



July 22, 2010

SUBJECT: SESCO's White Paper – *An Employer's Guide to Healthcare Reform*

Dear Valued Client:

As a retainer client, SESCO is providing a free copy of our white paper entitled, *An Employer's Guide to Healthcare Reform*.

As you will find in this special report, there are many unanswered questions about the new healthcare bill and as such, we, on your behalf, will monitor developments as this journey unfolds. In the meantime, you will find in this report a basic overview and our staff recommendations to include a timeline for compliance as well as suggested communication plans for managers and employees alike.

Further, please know that our professional firm, SESCO Insurance Group and Jason Stevens, will welcome the opportunity to educate, analyze and/or provide recommended solutions to your insurance needs.

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Please know we value our personal and professional relationship as a valued retainer client and always we're as close as your telephone.

Sincerely,

SESCO Management Consultants

A handwritten signature in black ink that reads 'William E. Ford'.

William E. Ford
President & CEO

copy: Jason Stevens
SESCO Staff

An Employer's Guide to Healthcare Reform

Prepared Exclusively for

SESCO Clients



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Introduction

As employers and the American public evaluate the affects of healthcare reform on their businesses and families, SESCO is offering information on what these initial changes mean and how they may affect the world of employee benefits beyond medical coverage. Healthcare reform has significantly changed the shape of the discussion surrounding employee benefits.

Now that healthcare reform is law, employers want to know what kinds of changes are needed to comply and when these changes must be made. Additionally, employers are seeking advice on what they should and shouldn't do in terms of healthcare and employee benefit packages and offerings.

Because this is a lengthy, complicated and very controversial law, SESCO and other practitioners will be sorting out how the various provisions will work and interact over the next several months and even years. Answers and solutions are likely to change as we move forward due to regulatory guidance, additional legislation, court cases, actual experience under the new law and how and when solutions evolve as generated through the marketplace.

As you read and consider the information compiled and prepared in this report, please know that healthcare reform is and will remain a work in progress for many months and years. SESCO will do its best to continually keep our valued clients informed of not only legislative requirements and compliance but also SESCO staff recommendations in revising and/or implementing benefit plans to not only ensure competitive offerings but also to ensure that offerings are affordable.

The following white paper contains input from various sources to include surveys, statistics and recommendations. Our initial hope is that this white paper provides some awareness and understanding of the basic timelines, requirements and potential solutions and recommendations.

Towers Watson Survey on Healthcare Reform – May 2010 (Excerpts from the Survey)

“Although employers appear to be bracing for the worst in light of the new healthcare reform bill, they are just beginning to assess the broader impact of the law on their health benefit strategies and total reward programs. This survey of more than 650 mid- to senior-level benefit professionals (is a survey of larger organizations), provides a snapshot of how employers are responding to a host of healthcare reform challenges that have far-reaching implications for retention, recruitment, productivity, workforce planning, change management and every aspect of the evolving employer-employee relationship.

Employers' Forecast Is Grim for Achieving Top Three Goals

Employers' top three goals for healthcare reform are containing costs, encouraging healthier lifestyles and improving the quality of care. But as they look down the road to when healthcare reform is fully implemented, few employers think this legislation will achieve the goals that are most important to them. Specifically:

- A mere 14% think healthcare reform will help contain healthcare costs.
- Just 25% think healthcare reform will encourage healthier lifestyles.
- Only 20% believe healthcare reform will improve the quality of care.

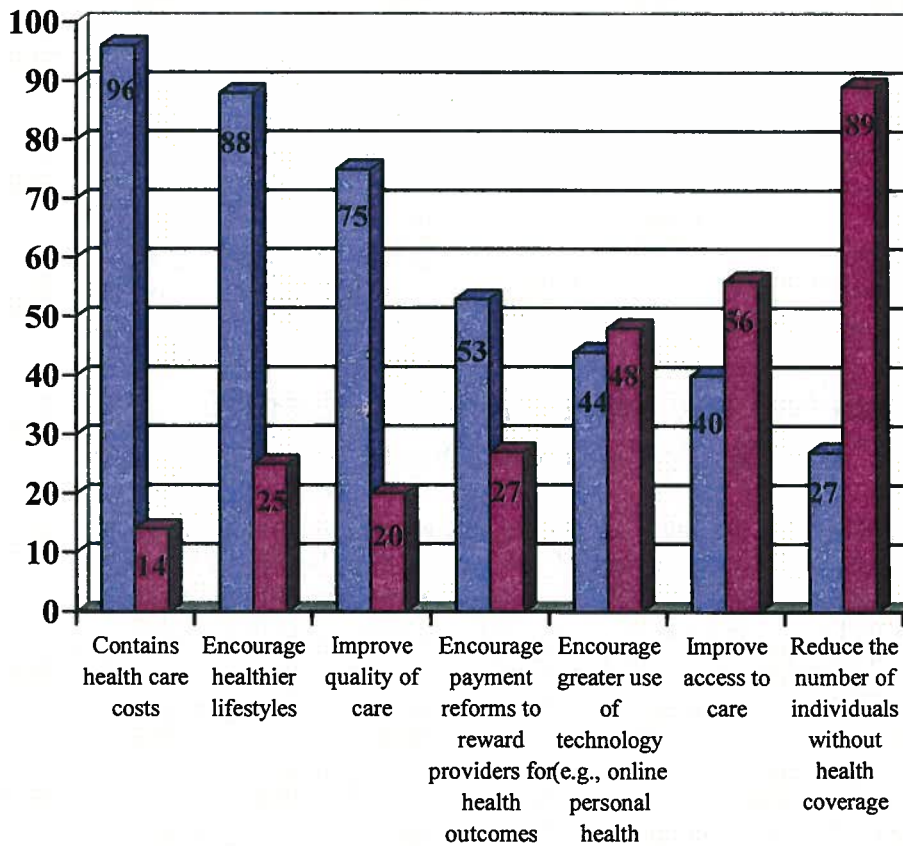
Indeed, the overwhelming majority, (90%) of employers, believe healthcare reform will increase their organization's healthcare benefit costs.

Employers do see some benefits of the new legislation. Eighty-nine percent (89%) of respondents expect healthcare reform to have a positive impact on reducing the number of individuals without health coverage, and 56% predict it will improve access to care. (Figure 1)

Beyond the Horizon: Employers Have Unprecedented Total Rewards Opportunities

By providing pre-65 retirees with access to health benefit coverage in the individual insurance market, healthcare reform may have a sweeping impact on many individuals who have been reluctant to retire. Yet nearly half of employers (48%) think these reforms will have no impact in supporting early retirement objectives for some.

Figure 1: Importance and Impact of Health Reform Goals

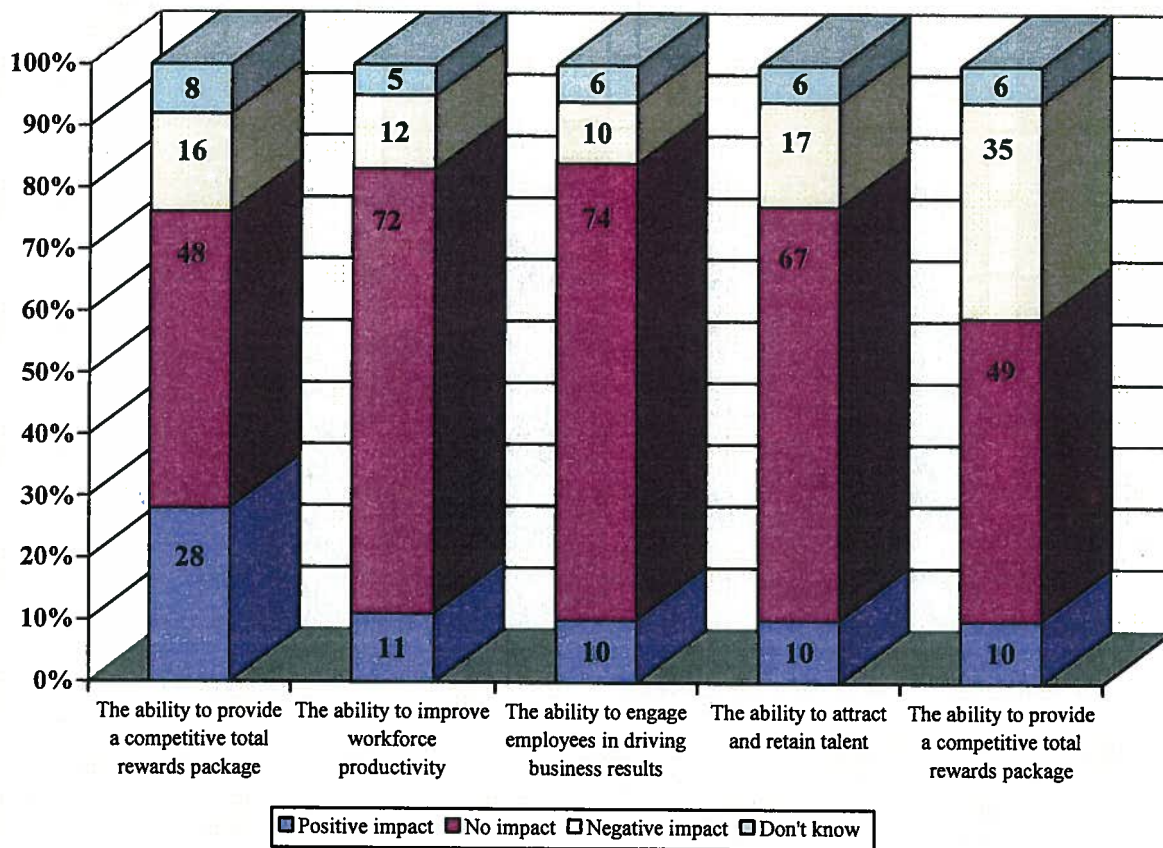


■ Goal is absolutely essential/high priority to organization ■ Reforms are expected to have a positive impact on goal

