

LOWENSTEIN SANDLER PC CLIENT ALERT

EMPLOYEE BENEFITS

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THE HEALTH REFORM LAW - IN A NUTSHELL

May 2010

On March 23, 2010, President Obama signed into law the Patient Protection and Affordability Care Act. The Act was almost immediately amended by the Health Care and Education Reconciliation Act of 2010 (the "fix-it" bill). These two laws (together called the Health Reform Act) will usher in a new era for health insurance. The changes are numerous and complex.

The centerpiece of the Health Reform Act is a requirement that most U.S. citizens and legal residents have health insurance, or pay a penalty. To provide a means for all individuals to obtain health insurance, the Act provides premium assistance credits to qualifying individuals and establishes health insurance exchanges. Large employers who either don't provide health coverage to full-time employees or don't cover all full-time employees are subject to penalty. These requirements will become effective January 1, 2014.

To help pay for premium assistance credits and other measures in the Act, a number of taxes and fees are imposed on individuals, employers, health insurers, drug and medical device manufacturers, and even tanning salons. Unlike the individual mandate for coverage, many of these taxes and fees become effective earlier and some are effective this year. Employers that provide "cadillac" coverage will be subject to a penalty tax beginning in 2018 in an amount equal to 40% of the value of the coverage over prescribed thresholds.

The Act also imposes a number of requirements on group health plans and insurance policies. Many of these requirements will become effective January 1, 2011. However, an important exception allows group health plans that were in effect on March 23, 2010 to escape some, but not all, of these requirements.

For most employer-sponsored group health plans (including those that were in effect on March 23, 2010), the

following provisions will become effective January 1, 2011:

- A ban on pre-existing condition exclusions for children under age 19;
- A ban on lifetime limits and unreasonable annual limits on the dollar value of essential benefits;
- A requirement that dependent coverage be continued for an unmarried child until he or she attains age 26; and
- A ban on the use of flex plan dollars for reimbursement of over-the-counter drugs.

Effective immediately is a requirement that an employer with 50 or more employees provide an employee who is a nursing mother with a reasonable break time and private place where she may express breast milk. The requirement also applies to employers with fewer than 50 employees unless it would impose an undue hardship on the employer.

The enclosed charts summarize most of the provisions of the Act that can be

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expected to affect employers and employer-sponsored group health plans. The charts are divided into the following three categories:

1. A summary of coverage, reporting and other requirements applicable to employer-sponsored group health plans;
2. A summary of the penalties imposed on large employers who fail to provide adequate or affordable health coverage to full-time employees; and
3. A summary of revenue-raising measures and related reporting requirements.

The various effective dates of each provision are included in the attached summaries, together with some observations for employers to consider when evaluating the impact of the Act on their group health plans.

To discuss how the Act affects your group health or flex plan, please contact one of the attorneys in our Employee Benefits and Executive Compensation Practice.

Andrew E. Graw
973 597 2588
agraw@lowenstein.com

Christine Osvald-Mruz
973 597 2440
cmruz@lowenstein.com

Richard Plumpton
973 597 6168
rplumpton@lowenstein.com

Karen W. Scheffler
973 597 2578
kscheffler@lowenstein.com

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www.lowenstein.com

New York
1251 Avenue of the Americas
New York, NY 10020
212 262 6700

Palo Alto
590 Forest Avenue
Palo Alto, CA 94301
650 433 5800

Roseland
65 Livingston Avenue
Roseland, NJ 07068
973 597 2500

2010 HEALTH REFORM ACT¹ – Part 1

COVERAGE, REPORTING AND CERTAIN OTHER REQUIREMENTS FOR GROUP HEALTH PLANS AND EMPLOYERS

This section summarizes particular requirements of the Act that group health plans and health insurance issuers will be required to follow. However, with some exceptions (noted below), the new requirements do not apply to “grandfathered health plans.” A grandfathered health plan is a group health plan that was in effect on the date of enactment (March 23, 2010), regardless of coverage renewals. A plan remains a grandfathered health plan for family members of individuals enrolled on March 23, 2010 and for new employees (and their families). The rule does not specifically mention existing employees (and their families) who are not enrolled in a plan as of March 23, 2010, but presumably, they may also join the plan without nullifying the plan’s grandfathered status. It remains to be seen whether future guidance will provide that modifications to a plan will cause it to lose its grandfathered status. For health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010, the plan is treated as a grandfathered plan until the date on which the last of the collective bargaining agreements relating to the coverage terminates.

