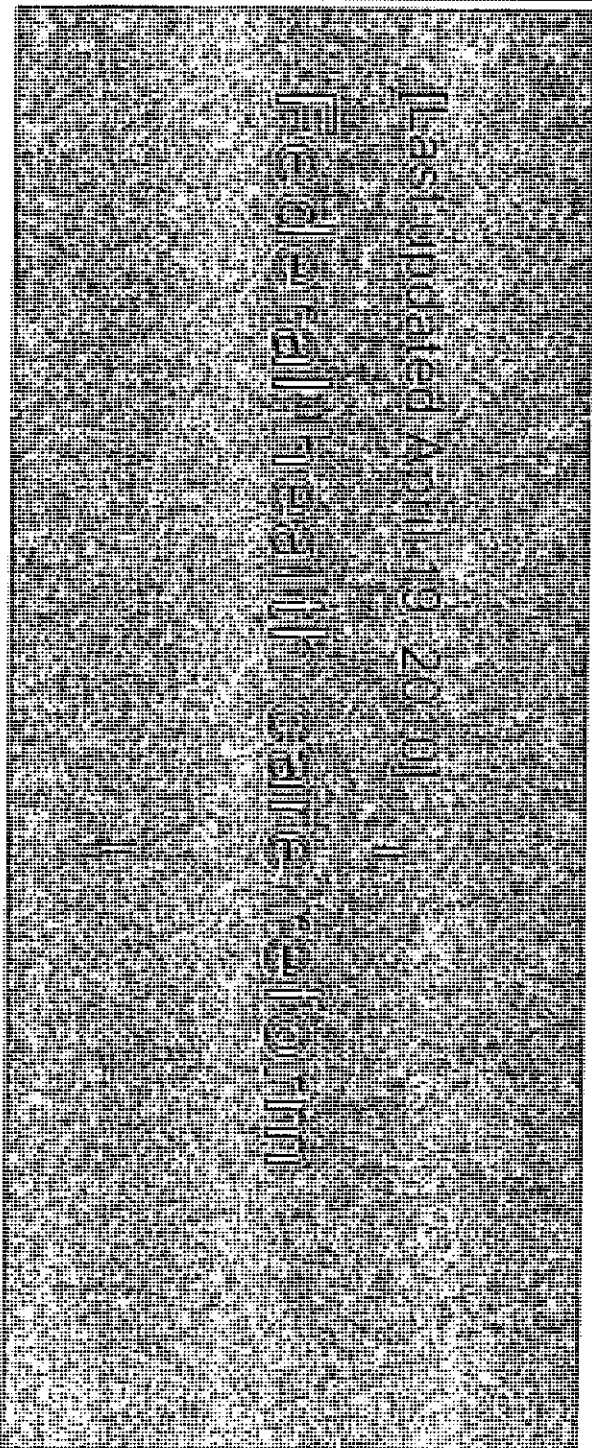
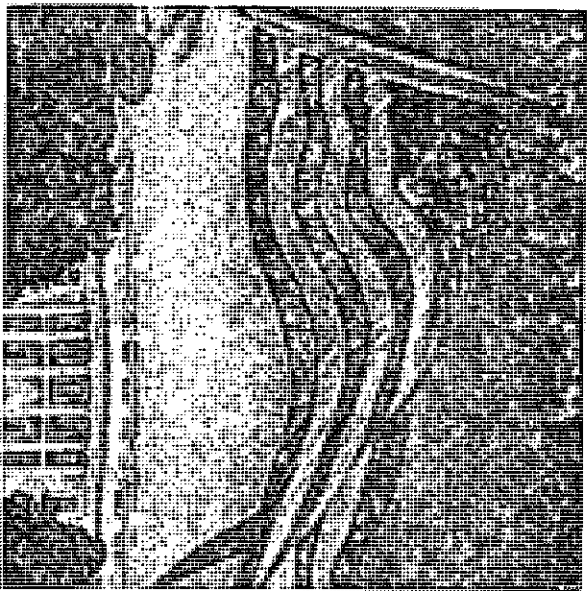


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Health care reform issues for employer-sponsored plans Beginning in 2010