Similarly, most employers predict these reforms will have no impact on their organization’s ability to achieve key workforce management goals such as improving productivity, attraction and retention, and providing a competitive reward package. Specifically, employers think healthcare reform will have no impact on these critical workforce management objectives: (Figure 2)

- Improving workforce productivity (72%)
- Engaging employees in driving business results (74%)
- Attracting and retaining talent (67%)
- Providing a competitive total rewards package (49%)

Figure 2: Expected Impact on Organizations’ Workforce Management Objectives



What’s more, 35% believe that healthcare reform measures may even have a negative impact on their ability to provide a competitive total rewards package. What employers may not have focused on yet is an unprecedented opportunity to reshape their deal with employees and their total rewards package overall.

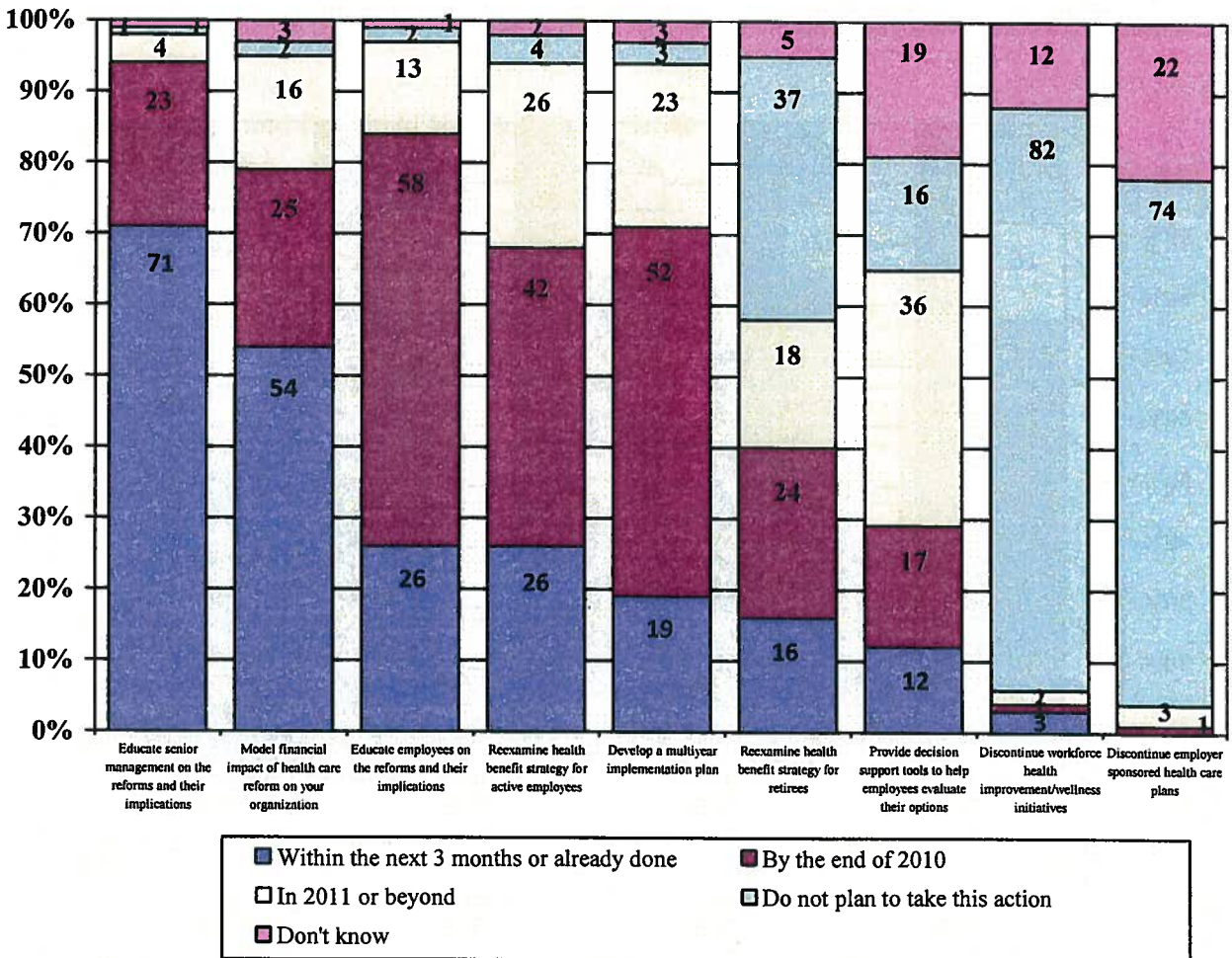
What these findings suggest is that respondents are just beginning to get their arms around this massive, highly complex legislation and have had little time to perform an in-depth analysis of its various business, benefit, workforce and total rewards implications. This limited insight may also be coloring the relatively high percentage of “don’t know” responses on key issues throughout this survey.

Employer Actions

Education Is Key

Now that healthcare reform is here to stay, respondents' most pressing short-term actions focus on educating senior management and employees on the reforms and their implications, and modeling the financial impact of healthcare reform on their organization. Figure 3

Figure 3: Organizations' Likely Actions and Time Frames in Response to Healthcare Reform



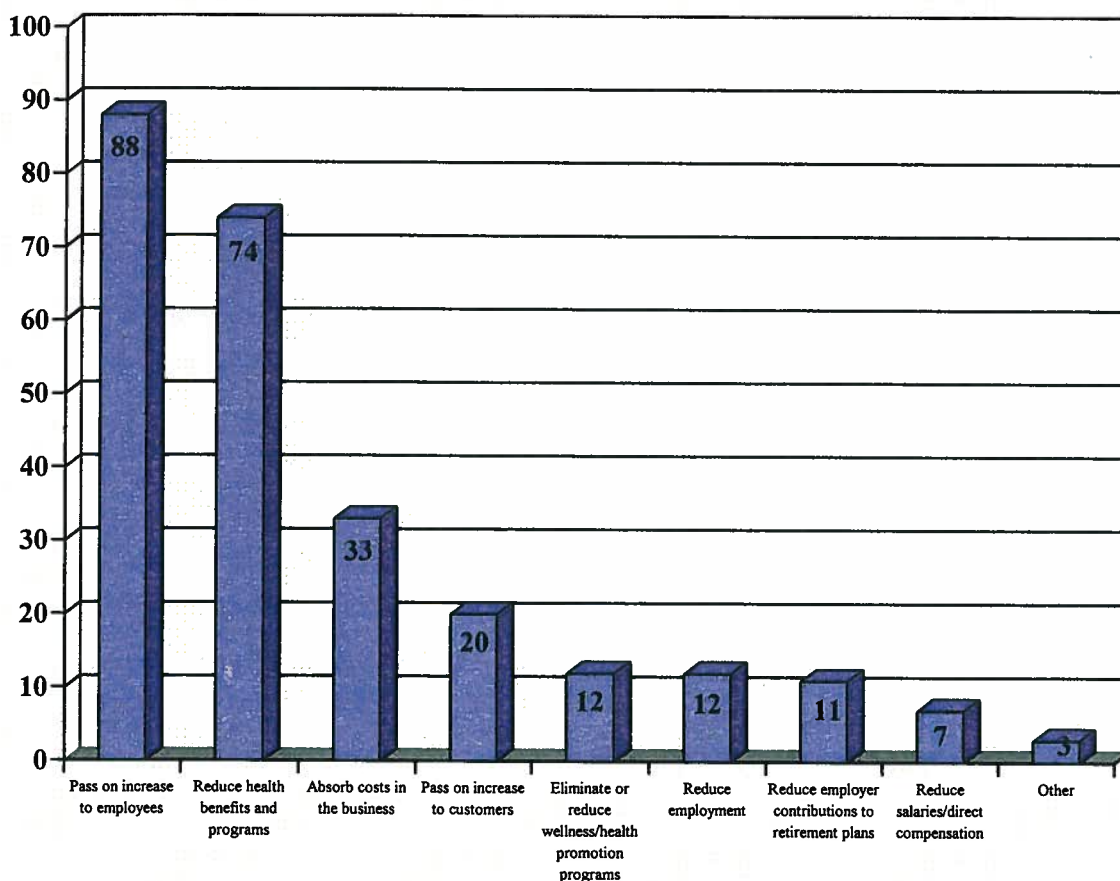
By the end of 2010:

- 94% of employers plan to educate senior management on the reforms and their implications.
- 79% of employers plan to model the financial impact of healthcare reform on their organization.
- 84% of employers plan to educate employees on the reforms and their implications.
- 71% of employers plan to develop a multiyear implementation plan.
- 68% of employers plan to reexamine their health benefit strategy for active employees, versus 40% for retirees.

