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HEALTH CARE REFORM UPDATE

"The Health Care Reform Train – Don't Be Left Standing at the Station"

Hope is Not an Effective Planning Solution

TUESDAY NOVEMBER 13, 2012

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OVERVIEW

Today's program will touch on the follow areas:

- Brief History of the Act
- The Mechanics
- Employer Responsibilities
- Tax Implications
- Post-Election Considerations
- Open Discussion and Questions

HISTORY

- On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act which put in place comprehensive health care reforms to be implemented during the next fours years and beyond

- One short week later, on March 30,2010, the President signed the Health Care and Education Reconciliation Act which amended some of the provisions in the Affordable Care Act as well as released billions for student loans and financial aid to college students

- The combination of these two bills put in place Health Care Reform, which has caused much discussion on both sides of the political spectrum, eventually leading up to the big question of legality that was taken up by the United States Supreme Court

SUPREME COURT DECISION

- On June 28, the Supreme Court declared the individual mandate to be permissible exercise of Congress's taxing powers under the Constitution.

- The mandate was not a penalty, but a tax and was allowed under Congress's power to tax under Article 1 of the Constitution.

- The government's arguments that the Constitution's Commerce Clause or the Necessary and Proper Clause authorized Congress to enact Health Reform were rejected.

- The mandate that requires people to purchase health insurance or make a shared-responsibility payment does not regulate existing commercial activity, but instead compels individuals to become active in commerce by purchasing a product.

CHANGES EFFECTIVE DURING 2012

- **2012 W-2 reporting** - Prepare for mandatory Form W-2 reporting for health coverage
- **SBC Completion** - Distribute the Summary of Benefits and Coverage (SBC's) to enrollees for renewals, and newly eligible employees
- **MLR Reimbursements** - Distribute Medical Loss Ratio (MLR) Rebates to group plan participants, if applicable

W-2 REPORTING OF BENEFITS

What gets reported?

- Employers are required to report the total cost of all employer sponsored health plans for each employee
- Includes both the employer and employee contributions, even if the coverage is not taxable to the employee.
- Included on Form W-2 in box 12 with the code DD
- Currently this reporting requirement is for informational purposes only and does not impose taxation on any of the benefits reported to either the employer or employee

W-2 REPORTING OF BENEFITS

Who must report?

- Mandatory for Large Employers
  - Defined as those employers whom issued more than 250 W-2s in the immediate proceeding year
- Effective for 2012 W-2 reporting which is completed in January 2013
- Currently those employers issuing fewer than 250 W-2s are exempt, however, the IRS has indicated that this reporting will eventually apply to ALL employer regardless of size

SUMMARY OF BENEFITS & COVERAGE SBC'S

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- A four-page "summary of benefits and coverage" ("SBC")is required to be provided to applicants and enrollees before enrollment or re-enrollment.

- This requirement applies in addition to ERISA's SPD and SMM requirements.

- First SBC must distributed by the first open enrollment occurring after September 23, 2012 or for those who enter the plan any other time, the plan or policy year beginning after September 23, 2012.

- The summaries must be presented in a uniform format and cannot be longer than four pages. In addition, the four-page summaries cannot include print that is smaller than 12-point font.

- The four-page summaries must be presented in a "culturally and linguistically appropriate manner".

SUMMARY OF BENEFITS & COVERAGE

- Generally, the four-page summaries must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment).

- Four-Page Summaries vs. SPDs and SMMs. Welfare plan SPDs and SMMs must be provided only to participants covered under the plan (and not to beneficiaries).

- Trigger's for distribution include, **Open Enrollment** (Renewal), **Initial Enrollment, Special Enrollment** and **Upon Request**. Electronic or Internet access to these documents via employer benefits website is acceptable as long as employee's are properly notified.

- Can be provided by paper or electronically. A **penalty of not more than $1,000** may apply **for each** willful failure to provide the required SBC.

MEDICAL LOSS RATIO REBATES -MLR

- Insurers are required to make the first round of rebates by August 2012 based on their 2011 MLR.

- Insurers must meet Medical Loss Ratio thresholds of 85% for “Large Groups” of 51 or more employee’s and 80% for Individual and “Small Groups” of 50 or fewer employee’s.

