

QUESTIONS & ANSWERS

HAYS SEMINARS ON APRIL 20, 2010 AND APRIL 23, 2010

AUTO-ENROLLMENT

Will employees be able to opt out of the plan after they have been auto-enrolled? Or will they need to wait until the next open enrollment or qualified status change?

Employees who are subject to auto-enrollment into the group health care plan must be allowed the opportunity to opt-out of the coverage prior to commencement of participation. Auto-enrollment will be required for new full-time employees.

Will we be required to auto-enroll existing employees at any point?

Currently, no. Further guidance may make changes to this requirement but at this time, the requirement will be for auto-enrollment of new full-time employees.

If we have to auto-enroll in the least expensive plan, what if that least expensive plan is an HMO that doesn't cover services for employees living in another geographic area? Do you enroll them in the more expensive plan? Are benefits like Executive physical programs "discriminatory" and prohibited? Will there be any kind of non discrimination testing?

Although the current legislation does not require employers to auto-enroll newly hired employees into the least expensive plan, such approach makes sense. However, until further guidance is provided, it also makes sense, in such a situation as the one described in this question, to provide a default into the least expensive plan that will provide coverage for the individual. In essence, an employer with multiple options may have to establish multiple criteria for determining to which plan an employee will be auto-enrolled.

If the benefit is fully insured, it will be subject to the nondiscrimination requirements of Code Section 105(h)(2) as well as similar rules under paragraphs (3), (4) and (8) and may not discriminate in favor of highly compensated employee. Such a plan will not be allowed under the new legislation. However, if the plan is a self-insured reimbursement plan that reimburses for the cost of medical diagnostic procedures for employees only (not the employee's spouse or dependents), then it is arguable that Treas. Reg. 1-105.11(g) applies, rather than the nondiscrimination rules of Code Sec. 105(h).

Is the 200 employees only benefit eligible or just 200 employees?

The threshold is more than 200 full-time employees. Although this section of the law does not define full-time, other sections identify such employees as working at least 30 hours per week. We interpret this to mean regularly scheduled to work 30 or more hours per week.

Would part time employees need to be auto enrolled?

Currently, no. The requirement will be for auto-enrollment of new full-time employees. Full-time is currently defined as working 30 hours per week in other parts of the legislation so it is anticipated this will be the standard absent any further guidance.

If you offer more than one plan, and are required to auto enroll employees. Can you auto enroll into the least expensive plan you offer? Any guidelines on this?

Although the current legislation does not require employers to auto-enroll newly hired employees into the least expensive plan, such approach makes sense. Absent further guidance that is our recommendation.

Does auto-enroll apply to grandfathered plans?

Yes. Auto-enrollment requirements will apply to all employers with more than 200 full-time employees.

Do you have to auto-enroll every year, or only the first time applicable?

The requirement will be for auto-enrollment of new full-time employees. The Law does not address part-time or seasonal workers who ultimately change to a full-time status. We expect guidance on that issue.

Open-enrollment - if they have previously waived coverage, do they have to waive it EVERY open-enrollment time to prevent auto-enroll?

The current requirement will be for auto-enrollment of new full-time employees.

If the least expensive plan is an HMO would the employer have to select the PCP for the employee?

Non-grandfathered plans and plans not subject to collective bargaining agreements (CBA) in place as of March 23, 2010, will be required to allow individuals to select the primary care physician of his or her choice from the available primary care providers. Grandfathered plans and plans subject to current CBAs may allow this choice as well. Ultimately, further guidance may allow the employer that is required to auto-enroll new employees to also select the primary care physician, as long as the employee has an opportunity to opt out of the coverage all together. However, absent further guidance, once enrolled, the employee will have the right to choose the primary care physician.

When you auto enroll in the least expensive plan, does that mean least expensive for the employer - such as self insured - or least expensive premiums for the employee?

Until further guidance is released, it is our opinion that the individual should be auto-enrolled in the least expensive plan *for that individual*. However, this is our opinion, not a specific requirement contained within the law.

If an employer has to auto-enroll employees is this every year and would they each year enroll employees regardless of their current election? (So if someone waived this year, would they be reenrolled and then have to opt out again in the following year?)

The requirement will be for auto-enrollment of new full-time employees.