A Broad Brushstroke of Employer Actions Is Anticipated — Depending on Costs

The majority of employers anticipate that healthcare reform will increase their organization's health benefit costs. In response, most say they plan to pass on the increase to employees (88%) or reduce health benefits and programs (74%). Figure 4

Figure 4: Likely Actions if Reform Increases Organization's Healthcare Benefit Costs (multiple responses allowed)



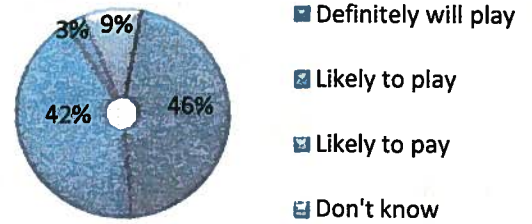
On the other hand, if healthcare reform reduces costs, most employers would retain the savings (59%), pass the savings on to employees by reducing their total share of healthcare costs or premiums (49%) or offer enhanced wellness/health promotion programs (45%).

On a positive note, 82% of employers remain committed to their leadership role in creating a culture of health by providing workforce health improvement/ wellness initiatives.

Play-or-Pay Implications: Employers Say They Will Play, Not Pay

Beginning in 2014, employers must offer minimal essential coverage to full-time employees or pay a penalty. When this provision takes hold, 88% of surveyed employers are either definitely, or likely, to play by continuing to provide health benefit coverage. But as the law's administrative and financial implications become clearer, employers can't rule out the possibility that their perspective may change. Figure 5

Figure 5: Likelihood that Organization Will Play or Pay



Reform Could Drive an Increase in Consumer-Driven Health Plans

Fifty-eight percent (58%) of employers surveyed believe healthcare reform will drive large employers to adopt replacement consumer-driven health plans (CDHP)* for their active employees. These plans are being offered by an increasing number of employers to drive down costs and encourage employees to be more accountable for managing their health and the cost of their care.

On another note, 48% of respondents believe the PPACA will increase the number of large employers offering wellness programs and support, which is consistent with our findings throughout this survey that focus on initiatives aimed at decreasing costs and improving productivity by promoting prevention and employee health.

The Excise Tax Could Hit Many Employers

Beginning in 2018, plans with group health coverage exceeding specified premium cost thresholds will be subject to an excise tax.

Among employers with medical plans for active employees:

- Less than half (43%) believe they will be subject to an excise tax.
- 6% don't know whether they will be subject to an excise tax.

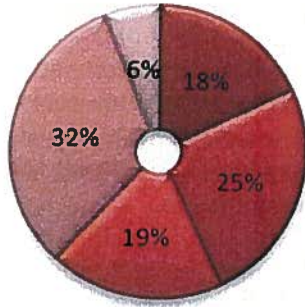
Among employers with medical plans for retirees:

- 34% believe they will be subject to an excise tax.
- 11% don't know whether they will be subject to an excise tax. Figure 6

Employers have reason to be more concerned about this provision of the PPACA than indicated by their responses. Insight gleaned from our extensive research and client experience indicates that more than 60% of companies will reach the proposed excise tax on high-cost plans in 2018 if the current trend continues. Of equal concern, the adverse impact of legislated caps would increase over time. The good news is that employers can take actions now to delay hitting the excise threshold by up to five years."

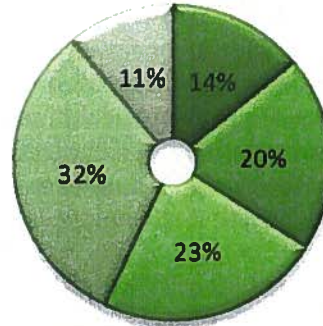
Figure 6: Likelihood that Organization will Be Subject to Excise Tax

Medical plans for active employees



- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely
- Don't know

Medical plans for retirees



- Very likely
- Somewhat likely
- Somewhat unlikely
- Very unlikely
- Don't know

New Realities in Wake of the Healthcare Law

Important Choices for Businesses

Employers must now challenge and take a new look at the offering of health insurance benefits. There will be many important choices/decisions for businesses as follows. The following should not be considered as SESCO staff recommendations, but only intended to serve as an outline to the new realities employers face with the passing of this new healthcare law.

- **Offering vs. Non Offering**
 - Small Business Tax Credit
 - Plan Requirements
 - Plan Costs vs. Penalty Costs
 - Vouchers
 - Affordability Penalties for Offering Firms
 - Employees' Subsidy Eligibility
- **Plan Cost Considerations**
 - Purchasing Traditional Insurance
 - Self-Insuring
 - Sending Employees to the Exchange
- **Other Benefit Considerations**
 - Long-Term Care
 - Retiree Prescription Drug Plans
 - Compensation: Salary vs. Benefits

- Consumer-Directed Account Options
- Employee Wellness Plans

To Offer, or Not to Offer?

Small Business Tax Credits: Employers of different sizes have different concerns here. The smallest employers (those with 25 or fewer employees and an average workforce salary of \$50,000 or less) may wish to consider utilizing the small business health insurance tax credits. These credits may pay for up to half of the costs of providing health insurance to employees, and will last two years past the creation of Exchanges (the credit is 35 percent before 2014 and 50 percent for two years after). However, there is no transition after the two year cutoff, so for some firms costs could double the next year, or they may be forced to drop a benefit that employees had relied upon or grown accustomed to.

Employers with between 25 and 50 employees are not eligible for subsidies, and will not be fined for failing to offer health insurance; however, if they do offer a plan, the plan may need to meet essential benefit and actuarial standards, or employees will still be subject to the individual mandate penalty.

Plan Requirements: In order to be a qualified health plan (and thus to exempt an individual from the individual responsibility penalty and an employer from the shared responsibility penalty), a health plan must meet both the actuarial requirements enacted in the PPACA (generally a 60 percent actuarial value), as well as cover all of the “essential benefits.” The essential benefits will be promulgated by the Secretary of Health and Human Services prior to the mandates taking effect in 2014 and will apply to fully-insured plans.

Plan Costs vs. Penalty Costs: For employers with more than 50 employees who choose not to offer coverage, no fines will be levied if all employees’ incomes are above 400 percent of the Federal Poverty Level (FPL). If any employees are below 400 percent of FPL, the likely fine will be \$2,000 times the number of employees minus 30 (provided that at least one employee gets an Exchange credit). The same goes for employers who have plans that do not meet government requirements. An employer’s number of employees is calculated via adding all employees who work 30 or more hours a week, to the number of “full-time equivalent” workers (roughly translated as, if one adds up the hours per week of all the part-time employees, how many times this can be divided by 30).

Vouchers and Affordability Credits for Offering Firms: Employers with more than 50 employees who do offer qualified health insurance to employees will also have new concerns. Many employers pay large portions of health insurance premiums on behalf of employees, and employees pay the remaining portion. If any employee’s contribution constitutes between 8 and 9.5 percent of his or her income, the employer is required to offer this employee a voucher that is equal to the employer’s expected contribution, to be used to purchase health insurance in an Exchange. If an employee’s contribution exceeds 9.5 percent of his income, he may (if income is below 400 percent of FPL) obtain an Exchange subsidy, incurring a \$3,000 fine for the employer. If enough employees have low enough incomes and get Exchange credits, an employer offering a qualified plan could be fined just as much as an employer offering no health insurance and paying the free-rider penalty.

