




**Success 2011—
Be Prepared for Upcoming Changes**

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Success 2011-Be Prepared for Upcoming Changes

Health Care Reform

November 1, 2010

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Health Care Reform: Immediate Concerns for Employers

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I. Introduction

A. General Effective Dates

1. Applicable Health Care Reform Laws.

(a) Patient Protection and Affordable Care Act, P.L. 111-148, passed on March 23, 2010 (the “Affordable Care Act” or simply the “Act”).

(b) Health Care and Education Reconciliation Act of 2010, P.L. 111-152, passed on March 30, 2010 (“Reconciliation Act”).

2. “Insurance Market Reforms”.

(a) Many of the so-called “insurance market reforms” under health care reform are effective as of the first day of the first plan year beginning on or after September 23, 2010 (six months after the date of enactment of the Affordable Care Act). These insurance market reforms include new rules with respect to rescissions, annual and lifetime limits on benefits, coverage of adult dependent children, and pre-existing condition exclusions.

(b) Under existing regulations adopted under the Health Insurance Affordability and Accountability Act of 1996 (“HIPAA”), the “plan year” of a group health plan is the 12 month period designated as the plan year in the plan document. If the plan document does not designate a plan year or there is no plan document, the plan year is the 12 month period used in administering deductibles and limits under the plan. If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year or, for a self-insured plan, the employer’s taxable year. 45 CFR §144.103 (Health and Human Services Department regulations); 29 CFR §2590.701-2 (Department of Labor regulations); 26 CFR § 54.9801-2 (Treasury Department regulations).

Note: Under this definition, the plan year of an insured employer health plan could be different from the policy year under the insurance policy.

(c) Thus, for calendar year plans and insurance contracts, these insurance market reforms are effective as of January 1, 2011.

3. Fundamental Reforms.

The more fundamental reforms, including the individual mandate, the employer “pay or play” mandate, and the establishment of insurance exchanges, are scheduled to take effect on January 1, 2014.

B. Grandfathered Plan Rules

Part VI of this outline describes the special rules for so-called “grandfathered plans”. If a plan qualifies for grandfathered status, the effective date of certain health reform requirements may be delayed and the application of other requirements may be suspended indefinitely.

II. A Selection of “Insurance Market Reforms”

A. Dependent Coverage to Age 26

1. General. The Affordable Care Act requires group health plans and health insurance issuers that provide dependent child coverage to make that coverage available until the child reaches age 26. Act Section 1001(5), adding new Section 2714 to the PHSA; Recovery Act Section 2301(a). Proposed regulations containing an interim final rule were issued by HHS, DOL, and Treasury on May 13, 2010. 75 Fed. Reg. 27121. The age 26 requirement applies to all group health plans otherwise subject to the Affordable Care Act, including insured and self-insured plans, excluding only certain plans (such as stand-alone dental or vision plans and some flexible spending accounts) that are currently exempt from HIPAA “portability” requirements.¹

2. Effective Date. In general, the new dependent coverage rules apply to group health plans as of the first day of the first plan year that begins on or after September 23, 2010 (so for calendar year plans the effective date is January 1, 2011). However, certain grandfathered group health plans (*i.e.*, plans in existence on March 23, 2010; see Part VI, below), may exclude an adult child until the first plan year beginning on or after January 1, 2014, if such child is eligible to enroll in an employer-sponsored health plan other than a plan of either parent.

3. Requirements.

(a) For a participant’s child under age 26 - whether a minor or adult child - a group health plan may no longer condition eligibility for dependent coverage on:

- (i) whether the child is financially dependent on the participant, or a dependent of the participant for income tax purposes;
- (ii) whether the child resides with the participant;
- (iii) the child’s marital status, student status, or employment status; or
- (iv) any combination of these factors.

¹ HIPAA portability requirements are set forth in Sections 9801 and 9802 of the Internal Revenue Code, Sections 701 and 702 of the Employee Retirement Income Security Act (ERISA) and Sections 2702-2706 of the PHSA.

For a child under age 26, eligibility for dependent coverage is now definable only by reference to the precise nature of the parent-child relationship.

(b) The interim final rules provide that the terms of coverage for dependent children cannot vary based on age. For example, a plan may not impose a surcharge for coverage of a child older than a specified age.

(c) The interim final rules did not define the term “child” for purposes of the required extension of coverage to age 26, but the Department of Labor has since said a plan could limit the application of the age 26 extension to natural and adopted children, step-children, and foster children. EBSA FAQs (September 20, 2010).

(d) Transition Rule – For a child who is younger than 26 on the effective date of the age 26 requirement for a health plan and is not covered under the plan:

(i) The plan must give notice of availability of coverage no later than the first day of the first plan year beginning on or after September 23, 2010 and offer an enrollment period of at least 30 days; and

(ii) If elected, coverage must begin no later than first day of the plan year, even if the election is made later.

26 CFR §54.9815-2714T(f).

4. Tax Law Change.

(a) Background: Under Sections 105 and 152(b) of the Internal Revenue Code (“Code”) as in effect before the Affordable Care Act, a group health plan could provide tax-free coverage for an employee, the employee's spouse, and other individuals who qualified as tax dependents. "Tax dependents" would include an employee's natural, adopted, step, and qualifying foster children, provided they met conditions related to age, residency, student status, and income. If a plan provided dependent coverage for individuals who did not meet the definition of a tax dependent – examples might include grandchildren or children of domestic partners – the value of that coverage was imputed income taxable to the employee.

(b) Under the Act and IRS Notice 2010-38, there is excluded from an employee’s taxable income the value of any employer-provided health coverage for an employee’s child for the period before the child turns age 26 and for the entire taxable year in which the child turns 26, regardless of whether the child qualifies as a tax dependent.

(c) Under IRS Notice 2010-38, the tax treatment described in paragraph (b) above also applies to coverage under cafeteria plans, health flexible spending accounts, and health reimbursement arrangements, but not health savings accounts (HSAs).

B. Elimination of Preexisting Condition Exclusions

1. Most group health plans are already subject to the portability rules under HIPAA. These rules limit the circumstances under which plans may impose preexisting condition exclusions (generally the exclusionary period cannot exceed 12 months, or 18 months for a late enrollee) and require that any exclusionary period be offset by prior creditable coverage. (Under HIPAA, a preexisting condition exclusion is, generally an exclusion from coverage based on the fact that a condition existed at the time of enrollment.) Under the Affordable Care Act, preexisting condition exclusions will become obsolete. The rule applies to individual policies as well as group plans. Act Section 1201, adding new Section 2704 to the PHSA; Act Sections 1253, 10103(e).

2. The Act provides that, effective for plan years beginning on or after September 23, 2010, including for grandfathered plans, a group health plan may not impose any preexisting condition exclusion on an individual under age 19. Any exclusionary period that applies at the time the prohibition goes into effect for a plan must immediately terminate. For example, if a child enrolled in a calendar year plan in October 2010 and has a preexisting condition that is subject to a six-month exclusionary period, the exclusion must end on January 1, 2011.

3. Plans may continue to apply preexisting condition exclusions (consistent with the HIPAA rules) with respect to individuals older than age 19 until the 2014 plan year, at which time no preexisting condition exclusions will be permitted.

4. Regulations containing interim final rules clarify that plans are prohibited from denying enrollment in the plan (not only benefit coverage) based on the existence of a preexisting condition. 54 CFR §9815-2704T; 29 CFR §715.2704; 45 CFR §147.108. As under HIPAA, the new rules do not preclude the complete exclusion of coverage for particular conditions, as long as the exclusion is not based on when the condition arose.

C. Limits on Rescission of Coverage

1. Under the Affordable Care Act, a “rescission” is a retroactive termination of coverage under a health plan. The Act prohibits both insurers and group health plans from rescinding coverage retroactively except in cases of fraud or intentional misrepresentation of material fact. The Act requires that, in an allowable case of retroactive rescission, the insurer or plan sponsor provide 30 days advance notice. Act Section 1001(5), adding new Section 2712 to the PHSA.

2. Regulations containing interim final rules clarify that the term “rescission” does not include a retroactive termination for failure to pay premiums in a timely manner. A prospective termination of coverage is not considered a rescission and may be permitted without proof of fraud or misrepresentation. 26 CFR §54.9815-2712T; 29 CFR §2590.701-2712; 45 CFR §147.128.

3. Comments on the regulations questioned, among other things, how the rescission rules relate to COBRA procedures, and whether a plan sponsor might drop ineligible dependents and ex-spouses retroactively. In FAQs issued on October 8, 2010, the Department of Labor distinguished between allowable retroactive terminations pursuant to regular

administrative processes (e.g., in the case of a terminated employee whose coverage is canceled when the employer regularly processes terminations, retroactive to his termination date, or in the case of an ex-spouse whose coverage is canceled retroactive to the date of the divorce, when the employer was not timely notified of the divorce – in both cases subject to COBRA rights), and prohibited rescission in cases of employer administrative errors (e.g., when the employer mistakenly continued regular coverage for an employee whose status changed from eligible full-time to ineligible part-time status, coverage can be terminated prospectively, subject to COBRA rights, but not rescinded retroactively).

D. Other “Insurance Market Reforms”

1. Other “insurance market reforms” include the elimination of lifetime and annual limits on benefits and mandatory coverage of certain preventative health services.

III. Tax Law Changes

A. Limitation on Tax-Free Reimbursements for Over-the-Counter Drugs

1. Beginning January 1, 2011, expenses incurred for a medicine or a drug will be treated as a non-taxable reimbursement for a medical care expense only if such medicine or drug is prescribed (determined without regard to whether it is available without a prescription) or is insulin. Code Sections 106(f) and 223(d)(2), as amended by Act Section 9003. Therefore, expenses incurred for medicines or drugs may be paid or reimbursed by an employer-provided plan on and after January 1, 2011, only if the medicine or drug (a) requires a prescription, or (b) is available without a prescription (an over-the-counter medicine or drug) but the individual obtains a prescription, or (c) is insulin.

2. Thus, the cost of over-the-counter drugs not prescribed by a physician may no longer be reimbursed through a health flexible spending account (FSA), a health reimbursement arrangement (HRA), or (on a tax-free basis) a health savings account (HSA).

3. A drug obtained with a prescription is considered a prescription drug - so that its cost may be paid from one of the sources described in III(A)(2) - even if it is available over-the-counter.

4. The change is effective for expenses incurred on and after January 1, 2011. Expenses incurred for over-the-counter drugs purchased without a prescription before January 1, 2011, may be reimbursed tax-free at any time, subject to the terms of the employer's plan. IRS Notice 2010-59, 2010-39 IRB.

5. The new prescription requirements do not apply to items required for medical care that are not medicines or drugs, including equipment such as crutches or blood sugar test kits. Expenses for such items remain reimbursable provided they meet the definition of an expense for medical care (not merely beneficial to general health).

6. Although, as noted, the expense for over-the-counter medicines and drugs for which an individual has a prescription may be reimbursed from an FSA or HRA, Internal Revenue Service Notice 2010-59 prohibits the use of an FSA or HRA debit card for such

purchases effective January 16, 2010 (a two-week grace period!), because of the inability of existing systems to substantiate compliance with the prescription requirement. Accordingly, a purchase of an over-the-counter medicine or drug with a prescription after January 15, 2010, will need to be reimbursed by the plan after receipt of appropriate substantiation (e.g., customer receipt with name, date, amount, prescription number). There is an exception for purchases at a pharmacy (a vendor 90 percent of whose gross receipts are from medical care expenses): debit card purchases of over-the-counter medicines or drugs may be continued to be made with an FSA or HRA debit card at such a pharmacy after 2010, provided the prescription requirement is satisfied.

B. W-2 Reporting

1. Beginning January 1, 2012, the cost of employer-provided health coverage must be reported on an employee's Form W-2. Code Section 6051(a)(14), as added by Act Section 9002. All employer-provided coverage is subject to the new requirement, other than employer HSA contributions (which are already required to be reported on W-2s). Employee contributions to FSAs are not considered employer contributions for this purpose. Query: Will a W-2 be required for a retiree with health coverage?

2. The cost of coverage is to be determined under rules similar to those used with respect to COBRA coverage.

3. Note: This requirement does not mean that such employer-provided coverage is taxable.

4. The original effective date was January 1, 2011. Internal Revenue Service Notice 2010-69 made reporting optional for 2011 and promised additional guidance.

C. FSA Annual Limit

1. Starting in calendar year 2013, employee salary reduction contributions to a health flexible spending account (health FSA) will be limited to \$2,500. Code Section 125(i), as amended by Act Section 10902 and Reconciliation Act section 1403. The limit does not apply to employer flex credits or employer seed money credited to FSAs.

2. The \$2,500 limit will be adjusted for inflation for tax years beginning after 2013.

3. This is the first time that health FSA contributions have been subject to an annual limit.

IV. Employer Notice Requirements

A. Summaries of Benefits and Coverages

1. By March 23, 2012 (the anniversary of the date of enactment of the Act), insurers or plan sponsors must provide a "uniform explanation of coverage" to each health plan participant. Act Section 1001(5), adding new section 2715 to the PHSA; Act Section 10107.

2. Contents:
 - (a) definitions of specified insurance and medical terms (at least 11 of each);
 - (b) description of coverage provided under the plan and cost sharing provisions requirements (description in statute is 25 lines long);
 - (c) exceptions, reductions, and limits on coverage;
 - (d) renewability and continuation coverage provisions;
 - (e) examples of common situations, such as:
 - (i) chronic condition, and
 - (ii) related cost sharing;
 - (f) information related to employee's eligibility for premium subsidy on an Exchange or premium tax credit, including a statement as to whether plan provides minimum essential coverage and whether the plan covers at least 60% of the actuarial value of benefits;
 - (g) contact information
3. The language used in the summary must be “culturally and linguistically appropriate and understandable to the average enrollee”.
4. Format: limited to 4 pages, in 12 point font.
5. The requirement applies to both insured and self-insured plans:
 - (a) For an insured plan: Insurance company obligation;
 - (b) For a self-insured plan: Sponsor (employer) obligation.
6. The Department of Health and Human Services is to publish standards for coverage summaries by March 23, 2011, after consulting with National Association of Insurance Commissioners.
7. \$1,000 per person per day penalty for failure to comply.
8. The new requirement does not replace or modify the ERISA requirements with respect to summary plan descriptions. Both sets of requirements presumably will apply.
9. The uniform coverage summary must be provided by March 23, 2012, for current participants. After that, the summary must be provided at enrollment or at issuance of a policy (possibly also required upon application for a policy).

B. 60-Day Prior Notice of Plan Changes

1. New PHSA section 2715(d)(4) requires a health plan to provide notice of a material change 60 days before the effective date of the change.

2. In contrast, ERISA summary plan description/summary of material modification rules for health plans require notice within 60 days after a material reduction in services or benefit.

3. The effective date of this requirement is not clear. A reasonable interpretation is that it applies to changes in the information to be provided in the notice described in IV(A) above – in which case the 60-day prior notice would be required for changes effective after March 23, 2012.

C. Notice Regarding Exchanges and Premium Subsidies

1. Beginning March 1, 2013, employers must provide written notice to all employees about State Insurance Exchanges. The notice must be provided at the time of hire, or by March 1, 2013 for current employees. Act Section 1512, adding new section 18B to the Fair Labor Standards Act (FLSA).

2. In general the employer must inform employees about how the State Insurance Exchange will work and its relation to the employer's plan. The notice must include information on:

- (a) the services provided by the Exchange;
- (b) how to contact Exchange;
- (c) that if the employer plan covers less than 60% of the actuarial value of health benefits, the employee may be eligible for premium tax credits and a cost sharing subsidy if the employee purchases insurance through an Exchange; and
- (d) if an employee purchases coverage through Exchange when he is not eligible for a free choice voucher, the employee will lose the employer's tax-free contribution toward health plan.

3. Note that the notice is required effective March 1, 2013, but the Exchanges are not required to be in operation until January 1, 2014.

4. HHS is to publish regulations, which may include model notices (as with COBRA notice models published by the Department of Labor).

V. New Nondiscrimination Rules for Insured Group Health Plans

A. Introduction

1. The Act imposes new nondiscrimination requirements for insured group health plans, effective for most non-grandfathered insured health plans as of the first day of the first plan year beginning on or after September 23, 2010.

2. There is not yet any official guidance on the new requirements, so it is not clear what the final rules will be. The following explanation of the nondiscrimination rules is based on the discrimination rules that have applied for many years to self-insured health plans. The Act calls for the nondiscrimination rules for insured health plans to be “similar to” the existing self-insured rules, which obviously leaves room for the federal regulators to treat insured plans differently. It is possible that the regulations, when issued, will include transitional rules or grace periods for bringing insured plans into full compliance.

3. Violations of the new discrimination rules can be punished by the imposition of an excise tax on the sponsoring employer of \$100 per day for each non-highly compensated employee. An IRS official confirmed this on September 20, 2010.

4. The nondiscrimination rules for self-insured plans (the new rules for insured plans when issued, must be “similar to” these rules) require that:

(a) A covered health plan must either benefit a certain percentage of all employees, or benefit a percentage of lower paid employees that is fair relative to the percentage of highly compensated individuals who are covered; and

(b) All benefits available to highly compensated individuals must also be available to all other employees.

5. If an employer's health plan does not cover all or substantially all employees or provides benefits to highly paid employees or owners that are not provided to all other employees, the employer should evaluate whether the plan complies with the new requirements and with the existing rules for self-insured plans. This may require an examination of the plan's benefit structure, age, service, and compensation data for all eligible and ineligible employees, and other information.

B. Discussion

1. Background

(a) The new rule—that insured group health plans not discriminate in favor of highly compensated individuals—is set forth in Section 2716 of the Public Health Service Act (PHSA), as amended by the Act. This new rule is effective for plan years beginning on or after September 23, 2010 for non-grandfathered health plans.

(b) The requirements of PHSA Section 2716 are incorporated into ERISA and the Internal Revenue Code, so violations of the new nondiscrimination rule can be punished by the imposition on the sponsoring employer of an excise tax equal to \$100 per day for each “affected individual”—that is, each non-highly compensated employee.

(c) Section 2716 states, in general, that a covered insured health plan “shall satisfy the requirements of Section 105(h)(2) of the Internal Revenue Code.” Section 105(h)(2) is the basic nondiscrimination rule that has applied for many years to self-insured health plans. Section 2716 also states that “rules similar to” the ancillary rules in Code Section 105(h) shall apply to covered insured health plans.

(d) As yet no official guidance on the new non-discrimination rules for insured plans has been issued by any of the federal agencies charged with administering the health care reform law (the Departments of Treasury, Labor and Health and Human Services). The Code Section 105(h) rules as they apply to self-insured plans are set out in IRS regulations issued in 1981 and never updated. It is not clear how closely the new regulations for insured plans, when issued, will follow the old IRS regulations for self-insured plans. The statute states only that “rules similar to” the rules for self-insured plans will apply to insured plans. The discussion in this outline is based on the rules for self-insured plans, as set out in these IRS regulations.

2. Plans to Which the New Rule Applies

The new nondiscrimination rule applies to all insured group health plans except the following:

(a) Grandfathered Plans – See Part VI of this outline.

(b) Dental and Vision Plans - The new nondiscrimination requirements do not apply to stand-alone dental or vision plans or any other plan that provides only “HIPAA excepted benefits,” such as most long-term care plans.

(c) Retiree Only Plans - The new nondiscrimination requirements do not apply to health plans that cover only retired or terminated employees (or that cover no more than one active employee).

(d) Governmental Plans - Finally, it appears (though is not certain) that the new nondiscrimination requirements do not apply to governmental plans.

3. Highly Compensated Individuals

(a) The basic rule under amended PHS Section 2716 is that an insured health plan may not discriminate in favor of “highly compensated individuals” as to either eligibility or plan benefits. “Highly compensated individuals” include the following.

- (i) the 5 highest paid officers;
- (ii) any 10% or greater shareholder; and
- (iii) any individual who is among the highest paid 25% of all employees.

(b) The class of “highly compensated individuals” is potentially much bigger than the class of “highly compensated employees” that is used in discrimination testing for qualified

retirement plans. Only employees with compensation over a dollar threshold — \$110,000 for 2010 — are considered “highly compensated” for retirement plan purposes.

(c) Note that this basic definition is specifically incorporated into the new statutory rule for insured plans.

4. The Rule Prohibiting Discrimination as to Eligibility

(a) Basic Eligibility Test. The following description of the eligibility rule is based on the rule for self-insured plans. Again, the rule for insured plans must be similar this rule.

A self-insured health plan complies with the eligibility rule if it satisfies any one of the following three tests:

(i) The plan benefits at least 70% or more of all employees;

(ii) 70% of all employees are eligible to benefit under the plan, and at least 80% or more of those eligible in fact benefit; or

(iii) the plan benefits a nondiscriminatory class of employees (the “nondiscriminatory classification test”).

(b) Rules For Application

(i) An employee is treated as “benefiting” under a self-insured plan that requires employee contributions only if the employee in fact elects to pay the employee premium and participates. It is not clear whether the rules for insured health plans will be interpreted in the same way, but this is likely.

(ii) The eligibility rule is applied on a controlled group basis.

(iii) The easiest eligibility test to meet is the “non-discriminatory classification” test, but it is also the most complex, as it requires review of the benefit structures and age, service, and compensation data for all eligible and ineligible employees.

(c) Excluded Employees. Certain employees can be excluded in determining whether the eligibility rule (described below) has been met by a self-insured plan, including:

(i) employees who have not attained age 25;

(ii) employees who have not completed 3 years of service;

(iii) part-time employees who customarily work fewer than 35 hours per week;

(iv) seasonal employees; and

(v) employees covered by a collective bargaining agreement.

5. The Rule Prohibiting Discriminatory Benefits

(a) Basic Rule. For self-insured plans, the “benefits test” is met only if all benefits under the plan that are available to highly compensated individuals are also available to all other participants. (This test looks at availability, not actual utilization.) Thus, the benefits test would not be met if highly compensated individuals have a lower deductible or co-pay than other participants, and probably would not be met if highly compensated individuals have optional coverages that are not available to lower paid employees.