Provision	Explanation	Observations/ Comments
<p>Pre-existing Condition Exclusions for children under age 19</p>	<p>Effective for plan years beginning on or after six months following the date of enactment, health plans (including grandfathered plans) are prohibited from imposing pre-existing condition limitations on children under age 19.</p> <p>The prohibition on pre-existing condition limitations is expanded to all covered individuals effective for plan years beginning on and after January 1, 2014.</p>	<p>Employers and plan administrators should begin to prepare to comply with this requirement as, for most, it will become effective January 1, 2011. Note that grandfathered plans are not exempt from this requirement.</p>
<p>Lifetime and Annual Limits</p>	<p>Effective for plan years beginning on or after six months following the date of enactment, health plans (including grandfathered plans) will be prohibited from imposing lifetime limits and “unreasonable” annual limits on the dollar value of “essential benefits” for any covered participant or beneficiary. Limits may continue to be imposed on non-essential benefits, subject to applicable State law requirements.</p> <p>Essential benefits are to be defined by the U.S. Department of Health and Human Services (HHS), but must include:</p> <ul style="list-style-type: none"> • Ambulatory benefits • Emergency benefits • Hospitalization • Maternity/newborn care • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventative and wellness/ chronic disease management; and • Pediatric services, including oral and vision. 	<p>These new restrictions will also begin, for most plans (including grandfathered plans), effective January 1, 2011. It appears that the restrictions on limits also apply to retiree plans, which could cause recognition of an expense under GAAP.</p>

¹The 2010 Reform Act refers to the Patient Protection and Affordability Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

2010 HEALTH REFORM ACT – Part 1 (continued)

COVERAGE, REPORTING AND CERTAIN OTHER REQUIREMENTS FOR GROUP HEALTH PLANS AND EMPLOYERS

Provision	Explanation	Observations/ Comments
Coverage of Adult Dependents	<p>Group health plans and insurance issuers that provide dependent coverage for children must continue to provide coverage for an unmarried child until he or she attains age 26.</p> <p>This requirement is effective for plan years beginning on or after six months following the date of enactment. For plan years beginning before January 1, 2014, grandfathered health plans are subject to this requirement only with respect to an adult child who is not eligible to enroll in an eligible employer-sponsored health plan (other than the grandfathered plan).</p>	<p>Employers and plan administrators should also begin to prepare to comply with this requirement as it will become effective, for most, January 1, 2011. The delayed effective date for grandfathered plans will only exclude adult children who have coverage through another employer anyway.</p>
Limitation on Flex Plans	<p>Effective January 1, 2011, Flexible Spending Arrangements (“FSAs”) (as well as health savings accounts and Archer medical savings accounts) may no longer reimburse expenses for over-the-counter drugs.</p>	<p>This will be a significant change for virtually all flex plans. Since the “use-it-or-lose-it” rule still applies, employees should be cautioned during open enrollment for 2011 that over-the-counter drugs will no longer be eligible for reimbursement.</p>
Preventative Care	<p>Effective for plan years beginning on or after six months following the date of enactment, group health plans and insurance issuers must provide, at a minimum, certain preventative and wellness care services without imposing any cost-sharing obligation on the covered individual.</p>	<p>Grandfathered plans are not subject to these requirements. Sponsors and administrators of grandfathered plans should be mindful of, and pay close attention to, future regulatory guidance that may explain how plan modifications might cause the loss of grandfathered status.</p>