- Insurers must generally provide rebates for individuals covered by group health plans to the policyholder—typically the employer sponsoring the plan.

- Who receives the rebate depends on the plan provisions and who paid the premiums.

- For Group Sponsored Plans, a participant “Contribution Holiday” (waiver of paycheck withholding's) is also deemed acceptable.

CHANGES EFFECTIVE DURING 2013

- **Health Flexible Spending Accounts (FSA's)** -The $2,500 limit on annual salary reduction contributions to health FSAs offered under cafeteria plans, effective for plan years beginning after December 31, 2012.

- **Additional Medicare Tax** -The employee portion of the hospital insurance tax part of FICA, currently amounting to 1.45% of covered wages, is increased by 0.9% on wages that exceed a threshold amount for tax years beginning after 12/31/2012.

- **Notice of Exchange** -Employers are required provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.

HEALTH FLEXIBLE SPENDING ACCOUNTS

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- All Health FSAs offered under cafeteria plans must comply and the $2,500 limit applies on an “EE by EE” and “ER by ER” basis.

- The limit does not apply to Dependent Care FSAs, HRAs or HSAs. The current “Use it or Lose” provision is currently under consideration.

- The $2,500 limit is effective for plan years post 12/31/12 and amount is indexed for inflation for taxable years beginning after December 31, 2013.

- The $2,500 limit is reduced for short plan years.

- By its terms, the $2,500 limit applies to health FSA salary reduction contributions and not to other employer contributions or “Flex Credits”

- Plans do not have to be amended until the end of the 2014 plan year.

ADDITIONAL MEDICARE TAXES

Beginning in 2013, employees will pay and employers will be required to withhold an ***additional*** 0.9 % of Medicare tax for any "Highly Compensated" employees.

- Defined as gross wages or self-employed income of
  - $ 200,000 for single filers
  - $ 250,000 combined for married joint filers
  - $125,000 for each spouse for those married filing separate
- Only the employee portion of FICA
  - Employers do not have to match the additional 0.9%
  - As with the medicare tax - No maximum wage base

ADDITIONAL MEDICARE TAXES

- Employers may rely upon the $200,000 single filer threshold as a safe-harbor before commencing with the additional 0.9% withholding to avoid penalties and interest (unless informed otherwise by there employees)
- Currently is reported and paid in the same manner as the Medicare tax is today
- Employees will be responsible for any deficiencies as calculated when filing their personal income tax returns
- Self-employed individuals will not be able to deduct the additional medicare tax

NOTICE OF EXCHANGE

- This disclosure requirement is generally effective for employers in a state beginning on March 1, 2013.

- Employees hired on or after the effective date must be provided the Notice of Exchange at the time of hiring.

- Employees employed on the effective date must be provided the Notice of Exchange no later than the effective date (i.e., no later than March 1, 2013).

- The existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.

- They may be eligible for a premium tax credit or a cost-sharing reduction (under PPACA 1402) through the Exchange if the employer plan's share of the total cost of benefits under the plan is less than 60%.

- That if the employee purchases coverage's through the exchange they will lose their employer contribution to health benefits offered by the employer.

CHANGES EFFECTIVE DURING 2014

- **Employer Mandate** - Certain large employers may be subject to penalty taxes for failing to offer health care coverage for all full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage under which the plan's share of the total allowed cost of benefits is less than 60%.

- **Waiting Periods** – for eligibility to participate in an employer plan.

- **Individual Mandate** - U.S. citizens and legal residents are required to have qualifying health coverage.

- **Establishment of Exchanges** - By January 1, 2014, each state must establish an American Health Benefit Exchange ("Exchange").

EMPLOYER MANDATE UNDER PPACA

All “Large” Employers with 50 or more “Full Time” or “Full Time Equivalent” Employees.

- Full Time: employees that work at least 30 hours per week
- Full Time Equivalent: number of part time employees (x) the number of hours worked during the month(/) 120.
- Does not include “Seasonal Employees” that work less than 120 days per year

EMPLOYER MANDATE UNDER PPACA

All Large Employers must provide its Full Time/Equivalent Employees the opportunity to enroll in a “Minimum Essential Coverage” health care plan.

