

**NATIONAL HEALTHCARE REFORM – INITIAL IMPACT STUDY**  
**The Patient Protection and Affordable Care Act (P.L. 111-148)**  
**The Health Care and Education Affordability Act of 2010**  
**(H.R. 4872 aka the “reconciliation bill”)**

**April 1, 2010**

While most of the provisions that will have a major impact on the health insurance marketplace are not scheduled to go into effect until 2014, some provisions that have been less publicized in the media have effective dates in 2010 or are even retroactive to the beginning of 2010.

**Effective *Immediately*:** “Six Months after Enactment” ( For most 2010 changes we interpret “six months” to mean the beginning of the plan year beginning on or after September 23, 2010). Where interpretation of the law is unclear, employers should consult their legal counsel for guidance.

**Grandfathering:** The new law provides that, under very limited circumstances, an employer may continue to maintain the employer-sponsored health plan it had in effect on the date of the act’s enactment (March 23, 2010), without having to comply with some of the otherwise mandatory benefit and other plan changes the act requires. Maintaining current coverage is called “grandfathering” in the act.

New Proposed Regulations have just been issued explaining how to maintain “Grandfathered” status. Look in the Table of Contents under “Grandfathered Plans”.

Grandfathered plans will not have to comply with the following provisions of PACA:

- The requirement to offer preventive health benefits without cost sharing
- Coverage of adult children eligible for other employer-sponsored coverage
- Annual reports on health care quality and care coordination
- Prohibition against discrimination as to coverage, eligibility or contributions
- New internal and external review and appeals procedures
- Choice of participating specialists as PCPs
- No prior approval for or higher out-of-network cost sharing for emergencies
- No denials of pre-existing conditions for children (primarily applies to individual plans)

In addition, Grandfathered plans are exempt beginning 1/1/2014 from the following:

- Restriction of annual limits (individual coverage only)
- Plain language disclosure of data on health plans
- Review of premium increases
- Modified community rating
- Restrictions on annual out-of-pocket limits
- Cover clinical trials
- Guaranteed access/renewability rules

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<b><i>New Law (2010)</i></b>	<b><i>Comments</i></b>
<p><b>Definition of Full-time Employees:</b> Full-time employees are defined as employees working 30 hours per week, averaged over a month.</p> <p>You determine the number of full-time equivalent (<b>FTE employees</b>) by taking the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) and dividing by 2080. Round down. Seasonal workers working fewer than 120 days per year are not counted.</p>	<p>The definition of full time employee and FTE employee becomes important in understanding which employers are subject to various mandates and which employees are eligible for mandated benefits under health reform.</p>
<p><b>Removal of Lifetime Limits:</b> Lifetime limits must be removed on <b><i>essential</i></b> benefits.</p> <p>A plan must also remove internal annual limits on essential benefits.</p> <p>The term “essential benefits” is defined by Section 1302 of the Act. Policies sold in the exchange must include all essential benefits. The categories of essential health benefits are:</p> <ul style="list-style-type: none"> <li>a) Ambulatory patient services</li> <li>b) Emergency services</li> <li>c) Hospitalization</li> <li>d) Maternity and newborn care</li> <li>e) Mental health &amp; substance abuse services</li> <li>f) Prescription drugs</li> <li>g) Rehabilitation services and devices</li> <li>h) Laboratory services</li> <li>i) Preventive and wellness services and chronic disease management</li> <li>j) Pediatric services, including oral and vision care</li> </ul> <p>Only <b><i>Individual</i></b> “Grandfathered” policies are exempt from this provision.</p>	<p>While this provision is written to be effective in 2010, effective for group health plan years beginning before Jan. 1, 2014, (calendar plan years 2011, 2012, and 2013) group health plans, including grandfathered plans, and health insurance issuers can establish restricted annual limits on the dollar values of plan participants' essential health benefits. The federal Secretary of Health and Human Services must issue rules defining restricted annual limits.</p> <p>Lifetime maximums, which we commonly see on PPO plans and POS plans, must be revised to unlimited maximums.</p> <p>According to an employer survey by the United Benefit Advisors, the largest survey of its kind, about 36% of workers insured by their employer’s plan have unlimited maximums. Another 39% have maximums of \$5 million or more. Only 5.1% have a \$1 million maximum and another 15.4% have a \$2 million maximum.</p> <p>Most plans also have a number of benefits with annual limits, such as rehabilitation and substance abuse services. Such limits must be removed.</p>

<i>New Law (2010)</i>	<i>Comments</i>
<p><b>Dependents become eligible to age 26:</b> Plans (medical, not dental or vision) must cover adult children up to age 26 (through age 25), regardless of student status, marital status or dependent status.</p> <p>Nothing in the law requires plans to provide dependent coverage. The age requirement affects only plans that choose to offer dependent coverage.</p> <p>A child is an individual who is the son, daughter, stepson, or stepdaughter of the employee, and a child includes both a legally adopted individual of the employee and an individual who is lawfully placed with the employee for legal adoption by the employee. A child also includes an “eligible foster child”, defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. An eligible child does not include a child of a child or a spouse of a child.</p> <p>IRS regulations prohibit surcharges for coverage of children under age 26 except where the surcharges apply regardless of the age. Also, for children under age 26, the plan cannot vary benefits based on the age of the child.</p> <p>For grandfathered plans: For plan years beginning before January 1, 2014, grandfathered group health plans are not required to extend adult dependent coverage if the child is eligible to enroll in another eligible employer-sponsored health plan.</p> <p>Children who age out of their parent’s policy may be able to purchase health insurance through COBRA or through an individual policy. Once the plan’s provisions are updated, parents may then reenroll their eligible children.</p>	<p>The Reconciliation Bill amended the tax code to provide that reimbursements from an employer-provided health plan for medical expenses of an adult child who has not attained age 27 as of the end of the calendar year are excluded from income.</p> <p>The exclusion from income for reimbursements for adult children also apply to cafeteria plans, including health flexible spending arrangements (FSAs), and to health reimbursement arrangements (HRAs).</p> <p>The IRS has also amended <b>Cafeteria plan rules</b> so that employers may immediately permit employees to make pre-tax, salary reduction elections under a cafeteria plan for eligible adult children, including contributions to a health FSA. Any cafeteria plan amendment needed to include adult children under age 27 may be made retroactively so long as the amendment is made by December 31, 2010.</p> <p>Distributions from HSA plans for adult children who do not pass the dependent test remain taxable.</p> <p>The IRS also intends to amend the regulations under § 106, retroactively to March 30, 2010, to provide that premiums for coverage for an employee’s child under age 27 is excluded from gross income.</p> <p><b>Special Open Enrollment:</b> All plans that cover dependent children will be required to offer a one-time 30-day open-enrollment period which must begin no later than the 1<sup>st</sup> day of the 1<sup>st</sup> plan year to which this change applies. Employees must receive a notice describing the open enrollment. Because it is a “Special Open Enrollment”, if a child qualifies but his or her parent is not currently enrolled in the plan, the plan must provide an opportunity for both the parent and the child to enroll. Also a parent insured on the plan may choose a different benefit option.</p>

