HEALTHCARE REFORM SURVIVAL GUIDE

for Employers

Alliant
EMPLOYEE BENEFITS

PATIENT PROTECTION AND AFFORDABLE CARE ACT
HEALTHCARE REFORM
OBAMACARE

They're all different names for the same thing.
But what does it mean to you as an employer?

It means changes.
Lots of changes.

Changes to your…

- **Plan design**
- **Plan administration**
- **Eligibility rules**
- **Plan finances**
- **Employee communication**

It also means changes for your employees and their dependents. In fact, there probably isn't a person in America who isn't affected by Healthcare Reform in some way.

We at Alliant know that it's hard to keep straight all of the changes that have already come, that are around the corner, and that are still a ways down the road. That's why we're providing you this Healthcare Reform Survival Guide.

Now, keep in mind, while we do **have** lawyers, we're not **your** lawyers. So you'll need to be in close touch with your plan's attorneys to be sure that you're doing what you're supposed to. But we hope that the Guide will help you survive all of the changes due to Healthcare Reform.

About this Guide

This guide is divided into six sections:

1. Plan Benefits
2. Plan Administration
3. Plan Finances and Taxes
4. Pay or Play
5. Communications
6. Participant Issues

Within each section, the specific provisions of Healthcare Reform are separated into those that are:

- Already in Effect
- Coming Up
  (Scheduled for implementation in the next year or so)
- Way Out There
  (Either not scheduled for implementation soon or likely to be delayed because of lack of guidance or proper infrastructure)

Also note that the following codes are used throughout the Guide:

ALL	This provision applies to all plans, regardless of grandfathered status
GF	This provision applies to grandfathered plans only
NOT GF	This provision does not apply to grandfathered plans
S	Applies only to small employers (fewer than 50 employees)
L	Applies only to large employers (50 or more employees)
XL	Applies only to large employers with more than 200 employees

Getting Started: A Vocabulary Lesson

Every time the government makes a new rule, it generally references new terms that need to be defined. Here are a few definitions to get you started. You'll be seeing these terms throughout the Guide, so we thought we'd put their meanings up front and center.

DEPENDENT CHILD

Healthcare Reform regulations don't define the term "child" for the purpose of deciding which children need to be offered dependent coverage. But as a rule, the following categories of children would be covered:

- Biological children
- Adopted children
- Stepchildren
- Eligible foster children

They are considered children under the plan for at least as long as the relationship lasts. For example, a stepchild is considered a dependent child by the plan as long as the stepparent and biological parent are married. Children of a domestic partner could be covered if the child is considered a stepchild under state law (for example, in states that recognize same sex marriage).

If you're not sure about the rules that apply to your plan, talk to your carrier or TPA for specifics.

ESSENTIAL HEALTH BENEFIT

The federal government hasn't officially defined what an essential health benefit is. However, we know that it will include benefits in the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use treatment, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services, including chronic disease management
- Pediatric services, including oral and vision care

Work with your carrier or TPA to decide which items and services are essential health benefits. Agencies will take into account a plan's good faith efforts to comply with these rules.

EXCEPTED BENEFIT

Excepted benefits are benefits that are not affected by some of the new Healthcare Reform rules. These include:

- **Fully-insured** dental and vision plans if the benefits are provided through separate insurance contracts.
- **Self-insured** dental and vision plans if the participant elects the coverage separately from the medical plan.
- **Health FSAs** if (1) the employee is eligible for other group health plan coverage (medical plan) AND (2) the employer contribution to the FSA is capped at (i) 2x (two times) the employee salary reduction election OR (ii) the employee salary reduction election plus $500 (whichever is greater).
- **Retiree-only** plans (still subject to various ACA fees)

GRANDFATHERED PLAN

A grandfathered plan is one that existed on March 23, 2010, otherwise known as the date Healthcare Reform was passed. The plan has also continued since that date without any major changes. Changes that trigger a loss of grandfathered status are generally those that are negative for the participant, such as increases in cost-sharing, limits on benefits, etc.

