

HEALTHCARE REFORM SUMMARY FOR EMPLOYERS

Presented By: Preferred Benefits Services Agency Inc.



HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
EXPANSION OF COVERAGE REQUIREMENTS	
<p>No Lifetime or Annual Coverage Limits</p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • <u>Group Health Plans</u> (self and fully insured) may not establish any lifetime limits or annual limits on the dollar value of benefits for any participant or beneficiary. <ul style="list-style-type: none"> ➤ Group Health Plans may still place annual or lifetime limits on specific covered benefits that are <i>not</i> <u>Essential Health Benefits</u>. ➤ For plan years beginning prior to 2014, Group Health Plans may place reasonable restrictions on annual limits, but not lifetime limits) that apply to Essential Health Benefits. • This requirement applies to <u>Grandfathered Plans</u>.
<p>Extension of Dependent Coverage</p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • Group Health Plans (self and fully insured) that provide dependent coverage of children must continue to make such coverage available for an adult child until the child turns age 26. • Coverage provided to adult children who as of the end of the tax year have not turned age 27 will not result in imputed income to the employee. • This requirement applies to Grandfathered Plans. However, for plan years beginning before January 1, 2014, this rule applies to Grandfathered Plans that are Group Health Plans only if the adult child is not eligible to enroll in any other <u>Eligible Employer Sponsored Health Plan</u>.
<p>Rescission of Coverage Prohibited</p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • Group Health Plans (self and fully insured) are prohibited from rescinding coverage with respect to a participant once covered, except in the event of fraud or intentional misrepresentation. • This requirement applies to Grandfathered Plans.

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
EXPANSION OF COVERAGE REQUIREMENTS	
<p>Cost Ratio Requirements</p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • Beginning no later than January 1, 2011, a <u>Health Insurance Issuer</u> offering Group Health Plans, including Grandfathered Plans, must provide an annual rebate to each enrollee on a pro rata basis if the ratio of the amount of premium revenue expended by the issuer on (i) reimbursement for clinical services provided to enrollees and (ii) for activities that improve healthcare quality, to the total amount of premium revenue is less than 85% in the large group market or 80% in the small group market. • A Health Insurance Issuer must also provide an annual report to the Secretary of Health and Human Services concerning its medical loss ratio. • The National Association of Insurance Commissioners, subject to certification by the Secretary of the Health and Human Services, is required to establish a uniform definition of the phrase “activities that improve health care quality” no later than December 31, 2010 • This requirement applies to Grandfathered Plans.
<p>Prohibition on Pre-Existing Condition Exclusions</p> <p><i>Effective for plan years beginning on or after January 1, 2014; however, for all enrollees < age 19, effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • Group Health Plans (self and fully insured) may not impose any pre-existing condition exclusions. • This requirement applies to Grandfathered Plans.
<p>Waiting Period Restrictions</p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p>	<ul style="list-style-type: none"> • Group Health Plans (self and fully insured) may not impose any waiting period in excess of 90 days. • This requirement applies to Grandfathered Plans.

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
EMPLOYER COVERAGE RESPONSIBILITIES	
<p>Penalties for Employers <i>Not Offering Coverage</i> <i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> • This penalty applies to <u>Large Employers</u> that employed an average of at least 50 FTEs in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (i.e., whether the employer employed an average of at least 50 full-time employees on business days during the preceding calendar year), but they are <i>not</i> counted to determine the amount of the penalty. • If a Large Employer with at least 50 FTEs (including FTE equivalents): <ul style="list-style-type: none"> ➤ <i>Does not provide</i> health coverage to its FTEs in any month; <i>and</i> ➤ At least one FTE of the employer enrolls in an Exchange and qualifies for a <u>Premium Tax Credit</u> or <u>Cost Sharing Reduction</u> for that month, <p>The employer must pay a penalty for that <i>month</i> equal to:</p> <p style="text-align: center;">Total number of FTEs x \$166.67 Or for that <i>year</i> equal to: Total number of FTEs x \$2,000</p> • In calculating this penalty, the first 30 FTEs do not count. • After 2014, the penalty amounts are subject to an inflation adjustment formula in the Act. • When no employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400% of the federal poverty line).