<b><i>New Law (2010)</i></b>	<b><i>Comments</i></b>
<p><b>Retroactive Cancellations of Policies are Prohibited:</b></p> <p>The new law bars this practice <u>for all new and existing policies</u>, except in cases of outright fraud.</p>	
<p><b>Preexisting Conditions Prohibited for Children:</b></p> <p>PPACA will prohibit preexisting health condition exclusion for children under 19, effective for plan years beginning after 9/23/2010. In other words such plans may not exclude benefits based on health conditions for qualifying children.</p> <p>This provision applies to all grandfathered and new group plans (including self-insured plans) and all new individual plans.</p>	<p>Almost all HMO plans in California have no pre-existing conditions clauses at all. Other plans are already subject to very liberal California HIPAA rules that provide continuity of coverage for pre-existing conditions if there has not been a substantial period of lapsed coverage.</p> <p>A strict interpretation of the law separates the guarantee for issuance of a health insurance policy from the prohibition against coverage exclusions for preexisting conditions once the policy is issued. Therefore, children could be denied the offer of coverage altogether (and the likelihood of denial is now increased) until 2014.</p>
<p><b>Emergency Services Must Be Paid In-Network:</b></p> <p>Emergency services will always be paid as though in-network.</p> <p>Also, the plan cannot impose a prior authorization requirement or increased cost-sharing for emergency services.</p> <p>Grandfathered policies are exempt.</p>	<p>You can go to a network emergency room but that does not mean that the ER doctor on duty, the radiologist or the anesthesiologist participates in your network. It doesn't matter now. All emergency services must be paid as an in-network benefit. This is a big plus when you need it.</p>
<p><b>Primary Care Physician:</b></p> <p>Enrollees may now designate any willing in-network doctor as their primary care physician.</p>	<p>Some women, for example, may wish to designate an OB-GYN as a primary care doctor. Many OB-GYNs do not want to be primary care doctors. However, if they are willing, plans must allow participants to select them as their PCP.</p>

<b><i>New Law (2010)</i></b>	<b><i>Comments</i></b>
<p><b>Certain Preventive Services Must Be Free:</b></p> <p>Specific “preventive services” cannot require any consumer cost-sharing.</p> <p>An independent panel of experts, the U.S. Preventive Services Task Force, is charged with identifying the specific preventive services that must be free.</p> <p><b>Preventive Care</b> – In the bill, the definition of “preventive care” includes the following:</p> <ol style="list-style-type: none"> <li>1. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force;</li> <li>2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and</li> <li>3. with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;</li> <li>4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph;</li> </ol> <p>for the purposes of this act, and for the purposes of any other provision of law, the current recommendations of the U.S. Preventive Service Task Force regarding breast cancer screening, mammography and prevention shall be considered the most current other than those issued in or around November 2009.</p> <p>Grandfathered policies exempt.</p>	<p>Research shows that preventive care services may save lives, but does not save money. Spending on preventive care increases overall health spending. As with any service that is offered for free, preventive care services without cost sharing may result in overutilization of such services.</p>

<b><i>New Law (2010)</i></b>	<b><i>Comments</i></b>
<p><b>New Temporary Tax Credit for Small Business:</b></p> <p>To qualify, an employer must:</p> <ul style="list-style-type: none"> <li>• Have fewer than 25 full-time equivalent employees for the tax year (FTEs)</li> <li>• The average annual wages of its employees for the year must be less than \$50,000 per FTE, and</li> <li>• The employer must pay premiums under a “qualifying arrangement” (the employer must contribute a uniform percent of the premium for all employees not less than 50% of the premium)</li> </ul> <p>The employer may be eligible for a sliding scale tax credit retroactive to 1/1/10 based upon the portion of the premium the employer paid.</p> <ul style="list-style-type: none"> <li>• The maximum credit is 35% of the employer’s qualifying premium expenses in 2010 – 2013 and 50% in 2014.</li> <li>• If you have 10 or less full-time equivalent employees and your average employee wage is less than \$25,000, you will be eligible for the maximum 50% credit for up to 2 years.</li> <li>• For non-profit employers the maximum credit is 25% of the employer’s qualifying premium expenses, but cannot exceed the total amount of income and Medicare tax the employer is required to withhold from employees’ wages for the year plus the employer share of Medicare tax on employees’ wages.</li> </ul> <p>For 2010 there will be transition relief issued by the IRS stating that employer contributions in 2010 that are not a uniform percent of premium for all employees will not disqualify the employer from eligibility.</p> <p>See the supplement at the end of this document for a more detailed explanation. Also see the Excel spreadsheet calculator which can help you estimate your eligibility for an amount of your tax credit.</p>	<p>Administering the credit has its challenges. For example the premium against which the credit is calculated is limited to the premiums that the employer would have paid for the coverage if the average premium for the small group market in the State were substituted for the actual premium. In California, small group premiums vary by age in 7 rate bands and are different for 9 different market areas. The department of health and human services will make the determination and the IRS will publish it on their website by the end of April.</p> <p>You determine the average annual wages (for FICA purposes without regard to the wage base limitation) by taking the total wages paid by the employer to employees during the employer’s tax year and dividing by the number of FTEs for the year.</p> <p>Generally business owners and their family members do not count as employees in the FTE determination, their salaries are not calculated in the average annual wage and their premiums are not eligible for the credit. Business owners include: sole proprietors, partners in a partnership, a shareholder owning more than 2% of an S corporation and any owner of more than 5% of other businesses.</p> <p>Members of a controlled group or an affiliated service group are treated as a single employer for purposes of the credit.</p> <p>The credit is claimed on the employer’s annual income tax return. Deductible premiums are reduced by the amount of the credit.</p>