(b) Treatment of Optional Coverages. Under the self-insured plan rules, if an employer offers optional coverages, the coverage options will be treated as a single benefit (thus making compliance with the benefits test easier) if (i) all eligible participants can elect any of the options and (ii) the required employee contributions are the same for all options. For example, a plan may offer an indemnity option and an HMO option under the same plan, provided that both options are universally available and the employee's share of the premium is the same for all options. Note: Under the rules that apply to self-insured plans, providing the same employer contribution for two or more options does not permit the options to be aggregated.

(c) Operational Test

(i) The rule prohibiting discriminatory benefits must be satisfied “in actual operation,” not merely in form. However, an operational violation would not occur merely because a highly compensated individual utilized certain (or all) benefits to a greater extent than other participants.

(ii) An operational violation might occur as a result of a plan amendment if the timing of the amendment suggests that it was intended to favor one or more highly compensated individuals. An example would be if a plan covered a certain medical treatment while it was needed by the sponsor's president, and was amended to drop this coverage once the president had completed the required treatments.

6. Other Considerations

(a) An employer may be able to aggregate otherwise separate health care arrangements into component “plans” so as to comply with the nondiscrimination rule, and/or disaggregate otherwise unitary components of a single plan for the same purpose.

(b) An employer who provides insured post-employment medical coverage to executives pursuant to employment or severance agreement may violate the nondiscrimination rule. Such arrangements should be investigated immediately.

VI. Grandfathered Plans

A. Exceptions for Grandfathered Plans. Certain plans in existence on March 23, 2010, are exempt from some of the mandates of the Act.

1. Statutory Rule Regarding Grandfathered Plans.

(a) Section 1251 of the Affordable Care Act, entitled “Preservation of Right to Maintain Existing Coverage”, provides that, with some exceptions, the Affordable Care Act does not apply to a group health plan in effect on March 23, 2010 (the date of enactment of the Act), regardless of whether such coverage is renewed, family members are added or new employees enrolled in the plan after this date. Act Sections 1251(a)(2), 1251(b), 1251(c).

To be a grandfathered plan, a group health plan must have had at least one individual enrolled in coverage on March 23, 2010, and the plan must have continuously covered someone since March 23, 2010 (even if not the same individuals). Any new policy, certificate, or contract of insurance (not including a renewed plan) issued after March 23, 2010 is not grandfathered. Reg. (75 Fed. Reg. 34537) §54.9815–1251T(a)(1)(ii).

(b) A separate provision of the Act provides that a health plan maintained pursuant to a collective bargaining agreement is exempt from many of the new requirements until the termination of such agreement. Act Section 1251(d).

(c) Pursuant to later provisions of the Act and provisions of the Reconciliation Act, many of the new requirements under health care reform apply to grandfathered plans. However, grandfathered plans are still exempt from several important new rules, including the following:

(i) the requirement that health plans cover certain preventive health services without any cost sharing under new Section 2713 of the Public Health Service Act (“PHSA”);

(ii) the prohibition on a health plan discriminating in favor of highly compensated individuals under new Section 2716 of the PHSA;

(iii) the requirements regarding claims and appeals procedures under new Section 2719 of the PHSA; and

(iv) certain new patient protection requirements, including provisions designed to ensure access to obstetric and gynecological care, set forth in Section 2719A of the PHSA.

These PHSA amendments were added and/or amended by Sections 1001(5), 10101(d), 10101(g) and 10101(h) of the Affordable Care Act.

2. Effect of Plan Changes Under the Regulations

(a) On June 17, 2010, the three federal agencies primarily responsible for administering the health care reform law issued guidance on the grandfathered health plan exemption. The interim final rule identifies a number of plan changes that will cause a plan’s grandfathered status to terminate. See paragraphs (g) of 26 CFR §54.9815-1251T, 29 CFR §2590.715-1251, and 45 CFR §147.140.

Specifically, the interim final rule provides that the following changes will cause a group health plan to lose its grandfathered status:

(i) Decrease in Employer Contribution. A plan will lose grandfathered status if an employer (or employee association) decreases its contribution rate toward the cost of any tier of coverage (e.g., self or family) by more than 5 percentage points below the contribution rate on March 23, 2010.

Example: As of March 23, 2010 the employer contributes 80% of the total cost of employee-only coverage and 60% of the total cost of family coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but retains the 80% contribution rate for employee-only coverage. The plan would cease to be a grandfathered health plan, because the 10 percentage point decrease in the contribution for family coverage exceeds the 5 percentage point maximum.

If a new tier of coverage is added, the employer contribution for the new tier is tested in comparison to the employer contribution for the corresponding tier available on March 23, 2010, if any.

Example: If the plan had two tiers – employee only and family, with a 50% employer contribution rate – and changed to employee only, employee plus one, employee plus two, and employee plus three or more, then the employer contribution rate for the new tiers must remain within 5 percentage points of 50% (that is, at least 45%) to retain grandfathered status.

(ii) Increase in Deductible or Out-of-Pocket Maximum. A plan will lose its grandfathered status if it increases a deductible or out-of-pocket maximum by more than the medical inflation rate plus 15 percentage points, as measured from March 23, 2010.

(iii) Increase in Copayment: A plan will lose its grandfathered status if it increases a copayment for any service by more than greater of: (A) \$5 (adjusted for medical inflation), or (B) the medical inflation rate plus 15 percentage points, as measured from March 23, 2010. The interim final rule contains a complex formula and examples that illustrate how to apply this requirement.

(iv) New or Increased Annual or Lifetime Limits. A plan will lose its grandfathered status if it imposes a new annual or lifetime limit on the dollar value of benefits, or decreases a lifetime limit (if there is no annual limit); or decreases an annual limit (if there is no lifetime limit), below the level in effect on March 23, 2010.

(v) Elimination of Particular Benefit. A plan will lose its grandfathered status if it eliminates all or substantially all benefits to diagnose or treat a particular condition (including a necessary element to diagnose or treat a condition).

Example: A plan covers mental health benefits, which include counseling and prescription drug benefits. The plan eliminates the counseling benefit.

According to the interim final rule, the plan has eliminated "an element that is necessary to treat the condition," and therefore has eliminated substantially all benefits to treat a condition. Accordingly, the plan loses its grandfathered status.

(vi) Increase in Coinsurance. A plan will lose grandfathered status if it increases its coinsurance percentage by any amount above the level at which it was set on March 23, 2010.

(b) The grandfather analysis applies on a benefit-by-benefit basis. For example, if a plan offers an HMO and PPO options, a change only to the HMO option will not affect the grandfather status of the PPO option. EBSA FAQs (September 20, 2010).

(c) The Preamble to the interim final rule states that the following plan changes, on their own, would not cause a plan to lose grandfathered status:

- (i) changes to a plan's premium;
- (ii) changes required to comply with federal or state law;
- (iii) changes to voluntarily comply with provisions of the Act or to increase benefits; and
- (iv) changes to a plan's third party administrator.

75 Fed. Reg. 34537, 34544 (June 17, 2010).

3. Collectively Bargained Plans.

(a) For health insurance coverage maintained pursuant to a collective bargaining agreement that was ratified prior to March 23, 2010, the coverage is deemed to be grandfathered until the date on which the last of the agreements in effect on March 23, 2010 terminates. Then, the otherwise applicable grandfathered plan rules apply. See paragraphs (f) of 26 CFR §54.9815-1251T, 29 CFR §2590.715-1251, and 45 CFR §147.140.

Example: A plan maintains insured coverage pursuant to a collective bargaining agreement that was in effect prior to March 23, 2010, which does not expire until December 31, 2011. The plan switches its insurance policy from Insurer A to Insurer B. The plan remains grandfathered because it is still under a collective bargaining agreement in effect on March 23, 2010.

(b) The preamble to the interim final rule clarifies that this special rule only applies to insured plans maintained pursuant to a collective bargaining agreement (not self-funded collectively bargained plans). 75 Fed. Reg. 34537, 34542.

(c) The preamble also provides that the special grandfathering rule for collectively bargained plans does not delay the effective date for insured collectively bargained plans to comply with the reforms in the Act that are applicable to grandfathered plans. Id. In other

words, an insured collectively bargained plan is subject to the same Affordable Care Act reforms that apply to other grandfathered plans at the same time as such reforms are applicable to other grandfathered plans. For example, an insured collectively bargained plan must comply with the requirement to continue dependent coverage to age 26 (see II.A, above) to the same extent as other grandfathered plans.

4. Disclosure of Grandfathered Status. The interim final rule requires that all plan materials notify participants of the plan's grandfathered status. See paragraphs (a)(2) of 26 CFR §54.9815-1251T, 29 CFR §2590.715-1251, and 45 CFR §147.140.

VII. The Employer "Pay or Play" Mandate

A. Background: The Individual Mandate and Premium Subsidies

1. The Individual Mandate - General. Beginning January 1, 2014, most US citizens must have health coverage that qualifies as "minimum essential coverage" or pay a penalty. Code Section 5000A, added by Act Section 1501(b). The penalty is phased in during 2014-2015 but by 2016, the penalty will be as high as \$695 per person per year (and this amount will be increased to reflect medical inflation after 2016).

There are some limited exemptions from the individual mandate (Code Sections 5000A(d)(2), 5000A(e)) for:

(a) Members of certain religious faiths that are exempt from FICA tax (e.g. certain Christian Science practitioners or members of other religious groups that share medical expenses);

(b) Undocumented aliens;

(c) Persons in prison;

(d) Individuals with income below the tax return filing threshold (\$9,350 in 2010);

(e) Individuals who can't find affordable coverage (generally, coverage is affordable if the cost is less than 8% of the individual's household income).

(i) For this purpose, "cost" means -

(A) with respect to an employer plan, the employee premium (whether paid by salary reduction or after-tax), or

(B) with respect to an individual policy, the cost of the cheapest "bronze" plan in the State, less any available subsidy.

Code Section 5000A(e)(1)(B).

2. Minimum Essential Coverage. Coverage under most employer-sponsored health plans will qualify as "minimum essential coverage"; i.e., it doesn't matter if the plan meets the

affordability and minimum value requirements relating to the employer mandate. Code Section 5000A(f); see V.C, below. Note, however, that by 2014 all employer-sponsored plan will be required to meet all of the other requirements under health care reform, some of which are summarized in Parts II and III, above. Coverage under the following will also qualify as “minimum essential coverage”:

- (a) Medicare, Medicaid, CHIP, TriCare, and
- (b) an individual policy purchased through an Exchange.

3. Premium Subsidies.

(a) To help lower-income individuals obtain and keep health insurance coverage, the Act provides for premium subsidies in the form of refundable tax credits (also called “premium assistance credits” or “Exchange subsidies”). Code Section 36B, added by Act Section 1401.

(b) An individual is eligible for a premium subsidy if:

- (i) the individual has household income above the Medicaid threshold but below 400% of the “federal poverty level” (see paragraph (f),below), and
- (ii) the individual is not eligible for coverage under an affordable employer health plan.

Code Section 36B(c).

(c) “Household income” means the modified adjusted gross income (adjusted gross income with tax-exempt interest and foreign earned income exclusions added back) of

- (i) the taxpayer, and
- (ii) all other individuals who are
 - (A) taken into account in determining the taxpayer's family size (i.e., all individuals the taxpayer is allowed to claim as dependents under Code §151), and
 - (B) who are required to file an income tax return for the tax year (the single filing threshold for 2009 is \$9,350).

Code §36B(d).

(d) The premium credit can be used by the eligible individual to buy coverage under a “qualified health plan”. A “qualified health plan” is a plan that:

- (i) provides “essential health benefits” (this term will be defined by regulations, but the Act (Section 1302(b)) requires that such term include a laundry list of services and treatments typically covered by health insurance);

- (ii) provides bronze, silver and gold coverage levels plan (which means that it has to have a minimum 60% actuarial value), or be a “catastrophic” plan covering an individuals under age 30;
- (iii) limits cost sharing (the details of this requirement remain to be worked out); and
- (iv) meets certain other requirements as to marketing, choice of providers, etc.

Act Section 1301.

(e) The amount of the subsidy will be such that the individual won’t have to spend more than a specified percentage of household income on health insurance. The maximum percentage ranges from

- (i) 2%, if household income is at or below 133% of the federal poverty level, up to
- (ii) 9.5%, if household income is 400% of the federal poverty level.

(f) Note: The federal poverty level is established each year by the U.S. Census Bureau. For 2010 the federal poverty level is \$10,830 for a single person and \$22,050 for a family of four. 400% of the federal poverty level (the maximum household income level for which premium subsidies are provide) is therefore \$43,320 for a single person and \$88,200 for a family of four.

B. “Applicable Large Employers” Subject To the Mandate

1. The employer “shared responsibility” mandate — sometimes called the “pay or play” mandate — is set forth in new Section 4908H of the Internal Revenue Code.

2. An employer is subject to the mandate if it is an “applicable large employer”, which means, in general, that it employed an average of 50 full-time employee during the preceding calendar year. Code Section 4980H(c)(2). For this purpose:

(a) A “full-time employee” is one who works 30 or more hours per week. Code Section 4980H(c)(4).

(b) All employers who are part of a controlled group or affiliated service group under Code Section 414(b), (c), (m) or (o) shall be treated as a single employer. Code Section 4980H(c)(2)(C).

(c) The employer can exclude full-time seasonal workers who worked 120 or fewer days during the preceding calendar year. The Department of Labor will define what a “seasonal worker” is. Code Section 4980H(c)(2)(B).

(d) A “full-time equivalent” computation is used under which the employer must count, in addition to full-time (30 hour or more per week) employees, a number determined by

dividing the total hours worked by part-time employees each month by 120. Code Section 4980H(c)(2)(E).

Example: An employer has 35 full-time employees who work 30 hours per week and 20 part-time employees who work 24 hours per week or 96 hours/month. The 20 part-time employees equate to 16 full-time equivalent (FTEs):

$20 \times 96 \text{ hours/month} = 1,920$

$1,920 \div 120 = \underline{16}$

The employer has 51 (35 + 16) FTEs and is therefore an applicable large employer.

C. When the Mandate Penalty Applies

1. The mandate penalty applies if:

(a) An applicable large employer either:

(i) does not offer all of its full-time employees and their dependents the opportunity to enroll in an employer health plan that provides minimum essential coverage; or

(ii) offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage, but such coverage is either not affordable to one or more full-time employees, or does not have a minimum actuarial value; and

(b) At least one employee enrolls in an Exchange plan and receives a premium tax credit with respect to such coverage (see V.A.3, above, with respect to premium subsidies) .

Code section 4980H(a), (b).

2. Coverage is unaffordable if the required employee premium is more than 9.5% of the employee's household income. (See V.A.3(c), above, with respect to household income.)

3. An employer plan will fail to have a minimum 60% actuarial value if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs". Code Section 36B(c)(2)(C)(ii). It isn't clear how this ratio will be computed, but it seems that an actuarial calculation of each health plan's value will be required.

D. Computation of the Mandate Penalty

1. "No Offer" Penalty. If the employer does not offer minimum essential coverage (C.1.(a)(i) above), the annual penalty is equal to \$2,000 times the number of the employer's full-time employees in excess of 30. Code Section 4980H(a). (The penalty is imposed monthly, in an amount equal one-twelfth of the \$2,000 annual figure for each full-time employee over 30.)

2. Penalty For Deficient Coverage. If the employer does offer minimum essential coverage but such coverage is either unaffordable or has an actuarial value below 60%, the penalty is equal to \$3,000 for each full-time employee who receives a premium tax credit (Exchange subsidy) with respect to coverage purchased through an Exchange. However, the

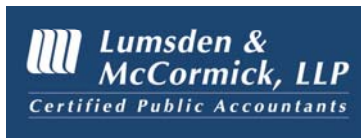
amount of this penalty is capped at the “no offer” penalty; i.e., \$2,000 times the number of the employer’s full-time employees in excess of 30. Code Section 4980H(b).

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INTERNATIONAL FINANCIAL REPORTING STANDARD



**STEPHEN T. LOVULLO, CPA
PARTNER**



INTRODUCTION



- Global momentum for IFRS as established by International Accounting Standard Board (IASB)
- Several Countries are using IFRS
- SEC are considering mandating IFRS
- SEC acknowledges that IFRS are high quality standards
 - Foreign filers using IFRS (as issued by IASB) no longer must reconcile to US GAAP.
- AICPA thinks it's a quality idea

INTERNATIONAL FINANCIAL REPORTING STANDARDS

INTRODUCTION



- SEC is proposing a seven year plan
- SEC Board Decision – 8/08
 - 2009 selected U.S. listed companies will have the option to use IFRS for filing in 2010
 - 2011 SEC will assess results
 - 2014 mandatory use of IFRS may begin
 - 2016 final adoption

INTERNATIONAL FINANCIAL REPORTING STANDARDS

INTRODUCTION



- AICPA amends Appendix A Rule 203
 - FASB designated in 1973 as **sole** standard setter
 - IASB designated in 2008 as an acceptable-principal creating body.
- The result, IFRS is an acceptable alternative to US GAAP **for private business entities**

INTERNATIONAL FINANCIAL REPORTING STANDARDS

COST BENEFIT TRADEOFFS



- Adoption of IFRS will be costly
 1. Recurring future cost savings for multinational businesses currently preparing statements on multiple standards
 2. Possible comparability benefit for investors
 3. One-time transition costs by firms and the economy as a whole

INTERNATIONAL FINANCIAL REPORTING STANDARDS

PERCEIVED BENEFITS OF IFRS



- Increase in the quality of standards
- Enhanced comparability of financial statements
- Improved corporate transparency

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IFRS... PRINCIPLES-BASED?



- Calls for substantial judgment
- Contains much less application guidance
- Younger and shorter
- Absence of conflicting standards/guidance

INTERNATIONAL FINANCIAL REPORTING STANDARDS

TECHNICAL DIFFERENCES BETWEEN US GAAP AND IFRS



Changes in fair value results in revenues and expenses on the income statement.

Measurements

- US GAAP – Revenues and expenses are recognized on the income statement using the matching principal.
- IFRS – Assets and liabilities are measured at fair value on the balance sheet.

Results

- Resulting assets and liabilities appear on the balance sheet.
- Changes in fair value results in revenues and expenses on the income statement.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

DIFFERENCES IN WHAT IS PROBABLE?

FASB	IASB
<p>“That which can reasonably be expected or believed on the basis of available evidence or logic, but which is not certain nor proven.”</p>	<p>“The degree of uncertainty that future economic benefits associated with the item will flow to or from the entity.”</p>
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IASB CONCEPTUAL FRAMEWORK

What are noticeable differences in IFRS conceptual framework?

- **Business Income** measures changes in assets & liabilities during the period
- **Reliability** is not precision
- Prudence not **conservatism**

INTERNATIONAL FINANCIAL REPORTING STANDARDS

ARE IFRS EARNINGS MUCH DIFFERENT?

	2006 IRS Earning*	2006 GAAP Earning*	% Change	Industry
Bayer AG	1,695	269	530.1%	Manufacturing
Reed Elsevier	625	399	56.6%	Information Solutions
Aegon NV	2,789	2,046	36.3	Insurance
Benetton Group	124.9	99.8	25.2%	Manufacturing
Air France	891	817	9.1%	Transportation

**Amounts in millions in Euros
Source: The Analyst's Accounting Observer*

INTERNATIONAL FINANCIAL REPORTING STANDARDS

DIFFERENCES

- **Concepts/approaches**
(e.g. revaluation of non-financial assets)
- **Levels of details**
(e.g. revenue recognition)
- **Approach to industry specific guidance**
(e.g. types of entities versus activities)
- **Scope**
(e.g. employee share compensation vs. all share-based payments)
- **Details**
(e.g. effective date and transition)
- **Converged standards are similar but different**

INTERNATIONAL FINANCIAL REPORTING STANDARDS

NUMEROUS IFRS AND US GAAP



Here are a just a few...

- Revaluation
- Impairment
- Intangible assets
- Revenue recognition
- Inventory

INTERNATIONAL FINANCIAL REPORTING STANDARDS

REVALUATION OF ASSETS



IFRS

US GAAP

- **Permits revaluation** of tangible and identifiable intangible **long-term assets** (flows to equity)
- **Requires** revaluation of **investment properties** (flows through income Statement)
- **Requires agriculture** revaluation (flows through Income Statement)

- **No revaluation** except for financial instruments & business combinations

INTERNATIONAL FINANCIAL REPORTING STANDARDS

REVALUATION OF PPE

IFRS	US GAAP
<ul style="list-style-type: none"> • Property Plant and Equipment (PPE) may be carried at historical cost or at revalued amount (If fair value (FV) can be measured reliably) less accumulated depreciation • Components approach required including major maintenance • Interest cost on qualifying assets may be expensed or capitalized (for now) 	<ul style="list-style-type: none"> • PPE must be carried at historical cost less accumulated depreciation • No requirement to use components approach • Interest cost on qualifying assets must be capitalized
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

REVALUATION

US GAAP – No revaluation permitted

IFRS- Revaluation allowed

If

Sales Price

- Costs to Sell

FAIR VALUE > CARRYING (BOOK) VALUE

Then

-Increase asset and equity (...revaluation surplus (reserve))

by amount of FV- Carrying Value (CV)

-Reset Accumulated Depreciation to zero by reducing Associated Asset Account

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IFRS: IMPAIRMENT OF REVALUED ASSET

- **First**
Reduce Revaluation Surplus and corresponding Asset.
- **If insufficient, then**
Charge remainder to P&L as impairment loss offsetting asset with a contra account, accumulated impairment loss.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENTS

IFRS	US GAAP
<ul style="list-style-type: none"> • Test & measure using Discounted Cash Flow (DCF) • Recoverable amount is higher of <ul style="list-style-type: none"> -Fair Value less cost to sell OR -Value in Use • Reverse, if recovers (except goodwill) 	<ul style="list-style-type: none"> • Two step process <ul style="list-style-type: none"> -Test using undiscounted cash flow (CF) -Measure impairment using DCF (FV) • Never reverse

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENTS	
IFRS	US GAAP
<ul style="list-style-type: none"> • Annual impairment testing required if <ul style="list-style-type: none"> -Indefinite life -Asset not available • Goodwill tested annually for impairment (more often impairment indicators exists) • Based on Cash Generating Units (CGU) or groups of CGUs 	<ul style="list-style-type: none"> • Annual impairment testing required if <ul style="list-style-type: none"> -Indefinite life • Goodwill tested annually for impairment (more often impairment indicators exists) • Based on Reporting Units
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IMPAIRMENT EXAMPLE
<ul style="list-style-type: none"> • Impairment Test The Corporate Protection Company (CPC) has a patent on new fingerprint security technology. The fair value of the patent is \$18 million excluding selling costs of \$3 million. The present value of future cash flows is \$14 million. The sum of the undiscounted future cash flows is \$19 million. CPC currently carries the patent at a value of \$20 million. -What journal entries would CPC prepare to record an impairment of the patent using both US GAAP and IFRS?
INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENT TEST - SOLUTION	
IRFS	US GAAP
<ul style="list-style-type: none"> • Test for impairment: does the carrying amount exceed the recoverable amount? • Yes, the carrying amount of \$20 million is higher than the recoverable amount of \$15 million. • The recoverable amount is calculated as the higher of the fair value less the selling costs (\$18 million - \$3 million = \$15 million) and the value in use (present value of future cash flows = \$14 million). 	<ul style="list-style-type: none"> • Recoverability test is the carrying value greater than the sum of the future undiscounted cash flows? • Yes, since \$20 million is greater than \$19 million.
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IMPAIRMENT TEST - SOLUTION	
IRFS	US GAAP
<ul style="list-style-type: none"> • Calculation of the impairment (note that the determination and calculation of impairment are the same step). • Carrying value – net fair value = \$20 million - \$15 million (\$18 million has selling costs of \$3 million) = \$5 million. 	<ul style="list-style-type: none"> • Calculation of the impairment. • Carrying value – discounted present value = \$20 - \$14 million = \$6 million.
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IMPAIRMENT TEST - SOLUTION

IRFS	US GAAP
<ul style="list-style-type: none"> • Journal entry to record the impairment <p style="margin-left: 20px;">Impairment loss \$5 million</p> <p style="margin-left: 20px;">Accumulated amortization \$5 million</p>	<ul style="list-style-type: none"> • Journal entry to record the impairment <p style="margin-left: 20px;">Impairment loss \$6 million</p> <p style="margin-left: 20px;">Accumulated amortization \$6 million</p>
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IMPAIRMENT EXAMPLE

- **Impairment of goodwill**

The Caring Card Company (CCC) had goodwill recorded in Two CGUs, as defined under IFRS.