Employees’ Subsidy Eligibility: Employees who do not meet these two specific “affordability” requirements and otherwise have an offer of a qualified plan from an employer are not eligible for Exchange credits. Thus the offer of an employer plan may be disadvantageous to some employees, who would be eligible for more generous subsidies if they were not offered a qualified plan through their employer. Further, in many cases the \$2,000 per employee fine will be significantly less than the average employer contribution to employees’ premiums. An offering employer will also need to list the value of

the benefit on employee W-2s starting in 2011. Employers will now need to weigh the decision whether or not to offer plans against the possible savings the employer could obtain by opting for the penalties, the possible fines that low-income employees could generate, and the possible subsidies that employees could receive if there is no plan offered.

Managing Plan Costs and Avoiding Penalties

Employers will need to take specific steps to make sure their plans meet new requirements in order to protect employers from “shared responsibility” penalties (the “free-rider” or employer mandate) and to protect employees from “individual responsibility” penalties (requiring individuals to have qualified health insurance). Further, the structure and value of a plan may have serious implications for employers as well.

Purchasing Traditional Insurance: Employers purchasing a fully-insured plan (a traditional health insurance product in which the insurer pays claims and takes on the risk) will need to verify that said plan is a qualified benefit going forward – by October of 2010 plans will need to meet new requirements relating to lifetime/annual limits, rescissions, and excess waiting periods. They will need to allow individuals up to the age of 26 to be listed as dependents. When the shared responsibility provisions kick in, in 2014, employers will need to verify that plans meet the essential benefits requirement (to be defined by the Secretary of HHS) and the actuarial requirements laid out in the law. There will be limitations on imposing annual limits, and first-dollar coverage of prevention with no cost-sharing will be mandated for everything selected by the U.S. Preventative Services Task Force. Starting in 2011 these plans will need to have new limits on Health Savings Accounts and Flexible Spending Arrangements as well. Fully-insured plans may be forced to “rebate” money to beneficiaries if the plan’s administrative costs exceed 15% starting in 2011. Depending on what definitions are developed for administrative costs, this could potentially be very challenging for plans attempting to innovate cost-containment strategies. Also, starting in 2014, there will be a tax specifically on fully-insured products, which could result in increased costs associated with these plans.

Self-Insuring: The alternative will be to self-insure (employer can form an ERISA plan in which the employer pays claims, manages risk, and will likely use an insurance company only to administer claims and offer stop-loss insurance for high-cost claims), which will shield employers from both state coverage mandates and the new health insurance tax, but will entail two key new risks: the employer will then become responsible for seeing to it that the plan meets all the new requirements (as well as new outside requirements under the Genetic Information Nondisclosure Act, the Mental Health Parity Act, and others), and, if the plan’s costs per beneficiary exceed certain amounts after 2017, the plan sponsor will be fined by the so-called “Cadillac tax.” Self-insured plans will need to report their costs on employees’ W-2s. Self-insured plans may not need to cover the “essential benefits” but will need to meet the actuarial valuation requirement of 60 percent.

Sending Employees to the Exchange: Employers wishing to have a firm grasp on health insurance costs will have the option of offering Exchange plans to their employees – small employers will be eligible at the outset, and states may allow large employers to participate starting in 2017. This may allow a defined contribution from employers, provided the contribution was significant enough to avoid “responsibility” penalties.

Offering Other Health-Related Benefits

Long-Term Care: Employers continue to report very low enrollment in long-term care benefits offered to employees. Starting in 2011, employers will be permitted to automatically enroll employees into the new CLASS program, which will on average every month deduct between \$146 (CBO) and \$240 (CMS) from

employee's pay checks. If an enrollee (after a five-year vesting period) becomes eligible (meaning he needs help with a major life activity like bathing, eating, or dressing) he or she may receive around \$75 per day from the program. Employees will need to be given a notice that they can affirmatively opt-out to avoid auto-enrollment.

Retiree Prescription Drugs: Employers who offer Part D prescription drug plans to their retired employees currently receive a 28% subsidy from the Medicare program, which has been excluded from taxation. In 2013 this exclusion will be removed, so the net subsidy from Medicare will be in effect reduced (meaning the overall costs to employers to provide Part D programs will be increased). Employers currently offering these benefits or considering beginning to offer these benefits should take these new costs into account. If a business ceases offering a Part D prescription drug plan, retirees will still be eligible to use the Part D program on their own.

Compensation: Effective within 90 days of enactment, individuals with pre-existing conditions will have access to high-risk pools. Starting in 2014, with the creation of Exchanges, all plans generally will be subject to guaranteed issue and community rating. This will have the effect of eliminating barriers to care for those who wait until they are sick to enroll; in other words, employees may enroll in an Exchange plan at any time and they will not be turned away or charged higher prices due to periods of being uninsured. The individual responsibility requirement, which also kicks in starting 2014, will max at the higher of \$695 or 2.5 percent of an individual's salary. Due to the removal of risk in having uninsured periods, and the low penalty for failing to obtain insurance, many employees may prefer compensation through income rather than through health benefits.

Consumer-Directed Account Options: Starting in 2011, there will be some important changes to Health Savings Accounts (HSAs), Flexible Spending Arrangements (FSAs), and the high-deductible health plans (HDHPs) that are paired with them. First (in 2011), the penalty for non-qualified purchases from HSAs (buying things not approved for tax-free purchase) is increased to 20 percent. At the same time, HSA and FSA funds will no longer be permitted to purchase certain items, including most over-the-counter medication without a prescription. In 2013 FSA contributions will be limited to \$2,500 per year, although the amount will be adjusted every year for inflation. In late 2010 HDHPs will need to meet the new rules relating to 100 percent coverage of preventative services, no lifetime and annual benefits, and no rescissions. New out of pocket limits could limit the usefulness of HDHPs to employers by distancing enrollees from their actual costs. As a result of these changes, HDHPs will be more expensive, and the accounts will be less flexible for consumers – so some employees may be less interested in using these rather than traditional PPO plans.

Employee Wellness Plans: The bill gives the Secretary of HHS authority to offer grants to some small employers who offer wellness plans to employees – these grants would be available to businesses with fewer than 100 employees who had no wellness program prior to the act, and the wellness programs would need to meet specific guidelines. This will be paired with a report by the Centers for Disease Control and Prevention that would lay out the most effective wellness policies, which would presumably then be engineered into the requirements for the grants. Starting in 2014, all employers will be permitted to vary health insurance premiums for employees up to 30 percent based on if they participate in wellness programs and meet certain health standards. The Secretary may later increase this to allow up to a 50 percent variation – meaning that employers could create extremely powerful incentives for employees to participate.

Selected Employer Provisions in Healthcare Reform

The following chart outlines, in depth, selected provisions in the Patient Protection and Affordable Care Act, the Senate-passed healthcare reform bill, and the subsequent changes made to that bill by the Health Care and Education and Reconciliation Act of 2010. The information is current as of April 16, 2010.

Provision	Selected, key healthcare reform provisions related to employers in the Patient Protection and Affordable Care Act (PPA) and the Health Care and Education Reconciliation Act of 2010 (HRA)
Employer Responsibility to Provide Health Insurance	<p>No employer mandate to provide health insurance but employers who employ 50 or more full time employees (defined as 30 or more hours of service per week) and the employer must also include in that number part-time employees (which is determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120) and don't offer health insurance must pay a fine if one of their employees receives a subsidy for coverage in the Exchange. (HRA, Sec. 1003)</p> <p>The amount of the assessment is determined by subtracting the first 30 full time employees from the number of 50 or more FTES. Then, for any number of employees above that first 30, the employer must pay an assessment (which has increased to \$2000 per Full time employee). For example, an employer with 51 full time employees, would subtract the first 30 FTEs and reach a number of 21 FTES, the employer's fine would be 21 x \$2000 or \$42,000. (HRA, Sec.1003)</p> <p>Employers do not pay an assessment for employees in a waiting period but beginning in 2014 there is a 90 day limit on the length of any waiting period. (HRA, Sec.1003)</p> <p>Levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan (stand alone dental and vision plans not included) with an annual premium that is exceeds \$10,200/individuals and \$27,500/families. For retirees (55+) and for plans that cover employees in "high risk professions" the tax applies to threshold amount of \$11,850 for single coverage and \$30,950 for family coverage. The dollar amount thresholds are automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office estimates in 2010. Employers with age and gender demographics that result in higher premiums are allowed to value the coverage provided to employees using the rates that would apply using a national risk pool. The dollar thresholds are indexed to inflation. The tax is effective in 2018 and applies to the amount of the premium in excess of the dollar threshold. (HRA, Sec. 1401)</p> <p>Beginning in 2011, employers are required to disclose the value of each employee's health insurance coverage on the annual Form W-2. (PPA, Sec. 9002)</p> <p>Employers would be required to provide a voucher worth the same amount as the largest premium contribution the employer makes to a health plan. To qualify for the voucher, employees must be eligible for coverage under an employer plan,</p>