Grandfathered status affects compliance with various rules.

ALREADY IN EFFECT

DOLLAR LIMITS ON ESSENTIAL HEALTH BENEFITS ALL

Currently, plans cannot have lifetime dollar limits on essential health benefits (see page 6). For plan years that started on or after January 1, 2014, plans cannot place annual limits on essential health benefits.

- **These rules apply to all plans regardless of grandfathered status.**
- **Make sure these rules are reflected in your plan document.**
- **You may want to consider using treatment-based limits (such as a limit on the number of office visits) as an alternative.**
- **Discuss your options with your carrier or TPA.**

DEPENDENT COVERAGE TO AGE 26 ALL

Plans that offer coverage for children must make that coverage available until the child reaches age 26 (through age 25). The plan can't deny coverage based on the child's employment, income level, ability to self-support, student status, or marital status. Coverage will generally be tax-free until the tax year when the child turns 27.

Make sure these rules are reflected in your plan document.

PATIENT PROTECTIONS NOT GF

Healthcare Reform added the following new rules. All of them took effect in plan years that began on or after September 23, 2010.

- **Participants must be allowed to choose any participating primary care provider (a pediatrician can be named as a child's primary care provider).**
- **Plans can't require pre-authorization or referral for care by a doctor of obstetrics or gynecology.**
- **Plans that provide benefits for emergency services can't do the following:**
  - Require pre-authorization for emergency care at in-network or out-of-network facilities.
  - Deny coverage because the facility is outside the network.
  - Impose administrative requirements or limits on coverage that are more restrictive in an out-of-network facility than they are at an in-network facility.
  - Require the patient to pay more than is allowable under cost-sharing rules.
- **Certain preventive health services must be covered with no cost sharing, including contraceptive coverage for most plans.**

- **Make sure your plan document reflects these changes.**
- **Talk to your carrier or TPA if you have questions about which preventive care items must be covered with no cost sharing.**

COMING UP

DOLLAR LIMITS ON ESSENTIAL HEALTH BENEFITS ALL

For plan years starting on or after January 1, 2014, plans cannot place annual limits on essential health benefits.

- These rules apply to all plans regardless of grandfathered status.
- Make sure these rules are reflected in your plan document.
- You may want to consider using treatment-based limits (such as a limit on the number of office visits) as an alternative.
- Discuss your options with your carrier or TPA.

REQUIRED COVERAGE OF CLINICAL TRIALS NOT GF

Starting on January 1, 2014, health plans must allow participation in an approved clinical trial and cannot discriminate against an individual participating in a clinical trial. Plans also can't limit or place conditions on coverage for routine patient care provided in the clinical trial.

If your plan is not grandfathered, make sure it is updated to reflect this change.

COST-SHARING LIMITATIONS APPLY

Out-of-Pocket Maximum Limits NOT GF

For plan years starting in 2014, out-of-pocket limits for self-only and family coverage can't be more than the limits for HSA-compatible HDHPs. These limits are indexed each year. In 2014, these limits are:

- $6,350 (individual coverage)
- $12,700 (family coverage)

If your plan is not grandfathered, make sure it is updated to reflect this change.

WAY OUT THERE

None.

ALREADY IN EFFECT

NEW STANDARDS FOR APPEALS NOT GF

The rules have the following effects:

- Expand the definition of adverse benefit determination.
- Clarify procedures regarding full and fair review of claims.
- Provide guidance on conflicts of interest.
- Provide new content requirements for notices, and that they be provided in a non-English language in some cases.
- Change the compliance standards and rules about exhausting other avenues of appeal.
- Require continued coverage while an appeal is in process.

Make sure the new claims appeal rules are reflected in your plan document.