We have 3 levels in our medical plan. When applying the auto enrollment requirement do we need to enroll staff in the plan that they are enrolled in at the time or should they be enrolled in the "lowest:" level plan as you suggested for all auto enrollments. Is there a requirement either way?

A. The requirement will be for auto-enrollment of new full-time employees. Until further guidance is released, it is our opinion that the individual should be auto-enrolled in the least expensive plan for that individual. However, this is our opinion, not a specific requirement contained within the law.

ADULT CHILDREN COVERAGE

For employees currently under employer sponsored health plans, how will the new law affect employee dependents currently without insurance? Will this affect the employer sponsored plan?

For plan years beginning on or after September 23, 2010, plans will be required to offer coverage for adult children up to age 26. In addition, if an employee is adding a child under the age of 19 during open enrollment on or after September 23, 2010, the plan may not impose a pre-existing condition limitation on that child. Plans may adopt these criteria prior to the first day of the next plan year on or after September 23, 2010.

Is coverage available for adult children up to age 26 or through the 26th year?

There are two separate parts of the Health Care Laws. One requires the health plan to cover adult children up to their 26th birthday. For grandfathered plans, until 2014, the adult dependent need not be allowed coverage if he/she is eligible for coverage under his/her own employer's group plan, whether or not the child takes the coverage. The other part changes the pre-tax premium application so that effective 3/30/10, any premium contribution for the adult child can be taken pre-tax as long as the child does not turn 27 by the end of the tax/calendar year.

Does the pre-tax provision apply to the employee contribution as well; in other words, can the payroll deduction for an adult child be a pre-tax deduction under a Section 125 Plan?

Yes, as long as the adult child does not turn 27 by the end of the tax/calendar year.

If adult children up to age 26 are not taxable for the Federal tax, am I correct in understanding that in Minnesota the State tax will also not apply any longer for these adult children?

This is a complex question. Many states have enacted laws requiring benefit coverage for adult children that extend beyond current required ages. In most cases, the states have not adjusted their tax codes to allow for pre-tax application for the premiums attributable to those children. Minnesota for example requires fully-insured plans to provide coverage for unmarried adult children up to age 25 but never addressed whether the premium cost for these children could be pre-taxed. As of the change in the federal law on 3/30/10, premium costs for these adult children may be pre-tax for purposes of federal taxes but not for state. It is important to check the state laws on this issue.

I have seen letters sent out that say adult children up to 30 years old? Is it 26 or 30?

Here again, there are some states that require fully-insured plans to provide coverage to adult children to age 30; some of these state laws have additional requirements, such as the child must be unmarried, or live in the state where the contract is issued. The new federal statute requires health plans to provide coverage to age 26. The coordination between state laws and the federal law is not exact. In cases where state law will require coverage beyond age 26 for a fully-insured plan, the state law will apply.

Is coverage for adult children something we have to "offer" or do we have to provide even if the parents don't want it?

Our understanding is that the plan has to "offer" the coverage and the parent needs to apply for the coverage during the appropriate enrollment period. The plan does not need to automatically enroll these children.

Do you have to cover the spouse of the child also?

The new health care laws do not require the plan to cover any dependents of the adult child, either a spouse or his/her dependent children.

Is the mandated health coverage "to" or "through" age 26?

According to the new laws, coverage only has to be included up to the adult child's 26th birthday.

What were the two health insurance companies you mentioned that are currently maintaining coverage for children up to age 26?

As of the date these programs were presented we had heard from Blue Cross Blue Shield of MN and Medica. We have since heard that many carriers have decided to implement these rules beginning as early as June 1, 2010.

If an adult child was taken off the plan because they reached the lifetime maximum and are disabled can they come back onto the plan?

If the adult child reached their lifetime maximum, once the plan eliminates the lifetime maximum limit, the child, if otherwise eligible under the terms of the plan, would become newly eligible and the parent could enroll the child.

We require our employees to pay for coverage of their children. Does the new law require us to cover the children and deduct money from the employee's pay to cover the cost or does it only require us to offer the coverage? If any employee would rather keep the money and not pay, does he have that option?

The new health care laws do not require the parent to cover adult children or indeed any dependents at all. The laws only require that the plan provide that adult dependents are eligible for coverage up to age 26.

The tax change for dependent children is effective immediately, so if we currently allow employees to age 25 per Minnesota law, there is no taxability for these dependents. Correct?

