



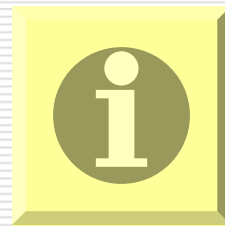
PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS RECONCILED

A SURVEY OF INSURANCE REFORMS AND
RELATED COSTS, PENALTIES AND TAXES

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INSURANCE REFORM

COVERAGE



Grandfathered Plans

- ❑ "Preservation of right to maintain existing coverage" aka Grandfathered Plans. No one is required to terminate participation in group coverage.
- ❑ Subtitle A (Immediate Improvements in Health Care Coverage for all Americans) and Subtitle C (Quality Health Insurance Coverage for All Americans) generally do not apply to grandfathered plans.
- ❑ **Except** the specific Minimum Loss Ratio provision and uniform coverage provisions (e.g. no pre-existing condition, no excessive waiting periods, lifetime and annual limits, prohibition on rescission, coverage of dependents through age 26, uniform explanation of coverage reports).

Grandfathered Plans

- There is no “sunset” for Grandfathered Plans in the legislation. However, it is unlikely that such will be allowed to exist in perpetuity.
- PPACA provides for Grandfathered Plans that do not change their coverage. What does this mean?

June 14, 2010 “Interim Final Regulations” issued

- Does and Do nots
- Anti-Abuse rules to prevent mergers or acquisitions designed to prevent transfer of employees between plans
- Employer/Plan required to provide participants with notice that the Plan is considered Grandfathered and must maintain records.

Generally, a Grandfathered Plan will lose its status if it:

- ❑ 1. Eliminates coverage for currently existing diseases/conditions.
- ❑ 2. Increases co-insurance from rate at 3/23/10.
- ❑ 3. Increases deductible or out of pocket limit by an amount greater than medical inflation plus 15%.
- ❑ 4. Increases co-pay by an amount greater than medical inflation plus 15% or \$5 increased by medical inflation.

Generally, a Grandfathered Plan will lose its status if it:

- ❑ 5. Decreases employer's contribution of premium payment by 5% or more.
- ❑ 6. Imposes lifetime or annual limits that did not exist; imposes annual limits previously non-existent to a limit higher than existing lifetime limits; provides for decreases in limits.
- ❑ 7. Changes insurance companies. Self-insured plans should be able to change third party administrators.

Grandfathered Cont.

- ❑ Must Maintain Plan Records as of 3/23/10 as well as any changes thereafter. This is to verify that the Plan qualifies for GFP status. Model language for notification can be found at §54.9815-125IT [pg 76 of the Regulations].
- ❑ The Government anticipates that as high as 64% and as low as 36 % of large employers will lose GFP status and as high as 80% and as low as 49 % of small employers will lose GFP status.

Dependent Coverage

Includes
married

- Dependent coverage for “children” up to age 26.
- Applies to Grandfathered Plans for plan years after 9/23/10 and **before 1/1/14, if the “child” is not eligible for another employer-sponsored plan.**

Dependent Coverage Cont.

- ❑ Also note tax exclusion for employer provided benefits for person who was not age 27 at the end of the taxable year [HCERA 1004(d)].
- ❑ 75 Federal Register 27122 provides “final interim rule” on requirements and IRS Notice 2010-38 provides Tax Treatment
- ❑ Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.

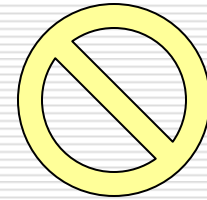
Annual Limits

- ❑ Restricted annual limits on "essential health benefits" for plan years **pre 1/1/14**. No annual limits at **all beginning 1/1/14**. [Caveat for "per beneficiary" annual limits for non essential health benefits - can place limits on specific benefits if otherwise allowed under federal or state laws].
- ❑ Applies to Grandfathered Group Plans **not** Individual Plans.
- ❑ Technically 9/23/10 but for Plan years beginning after effective date 1/1/11.

Annual limit Phase -Out

□ June 22 “Interim Final Regulations” Provides for Phase “out” of Annual Limits

- For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000;
- For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and
- For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million.



Lifetime Limits

- ❑ No lifetime limits. [Caveat for "per beneficiary" lifetime limits for non-essential health benefits, if otherwise permitted by federal or state laws].

- ❑ Applies to Grandfathered Plans.

- ❑ Technically 9/23/10 but for Plan years after effective date so look to 1/1/11.

Salary Non-Discrimination

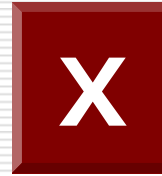
- Existing non-discrimination rules in favor of highly compensated employees now apply also to group insured plans.

- Subject to excise tax of \$100 per day per plan employee until plan is in compliance.
 - Self-funded plans subject to prohibition since 1980s

- Does not apply to Grandfathered Plans.

- Technically 9/23/10 but for Plan years after effective date so look to 1/1/11.

Pre-Existing Conditions



- No pre-existing condition exclusions for “children” under age 19
 - 9/23/10 through 12/31/2013
 - Many Plans adopted early

- “Interim Final Regulations” reads as though not only can benefits not be denied based on pre-existing but that coverage must be extended [early guaranteed issue requirement which is not applicable to Grandfathered Plans]

- **Effective 1/1/14** no Pre-X regardless of age.