	<p>whose required premium contribution is between 8 and 9.8% of their income, and their total household income does not exceed 400% of the federal poverty level. The voucher would be used by the employee to purchase health insurance in an exchange in lieu of the employer sponsored plan. The amount of the voucher would not be taxable and the employee would be able to retain any excess amount. (PPA, Sec. 10108)</p> <p>Beginning in 2013 Modifies the tax to include net investment income in the taxable base. Currently, the Medicare tax does not apply to net investment income. The Medicare tax on net investment income does not apply if modified adjusted gross income is less than \$250,000 in the case of a joint return, or \$200,000 in the case of a single return. (HRA, Sec 1402)</p>
<p>Auto-Enrollment Provisions</p>	<p>Employers with more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans required to automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law). Any automatic enrollment program must include "adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in." (PPA, Sec. 1511)</p>
<p>Wellness</p>	<p>Requires the CDC to study and evaluate best employer-based wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion to employers. (PPA, Sec. 4303)</p> <p>Any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.(PPA, Sec. 4303)</p> <p>Permits employers to establish premium discounts or rebates, or modify co-pays or deductibles up to 30% to encourage participation in health promotion or disease prevention program. The Secretary would have authority to issue regulations to allow financial incentives up to 50%. (PPA, Sec. 2705)</p>
<p>Health Insurance Exchange</p>	<p>Creates separate exchanges for the small group and individual markets.</p> <p>Employees of non-small business employers may participate in the Exchange IF:</p> <ul style="list-style-type: none"> - The employer did not provide minimum, essential coverage OR - The employer provided such coverage but it was deemed unaffordable. (PPA. Sec. 1311) <p>Exchange eligible employers choose a level of coverage (bronze, silver, gold, platinum -see "Mandated Benefits" for definitions) and employees can choose any plan offered in that level of coverage in the Exchange. (PPA, Sec 1312)</p> <p>The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans. (PPA, Sec 1312)</p>

	<p>Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market (employers over 100 employees) in the State to offer qualified health plans in such market through an Exchange. (PPA, Sec 1312)</p> <p>All legal U.S. residents may obtain insurance coverage through the health insurance exchanges. People with employer coverage are not eligible for an income-based tax credit for coverage obtained in an exchange unless their share of the premium for the employer plan would exceed 9.8% of income or if the employer plan has an actuarial value of less than 60%. (PPA, Sec. 1401)</p>
Mandated Benefits	<p>Creates four benefit categories: Bronze (60% actuarial value), Silver (70% actuarial value), Gold (80% actuarial value), and Platinum (90% actuarial value). (PPA, Sec 1312)</p> <p>Includes a "young invincible plan" for people 30 and younger that only includes catastrophic coverage in the individual market. (PPA, Sec. 1302)</p> <p>All plans must provide services outlined in Senate Finance Committee bill. However, the Secretary of Health and Human Services shall ensure that the scope of the essential health benefits is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. The Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey. (PPA, Sec. 1302)</p> <p>In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed— \$2,000 in the case of a plan covering a single individual; and \$4,000 in the case of any other plan. (PPA, Sec. 1302)</p> <p>No lifetime limits or overall annual dollar limits on benefits. (PPA, Sec. 1302)</p> <p>In 2014, group health plans must prohibit pre-existing condition exclusions, restrict annual limits beginning six months after enactment, and prohibit them starting in 2014. (HRA, Sec. 2301)</p> <p>All existing health insurance plans must starting 6 months after enactment of the bill, prohibit lifetime limits, prohibit rescissions, limitations on excessive waiting periods, and a requirement to provide coverage for non-dependent children up to age 26. (HRA, Sec. 2301)</p> <p>For coverage of non-dependent children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage. (HRA, Sec. 2301)</p>
FSAs/HSAs	<p>Beginning in 2013, Proposed limit of \$2,500/year for health FSA contributions to be implemented in Dec. 2010. Limit is indexed to cost of living adjustments in the following years in increments of \$50. (PPA, Sec. 9005; HRA Sec. 1403)</p> <p>Increases the penalty from 10% to 20% for distributions from HSAs that are not used to pay for health related expenditures. (PPA, Sec. 9004)</p>

	<p>Nontaxable reimbursements from health FSAs, HRAs, and HSAs could no longer be used for medicine or drugs unless the medicine or drug is prescribed or is insulin. (PPA, Sec. 9003)</p>
Dependent Coverage	<p>All existing health insurance plans must starting 6 months after enactment of the bill, prohibit lifetime limits, prohibit rescissions, limitations on excessive waiting periods, and a requirement to provide coverage for non-dependent children up to age 26. (PPA, Sec. 2714; HRA, Sec. 2301)</p> <p>For coverage of non-dependent children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage. (HRA, Sec. 2301)</p>
Small Business Provisions	<p>Provide small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees with a tax credit. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% in Phase I and 35% in Phase II of the employer's contribution toward the employee's health insurance premium. (PPA, Sec. 1421)</p> <p>Phase I: For 2010 through 2013, tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. (PPA, Sec. 1421)</p> <p>Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. (PPA, Sec. 1421)</p> <p>Establishes a 5-year, \$200,000,000 grant program to help small employers (less than 100 employees) who do not have wellness programs already in place provide comprehensive wellness programs to their employees. The grant program begins in 2011 and extends through 2015 or until all the money has been appropriated. The Secretary of Health and Human Services will lay out criteria for eligibility but wellness programs must include the following to be eligible: health awareness initiatives (including health education, preventive screenings, and health risk assessments); efforts to maximize employee engagement (including mechanisms to encourage employee participation); initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, online programs, and self-help materials); and supportive environment efforts (including workplace policies to encourage healthy lifestyles, healthy eating, increased physical activity, and improved mental health). (PPA, Sec. 10408)</p>
Retiree Provisions	<p>Beginning in 2013, eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees. (PPA, Sec. 9012; HRA, Sec. 1407)</p>

	<p>Establishes a \$5 billion, temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. Participating employment-based plans will be reimbursed for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000. Plans are required to use the funds to lower costs borne directly by participants and beneficiaries. (PPA, Sec. 1102)</p>
<p>Individual Coverage Requirements</p>	<p>Requires U.S. citizens and legal residents to have qualifying health coverage, with certain exceptions including but not limited to hardship, American Indians, religious objections. (PPA, Sec. 1501)</p> <p>Tax penalty assessed on those who do not comply. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (PPA, Sec. 1501; HRA Sec. 1002)</p> <p>The assessment that individuals who choose to remain uninsured pay is \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee OR 1.0% in 2014, 2.0% in 2015, and 2.5% for 2016 and subsequent years (HRA, Sec. 1002).</p> <p>Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. (PPA, Sec. 1501)</p>
<p>Cafeteria Plans</p>	<p>Establishes a Simple Cafeteria Plan, codified in Section 125 of the Internal Revenue Code of 1986, for businesses with 100 or fewer employees during either of the two years prior to the establishment of the plan. (PPA, Sec. 9022)</p> <p>Employer is required, regardless of whether a qualified employee makes any salary reduction contribution, to contribute a uniform percentage (not less than 2%) of the employee's compensation or an amount which is not less than the lesser of 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee. (PPA, Sec. 9022)</p> <p>The provision also exempts employers who make contributions for employees under a simple cafeteria plan from pension plan nondiscrimination requirements applicable to highly compensated and key employees. (PPA, Sec. 9022)</p> <p>All employees who had at least 1,000 hours of service for the preceding plan year must be eligible to participate and each eligible employee may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan. (PPA, Sec. 9022)</p> <p>Exceptions to the employee eligibility requirement include: any employee not yet 21 before the close of the plan year; employees who have less than one year of service with the employer as of any day during the plan year; nonresident aliens working outside the US; and employees who are covered under a collective</p>

	<p>bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer. (PPA, Sec. 9022)</p>
Anti-Discrimination	<p>Employers that provide health coverage would be prohibited from limiting coverage eligibility based on the wages or salaries of full time employees. (PPA, Sec. 2716)</p> <p>Any wellness or health promotion activity implemented under this Act may not require the disclosure or collection of any information relating to the lawful use or possession of a firearm. (PPA, Sec. 2716)</p> <p>Would amend the Fair Labor Standards Act (FLSA) to ensure that employees who receive premium tax credits are not discriminated against with respect to their compensation, terms, conditions, or other privileges of employment. (PPA, Sec. 1558)</p>
Miscellaneous	<p>Limits the deductibility of executive compensation under Section 162(m) to \$500,000 for insurance providers if at least 25% of the insurance provider's gross premium income from health business is derived from plans that meet the minimum essential coverage requirements of the bill. This applies to all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider. (PPA, Sec. 9014)</p> <p>Would amend the FLSA to require employers with 50 or more employees to provide break time and a place for breastfeeding mothers to express milk. There are no monetary damages for noncompliance. (PPA, Sec. 4207)</p> <p>Provides for a one-time adjustment to corporate estimated taxes for payments made during calendar year 2014 (increased by 14.5 percentage points). (HRA, Sec. 1410)</p>

Complying with the New Healthcare Reform Regulations

The Patient Protection and Affordable Care Act and the reconciliation bill, the Healthcare and Education Reconciliation Act make sweeping changes to current healthcare system practices and also impose many new requirements on employer-sponsored group health plans. The following highlights major changes required by the legislation.