HealthCare Reform Summary for Employers

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EMPLOYER COVERAGE RESPONSIBILITIES	
<p>Penalties for Employers <i>Offering Coverage</i></p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> • This penalty applies to <u>Large Employers</u> that employed an average of at least 50 FTEs in the preceding year, applying the controlled group rules. FTEs are employees who work an average of 30 hours per week. FTE equivalents are counted to determine if the employer is subject to this penalty (i.e., whether the employer employed an average of at least 50 full-time employees on business days during the preceding calendar year), but they are <i>not</i> counted to determine the amount of the penalty. • If a Large Employer with at least 50 FTEs (including FTE equivalents): <ul style="list-style-type: none"> ➢ <i>Provides</i> qualifying health coverage to its FTEs in any month; <i>and</i> ➢ At least one FTE of the employer enrolls in an Exchange and qualifies for a <u>Premium Tax Credit</u> or <u>Cost Sharing Reduction</u> for that month, <p>The employer must pay a penalty for that <i>month</i> equal to the lesser of:</p> <p style="text-align: center;">Total number of FTEs receiving a Premium Tax Credit and/or Cost Sharing Reduction x \$250</p> <p style="text-align: center;">or</p> <p style="text-align: center;">Total number of FTEs x \$166.67</p> <p>Or for that <i>year</i> equal to the lesser of :</p> <p style="text-align: center;">Total number of FTEs receiving a Premium Tax Credit and/or Cost Sharing Reduction x \$3,000 or total number of FTEs x \$2,000</p> • In calculating this penalty, the first 30 FTEs do not count. • After 2014, the penalty amounts are subject to an inflation adjustment formula in the Act. • An employer is not assessed a penalty with respect to any employee receiving a free choice voucher (see below). • When employer coverage is offered, an employee is eligible for a Premium Tax Credit or Cost Sharing Reduction if the employee meets the income requirements for such assistance (generally must have a household income between 133-400% of the federal poverty line); <i>and</i> either: <ul style="list-style-type: none"> ➢ The employee’s contribution under the employer plan exceeds 9.5% of household income (indexed after 2014); <i>or</i> ➢ The employer plan pays less than 60% of the total cost of benefits provided under the plan.

HealthCare Reform Summary for Employers

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EMPLOYER COVERAGE RESPONSIBILITIES	
<p>Employers Offering Coverage: Free Choice Vouchers for Certain Low-Income Employees</p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> • Employers that offer <u>Minimum Essential Coverage</u> to employees and pay a portion of the premiums of that coverage are required to provide vouchers to eligible employees for purchase of coverage in an <u>Exchange</u>. • An employee is eligible if the employee's required premium contribution under the employer's health plan is between 8% and 9.8% of the employee's household income for the year, the employee's household income does not exceed 400% of the federal poverty line, <i>and</i> the employee does not participate in the employer's plan. The percentages are indexed after 2014. • The voucher equals the amount the employer would have paid to provide single coverage for the employee under the plan (or family coverage if elected by the employee) with respect to which the employer pays the largest portion of the cost of the plan. • The employer is required to pay the voucher amounts to the Exchange, and the Exchange is required to credit the amount of any voucher to the monthly premium of any <u>Qualified Health Plan</u> in the Exchange in which the qualified employee is enrolled. • The voucher amount is not taxable to the employee to the extent used to pay for coverage on the Exchange. • Any amount of the voucher in excess of the cost of coverage on the Exchange is paid to the employee, but is taxable. • Employers may deduct the amount of a free choice voucher as an amount for compensation for personal services actually rendered. • Employers are not required to pay any penalties with regard to employees to whom they provide free choice vouchers.
<p>Automatic Enrollment for Employers Offering Coverage</p> <p><i>Effective by regulation.</i></p>	<ul style="list-style-type: none"> • Employers with more than 200 FTEs that offer health coverage are required to automatically enroll new full-time employees, subject to any waiting period of 90 or less days. • Automatic enrollment must include adequate notice and opportunity for an employee to opt out of coverage.