<i>New Law (2010)</i>	<i>Comments</i>
<p><b>New Disclosure Rules for Material Modifications to Health Plans:</b> New rules beginning for plan renewals on or after 10/01/2010 require that employers give employees 60 days advance notice of any material modifications to their plan. “Material Modification” has not yet been defined.</p> <p>Plans must also distribute notices of new, written, internal and external appeals processes. The processes offer impartial review, give participants access to their records and offer them a hearing on appeal.</p>	<p>This will be a significant challenge for small employers unless insurers can suddenly accelerate their timetables for releasing renewal rates.</p> <p>This would also require states like California that are notoriously slow in approving new rates to also beef up their staffs and provide prompt service.</p> <p>The effective date of this requirement is unclear. Advance notice should be provided at least with respect to changes occurring on or after 3/23/2012. A safer approach would be to comply immediately.</p>
<p><b>New Taxes on Pharmaceuticals:</b> Pharmaceutical companies are going to be hit with a big fee; importantly, these companies can pass this fee through to consumers in the cost of their product. Starting in 2011, the pharmaceutical industry will be subject to a \$2.5 billion annual excise (non-deductible) tax. The tax increases in subsequent years, rising to \$4.2 billion in 2018. The tax is based on a company’s market share.</p>	<p>You should anticipate an increase in the pharmaceutical expense component of your medical plan beginning with renewals occurring in 2010.</p>
<p><b>New Non-discrimination Rules for Fully Insured Health Plans:</b> For employers’ (with more than 50 employees) plan years beginning on or after September 23, 2010, Insured group health plans will be required to comply with the IRS 105(h) rules that prohibit discrimination in favor of highly compensated individuals.</p> <p>Under 105(h) rules, to be non-discriminatory, a plan must cover 70% or more of all employees or, if less than 100% of all employees are eligible for benefits, it must cover at least 80% of all eligible employees so long as at least 70% are eligible (56% of all employees covered). In performing the test, the employer may exclude employees who: have not completed three years of service, are under age 25, are part-time, are seasonal employees or are union employees.</p> <p>In addition, the plan must provide the same benefits to the non-Highly Compensated Individuals as the HCIs.</p>	<p>Formerly, these rules applied only to self-funded plans.</p> <p>This spells the end of new sales of insured supplemental health reimbursement plans, such as Exec-U-Care and similar plans.</p> <p>Under Section 105(h) for self-funded plans the penalty for failing the test was a partial loss of the favorable tax treatment for plans. Under health reform the penalty is instead be a \$100 per day per affected participant non-deductible excise tax up to an annual limit of \$500,000 per year!</p>

<b><i>New Law (2010)</i></b>	<b><i>Comments</i></b>
<p><b>New Federal Temporary High-Risk Pool Program:</b></p> <p>The new law establishes a high-risk pool program for individuals who cannot obtain individual coverage due to pre-existing conditions. It begins within 90 days of enactment.</p> <p>The program is available to people with pre-existing conditions that have been uninsured for at least 6 months.</p>	<p>Employers are prohibited from sending individuals to the high-risk pool.</p> <p>Applicants should expect to pay standard rates for the individual insurance market in their region, at least until the subsidy money (\$5 Billion) runs out.</p>
<p><b>Wellness:</b></p> <p><b>Firearms:</b> Effective in 2010, wellness programs may not require disclosure or collection of any information relating to the presence of firearms, and may not base premiums, discounts, rebates or rewards on the basis of firearm or ammunition ownership.</p> <p><b>Break Time for Nursing Mothers:</b> Effective immediately, employers covered by the FLSA must provide reasonable break time and private space, other than a restroom, for a nursing mother to express breast milk for up to one year after the birth of a child. Employers do not need to compensate for the time. Employers with less than 50 employees may qualify for exceptions.</p>	
<p><b>Self-funded health plans must provide for external independent medical review</b> of certain claims, such as claims that are denied based upon medical necessity.</p>	
<p><b>New Temporary Reinsurance for Employers who Provide Retiree Health Coverage:</b></p> <p>A temporary reinsurance program for employers that provide retiree health coverage for employees over age 55 and not eligible for Medicare begins within 90 days of enactment</p>	<p>This program will reimburse employers, including State and local governments, for 80% of their pre-Medicare-eligible early retiree expenses between \$15,000 and \$90,000 per year, indexed for inflation. Employers must use the reimbursements to lower the cost of coverage for plan participants. Program details are expected by late June 2010. The program incentivizes plans to implement programs and procedures to better manage chronic conditions. The Act appropriates \$5 billion for this fund and funds are available until expended, or on January 1, 2014.</p>

**Loss of Medicare Part D Subsidy for Retirees:**

Employers that provide a Medicare Part D subsidy to retirees will have to account for the future loss of the deductibility of this subsidy on liability and income statements now.

The new law eliminates a subsidy for for-profit employers who provide a Medicare Part D subsidy to retirees beginning in 2013. Employers must account for this on their financial statements in 2010.

→ **EFFECTIVE 2011**

<b><i>New Law 2011</i></b>	<b><i>Comments</i></b>
<p><b>W-2 Reporting:</b> Beginning with the 2011 tax year, employers must show the aggregate cost of employer sponsored health benefits on each employee’s W-2. The new W-2 will be due in January 2012. The cost of coverage will include both employer and employee contributions. It will include major medical coverage, amounts under HRAs, Medicare supplemental coverage, employer-provided Medicare Advantage plans, the value of on-site medical clinics and “mini-medical plans”.</p>	<p>NOTE: This amount is <b><i>not</i></b> included as a part of an employee’s taxable income.</p> <p>Reporting will exclude: pre-tax employee deferrals to health savings accounts, Archer medical savings accounts, health flexible spending accounts, stand-alone dental and vision, long-term care, fixed indemnity insurance, specific illness, accident only, disability income and workers compensation.</p>
<p><b>Over-the-Counter Drugs:</b> Effective 1/1/2011, employees will not be able to receive pre-tax reimbursements from their FSA, HRA or HSA for over-the-counter drugs, except insulin, unless prescribed by a doctor.</p>	<p>Employers should remind employees to be mindful of this change when making their elections for plan years that extend beyond 2/1/2011.</p>
<p><b>SIMPLE Cafeteria Plans for Small Businesses:</b></p> <ul style="list-style-type: none"> <li>• Effective 1/1/2011, employers with fewer than 100 employees for each of the past two years are eligible. (If the company grows beyond 100 employees, the employer may keep the Plan in place until they have 200 employees)</li> <li>• The employer must either: <ul style="list-style-type: none"> <li>○ Make a minimum matching contribution to participating employees, or</li> <li>○ Make a minimum non-elective contribution on behalf of each eligible employee</li> </ul> </li> </ul> <p>See the section on SIMPLE Cafeteria Plans for more information.</p>	<p>The benefit to the employer is:</p> <ul style="list-style-type: none"> <li>• The employer no longer needs to complete a Form 5500</li> <li>• The plan is deemed to meet the nondiscrimination rules applicable to: <ul style="list-style-type: none"> <li>○ Group term life insurance</li> <li>○ Self-insured medical coverage</li> <li>○ Dependent care assistance</li> </ul> </li> <li>• The highly-compensated employees may fully participate in the Plan.</li> </ul>
<p><b>New Federal Tax on Health Premiums:</b> A new federal tax equal to \$2 per enrollee (per year) will be used to fund research related to best treatments from a quality perspective.</p>	