- **Minimum Essential Coverage:**
  either an “eligible employer-sponsored plan”, various forms of government sponsored health coverages or an individual market plan, which provides “essential health benefits”.

  - **Eligible Employer-Sponsored Plan**: a group health plan or group health insurance coverage offered by an employer to the employee which does not consist of “excepted benefits” (limited dental or vision and most health FSAs and HSAs)

  - **Essential Health Benefits** include: ambulatory, emergency, hospitalization care, maternity and newborn care, mental health and substance disorder, behavior health, rehabilitation services and devices, preventative and wellness and pediatric care

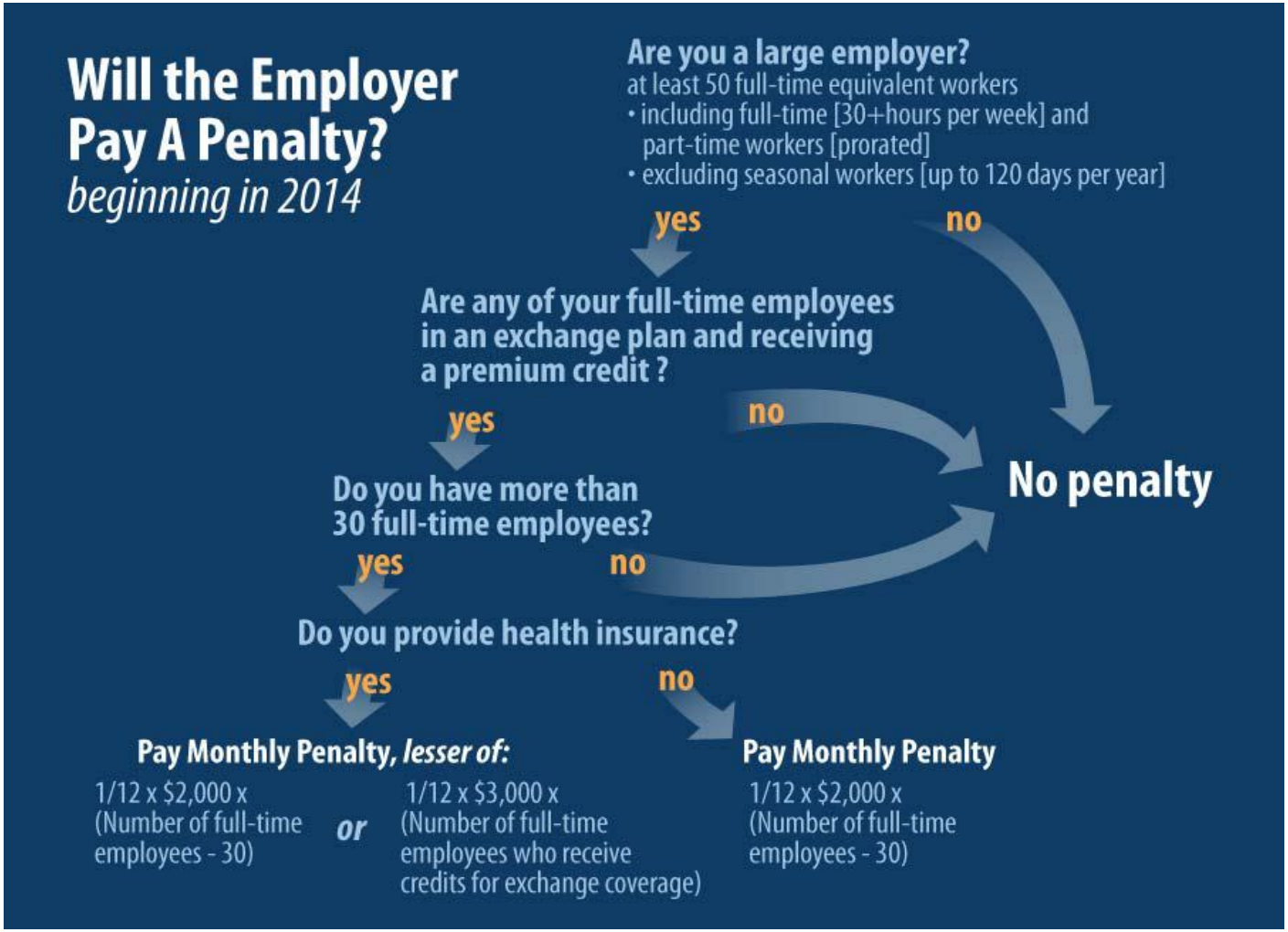
EMPLOYER MANDATE UNDER PPACA

Enforcement and Penalties

- Failure to provide “Minimum Essential Coverage” to all “Full-Time” or “Equivalent” employees and their dependents **and** one employee having enrolled in a “state health care exchange”—then employer must pay penalty , multiplied by the number of full time employees for all months in which the required coverage is not offered.
    - Penalty equals 1/12 of $2,000 x number of full time employees for all months with no coverage.

- Employers required to pay at least 60% of cost of all benefits for each Full Time employee, **or** cover enough cost of plan so that employee does not pay more than 9.5% household income (or W-2 wages-), assuming employee is enrolled in a health care exchange.
