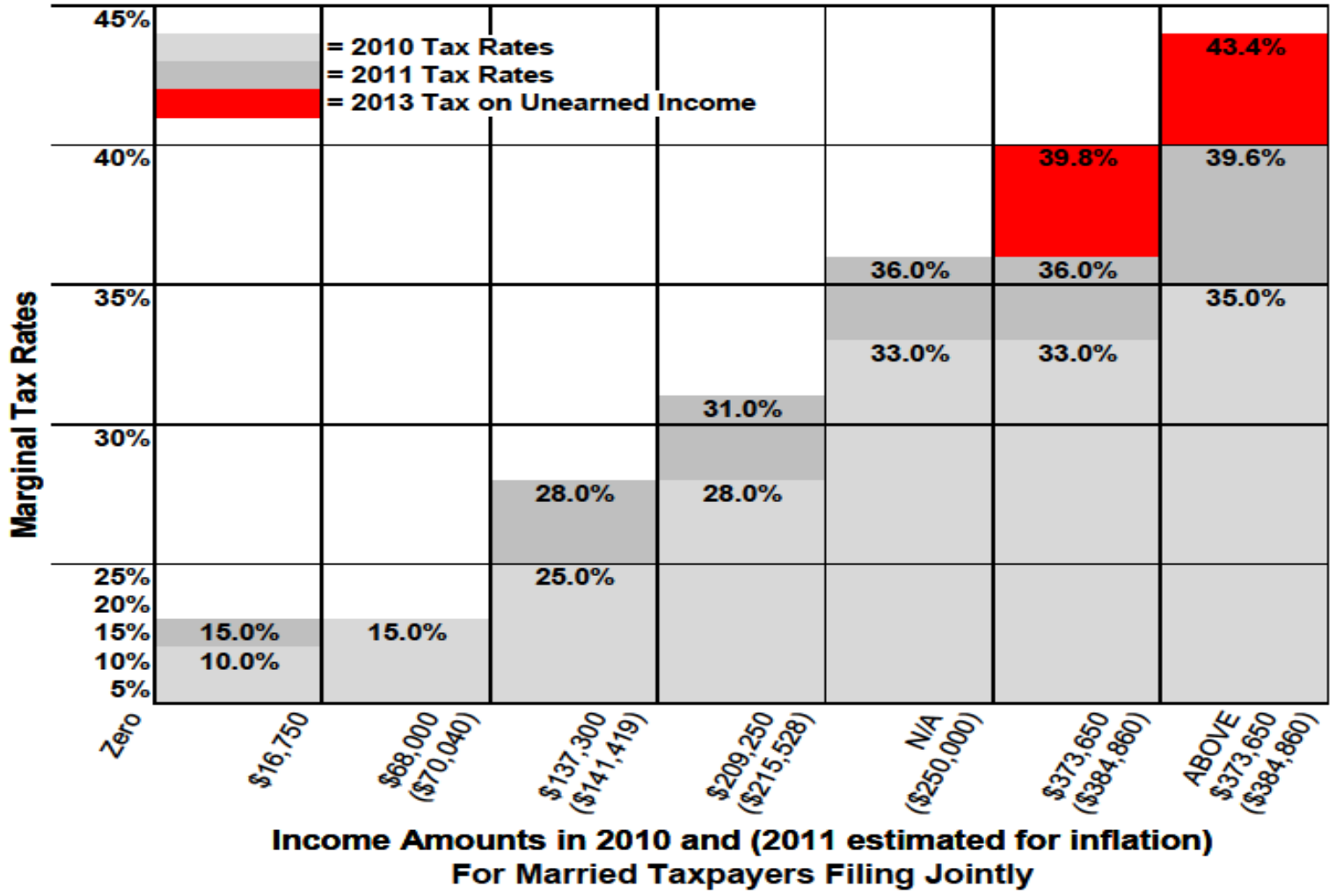
3.8% Tax on Unearned Income (continued)



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2014

Insurance Market Reforms	Provisions Impacting Employers	Employer Action Items	When
• State-based Exchanges established. • Generally, employers with more than 50 employees must offer coverage. • Required to offer at least the essential health benefits package. • Requires guaranteed issue and guaranteed renewal. • Prohibited from denying coverage for pre-existing conditions for any covered person. • Exchanges are limited in rating variation based on age, rating area factor, family composition and tobacco use. • Allows states to merge individual and small group markets.	**Insurance offerings must comply with the following:** • Insurance for full-time employees (over 30 hours) • 60 percent minimum actuarial value • No waiting periods over 90 days • No pre-existing conditions exclusions • No Annual Limits • Affordability threshold of 9.5 percent of AGI • Penalty of $3,000-per-employee receiving federal subsidy or $2,000-per-employees, first 30 employees excluded • Free choice vouchers between 8.0 percent and 9.8 percent of AGI, age-rated.	• Verify that all plan designs qualify as "minimum essential coverage" • Change waiting period definition, if applicable • Update administrative system. • Estimate potential population that could qualify for subsidies or free choice vouchers • Provide reporting to the government • Communicate plan design changes • Explain how to use vouchers • Update SPDs, Plan Documents, HIPAA certificates	Effective for plan years beginning on or after 1/1/14
	Employers will have a role in communicating to employees about broader market reforms: • Exchanges established. • Individual responsibility to purchase insurance (phased-in penalty of up to $695 or 2.5 percent of income). • Individuals must be enrolled in a plan with 100 percent of preventive care covered to satisfy responsibility. • Subsidies from 133 percent to 400 percent of Federal Poverty Level (est. $5,200 in 2015, $6,000 in 2019). • Fees on insurance companies.	• Communicate opportunities, requirements and penalties during open enrollment within broader context of overall strategy • Reflect in premiums if any new fees are passed through on insured (and potentially self-insured) renewals	Beginning 1/1/14

2014 (continued)

Insurance Market Reforms	Provisions Impacting Employers	Employer Action Items	When
• See previous page	**Wellness Program Rewards Cap** The cap on rewards for participating in wellness programs is increased from 20 percent to 30 percent of the cost of the employee's coverage. A state pilot program will be created to permit participating states to apply similar rewards for participating in wellness programs in the individual market.	• Evaluate your approach to wellness incentives • Review process for administering incentives if the approach changes • Engage employees in new incentives and wellness initiatives in order to promote better health and increased productivity • Reporting on the effectiveness and impact of wellness programs will be required	1/1/14

Beginning in 2014, large employers (those with 50 or more FTE employees) will have the option of providing health insurance to employees. If a large employer chooses not to provide health insurance coverage, the employer will be required to pay $2,000 for every FTE employee, but the first thirty employees will not be counted.

Those who do offer insurance must provide "minimum essential coverage." Even if they do so, they may be subject to a penalty ($2,000 for every FTE employee, minus the first thirty employees) if one or more employees opt to instead purchase coverage through an insurance exchange, and receive government assistance to do so.

2015 & Beyond

Additional provisions go into effect after 2014. Regulatory activity will shape how these future provisions will be enacted, therefore we believe it's premature to go into detail at this time. Work with your insurance broker and your tax and legal counsel to navigate the additional changes ahead.

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