- Applies to Group Grandfathered Plans **BUT** not Individual Grandfathered Plans.
 - Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.

High Risk Pool



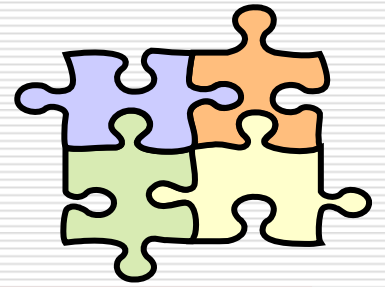
- High Risk Insurance Pool to be established by HHS [through 1/1/14]. Eligible if 1) U.S. Citizen or in the U.S. lawfully; 2) not covered under creditable coverage during 6 months before application date; and, 3) has a pre-existing condition.
- \$5 Billion available from HHS to pay claims (and administrative costs) that exceed premiums collected. Plan must cover 65% of health care costs for "standard" population. Premiums not yet determined.
 - * On April 2, 2010 HHS gave States choice of operating under certain options or do nothing, and the HHS would run it.
- Plans that encourage individuals to de-enroll could be liable to reimburse Pool for medical expenses.

High Risk Pool Cont.

- ❑ Mississippi Department of Insurance is not operating
- ❑ HHS will carry out coverage program
 - Pre-existing Condition Insurance Plan [PCIP]; \$2,500 deductible, \$25 co-pay and \$4 to \$30 for most prescriptions with out of pocket per year of no more than \$5,950
 - Premiums: Age 0-34 = \$277; 35-44 = \$332; 45-54 = \$424 and 55+ = 590.
- ❑ Estimated cost for the two years of funding \$46 million
- ❑ Effective 7/1/2010 through 1/1/14

Rescission

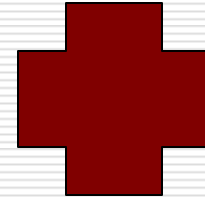
- ❑ Prohibits rescission of coverage except for fraud or intentional misrepresentation.
- ❑ Applies to Grandfathered Plans.
- ❑ Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.



Preventive Services

- Coverage for certain preventive services and immunizations without cost-sharing requirement. [For example, no deductible or co-pay for vaccines.]
 - Includes preventative care and screenings set forth in Health Resources and Services Administration [such as breast cancer screening and mammograms, etc.]
 - Interim Final Regulations Issued 7/19/10
- Does not apply to Grandfathered Plans.
- Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.

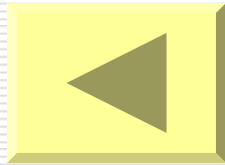
Patient Protections



- Patient Protections requirements: if required to designate primary care physician, then allowed to select any that is available to accept; allows choice of pediatrician as child's primary care physician; women allowed to choose a participating OB/GYN without referral; emergency services without pre-authorization and treat as in network.

- Does not apply to Grandfathered Plans.
- Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.

MLVs



- ❑ Minimum Loss Ratios: Rebates required if minimum loss ratios [general premium to benefits] are not met. [80% Small Groups and Individuals and 85% Large Groups]
- ❑ Applies to Grandfathered Plans but not self-funded plans.
- ❑ Technically 9/23/10 but for Plan years beginning after effective date so look to 1/1/11.

Limited Waiting Period

- ❑ No waiting period in excess of 90 days for employer plans. [See IRS Notice 2011-36 requesting comments on how to interpret this provision].
- ❑ Penalty for periods of less than 60 days was deleted through Reconciliation process
- ❑ Includes Grandfathered Plans.
- ❑ Effective Year 2014.

Guaranteed

- ❑ Guaranteed renewability of coverage [exceptions for not paying premium, policy no longer offered in the market, etc]
- ❑ Guaranteed Issue ["Guaranteed Availability of Coverage" and "Prohibiting Discrimination Against Individuals Participants and Beneficiaries Based on Health Status"] for all individual and group plans.
- ❑ Does not apply to Grandfathered Plans.
- ❑ Effective Year 2014

Appeal Procedures

- ❑ Claim Appeal Procedures - comply with appeal procedures in place at time of enactment [and when updated].
- ❑ Applies to Internal and External appeal procedures.
- ❑ Notify participant of appeal rights in a “culturally and linguistically appropriate” manner and right to review file and present evidence.
- ❑ Mississippi will use National Insurance Commissioners’ Model Policy.
- ❑ Does not apply to Grandfathered Plans

APPEALS CONTINUED: INTERNAL

- ❑ Broader definition of adverse benefit determination
- ❑ Quicker notification on urgent care decisions
- ❑ New evidence relied upon in decision must be made available to claimant
- ❑ Safeguards to limit conflict of interest
- ❑ Expands Information Required on Denials
- ❑ Consequence of Non-Compliance is exhaustion of internal appeal requirement

APPEALS CONT: EXTERNAL

- ❑ MS did not have external statutory mechanism
- ❑ Insured plans, nonfederal government, church plans and MEWAs that are not Grandfathered will follow mechanisms at least as stringent as NAIC Model Act
- ❑ Non-grandfathered self-insured plans will follow federal claims review standards set by HHS

Clinical Trials 2014

- Qualified Individual is one with cancer or other life threatening disease referred by network provider or who otherwise provides evidence for participation.