    - Penalty equals 1/12 of $3,000 for any applicable month x number of Full Time employees , minus 30, x 1/12 of $2,000 for any applicable month.

PAY OR PLAY



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EMPLOYER MANDATE UNDER PPACA

Automatic Enrollment Requirement:
All Employers with more than 200 Full Time employees, which offer employees enrollment in one or more health benefit plans must automatically enroll new Full Time employees in one of the plans offered. Must provide employees notice of opportunity to enroll and to opt out.

Free Choice Vouchers:
Employers that offer "minimum essential coverage" options through eligible health plans, that pay portions of the plan costs, make "Free Choice Vouchers" available to qualified employees for use to purchase coverage through a health care exchange.

- Amount of voucher is equal to monthly portion of the cost provided by employer towards employer-sponsored health plan. Limited to amount employer would pay for "self-only" coverage, unless employee selects family coverage.

WAITING PERIODS

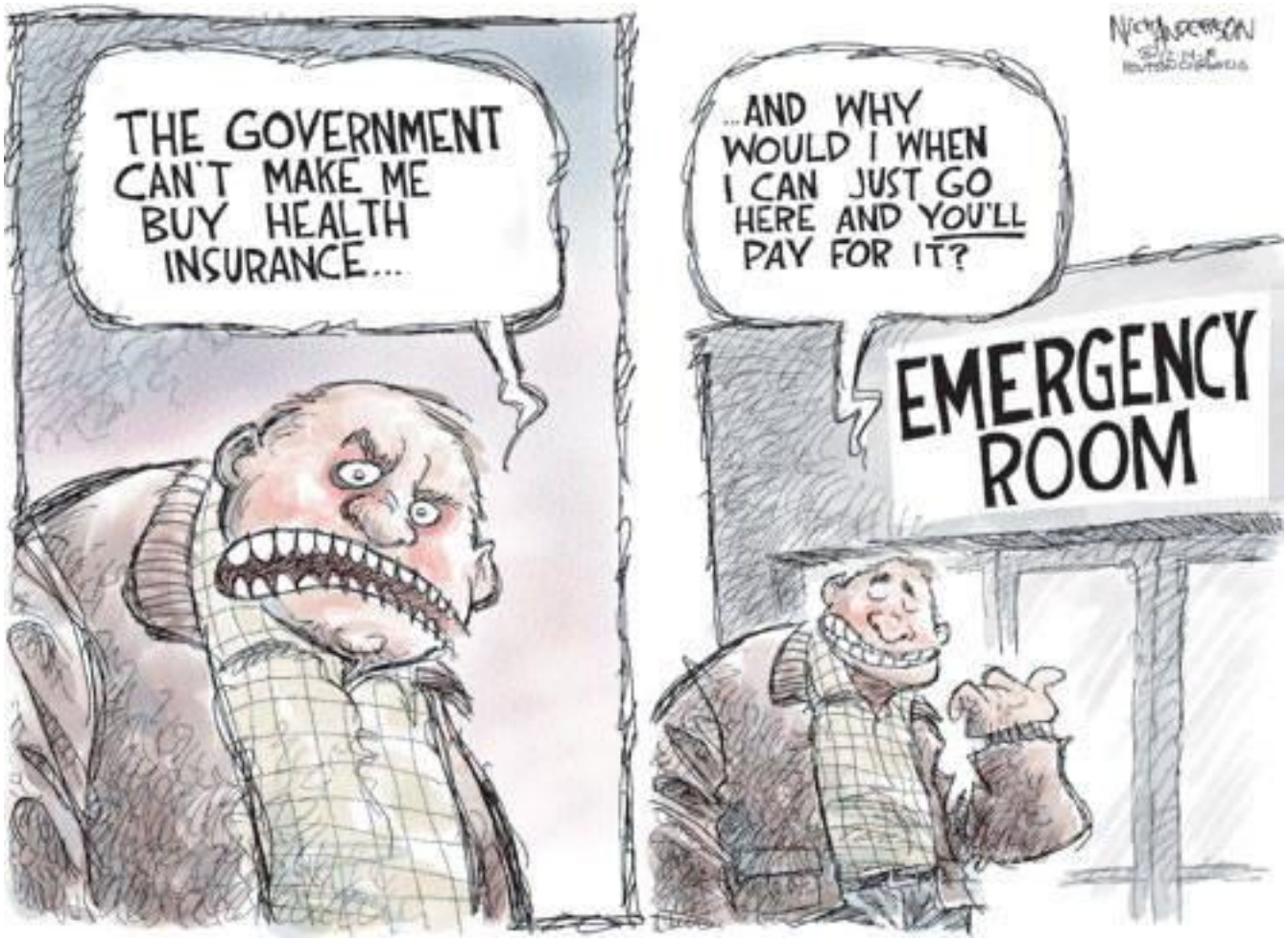
- A plan must not apply a waiting period to become eligible to participate in the employer sponsored group health plan that exceeds 90 days.