HealthCare Reform Summary for Employers

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EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES	
<p>Uniform Notice of Coverage Requirements</p> <p><i>Effective for plan years beginning on or after September 23, 2010.</i></p>	<ul style="list-style-type: none"> • By March 23, 2012, plan administrators, sponsors and insurers must provide a summary of benefits and coverage explanation that accurately describes benefits and coverage under the Group Health Plan to participants prior to enrollment. The summary must be presented in a culturally and linguistically appropriate manner utilizing terminology understandable by the average plan enrollee. • The content and format is prescribed by statute and standards developed by the Secretary of Health and Human Services. The summary must state whether the Group Health Plan: <ul style="list-style-type: none"> ➢ Provides Minimum Essential Coverage: and ➢ Pays less than 60% of the total cost of benefits provided under the plan. • In addition, the summary must provide information such as; a description of coverage and cost-sharing under the plan; exceptions, reductions and limitations on coverage; renewability and continuation of coverage provisions; a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions; and contact numbers and web addresses where the actual group certificate or policy may be obtained. • Plan administrators/sponsors and insurers of group health plans must provide notice to participants of any material modification to the Group Health Plan terms or coverage no later than 60 days prior to the effective date of the change. • Penalty for willful noncompliance is \$1,000 per failure.
<p>Reporting to Internal Revenue Service of Health Insurance Coverage</p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> • Employers that provide Minimum Essential Coverage are required to file a report with the Internal Revenue Service by January 31 of the following year that provides information about the employees who are covered by the Minimum Essential Coverage, the portion of the premium (if any) required to be paid by the employer, and such additional information as may be required if the Minimum Essential Coverage is offered through an Exchange. • The employer must provide to each employee included in the report a statement showing the information reported with respect to that employee.

HealthCare Reform Summary for Employers

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EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES	
<p>Large Employer Reporting to Internal Revenue Service Regarding Coverage Offered</p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> Large Employers (for purposes of applying the employer penalties) are required to file a report with the Internal Revenue Service by January 31 of the following year that provides certification as to whether the employer offers FTEs the opportunity to enroll in Minimum Essential Coverage through an Eligible Employer Sponsored Health Plan, and if so, information on the length of waiting periods imposed, costs of premiums, total cost paid by the employer, number of FTEs, and information on each FTE and the months covered under the plan. The information required to be reported must also be provided in a statement to each FTE.
<p>Employee Notices Regarding Exchange</p> <p><i>Effective March 1, 2013.</i></p>	<ul style="list-style-type: none"> Employers must provide written notices to employees regarding the Exchange at the time of hire for new employees and for all other employees by March 1, 2013. The notice must inform the employee of: the existence of an Exchange, its services, and how to contact the exchange; that if the employer plan's share of the total allowed costs of benefits under the plan is less than 60% of such costs, that the employee may be eligible for a Premium Tax Credit or a Cost Sharing Reduction through the Exchange; and that if the employee purchases a plan through the Exchange, the employee will lose the employer contribution (if any) to any health plan offered by the employer and that all or a portion of such contribution may be excludable from federal incomes taxes.
<p>Cost of Employer-Sponsored Health Coverage Included on W-2</p> <p><i>Effective January 1, 2011.</i></p>	<ul style="list-style-type: none"> Employer must report the cost of employer-provided coverage (employee plus employer portion) on their employees' Form W-2.
<p>Coverage through an Exchange</p> <p><i>Effective January 1, 2014.</i></p>	<ul style="list-style-type: none"> A Small Employer can offer Qualified Health Plan coverage to its full time employees through an Exchange. An employer in the small group market generally must have between one and 100 employees during the preceding year, applying the controlled group rules. However, for plan years beginning before January 1, 2016, a state can elect to limit the small group market to employers with no more than 50 employees. An employer providing coverage through an Exchange that outgrows the parameters for the small group market is permitted to continue to offer coverage through the Exchange until such time as the employer discontinues coverage. Beginning in 2017, states may elect to permit employers in the large group market to offer insurance through an Exchange.