2010 HEALTH REFORM ACT – Part 1 (continued)

COVERAGE, REPORTING AND CERTAIN OTHER REQUIREMENTS FOR GROUP HEALTH PLANS AND EMPLOYERS

Provision	Explanation	Observations/ Comments
Nondiscrimination Requirements	Effective for plan years beginning on or after six months following the date of enactment, insured group health plans must meet the same non-discrimination requirements applicable to self-insured plans pursuant to Section 105(h) of the Internal Revenue Code.	<p>Many employers have special insurance policies for executives. Until now, such insurance policies were not subject to nondiscrimination restrictions.</p> <p>Although grandfathered plans covering executives may continue to be maintained, any modification to such a plan should be implemented with concern to losing the plan's grandfathered status.</p>
Appeals	Effective for plan years beginning on or after six months following the date of enactment, group health plans and insurance issuers must implement an effective process for appeals of coverage determinations and claims. Among other minimum standards, enrollees must receive notice of the appeals process in a "culturally and linguistically appropriate manner" and be permitted to present "evidence and testimony" as part of the appeals process. In addition, the enrollee must have the right to receive continued coverage pending the outcome of the appeal. The appeals process must also include an "external review process."	<p>Regulatory guidance will presumably clarify what is meant by a "culturally and linguistically appropriate manner."</p> <p>The requirement that a claimant be permitted to present evidence and testimony conjures up visions of hearings that could take on the appearance of quasi-trials. The claims procedures are likely to contribute to additional administrative expense in maintaining a health plan.</p>
Reporting Requirements	Subject to issuance of regulations by the HHS (required within two years of enactment), group health plans and insurance issuers will be required to provide annual reports to HHS on information intended to: (i) improve health outcomes through such things as effective case management and care compliance initiatives, (ii) implement activities to prevent hospital readmissions, (iii) implement activities to improve patient safety and reduce medical errors, and (iv) implement wellness and health promotion activities.	Regulations will define the scope of these new reporting requirements, which will likely be more burdensome for self-insured plans to follow given the nature of such plans.

2010 HEALTH REFORM ACT – Part 1 (continued)

COVERAGE, REPORTING AND CERTAIN OTHER REQUIREMENTS FOR GROUP HEALTH PLANS AND EMPLOYERS

Provision	Explanation	Observations/ Comments
Uniform Coverage Documents	HHS is directed to issue regulations within one year following enactment to establish standards for use by group health plans and insurers in compiling and providing enrollees with benefit summaries and coverage explanations that are uniform in appearance, are provided in a “culturally and linguistically appropriate manner” and include certain specified information, including uniform definitions for descriptions of coverage and medical terms; coverage exceptions; cost-sharing provisions; and a “coverage facts label” that includes samples illustrating common benefit scenarios.	Again, it remains to be seen how regulations define a “culturally and linguistically appropriate manner.” The elements required for the new forms to be issued will likely prove to be more onerous for self-insured plans to include.
Prohibition on Excessive Waiting Periods	Effective for plan years beginning on or after January 1, 2014, group health plans (including grandfathered plans) and insurance issuers are prohibited from establishing a waiting period for coverage of longer than 90 days.	While this requirement will affect many plans, it is not effective until 2014 so there is time to prepare.
Wellness Programs	While the Act prohibits discrimination by group health plans and insurance issuers regarding eligibility or continued eligibility based on, among other things, health status and claims experience, effective for plan years beginning on or after January 1, 2014, the Act codifies existing HIPAA regulations that permit wellness incentives and penalties to foster good health behavior (e.g., a program that provides a reward to quit smoking). The Act increases the potential incentive or penalty that may be used from 20% to 30% of the applicable premium, and authorizes the Departments of Labor, Treasury and HHS to increase the incentive/penalty to 50% after study.	Some plans have begun to incentivize good health behavior through premium rebates or reductions. The Act generally allows such incentives to continue.

2010 HEALTH REFORM ACT – Part 1 (continued)

COVERAGE, REPORTING AND CERTAIN OTHER REQUIREMENTS FOR GROUP HEALTH PLANS AND EMPLOYERS

Provision	Explanation	Observations/ Comments
Prohibited Discrimination Based on Salary	Effective for plan years beginning on or after six months following the date of enactment, the plan sponsor of a group health plan (other than a self-insured plan) may not base a full-time employee's eligibility for health insurance coverage (or continued eligibility) on the employee's total hourly or annual salary, or establish eligibility rules that have the effect of discriminating in favor of higher wage employees. The rule does not, however, prohibit employers from establishing lower contribution requirements from lower-paid employees.	
Nursing Mothers	Employers are required to provide an employee who is a nursing mother with a reasonable break time and private place (other than a bathroom) where she may express breast milk. The obligation is for one year following the child's birth. An employer is not required to pay the employee for the break time. Employers with fewer than 50 employees are not subject to this requirement if doing so would impose an undue hardship on the employer.	No effective date is specified in the Act. This provision is considered effective immediately. Accordingly, employers with 50 or more employees should take immediate action to comply with the new requirement.
Rescission of Coverage	Effective for plan years beginning on or after six months following the date of enactment, group health plans and insurance issuers (including grandfathered plans) cannot rescind the plan or coverage with respect to a covered individual unless the individual commits fraud or makes an intentional misrepresentation of material fact prohibited by the plan or policy.	This requirement should have little impact on employer-sponsored health plans.