<b><i>New Law 2011</i></b>	<b><i>Comments</i></b>
<p><b>Long-Term Care Plan:</b> AKA the Community Living Assistance Services and Supports (CLASS Act). PPACA creates a new publicly administered, voluntary long-term care program and requires all employers to enroll employees under an automatic enrollment arrangement, unless the employee elects to opt out.</p> <p>Eligible employed individuals can enroll in the program and would not be subject to underwriting and could therefore enroll regardless of pre-existing conditions.</p> <p>The benefit is administered like an automatic enrollment 401(k). Employees are enrolled unless they elect out.</p> <p>Employers can choose whether or not to participate.</p>	<p>Employees who enroll will not be eligible to receive benefits until after paying premiums for 5 years. This could be as a raw deal for the insured and the primary purpose of this plan was to add 5 years of premium contributions without any claim liability in order to make the reform bill appear more affordable. This Act is one of the most controversial provisions in PPACA and may be cancelled before it begins. For more on this see Long Term Care – The CLASS Act in the Table of Contents.</p>
<p><b>HSA Penalty Tax:</b> The penalty on distributions from an HSA account, that are not used to offset unreimbursed qualified medical expenses, increases from 10% to 20%.</p>	
<p><b>Wellness Grant Money:</b> A federal grant program for small employers providing wellness programs to their employees takes effect.</p>	<p>The new law authorizes \$200 million in grants from 2011 through 2015 to small employers that offer comprehensive workplace wellness programs. Contact us for more information.</p>
<p><b>Medical Loss Ratio Requirements:</b></p> <p>Beginning January 1, 2011 group plans must spend a minimum percent of premium revenue on clinical services and activities to improve health care quality.</p> <ul style="list-style-type: none"> <li>• For large-group plans (101 employees or more) the minimum percent is 85%.</li> <li>• For small-group plans and individual plans the minimum percent is 80%.</li> <li>• Federal and state taxes and licensing or regulatory fees are not considered in calculating the percent.</li> </ul>	<p>These provisions will be difficult to meet by high deductible health plans because administration as a percent of premium is necessarily higher. These plans may disappear from the market.</p> <p>Self-funded plans are not subject to this provision in the act. Regulations, when written, could change this.</p>

→ **EFFECTIVE 2012**

<i>New Law 2012</i>	<i>Comments</i>
<p><b>New Communication Requirements:</b> Imposes new requirements on employers related to communicating benefits to their employees.</p> <ul style="list-style-type: none"> <li>• At point of application</li> <li>• Upon enrollment or reenrollment</li> <li>• At policy delivery, and</li> <li>• Upon material modification to the plan.</li> </ul> <p>The summary and explanation can be provided electronically or in written form, and it must be no more than 4 pages in length with print no smaller than 12 point font written in a culturally linguistically appropriate manner. The summary must contain information about cost sharing, continuation of coverage and limitations on coverage.</p> <p>There is a \$1,000 per enrollee fine for willful failure to provide the information.</p>	<p>This is in addition to the SPD</p> <p>The Secretary of HHS is to issue a model summary by March 23, 2011 with plan administrator compliance required by March 23, 2012.</p>
<p><b>Issue 1099s for corporate service providers:</b></p> <p>Employers must provide an IRS Form 1099 to all corporate service providers receiving more than \$600 per year for services or property.</p>	<p>Currently, 1099s need only be generated for non-corporate service providers and only on services.</p>

→ **EFFECTIVE 2013**

<b><i>New Law 2013</i></b>	<b><i>Comments</i></b>
<p><b>Limit on FSA Contributions:</b></p> <p>FSA contributions are limited to \$2,500 per annum. Beginning 1/1/2014 the \$2,500 cap will be indexed to inflation.</p> <p>This impacts the Medical FSA only. Dependent care and other accounts remain unchanged.</p>	<p>The Cap is per individual. A husband and wife each working at two different companies may both partake in their company’s FSA Plan at the \$2,500 cap, potentially providing them with a total of \$5,000 in medical FSS contributions.</p>
<p><b>New Excise Taxes on Durable Medical Equipment:</b></p> <p>The new law imposes an excise tax of 2.9% on some durable medical devices. Importantly, the manufacturers can pass this increase in cost on to the consumers.</p>	<p>This tax will apply to sales occurring after 12/31/2012.</p>
<p><b>Employee Notification about SHOP Exchanges:</b></p> <p>In March, 2013, employers will need to begin notifying employees about state exchanges and the availability of premium subsidies and about free choice vouchers which will be available beginning in 2014</p>	<p>Effective no later than March 1, 2013, the law requires employers to:</p> <ul style="list-style-type: none"> <li>• Inform employees of the existence of an Exchange and the services it provides.</li> <li>• Inform employees if the employer contributes less than 60 percent of plan costs, and if so, that the employee may be eligible for a premium assistance tax credit and cost sharing reduction.</li> <li>• Inform employees that if they purchase a qualified health plan through the Exchange, the employee will lose the employer contribution, if any, to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for federal income tax purposes.</li> </ul>