HealthCare Reform Summary for Employers

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EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES	
<p>Transitional Small Employer Tax Credit</p> <p><i>Effective January 1, 2010.</i></p>	<ul style="list-style-type: none"> • An employer with no more than 25 FTEs and average wages of less than \$50,000 that purchases health insurance for its employees and covers at least 50 % of total premium cost is eligible for a tax credit: <ul style="list-style-type: none"> ➢ For 2010-2013, the tax credit equals up to 35% of the employer's premium cost based on the average premium contribution in the small group market (up to 25% credit in the case of tax-exempt employers). ➢ For 2014 forward, the tax credit equals up to 50% of the lesser of the employer's premium contribution toward insurance that is purchased through an Exchange, or the average premium contribution in the small group market (up to 35% in the case of tax-exempt employers). • The amount of the credit is phased out based on the small employer's number of employees and average wages. • Beginning in 2014, the credit is only available for two years.
<p>Insurance Access and Premium Rating</p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p>	<ul style="list-style-type: none"> • Premium rates charged by Health Insurance Issuers for health insurance coverage offered in the small group market (and large group market if offered through an Exchange) cannot vary except with respect to certain factors: <ul style="list-style-type: none"> ➢ Individual vs. family coverage; ➢ Rating area; ➢ Age (limit of 3 to 1); and ➢ Tobacco use (limit of 1.5 to 1).

HealthCare Reform Summary for Employers

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EMPLOYER DISCLOSURE AND REPORTING RESPONSIBILITIES	
<p>Simple Cafeteria Plans</p> <p><i>Effective January 1, 2011.</i></p>	<ul style="list-style-type: none"> • An employer that employed on average 100 or fewer employees in the preceding two years is permitted to establish a “Simple Cafeteria Plan” by complying with the contribution, eligibility, and participation requirements established for “Simple Cafeteria Plans.” • Employers that establish a Simple Cafeteria Plan, but later grow beyond 100 employees may continue to offer the Simple Cafeteria Plan until they reach 200 employees. • The contribution requirements require an employer to make <i>employer</i> contributions to qualified benefits under a cafeteria plan (regardless of whether an employee makes salary reduction contributions) in an amount equal to: (i) a uniform percentage (of at least 2%) of an employee’s compensation for a plan year; or (ii) the lesser of 6% of an employee’s plan year compensation or twice the amount of the salary reduction amounts of the employee. • The eligibility requirements require that all employees who had at least 1,000 hours of service in the preceding plan year be eligible to participate and be able to elect any benefit offered through the cafeteria plan. Certain employees are excludable such as those under age 21, those with less than one year of service, those who are collectively bargained, and those who are nonresident aliens. • If the Simple Cafeteria Plan requirements are met by an eligible employer, the plan is treated as meeting any applicable non-discrimination requirements under Internal Revenue Code Section 125.

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
WELLNESS PROGRAM INCENTIVES	
<p>Requirements for Wellness Programs Offered by an Employer</p> <p><i>Effective for plan years beginning on or after January 1, 2014.</i></p>	<ul style="list-style-type: none"> • Employer can establish wellness programs that provide a premium discount or rebate or other reward for participation without violating the nondiscrimination rules that prevent discrimination in Group Health Plans based on Health Status-Related Factors. These wellness programs are permissible under the following circumstances: <ul style="list-style-type: none"> ➤ If the reward <i>is not</i> based on the participant satisfying a health standard, the program is permitted if the reward is made available to all similarly situated individuals. ➤ If the reward <i>is</i> based on the participant satisfying a health standard, the program is permitted if: <ul style="list-style-type: none"> (i) The reward is not greater than 30% of the cost of the health plan's coverage (taking into account both employer and employee contributions to the coverage); (ii) The program is reasonably designed to promote health or prevent disease; (iii) Individuals eligible for the program have an opportunity to qualify for the reward at least once per year; (iv) The full reward is available to all similarly situated individuals (including provision of reasonable alternatives for those unable to satisfy the health standard due to a medical condition); and (v) The availability of reasonable alternatives is disclosed in plan materials describing the terms of the program. • The Act permits the Secretaries of Labor, Health and Human Services and the Treasury to increase by regulation the reward available to up to 50% of the cost of coverage. • The Act also creates a wellness program demonstration projects for ten states under which the participating states will apply the wellness program rules to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in each state.