- Must participate in network trial, if available
 - If Plan does not cover out of network services, then Plan not required to cover out of network clinical trial.
 - Covers routine costs of clinical trial items and services typically covered under the Plan for those not participating.
 - Does not cover cost of the investigational device or data gathering.

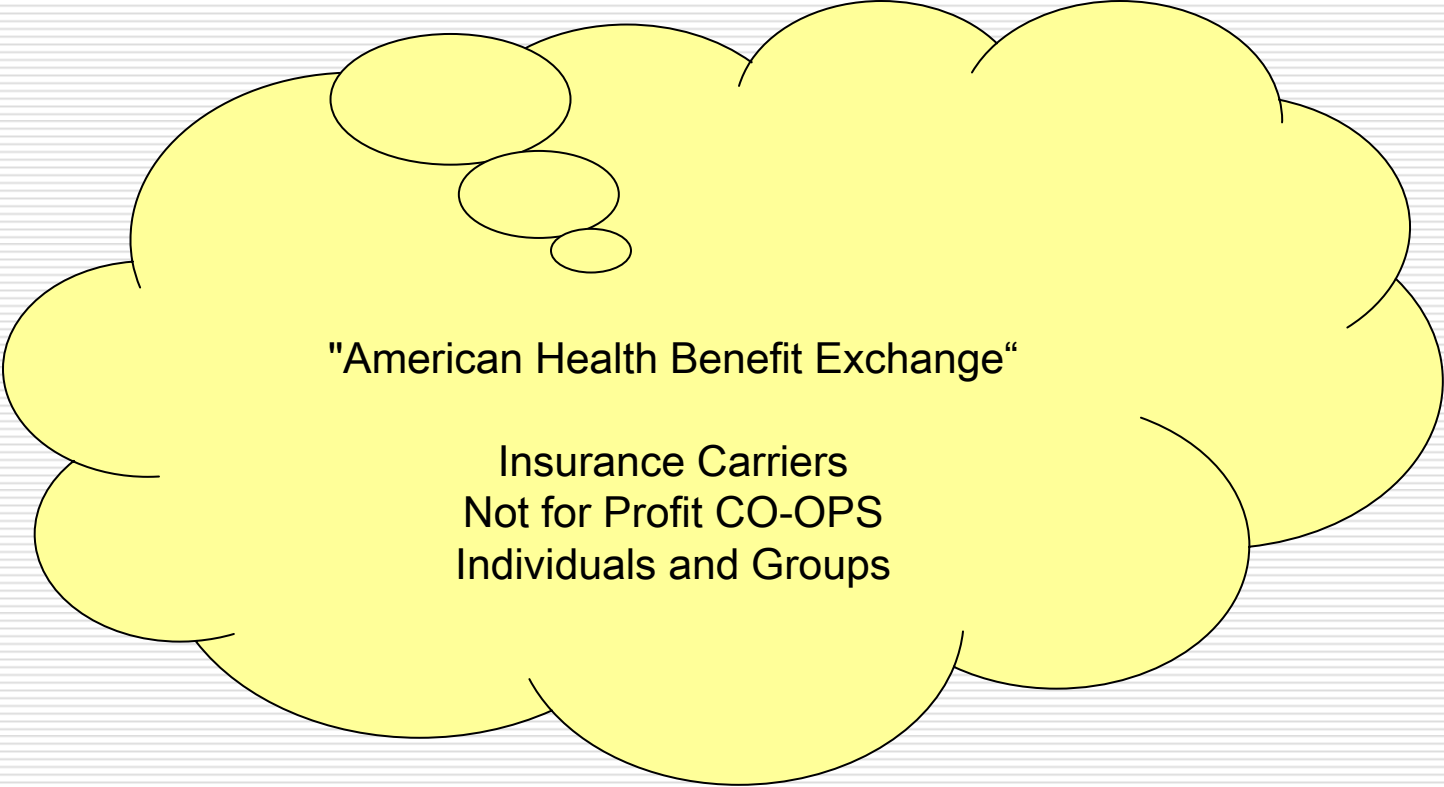
- Does not Apply to Grandfathered Plans

Deductibles

- ❑ Small group market - deduction limitations \$2000 individual and \$4000 “other” with formula increase after 2014.
- ❑ May be increased by maximum amount of reimbursement which is reasonably available under FSAs.
- ❑ Does not apply to Grandfathered Plans.
- ❑ Effective Year 2014.

Premium Controls

- "Value for Dollars" requires premium rate review - for unreasonable rate increases.
- Provides grants to States to review premiums and Medical Reimbursement Data Centers created to review rates.
 - \$250 million available; \$51 million authorized in June 2010.
- State may recommend health insurance issuers be excluded from the "American Health Benefit Exchange" aka Exchange if they have a history of "unjustified" premiums.