<b><i>New Law 2013</i></b>	<b><i>Comments</i></b>
<p><b>New Fees on Employer Plans:</b></p> <p>Effective 2013 a fee will be assessed on employers with self-funded plans to fund a comparative effectiveness research agency. For employers with fully insured plans, the health insurer will be assessed the fee and employers will pay it indirectly.</p> <p>In 2013 the fee is \$1 times the average number of lives covered under the plan; for 2014 to 2019 the fee will be \$2 times the average number of covered lives. The fee ends on September 30, 2019.</p>	
<p><b>Additional Medicare Taxes:</b></p> <p>There will be an additional 0.9% Medicare tax imposed upon employees who have wages over \$200,000 (\$250,000 for joint tax filers).</p> <p>There will also be a new 3.8% Medicare tax imposed upon unearned income (interest, dividends, annuities, royalties and rents) for single taxpayers with income above \$200,000 (\$250,000 for joint tax filers).</p>	<p>Unearned income includes: interest, dividends, annuities, royalties and rents.</p>
<p><b>Elimination of Medicare Part D Subsidy Deduction:</b></p> <p>The act also eliminates an employer's tax deduction for the amount of the Medicare Part D retiree drug subsidy. In other words, the employer's allowable tax deduction for retiree prescription drug expenses must be reduced by the amount of the tax-free subsidy payment the employer receives. Although this provision does not go into effect in 2013, for companies subject to FASB4 rules, FASB 106 requires the immediate recognition of the loss of this future tax benefit.</p>	<p>This only affects employers who provide retiree prescription coverage.</p> <p>This is causing massive charges to corporate profits in 2010 and may influence some employers to end or reduce benefits for retirees.</p>

→ **EFFECTIVE 2014**

<b><i>New Law 2014</i></b>	<b><i>Comments</i></b>
<p><b>Pre-existing Conditions:</b> Remove Pre-existing Conditions on all members on all plans.</p>	<p>H.R. 4872 tweaked this language. Plans can impose a pre-existing condition exclusion only if the exclusion relates to a condition that was diagnosed or treated in the 30 days before the date of enrollment (Under HIPAA, this used to be 6 months). The exclusion can last no more than three months (Under HIPAA, this used to be 12 months). In the case of a late enrollee the exclusion may last for 9 months (Under HIPAA, this used to be 18 months). This certainly is more workable.</p>
<p><b>Guaranteed Issue:</b> All plans must be offered on a guaranteed issue basis.</p>	
<p><b>Cap on Waiting Periods:</b> Waiting periods of longer than 90 days are prohibited. Affects all plans. Grandfathering is not available.</p>	<p>Beginning with renewals effective 2/1/2013 employers should amend their waiting periods or at least confirm that their carrier will permit a mid-year change to the waiting period.</p>
<p><b>Establishes Minimum Coverage Requirements:</b></p> <ul style="list-style-type: none"> <li>• Mandated benefits</li> <li>• Cost-sharing requirements</li> <li>• Out-of-pocket limits</li> <li>• Actuarial value.</li> </ul> <p>Plans must offer five benefit levels: Bronze, Silver, Gold, Platinum and Young Adult. The Bronze coverage provides coverage that is actuarially equivalent to 60% of the essential health benefit package defined by your government. Silver coverage has a 70% actuarial value, gold coverage is 80%, Platinum coverage is 90%. Young Adult plans are catastrophic coverage only.</p>	

<b><i>New Law 2014</i></b>	<b><i>Comments</i></b>
<p><b>Catastrophic Coverage Exception:</b> Catastrophic coverage may be allowed for members under the age of 30</p>	<p>The thinking is that the young invincible may be more attracted to catastrophic coverage at a lower price.</p>
<p><b>Wellness Rewards Increased:</b> Employers can offer rewards equal to 30% of the cost of coverage to employees who participate in wellness programs.</p>	<p>Under HIPAA, an incentive was limited to 20% of the cost of coverage.</p>
<p><b>Expands Mental Health Parity and Addiction Equity Act</b> to groups under 50 employees and to individual health insurance coverage.</p>	
<p><b>State Purchasing Exchanges Begin:</b> State Exchanges, called the Small Business Health Options Program (SHOP), will be created for employers with 100 or fewer employees and for individuals to buy coverage.  Your employees may choose between your plan or plans directly from the Exchange.</p>	<p>States may reduce the requirement to purchase from the Exchange from 100 employees to 50 employees until 2016.  Beginning in 2017, states may choose to open the exchanges to employers with more than 100 employees.</p>
<p><b>Community Rating Standards:</b>  All fully insured individual and small groups up to 100 employees (and any larger groups purchasing coverage through the exchange) will have to abide by strict modified community rating standards.  Premium variations are allowed for age 3:1.  Premium variations are allowed for tobacco use 1.5:1  Premium variations are allowed for family composition and geographic regions to be defined by states.  Experience rating would be prohibited.  Wellness discounts are allowed for group plans under certain circumstances.</p>	<p>3:1 means that the highest rate for the oldest cohort may be no more than 3 times the rate of the youngest age cohort's rate. This rate structure may cause all carriers in the small group market to move to age banded rates. This is exactly what happened following California health reform in 1993. Although all carriers were permitted to offer composite rates. The fear of being selected against prevented carriers from doing so.  If this occurs, the oldest and most expensive cohort will almost certainly face a 40% excise tax on at least some of their health premiums. Legislators who supported the bill all claimed they read it and understood it. Was it the plan that the old and sick would pay the Cadillac tax? See page 20 "<b>Cadillac Plan Tax</b>".</p>

<b><i>New Law 2014</i></b>	<b><i>Comments</i></b>
<p><b>Free-Rider Penalties:</b> If an employer has 50 or more full-time employees (see definition P.2), then the employer may be subject to penalties under the law if it provides either:</p> <ol style="list-style-type: none"> <li>1) No health coverage to full-time employees, or</li> <li>2) Provides coverage to full-time employees that is not affordable.</li> </ol> <p>Employer offers no health coverage:</p> <ol style="list-style-type: none"> <li>1) Employers with more than 50 Full Time Equivalent Employees (FTEs) that do not offer “minimum essential coverage” will pay an annual \$2,000 “Free-Rider” penalty if even one employee opts to buy health insurance through one of the SHOP exchanges and receives a tax credit. The \$2,000 per employee penalty is not assessed on the first 30 full-time employees.</li> </ol> <p>Employer provides coverage that is not affordable:</p> <ol style="list-style-type: none"> <li>2) If the employer offers “minimum essential coverage” and an employee opts out of the plan and receives a premium tax credit or cost-sharing reduction because either: <ol style="list-style-type: none"> <li>A. the employee’s share of the premium exceeds 9.5% of the employee’s income, or</li> <li>B. the employer contributes less than 60% of the cost of the plan</li> </ol> <p>In this case, the employer will pay a penalty of \$3,000 for each person receiving a tax credit or \$750 for each full-time employee (whichever is less).</p> <p>Note: The employer will be notified by the exchange if the employee qualifies. The penalty is capped and cannot exceed the total penalty that would have been imposed had the employer offered employees no coverage. Penalties are assessed monthly.</p> <p>Employers with 50 or fewer employees are exempt from penalties.</p> </li> </ol>	<p>Additionally, employers must establish procedures to collect data from those employees who choose to opt out of coverage under your plans due to coverage available from another employer or other source.</p> <p>Each employee will have 3 choices:</p> <ol style="list-style-type: none"> <li>1) No coverage and face a tax penalty</li> <li>2) Take employer-sponsored coverage</li> <li>3) Buy coverage through an Exchange</li> </ol> <p>There is no certainty that an employee will choose the option that serves him/her best. This will be incomprehensible for most employees without help.</p> <p>We will be developing a calculator to help with your plan design and premium contribution strategy to minimize the possibility of penalties.</p> <p>While this exemption is a very broad exemption, you must count all employees including part-time employees (pro-rata) toward the 50 employee threshold.</p>