HealthCare Reform Summary for Employers

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WELLNESS PROGRAM INCENTIVES	
<p>Grants to Small Employers to Establish Wellness Programs</p> <p><i>Effective January 1, 2011.</i></p>	<ul style="list-style-type: none"> • The Secretary of Health and Human Services is authorized to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs. • An employer is eligible if it employs less than 100 employees who work 25 hours or greater per week and did not provide a wellness program prior to March 23, 2010. • \$200 million has been appropriated for these grants for fiscal years 2011 through 2015.
CHANGES FOR RETIREE HEALTH INSURANCE	
<p>Temporary Reinsurance Program for Early Retirees</p> <p><i>Effective no later than June 22, 2010.</i></p>	<ul style="list-style-type: none"> • Employment-based plans (self or fully insured) providing health benefits, including prescription drugs, to early retirees (retirees age 55 through 64) and their dependents can apply to receive reimbursement for a portion of the cost of coverage. <ul style="list-style-type: none"> ➢ An employment-based plan is a plan maintained by a current or former employer (including a state or local government), employee organization, VEBA, or multiemployer plan. ➢ An employment-based plan that participates in the reinsurance program must implement programs and procedures to generate cost savings with respect to participants with chronic or high cost conditions. • Reimbursement is 80% of a valid retiree claim between \$15,000 and \$90,000 (as adjusted each year based on the Medicare percentage increases). • Reimbursements must be used to lower costs for the plan. • Reimbursements are not included in the employer's gross income. • The reinsurance program ends on January 1, 2014; however, only \$5 billion has been allocated to this program and the Secretary has authority to stop taking applications for the program based on the availability of funding.

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
CHANGES FOR RETIREE HEALTH INSURANCE	
<p>Elimination of Deduction for Retiree Prescription Drug Subsidy</p> <p><i>Effective for tax years after December 31, 2012.</i></p>	<ul style="list-style-type: none"> Employers who receive a federal subsidy for maintaining retiree prescription drug coverage can no longer deduct the amount of the subsidy.
<p>Elimination of Medicare Doughnut Hole</p> <p><i>Effective beginning in 2011 with the complete elimination of the doughnut hole effective by 2020.</i></p>	<ul style="list-style-type: none"> Part D Medicare beneficiaries who hit the doughnut hole in 2010 will receive a \$250 rebate. In 2011, Part D Medicare beneficiaries who hit the doughnut hole are eligible for a 50% discount in brand name drugs. Beginning in 2010, preventive care is free of copayments and deductibles. The doughnut hole will be eliminated by 2020.
CLASS ACT	
<p>Voluntary Employer Participation in CLASS Program Premium Collection</p> <p><i>Effective January 1, 2011.</i></p>	<ul style="list-style-type: none"> The Community Living Assistance Services and Supports Act (CLASS Act) is a national voluntary insurance program for purchasing community living assistance services and supports. The Secretary is authorized to create a system under which employers will automatically enroll employees in the CLASS program in the same manner as an employer may elect to automatically enroll employees in a 401(k), 403(b), or 457(b) plan. Employees may elect to opt-out of the class program. Employers that enroll employees in the CLASS program are responsible for making the monthly payroll deduction for the premium applicable to each employee enrolled in the CLASS program. An employer only has to make deductions and withhold premiums for individuals enrolled in the CLASS program if the employer so elects. Benefits will be no less than an average of \$50 per day for qualifying individuals; however, there is a 5 year vesting period which means that an individual must pay premiums for 5 years before any benefits can be paid.