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|---|
| <p>Health plan standards – all plans Effective for plan years beginning on or after Sept. 23, 2010; delayed for certain collectively bargained plans*</p> | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Offer extended dependent coverage to age 26 for covered employee's child without access to other employer coverage (regardless of whether tax dependent, student, married, or residing with employee) <ul style="list-style-type: none"> – Effective March 30, 2010, extend tax-free treatment for employer-provided health care to an employee's child until the end of the year in which the child turns age 26 ▪ Generally, no lifetime dollar limits ▪ Restricted annual dollar limits on essential health benefits ▪ No pre-existing condition exclusions for children under age 19 ▪ No rescissions |
| <p>Health plan standards – insured plans only Effective January 1, 2011</p> | <p>All insured (but not self-insured) group health plans must meet minimum medical loss ratios:</p> <ul style="list-style-type: none"> ▪ 85% if employer has more than 100 employees ▪ 80% if employer has 100 or fewer employees |

****“Collectively bargained coverage”** For health coverage under collective bargaining agreements (CBAs) ratified before March 23, 2010, PPACA's coverage and cost-sharing mandates will apply on the termination date of the last CBA relating to the coverage. Any CBA amendment to comply with these new mandates will not be treated as terminating the CBA. Thus, while collectively bargained plans may get a postponement, they don't have a permanent exemption from the new standards.

Health care reform issues for employer-sponsored plans Beginning in 2010

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|---|
| <p>Health plan standards – new and nongrandfathered plans**</p> <p>Effective for plan years beginning on or after Sept. 23, 2010; delayed for certain collectively bargained plans *</p> | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Provide mandated preventive services with no cost-sharing ▪ Establish and provide notice of internal and external appeals procedure ▪ Emergency services coverage <ul style="list-style-type: none"> – Cannot be limited to in-network providers – Cannot include higher cost-sharing for out-of-network providers – Cannot require preauthorization ▪ Plans requiring or providing for primary care physician designation <ul style="list-style-type: none"> – Must allow designation of any participating primary care physician or pediatrician – May not require preauthorization or referral for OB/GYN services ▪ Insured plans cannot discriminate in favor of highly compensated individuals |

****Grandfathered plans**** A grandfathered plan is one in place before March 23, 2010. The law doesn't say how a plan's grandfathered protection can terminate or be lost. The PPACA does permit a grandfathered plan to enroll new hires and their family members, as well as the family members of any employee covered before March 23, without affecting its status. However, the law doesn't say whether a plan can enroll employees who weren't covered before March 23 or make cost-sharing, benefit or other changes – including PPACA-required changes – without losing grandfathered status. Just how long a plan will enjoy grandfathered status will be difficult to know until regulatory guidance is issued.

Health care reform issues for employer-sponsored plans Beginning in 2010

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|---|
| <p>Reinsurance for early retiree medical plans By June 2010 and ending by Jan. 1, 2014</p> | <p>Temporary reinsurance program will reimburse cost of providing health coverage to retirees aged 55 – 64 (and not Medicare eligible)</p> <ul style="list-style-type: none"> ▪ Eligible plans may submit claims and receive 80% reimbursement of costs between \$15,000 and \$90,000 for a covered individual (including spouse, surviving spouse or dependent) ▪ To be eligible, plan must use cost-saving procedures for chronic and high-cost conditions ▪ Reimbursement may only be used to reduce retiree costs (such as premiums, coinsurance or deductibles) and may not be treated as general revenue ▪ Reimbursements are tax-free ▪ Employers likely will be required to document actual claims cost ▪ Program capped at \$5 billion |

Health care reform issues for employer-sponsored plans

Effective date is unclear

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|---|
| <p>Auto-enrollment requirement for employers with more than 200 full-time employees Effective date is unclear</p> | <ul style="list-style-type: none"> ▪ Unclear when it applies; may be effective: <ul style="list-style-type: none"> – March 23, 2010 – Once DOL issues regulations – 2013 or 2014 ▪ Must automatically enroll new full-time employees in employer-sponsored plan ▪ Must automatically continue plan enrollment for current employees ▪ Required notice and opt-out opportunity |
| <p>60-day advance notice of plan design changes Effective date is unclear</p> | <ul style="list-style-type: none"> ▪ Unclear when it applies; may be effective: <ul style="list-style-type: none"> – Plan years starting on or after March 23, 2010 – Plan years beginning on or after March 23, 2012 ▪ Must give 60-days prior notice before any material modifications can be made to the plan <ul style="list-style-type: none"> – Includes premium and cost-sharing increases, benefit decreases |