- This prohibition applies to group health plans and insurers but not to certain “excepted benefits.”

- Grandfathered health plans must also comply with the waiting period requirements.

- This provision does not require offering benefits to part-time employees, however if an employee goes from part-time to full-time status, the 90 day eligibility clock begins on first day of full time employment.

INDIVIDUAL MANDATE



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INDIVIDUAL MANDATE

- Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.

- The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.

- Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

INDIVIDUAL MANDATE

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 (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

ESTABLISHMENT OF THE EXCHANGES

- If a state does not establish an Exchange, then the federal government will establish a "Federally Facilitated Exchange" (FFE).

- The Exchanges will perform a variety of functions required by health care reform, including certifying QHPs, determining eligibility for enrollments in QHPs, and for insurance affordability programs (e.g., premium tax credits), and responding to customer requests for assistance.

- HHS is required to determine by January 1, 2013 whether each state's Exchange will be fully operational by January 1, 2014. Notification by 11/16/12, but details delayed until 12/14/12, Fed app due 2/15/13.

- This is important because of assessing whether the Exchange will be able to start the initial open enrollment period on October 1, 2013. HHS may conditionally approve a state-based Exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013.

ESTABLISHMENT OF THE EXCHANGES

- In states that don't obtain HHS approval by January 1, 2013, or in states that decide not to establish an Exchange, a FFE would be implemented by HHS for 2014.

- A state that does not obtain initial approval by January 1, 2013 can seek approval for a subsequent year, but it must do so at least 12 months prior to the Exchange's first effective date and must work with HHS to plan the transition from the FFE that will have been put in place for 2014 to the then-approved state Exchange.

- In states without a state-based Exchange, HHS will establish a FFE and perform all Exchange functions including plan management functions and consumer-assistance functions.

- Insurers can only offer "Qualified Health Plans" on the FFE. Four "Metal Levels" – Bronze(60%), Silver(70%), Gold(80%), Platinum(90%)

ESTABLISHMENT OF THE EXCHANGES

- A state may, however, choose to establish a state partnership FFE which permits the state to administer plan management functions and/or consumer-assistance functions.

- In either case, states will continue performing their traditional regulatory role for insurers and health plans—an insurer that offers QHPs through an FFE must meet both applicable state requirements and QHP certification standards.

- In General: - 15 states plus the District of Columbia have established state-based exchanges.

- **Michigan** -Governor decided to apply for a state-federal partnership health insurance exchange after failing to persuade Republican legislators in the House to pass a Senate-approved bill that would allow the state to run its own exchange.