These two CGUs make up one reporting unit (RU), as defined under US GAAP, CCC carries the first CGU at a value of \$2 million, which includes \$500,000 of goodwill. The fair value is \$4 million and the recoverable amount of the unit is \$4 million.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENT EXAMPLE



• **Impairment of goodwill** *(con't)*

CCC carries the second CGU at a value of \$3.5 million, which includes \$750,000 attributable to goodwill. The fair value of the CGU is \$3 million and the recoverable amount of the unit is \$3 million.

Compute the amount of impairment CCC should record Using US GAAP and provide any necessary journal entries.

Compute the amount of impairment CCC should record using IFRS and provide any necessary journal entries.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENT OF GOODWILL - SOLUTION



• **Impairment of goodwill**

	value of CGU (including goodwill)	Carrying value of goodwill	Fair Value	Recoverable amount of CGU	Implied fair value of goodwill*
CGU 1	\$2.0 million	\$0.5 million	\$4.0 million	\$4.0 million	\$2.50 million
CGU 2	\$3.5 million	\$0.75 million	\$3.0 million	\$3.0 million	\$0.25 million
Reporting Unit (RU)	\$5.5 million	\$1.25 million	\$7.0 million	\$7.0 million	\$2.75 million

* *The fair value of the unit less the carrying value of the unit, excluding goodwill. Note that this calculation is provided only for informational purposes as it is only needed in the event that impairment exists under US GAAP.*

INTERNATIONAL FINANCIAL REPORTING STANDARDS

IMPAIRMENT OF GOODWILL - SOLUTION

IFRS	US GAAP				
<ul style="list-style-type: none"> • Test of impairment- does the carrying value of the CGU exceed the recoverable amount of the CGU? <ul style="list-style-type: none"> -CGU 1 : No, since \$2 million is less than \$4 million. -CGU 2 : Yes, since \$3.5 million is greater than \$3 million by \$500,000. • Journal entry to record the impairment. <table style="margin-left: 20px;"> <tr> <td>Impairment loss-</td> <td>\$500,000</td> </tr> <tr> <td>Goodwill-</td> <td>\$500,000</td> </tr> </table> 	Impairment loss-	\$500,000	Goodwill-	\$500,000	<ul style="list-style-type: none"> • Recoverability test: does the carrying value of the RU exceed the fair value of the RU? • No, since \$5.5 million is less than \$7 million.
Impairment loss-	\$500,000				
Goodwill-	\$500,000				
INTERNATIONAL FINANCIAL REPORTING STANDARDS					

INTANGIBLE ASSETS - R&D

IFRS	US GAAP
<ul style="list-style-type: none"> • Research is expenses. • Development costs must be capitalized and amortized if criteria are met. • Cost to develop websites must be capitalized if criteria are met. • IPR&D acquired as part of a business combination is capitalized. • Revaluation permitted. 	<ul style="list-style-type: none"> • Expense research and development as incurred. • Website costs capitalization depends on phase of spending, based on SOP 98-1. • IPR&D as part of a business combination capitalized and amortized expenses at date of acquisitions (for now). • Revaluation not allowed.
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

INTANGIBLE ASSETS - R&D
CARRYING VALUE/ RECORDING REVALUATIONS EXAMPLE



- Intangibles Inc. owns a freely transferable bus operator's license, which it acquired on January 1, 2009 at an initial cost of \$100,000. The useful life of the license is five years (based on the date until which it is valid). The entity uses the straight-line method to amortize the intangible.
- Such licenses are frequently traded between existing operators. At the balance sheet date, December 31, 2010, due to a government-permitted increase in fixed bus fares, the traded value of such a license was \$120,000. The accumulated amortization on December 31, 2010, amounted to \$40,000.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

INTANGIBLE ASSETS - R&D
CARRYING VALUE/ RECORDING REVALUATIONS EXAMPLE



- What journal entries are required on December 31, 2010 to reflect the change in carrying value (cost or revalued amount less accumulated amortization) on the revaluation of the operating license using US GAAP and IFRS?
- What journal entries are required on December 31, 2011 using US GAAP and IFRS?

INTERNATIONAL FINANCIAL REPORTING STANDARDS

**INTANGIBLE ASSETS - R&D
CARRYING VALUE/RECORDING REVALUATIONS**



IFRS- SOLUTION 2010

Accumulated amortization-	\$40,000	
Intangible asset-		\$40,000
Intangible asset-	\$60,000	
Revaluation surplus intangibles -		\$60,000

The net result is that the asset has a revised carrying amount of \$120,000 (\$100,000 - \$40,000 + \$60,000). The accumulated amortization may alternatively be restated proportionately.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

**INTANGIBLE ASSETS - R&D
CARRYING VALUE/RECORDING REVALUATIONS**



US-GAAP- SOLUTION 2010

Revaluation is not permitted

INTERNATIONAL FINANCIAL REPORTING STANDARDS

**INTANGIBLE ASSETS - R&D
CARRYING VALUE/RECORDING REVALUATIONS**



IFRS- SOLUTION 2011

Amortization expense-	\$40,000	
Accumulated amortization-	\$40,000	
		(120,000 3 years = 40,000)

Revaluation surplus intangibles-	\$20,000	
Retained earnings-	\$20,000	
		Note that this journal entry is optional.

INTERNATIONAL FINANCIAL REPORTING STANDARDS

**INTANGIBLE ASSETS - R&D
CARRYING VALUE/RECORDING REVALUATIONS**



US GAAP- SOLUTION 2011

Amortization expense-	\$20,000	
Accumulated amortization-	\$20,000	
		(100,000 5 years+\$20,000)

INTERNATIONAL FINANCIAL REPORTING STANDARDS

REVENUE RECOGNITION

- **IFRS**
 - 2 standards and 3 interpretation
 - Multiple element guidance – one paragraph

- **US GAAP**
 - 5 SOPs, 24 ETIFs, 16 standards plus SABs
 - Substantial multiple element guidance
 - Considerable industry specific guidance

INTERNATIONAL FINANCIAL REPORTING STANDARDS

REVENUE RECOGNITION

IFRS

IAS11 and IAS18 deal with general revenue recognition requirements. No specific guidance for software, upfront fees, or multiple deliverable arrangements but some general guidance exists within Appendix to IAS 18.

US GAAP

SAB 104 provides guidance on revenue recognition. Specific accounting guidance for software (SOP 97-2), upfront fees (SAB 104) and multiple deliverable arrangements (ETIF 00-21).

INTERNATIONAL FINANCIAL REPORTING STANDARDS

REVENUE RECOGNITION – SALE OF GOODS

IAS 18	SAB 104
<ul style="list-style-type: none"> • Probable future economic benefits. • Revenue can be measured reliably. • Costs can be measured reliably. • Significant risks & rewards of ownership transferred. • Do not retain managerial involvement to degree of ownership nor retain effective control. 	<ul style="list-style-type: none"> • Persuasive evidence of an arrangement • Collectability reasonably assured • Price fixed or determinable • Delivery occurred/services rendered • Persuasive evidence of an arrangement
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

REVENUE RECOGNITION – SALE OF GOODS

IAS 18	SAB 104
<ul style="list-style-type: none"> • Probable future economic benefits. • Revenue can be measured reliably. • Costs can be measured reliably. • Significant risks & rewards of ownership transferred. • Do not retain managerial involvement to degree of ownership nor retain effective control. 	<ul style="list-style-type: none"> • Persuasive evidence of an arrangement • Collectability reasonably assured • Price fixed or determinable • Delivery occurred/services rendered
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

INVENTORY



- **IFRS** – market value centers around an exit price... Net Realizable Value
- **US GAAP** – market value is based on an entry price... Replacement Cost

Note IFRS does not permit LIFO

- LIFO firms face potentially large tax liability that may be amortized over 4 years

INTERNATIONAL FINANCIAL REPORTING STANDARDS

NUMEROUS TECHNICAL DIFFERENCES



Here are just a few more....

- Income statement format/classification
- Recycling/comprehensive income
- Debt vs. Equity
- Consolidations

INTERNATIONAL FINANCIAL REPORTING STANDARDS

INCOME STATEMENT FORMAT/CLASSIFICATION	
IFRS	US GAAP
<ul style="list-style-type: none"> • 5 minimum lines • No definition of operating income • Non-GAAP measures not prohibited • Use nature or function classification • No extraordinary items 	<ul style="list-style-type: none"> • Regulation S-X specifies items and percentage threshold • Extensive classification guidance • Specified extraordinary items
<p>Practice Issues: Columnar presentation, Boxed earnings. See next page.</p>	
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

INCOME STATEMENT FORMAT/CLASSIFICATION

	Note	Period ended 5 August 2006	Year ended 31 July 2005
Revenue	1	3,522.9	3,005.4
Cost of sales		(2,111.2)	(1,814.7)
Gross profit		1,411.7	1,190.7
Sales and distribution costs		(354.7)	(283.3)
Administrative expenses normal activities		(587.8)	(534.1)
impairment of financial asset		(325.0)	
Profit on disposal of businesses	29	16.4	8.7
Operating profit	2	160.6	382.0
Interest receivable		4.2	15.0
Interest payable		(58.4)	(38.2)
Other financing losses		(0.5)	(4.2)
Other finance income - retirement benefits		27.6	11.3
Finance costs	5	(27.1)	(16.1)
Share of post-tax losses of associated companies		(1.1)	
Profit before taxation		132.4	365.9
Comprising			
Headline profit before taxation	3	492.1	403.8
Exceptional operating items	4	(14.5)	(28.0)
Amortization of acquired intangible assets	11	(16.9)	(5.7)
Financing losses		(3.3)	(4.2)
impairment of financial asset		(325.0)	
		132.4	365.9
Taxation	6	(108.2)	(94.1)
Profit for the period attributable to equity shareholders of the Parent Company		24.2	271.8

Boxed Earnings

OTHER COMPREHENSIVE Income (OCI)	
IFRS	US GAAP
<p>Split Decision</p> <ul style="list-style-type: none"> • Yes, recycle to Net Income <ul style="list-style-type: none"> -US GAAP items • No, flows to equity <ul style="list-style-type: none"> -Revaluation of long-lived assets (flows to equity... revaluation surplus) -Actuarial gains and losses (OCI amount recognized immediately in retained earnings) 	<p>Always recycle (OCI)</p> <ul style="list-style-type: none"> • Cumulative transaction adjustments • Unrealized gains and losses on AFS securities • Unrealized gains and losses on effective cash flow hedges • Actuarial Gains/Losses
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

IS IT DEBT, EQUITY OR SOMETHING ELSE?	
IFRS	US GAAP
<ul style="list-style-type: none"> • Classification <ul style="list-style-type: none"> -Separate regardless • Presentation <ul style="list-style-type: none"> -Debt or equity -No mezzanine • Measurement <ul style="list-style-type: none"> -Liabilities at FV -Equity as residual 	<ul style="list-style-type: none"> • Classification <ul style="list-style-type: none"> -Don't separate <u>unless</u> -Detachable -Convertible in the money at issue date -Embedded derivative requiring separation • Presentation <ul style="list-style-type: none"> -Debt equity or Mezzanine (SEC) • Measurement <ul style="list-style-type: none"> -May differ, it depends
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

CONSOLIDATION	
IFRS	US GAAP
<ul style="list-style-type: none"> • Model <ul style="list-style-type: none"> -Focus is on the concept of the power to control, with control being the parent's ability to govern the financial and operating policies • Rules <ul style="list-style-type: none"> -Potential voting rights -No QSPE • Practice <ul style="list-style-type: none"> -de facto control <u>must be considered</u> 	<ul style="list-style-type: none"> • Model <ul style="list-style-type: none"> -Focus is on controlling financial interest. All entities are first evaluated as potential variable interest entities (UIF's) • Rules <ul style="list-style-type: none"> -No potential voting rights -Automatic pass on QSPE (for now) • Practice <ul style="list-style-type: none"> -de facto control is rare
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

CONSOLIDATION	
IFRS	US GAAP
<ul style="list-style-type: none"> • Consolidation based on power to control. <ul style="list-style-type: none"> -Potential voting interests are considered for control and significant influence de facto control. • Requirement for uniformity of accounting policies throughout the financial statements, including equity method investees. 	<ul style="list-style-type: none"> • Consolidation based largely on voting interests. <ul style="list-style-type: none"> -Potential voting interest are not considered. • No requirement for uniformity of accounting.
INTERNATIONAL FINANCIAL REPORTING STANDARDS	

REVIEW



- Note some substantial differences in the accounting framework under IFRS compared with US GAAP.
- Examine some key technical differences between US GAAP and IFRS including revaluation, impairment, research and development, inventory, intangibles, recycling/comprehensive income, debt versus equity classification, consolidation and more.

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Current Developments in Estate Planning

**DALE B. DEMYANICK, CPA
PARTNER**



Overview of Federal Gift Tax Statutes

- Annual Exclusion Gifts - \$13,000
- Annual Exclusions are only available for gifts of present interests
- Lifetime Exclusion for gifts in excess of the \$13,000 annual exclusion - \$1 million
- The use of the \$1 million lifetime exemption reduces the credit available at death

Current Developments in Estate Planning

Overview of current (2010) Federal Estate Tax Statutes

- No Estate Tax!
- Carryover Basis
- Limited step-up in basis
 - \$1.3 million
 - \$3.0 million for spouse
- Possible retroactive reinstatement of estate taxes

Current Developments in Estate Planning

Federal Estate Tax Statutes for 2011

- \$1 million exemption
- Step-up in basis
- 55% top rate

Current Developments in Estate Planning

Comparison of Federal Estate Tax

Year	Exemption Amount	Highest Rate
2002	\$1,000,000	50%
2003	1,000,000	49%
2004	1,500,000	48%
2005	1,500,000	47%
2006	2,000,000	46%
2007	2,000,000	45%
2008	2,000,000	45%
2009	3,500,000	45%
2010	Repealed	No Estate Tax *
2011	1,000,000	55%

* Limited step-up in basis for income tax purposes.

Current Developments in Estate Planning

Recent Proposals for 2011 and Future Years

1. Reinstate the 2009 rules
 - \$3.5 million exemption
 - 45% top rate
 - Step-up in basis

2. Reinstate the 2009 rules, but
 - \$3.5 million exemption increasing by \$250,000 per year for 6 years until exemption reaches \$5 million
 - 45% top rate
 - Step-up in basis

Current Developments in Estate Planning

Recent Proposals for 2011 and Future Years.

3. Reinstatement 2009 rules, but
 - \$5 million exemption
 - 35% top rate
 - Step-up in basis
4. Continue full repeal

Current Developments in Estate Planning

New York State Tax Provisions

- \$1 million exemption
- Highest marginal rate is 16%
- NYS tax on a \$3.5 million estate amounts to \$229,000

Current Developments in Estate Planning

Planning Opportunities – Gifting

- \$13,000 annual exclusion gifts
- Unlimited direct payment of tuition and medical expenses
- Utilize \$1 million lifetime gift exclusion
- Unlimited marital deductions
- Charitable deductions
- Gifting of discounted assets

Current Developments in Estate Planning

Planning Opportunities – Family Planning

- Make loans at low interest rates to family members
- Sales to grantor trusts
- Use of grantor retained annuity trusts (GRATS)
- Irrevocable Life Insurance Trusts

Current Developments in Estate Planning

Grantor Retained Annuity Trusts



- Transfer of property to GRAT
- Grantor receives annuity payments during term of GRAT
- The annuity payments are based upon an IRS published rate and the term of the GRAT
- Any assets remaining in the GRAT at the end of the term passes gift and estate tax free to remainder beneficiaries
- Grantor must outlive term of the GRAT

Current Developments in Estate Planning

Irrevocable Life Insurance Trusts



- Payment of premiums may qualify for annual exclusion gifts (Crummey Provisions)
- Proceeds at death are income tax free and also escape estate taxation (as long as decedent didn't have incidents of ownership within 3 years of death)
- Can be structured to skip a generation for estate tax purposes
- Provide liquidity for estate administration and tax expenses

Current Developments in Estate Planning

Other Proposed Legislation

- Potential elimination of discounts for gift and estate tax purposes
- Potential elimination of discounts for gift and estate tax purposes for closely held business interest if the family retains control
- Potential elimination of GRAT benefits, including a required 10 year minimum term

Current Developments in Estate Planning

Current Developments in Estate Planning

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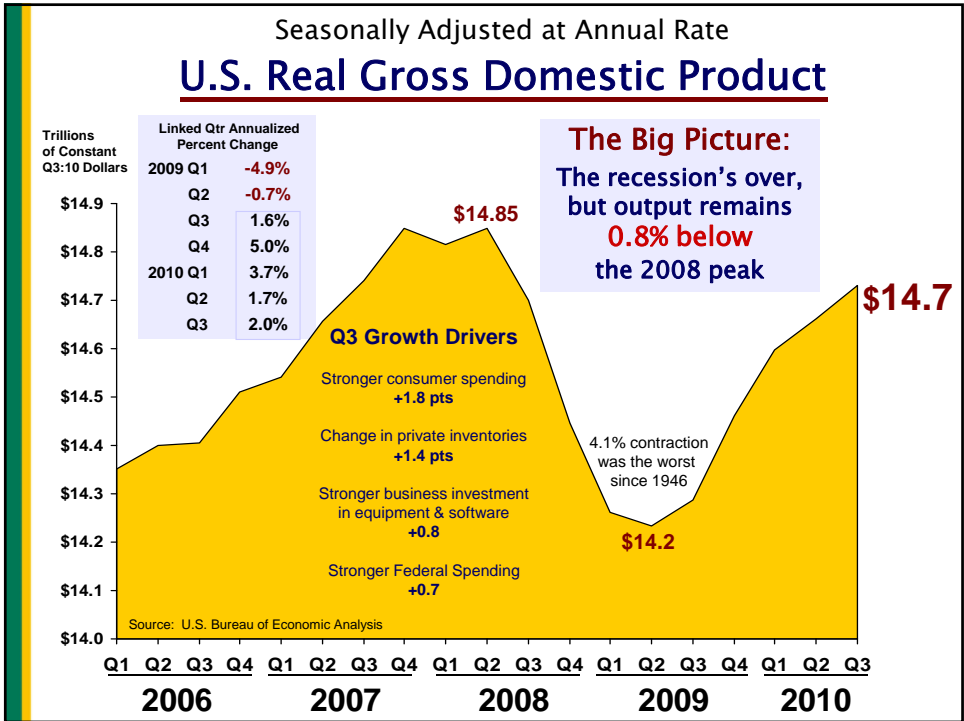