LIMITS ON CANCELING COVERAGE RETROACTIVELY ALL

Except in cases of fraud or intentional misrepresentation (lying), plans can't retroactively cancel coverage (called "rescission of coverage"). And even when there is fraud or lying, the plan document must state that it has the right to retroactively terminate coverage in these circumstances, and must give written advance notice of the rescission. Retroactive cancelation because of a failure to pay premiums is not considered a rescission and is, therefore, allowed.

Update your plan document to ensure that you can retroactively cancel coverage in the event of fraud or lying. Discuss with your carrier or TPA.

LIMITS ON PRE-EXISTING CONDITION EXCLUSIONS ALL

Any plan limits on pre-existing conditions cannot apply to children under age 19. Starting in 2014, plans can't apply pre-existing condition exclusions to any participant.

Make sure these changes have been included in your plan document.

REPORTING THE COST OF EMPLOYER-SPONSORED COVERAGE ON FORM W-2 ALL

Employers must report the aggregate cost of employer-sponsored coverage on Form W-2.

- For a **fully-insured** plan, the aggregate cost of coverage is the combined employer and employee contribution to premium.
- For a **self-insured** plan, aggregate cost of coverage is usually the COBRA applicable premium minus the 2% administration fee.

Excepted benefits (see page 4) do not have to be reported. Employers who issued fewer than 250 W-2s in the previous calendar year are currently not required to report. However, note that after you cross the 250 W-2 threshold, you will be required to report in the following year.

- **Make sure your payroll teams are prepared for this new reporting requirement.**
- **Ask your Alliant representative for a copy of our comprehensive W-2 reporting guide for additional support.**

ALREADY IN EFFECT

HEALTHCARE FSA CONTRIBUTIONS CAPPED AT $2,500 ALL

Employee contributions are limited to $2,500 (indexed for inflation starting in 2014). Employer contributions generally don't count toward the limit unless an employee could elect cash instead of the employer contribution. Please note that:

- The $2,500 limit applies on an employee-by-employee basis. This means that two spouses employed by the same employer could each contribute $2,500.
- The $2,500 limit also applies on an employer-by-employer basis. This means that employees with more than one employer could contribute $2,500 under each employer's FSA.

There has been no change to the allowable contribution for Dependent Care FSAs.

- Make sure your cafeteria plan document includes this change.
- Communicate the new limit to employees.

COMING UP

NON-DISCRIMINATION RULES

Healthcare Reform rules state that non-grandfathered fully-insured plans will now have to comply with similar non-discrimination rules that already apply to self-insured plans. In short, these rules prohibit discrimination in favor of highly compensated individuals. Technically, this rule is already in effect for self-funded plans. It is not yet being enforced against fully-insured plans.

So, here's what you need to know:

- If you plan is fully-insured and non-grandfathered, your plan will need to comply once guidance is released.
- If your plan is self-insured, carry on and don't discriminate.

- Be on the lookout for new guidance.
- If you have any plan terms that are a concern (for example, a plan that provides better coverage for certain classes of employees), know that these will probably need to be changed once regulations are released. Discuss any concerns with your carrier/TPA or legal counsel.

Important Note!

The following designs tend to raise "red flags" for discrimination purposes. These features won't necessarily cause a testing failure, but should be looked at to make sure they don't violate the discrimination rules.

- Having different plans available only to certain classes of employees
- Different eligibility provisions such as waiting periods for different classes of employees
- Employer contributions that increase with an employee's tenure or a percentage of the employee's compensation
- Different employer contributions for different classes of employees

AUTOMATIC ENROLLMENT FOR LARGE EMPLOYERS ONLY ALL XL

Healthcare Reform rules are designed to ensure that everyone has healthcare insurance coverage. Therefore, large employers (200+ counted employees) must ensure coverage for benefits-eligible employees by:

- Automatically enrolling new full-time employees in one of the employer's benefit plans
- Automatically continuing the enrollment of current employees from one plan year to the next (called "passive enrollment").

