



Health Care Reform

Summary & Timeline For Employers

Year	Health Reform Law
2010	<p>Small business tax credits –</p> <ul style="list-style-type: none"> • Small employers with 10 or less full-time employees and average annual wages of less than \$25,000 will be eligible for a tax credit of 35% of the employer’s contribution toward the employee’s health insurance premium, if the employer contributes at least 50% of the total premium cost. • Small employers with 11 to 25 workers and average annual wages of up to \$50,000 are eligible for partial credits. • The credit increases to 50% by 2014. <p>Early retiree reinsurance program – Beginning 90 days after enactment, a temporary reinsurance program will reimburse employer plans for 80% of the cost of benefits provided to retirees age 55 through 64 in excess of \$15,000 and below \$90,000. The program will end by 2014 or when the funding of \$5B is exhausted.</p>
2011	<p>Employer group health plans – Beginning with the 2011 plan year*, for calendar-year plans, employer group health plans:</p> <ul style="list-style-type: none"> • Must offer coverage to adult children up to age 26 who are not eligible for coverage under another employer’s health plan. (In 2014, the requirement that the nondependent child not be eligible for coverage under another employer’s health plan will no longer apply). The coverage is not taxable to the employee or dependent, and adult children are covered in this manner regardless of whether they qualify as a dependent of the employee for tax purposes. • May not impose lifetime limits on benefits and can impose only “restricted” annual limits; no annual limits on benefits will be permitted beginning in 2014. • May not impose preexisting condition exclusions on children under age 19; no preexisting condition exclusions will be permitted for any participants beginning in 2014. <p><i>*These changes take effect for plan years that begin following six months after enactment. As a result, some plans that are not on a calendar-year basis may have effective dates earlier than January 2011.</i></p> <p>Account-based plans – Over-the-counter medicines are no longer eligible for reimbursement from a health flexible spending account (FSA), health savings account (HSA) or health reimbursement arrangement (HRA) unless obtained with a prescription. Tax penalty is increased from 10% to 20% for distributions from HSA’s that are not used to pay for health related expenses.</p> <p>Form W-2 reporting – Employers must disclose the value of each employee’s health coverage on W-2’s beginning with 2011 W-2 Forms.</p>
2013	<p>Change in employer tax treatment of the Medicare Part D RDS – Reduction in employer’s tax deduction to the extent the employer’s drug expenses are reimbursed under the Medicare Part D retiree drug subsidy (RDS) program. Employers participating in the RDS program will be required to recognize the full accounting impact of the 2013 tax law change in the financial statements for the accounting period beginning in 2010, when the legislation was signed.</p> <p>Medicare Tax Base Increases – Increases the Medicare tax rate on earned income above \$200,000 (\$250,000 for joint returns) from 1.45% to 2.35%. This only applies to amounts paid by the employee. For these same taxpayers, Medicare taxes of 3.8% will be imposed on income from interest, dividends, annuities, rents, capital gains and royalties. The tax is not applied to distributions from qualified plans.</p>

	<p>Limit on Health Flexible Spending Account Contributions – Pretax salary contributions will be limited to \$2,500 per year, indexed to the CPI.</p>
2014	<p>Employer “pay or play” responsibility – If an employer with more than 50 full-time employees (defined as 30 or more hours of service per week) chooses to:</p> <ul style="list-style-type: none"> • <u>Offer coverage</u>, but has at least one full-time employee who receives subsidized health coverage in an Exchange because the employer’s plan is considered “unaffordable” (employee’s premium exceeds 9.5% of family income), the employer will pay the <i>lesser</i> of – <ul style="list-style-type: none"> ○ \$3,000 multiplied by the number of full-time employees who receive subsidized coverage in an Exchange, OR ○ \$2,000 multiplied by the total number of full-time employees • <u>Not offer coverage to employees</u>, the employer will pay \$2,000 multiplied by the total number of full-time employees (minus the first 30), if at least one full-time employee obtains subsidized health coverage in an Exchange. <i>For example, an employer with 51 full-time employees would subtract the first 30 FTE’s and reach a number of 21 FTE’s. The employer’s fine would be 21 x \$2,000 or \$42,000.</i> <p>No penalty is applied to employees who are in a waiting period for benefits of up to 90 days. Waiting periods cannot be longer than 90 days.</p> <p>Employer free-choice vouchers – Requires employers that offer coverage to provide a free choice voucher to employees with incomes less than 400% of the federal poverty level whose share of the premium is between 8% and 9.8% of their income, and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage under the employer’s plan. Employers providing free-choice vouchers will not be subject to penalties for employees who participate in the Exchange.</p> <p>An employee will not be taxed on the portion of a voucher used to pay premiums in an Exchange, but will be taxed on any amount in excess of the cost of Exchange-based coverage.</p> <p>Wellness incentives – Allows employers to offer premium discounts or rebates or modify co-pays or deductibles up to 30% of the total premium to encourage participation in health promotion or disease prevention programs. (Regulators have the authority to increase this incentive up to 50%). Small employers that establish wellness programs may be eligible for grants.</p> <p>Employer health coverage reporting – Beginning in 2014, employers will be required to report annually to the government on:</p> <ul style="list-style-type: none"> • Whether they offer minimum essential coverage to their full-time employees and their dependents • The length of any applicable waiting period • The lowest-cost option in each enrollment category under the plan • The employer’s share of the total allowed costs of benefits provided under the plan • The total number and names of full-time employees receiving health coverage <p>Automatic enrollment and ongoing employee notice requirement – Amendments to the Fair Labor Standards Act will require employers:</p> <ul style="list-style-type: none"> • With more than 200 full-time employees to automatically enroll full-time employees in health coverage; employees will have the opportunity to opt-out • To provide new employees with a notice regarding the health insurance Exchanges, whether the employer’s plan meets minimum coverage requirements and how to access information regarding premium subsidies that may be available for Exchange-based coverage; current employees must receive this notice no later than March 31, 2013.
2018	<p>Excise tax on high-cost health plans – Nondeductible 40% excise tax on the amount of premium for insured and self-insured group health coverage that exceeds a threshold of \$10,200 for single coverage and \$27,500 for family coverage. The threshold will be indexed to the rate of general inflation plus 1%. Thresholds are higher for retirees and those in designated high-risk professions. Additional adjustments may be made to the thresholds based on actual experience vs. projections.</p>