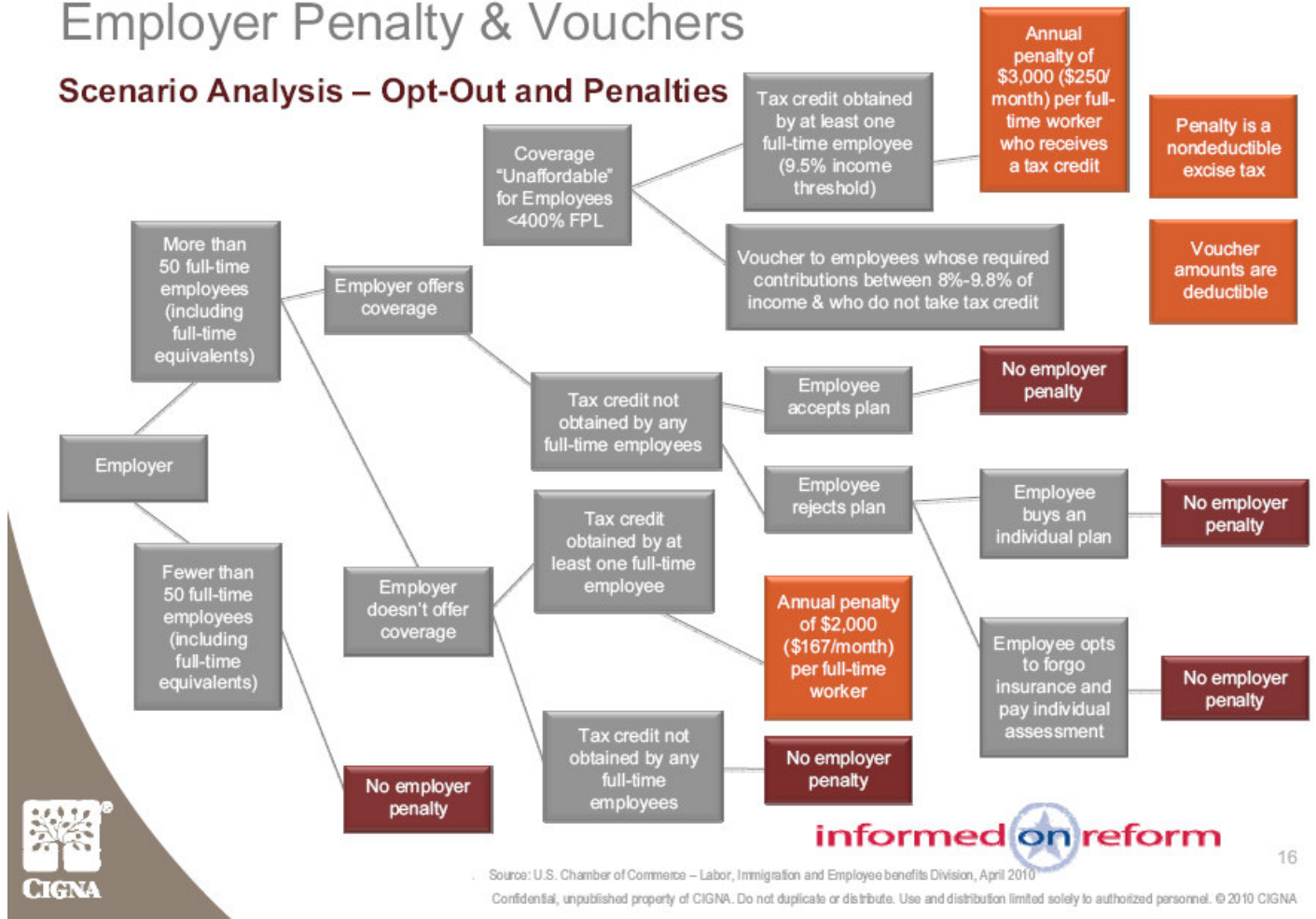
<b><i>New Law 2014</i></b>	<b><i>Comments</i></b>
<p><b>Free Choice Vouchers:</b></p> <p>There are conditions that must be satisfied before an employee is eligible for a free choice voucher. If the value of the free choice voucher exceeds the cost of health coverage for the employee who obtains exchange coverage, the excess funds must be paid to the employee. These apply to employers that:</p> <ol style="list-style-type: none"> <li>1) Offer health coverage and pay any portion of the cost of that coverage, and</li> <li>2) The employee's income falls below 400% of the federal poverty level, and</li> <li>3) The employee's share of premium is greater than between 8% and less than 9.8% of their income for qualifying coverage, and</li> <li>4) The employee does not participate in the employer's health plan.</li> </ol> <p>If these conditions are satisfied, the employer must pay to the exchange the value of what the employer would have paid toward the employee's cost of health coverage under the most expensive plan that the employer offers.</p>	<p>Effective January 1, 2014, any employer that offers group health coverage to its employees must provide a free choice voucher to employees with incomes less than 400% of the federal poverty level if the employee's share of the premium exceeds 8% (but is less than 9.8%) of his or her income and if the employee chooses to purchase a health insurance plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's most expensive plan.</p> <p>Any voucher amount in excess of the employee's cost must be paid to the employee in cash. Therefore, healthy employees and non-smokers are incentivized to choose low benefits in the exchange plus cash, worsening claim pools for high coverage plans.</p> <p>Younger employees working for employers who use composite rates are incentivized out of the employer's plan into the age-banded state pool, thus increasing the average age in the employer's plan. The employer's insured population may evolve older and sicker than otherwise would be the case. If this begins to happen, the exchange rates will become increasingly more competitive at the expense of employer-sponsored private plans.</p> <p>An employer that provides free choice vouchers will not be required to pay the free-rider fees described previously.</p> <p>The employer will need to decide which is best: 1) the free-rider penalty, 2) the cost of their own plan with adverse selection, or 3) higher employer contributions. We may also see an evolution into age-banded rates for plans of all sizes.</p> <p>The employer's payment to the exchange is based on the kind of coverage the employee purchases in the exchange (self only or family).</p>