COMING UP

If you're a large employer, watch for guidance on this and let your human resources/benefits administration teams know this is coming.

NO PRE-EXISTING CONDITION EXCLUSIONS

ALL

Starting in 2014, plans can't apply pre-existing condition exclusions to any participant.

Make sure these changes have been included in your plan document.

EXCESSIVE WAITING PERIODS PROHIBITED

ALL

Starting with the first plan year on or after January 1, 2014, plans can't apply a waiting period that is longer than 90 days. If your plan currently extends eligibility on the first of the month after 90 days, the plan will not be compliant. Coverage must begin no later than day 91. This is a true "days passed" standard and includes weekends and holidays. Note that state mandates might require waiting periods shorter than 90 days for some fully-insured plans.

EXAMPLE:

ABC Company has always allowed employees to participate in its health plan starting the first of the month after the employee has worked 90 days. Will this "first of the month after 90 days" standard be acceptable under the new Healthcare Reform rules?

No. Suppose ABC Company hires Danny as a full-time employee on June 1, 2014. Ninety days from Danny's first day of employment (June 1, 2014) is August 29, 2014. Waiting until September 1 to enroll Danny would violate the Healthcare Reform rules because this would result in a waiting period longer than 90 days.

Additional guidance on how waiting periods are applied in connection with the "Pay or Play" rules may be issued. Please see page 11 for more information on Pay or Play.

Make sure this change is included in your plan document.

REPORTING HEALTH INSURANCE STATUS TO IRS

ALL L

Employers with 50 or more full-time employees who offer employer-sponsored coverage must report coverage status to the government. A summary of the reported information must be given to employees.

EMPLOYER ACTION ITEM

- **Watch for additional guidance.**
- **Make sure your payroll teams (or teams who will be responsible for this reporting) are prepared for this new reporting requirement.**

WAY OUT THERE

None.

ALREADY IN EFFECT

INSURANCE CARRIERS MUST ISSUE REFUNDS TO CERTAIN FULLY-INSURED PLANS ALL

Carriers must refund a portion of your plan's premiums if the carrier does not spend a minimum amount of your premiums on paying plan claims.

- In large groups, the minimum is 85%
- In small groups, the minimum is 80%

There are special rules about how refunds can be used. It will depend on:

- The terms of your plan
- Whether it's an ERISA, non-ERISA, or church plan
- Whether the refund is considered a plan asset

This rule does not affect self-insured plans.

Review your plan and talk to your carrier.

PATIENT-CENTERED OUTCOMES RESEARCH FEE ALL

Fees are based on the number of employees and dependents covered by the plan. If an employer has more than one self-insured plan and if the self-insured plans have the same plan year, participants of both plans will usually be counted only once for the fee.

The fee is $2 per person per year.

Get familiar with the different methods for taking a "headcount" and submit the fees by the date due (generally July 31).

COMING UP

ANNUAL FEES FOR INSURANCE CARRIERS OF FULLY-INSURED PLANS

Carriers will probably pass the fees along to plans, and they could increase premiums 1.5% – 4.0%. Fees are payable to the government in 2014.

If your plan is fully-insured, talk to your carrier about how much the fee will be and when it will be collected.

REINSURANCE FEES FOR INSURANCE CARRIERS AND SELF-FUNDED PLANS

Insurance carriers and TPAs (on behalf of self-funded plans) must contribute to a temporary reinsurance program. The fee is estimated at $63 per covered life, and lasts for three benefit years (2014–2016). Self-funded plans are ultimately responsible for these fees, and carriers will likely pass fees along to policyholders.

Talk to your carrier or TPA for information about how the fees will apply to your plan.

SECTION 4 PAY OR PLAY ALL L (SHARED RESPONSIBILITY TAX)

Because "Pay or Play" is such a big part of Healthcare Reform, we're devoting a whole section of the Guide to it. In this section, you'll get a good overview of how Pay or Play works, and how it will affect your organization.