It is divided into two key sections:

Section 1: Requirements by topic to include

- Group health plans
- Employer responsibilities
- Reporting requirements
- Payroll implications
- Taxes and fees

Section 2: Timeline for Compliance

Section 1: Requirements for Group Health Plans

Adult Children Coverage - Employers offering dependent coverage must extend coverage to adult children (regardless of marital status) up to age 26. Employers are not required to offer coverage to an adult child's spouse or children. Grandfathered plans may exclude adult children who are eligible for coverage under another employment-based health plan. [Plan years beginning on or after September 23, 2010]

No Rescissions - Employers and insurance companies may no longer retroactively cancel coverage except in limited circumstances. There is an exception for fraud. [Plan years beginning on or after September 23, 2010]

Restrictions on Lifetime and Annual Limits - Employers may no longer set lifetime limits on essential benefits. Only "reasonable" annual limits on essential benefits are permitted until 2014, with the Secretary of HHS to further define what limits are reasonable. Starting in 2014, annual limits on essential benefits are prohibited. [Plan years beginning on or after September 23, 2010]

No Preexisting Condition Exclusions - Employers may not exclude coverage for preexisting conditions. [Provision applies to dependents under age 19 for plan years beginning on or after September 23, 2010. Provision applies to all other individuals starting January 1, 2014]

Automatic Enrollment - Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible for coverage. Employees may opt out of coverage. [January 1, 2014]

No Reimbursement for Over-the-Counter Drugs - Employees may no longer purchase non-prescription over-the-counter drugs on a pre-tax basis through health FSAs, HSAs, Archer MSAs or HRAs. [Tax years beginning on or after January 1, 2011]

Changes to Taxation of HSA Withdrawals - Reform increases the tax on non-medical withdrawals from health savings accounts from 10% to 20%. [January 1, 2011]

Cap on FSA Contributions - Reform imposes a \$2,500 cap on employee health flexible spending account contributions. Previously, there was no Federal limit on employee health FSA contributions, but many employ-sponsored plans already impose a cap. This cap is indexed to inflation starting in 2014. [January 1, 2013]

90-Day Limit on Waiting Period - Employers may not impose a waiting period longer than 90 days for health care coverage. [Plan years beginning on or after January 1, 2014]

Wellness Programs - Reform increases the wellness program incentives cap from 20% to 30%. Employers may encourage employees to participate in wellness programs through premium assistance, waiver of cost sharing or other incentives, but employers must provide an alternative arrangement for individuals who are unable to participate due to certain limitations. [Plan years beginning on or after January 1, 2014]

Employer Responsibilities

Required Breaks for Nursing Mothers - The Patient Protection Act amends the Fair Labor Standards Act (FLSA) to require that employers provide reasonable break time for up to one year after the birth of a child, and a place other than a bathroom, for nursing mothers so they can express breast milk. Employees

need not be compensated for this time, despite the fact that other rest breaks are considered compensable working time. Employers with fewer than 50 employees don't have to comply if doing so would create an undue hardship by causing the employer significant difficulty or expense. State laws that provide greater protections to employees are not preempted by the new federal requirements, and employers are obligated to provide any greater protections prescribed by state law. [March 23, 2010]

Requirement of Employer Provided Coverage - Reform requires employers with 50 or more "full-time equivalent employees" to provide minimum essential coverage to all full-time employees (those working 30 or more hours per week) and their dependents. Part-time employees are counted as partial employees for determining whether the employer has 50 "full-time equivalent employees," but the tax penalties for failing to provide coverage (calculated per full-time employee) do not apply to part-time employees. If an employer fails to offer minimum coverage to all full-time employees, and at least one employee receives coverage through the state-based exchanges (discussed below), the employer must pay an assessment of \$2,000 per full-time employee. Reform permits employers to subtract 30 full-time employees before calculating the tax. [January 1, 2014]

Minimum Essential Coverage - Employers must cover at least 60% of the cost of "minimum essential coverage" for employees and the total employee cost for health care coverage should not exceed 9.5% of any employee's household income (or the Free Rider Penalty, described below, may apply). Benefits shall include at least the following general categories and the items and services covered with the categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

[January 1, 2014]

Free Rider Penalty - If any employee's cost of coverage exceeds 9.5% of household income, and at least one employee purchases coverage through the exchange, the employer will be deemed to have failed to provide affordable coverage. The employer must pay an assessment equal to the lesser of \$3,000 per employee who obtains coverage through a state-based exchange or \$2,000 per full-time employee. [January 1, 2014]

Free Choice Vouchers - If any employee's cost of coverage exceeds 8% of household income (but does not exceed 9.8% of household income), and the employee's household income is less than 400% of the Federal poverty level, employers must offer that employee a "free choice" voucher to be used to purchase coverage through a state-based exchange. The voucher amount will be the cost the employer would have paid to cover the employee under the most generous option in the employer's plan. The amount is for self-only or family coverage, depending on the employee's election. The employer pays the amount directly to the exchange, with the employee retaining the excess amount if the cost of coverage in the exchange is less than the cost of the employer's coverage. [January 1, 2014]

Reporting Requirements

New Form W-2 Reporting Requirement - Employers are responsible for reporting the total cost of medical benefits provided on employee Form W-2s. Employers should use COBRA rates to determine the value of benefits. [January 1, 2011, with the cost of coverage to be reported on January 2012 Form W-2s]

Uniform Explanation of Coverage - Employers must provide a summary of benefits and a coverage explanation to all participants at the time of enrollment and each subsequent year during annual enrollment. Employers may provide the summary in paper or electronic form. The summary must be no more than four pages in length, a minimum of 12 point font, and should be written in a manner that is easy for the average participant to understand. The summary should contain information regarding cost sharing, continuation of coverage, limitations on coverage and details on where participants can obtain more information. The Secretary of HHS will provide a model summary in advance of the reporting requirement. Failure to comply will result in a fine. [March 23, 2012]

Employee Notice Requirements - Employers must provide new and existing employees with information about the exchange, including information on employee eligibility if the employer's coverage is not affordable and information on free choice vouchers and premium credits. [March 1, 2013]

Certification of Health Care Coverage - Employers must certify that all full-time employees were offered health care coverage. The certification should specify the length of the waiting period under the plan, the time period during which coverage was available, the premium charged and the employer's share of the cost. The Secretary will use the certification to enforce the individual mandate. [January 1, 2014]

Payroll Implications

Long-Term Care Benefit - Reform creates a new employee-funded long-term benefit program. This is a voluntary program that employers may choose to implement. Employees would pay monthly premiums through payroll deduction. After five years of contributing, the employee becomes eligible to receive assisted living funding in the event the employee is no longer able to perform normal daily activities. Employee participation is also voluntary, but employers who choose to implement the program must automatically enroll employees unless they opt out. [January 1, 2011]

Medicare Tax on High Income Earnings - Reform increases the Medicare Hospital Insurance withholding requirement by 0.9% for high earners (individuals earning more than \$200,000 and families earning more than \$250,000). The increase only applies to wages in excess of the thresholds. There is no similar increase for employers' Medicare contribution. [January 1, 2013]

Taxes and Fees

Comparative Effectiveness Fee - Reform imposes a new comparative effectiveness research fee. Starting in 2012, employers sponsoring group health plans must pay \$1 per participant. The fee increases to \$2 per participant in 2013, then to an amount indexed to national health expenditures thereafter. The comparative effectiveness fee phases out by 2019. Revenue from this fee will fund research to determine the effectiveness of various forms of medical treatment. [Plan years ending after September 30, 2012]

Cadillac Tax - Reform imposes a 40% excise tax on the value of health insurance benefits exceeding a certain threshold. The tax includes all employer and employee amounts paid for medical, including pre-

tax employee premiums, but it does not include dental or vision. The thresholds are \$10,200 for individual coverage and \$27,500 for family coverage (indexed to inflation). The plan administrator is responsible for calculating the value of coverage and dividing the tax pro rata among insurers (including the employer, if self-insured). The thresholds increase for individuals in high-risk professions and for employers that have a disproportionately older population. [Tax years beginning on or after January 1, 2018]

Section 2: Timeline for Compliance

2010

Insurance Reforms - As of the signing of the Health Care and Education Affordability Reconciliation Act of 2010, effective immediately, all existing health insurance plans are now subject to new regulations that prohibit lifetime limits, rescissions, and excessive waiting periods. Compliance must be met within six months. Additionally, a requirement to provide coverage for non-dependent children requires them to be able to stay on their parent's policies until age 26. Prior to 2014, the requirement is limited to those adult children without an offer of employer-sponsored coverage. Also restricts annual limits for group health plans and requires all plans (individual and group) to provide first dollar coverage for preventive services.