The federal law permits coverage for these adult children to be covered on a pre-tax basis as long as the adult child does not turn 27 during that same tax/calendar year. State Law in Minnesota does not currently provide this application.

Some carriers require the adult child or other dependent to be a tax dependent, will this go away?

For the adult child, the carrier/plan cannot require the tax dependency status. There is no clarification on whether or not the requirements for other dependents under the age of 19 are changing.

Does your 25-year-old married child still have to be your tax dependent and/or live with you in order to be eligible for coverage?

No.

Do the married children need to be living with the parent?

No.

You said that the spouse and/or dependents of the married child do not NEED to be covered, but CAN they be covered?

Each plan could provide this coverage. However, before this is decided, the fully-insured carrier needs to be consulted. For self-funded plans, any stop loss carrier should be asked if there would be any cost/coverage ramifications.

For a grandfathered plan, do children have to be covered to age 26?

The requirement is that coverage must be available for adult children up to age 26 if coverage is offered to dependents. This requirement will apply to grandfathered plans beginning with the first day of the next plan year beginning on or after September 23, 2010. Grandfathered plans are not required to provide coverage for adult children who are eligible for coverage under the child's employer's group health plan. This exception will not apply as of 2014.

Should we stop taxing employee's premiums because they have non-student children age 19+ on the plan? Our plan year begins October 1st. Can adult children age 25 enroll in the plan at that time? Can a married child add coverage at that time?

There are really three questions here. First, if the adult child currently covered does not turn age 27 prior to 12/31/2010, then the cost attributable for that child can be taken pre-tax under federal law (stat elaw may still apply taxes to the imputed value of this coverage). Second, as of your plan year anniversary on 10/1/2010, the employee can enroll his/her adult children under age 26 at that time. Third, the employee can enroll his/her married child under age 26 at that time.

LIFETIME LIMITS

If an Employee or their dependant reaches the Lifetime limit prior to our plan's effective date (01/01/2011) - will they be restrained by the Lifetime limit AFTER 01/01/2011, or will the limit be lifted at that time and additional costs/claims covered?

Based on our understanding, at the time the lifetime limits are removed from your plan, eligible claims costs incurred on or after that date would be eligible. If the child has been dropped from coverage because he/she reached the maximum lifetime limit, the employee will have the opportunity to re-enroll the child.

LONG TERM CARE PLAN (CLASS)

If you currently offer a LTC program (voluntary benefit) do you have to offer this government plan (CLASS ACT) as well?

Employers may elect to automatically enroll participants in this program, similar to 401(k) requirements. Our understanding is that this product will be voluntary to the employee as well if offered by the employer (they can opt out). An employer may choose to payroll deduct the cost and submit to the CLASS Act program. In effect, the employer could be offering this program as well.

VARIOUS TAX ISSUES

The 40% tax, is it on the lowest or highest cost plan available?

The excess value tax or "Cadillac Plan" tax is imposed on the value of the plans that cover the individual in excess of threshold amounts set by the law. Therefore, each plan, if valued in excess of the applicable threshold, could be subject to this tax. As of now, the basic thresholds are \$10,200 for individual coverage, and \$27,500 for family coverage.

Are the dollar limits for the "Cadillac tax" stated in today's dollars or 2018 value?

They are stated in today's dollars but will be adjusted annually based on a health cost adjustment to take into account the increases in health care costs.

How is value defined for the excess tax on Cadillac plans?

The premium equivalent for the plan (employee plus employer contribution) and the value includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage but excludes dental and vision coverage. The excise tax is applicable on a monthly basis.

The information contained in this document represents our understanding of the health care reform laws as of this time. Further clarification may change some or all of the interpretations. Questions on how this law will affect your firm should be directed to your legal counsel. 5/2010



EMERGENCY SERVICES

Regarding Emergency Services, can we apply additional co-pay if still considered in-network?

If we are reading this question correctly, the answer is that the laws require plans to consider in-network and out-of-network benefits for emergency services at the in-network benefit levels. The plan cannot apply additional co-pays if these are not applicable to in-network benefits.

Is there a time when grandfather plans MUST have ER the same for in and out of network?

No. Until the plan loses its grandfathered status, this provision will not apply to a grandfathered plan.