OVERVIEW

The Pay or Play rules require that large employers offer minimum essential coverage to their full-time employees or pay a penalty. If an employer doesn't provide minimum essential coverage, it must pay an annual tax of $2,000 per employee starting with employee number 31. (There is no penalty for the first 30 employees.)

If an employer provides minimum essential coverage but the coverage is unaffordable or doesn't provide minimum value, the employer must pay an annual tax of $3,000 for each employee who gets subsidized coverage through an Exchange.

WHAT IS A LARGE EMPLOYER?

A large employer has at least 50 full-time or full-time equivalent employees. Add together the number of actual full-time employees and the number of full-time equivalent employees to see if there are at least 50 employees. Employers with 50–100 full-time and/or full-time equivalent employees will not be subject to penalties until the beginning of their 2016 plan years (so long as benefits and benefits eligibility under existing plans are not eliminated or materially reduced).

Ask your Alliant representative if you need assistance determining if your company is considered a "large employer."

LARGE EMPLOYER

50+ FULL-TIME EMPLOYEES AND/OR FULL-TIME EQUIVALENT EMPLOYEES

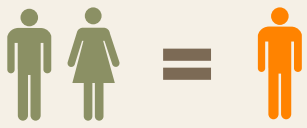
WHAT MAKES AN EMPLOYEE FULL-TIME?

Full-time is defined as 130 hours per month. This includes:

- Actual hours worked
- Hours paid, but not worked (for example, paid sick time or vacation time)

WHAT IS A FULL-TIME EQUIVALENT EMPLOYEE?

Multiple part-time employees can be "added together" to make one full-time equivalent employee. For example, two employees working 65 hours per month (approximately 15 hours per week) add up to one full-time employee working 130 hours per month.



2 part-time employees 65 hrs./mo.

1 full-time employee 130 hrs./mo.

PAY OR PLAY REQUIREMENTS

1. PLANS MUST PROVIDE MINIMUM ESSENTIAL COVERAGE

Most employer-sponsored major medical plans will be considered minimum essential coverage.

2. PLANS MUST PROVIDE MINIMUM VALUE

In order to provide minimum value, a plan's share of the cost of benefits must be at least 60%. Employers will have different options to make sure their plans meet this threshold.

- HHS and the IRS have created an Excel-based calculator
- A safe harbor or checklist method is also available
- An actuarial analysis could be done (probably the least appealing option due to the expense)

3. COVERAGE MUST BE AFFORDABLE TO EMPLOYEES

Under Healthcare Reform, coverage that costs more than 9.5% of the employee's household income will not be considered affordable. Because employers will usually not know an employee's household income, the rules allow employers to use the following methods to calculate affordability. Calculations are based on employee-only coverage for the lowest cost plan offered that provides minimum value:

- **W-2 wages method:** The employee's annual premium contribution does not exceed 9.5% of W-2 wages.
- **Rate of pay method:** The employee's cost does not exceed 9.5% of the employee's hourly wage X 130 per month. (Note: 130 hours per month is used for the calculation even if an employee works more hours than 130.)
- **Federal Poverty Line (FPL) method:** The employee's cost does not exceed 9.5% of the federal poverty line for a single individual.

EXAMPLES

W-2 WAGES METHOD

Kathy earns $50,000 per year and pays $300 per month for single coverage on her employer's lowest cost plan. Kathy's annual contribution to coverage is affordable because it does not exceed 9.5% of her W-2 wages. (50,000 X .095 = 4,750, the maximum contribution that could be charged annually and still be considered affordable.) Kathy's contribution is below this threshold—she pays $3,600 in premiums annually.

RATE OF PAY METHOD

John makes $15.00 per hour and works 40 hours per week. He pays $150 per month for single coverage on his employer's lowest cost plan. John's contribution to coverage is affordable under the rate of pay method because it does not exceed 9.5% of his hourly wage multiplied by 130 hours (15 x 130 = 1950; 1950 x .095 = 185.25, the maximum contribution that could be charged and still be considered affordable).