HIDDEN COSTS

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PASSIVE INCOME TAX

2013 also marks the first year in which a new 3.8% passive income tax is asserted on “High Income” individuals for their “Net Investment Income”.

- High Income earners are defined as those individuals with adjusted gross income of:
  - $ 200,000 for single filers
  - $ 250,000 combined for married joint filers
  - $125,000 for each spouse for those married filing separate
- The surtax is in addition to any other tax imposed on individuals
  - This means Alternative Minimum Tax (AMT) still applies

NET INVESTMENT INCOME

The term net investment income can be broken down into three basic categories of gross income. Within those categories, the deductions properly allocable to such income or net gain may be used to reduce the amount that is taxed.

- Category # 1 – Gross income from interest, dividends, annuities, royalties and rents
  - Would exclude tax-exempt municipal bond interest
  - Does not matter that these type of income pass-through from partnership or S-corporation on Form K-1
    - The character of income at the entity level, flows through to the individual

NET INVESTMENT INCOME

- Category # 2 – Gross income from a “passive activity” or an entity in the business of trading financial instruments or commodities
  - Passive activity defined as a business in which one does NOT materially participate in - 500 hour test
  - Includes K-1 flow though income from closely held businesses where some members/shareholder are not active within the business and therefore may not be subject to the self-employment tax
  - Also includes rental income from passive activities
    - Depreciation and expenses would reduce the rents received

NET INVESTMENT INCOME

- Category # 3 – Net Gains to the extent taken into account in computing taxable income
  - Includes Capital Gains – both from stocks and the sale of a business
    - The term net gain seems to imply losses in the current year could be used to offset current year gains. Based on current guidance, it is still unclear if prior years capital losses, that have been carried forward, would be allowed in calculating the net gain subject to the 3.8% surtax.
  - As the law indicates “to the extent taken into account in computing taxable income” there are a number of gain type items that are not subject to the surtax. A few of the major items are:
    - The gain on the sale of a principal residence that is excluded from income ($250,000 for single filers and $500,000 for married couples)
    - The gain on a tax-free like kind exchange
    - The internal “build up” of value inside a life insurance policy

NET INVESTMENT INCOME

- Along with the definition of what is included in “Net Investment Income”, there are a few exceptions expressly written into the statute. These exceptions include distributions from a few of the following type of retirement accounts:
  - Qualified pension, profit-sharing and stock bonus plans
  - Individual Retirement Accounts (IRA)
  - Roth IRAs
  - Qualified annuity plans
- The taxable distributions from these accounts do however get included when determining the adjusted gross income thresholds

THE FISCAL CLIFF

While specifically NOT part of the Patient Protection and Affordable Care Act, the are also a number Bush era tax cuts that are set to expire at the end of 2012 unless Congress acts to extend some of these provisions. Some of these key provisions set to expire are:

- Qualified dividends no longer taxed at capital gain rates
  - now taxed as ordinary income
- Individual income tax rates increase
  - Highest federal rate goes 39.6%
  - No more 10% bracket
  - Average 3% increase for ALL tax brackets
- Capital gains maximum rate goes to 20%

THE FISCAL CLIFF

Some of key provisions set to expire are: (continued)

- Accelerated depreciation is reduced on fixed assets purchases
  - No more bonus depreciation for qualifying fixed asset purchases
  - Section 179 expense limits reduced to $25,000
- Estate and Gift tax exemption reverts back to 1 million dollars per individual
  - Exemption is 5 million in 2012
- Top Estate and Gift tax rates increase to 55%
  - Up from current 35%

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President Obama's Promise

"President Obama passed the Affordable Care Act to restore health care as a basic cornerstone of middle-class security in America. The Affordable Care Act will make health care more affordable for families and small businesses and brings much-needed transparency to the insurance industry.

When fully implemented, the Affordable Care Act will keep insurance companies from taking advantage of consumers—including denying coverage to people with pre-existing conditions and cancelling coverage when someone gets sick.