"American Health Benefit Exchange"

Insurance Carriers
Not for Profit CO-OPS
Individuals and Groups

The Exchange 2014

- ❑ "American Health Benefit Exchange," aka Exchange, are to be operational in each State [must include "Small Business Health Options Program" [SHOP] or have a separate SHOP Exchange].
- ❑ Exchanges must include - at least 2 Multi-State Qualified Health Plans to be offered in each State Exchange [at least one must be non-profit].
- ❑ Exchanges must include at least one "CO-OP Plan," if they offer qualified health plan. Must be not-for-profit.

Exchange Status

- ❑ HHS to determine by 1/1/13 whether a State's Exchange will be operational by 1/1/14.
- ❑ The 2 Bills in the Mississippi 2011 Legislative Session failed to pass.
- ❑ If not, HHS has authority to take actions as are necessary to establish and operate such Exchange and take such actions as are necessary to implement such other requirements.

Qualified Health Plan

- General definition of a "Qualified Health Plan" Q.H.P. =
- 1) Certified;
- 2) Provides Essential Health Benefits Package (a. Essential Health Benefits b. Limits cost sharing c. Provides Bronze, Silver, Gold or Platinum plans); and,
- 3) Offered by health insurance issuer who
 - a) is licensed in the State;
 - b) agrees to offer at least one Q.H.P. in Silver and in Gold;
 - c) charges same premium for Q.H.P. whether offered in Exchange, directly through the issuer/agent; and,
 - d) follows all other regulations applicable to Exchanges in the PPACA and as later may be established.
- An Essential Health Benefits Package does not have to include abortion services §1303(a)(1)(A)(i).
- Self-funded plans and MEWAs not included in Q.H.P. regulations.

Essential Health Benefits

- Essential Health Benefits established aka Minimum Essential Coverage from essential health benefits:
 - (A) Ambulatory Patient Services;
 - (B) Emergency Services;
 - (C) Hospitalization;
 - (D) Maternity and Newborn care;
 - (E) Mental health and substance use disorder services, including behavioral health treatment;
 - (F) Prescription Drugs;
 - (G) Rehabilitation and habilitative services and devices;
 - (H) Laboratory Services;
 - (I) Preventive and wellness services and chronic disease management; and,
 - (J) Pediatric services, including oral and vision care [can have a stand alone Dental Plan- PPACA §1311(d)(2)(B)(ii)]
 - WATCH FOR HHS REGULATIONS

Who is Qualified?

- ❑ **Qualified Individual** for a Q.H.P. : 1) seeks to enroll in a QHP and 2) resides in that State. Does not include those in jail.
- ❑ **Qualified Employer** for a Q.H.P. : Small Employer is one who elects to make all Full Time Employees, as defined, eligible for one or more Q.H.P.s offered in the Small Market Group in the Exchange. Will include Large Employers, if State opts to allow their participation, in 2017.

§1312(f)(2)(A) and (B)

Plans in the Exchange

- ❑ Defines Bronze, Silver, Gold and Platinum Levels in terms of actuarial value of benefits (60%, 70%, 80% and 90%).
- ❑ Child-Only Plans: A Q.H.P. at any level must be offered as a separate Plan for individuals less than 21 yrs.
- ❑ Catastrophic Plan: A catastrophic plan is offered in individual market for those under 30 before the beginning of the Plan Year or for those who meet certain hardship or uninsured requirements. Must offer at least three primary care visits. No "essential health benefits" coverage until certain cost-sharing requirements are met.
- ❑ Exchange Qualified Health Plans must be equal to scope of benefits offered by typical employer sponsored plans.

Cost-Sharing in the Exchange

- ❑ Exchange Qualified Health Plans must include cost sharing provisions.
- ❑ Cost-sharing=co-payment, deductible or any expense incurred by the individual that would qualify as a medical expense under the I.R.C. (not including though such expenses as premiums).

Self-Sustaining

- ❑ State Exchanges must be self-sustaining by 2015 [Must be operational by 1/14]
- ❑ Can charge assessments and user fees.