FEDERAL POVERTY LINE METHOD

Using John from the previous example, would his $150 monthly contribution still be considered affordable using this method? No. If John lives in the continental U.S., the federal poverty level for a single individual is $11,490. 11,490 X .095 is $1,091.55 per year, or $90.96 per month (the maximum contribution that could be charged and still be considered affordable). John's $150 monthly contribution exceeds this threshold.

DETERMINING ELIGIBILITY FOR COVERAGE

Coverage must be available to all full-time employees. So the first thing employers need to do is determine which employees—in the eyes of the federal government—are considered "full-time."

WHO IS FULL-TIME?

The rules here are fairly complex. In short, employers must put employees into different categories. Employees who are working full-time (130 hours per month) generally must be offered coverage to avoid a penalty. Other employees whose hours are unpredictable will have their full-time status determined by looking back over a period of time called a measurement period.

HOW LONG IS THE MEASUREMENT PERIOD?

The measurement period is set by the employer, but can't be longer than 12 months. Most employers will have an initial measurement period for new and variable hour employees and a standard measurement period for ongoing employees. If, at the end of the measurement period, the employee has met the threshold for full-time status, he or she must be offered coverage to avoid a penalty.

WHAT IS A STABILITY PERIOD?

At the end of the measurement period, the employee usually enters what's called a stability period. The stability period has to be at least as long as the measurement period was, and during the stability period, employees are vested in their benefits coverage regardless of how many hours they actually work.

WHAT IS AN ADMINISTRATIVE PERIOD?

The rules allow an employer to use an administrative period—a time when the employer can:

- Collect paperwork
- Answer questions from employees
- Take care of other administrative tasks

The administrative period can't be longer than 90 days. The administrative period and measurement period together cannot last past the last day of the first month following the one-year anniversary of an employee's start-date.

- For example, if the employee is hired February 15, the combined measurement period and administrative period must end on or before March 31 of the following year.

PRACTICAL APPLICATION

Since most employers administer their plans on a monthly basis, the most common arrangement will be for an employer to have 13 distinct measurement periods:

- 12 "initial" measurement periods starting on the first day of each month for new employees. For example, if an employee starts work on March 13, his initial measurement period would start April 1.
- One "standard" measurement period for ongoing employees. Employers will likely want the standard measurement period to end close to their annual benefits enrollment so that eligibility for benefits is determined prior to annual enrollment beginning.

Most employers will probably use a split administrative period, with some administrative time before the measurement period starts (to answer questions and do initial paperwork) and after it ends (to calculate hours and complete enrollment). It would look like this:

EXAMPLE

Jane Doe is hired February 15 and is expected to have variable hours.

- Administrative Period #1 (February 15–February 28): She will enter the front end of an administrative period on February 15, which will last until the employer's next initial measurement period starts (March 1).
- Initial Measurement Period (March 1–January 31): Let's say the employer has an 11-month initial measurement period in order to have a longer administrative period. In this case, Jane finishes the initial measurement period on January 31.
- Administrative Period #2 (February 1–March 31): On February 1, she enters the back end of the administrative period, which will last until the end of the following month, or March 31.
- Eligibility Begins (April 1): If she is a full-time employee based on the measurement of her hours, she would be treated as full-time beginning April 1.

WHO IS FULL-TIME? (continued)

What happens if an employee does not meet the full-time threshold in the initial measurement period?

In this case, the employee enters what's called a "limited" stability period. It's considered limited because it will not necessarily last the same number of months as the measurement period—it will only last until the employer's standard measurement period for ongoing employees ends.

At the end of the limited stability period, the employer would take a second measurement of the employee's hours based on the standard measurement period—the one that started on or after the employee's hire date and generally ends just prior to annual enrollment. If the employee is full-time using this method, he or she will need to be offered coverage to avoid a penalty.