HealthCare Reform Summary for Employers

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ADOPTION ASSISTANCE	
<p>Adoption Assistance</p> <p><i>Effective January 1, 2010.</i></p>	<ul style="list-style-type: none"> • The dollar limitation for the credit for qualified adoption expenses and for the tax exclusion from gross income for such expenses paid under an employer's adoption assistance program increases from \$10,000 to \$13,170, adjusted for inflation after 2010. • The tax exclusion from gross income for expenses paid under an employer's adoption assistance program is currently set to decrease to \$5,000 after December 31, 2010. This sunset date is changed to December 31, 2011. • The adoption credit is changed to a refundable tax credit.
TAX PROVISIONS AFFECTING EMPLOYER-BASED HEALTHCARE	
<p>Increase in FICA Taxes on Earned Income</p> <p><i>Effective for compensation received after December 31, 2012.</i></p>	<ul style="list-style-type: none"> • There will be an increase of 0.9% in the FICA tax paid on wages during a taxable year above \$200,000 (\$250,000 for joint returns). • The increase applies only to the employee-paid FICA taxes.

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
TAX PROVISION AFFECTING EMPLOYER-BASED HEALTHCARE	
<p>Excise Tax on High Cost Employer-Sponsored Health Coverage</p> <p><i>Effective January 1, 2018.</i></p>	<ul style="list-style-type: none"> • A tax is imposed on the coverage provider of high-cost health plans which is equal to 40% of the “excess benefit”. For insured plans, the coverage provider will be the issuer and for self-insured plans the coverage provider will generally be the plan administrator. • The “excess benefit” is the amount of annual coverage that costs <i>more than</i> \$27,500 for family coverage. These limits are for 2018, but may be adjusted before that time under a formula set for in the Act. • Any coverage provided under a group health plan that is included in the cost calculation, including employer and employee pre-tax contributions to flexible spending accounts, health reimbursement accounts, and employer contributions to health savings accounts. The following are <i>not</i> included in the cost calculation: <ul style="list-style-type: none"> ➤ Coverage for long-term care; ➤ Dental and vision coverage offered under separate policies or certificates; and ➤ Specific disease or hospital indemnity policies if the payment for the coverage is not excludable from any employee’s income. • There is a higher dollar threshold for qualified retirees and high risk professions, and adjustments are made for age and gender. • The employer is responsible for calculating the tax and notifying providers and the Secretary of Health and Human Services. • This tax does not go into effect until 2018.

HealthCare Reform Summary for Employers

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TAX PROVISION AFFECTING EMPLOYER-BASED HEALTHCARE	
<p>Revenue Provisions Affecting HSAs, FSAs and HRAs</p> <p><i>Effective January 1, 2011; however, the dollar limits on contributions to a health FSA is effective January 1, 2013.</i></p>	<ul style="list-style-type: none"> • Over the counter (OTC) drugs are no longer qualified for purposes of distributions/reimbursements under HSAs, Archer MSAs, health FSAs and HRAs, <i>except for</i> prescription medicines and insulin. This provision is effective January 1, 2011. • The tax on distributions from HSAs for nonqualified medical expenses is increased from 10% to 20%. This provision is effective January 2, 2011. • The tax on distributions from Archer MSAs for nonqualified medical expenses is increased from 15% to 20%. This provision is effective January 1, 2011. • Contributions to a health FSA under a cafeteria plan is limited to \$2,500 per year, indexed for inflation after 2013. This provision is effective January 1, 2013.
<p>Increase in FICA Taxes on Earned Income</p> <p><i>Effective for compensation received after December 31, 2012.</i></p>	<ul style="list-style-type: none"> • There will be an increase of 0.9% in the FICA tax paid on wages during a taxable year above \$200,000 (\$250,000 for joint returns). • The increase applies only to the employee-paid FICA taxes.
<p>Increase in FICA Taxes on Unearned Income</p> <p><i>Effective for taxable years beginning after December 31, 2012.</i></p>	<ul style="list-style-type: none"> • There will be a new tax imposed that is equal to 3.8% of the lesser of: the net investment income for a taxpayer's taxable year, or the modified adjusted gross income for such taxable year over \$25,000 for joint filers (or \$150,000 for married individuals filing as single, or \$200,000 for single filers). • Net investment income includes gross income from interest, dividends, annuities royalties, rents, other gross income derived from passive activities related to a trade or business, and net gain attributable to the disposition of property other than property held in a trade or business (subject to exceptions). • This tax does not apply to distributions under retirement plans under Internal Revenue Code Sections 401(a), 403(a), 403(b), 408, 408A or 457(b).