Additional Provisions

INDIVIDUALS

Itemized deductions for unreimbursed medical expenses – Beginning in 2013, individual taxpayers may only deduct medical expenses in excess of 10% of their adjusted gross income, up from the current level of 7.5% of income. (Begins in 2017 for those age 65 or over).

Individual health coverage mandate – Beginning in 2014, individuals who do not enroll in “minimum essential coverage” will pay a penalty based on the greater of a flat dollar amount or a percentage of income. Minimum essential coverage includes Medicare, Medicaid, employer plans and Exchange-based health coverage.

- The annual flat dollar penalty equals \$95 in 2014, \$325 in 2015, \$695 in 2016 and indexed thereafter.
- The percentage of income penalty equals 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and subsequent years.

Families will pay half the amount for children up to a cap of \$2,250 for the entire family. Individuals with income below the tax filing threshold will not pay the penalty.

Federal premium subsidies for low- and middle-income individuals – Beginning in 2014, premium subsidies and reduced cost sharing will be provided on a sliding scale to individuals earning up to 400% of the federal poverty level who enroll in options offered through the Exchanges, where coverage will be available up to age 65. Employees who are offered minimum acceptable coverage by an employer are only eligible for subsidies if the employee’s premium contribution to the employer plan exceeds 9.5% of the employee’s household income. If the required contribution equals between 8% and 9.5% of household income, the employers will be required to offer such employees a free-choice voucher to be used to purchase Exchange-based coverage.

Medicaid eligibility expansion – Beginning in 2014, national Medicaid eligibility will be expanded to those with incomes up to 133% of the federal poverty level. The federal government will pay the cost associated with these newly eligible Medicaid beneficiaries at levels beginning at 100% in 2014 and reducing annually to 90% for 2020 and later years. States will be required to pay the difference in the cost of this newly eligible class of Medicaid beneficiaries. This income-based expansion of Medicaid will not extend to those over age 65 or to those who are entitled to or enrolled in Medicare Part A, or enrolled in Medicare Part B.

HEALTH INSURERS

New fees – Beginning in 2014, new annual fees will be imposed on health insurers allocated according to their market share of net written premiums.

Insurance market reforms – Beginning in 2014, insurers in the individual and small-group markets will be required to offer coverage to those up to age 65 via new state-based health insurance Exchanges. This coverage will be offered on a guaranteed available and renewable basis with no health status underwriting, no preexisting condition exclusions and limits on permissible premium rating bands.

Health Benefit Exchanges – Beginning in 2014, states will be required to establish an insurance Exchange to facilitate the offering and purchase of approved, qualified health plans to small businesses and individuals up to age 65.

MEDICARE

Medicare prescription drug “donut hole” – Medicare Part D beneficiaries who have reached the “donut hole” will receive a \$250 rebate in 2010. The law will gradually reduce the donut hole in subsequent years by phasing down the coinsurance in the coverage gap each year. The “donut hole” refers to the gap in prescription drug coverage that occurs

when the coverage limit is reached and catastrophic coverage begins. Medicare Part D beneficiaries are financially responsible for the full cost of prescription drugs during that period.

Medicare Part D drug discounts – Beginning in 2011, drug manufacturers are required to provide a 50% discount to Medicare Part D beneficiaries on brand-name drugs and biologics in the donut hole coverage gap.

Medicare Advantage Plans – Beginning in 2011, and phased in over 3 years, the law will change payments to Medicare Advantage plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates.

Means testing Part D premiums – Beginning in 2011, Medicare Part D premiums will be set higher than the standard level for those with incomes above \$85,000 for individuals and \$170,000 for couples.

PHARMACEUTICAL MANUFACTURERS

New fees - Beginning in 2011, new annual fees will be imposed on pharmaceutical manufacturers.

MEDICAL DEVICE MANUFACTURERS

Tax – Beginning in 2013, an excise tax of 2.3% will be imposed on the sale of medical devices, with certain exceptions.

Disclaimer: The information provided in this document provides a high-level summary, in rough chronological order, of many key employer-related provisions of the health care reform law. Not every employer-related provision is listed here, not does the list include many other provisions directly affecting health care providers and the health care delivery system. Individuals and employers should rely on the actual language of the health care reform law, and not solely on this summary, for interpretation of the provisions of the law.