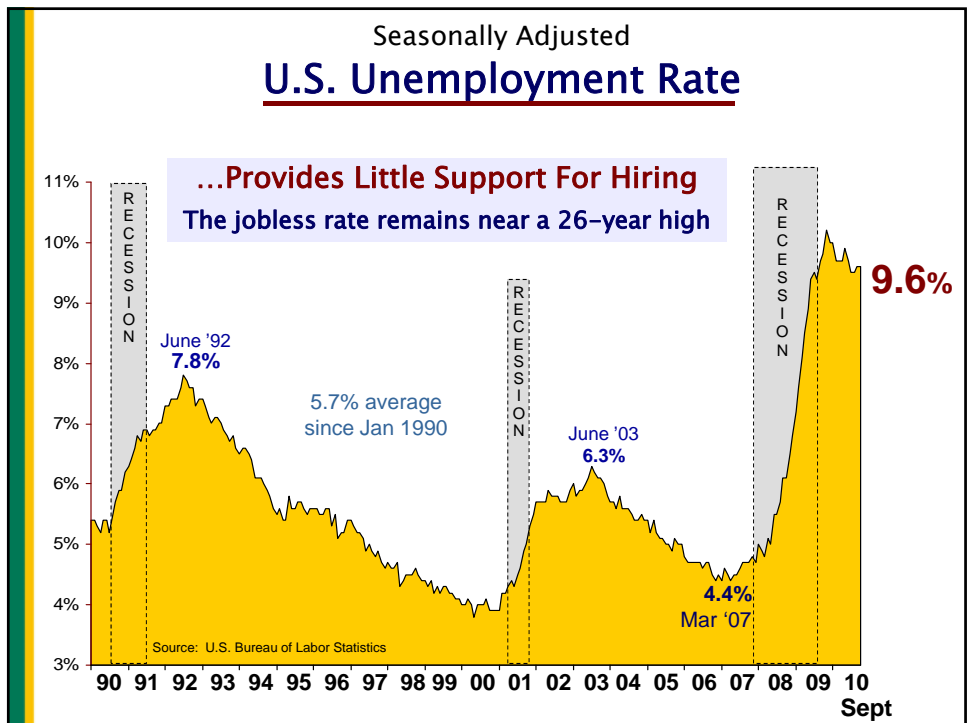
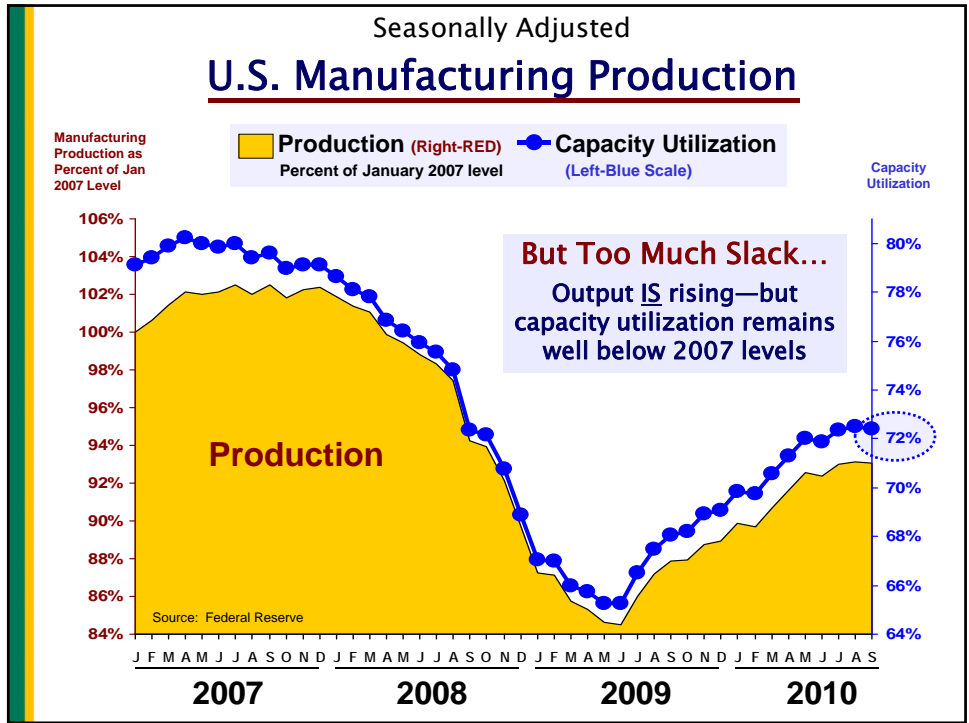


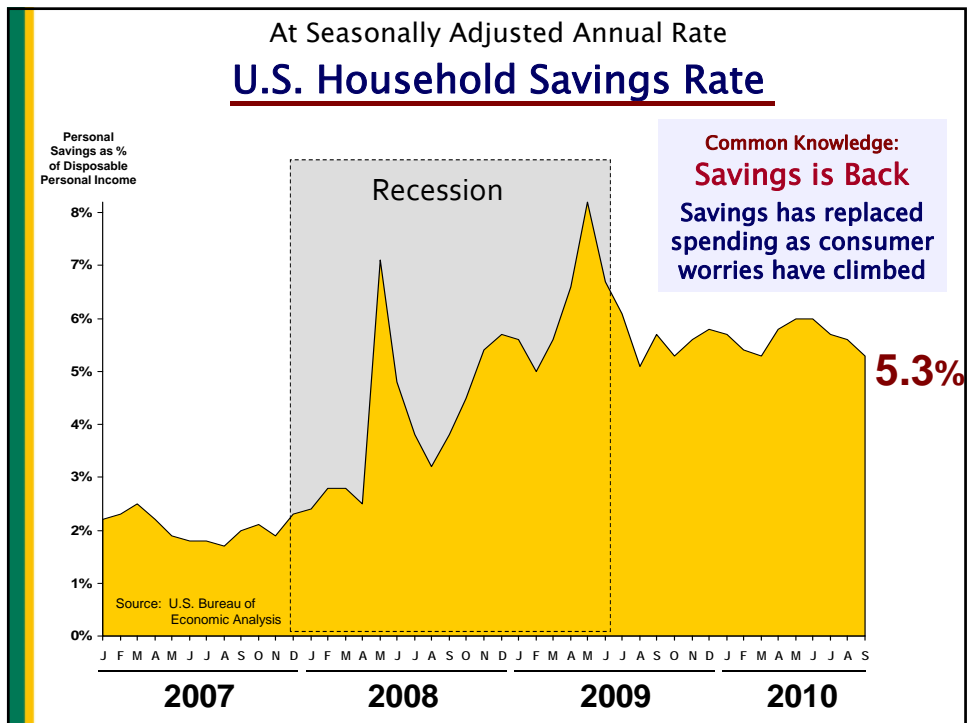
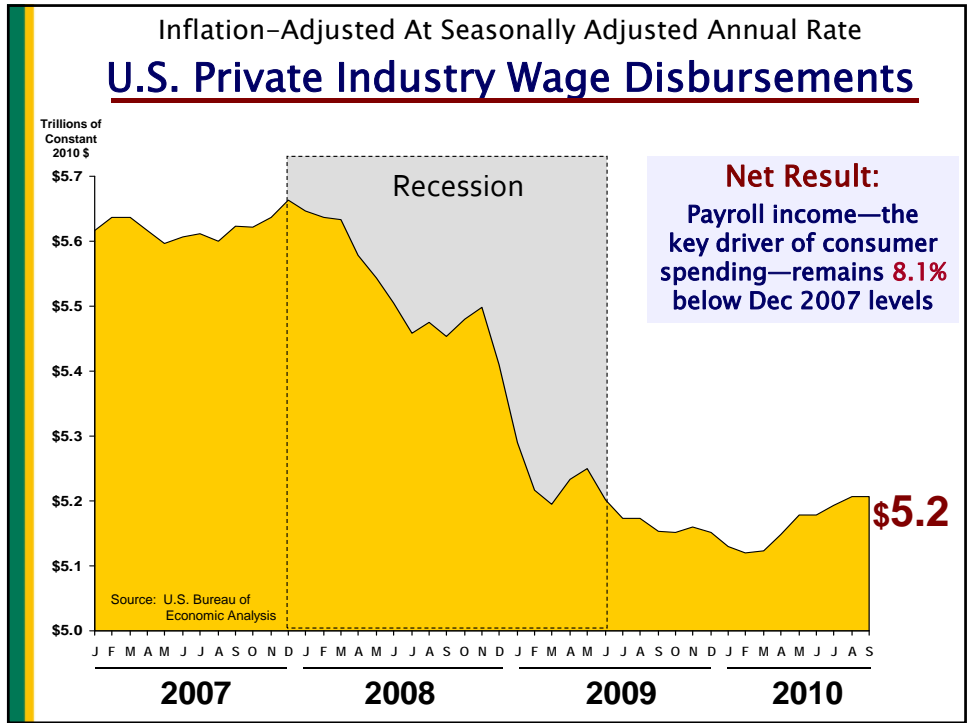
U.S. & Buffalo Area Economic Outlook

Gary Keith – Regional Economist
November 1, 2010

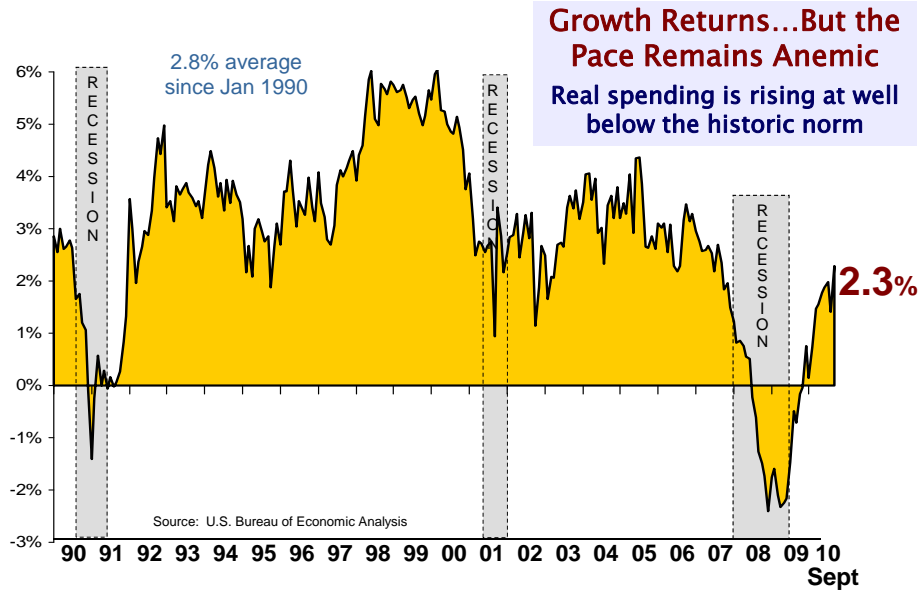
M&T Bank
Understanding what's important



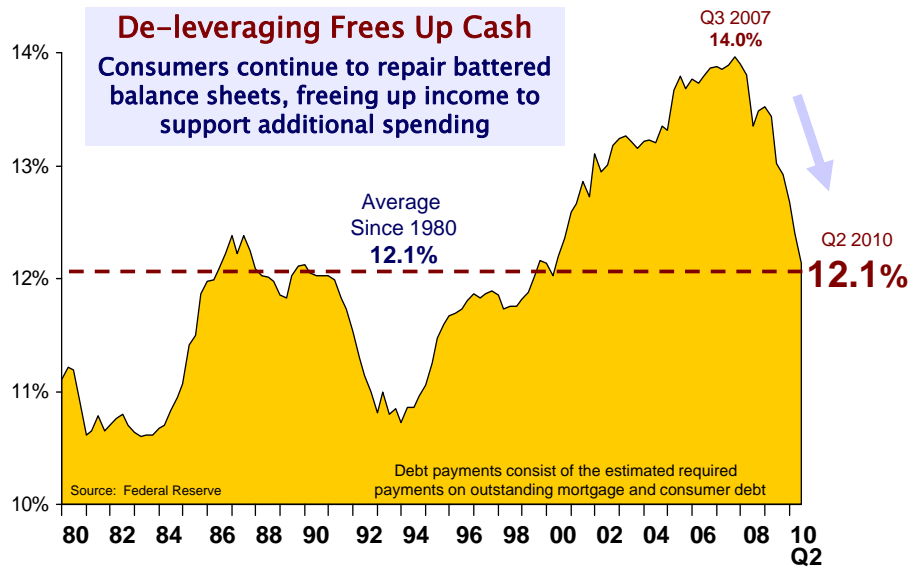




Inflation-Adjusted Year-Over-Year Percentage Change U.S. Personal Consumption Expenditure Growth



U.S. Household Debt Payments As a Percent of Disposable Income

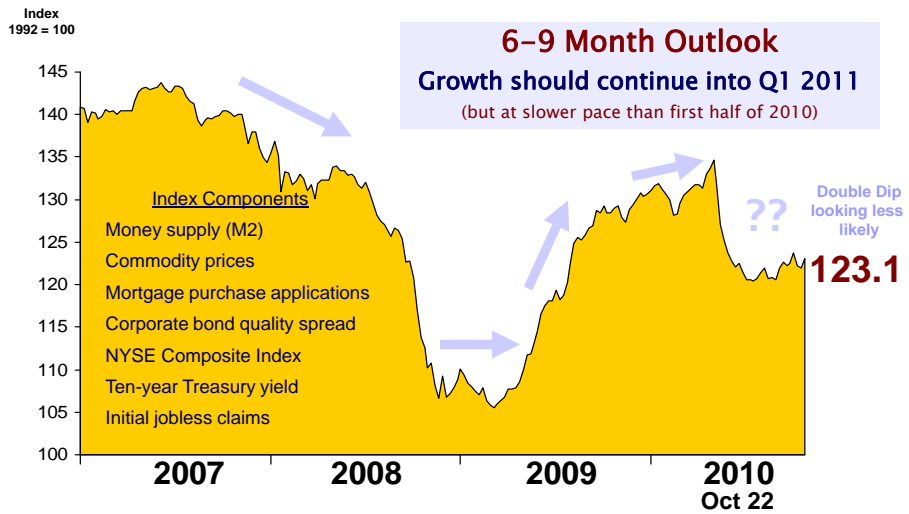


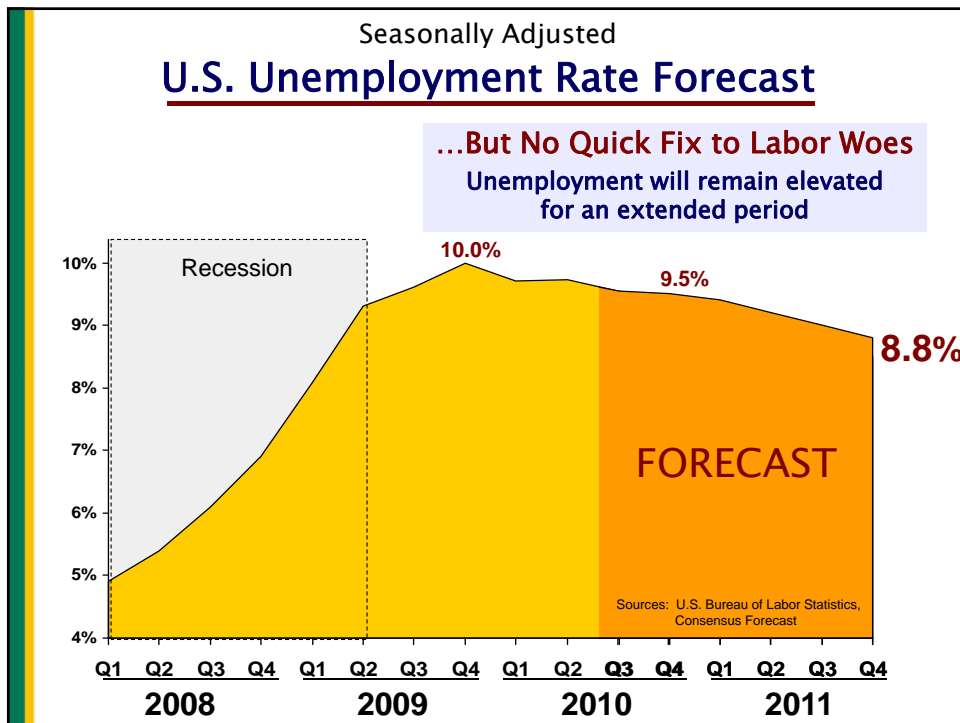
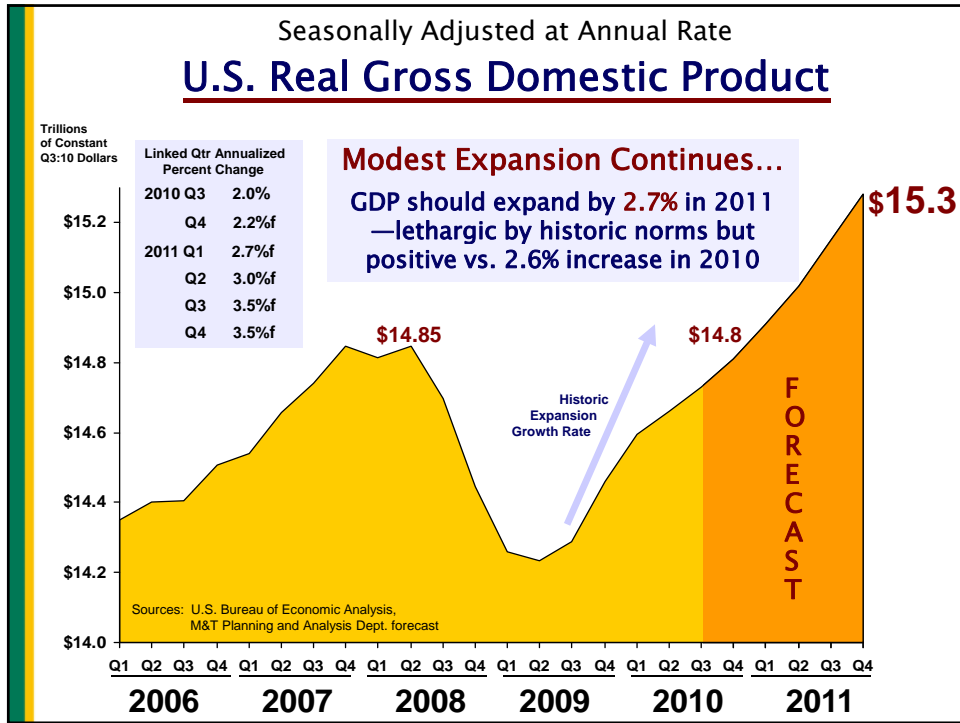
...So, where do we go from here?

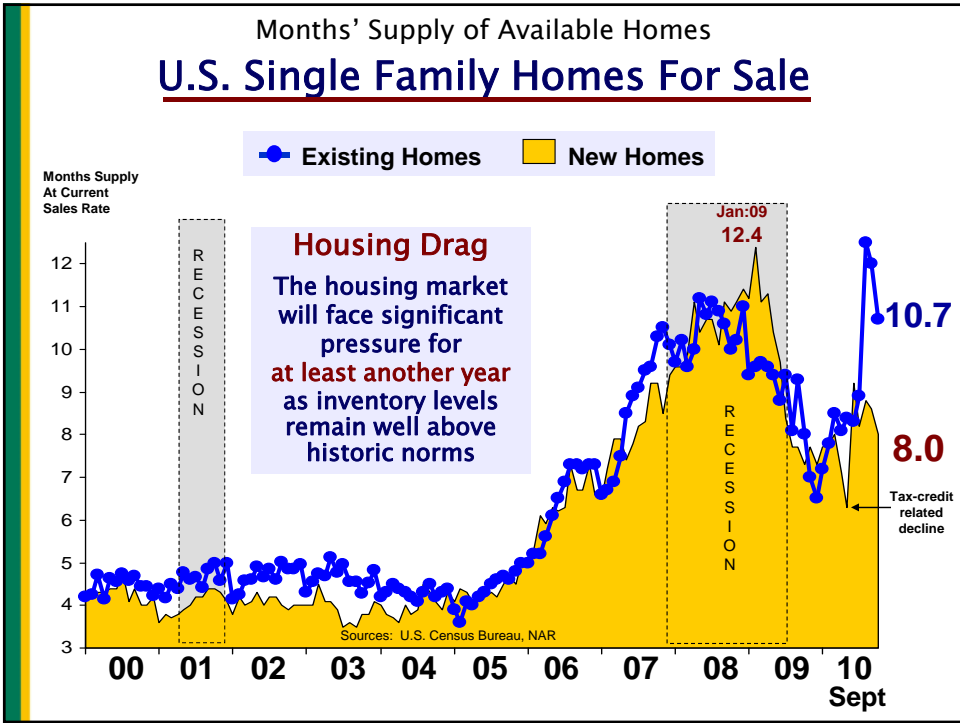
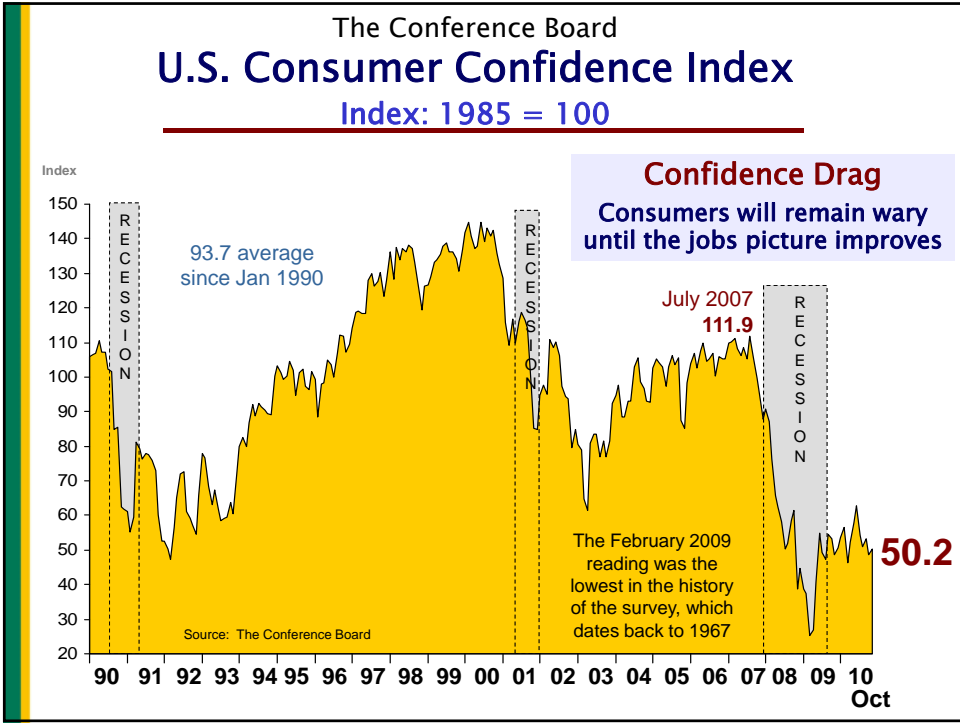
Economic Cycle Research Institute