Health care reform issues for employer-sponsored plans Beginning in 2011

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|--|
| Form W-2 reporting | <ul style="list-style-type: none"> ▪ Employers must include the aggregate cost of an employee's health coverage ▪ "Aggregate cost" to be determined using methodology similar to that for determining COBRA premiums (excluding pre-tax health FSA contributions, employee HSA contributions) ▪ Unclear if reporting must first be made in 2011 to reflect 2010 coverage, or in 2012 to reflect 2011 coverage |
| No reimbursement for over-the-counter drugs | <ul style="list-style-type: none"> ▪ No reimbursement for over-the-counter drugs from a health plan, health flexible spending account, health reimbursement arrangement, or health savings account <ul style="list-style-type: none"> – Reimbursements limited to physician-prescribed drugs and insulin |
| Increased penalty for nonqualified HSA distributions | <ul style="list-style-type: none"> ▪ Penalty for using health savings account (HSA) funds for nonqualified medical expenses (including over-the-counter drugs) will increase to 20% (in addition to income tax) |

Health care reform issues for employer-sponsored plans Beginning in 2011

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|--|
| CLASS Act | <ul style="list-style-type: none"> Employers may participate in CLASS Act employee-pay-all voluntary long term care program |
| Tax on pharmaceutical manufacturers | <ul style="list-style-type: none"> Annual fee begins for pharmaceutical manufacturers and importers |
| Part D premium increase for high-income individuals | <ul style="list-style-type: none"> Medicare beneficiaries with high incomes face higher Medicare Part D premiums |
| Medicare Advantage payment reductions | <ul style="list-style-type: none"> Medicare Advantage plan payments for 2011 will be frozen at 2010 levels, and reductions will be phased in starting in 2012 |

Health care reform issues for employer-sponsored plans Beginning in 2012

| Issue | Patient Protection and Affordable Care Act, as amended |
|-------------------------|---|
| Group health plan fee | <ul style="list-style-type: none"> ▪ Group health plans must pay a fee of \$1 per participant, increasing to \$2 for the second year and then a formula thereafter, to fund federal research on comparative effectiveness research ▪ Sunsets in 2019 |
| Uniform benefit summary | <ul style="list-style-type: none"> ▪ Employers must provide a 4-page uniform benefit summary at initial enrollment and annual enrollment ▪ Includes information about covered benefits, exclusions, cost-sharing and continuation coverage ▪ In addition to SPD and other currently required disclosures |

Health care reform issues for employer-sponsored plans

Beginning in 2013

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|--|
| <p>\$2,500 health FSA contribution cap</p> | <ul style="list-style-type: none"> ▪ Annual contributions to health FSAs capped at \$2,500 <ul style="list-style-type: none"> – Adjusted annually for increases in the cost of living |
| <p>Health insurance exchange notice</p> | <ul style="list-style-type: none"> ▪ Employers must notify new hires about health insurance exchanges: <ul style="list-style-type: none"> – Eligibility for federal assistance to buy exchange-based coverage if employer's plan pays less than 60% of covered benefits |
| <p>New Medicare taxes for high-income households</p> | <ul style="list-style-type: none"> ▪ Additional Medicare taxes imposed on taxpayers with income over \$200,000/individual or \$250,000/couple: <ul style="list-style-type: none"> – 0.9% increase in Medicare payroll tax – 3.8% tax on net investment income |
| <p>Retiree drug subsidy tax treatment changes</p> | <ul style="list-style-type: none"> ▪ Employers' tax deduction for prescription drug claims paid will be reduced by the 28% RDS subsidy received in 2013 or after <ul style="list-style-type: none"> – Companies may have to recognize accounting impact in early 2010 |
| <p>Tax on medical devices</p> | <ul style="list-style-type: none"> ▪ A 2.9% tax will apply to medical devices |



Health care reform issues for employer-sponsored plans Beginning in 2014

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|--|
| <p>Health plan standards – all plans Effective for plan years beginning on or after Jan. 1, 2014; delayed for certain collectively bargained plans</p> | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Offer coverage to dependent children to age 26 regardless of access to other employer coverage ▪ No preexisting condition exclusions ▪ No waiting periods exceeding 90 days ▪ No annual dollar limits on essential benefits |
| <p>Health plan standards – new and nongrandfathered plans**</p> | <p>Insured and self-insured plans</p> <ul style="list-style-type: none"> ▪ Mandated coverage of costs in connection with clinical trials |
| <p>HIPAA wellness incentive limit increased to 30% Plan years beginning on or after Jan. 1, 2014</p> | <ul style="list-style-type: none"> ▪ HIPAA limit on group health plan wellness incentives based on health status increased to 30% (up from 20%) of the total cost of coverage ▪ Regulators given authority to raise the limit to 50% |