FLEXIBLE BENEFIT PLAN CHANGES

When you get to the FSA plan changes (annual limits), can you mention when this is effective? Our plan year is August 1 of each year.

When the laws refer to any of the required adjustments to FSA plans, the changes are specified as being for tax/calendar years. This causes problems for plans, like yours, with mid-year renewals. Technically, a plan starting on August 1st could have one maximum for the first five months and the lower for the last seven months. However, the most practical approach would be to change to the \$2500 maximum upon the plan renewal prior to the year it is required. This would cause the fewest headaches. We anticipate that there will be additional guidance on this issue.

If you have a doctor's prescription for an over-the-counter drug, could that prescription be covered under the FSA/HSA?

Our understanding is that any over-the-counter drug that is prescribed by a physician will still be eligible for reimbursement under these plans.

Are you saying supplies (contact solution) will continue to be covered under FSA or HSA?

The health care laws specifically refer to over-the-counter drugs. In as much as medical supplies, like contact lens solution and bandages, are not drugs, the laws do not appear to exclude them from coverage. Medical supplies and devices were also eligible for reimbursement prior to the change that allowed OTC drugs to be eligible.

EMPLOYER TAXES

I don't think that it will happen until 2014, but what are the fees and fines that companies will pay related to employees that qualify for subsidies from the government for their health insurance premiums

Employers with more than fifty (50) full-time equivalents (FTES) that offer coverage but have at least one employee receiving the premium tax credit (discussed above) will pay the lesser of \$3,000 for each employee receiving the credit or \$2,000 for each FTE. An FTE is generally equal to a person working 30 hours per week.

Is the penalty \$95 or 1% whichever is larger? Or whichever is smaller?

Individuals that chose to not be covered will be assessed an annual amount of *the greater of* \$95 in 2014 or 1% of the individual's taxable income, \$325 in 2015 or 2% of the individual's taxable income and \$695 in 2016 or 2.5% of the individual's taxable income. After 2016, the penalty is increased based upon the cost of living increase.

What is the definition of a full-time employee? I.e. Who is an eligible employee?

Currently, a full-time employee is defined as working 30 hours per week.

We currently exclude from our health plan employees that work less than 30 hours per week. Will we now have to cover all employees?

Not at this time. Currently, the requirement is to offer coverage to full-time employees, defined as those employees working 30 hours per week. However, for the 50-FTE threshold with regard to determining whether the employer is required to offer coverage, part-time employees are included in the full-time equivalent (FTE) formula.

GRANDFATHER CLAUSE

Does a premium increase change the grandfathered status?

Grandfathered status may be lost when there is a material change to the plan but we do not yet have a clear definition of what a material change will be. At this time, absent further guidance, it seems the idea of material change should apply to the benefits the plan provides and the manner in which the benefits are provided. We do not anticipate that an increase in premium will cause a plan to lose grandfathered status but until specific guidance is released, we can only speculate on this result. Further guidance will be welcome.

If we change providers but the terms of the plan do not change - does that qualify as a grandfathered plan?

It is our opinion that if there is no change to the terms of the plan, including, for example, provider networks, the plan should not lose its grandfathered status. If this change results in a change of network, then it is very possible that will be considered a material change. Further guidance will be welcome.

My company is a grandfathered plan with a renewal date of 1/1/2011. Does this mean that we do not have to comply with the 2010 mandates until 1/1/2011 so long as we do not make any plan changes? Does this allow us to delay implementing designating a place for employees to express breast milk or must we do this now since it was effective March 23rd?

Yes, this means the mandated changes, such as providing coverage for adult children to age 26, can be implemented January 1, 2011 for your plan, assuming this is the first day of the next plan year on or following September 23, 2010. No, you may not delay implementing or designating a room for lactation purposes as this requirement was immediately effective.

You talked about increase in employee premium could cause loss of "grandfather" status? Does this mean change in subsidy percentage or any increase in premium even if the subsidy % stays the same?

Grandfathered status may be lost when there is a material change to the plan but we do not yet have a clear definition of what a material change will be. At this time, absent further guidance, it seems the idea of material change should apply to the benefits the plan provides and the manner in which the benefits are provided. We do not anticipate that an increase in premium will cause a plan to lose grandfathered status but until specific guidance is released, we can only speculate on this result. Further guidance will be welcome.

Do vendor changes within a qualified cafeteria plan negate grandfathered plan status?