HealthCare Reform Summary for Employers

TOPIC	SUMMARY OF PROVISIONS
TAX PROVISION AFFECTING EMPLOYER-BASED HEALTHCARE	
<p>New Federal Premium Tax</p> <p><i>Effective for plans/policies ending after September 30, 2012.</i></p>	<ul style="list-style-type: none"> • Group health Plans (self and fully insured) will be assessed a tax of \$2 (\$1 in the case of plan years during fiscal year 2013) per average number of insured lives to finance a comparative effectiveness research program. • This tax will be paid by the plan sponsor, which is the employer in the case of a single employer plan, an employee organization in the case of a plan established by such an organization, or associations, committees, or trustees in the case of a VEBA, MEWA or other multiple employer plan. • This tax will be indexed annually, and sunset for plan years ending after September 30, 2019.

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HealthCare Reform Summary for Employers

Glossary of Terms

Cost Sharing Reduction - A reduction in the cost-sharing amounts required of certain low-income taxpayers (generally, taxpayers whose household income does not exceed 400% of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Cost Sharing Reduction is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Plan equals or exceeds 9.5% of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Plan is less than 60%.

Eligible Employer Sponsored Health Plan - A Group Health Plan (self or fully insured) offered by an employer to an employee which is a governmental plan or any other plan or coverage offered in the small or large group market within a state, including a Grandfathered Plan offered in a group market.

Essential Health Benefits - Benefits that are required to be included as part of any Qualified Health Plan that is made available through an Exchange. The scope of Essential Health Benefits is intended to be equal to the scope of benefits provided under a typical employer plan, as defined by the Secretary of Health and Human Services. Essential Health Benefits include items and services covered within the following general categories:

- a. Ambulatory patient services
- b. Emergency services
- c. Hospitalization
- d. Maternity and newborn care
- e. Mental health and substance use disorder services, including behavioral health treatment
- f. Prescription drugs
- g. Rehabilitative and habilitative services and devices
- h. Laboratory services
- i. Preventive and wellness services and chronic disease management; and
- j. Pediatric services, including oral and vision care.

HealthCare Reform Summary for Employers

Essential Health Benefits Package - Group health plan coverage that:

- a. Provides for Essential Health Benefits
- b. Limits cost-sharing amounts (e.g. deductibles, coinsurance, copays) incurred by participants to the limits on health savings accounts (currently \$5,950 for single coverage and \$11,900 for family coverage), indexed after 2014
- c. Limits the deductible to \$2,000 for single coverage and \$4,000 for family coverage, increased by employee and employer contributions to a flexible spending account, indexed after 2014
- d. At minimum, excepting only catastrophic plans for certain young individuals, provides benefits that are actuarially equivalent to 60% of the full actuarial value of the essential health benefits provided under the plan, taking into account employer contributions to a health savings account.

Excepted Benefits - Benefits under one of the following:

- a. Coverage only for accident or disability income insurance
- b. Coverage issued as a supplement to liability insurance
- c. Liability insurance, including general liability insurance and automobile liability insurance
- d. Worker's compensation or similar insurance
- e. Automobile medical payment insurance
- f. Credit only insurance
- g. Coverage for on-site medical clinics and
- h. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Excepted Benefits also include, if provided under a separate policy, certificate or contract of insurance;

- a. Limited scope dental or vision benefits
- b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof
- c. Coverage only for a specified disease or illness and
- d. Hospital indemnity or other fixed indemnity insurance.

HealthCare Reform Summary for Employers

Exchange - A governmental agency or nonprofit entity that is established by the state for the purpose of making Qualified Health Plans available to qualified individuals and qualified employers.

Group Health Plan - any plan, fund or program established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the plan) directly or through insurance, reimbursement or otherwise.