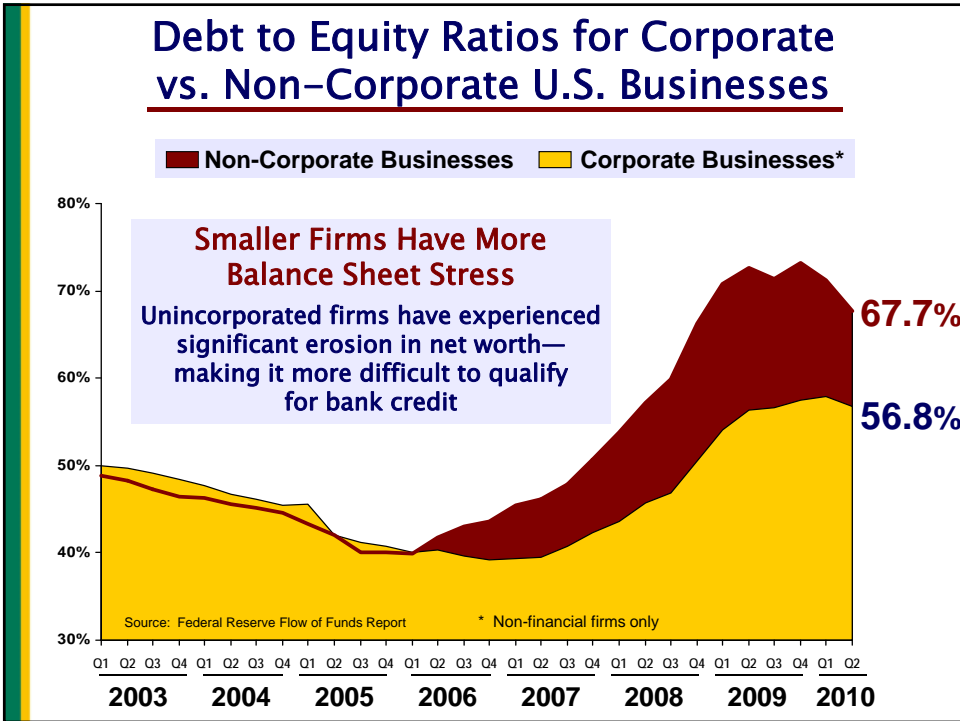
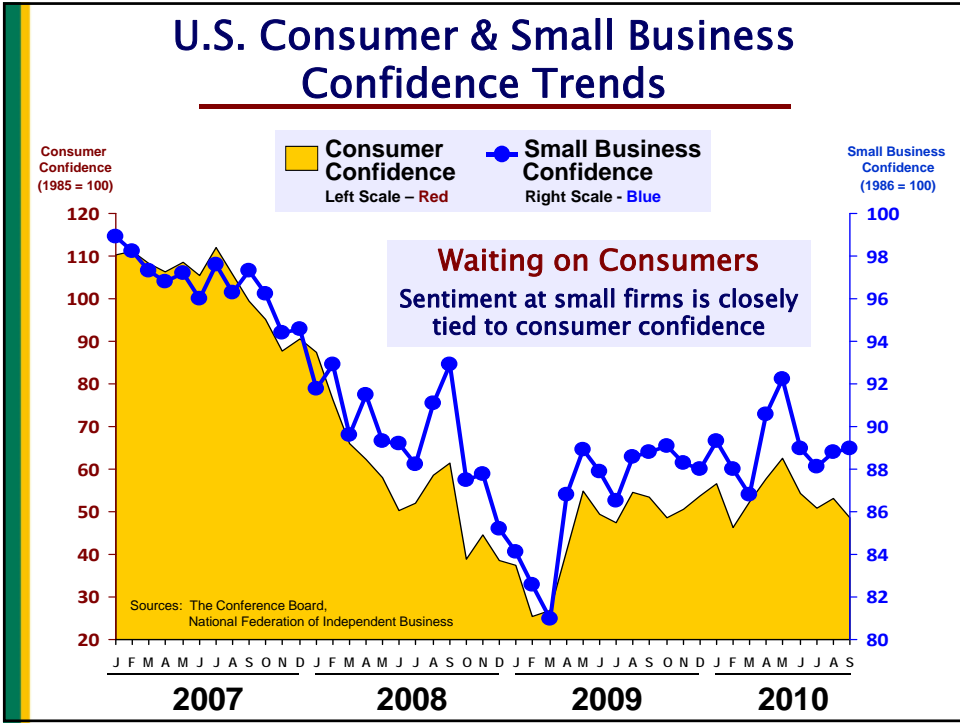
U.S. Leading Economic Index

Indicates a turning point in the economic cycle when changes in the direction of the index are persistent, pronounced, and pervasive over several months. Designed to turn down before a recession and turn up before an expansion.



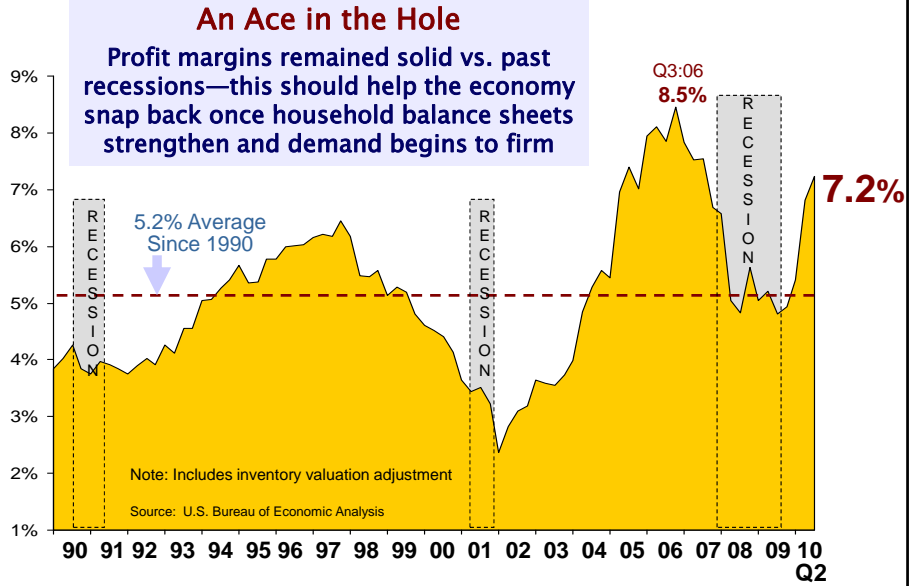






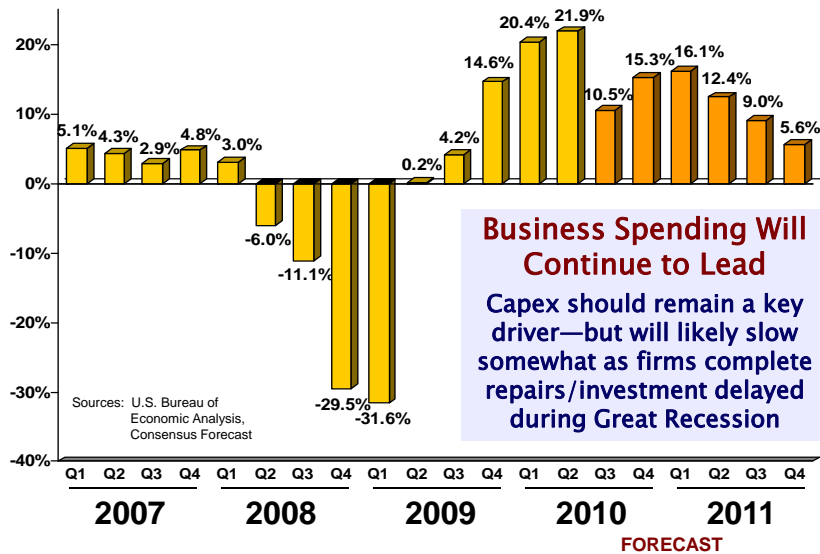
U.S. Corporate Profits as a Percent of GDP

Domestic Non-Financial Industries



Inflation-Adjusted Percentage Change From Previous Quarter at Annualized Rate

Fixed Investment in Equipment & Software by U.S. Businesses

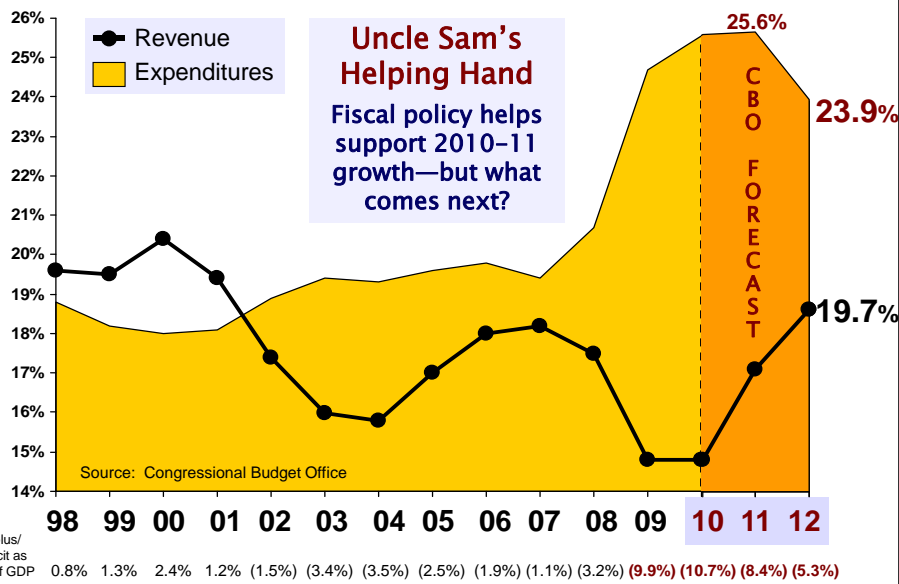


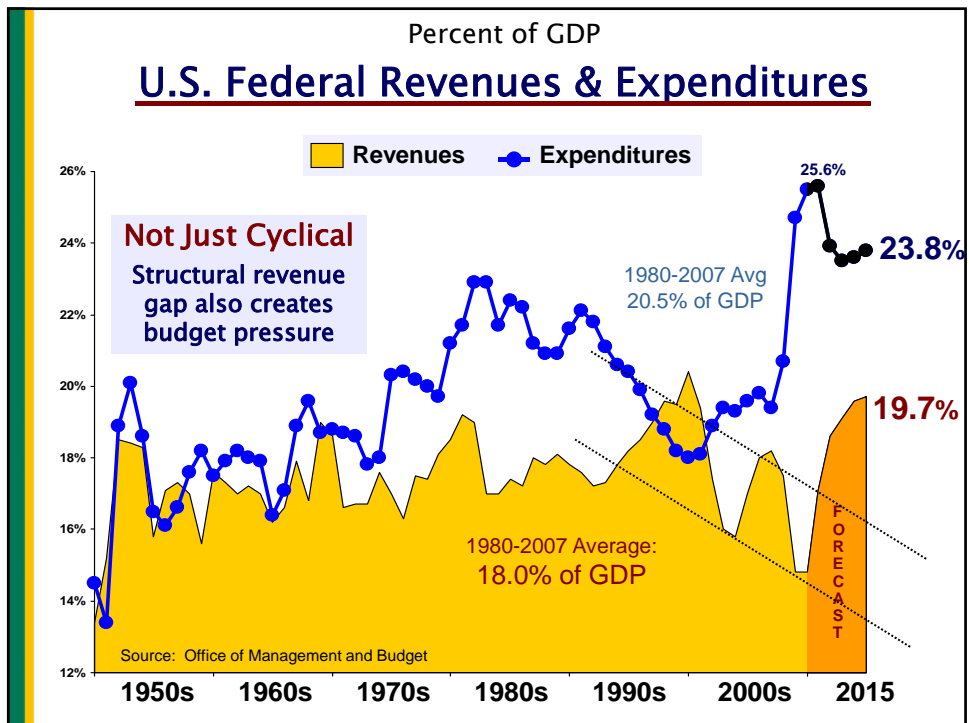
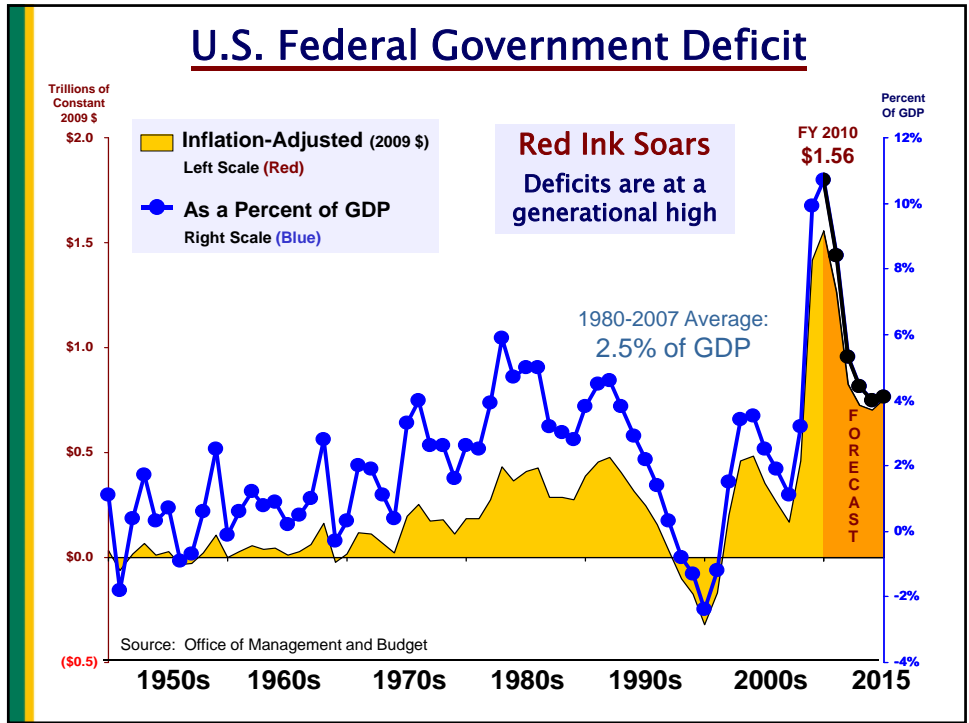
Real GDP Growth Forecast by Region

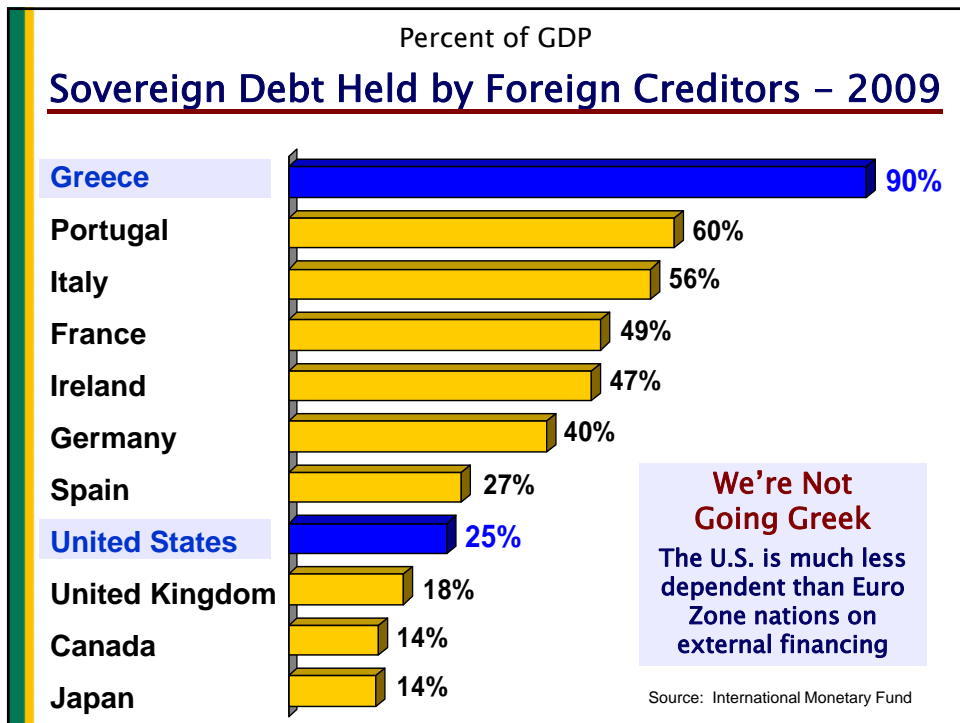
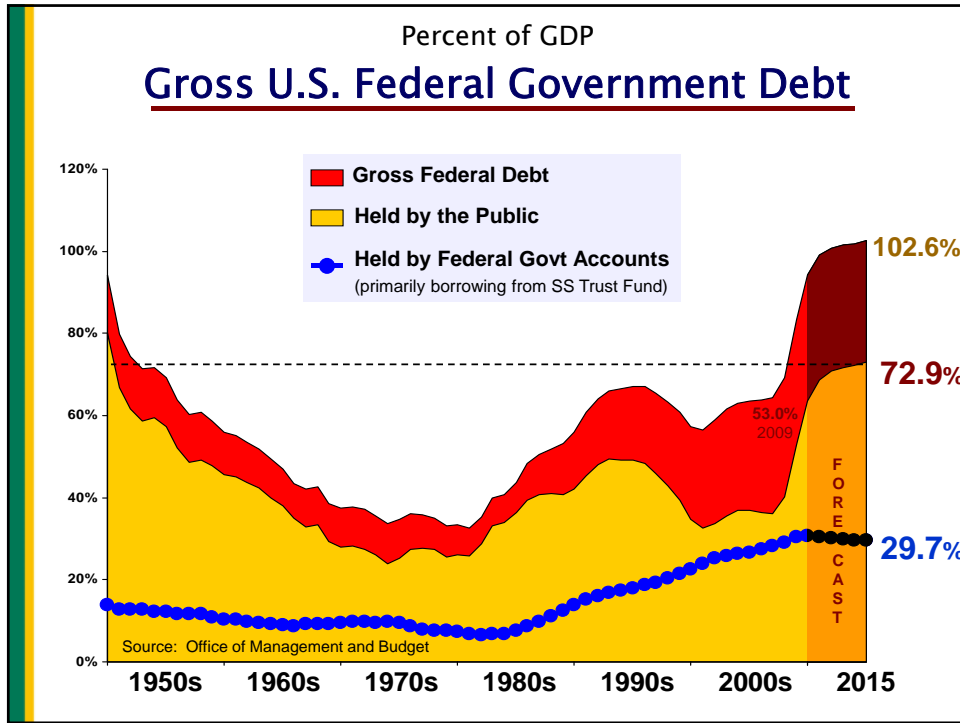
Source: International Monetary Fund,
October 2010

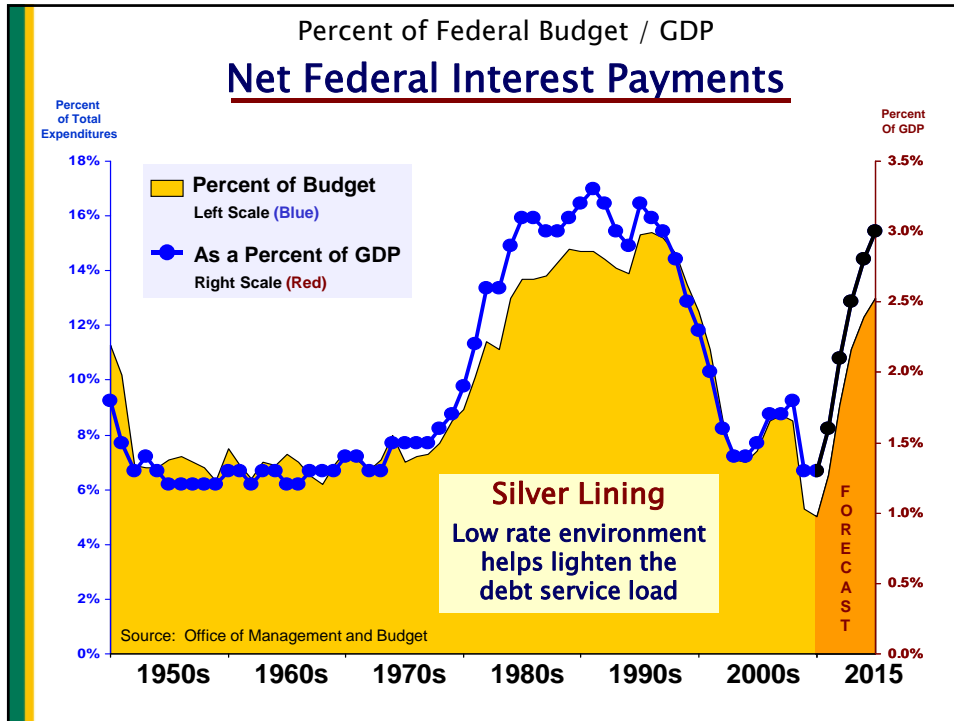
	2009	2010	2011
Developing Asia	6.9%	9.4%	8.4%
Emerging Markets	2.5%	7.1%	6.4%
United States	-2.6%	2.6%	2.3%
Canada	-2.5%	3.1%	2.7%
United Kingdom	-4.9%	1.7%	2.0%
Euro Zone	-4.1%	1.7%	1.5%
World	-0.6%	4.8%	4.2%