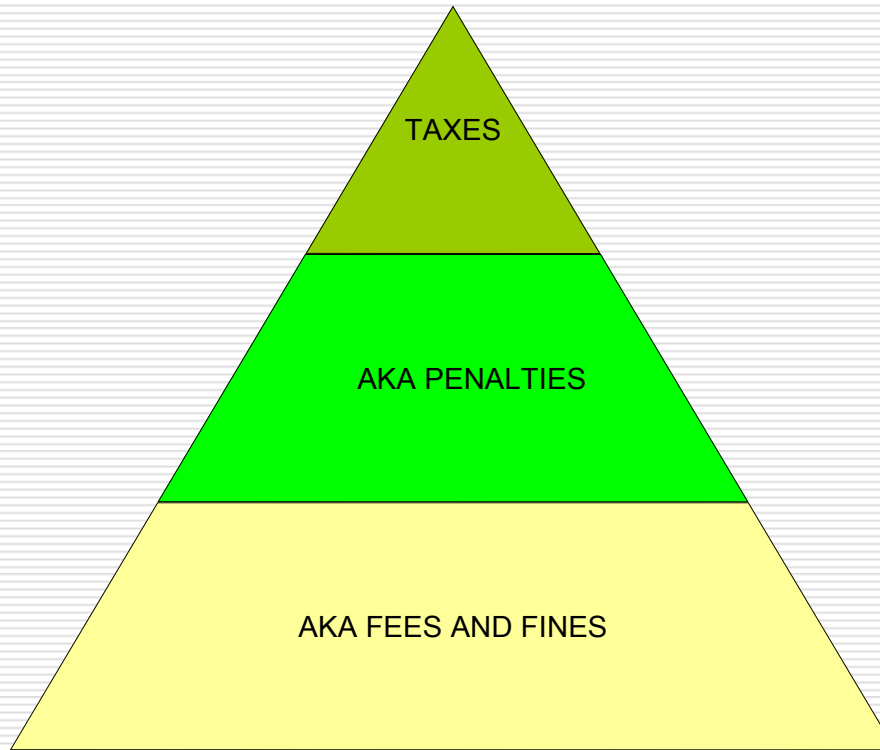
Large Employers in Exchange

- ❑ Exchanges open to Large Employers, if allowed by the State.
- ❑ Generally 101 employees is Large; 100 or less is Small but for any plan year before 1/1/16, the State may limit Small Employers to 50 or less employees.
- ❑ 2017

Basic Health Program

- HHS establishes a "Basic Health Program" under which States may enter into contracts to offer one or more "Standard Health Plans" [must include the "essential health benefits"] for uninsured residents of the State or aliens lawfully present in the United States under 65 yrs whose income is within the federal poverty level of 133-200% and who would otherwise be eligible to participate in the Exchange and obtain a premium subsidy.
- Effective 1/1/2014.

PPACA DIRECT COSTS



Small Business Tax Credit

Year 2010-13

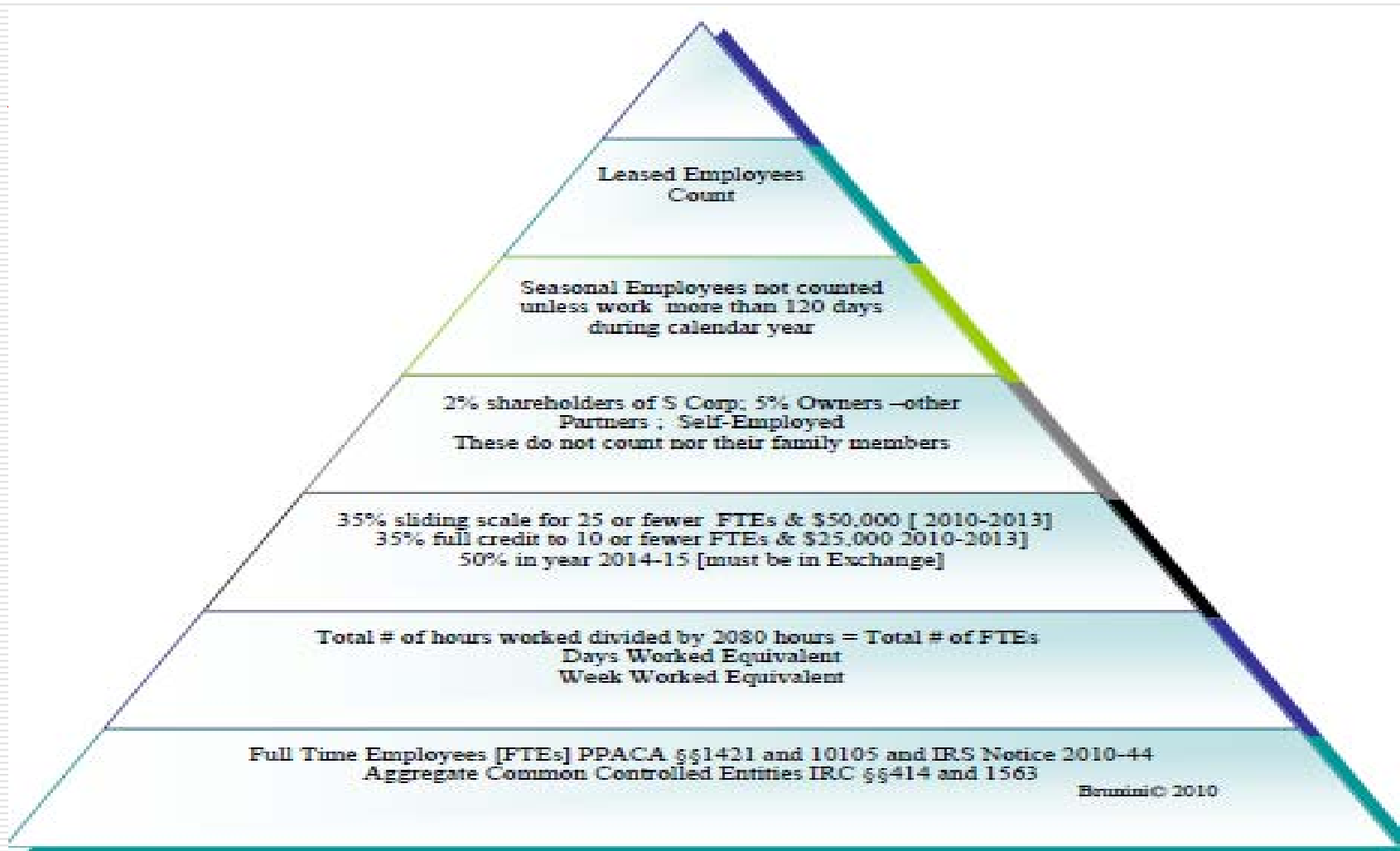
- ❑ Small Business Tax Credit: 25 or fewer full time employees [defined] and average annual wages of less than \$50,000 are eligible for tax credits up to 35% [25% tax exempt eligible small employer] of the employer's non elective contribution toward the employee's health insurance premium.
- ❑ Employers with 10 or fewer full time employees [defined] and average annual wages of less than \$25,000 is allowed full credit.
- ❑ Employers must pay for at least 50% of the employee's premium.