We do not think this will affect the plan's grandfathered status as long as it does not result in any material plan changes. Further guidance will be welcome.

MISCELLANEOUS QUESTIONS

Do minimum loss ratios apply to self insured plans?

The laws currently refer to minimum loss ratios for insurance issuers so it does not appear to apply to self-insured plans. We will need to wait and see if the regulations are extended to self-insured/self-funded plans.

Are reasonable annual limits out-of-pocket maximums?

This is a concept which has not been explained. We will need to wait until Regulations are issued.

For the PCP designation, this already applies to HMO plans, how is this going to change?

This requirement will impact plans that currently restrict designation of primary care providers.

Does health care include vision and dental?

It *appears* the market reform provisions, such as coverage for adult children, will not apply to stand-alone dental or vision plans and other coverages that are considered to be excepted benefits under the HIPAA Portability provisions but, as with much of this legislation, we are awaiting further guidance.

How does this legislation apply to expatriates or inpatriates who are covered under a global medical plan?

The mandates and eligibility for participation in the health care exchanges will apply to U.S. citizens and residents and aliens lawfully present in the United States. It appears that individuals permanently living outside the U.S. will not be required to purchase health insurance. A medical plan written in the US covering U.S. citizens and residents OR aliens lawfully in the U.S. will be required to comply with the law. Further guidance is needed to determine whether a plan covering individuals in the U.S. and outside the U.S. may treat these individuals differently.

On the tax credit for small businesses, is there a definition of 25 employees--i.e., if a company has 10 full time and 20 part-time employees, would this be 30 employees or can you do a time calculation for full-time equivalent?

From the IRS web site <http://www.irs.gov/newsroom/article/0,,id=220839,00.html>:

The number of an employer's full-time equivalents (FTE) is determined by dividing

(1) The total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by (2) 2,080.

The result, if not a whole number, is then rounded to the next lowest whole number. See Q/A-12 through 14 for information on which employees are not counted for purposes of determining FTEs.

Example: For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

The employer's FTEs would be calculated as follows:

- (1) Total hours not exceeding 2,080 per employee is the sum of:
 - a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 x 2,080)
 - b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 x 1,040)
 - c. 2,080 hours for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080)

These add up to 15,600 hours

Will small business tax credit impact smaller companies within a corporate entity if each business has it's own tax ID#?

It appears the control group rules will apply however, this is a corporate structure/tax question that should be reviewed by your tax advisor and legal counsel.

Will the \$200K/\$250K filing amounts be indexed?

We assume so, however, this is something that will be monitored.

The designation of PCP does not apply to grandfathered plans. Is this a permanent exclusion or does it go into effect upon your renewal date?

This exclusion will apply as long as the plan retains grandfathered status.

Does this mandate require employers to allow health coverage for all staff even if part time or on call?

The current requirement for 2014 is that employers will be required to offer health care coverage to full-time employees, defined as working 30 hours per week.

Prohibits Cost-Sharing from Exceeding HSA limits - does this mean, if the HSA limit is now \$2,500 that the employee's Out of Pocket Maximum, (deductible and Co-Pay) can not exceed \$2,500 ?

The Health Savings Account (HSA) law sets an annual out-of-pocket maximum allowed under the plan in order to be considered a High Deductible Health Plan (HDHP) for HSA purposes. The 2010 out-of-pocket maximums for an HDHP are \$5,950 for self-only coverage and \$11,900 for family coverage (anything other than self-only coverage). Presumably, these amounts will be indexed for inflation and will be the standard for cost *sharing* maximums.

We have union and non union employees what if you have over 100 employees yet they are on 2 different health plans example 80 union 25 non union are we still considered a small business

The size of the business, for purposes of identifying compliance thresholds, such as the requirement to offer health care coverage, is based on 50 Full Time Equivalents (FTE). An FTE is 30 hours. It is not based upon union or non-union participation.

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We currently provide our staff with credits to purchase insurance if they elect not to enroll in our plan. Would that be considered a voucher or is there a specific way that needs to be documented?

It appears that there will be a specific method for identifying the voucher amount as this amount will need to be communicated to the Health Care Exchanges. We anticipate a web-based reporting process. Note that the voucher will be equal to the amount the employer would have contributed had the employee elected the employer's coverage and the employee is eligible for the premium credit.