Federal Government Revenue & Expenditure As a Percent of GDP



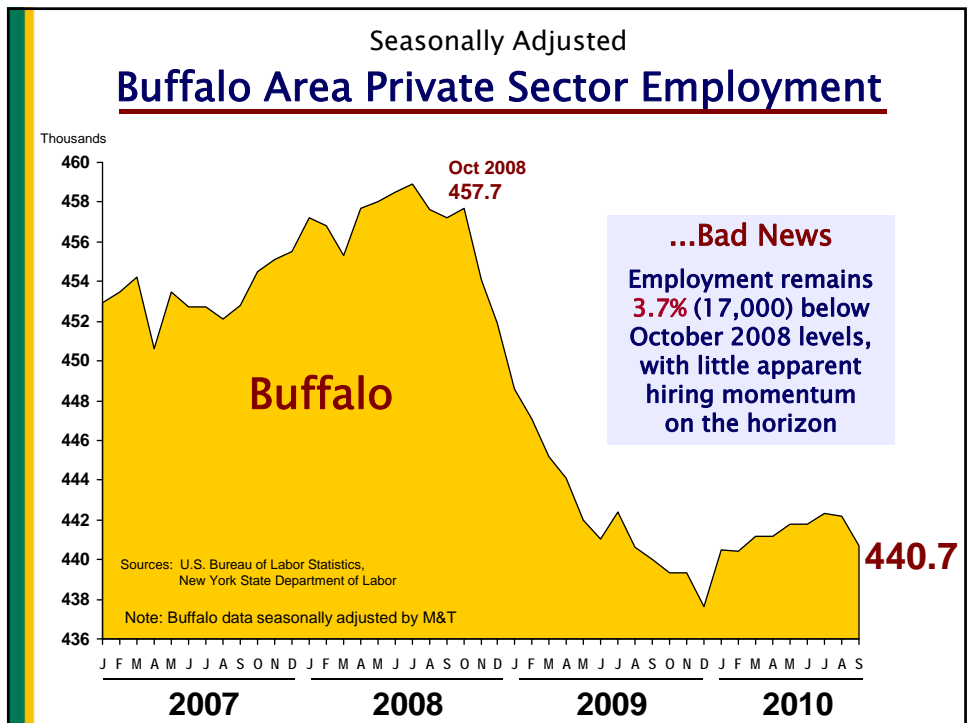
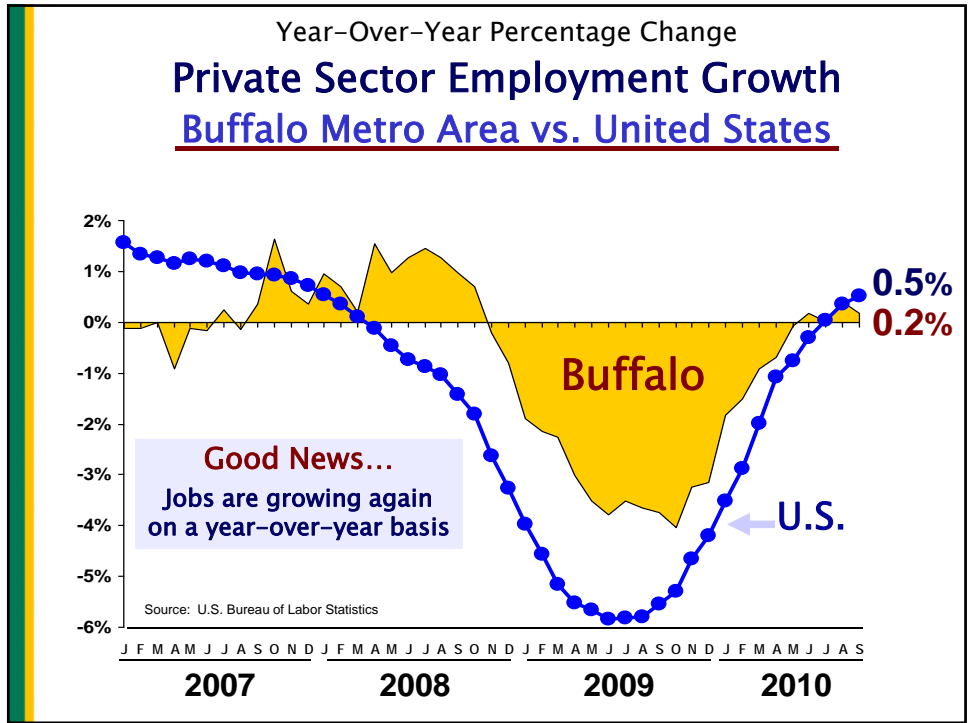


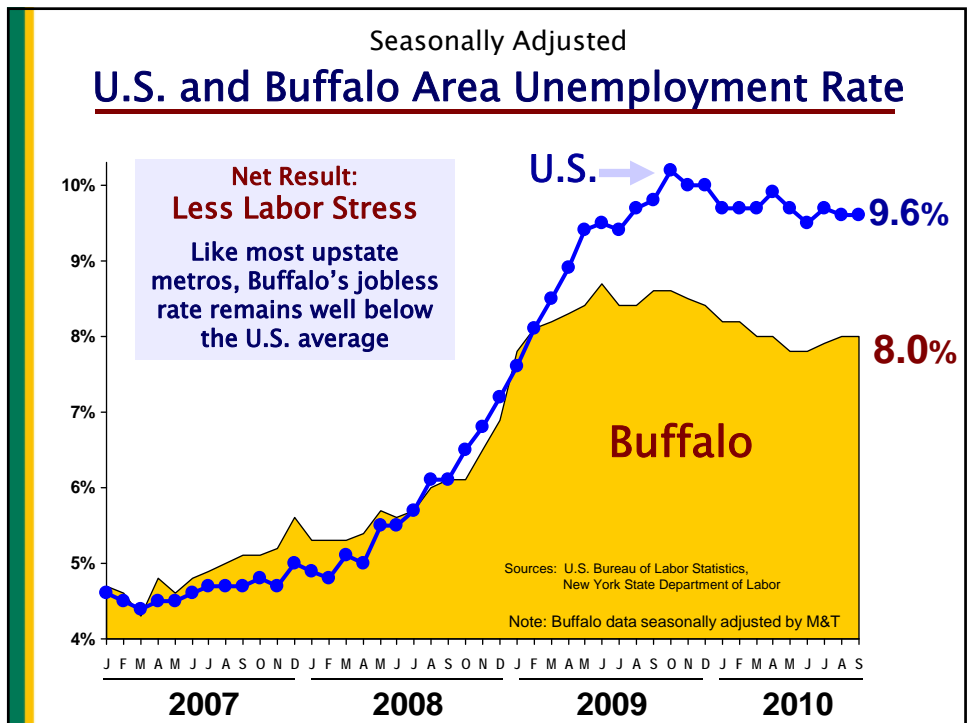
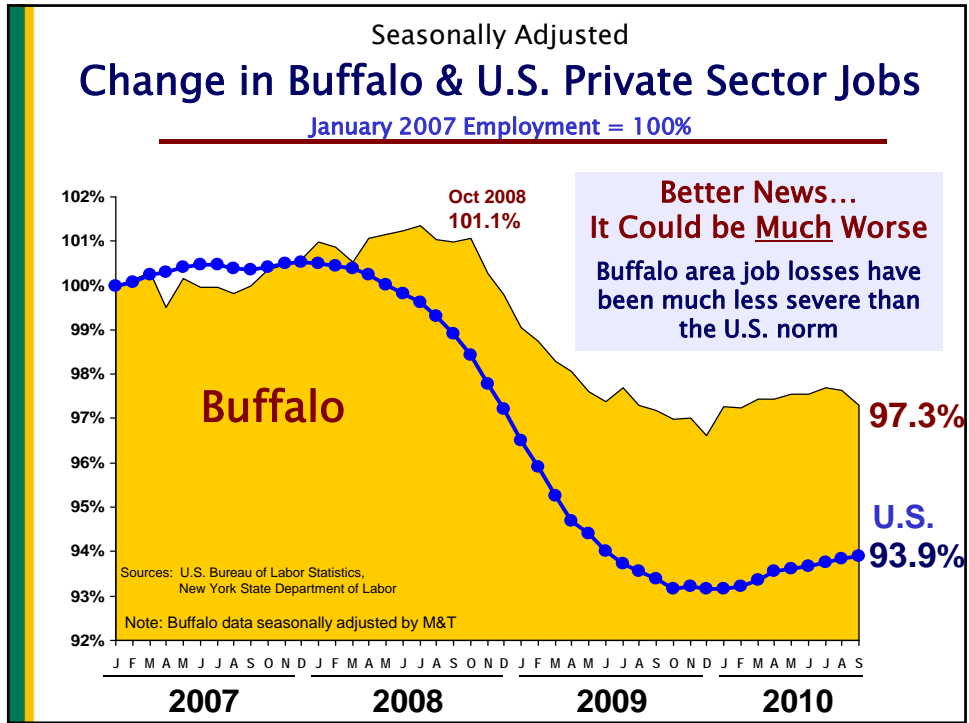


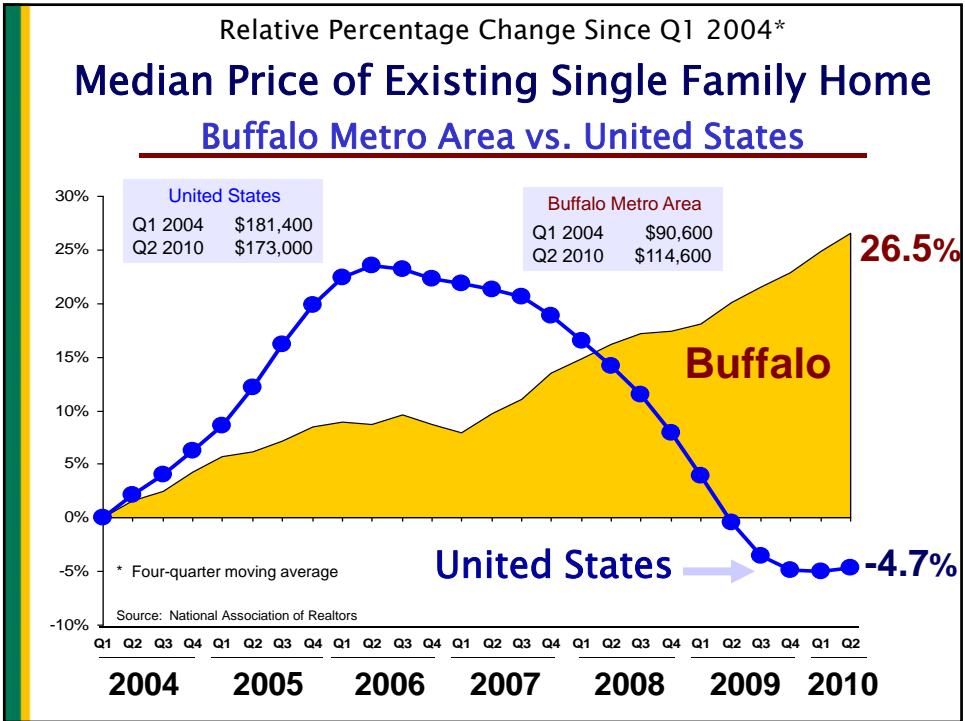
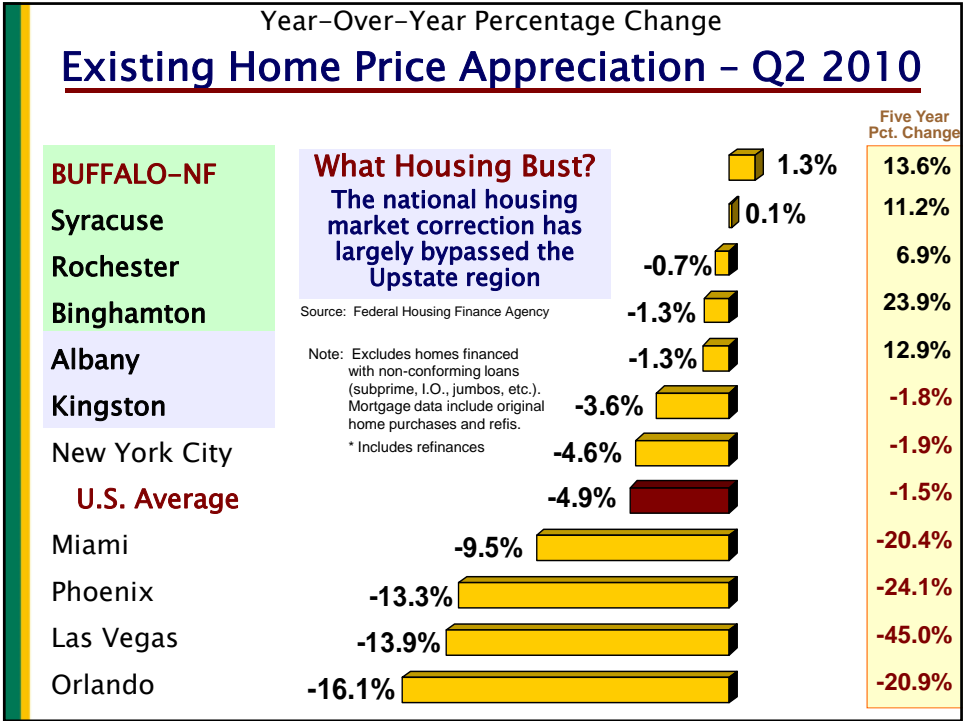


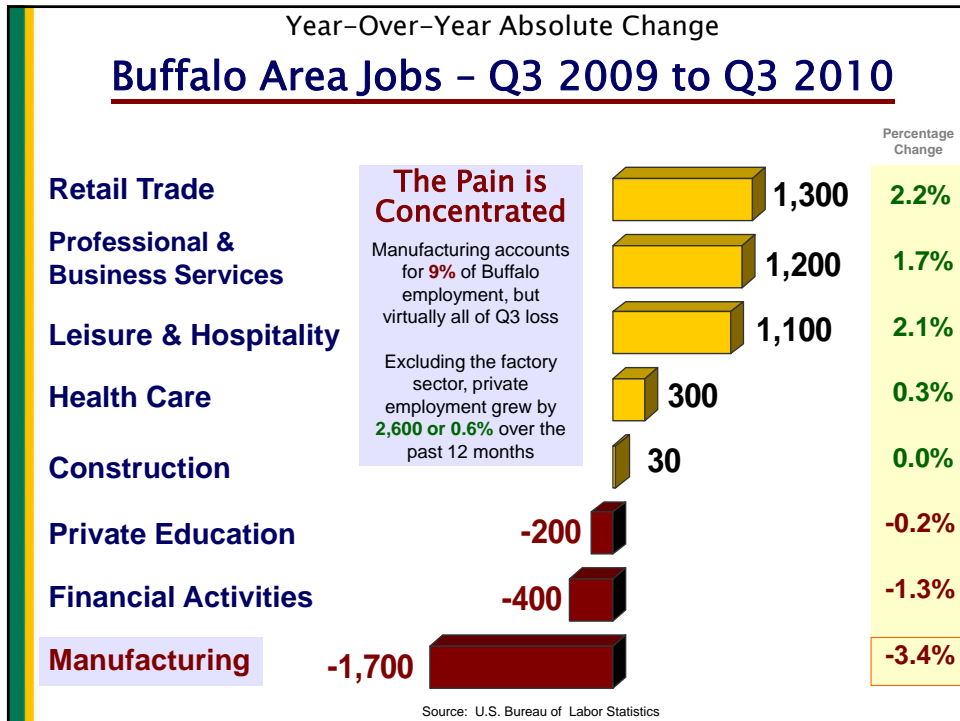
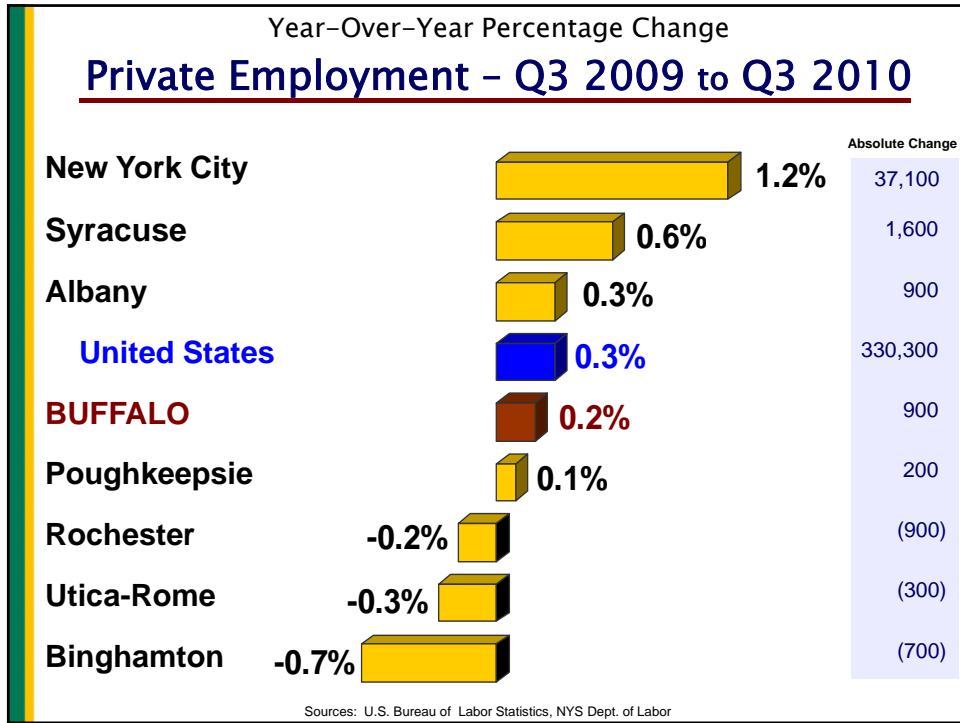
How is WNY performing in this environment?

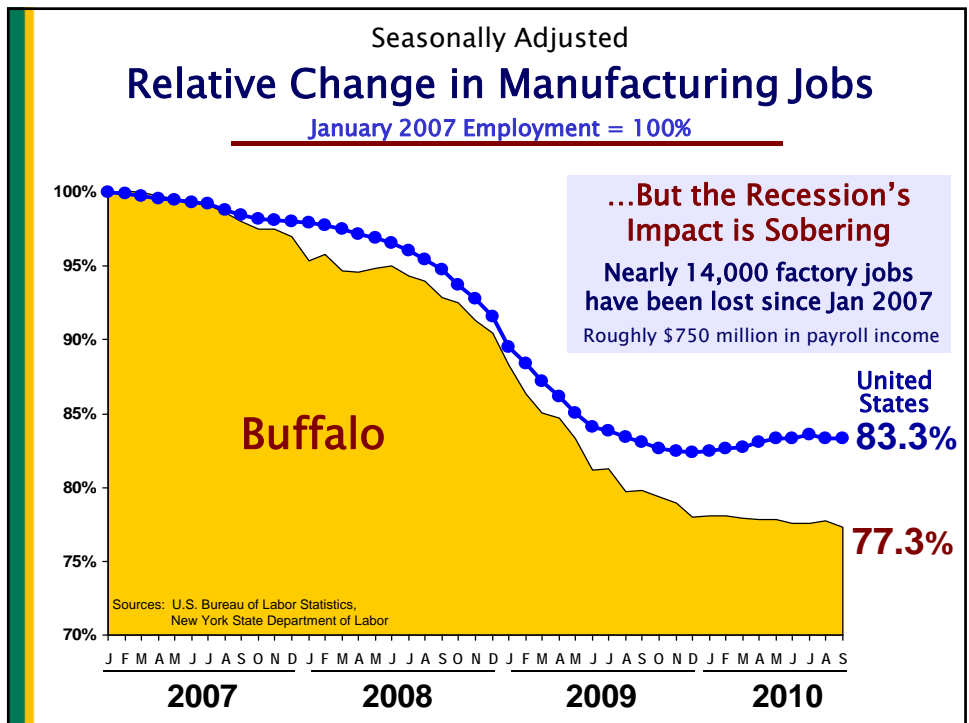
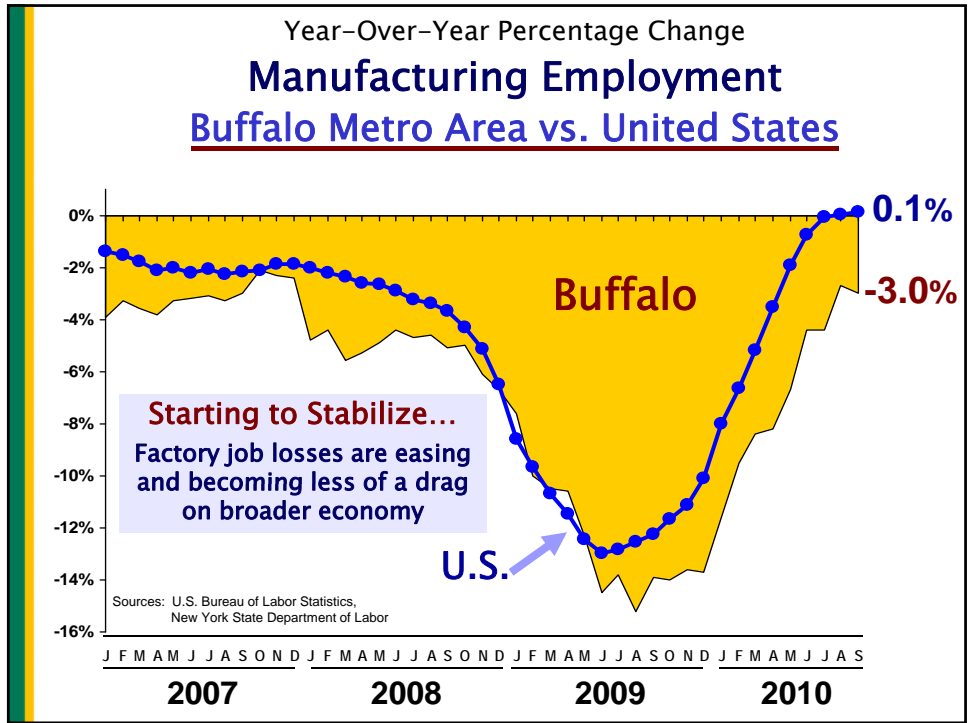
M&T Bank *Understanding what's important.*