Because of the new law, 34 million more Americans will gain coverage—many who will be able to afford insurance for the first time. Once the law is fully implemented, about 95 percent of Americans under age 65 will have insurance." – www.barackobama.com

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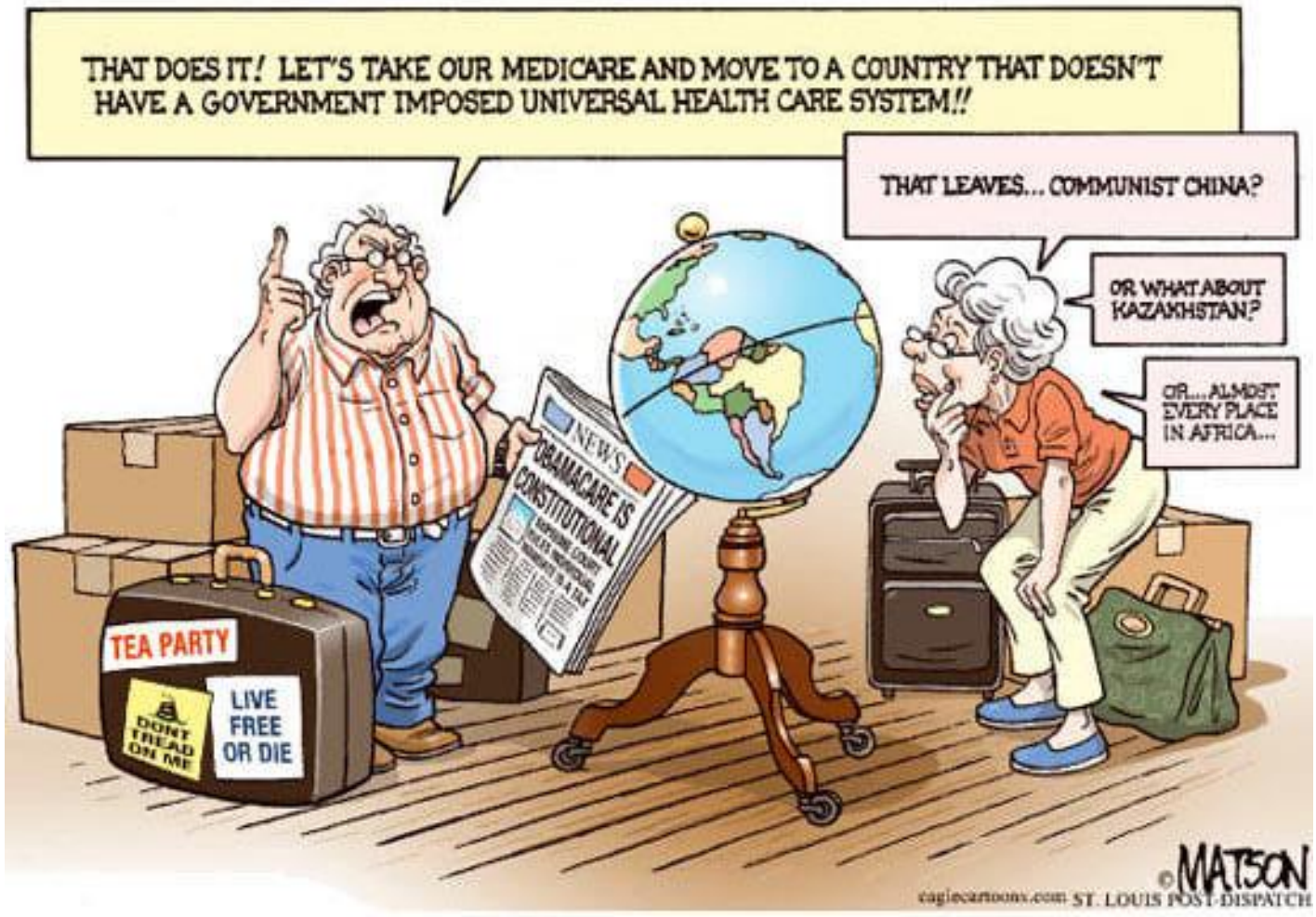
The Harsh Reality

- Economy is still trying to recover, can it sustain the tax increase
- Divided Congress
- Uncertainty as to what employers will do
- Approximately half of population has consistently opposed the law since day one.
- Health care reform is still grossly underfunded, how is it going to be paid for

THE LAST RESORT!



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QUESTIONS AND COMMENTS

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