Small Business Tax Credit

Year 2014

- ❑ Employers with 25 or fewer employees and average annual wages of less than \$50,000 are eligible for tax credits up to 50% [35% tax exempt eligible small employer] of the employer's non elective contribution toward the employee's health insurance premium.
- ❑ Employers with 10 or fewer full time employees [defined] and average annual wages of less than \$25,000 is allowed full credit.
- ❑ Employers must pay for at least 50% of the employee's premium.
- ❑ Can only claim Tax Credit for 2 years beginning in 2014 and only if employees are in the Exchange.

EMPLOYEE COUNT FOR SMALL EMPLOYER TAX CREDIT



“No Coverage” Tax

- Employers with 50 or more employees who do not offer their employees health coverage will be subject to a 1/12th of \$2,000 tax penalty /per full-time employee (per month) if one of their employees is enrolled for a tax credit subsidy (first 30 employees exempted) [See IRC 4980H].

"Unaffordable" Coverage Tax

- Employers with 50 or more employees who offer minimal "unaffordable" coverage but who have employees who qualify for premium tax credit or cost sharing reductions and who have been certified as enrolled in a qualified health plan, will be subject to a tax of 1/12th of \$3,000 for each full time employee per month. Total penalty is capped at amount of total penalty employer would have paid if no coverage had been offered.
- ""Unaffordable" is premium paid by employee that is more than 9.5% of the employee's household income [as further defined by PPACA] or the actuarial value of coverage is less than 60%.

Unaffordable v. No Coverage

- In reaching a maximum penalty for Unaffordable Coverage, the penalty will be **the lesser** of what the penalty would have been if there was No Coverage [FTEs - 30 employees * \$2,000] or the penalty for Unaffordable coverage [FTEs who receive Exchange credit * \$3,000]

IRS Notices

- IRS Notice 2010-40 provides guidance on how to count full time employees.
- IRS Notice 2011-36 requests comments on how to define employer, employee, how to count hours, how to determine full time equivalents.



Premium Assistance

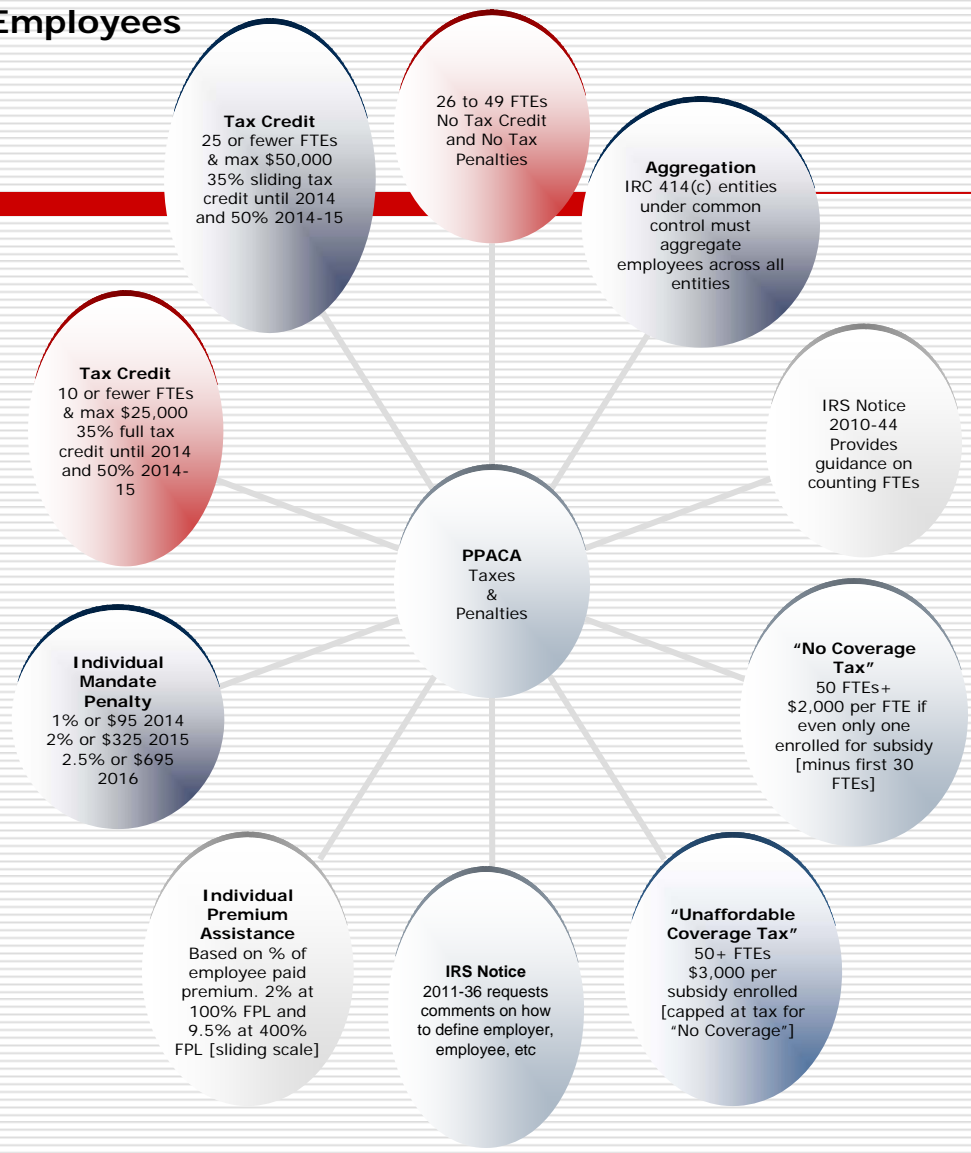
- ❑ Premium Assistance Tax Credit for those who purchase insurance in the Exchange. Paid by the IRS directly to the insurance carrier in advance and any balance is paid by the individual through payroll deductions.
- ❑ Assistance is available to those at 400% poverty level [\$43,320 individual and \$88,200 family of four]. The Credit is sliding scale based on percentage of income: 2% of income at 100% poverty level and 9.5% of income at 400% of poverty level.
- ❑ Effective Year 2014.