Temporary Retiree Reinsurance Program - This is a federal government-sponsored reinsurance program for employers that sponsor retiree medical benefits for early retirees (and their spouses, surviving spouses, and dependents) who are ages 55 through 64. To participate in this reinsurance program, the employment-based plan must submit an application for certification to Health and Human Services (HHS). To be certified, the plan must implement programs and procedures to generate cost savings with respect to participants with chronic and high-cost conditions and provide documentation of the actual cost of medical claims involved. Upon submission of a valid claim, HHS will reimburse a plan for 80 percent of that portion of the costs attributable to such claims that are \$15,000 or more but less than \$90,000. These amounts will be adjusted each fiscal year based on changes in the medical care component of the Consumer Price Index for all urban consumers.

Payments to the plan will be used to lower costs for the plan; they cannot be used as general revenues for the sponsoring entities. The payments may be used to reduce premium costs or to reduce copayments, deductibles, coinsurance, or other out-of-pocket costs for plan participants. All employers except the federal government are eligible to apply for the reinsurance payments. The program begins June 23, 2010 and ends on the earlier of January 1, 2014 or when the \$5 billion program allotment is exhausted.

Small Business Health Tax Credit - This tax credit is specifically targeted to help small businesses and tax-exempt organizations that primarily employ low and moderate income workers. It is available to small employers that pay at least half the cost of single coverage for their employees in 2010.

For tax years 2010 to 2013, the maximum credit is 35 percent of premiums paid by eligible small business employers and 25 percent of premiums paid by eligible employers that are tax-exempt organizations. The maximum credit goes to smaller employers – those with 10 or fewer full-time equivalent (FTE) employees – paying annual average wages of \$25,000 or less. The credit is completely phased out for employers that have 25 FTEs or more or that pay average wages of \$50,000 per year or more. Because the eligibility rules are based in part on the number of FTEs, not the number of employees, businesses that use part-time employees may qualify even if they employ more than 25 individuals.

Taxation - A 10% tax on indoor tanning services will be imposed on 7/1/10. Further, the exclusion of the paper manufacturers' "black liquor" tax credit also goes into effect.

2011

W-2 Reporting - Employers will be required to report the value of employees' health benefits on W-2s.

HSA & FSA Limits - Consumers can no longer use HSAs and FSAs to purchase certain items, including most over-the-counter medication unless prescribed by physicians.

Brand-name Drugs - An annual fee will be imposed on manufacturers and importers of brand-name drugs. The amount is set at \$2.5 billion for 2011, \$2.8 billion per year for 2012 and 2013, \$3 billion per year for 2014 through 2016, \$4 billion for 2017, \$4.1 billion for 2018, and \$2.8 billion for 2019 and thereafter. This cost will be passed on to consumers.

HSA Penalty - The penalty for making non-qualified purchases with an HSA increases to 20%.

Federally Subsidized Long-term Care - Voluntary payroll deductions begin for the CLASS long-term care program. Working adults may be automatically enrolled unless they choose to opt out. According to the Congressional Budget Office, this program will almost certainly cost the federal government far more than what the payroll deductions will cover. It appears this entitlement is yet another unfunded liability to add to the federal deficit for decades to come.

2013

Elimination of Deduction for Part D Subsidy - The existing employer tax deduction for the Part D subsidy is eliminated.

Fewer Deductible Medical Expenses - New limits are placed on the deductibility of medical expenses on individual income tax returns. This provision raises the 7.5% Adjusted Gross Income (AGI) floor on medical expenses deductions to 10%. The AGI floor for those 65 and older (and their spouses) remains at 7.5% through 2016.

Medicare Payroll Taxes - The Medicare payroll tax on wages and self-employment income in excess of \$200,000 (\$250,000 joint) will increase by 0.9%, and also applies for the first time, to net investment income. Earners in excess of \$200,000 (\$250,000 joint) will pay an additional 3.8% Medicare tax on investment income. The income thresholds are not indexed to inflation. This tax marks the first time that funds designated for Medicare will be diverted elsewhere – specifically to pay for the insurance policies of people under the Medicare age. This establishes a precedent for treating the payroll tax as a revenue raiser for other purposes.

FSA Limits - Cafeteria plan FSA contributions will be limited to \$2,500 (inflation adjusted after 2013.)

Medical Device Tax - A 2.3% excise tax on manufacturers and importers of certain medical devices will begin. These costs will ultimately be borne by the consumer.

2014

Health Insurance Exchanges - Up until 2014, the bill collects a great deal of taxes, but most of the insurance market reforms are not implemented. In 2014, that begins to change with the opening of insurance exchanges. States must establish an American Health Benefit Exchange that will facilitate the purchase of “qualified health plans” and includes an exchange for small businesses. Individuals can enroll in a plan through the state exchange and small employers can offer a choice of plans to their employees through the exchange.

Benefits Package - Federal government finalizes what is considered an essential benefits package. All qualified health plans must offer the essential health benefits package.

Individual Mandate - Starting in 2014, all U.S. citizens and legal residents must have qualifying health coverage or pay penalties. Other than individuals who meet a hardship exemption, individuals will be required to carry eligible health coverage. The fully phased-in penalty for not having health insurance is the greater of \$695 or 2.5 percent of income.

Employer Mandate - The bill contains a complex employer mandate requiring some firms to provide insurance, pay penalties or both. The penalties are based on (1) the number of full-time employees, (2) whether or not the firm offers coverage, and (3) whether or not one or more employees qualify for government subsidies toward the purchase of health insurance. An employee qualifies for a subsidy if his or her household income is below 400% of the federal poverty line (\$88,000 for a family of four). Here are some of the rules:

- More than 50 full-time employees. Does not offer insurance. Has one or more employees receiving premium subsidies. The first 30 workers would be subtracted from the calculation. Penalty = \$2,000 per employee.
- More than 50 full-time employees. Offers insurance. Has one or more employees receiving premium subsidies. Penalty = lesser of \$3,000 per subsidized employee or \$2,000 per employee.
- More than 50 full-time employees. Offers insurance. Has no employees receiving premium subsidies. No penalty.
- 50 or fewer full-time employees. No penalty.

Premium Credits - The federal government begins subsidizing individuals up to 400% of the federal poverty line. These credits will subsidize individuals purchasing insurance in exchanges, but generally speaking, will not be available to those with traditional employer-sponsored plans. Subsidies will be paid directly to insurers, not individuals.

Medicaid Eligibility Expands - The income level for Medicaid eligibility rises, bringing tens of millions of new people into Medicaid. This expansion of Medicaid will account for around half of the total increase in insurance coverage and will place considerable new financial pressure on states, with higher state taxes a likely response.

2015

IPAB - Establishes an Independent Payment Advisory Board (IPAB) charged with recommending reductions in Medicare spending. Congress must either adopt the IPAB's proposed cuts or pass an alternative with equivalent savings. The IPAB will first propose cuts in 2014 for implementation in 2015.

2018

Cadillac Tax - The government will collect a so-called "Cadillac Tax" – a 40 % excise tax on health coverage in excess of \$10,200 annually for an individual or \$27,500 annually per family, with increased thresholds of \$11,850 individual and \$30,950 family for certain high-risk professions and retirees over the age of 55. This tax is inadequately indexed for medical inflation, so as healthcare costs rise, more and more people will be swept into this tax each year. This is similar to the alternative minimum tax –

designed to hit the “rich” but reaching farther and farther into the middle class each year. For the first two years it is indexed to CPI+1%, but to CPI only in 2020 and beyond.