2010 HEALTH REFORM ACT – Part 2

**HEALTH INSURANCE MANDATE FOR INDIVIDUALS;
PENALTIES FOR EMPLOYERS THAT DO NOT PROVIDE ADEQUATE OR AFFORDABLE COVERAGE**

The centerpiece of the Act is a requirement that most U.S. citizens and legal residents have health insurance, or pay a penalty. To provide a means for all individuals to obtain health insurance, the Act provides premium assistance credits to qualifying individuals and establishes health insurance exchanges. Large employers that either don't provide health coverage to full-time employees or don't cover all full-time employees are subject to penalty. These requirements will become effective January 1, 2014.

Provision	Explanation	Observations/ Comments
<p>Individual Mandate</p>	<p>Beginning January 1, 2014, all U.S. citizens and legal residents (except for individuals who qualify for a religious exemption), must have “minimum essential (health) coverage” either through a governmental program (such as Medicare or Medicaid), an employer-sponsored plan or through the purchase of an individual policy.</p> <p>Individuals who fail to maintain coverage for a month will be subject to a “shared responsibility penalty” for that month. When fully effective after a two year phase-in period, the penalty (on an annual basis) will be equal to the lesser of (i) the national average premium for “bronze” coverage provided through an Exchange (see below), or (ii) the lesser of \$695 per adult and \$347.50 per child (up to a maximum of \$2,085 per family) or 2.5% of household income in excess of the threshold income required for filing a Federal income tax return.</p> <p>For 2014 and 2015, the dollar penalties are \$95 and \$325, respectively (\$47.50 and \$162.50 per child), and the percentage of household income is 1.0% and 2.0%, respectively. The maximum family penalty is \$285 for 2014 and \$975 for 2015. Beginning in 2017, the dollar limits are subject to cost-of-living adjustment in increments of \$50.</p>	<p>The Act utilizes several “carrot-and-stick” approaches to enforce the mandate that all individuals have health insurance coverage. For example, there are premium assistance tax credits to help low income individuals and families pay for the cost of coverage, but penalties for those who do not obtain coverage. As discussed below, “large” employers who fail to maintain affordable coverage or who don't cover all full-time employees are subject to penalties, and must provide vouchers to employees who opt out of the employer's plan that they can use to obtain coverage from a State insurance exchange.</p>

2010 HEALTH REFORM ACT – Part 2 (continued)

HEALTH INSURANCE MANDATE FOR INDIVIDUALS; PENALTIES FOR EMPLOYERS THAT DO NOT PROVIDE ADEQUATE OR AFFORDABLE COVERAGE

Provision	Explanation	Observations/ Comments
<p>Premium Assistance Credits</p>	<p>To assist low income individuals in meeting the individual mandate discussed above, the Act provides premium assistance tax credits to taxpayers who enroll in an Exchange plan, whose household income is at least 100% but not more than 400% of the federal poverty level (FPL) and who are not eligible for Medicaid or employer-sponsored insurance that offers affordable minimum essential coverage under which the plan pays at least 60% of the covered benefits. Coverage under an employer plan won't be considered "affordable" if the employee is required to contribute 9.5% or more of his or her household income for it.</p> <p>The amount of premium credits an individual will be eligible for depends on his or her household income. The maximum credit is equal to 9.5% of household income.</p>	
<p>Penalties on Large Employers</p>	<p>Although the Act does not require employers to provide health coverage to their employees, employers with 50 or more full-time employees ("large employers") will be subject to penalties if they do not offer affordable minimum essential coverage to all full-time employees and any of those employees purchases coverage through an Exchange. A full-time employee is defined as an employee who is employed on average for 30 or more hours per week. Seasonal employees are not treated as full-time employees.</p> <p>Employers who do not offer health coverage: If a large employer does not offer minimum essential coverage and any of its full-time employees qualifies for the premium assistance credit above, the employer will be subject to a non-deductible assessment in the amount of \$2,000 per full-time employee, excluding the first 30 full-time employees.</p> <p>Employers who offer health coverage, but the coverage either is not affordable or does not pay at least 60% of covered benefits: Where a large employer offers minimum essential health coverage, but one or more its employees qualifies for the premium assistance credit (either because the plan is not "affordable" (see above) or does not pay at least 60% of covered benefits), the employer will be required to pay a non-deductible assessment in the amount of \$3,000 per full-time employee who receives a premium assistance credit. The amount of the assessment is capped, however, by the maximum amount the employer would have been assessed had it not offered any plan.</p>	<p>Large employers have traditionally provided health coverage, or made coverage available, to full-time employees. While most will likely continue to do so to remain competitive for qualified employees, it can be expected that many if not most employers will reevaluate their health plans in light of the Act, and consider whether or not to modify or even discontinue their health plans based on, among other things, the cost of providing health coverage, the penalties for not doing so, and alternative coverage that would be available to employees.</p>