SHARED RESPONSIBILITY

- ❑ Tax penalties aka "shared responsibility penalty" occur for those who are not enrolled in a health plan aka "individual mandates."
- ❑ The greater of \$95 for 2014 and \$325 for 2015 OR 1% beginning in 2014, 2% in 2015 and 2.5% after 2015. After 2016, greater of \$695 adjusted for cost of living or 2.5% of taxable income. Flat dollar is per person required to have insurance up to 300% of applicable \$ amount.
- ❑ Not subject to penalty for certain reasons: financial hardship, religious objections, American Indians, illegal aliens, those in jail, those without coverage for less than three months, those for whom the "bronze plan" [lowest option in an Exchange] exceeds 8% of household income, incomes below filing threshold and those living outside the U.S. [See IRC§5000A(c)]. 8% changes in 2015 to a percentage set by HHS under IRC 5000A(e)(1)(B)(i).

INSURANCE RELATED TAXES AND PENALTIES

FTEs = Full Time Employees



Individual Taxes

- ❑ Increase Medicare tax rate on employee wages by .9% on high income individuals. [\$200,000 single; \$250,000 joint].
- ❑ New Medicare tax 3.8% on unearned income takes effect [\$200,000 single; \$250,000 joint].
- ❑ Effective Tax Year 2013

Fees on Plans

- For each fiscal year 2013-2019 there is a fee on employer-sponsored plan to fund Comparative Clinical Effectiveness Research. [\$1 for policy year ending 2013].
- [\$2 * average # of lives covered under the policy 2014-2019]
- Insured and Self Insured.

Tax Deductions

- ❑ Medical expense deduction raised from 7.5% to 10%
- ❑ If tax payor or spouse is 65+ then stays at 7.5% for tax years 2013-2016
 - ❑ Effective Tax Year 2013
- ❑ Floor on deductible medical expenses is raised to 10% AGI for all taxpayers, including 65 and over in 2017

Cafeteria Plans

- ❑ Small Employers [100 or less] can create Simple Cafeteria Plans.
- ❑ Must meet certain employee eligibility and minimum contribution requirements in order to have safe harbor from non-discrimination requirements relating to highly compensated employees.
- ❑ Effective Year 2011.

FSA Limits

- ❑ Lower contribution limits on Health Flexible Spending Arrangements (FSAs) take effect for purposes of being a "qualified benefit" (employee contribution limited to \$2,500 per year).
- ❑ Includes grandfathered plans.
- ❑ Effective Year 2013.

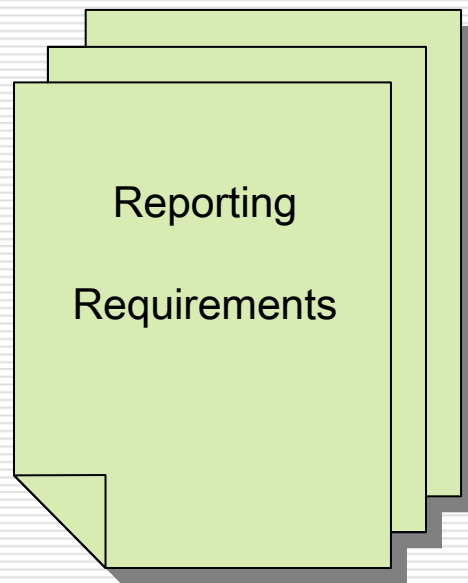
HSA, FSA, Archer MSA

- ❑ Health saving accounts, flexible spending accounts, Archer MSA can no longer be used to purchase over the counter medicines - **only prescribed drugs and insulin.**
- ❑ Reimbursements for such will be included in employee's gross income, and if an HSA or Archer MSA, then not only will distributions of the accounts be included in gross income they will also be subject to additional penalty.
- ❑ Includes grandfathered plans
- ❑ Effective Year 2011.