Compliance Timeline-Quick Reference Guide

June 23, 2010	Temporary Retiree Reinsurance Program
Effective Plan Years Beginning on or After September 23, 2010	<ul style="list-style-type: none"> • No Lifetime Limits • Adult Children Coverage • No Rescissions • Restricted Annual Limits • No Preexisting Condition Exclusions for Children
January 1, 2011	<ul style="list-style-type: none"> • No Reimbursement for OTC Drugs • Form W-2 Reporting of Value of Benefits • Long-Term Care Program • Increased Penalty for Non-Medical HSA Withdrawals
March 23, 2012	<ul style="list-style-type: none"> • Uniform Explanation of Coverage • 60-Day Notice in Advance of Modifications
January 1, 2013	<ul style="list-style-type: none"> • Medicare Tax Increase for High-Earners • No Deduction for Retiree Drug Subsidy • Cap on Health FSA Contributions • Comparative Effectiveness Fee
January 1, 2014	<ul style="list-style-type: none"> • State-Based Exchanges • Free Rider Penalty • No Preexisting Condition Exclusions • Employer Certification of Coverage • Increased Wellness Program Incentives • Individual Mandate • Free Choice Vouchers • No Annual Limits • 90-Day Limit on Waiting Periods • Retiree Reinsurance Program Ends

SESCO Staff Recommendations – What to do Now

Obviously healthcare reform presents a host of challenges for employers that go well beyond health benefit costs. However, there are a number of actions employers can take right now. Although there is no one-size-fits-all strategy, the following are some initial actions employers may want to consider:

- Educate management on the reforms and the implications to your business
- Consider the financial impact of healthcare reforms on your organization through long-term budgeting
- Educate employees on reforms and their implications
- Reexamine the health benefit strategy for active employees
- If applicable, reexamine the health benefit strategy for retirees
- Continue to stay abreast of the expected changes forthcoming

SESCO will continually monitor the short and long-term effects, changes and implications the healthcare reform bill will have on our valued clients.

In Summary

As stated in the introduction of this important white paper, the information provided herein is factual and current; however, only provided as a matter of initial education, awareness and to ensure compliance. We fully expect healthcare reform to be an evolving journey and as such SESCO will provide original updates and alerts as this journey unfolds.

In the meantime, please do not hesitate to contact your SESCO consultant should you have any questions about the contents of this white paper, your compliance posture or preparing for the apparent challenges this reform bill poses.

Appendix

Sample Employer Communications on Healthcare Reform

Sample A

The Patient Protection and Affordable Care Act of 2010

President Obama recently signed the Patient Protection and Affordable Care Act ("PACA"). Many of the provisions in PACA do not become effective until 2014 and beyond. In general, PACA is designed to:

1. Provide health insurance coverage for those who do not have it.
2. Impose coverage standards in the policies for those who do have coverage.
3. Require simplified disclosures about the benefits in health coverage.

Below are a few questions that you may have about PACA and your [Company name] benefits.

Q: How will PACA impact my [Company name] health insurance plan?

A: PACA will have very little impact on the benefits you currently receive.

- Your current [Company name] health insurance plan meets or exceeds all of PACA's cost-share and essential benefit requirements. For example, your [Company name] plan does not have any pre-existing condition prohibitions or lifetime benefit limits that PACA is designed to eliminate. Your [Company name] plan also does not have any cost-share for preventive care, and your overall cost-share is well below the PACA maximum.
- One important improvement is that for plan year 2011, dependents may stay on your [Company name] health plan up to age 26 without being a full-time student.

Q: Will PACA increase my health insurance costs?

A: It is not clear at this point how PACA will impact insurance costs, if at all.

- PACA's intended purpose is to reduce administrative costs, increase competition between insurance companies and create a larger pool of insured Americans. The Congressional Budget Office has stated that those changes may result in reduced insurance costs. However, it is difficult to predict how the health insurance market will react to the changes PACA imposes.
- [Company name] is committed to providing competitive health insurance benefits to all of its employees. The enactment of PACA does not change this commitment.

Q: Does PACA provide any greater protection to unions?

A: No.

- PACA has a provision that exempts current collectively bargained agreements from the changes until that specific agreement runs out. As a result, employees under those agreements are not eligible for the benefits improvements, or any cost reductions, while still under those contracts.
- PACA makes no distinction between benefits provided under a collective bargaining agreement

or directly from an employer. All insurance plans must meet PACA's benefits, disclosure and cost-share requirements, and all plans within [Company name] meet those requirements.

Q: Whom can I talk to within [Company name] to obtain more information about PACA and how it will impact me?

A: The [team name] is ready to answer any questions that you may have about your [Company name] health insurance benefits. You can contact the [team name] by calling XXX-XXX-XXXX or 1-XXX-XXX-XXXX (toll free) or via e-mail at _____

Sample B

Your (Company Name) Benefits and New Healthcare Legislation

As everybody knows, legislation of historic proportions was recently enacted to address complex, expensive and restrictive healthcare coverage that has been in place for so long.

[Company name] wants its U.S. employees to know during these early days, as we get down to the business of understanding the implications of healthcare reform legislation, our core approach will guide us: extensive due diligence on the legislation and regulatory issues; thoughtful, responsible impact analysis; and direct communications to employees when we have something concrete to say.

The Top Five Things You Need to Know About How Healthcare Legislation Impacts You...For Now!

1. Nothing affects your 2010 benefits

The changes signed into law this year won't begin to take effect until 2011 ... and even those are few, and will be fully explained to you during Benefits Enrollment in October. There are additional reforms that are scheduled to go into effect over the next several years.

2. As of 2011, the age limit for dependent coverage will go from 23 to 26.

This will affect you if your dependent does not have access to other employer-based coverage.

3. As of 2011, there will no longer be lifetime maximum limits on health coverage

In the event of catastrophic injury or illness, your coverage will never run out.

4. As of 2011, the annual value of your benefits will be reported on your W-2.

This is a requirement for [the Company] and will have absolutely no tax implication or burden for you.

5. As of 2011, Health Savings Accounts and Flexible Spending Account rules will change.

You will no longer be able to pay for over-the-counter drugs from your HSA or FSA. You have plenty of time to understand and adjust your HSA and FSA contribution strategies!

What's in Effect Right Now

- The well-being of employees - health, wealth and work-life - remains a [Company] business goal.
- It's still a partnership between [Company name] and its employees.
- We want you to have the best decision-making tools and resources to help you secure your health, your wealth and your future.
- We will continue to keep you informed!

For general information on new health reform legislation: HealthReform.gov

Sample C

For the past year, we've been closely monitoring the healthcare reform debate in Washington because of its potential affect on certain aspects of our business and the benefits we offer our associates. Healthcare reform has been passed by Congress. President Obama signed this bill into law.

Here's what we know:

- Healthcare Reform will be phased in between now and 2018.
- We are reviewing the final legislation at this time, and we will report out to you what is included in the final legislation in our next communication.
- Reform does not impact any [Company name] benefits you're enrolled in for this year.

In the coming months, we'll provide you with information so that you can:

- Plan for future changes in coverage and contributions.
- Consider your health coverage needs for more than just the next year.
- Use [Company name] resources to help you plan and maximize the value of your health coverage.

[Company name] presently intends to continue:

- Existing PPO coverage options throughout the healthcare reform implementation period. These options include our PPO options - Health Savings Choice, PPO Basic and PPO Premium, as well as the Health Savings Account, Family Medical
- Flexible Spending Account, supplemental accident, dental and vision.
- Many of the existing Health Maintenance Organization (HMO) options.
- Soliciting vendors each year looking for new coverage opportunities that may become available as part of healthcare reform.



About SESCO

SESCO Management Consultants is the **oldest** and one of the largest human resource and employee relations consulting firms in the country. We are an employee-owned professional firm of management and employee relations specialists dedicated to providing results-oriented human resource solutions that contribute to our clients' people management goals.

Founded in 1945, SESCO's client base includes employers in all industries. We are very proud of our complete "toolbox" of consulting services which has been developed based on practical, hands-on experience.

Professional Service Agreement

SESCO's original service is that of our Professional Service Agreement. We have found over our sixty-three (63) years of providing professional service that clients and human resource professionals have the need to establish a reliable and cost effective, professional relationship to discuss day-to-day people problems, compliance issues, conduct special research, review systems, provide wage data and other information and resources on a daily basis.

SESCO clients appreciate this service because they can contact us as needed without additional charges or fees. It is truly an unlimited service and therefore, it is more cost effective than hiring a human resource assistant, paying legal fees or their personal time in performing these duties.

Although the Service Agreement can be customized per the client's needs, the Service Agreement typically provides the following:

- Unlimited telephone, e-mail, research, fax consulting services on a daily or as-needed basis. We are experts in federal and state employment regulations and offer assistance in handling issues such as terminations, discipline, performance, recruitment and retention, etc.
- *The SESCO Report*, SESCO's monthly newsletter to be mailed to all managers as elected.
- A free review of the organization's employee handbook on an annual basis to ensure that it remains legally attentive and people sensitive.
- Onsite visits. These visits can be customized to include onsite compliance assessments which is an assessment of all human resource functions and systems to determine compliance to federal and state employment regulations. The assessment is also designed to review current personnel systems to determine effectiveness and efficiency.

Other visits may include management training/round tables, mini employee surveys, special project work, etc.

- Free federal and state compliance posters.