2010 HEALTH REFORM ACT – Part 2 (continued)

**HEALTH INSURANCE MANDATE FOR INDIVIDUALS;
PENALTIES FOR EMPLOYERS THAT DO NOT PROVIDE ADEQUATE OR AFFORDABLE COVERAGE**

Provision	Explanation	Observations/ Comments
Free Choice Vouchers	<p>Employers who offer minimum essential coverage, but require employees whose annual household income does not exceed 400% of the FPL to pay between 8% and 9.8% of their household income (indexed for premium growth after 2014), must provide such employees with “free choice vouchers” if they decline to participate. The employees can use the vouchers to purchase insurance through an Exchange. The amount of each voucher will be equal to the monthly cost of the coverage that would have been paid by the employer had the employee been covered by the employer’s plan. If the amount of the voucher exceeds the cost of insurance through the Exchange, the employee gets to keep the excess (which is includible in the employee’s gross income).</p> <p>An employee who receives a free choice voucher is not also eligible for premium assistance credits. Likewise, an employer that provides a voucher is not subject to the penalty assessment above for that employee. Vouchers are treated as deductible compensation expenses for employers.</p>	<p>It remains to be seen how a voucher system will be implemented. Employers that face the prospect of providing vouchers may consider adjusting employee contribution levels to avoid having to provide vouchers and meeting ancillary notice and reporting requirements.</p>
Automatic Enrollment for Employers with more than 200 Full-time Employees	<p>Subject to regulations to be issued by the Department of Labor, employers with more than 200 full-time employees that offer one or more health plans will be required to automatically enroll new full-time employees in one of them. Employees must be afforded the right to decline coverage.</p>	
Insurance Exchanges	<p>The Act requires each state to establish a health insurance Exchange or to join together to form regional Exchanges. Exchanges are vehicles through which health plan coverage will be offered to qualified individuals. Participating plans must meet certain minimum standards of affordability, benefits and consumer protection. Exchanges are required to provide four levels of coverage – called bronze, silver, gold and platinum coverage.</p> <p>During 2014 -2016, only individuals and small employers may participate in Exchanges. After 2016, Exchanges may, but are not required to, permit large employers to participate.</p>	

2010 HEALTH REFORM ACT – Part 3

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Apart from the potential assessments that apply to employers that do not provide adequate or affordable health coverage for employees, the Act imposes a number of taxes and fees.

Provision	Explanation	Observations/ Comments
<p>Tax on “Cadillac” Plans</p>	<p>Effective for tax years beginning after 2017, the Act imposes a 40% non-deductible excise tax on the value of employer-provided health coverage that exceeds a dollar amount multiplied by a “health cost adjustment percentage.” For single coverage, the amount is \$10,200; for family coverage, the amount is \$27,500. The health cost adjustment percentage will be determined based on the increase in cost of health insurance for federal employees during the period 2010 to 2018. The cost of health coverage is to be determined in the same manner as COBRA costs, but without any cost attributable to this tax.</p> <p>With exceptions for retirees age 55 and older who are not yet eligible for Medicare and employees in certain high-risk professions, the tax applies to coverage provided to employees (including former employees) under a fully-insured plan or under a self-insured plan. If provided through insurance, the health insurance issuer is liable for the tax. If provided through a self-insured plan, the employer is responsible for the tax. For multi-employer plans, it appears that the plan administrator is responsible for the tax.</p> <p>Employers are required to calculate the tax and notify the IRS of how the amount was determined. For multi-employer plans, the plan sponsor (typically a board of trustees) is responsible for calculating the tax and providing the notice.</p>	<p>Given the thresholds at which the excise tax applies, it seems unlikely that it would impact many employers. Nonetheless, given the severity of the penalty as 2018 approaches employers should assess the cost of their health plans to determine if the tax will apply.</p>