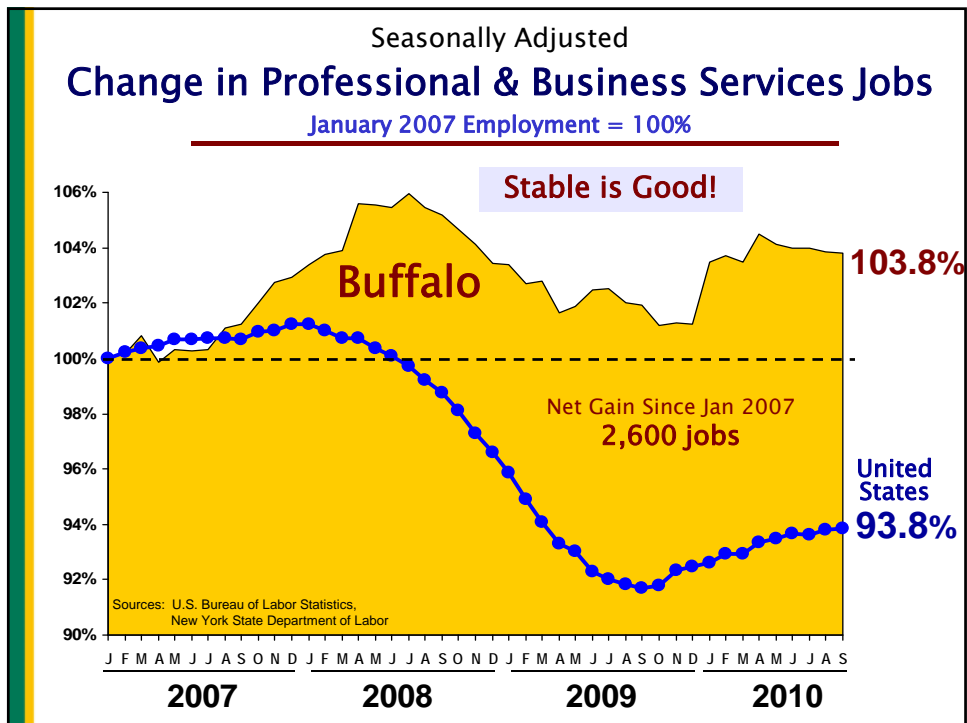
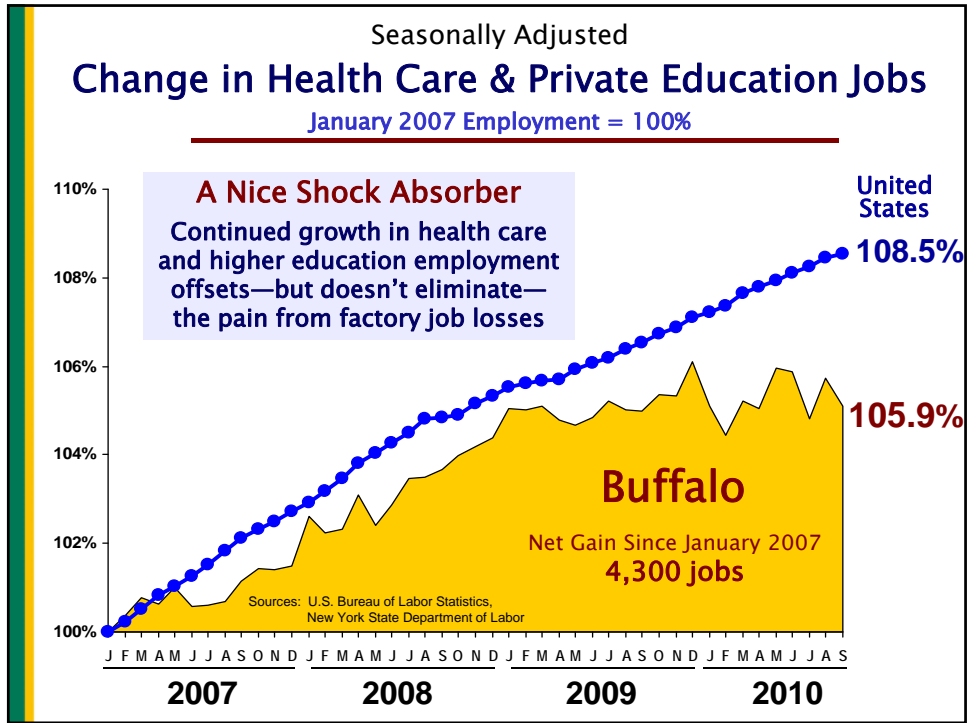


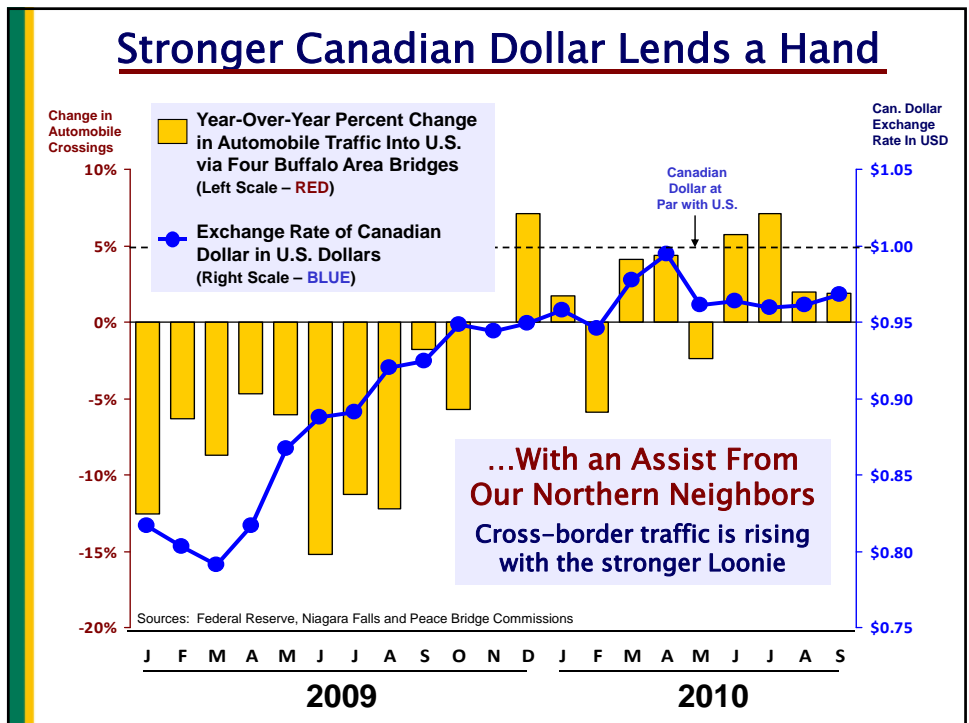
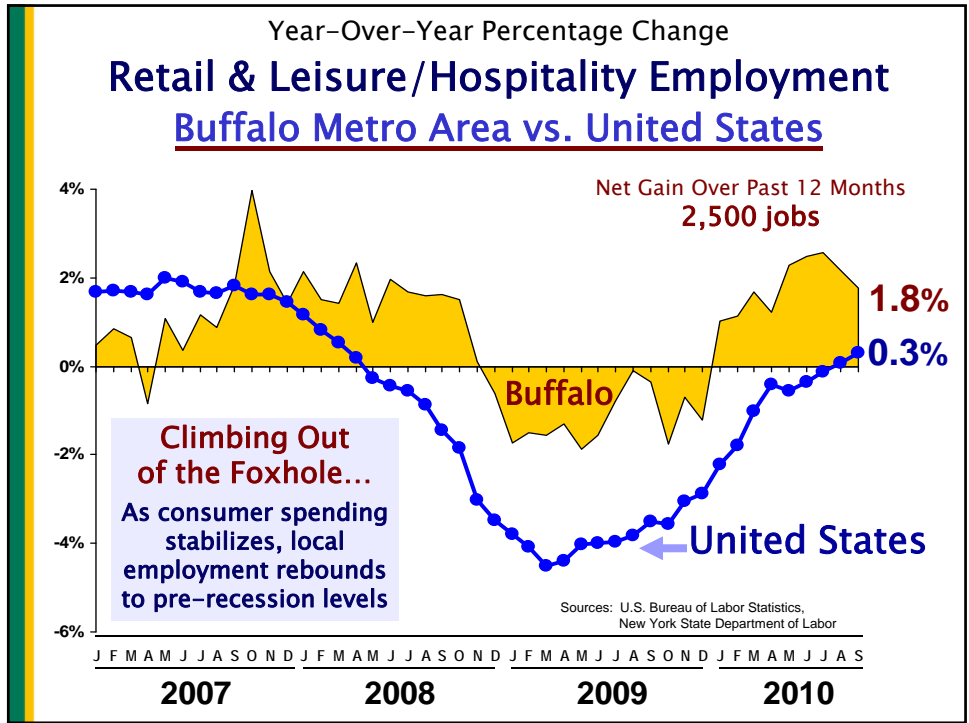






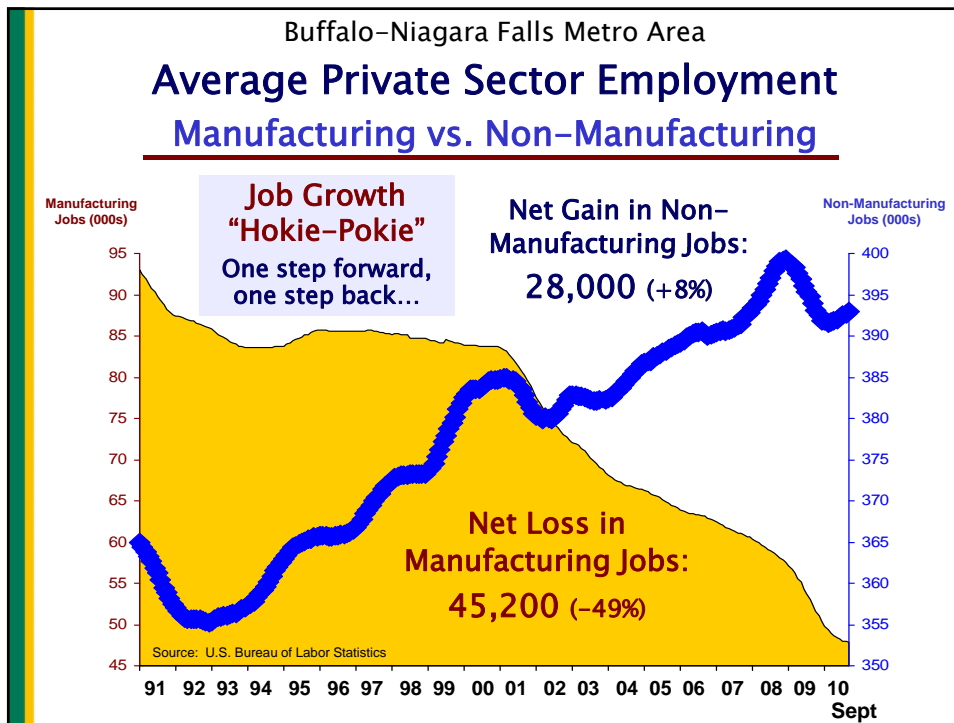




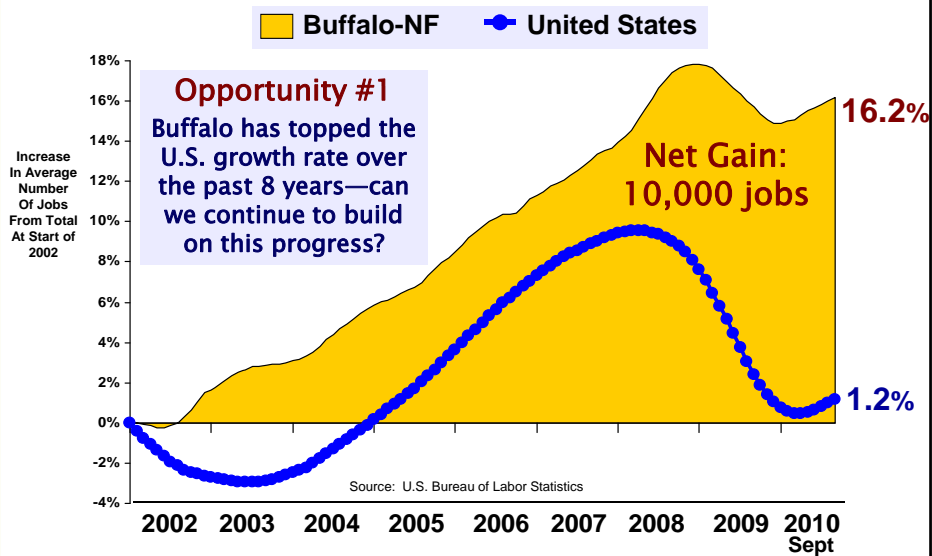


What does WNY's long-term future look like?

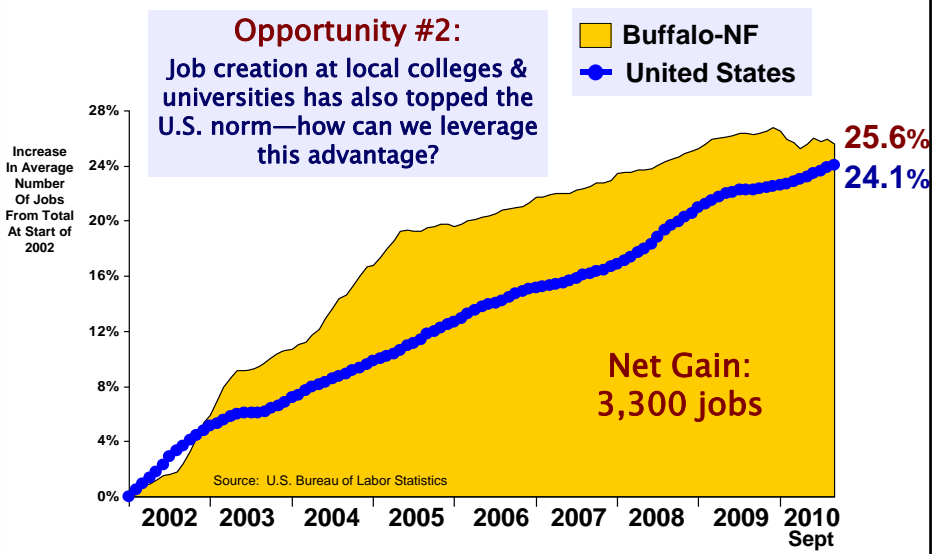
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Buffalo–Niagara Falls Metro Area vs. United States
Increase in Professional & Business Services Jobs
 Since January 2002

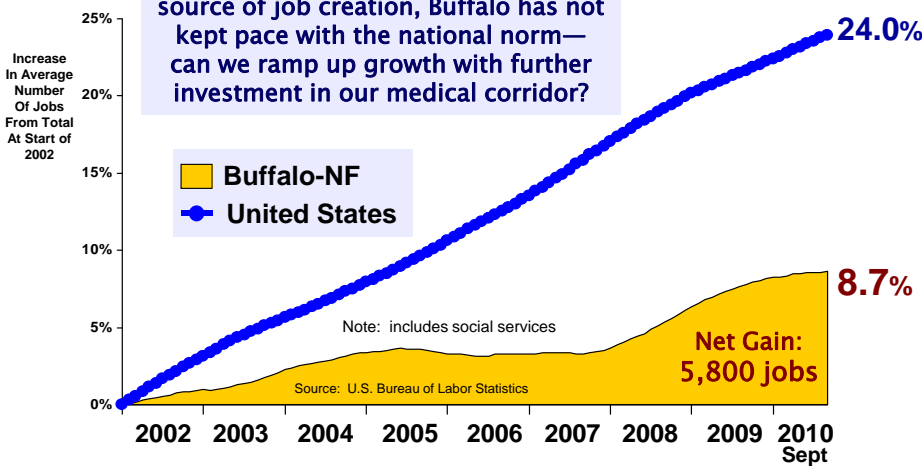


Buffalo–Niagara Falls Metro Area vs. United States
Increase in Private Education Employment
 Since January 2002



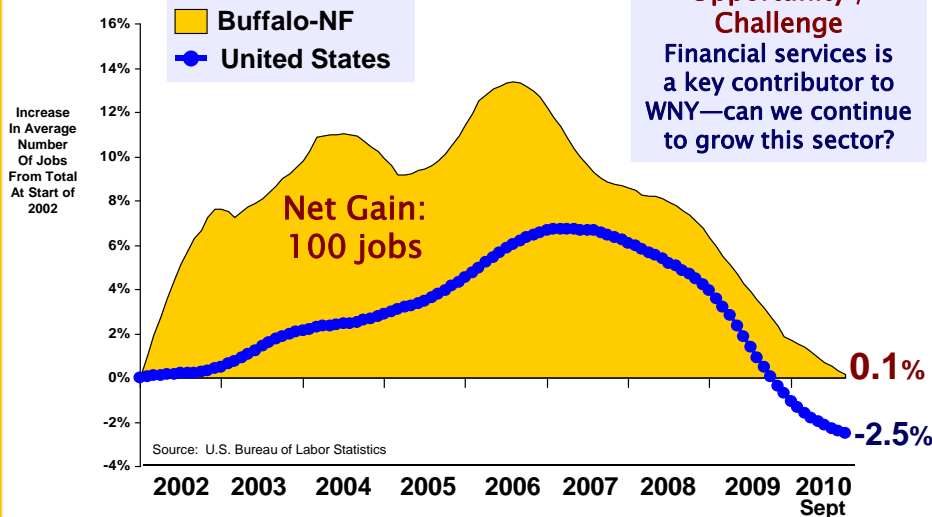
Buffalo–Niagara Falls Metro Area vs. United States
**Increase in Private Health Care Services Jobs
 Since January 2002**

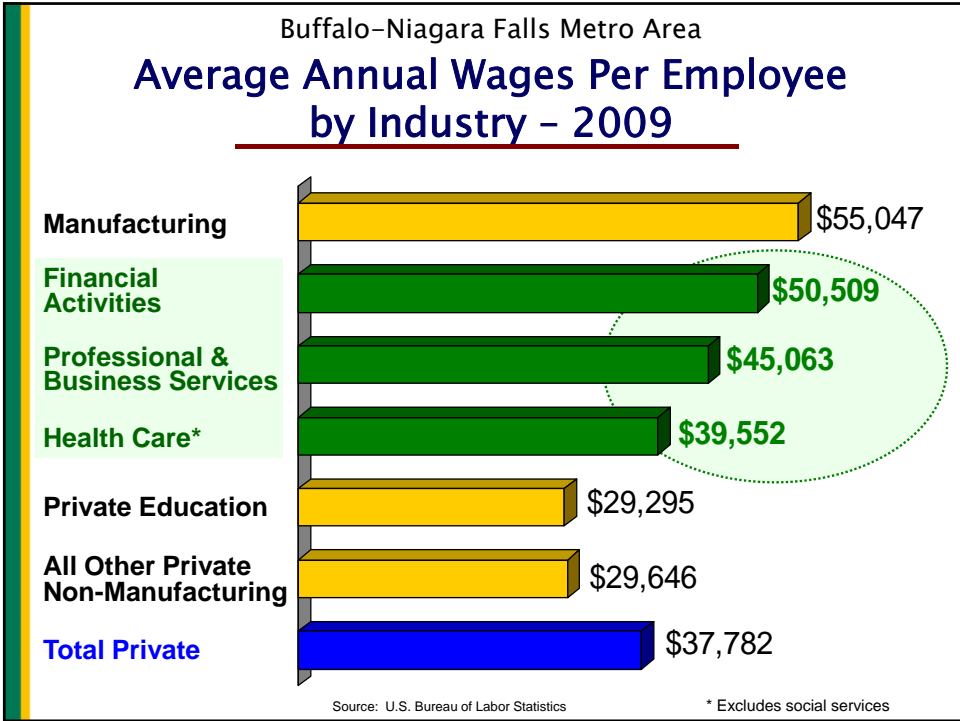
Opportunity / Challenge:
 While health care has been a steady source of job creation, Buffalo has not kept pace with the national norm—can we ramp up growth with further investment in our medical corridor?



Buffalo–Niagara Falls Metro Area vs. United States
**Increase in Finance & Insurance Employment
 Since January 2002**

Opportunity / Challenge
 Financial services is a key contributor to WNY—can we continue to grow this sector?



