



To: Allegiance Companies' Clients
Date: June 1, 2010
Re: Third Installment: Key Provisions Affecting Employers Between Calendar Years 2011 through 2013, with Tax Implications

This is the third in a series of Allegiance articles concerning the recently enacted Patient Protection and Affordable Care Act (PPACA) ("the Act") of 2010.

This installment identifies when and to what extent the new rules, including tax implications, will apply to plans between December 31, 2011 and 2013.

As discussed in previous client communication, a "grandfathered" plan is defined under the law as any group health plan or individual coverage that was in effect on March 23, 2010. New enrollees are intended to be included in a grandfathered plan.

The requirements discussed below apply to all plans, even those with grandfathered status.

A recent report issued by the Congressional Research Service identifies more than 40 provisions in the new law, which require, permit, or contemplate rulemaking by federal agencies to implement the legislation. Regulations have been slowly trickling out of the various agencies entrusted with clarifying various provisions in the new law, including health-related financing and revenue changes to PPACA, and regulatory deadlines.

2011 Provisions:

1. Small Business Tax Credits. Small businesses are eligible for new tax credits to offset their premium costs in 2010. The credit is effective for taxable years beginning in 2010 and through 2013. For tax years 2010 to 2013, the maximum credit is 35 % of premiums paid by eligible small business employers and 25 % of premiums paid by eligible employers that are non-profit section 501(c) tax-exempt organizations which are exempt from tax under 501(a). Special rules apply for calculating the credit for a tax-exempt qualified employer. A governmental employer is not, for the most part, a qualified employer. For tax-exempt organizations that qualify, the credit is against payroll. For-profits, on the other hand, have a credit against income tax but they will only qualify if there is income to take that credit against. The full credit will be available to smaller employers – those with 10 or fewer employees and average wages of \$25,000 or less. The credit is completely phased out for employers that have 25 full-time employees or more or that pay average wages of \$50,000 per year or more. Eligible small businesses can claim the credit as part of the general business credit starting with the 2010 income tax return they file in 2011. Since it is a tax credit and not a deduction, small employers will be able to carry the credit forward to future years.
2. Over-the-Counter Drug Costs Reimbursement Restrictions in HRA, HSA, FSA plans. Over-the-counter drugs not prescribed by a doctor cannot be reimbursed through a health reimbursement arrangement or health flexible spending account. If there is a prescription, over-the-counter drugs can still be paid pre-tax through flex HRAs, HSAs, etc. Such drugs, without prescriptions, cannot be reimbursed on a tax-free basis through an HSA or Archer MSA effective January 1, 2011.
3. Value of Employer Benefits Reported on W-2 Forms. Employers are required to disclose the value of benefits provided by the employer in 2011 for each employee's health insurance coverage on the 2012 W-2 forms. "Value", as used in the law, means the total value of coverage provided which is similar to "value" as used to determine imputed income, which is equal to the

applicable COBRA rate. The W-2 reporting is only for informational purposes, not as a taxable item.

4. Simple Cafeteria Plan For Small Employers. Cafeteria plan non-discrimination rules do not apply to small employers which means, in this instance, 100 employees or less.
5. Medical Loss Ratios. Requires health plans offering fully insured group health insurance coverage in the large group market to maintain a medical loss ratio (MLR) of at least 85 % in order to avoid paying rebates to individual enrollees. Health insurers offering coverage in the small group market on in the individual market will have to maintain an MLR of at least 80%. These requirements do not apply to Administrative Services Only plans. Rules governing the calculation of MLRs are being developed. States are given the chance to impose more stringent MLR requirements.

2012 Provisions:

1. Summary of Benefits and Explanations of Coverage. Employers in both insured and self-funded plans will have to distribute a summary of benefits and explanations of coverage, to be based on forthcoming HHS regulatory standards and format. The summary will be limited to 4 pages, must be in font no smaller than 12 point, and must state whether the plan provides minimum essential coverage and whether the plan meets 60% actuarial value. These summaries must be provided to employees when they enroll in the plan. The explanation will be required to be provided in addition to the plan's ERISA-required summary plan description.
2. Advance Notice of Material Modifications to a Plan. Plan participants must receive advance notice of any "material modification" in coverage under the plan. The notice must be provided no less than 60 days before the modification is to take effect. This requirement alters ERISA's requirement to follow this mandate.
3. Comparative Effectiveness/Annual Per-Participant Fee (Tax). A new federal premium tax of \$1.00 on each covered life in a fully insured or self-funded health plan would be assessed to finance a comparative effectiveness research program in 2013. The tax would increase to \$2.00, indexed to inflation, in 2014 – 2019, and then sunsets in 2020.
4. Insurer Administrative Simplification Requirements. Health plans must adopt and implement administrative simplification standards for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

2013 Provisions:

1. Limits on Contributions to FSAs. Health reimbursement FSA salary reductions are limited to \$2,500 a year, indexed to the consumer price index for subsequent years. This limit will present issues for plans that do not run on a calendar year because the \$2,500 cap accrues on a calendar year basis.
2. Deduction Eliminated for Retiree Drug Subsidy (Tax). Employers will no longer be permitted to deduct the amount of the 28% federal retiree drug subsidy (which is provided tax-free) to the extent they receive the subsidy for maintaining a retiree prescription drug program.

We hope you find this information helpful in guiding your compliance with health care reform.