2010 HEALTH REFORM ACT – Part 3 (continued)

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Provision	Explanation	Observations/ Comments
Additional Medicare Tax on High Wage Earners	<p>Beginning in 2013, the Act imposes an additional 0.9% Medicare Hospital Insurance tax (“HI” tax) on self-employed individuals and employees with respect to earnings and wages received during the year above specified thresholds. This additional tax applies to earnings of self-employed individuals or wages of an employee received in excess of \$200,000. If an individual or employee files a joint return, then the tax applies to all earnings and wages in excess of \$250,000 on that return. The Act does not change the employer HI tax. Self-employed individuals are not permitted to deduct any portion of the additional tax.</p> <p>For wage earners, the Act requires the employer to withhold the employee’s tax from wages paid to the employee in excess of \$200,000. In determining its withholding obligation, the employer is not required to consider wages that may be received by the employee’s spouse that would be subject to this tax. As a result, some married couples may have liability for the additional HI tax that is not satisfied by withholding.</p> <p>If the employer fails to collect the tax, and the employee subsequently pays the tax, then the tax will not be collected from the employer, but the employer will remain liable for penalties.</p> <p>The additional HI tax applies to wages received and taxable years beginning after December 31, 2012.</p>	<p>In contrast to the regular HI tax of 1.45% of wages, the additional 0.9% HI tax applies to the combined wages of an employee and his or her spouse (if filing a joint return); though withholding is only based on the employee’s wages.</p>

2010 HEALTH REFORM ACT – Part 3 (continued)

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Provision	Explanation	Observations/ Comments
<p>Surtax on Unearned Income</p>	<p>For taxable years beginning after December 31, 2012, the Act imposes a 3.8% Medicare surtax on the lesser of a taxpayer's net investment income or modified adjusted gross income (AGI) in excess of \$200,000 for single filers and \$250,000 for joint filers.</p> <p>Net investment income includes income from interest, dividends, capital gains, annuities, royalties, and rents, other than non-taxable income (such as tax-exempt interest) and income that is derived in the ordinary course of a trade or business and not treated as a passive activity.</p> <p>The new tax is subject to general estimated tax rules for individuals.</p>	<p>The 3.8% surtax and the 0.9% additional HI tax (described above) apply independently. For example, if an individual had wages of \$190,000, investment income of \$30,000, and modified AGI of \$210,000, that individual would not be subject to the additional HI tax but would be subject to the 3.8% surtax on the \$10,000 by which his or her modified AGI exceeded \$200,000. Alternatively, if the taxpayer had wages of \$300,000, investment income of \$60,000, and modified AGI of \$350,000, then the taxpayer would pay the wage-based HI tax on \$100,000 and the 3.8% Medicare surtax on \$60,000.</p>
<p>Limit on Flexible Spending Arrangements</p>	<p>Effective for tax years after 2012, a health FSA under a cafeteria plan will not be qualified benefit unless the plan provides for a \$2,500 maximum annual salary reduction contribution to the FSA. A failure by the plan to limit the contribution to \$2,500 will subject employees to tax on distributions from the FSA.</p> <p>For tax years after 2013, the \$2,500 limitation will be adjusted annually for inflation.</p>	<p>Currently, there is no limitation on pre-tax contributions to an FSA. Often, employers will limit FSA contributions to no more than \$5,000 however. For many FSA plans, the new limit will therefore be a reduction.</p>