Health care reform issues for employer-sponsored plans Beginning in 2014

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|--|
| <p>Employer shared responsibility penalties Beginning in 2014</p> | <ul style="list-style-type: none"> ▪ Shared responsibility provision apply to employers with more than 50 full-time employees (FTEs) defined as employees working 30 or more hours per week on average in a month (or full-time equivalents based on separate statutory formula) ▪ Employers <i>offering coverage</i> to full-time employees that is unaffordable (i.e., employee contribution constitutes more than 9.5% of household income) or pays less than 60% of benefits covered by the plan (i.e., 60% minimum actuarial value) <ul style="list-style-type: none"> - Up to \$3,000 annually for each FTE receiving income-based assistance for health insurance exchange coverage - Penalties capped at \$2,000 times total number of FTEs - not counting first 30 FTEs - Employers <i>not offering coverage</i> <ul style="list-style-type: none"> - Up to \$2,000 annually for every FTE if at least one FTE receives income-based premium assistance to buy coverage through new health insurance exchanges - Penalties do not apply to first 30 FTEs |

Health care reform issues for employer-sponsored plans Beginning in 2014

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|--|
| <p>Free choice vouchers for certain employees Beginning in 2014</p> | <ul style="list-style-type: none"> ▪ Offer vouchers to employees with household incomes at or below 400% of the federal poverty level (FPL) if their contribution for employer-sponsored coverage would be 8% to 9.8% of household income <ul style="list-style-type: none"> – Voucher amount equal to highest (percentage) employer contribution to any of its own plans ▪ Vouchers to be used for purchasing exchange-based coverage ▪ Employees could keep any excess amounts ▪ No penalty associated with free choice vouchers |

Health care reform issues for employer-sponsored plans

Beginning in 2014

| Issue | Patient Protection and Affordable Care Act, as amended |
|---|---|
| <p>Individual coverage mandate Beginning in 2014</p> | <ul style="list-style-type: none"> ▪ Individuals must obtain minimum essential coverage ▪ Certain exceptions (e.g., lowest cost plan exceeds 8% household adjusted gross income, no coverage for less than 3 months, income below the income tax filing threshold) ▪ Penalty would be the greater of a flat dollar amount (\$325 in 2015, rising to \$695 in 2016) or 2.5% of income |
| <p>Health Insurance Exchanges Beginning in 2014</p> | <ul style="list-style-type: none"> ▪ Federal funding for states to create health insurance exchanges to facilitate purchase of insurance by individuals and small groups ▪ Employer size initially limited to 50 or fewer employers <ul style="list-style-type: none"> – Federal threshold gradually rises to 100 or fewer, with state flexibility to let employers of any size participate ▪ Income-based assistance for individuals or families with incomes below 400% of federal poverty level |

Health care reform issues for employer-sponsored plans 2018 and beyond

| Issue | Patient Protection and Affordable Care Act, as amended |
|--|--|
| <p>Excise tax on high cost coverage Effective for all plans in 2018</p> | <ul style="list-style-type: none"> ▪ 40% excise tax on "high cost" coverage, including medical, health FSA contributions, onsite medical clinics, and employer contributions to HSAs <ul style="list-style-type: none"> – Does not include stand-alone insured dental and vision coverage ▪ Initial cap set at \$10,200/single and \$27,500 family <ul style="list-style-type: none"> – Higher thresholds (\$11,850/\$30,950) for retirees and workers in high-risk professions – Higher threshold (\$30,950) for multiemployer plan coverage – Indexed to CPI+1% ▪ Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums ▪ Employers must determine aggregate cost <ul style="list-style-type: none"> – Insurers responsible for tax for insured coverage – Benefit administrators responsible for tax for self-insured coverage – Employers responsible for tax for HSA contributions |
| <p>New industry fees</p> | <ul style="list-style-type: none"> ▪ Health insurer fees begin |

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