Grandfathered Plan - A Group Health Plan (self or fully insured) in effect on March 23, 2010. A Grandfathered Plan retains grandfathered status even if (i) family members of a participant who was enrolled in the Grandfathered Plan on March 23, 2010, are permitted to enroll in the Plan after March 23, 2010; and (ii) new employees and their families are permitted to enroll in the plan after March 23, 2010. A Grandfathered Plan also includes any health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010.

Health Insurance Issuer - An insurance company, insurance service, or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance, and does not include a Group Health Plan.

Health Status Related Factor - Any of the following factors in relation to an individual or a dependent of the individual:

- a. Health status
- b. Medical condition (physical and mental)
- c. Claims experience
- d. Receipt of health care
- e. Medical history
- f. Genetic information
- g. Evidence of insurability
- h. Disability
- i. Any other health status-related factor determined appropriate by the Secretary.

HealthCare Reform Summary for Employers

Large Employer -

- a. For purposes of applying the employer penalties, an employer who employed an average of at least 50 FTEs on business days during the preceding calendar year, applying the controlled group rules. A FTE means an employee who is employed on average at least 30 hours of service per week.
- b. For purposes of eligibility to participate in the Exchange, an employer who employed an average of at least 101 employees on business days during the preceding calendar year, applying the controlled group rules, and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Large Employer as an employer who employed an average of at least 51.

Premium Tax Credit - A tax credit available to certain low-income taxpayers (generally, taxpayers whose household income does not exceed 400% of the federal poverty line) who purchase health coverage in the individual market through an Exchange. The Premium Tax Credit is not available to any taxpayer who is eligible for Minimum Essential Coverage outside of the individual market unless (i) required contributions under the Eligible Employer Sponsored Plan equals or exceeds 9.5% of the taxpayer's household income; or (ii) the actuarial value of the Eligible Employer Sponsored Plan is less than 60%.

Minimum Essential Coverage - Coverage under Medicare, Medicaid, CHIP, TRICARE for Life, the Veteran's health care program, the Peace Corps volunteer program, an Eligible Employer Sponsored Plan, a health plan offered in the individual market, a Grandfathered Plan or a state health benefits risk pool. Excepted Benefits are *not* treated as Minimum Essential Coverage.

Qualified Health Plan - A fully-insured Group Health Plan that (i) has been certified that it meets the criteria for certification in an Exchange; (ii) provides an Essential health Benefits Package; and (iii) is offered by a Health Insurance Issuer that is licensed to offer health insurance coverage in that state and meets certain other requirements.

Small Employer -

- a. For purposes of applying the employer penalties, an employer that is not a Large Employer.
- b. For purposes of eligibility to participate in an Exchange, an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. However, for plan years beginning before January 1, 2016, individual states can elect to define Small Employer as an employer who employed an average of at least one but not more than 50 employees.

HealthCare Reform Summary for Employers

Rules That Apply to Both “New” & Grandfathered Plans

2011

- No annual limit or lifetime limits on essential benefits
- No rescissions (except fraud or misrepresentation)
- Coverage for adult children up to age 26
- No pre-existing condition exclusion for enrollees under 19 years old
- Reporting Medical Loss Ratios

March 2012

- Summary of Benefits using HHS uniform definitions

2014

- No pre-existing condition exclusions on any enrollees
- Waiting period limited to 90 days

Other

- Employer Mandates
- Cadillac Plan Tax
- FSA/HAS/HRA Changes

HealthCare Reform Summary for Employers

Additional Rules for Non-Grandfathered Plans

2011

- No cost sharing for immunization or preventive care
- No discrimination in favor of highly compensated individuals
- Must allow individuals to choose pediatrician for child's primary care physician
- Must allow females to choose gynecologist or obstetrician without referral
- Must provide internal appeals and external review process
- Must allow emergency services without preauthorization and treat as in-network.

2014

- Rating limitations, guaranteed issue, guaranteed renewability, essential benefits
- Cost sharing/deductible limits
- No discrimination against individual participating in clinical trial
- No discrimination based on health status/allowable wellness reward increased to 30%