<b><i>New Law 2014</i></b>	<b><i>Comments</i></b>
<p><b>Notices:</b> You will have to provide notice to employees that the Exchange exists, and where they can find more information about that.</p>	<p>This feature creates an additional administrative burden for employers.</p>
<p><b>Wellness Incentives:</b> You will be able to increase Wellness incentives to 30% of premiums. The HHS Secretary has the discretion to increase the incentives to 50% of premiums</p>	<p>Currently, federal guidelines indicate that an employer can differentiate premium rates up to 20% of the single rate based on an employee’s participation in a Wellness initiative; this significantly increases that differential. Of course, this may reduce employee contributions to the cost of the medical benefit.</p>
<p><b>The Individual Responsibility Mandate: Individuals must purchase insurance:</b> Individuals have the personal responsibility to obtain qualifying health coverage, with some exceptions.</p> <p>The Penalty: An individual without insurance must pay the following penalties:</p> <p>In 2014, the higher of \$95 or 1% of income.</p> <p>In 2015, the higher of \$325 or 2% of income.</p> <p>In 2016, the higher of \$695 or 2.5% of income and capped at the average “bronze” level insurance premium.</p> <p>Families will pay half the penalty for children, with a cap of \$2,085 per family.</p> <p>There will be exemptions for financial hardship and other circumstances.</p> <p>Subsidies to buy insurance in new state exchanges will be available in the form of refundable tax credits and cost-sharing assistance for people above Medicaid eligibility but below 400 percent of the federal poverty level. Medicaid eligibility will be increased to 133 percent of the federal poverty level.</p> <p>For Tax Credits, see supplemental Tables:</p>	<p>Individuals can meet their responsibility by enrolling in an employer- sponsored health plan, a government-sponsored health plan (such as Medicare, Medicaid, TRICARE, etc.), or a health plan in the exchange, if they meet the criteria to qualify to buy in the exchange.</p> <p>Individuals will have to provide coverage documentation to the IRS.</p> <p>Subsidies are only available if the individual purchases coverage from the exchange. Even though “You can keep your own insurance if you like it”, Grandfathered policies do not qualify for any subsidies.</p>

<i>New Law</i>	<i>Comments</i>
<p><b>Cadillac Plan Tax:</b></p> <p>The law imposes a 40% excise tax if a plan’s cost exceeds a threshold limit. The tax applies to costs exceeding the limit. The limits are:</p> <ul style="list-style-type: none"> <li>• \$10,200 Self-only</li> <li>• \$27,500 Family</li> </ul> <p>For individuals receiving retiree coverage at age 55 or over, or for an employee who participates in a plan for high-risk professions, the limits are:</p> <ul style="list-style-type: none"> <li>• \$11,850 Self-only</li> <li>• \$39,950 Family</li> <li>• Additional adjustments may be made for “high cost states”</li> <li>• Limits Indexed to CPI +1% in 2019 and by CPI thereafter</li> <li>• Limits include FSA, HSA &amp; HRA contributions, onsite clinics and wellness plans</li> <li>• Stand-alone dental, vision, disability, long-term care, life, AD&amp;D and after-tax indemnity or specific disease coverage premiums are not included</li> <li>• Union plans, who often use “super-composite” rates (a blend of employee only and family rates) are only subject to the Family thresholds.</li> </ul>	<p>Since this provision takes effect over seven years from now, one or more of your existing plans may be subject to this “Cadillac Plan” tax even if premiums today are far below the limits.</p> <p>Mandated benefit levels may be significantly richer and at a higher cost than your current plan.</p> <p>The guaranteed issue mandate with no exclusions for pre-existing conditions and other health reform changes will increase costs. Price Waterhouse Coopers estimated that health premiums will rise by 111% between 2009 and 2019 if the Senate reforms are implemented.</p> <p>If health care costs continue to rise at rates in excess of CPI, a larger portion of premium costs will be subject to tax.</p> <p>Coverage subject to this tax includes employee and employer contributions, whether pre-tax or after-tax.</p>
<p><b>Automatic Enrollment:</b></p> <p>Requires employers with more than 200 FTEs to automatically enroll all new full-time employees in the lowest cost plan that the employer offers, unless the employee affirmatively opts out or selects another plan.</p>	<p><b>Unknown effective date:</b></p> <p>The written notice must describe the employees’ option to enroll in a health care exchange, their eligibility for a premium tax credit and their forfeiture of any employer contribution to the employer-sponsored plan, if an employee chooses coverage through an exchange.</p>

# Employer Penalty & Vouchers

## Scenario Analysis – Opt-Out and Penalties



Source: U.S. Chamber of Commerce – Labor, Immigration and Employee benefits Division, April 2010  
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### End Notes:

Regardless of your position on the reform bill overall or its parts, the challenge now is to comply with the new law and understand how it will impact both employers and insured individuals.

To view a recorded webinar about health reform presented by Janet Trautwein, CEO of the National Association of Health Underwriters, follow this link:

Here you go - [http://www.nahu.org/corporatepartners/united\\_benefit\\_advisors/UBA.4.1.wmv](http://www.nahu.org/corporatepartners/united_benefit_advisors/UBA.4.1.wmv)

Slides for the webinar are located on our website at [www.cabenefits.com](http://www.cabenefits.com). Look on the resources / news tab.

## Supplemental Tables:

### Refusal to Purchase Health Coverage - Sample Annual Penalty Table

Household Income	2014 Penalty	2015 Penalty	2016 Penalty
\$10,830	\$108.30	\$325.00	\$695.00
\$21,660	\$216.60	\$433.20	\$695.00
\$32,490	\$324.90	\$649.80	\$812.25
\$43,320	\$433.20	\$866.40	\$1,083.00
\$55,125	\$551.25	\$1,102.50	\$1,378.13
\$66,150	\$661.50	\$1,323.00	\$1,653.75
\$77,175	\$771.75	\$1,543.50	\$1,929.38
\$88,200	\$882.00	\$1,764.00	\$2,205.00

### Low Income Premium Subsidy Tax Credit Table

The tax credit covers any *difference between* the actual cost of health insurance purchased through an Exchange and the maximum **monthly** premium cost noted below (based on the individual's household modified Adjusted Gross Income). Incomes representing levels of Federal Poverty Level are projected out to 2014 when premium subsidies become available.