2010 HEALTH REFORM ACT – Part 3 (continued)

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Provision	Explanation	Observations/ Comments
Modified Threshold for Medical Expense Deductions	<p>Effective for tax years beginning after December 31, 2012, the threshold to claim an itemized deduction for unreimbursed medical expenses will increase from 7.5% of AGI to 10% of AGI for regular income tax purposes.</p> <p>Taxpayers who are age 65 and older before the close of the tax year are exempt from this increased threshold. This is a temporary waiver for this group, and applies to tax years beginning after December 31, 2012 and ending before January 1, 2017.</p>	<p>The change represents a significant increase in the hurdle needed to be met by an individual taxpayer to deduct unreimbursed medical expenses.</p>
Elimination of Employer Deduction for Coverage of Eligible Medicare Drug Retirees	<p>Currently, a company that provides a qualified retiree prescription drug plan to its retired employees is eligible for an annual subsidy payment from the federal government based on the cost of providing the coverage. Even though a portion of the company's retiree drug costs are subsidized by the Federal government, the company is nonetheless permitted to deduct the full amount of its retiree drug costs.</p> <p>Effective for tax years beginning after December 31, 2012, a company's business deduction for retiree prescription drug costs will be reduced by the amount of any qualified retiree prescription drug plan subsidy.</p>	<p>Repeal of the deduction increases the after-tax cost of providing retiree drug coverage. The deduction was an inducement to employers to continue to provide retiree drug coverage after the enactment of Medicare Part D. With the elimination of the deduction attributable to the subsidy, employers may now revisit their willingness to continue their retiree drug plans.</p>

2010 HEALTH REFORM ACT – Part 3 (continued)

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Provision	Explanation	Observations/ Comments
W-2 Reporting	<p>Effective for tax years beginning after December 31, 2010, employers will be required to report the aggregate cost of applicable employer-sponsored health coverage on each employee's Form W-2. The aggregate cost of coverage is calculated under rules similar to the rules applicable to calculating applicable premiums for COBRA purposes.</p> <p>Coverage is considered to be applicable employer-sponsored coverage without regard to whether the employer or the employee actually pays the cost of the coverage, and generally includes coverage under any group health plan. Applicable employer-sponsored coverage does not include coverage for long term care, accident or disability income insurance, or salary reduction contributions to a flexible spending arrangement under a cafeteria plan.</p>	<p>It is unclear whether or to what extent this reporting obligation will be imposed with respect to coverage that an employee receives under a multiemployer plan. Presumably, the employer will have to receive the cost information from the plan in order to include it on employee's W-2.</p>
Health Industry Fees	<p>The Act imposes certain fees on the health care industry.</p> <p>Fees on Manufacturers and Importers of Prescription Drugs and Health Insurance Providers; Excise Tax on Sale of Medical Devices. Under the Act, new annual fees are imposed on manufacturers and importers on U.S. sales of branded prescription drugs. The aggregate fee imposed on all covered entities starts at \$2.5 billion for 2011, increasing up to \$4.1 billion for 2018. For 2019 and later years the number drops to \$2.8 billion. Fees will be apportioned based on each entity's relative market share of covered sales. The fees apply in calendar years starting in 2011.</p> <p>Effective in calendar years beginning after 2013, new annual fees are also imposed on net premiums written by certain providers of health insurance for any "United States Health Risk" (the health risk of any individual who is a U.S. citizen, a U.S. resident, or located in the U.S.). Fees are based on relative market share of net premiums written for the prior year.</p>	<p>Although these fees and taxes are imposed on insurance carriers and drug and medical device manufacturers, it can be expected that such additional costs will translate into higher medical premiums and costs for individuals and employers as the fees and taxes become effective.</p>

2010 HEALTH REFORM ACT – Part 3 (continued)

SUMMARY OF OTHER TAX AND REPORTING REQUIREMENTS

Provision	Explanation	Observations/ Comments
<p>Health Industry Fees (continued)</p>	<p>In addition, a new excise tax (equal to 2.3% of the price as sold) is imposed on the sales of certain medical devices. The new excise tax applies to sales after 2012.</p> <p>Annual Fee on Health Insurance Providers. Effective in 2014, health insurers meeting certain criteria must pay a fee based on the amount of health insurance premiums collected. Certain reporting requirements are also imposed. Insurers with net premiums of \$25 million or less are exempt; for those with net premiums over \$25 million but less than \$50 million the fee is based on 50% of net premiums; and for insurers with net premiums in excess of \$50 million, all premiums are used in calculating the applicable fee.</p> <p>The specific fee applicable to any insurer is equal to the amount that bears the same ratio as the insurer's net health premiums for the previous calendar year bears to the aggregate net health insurance premiums of all covered entities.</p> <p>Excise Tax on Indoor Tanning Salon Services. Under the Act, a 10% excise tax is imposed on amounts paid for indoor tanning services. The tax is effective on and after July 1, 2010. The owner of the tanning service is required to collect the tax and remit to the IRS on a quarterly basis.</p>	