Industry Taxes

- Insurance Industry
 - 2014 - \$8 Billion
 - 2015 - \$11.3 Billion
 - 2016 - \$11.3 Billion
 - 2017 - \$13.9 Billion
 - 2018 - \$14.3 Billion

- Pharmaceutical
 - 2011 - \$2.5 Billion
 - 2012 - \$2.8 Billion
 - 2013 - \$2.8 Billion
 - 2014-16 - \$3 Billion
 - 2017 - \$4 Billion
 - 2018 - \$4.1 Billion
 - 2019+ \$2.8 Billion



W-2 Reporting

- The value of employer-sponsored health benefits for tax year 2012 must be reported on W-2 issued in 2013
- transitional exemption for small employers with less than 250 W-2 forms issued for the preceding calendar year.
- transitional exemption for Church plans
- Not applicable to Form 1099s since not an employer/employee relationship.

Disclosure of Exchange

- Employers are required to disclose details of Exchange to employees.
 - Tax credits, vouchers, individual mandates
 - Cost sharing, etc.

- Effective 3/1/2013

Quality of Care Reporting

- New health quality reporting required by group health plans and insurers "Ensuring the Quality of Care".
 - A) improve health outcomes through quality reporting, effective case management, care coordination, chronic disease management, etc.;
 - B) implement activities to prevent hospital readmission;
 - C) implement activities to improve patient safety and reduce medical errors; and,
 - D) implement wellness and health promotion activities.

- Not grandfathered plans
- Effective 3/23/2012

Summary of Benefits and Coverage

- HHS is to develop standards for summary of benefits and coverage information to be provided to participants.
 - E.g., definitions of insurance and medical terms, essential benefits, coverage and contact names and numbers

Effective 3/23/2011 - However, this deadline was not met by HHS.

- Standardized summaries of benefits and coverages using HHS uniform definitions required. [4 page summary] \$1000 for each failure and failure with respect to each enrollee will constitute a separate offense.

Effective 3/23/2012 – However, since 3/23/11 deadline not met, this deadline will likely be extended.

- Includes grandfathered plans.

Certification of Plan

- Health Plan Certification: Employers required to annually certify data and information compliance for electronic funds transfers, eligibility for a health plan, health claim status and health care payment and remittance advice.
 - Effective no later than 12/31/2013

- Penalty assessed by HHS to plans that fail to certify data and information compliance for electronic funds transfers, eligibility for a health plan, health claim status and health care payment and remittance advice.
 - Effective 1/1/2014.

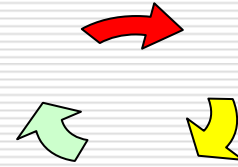
Compliance Certification

- Plan to certify compliance with HHS operating rules for health claims, enrollment, premium payments, etc.

- 2015.



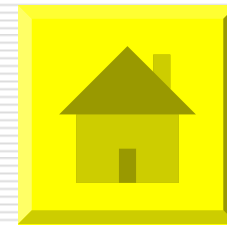
Health Care Workforce



- Increase number of health care professionals through student loans, repayment, forgiveness and “corps”
 - Primary care physicians
 - Pediatric
 - Nurses
 - Allied Health
- National Health Service Corps
- Ready Reserve Corps
 - Subject to be called up by Surgeon General

Home and Community Based

- Allow more Medicaid and Medicare Participants access to home health and community services vs. institutional settings.
 - Home health visits
 - Respite care
 - Adult day care
 - Household chores
- Must meet certain age and health criteria.



Community Living Assistance Services and Supports (CLASS)

- Long term care insurance program [voluntary but must opt out]
 - Payroll deductions
 - Nominal premium of \$5 for poverty level or full time student under 22yrs
- 5 Years to Vest
- Not less than \$50 a day cash to pay for CLASS benefits [Advocacy Services and Advice and Assistance Counseling]
- Functional limitations, defined, for more than 90 days
- Effective Year 2011

Wellness Program Grants

- Grants available to establish Wellness Programs to small employers [less than 100 employees who work 25hrs or more per week] and
- Who did not have a Wellness Program in place as of 3/23/10. Grants available through 2015.

Wellness Rewards

- Wellness Incentive "rewards" for employees up to 30% of employee only premium [or 50% if deemed appropriate by HHS]. Wellness programs defined by Act. Rewards available in certain programs that also require a standard health status factor or reasonable alternative or waiver for employee for whom it is not reasonable to achieve due to a medical condition. CDC Director to provide technical assistance to employers for wellness programs.
- Effective 1/1/2014.



□ **IRS Circular 230 Notice**

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- This Presentation is not designed or intended to provide legal or professional advice, as any such advice requires the consideration of the facts of the specific situation. Brunini @ 2010