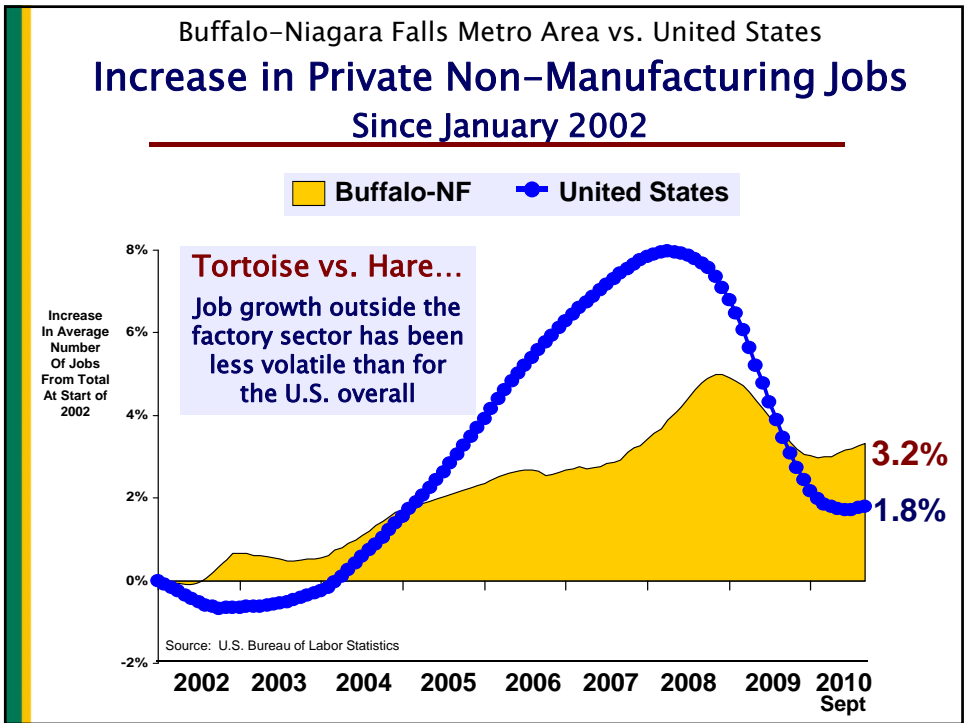
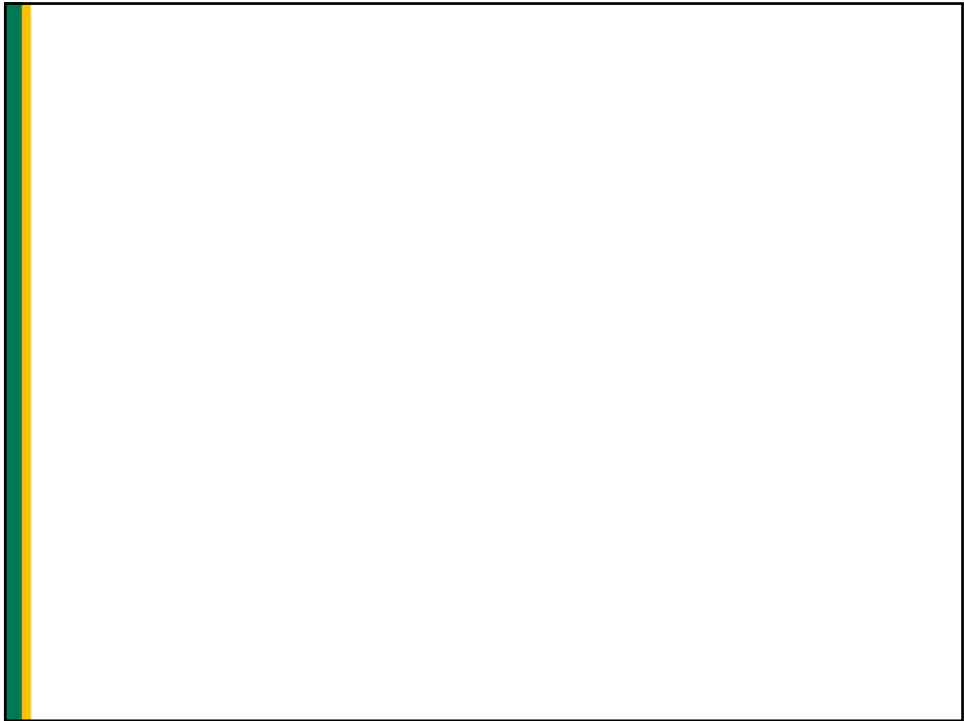


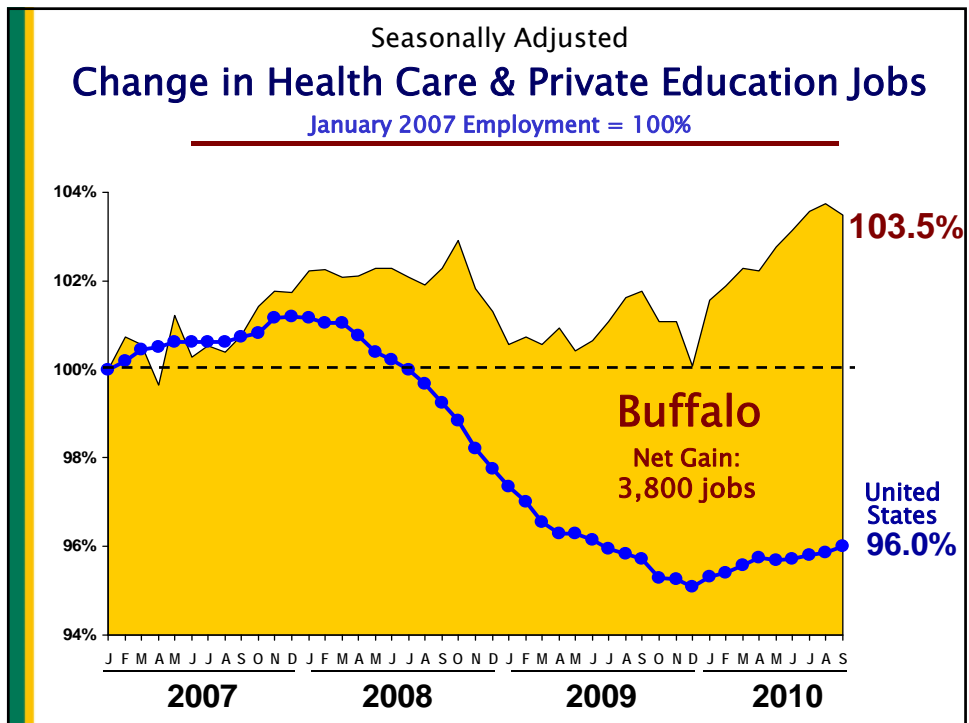
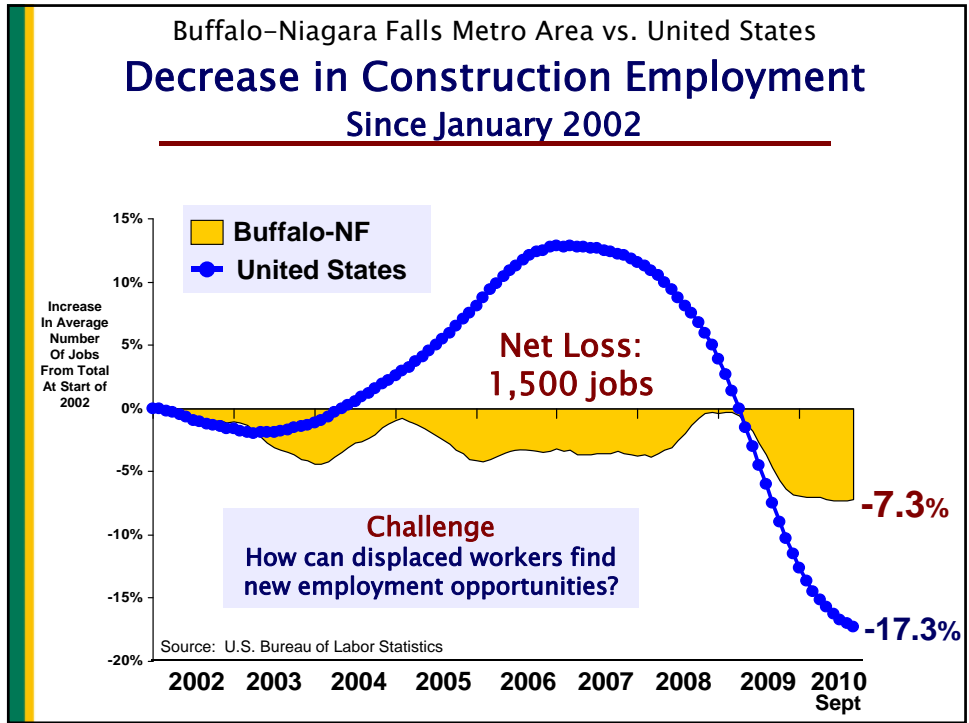
Questions?

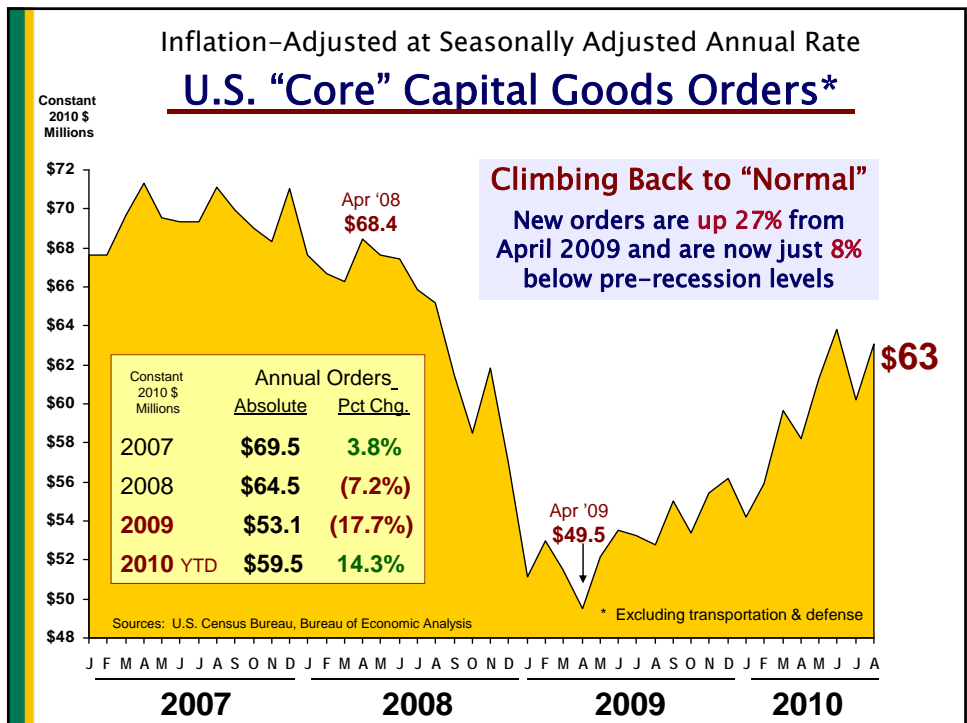
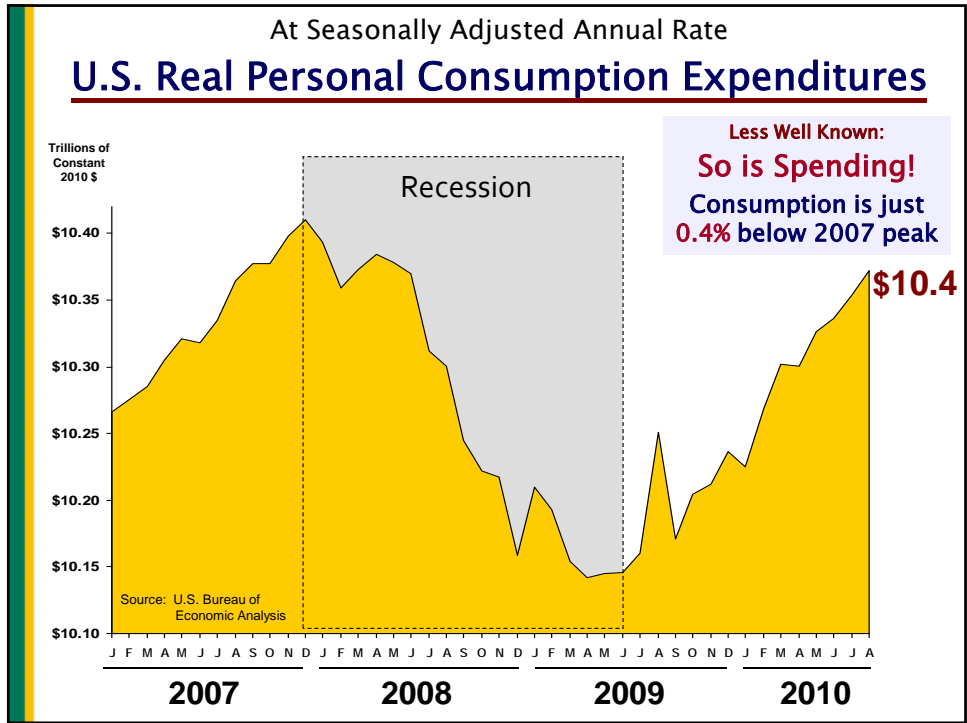
gkeith@mtb.com

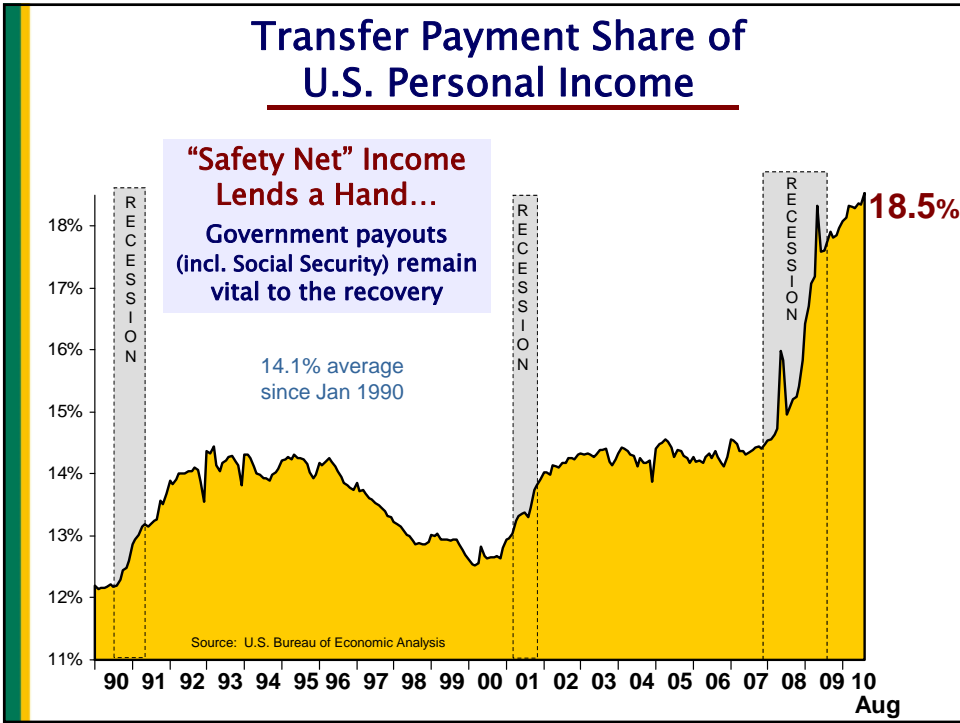
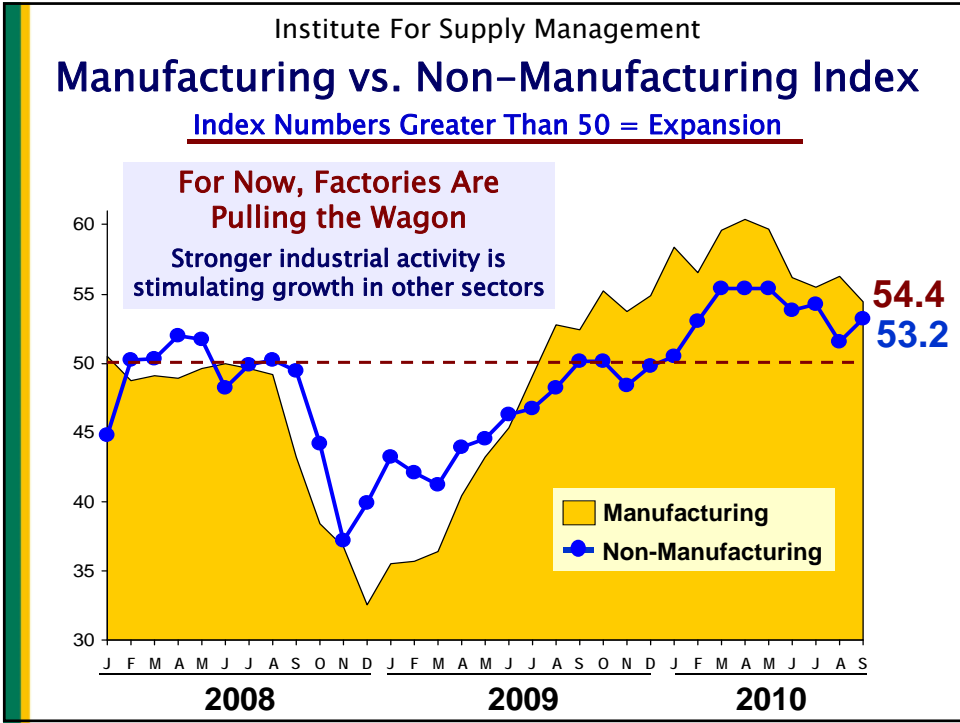

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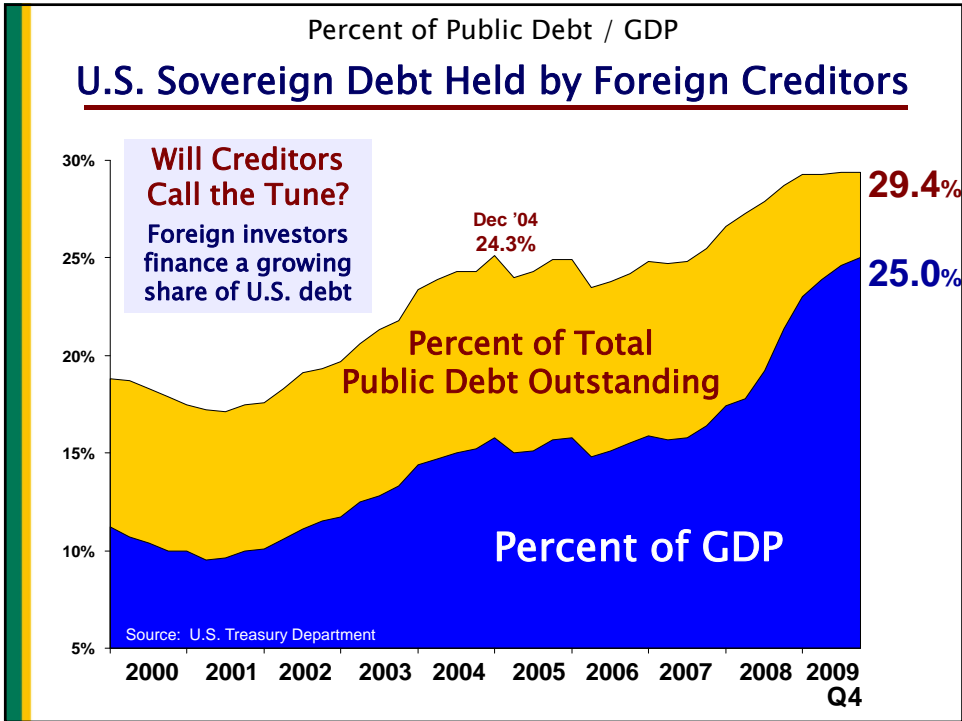
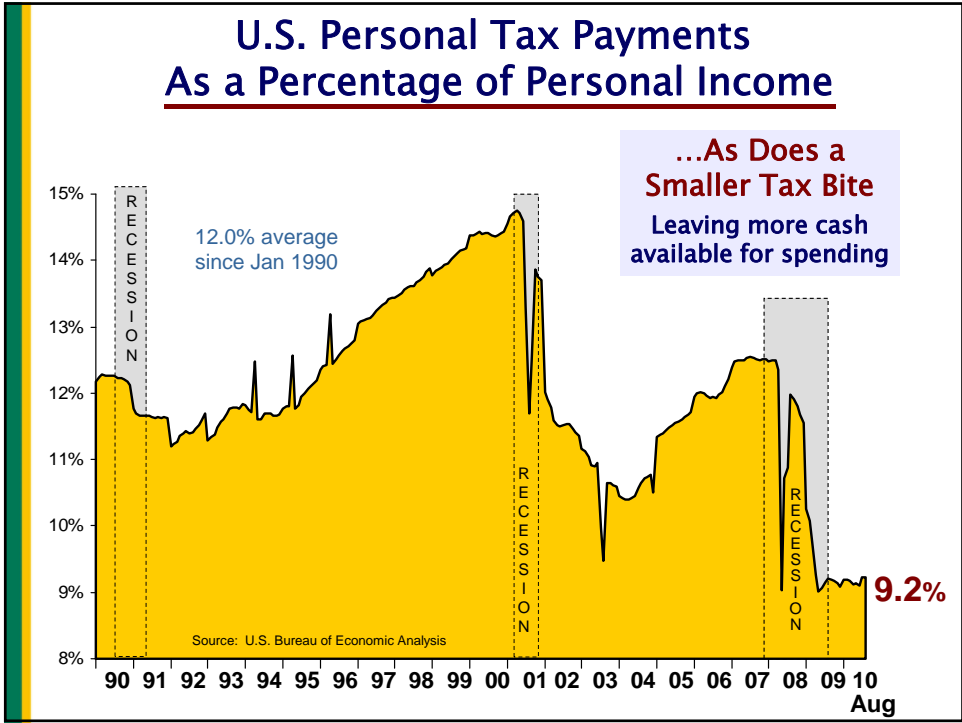












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Dale is the partner-in-charge of the Firm's tax department and is responsible for the coordination of tax planning and compliance services and the supervision of approximately 20 tax professionals. He has been a partner since 1991. Dale works with business and individual tax clients in order to assure conformity with federal and state tax standards and to minimize taxes and related costs. He is an expert in the areas of individual income taxation, estate, trust and gift tax planning and succession planning for privately held businesses. Dale is active in the community serving on several boards of directors including: Secretary/Treasurer of the Board of Trustees of Daemen College; Professional Advisors Council of the Community Foundation for Greater Buffalo; Past President and Member of the Estate Analysts of WNY; Past President and Member of the Financial Planning Counselors of WNY; Past President and Trustee Emeritus of the Board of Trustees of the Community Music School of Buffalo; and a director of several private foundation boards. He is also a member of the American Institute of Certified Public Accountants and New York State Society of Certified Public Accountants. Dale is a Cum Laude graduate of Daemen College with a Bachelor of Science in accounting.

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Michele O. Heffernan is a Partner at Jaeckle Fleischmann with three decades of experience in the area of Employee Benefits. Her background includes analysis and drafting of all forms of pension, profit sharing, 401(k), employee stock ownership, and welfare plans; advising businesses regarding supplemental retirement, deferred compensation, incentive, stock option, and other executive compensation programs; representation of clients with respect to multiemployer pension plan issues; and consultation regarding benefit plan issues arising in business acquisitions and divestitures. She also currently serves as General Counsel for the Hauptmann-Woodward Medical Research Institute, Inc.

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Throughout a 26-year career at M&T Bank, Gary D. Keith has provided economic research and analysis support to M&T's executive management and commercial banking business units. In addition to giving frequent updates to business and trade groups and the Federal Reserve Bank of New York, he holds regular discussions with M&T commercial customers, helping to tie together the economic variables that describe the macro economy with real world decisions that businesses make every day. Mr. Keith has a BS degree from Niagara University and an MBA from the State University of New York at Buffalo. He is a member of the National Association of Business Economics, the Upstate Economic Roundtable of the Federal Reserve Bank of New York, and writes a monthly column on regional economic trends for the *Rochester Business Journal*. In addition to his economic analysis role, Mr. Keith also manages the bank's commercial market research department.

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Steve has over thirty-five years of experience performing audit, tax, and business advisory services for auto dealerships, commercial businesses, and other organizations. Steve is the Firm's accounting and auditing director. He is responsible for a variety of businesses in the areas of auditing, consulting, tax planning and compliance, and audit standards applications. He has reinforced technical expertise through, among other things, his service on the technical issues committee of the American Institute of Certified Public Accountants. Steve has spent his entire professional career here at Lumsden & McCormick, he joined the Firm in 1974 after graduating from Canisius College. Steve is very active in the community serving on the Board for Kavinoky Theatre, Board Member; Mid-Day Club, Treasurer; Canisius College, Council on Accountancy, Vice Chairman and Board of Regents; and Cradle Beach Camp, Treasurer. He is a member in good standing with the American Institute of Certified Public Accountants; New York State Society of Certified Public Accountants; Healthcare Financial Management Association; and International Foundation of Employee Benefit Plans.

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