What if an employer misses someone?

It is possible to mistakenly determine that an employee is not full-time (and therefore not benefits-eligible) when in fact he or she is eligible. The rules provide some relief here. An employer who fails to offer coverage to a small number of full-time employees (5% or less) will not face the full pay or play penalty that would otherwise apply. This is known as the de minimis rule. As transitional relief for 2015 only, this de minimis rule applies if an employer fails to offer coverage up to 30% of its full-time employees.

- **Familiarize yourself with these basic rules.**
- **Consider what groups within your organization will need training. For example, human resources and payroll teams will likely need training.**
- **Please contact your Alliant representative with specific questions on how the rules apply to you. The rules are complicated and represent a major change for most employers. Don't hesitate to reach out for assistance.**

WAY OUT THERE

CADILLAC TAX: TAX ON THE EXCESS BENEFIT OF HIGH COST HEALTH COVERAGE (2018)

A plan is considered a "Cadillac" plan if it provides a level of benefits that results in an annual premium of:

- **$10,200 for individual coverage**
- **$27,500 for family coverage**

Generally, these plans require little or no out-of-pocket cost for the participant, which tends to encourage overuse of medical care.

These plans will incur a 40% excise tax on the excess benefit (meaning, premiums that exceed these thresholds). There are many exceptions based on location and job classification.

- **Watch for guidance as the effective date approaches.**
- **Keep an eye on whether plans are trending toward the premium level, which would trigger the Cadillac tax.**

ALREADY IN EFFECT

PLANS MUST PROVIDE A SUMMARY OF BENEFITS AND COVERAGE (SBC)

Summary information using a template SBC must be provided to participants. The template allows for four double-sided, letter-size pages. Aside from adding the plan's specific information, the template cannot be changed. SBCs are not required for excepted benefits.

- **Work with your carrier/TPA to ensure the SBC is written accurately and distributed to all individuals who should receive them.**
- **Determine if your dental and/or vision plans are required to provide SBCs. (See page 4 for information on excepted benefits.)**

COMING UP

EMPLOYERS MUST PROVIDE NOTICE OF EXCHANGES

Employers must provide employees with a written notice about the Exchange and the effect of buying Exchange coverage instead of employer-sponsored coverage. Regulators have issued a model notice. A pared down Alliant version of the notice is also available and will simplify the process for employers.

Distribute notice according to regulatory deadlines: October 1, 2013 (for employees hired on or after October 1, within 14 days of the employee's start date).

WAY OUT THERE

None.

ALREADY IN EFFECT

HSA PENALTIES INCREASE

If a participant uses HSA money for non-qualifying medical expenses, they are liable for a 20% penalty on the non-qualifying distribution. This is in addition to the regular income tax which would be due.

EMPLOYER ACTION ITEM

Even though it's not required, you may wish to communicate this change to employees in high deductible plans with HSAs.

RESTRICTIONS ON REIMBURSEMENTS FOR OVER-THE-COUNTER DRUGS

Over-the-counter medicines (other than insulin) cannot be reimbursed from an FSA, HSA or HRA unless prescribed by a doctor.

- **Make sure your cafeteria plan document has been updated to reflect this change.**
- **You will want to communicate this change to employees during annual enrollment if you offer a Healthcare FSA, an HRA or a high-deductible plan with an HSA.**

COMING UP

Exchange coverage available. Employees can purchase coverage in a state on federally run exchange. Individuals with incomes between 100% – 400% of the federal poverty level (FPL) may be eligible for subsidies.

Watch for additional guidance as we get closer to the effective date.

WAY OUT THERE

None.

QUESTIONS?

Contact your Alliant Employee Benefits representative if you'd like more information on Healthcare Reform and what it means to your company.

NOTES

Revised 05-2014

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EMPLOYEE BENEFITS