On slide 31 is there an implied minimum wage of \$7.00/hr if employee contribution is \$90/month?

The criteria noted are a percentage of the employee's income for purposes of determining eligibility for the "free choice voucher." It may, or may not correlate with a particular hourly wage.

If you are an employer with less than 50 employees but you provide health insurance, are you still subject to the penalties / requirements in 2014 when all the regulations go into effect? IE: "Free Choice Voucher"

Currently, the penalties will apply to employers with 50 or more FTEs.

Given penalty levels, is there an implied minimum contribution level of \$2,000/year

The criteria noted are the penalties amounts as currently state in the law. These amounts may, or may not correlate with a particular contribution level.

Is the 8% cost of coverage based on the lowest cost plan? Is it based only on the employee's premium or total exposure?

It appears to be based upon the employees share of contribution towards the coverage. However, we anticipate further guidance clarifying whether an employer with multiple plans may assume the standard will be the least expensive plan.

We are a multi-state employer with 2 separate tax IDs. Currently all employees are insured under the larger employer's plan (100+) per the second location (less than 50 employees). Do we need to purchase a separate qualified plan or can we continue to offer them the plan of the larger employer?

Assuming this is part of a control group, the employer may continue to offer the same plan.

What is the "fix" if you fail the non-discrimination test?

If the plan is determined to be discriminating as to eligibility and/or benefits with regard to highly compensated employees (HCE), the criteria that has created the discriminatory result must be altered so that non-HCEs are eligible at the same time and under the same terms as HCEs and benefits provided to HCEs must be provided to non-HCEs. The HCEs may be taxed on the benefits they could have received under the plan as well.

NURSING MOTHERS PROVISIONS

Is the nursing mother's break required to be paid time?

No. However, some state laws may require this to be paid time.

The requirement regarding break time and private area for nursing apply to all employers regardless of size?

The law does not have any size exemptions. However, it does indicate that an exemption is applicable if maintaining the program for employers with less than 50 employees would "impose an undue hardship by causing the employer significant difficulty or expense."

Will employers have to pay employees to nurse? (In addition to providing the facility and the time.)

No. However, some state laws may require this to be paid time.

60 DAY ADVANCE NOTICE OF PLAN CHANGES

Exactly when does the 60-day notice requirement start?

The requirement is effective January 1, 2012. We recommend preparing to provide at least 60-days notice prior to January 1, 2012 for plan years beginning on that date.

How will Hays handle the required 60 day notice to employees re: rates and benefit changes

It will take input from all sources, including the employer-plan sponsor, in order to meet this requirement. We will be working with our clients and the carriers to ensure the necessary flow of information is maintained in order for our clients to comply with this requirement

Does the preventive care requirement apply to both in-network and out-of-network coverage?

We are awaiting further guidance on this issue.

EARLY RETIREE SUBSIDY

If the retiree pays the entire premium themselves, does it still apply?

Our understanding is that who pays the premium is not the issue. The program is available regardless of who pays the premium. Any reimbursements should be used to reduce the cost to the retirees participating and not to reduce the employer cost.

Regarding the early retiree reimbursement of claims, is this clause referring to fully insured plans and ASO plans?

This particular law applies to any early retiree plan whether it is fully-insured or self-funded with an ASO administrator.

Are there any rules defining retiree plans?

The only requirement that is apparent is that the early retiree plan may cover individuals who are age 55 or over but not yet 65. The plan design is up to the employer. For example, the plan could cover early retiree at age 60 who worked for the employer for 10 or more years - as long as the plan is not discriminatory, favoring highly-compensated employees. The law does not require employers to establish early retiree programs.

SELF-FUNDED PLANS

Did I understand you to say that self-insured plans do not have to comply with the new laws?

These are federal laws. Since self-insured/self-funded plans are permitted by federal law, they are subject to the new laws. The only area where there may be some flexibility is in the loss ratio requirements. Otherwise, self-funded/self-insured plans do need to comply.

W-2 REPORTING REQUIREMENTS

Will the W2 reporting requirement be for employer and employee portions?

Based on the current information, both the employer and employee portions of the cost will be included. This includes any medical, dental, and vision plan cost.

Do we assume the W-2 reporting requirement will lead to taxation of those amounts in the future?

We are not willing nor able to project any future use for this information at this time.