% of FPL	Max. %	Single Income	Maximum Single Premium	Family of 4 Income	Maximum Family of 4 Premium
133%	3.00%	\$14,404	\$36.01	\$29,327	\$73.32
150%	4.00%	\$16,245	\$54.15	\$33,075	\$110.25
200%	6.30%	\$21,660	\$113.72	\$44,100	\$231.53
250%	8.05%	\$27,075	\$181.63	\$55,125	\$369.80
300%	9.50%	\$32,490	\$257.21	\$66,150	\$523.69
400%	9.50%	\$43,320	\$342.95	\$88,200	\$698.25

The premium credits will be provided as advanceable, refundable federal tax credits ultimately calculated through individual tax returns (although the credit payments will go directly to insurers). The credits can only be obtained by qualifying individuals who file tax returns.

Premium credits will only be available to individuals enrolled in a plan offered through an exchange. Individuals may enroll in a plan through their state's exchange if they are (1) residing in a state that established an exchange; (2) not incarcerated, except individuals in custody pending the disposition of charges; and (3) lawful residents.

Only lawful residents may obtain exchange coverage. Undocumented ("illegal") aliens will be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without any subsidy. Because

PPACA prohibits undocumented aliens from obtaining exchange coverage, they will therefore not be eligible for premium credits.

To be eligible for credits, an individual cannot be *eligible* for other acceptable coverage—that is, “minimum essential coverage,” defined as Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), coverage related to military service, an employer-sponsored plan, a grandfathered plan,<sup>8</sup> and other coverage recognized by the Secretary. An individual eligible for, but not enrolled in, an employer-sponsored plan may still be eligible for premium credits if the employer’s coverage is not “affordable”—that is, the employee’s contribution toward the employer’s lowest-cost self-only premiums would exceed 9.5% of household income<sup>9</sup>—or if the plan’s payments cover less than 60% of total allowed costs.

Eligibility for Medicaid as expanded under PPACA interacts with the provisions regarding premium credits for exchange coverage. From 2011 to 2013, states have the *option* to expand Medicaid to all nonelderly, non-pregnant individuals who are otherwise ineligible for Medicaid up to 133% FPL. Beginning in 2014, states with Medicaid programs will be *required* to extend Medicaid to these individuals. Thus, in 2014, all non-elderly *citizens* and certain legal aliens up to 133% FPL will be eligible for Medicaid. (If a person who applied for premium credits in an exchange was determined to be eligible for Medicaid, the exchange must have them enrolled in Medicaid.) When the credits become available in 2014, lawfully present taxpayers below 133% FPL who are not eligible for Medicaid may be eligible for premium credits. Neither premium credits nor full-benefit Medicaid will be available for individuals who are not lawfully present.

PPACA says premium credits are available to those whose income “exceeds 100 percent [FPL] but does not exceed 400 percent [FPL]...” PPACA then provides for lawfully present noncitizens who are at or below 100% FPL and who are not eligible for Medicaid to obtain premium credits.

### **Free Choice Voucher Qualification Table**

An employer that provides and contributes to health coverage for employees must provide free choice vouchers to each employee who is required to contribute between 8.0% and 9.8% of the employee's household income toward the cost of coverage, if:

- Such employee's household income is less than 400% of FPL and
- The employee does not enroll in a health plan sponsored by the employer.

The amount of the voucher must be equal to the amount the employer would have provided toward such employee's coverage (individual vs. family based on the coverage the employee elects through the Exchange) with respect to the plan to which the employer pays the largest portion of the cost.

% of FPL	Single Income	8.0% (Monthly)	9.8% (Monthly)	Family of 4 Income	8.0% (Monthly)	9.8% (Monthly)
100%	\$10,830	\$72.20	\$88.45	\$22,050	\$147.00	\$180.07
150%	\$16,245	\$108.30	\$132.67	\$33,075	\$220.50	\$270.11
200%	\$21,660	\$144.40	\$176.89	\$44,100	\$294.00	\$360.15
250%	\$27,075	\$180.50	\$211.11	\$55,125	\$367.50	\$450.19
300%	\$32,490	\$216.60	\$265.34	\$66,150	\$441.00	\$540.23
400%	\$43,320	\$288.80	\$353.78	\$88,200	\$588.00	\$720.29

## Collecting Your Small Business Tax Credit

The new law provides a tax credit to eligible small employers that provide health care coverage to their employees. The credit is temporary and begins this year (2010). IRS Notice 2010-44 provides detailed guidance on calculating the small employer tax credit.

**Eligible small employers:** In order to qualify for the tax credit:

- An employer must have fewer than 25 full-time equivalent employees (FTEs) for the tax year,
- The average annual wages of its employees for the year must be less than \$50,000 per FTE, *and*
- The employer must pay the premiums under a “qualifying arrangement”.

IRS has stated that tax exempt organizations are entitled to the credit, but must calculate the credit under special rules.

**Calculation of the credit:** Only premiums paid under a “qualifying arrangement” are eligible for the credit. To meet the “qualifying arrangement” rule, the employer must pay a uniform percentage (not less than 50 percent) of the total premium cost of the coverage. Fixed dollar contributions do not qualify.

*Eligible Premiums:* The credit is applied only to the portion of the premium paid by the employer. Premiums paid under a salary reduction arrangement under a Sec. 125 cafeteria plan is not treated as paid by the employer. IRS has announced that premiums paid in 2010, but before the new health reform legislation was enacted on March 23, 2010, may be counted in calculating the credit.

The amount of an employer’s premium payments that counts when calculating the credit may be less than the amount you paid. The premium that is eligible for the credit cannot exceed the average small group premium in the State or market in which you offer coverage. The Department of Health and Human Services (HHS) determines the amount and the IRS publishes the amount on its website. Search for IRS Revenue Ruling 2010-13.

The IRS has also confirmed that premiums for dental, vision and other limited-scope coverage are also eligible for the tax credit as long as the employer pays at least 50% of the premium.

*Maximum credit amount* - For tax years beginning in 2010 through 2013, the maximum credit is 35 percent of the employer’s eligible premium expense.

*Maximum credit for a tax-exempt qualified employer* - For tax years beginning in 2010 through 2013, the maximum credit for a tax-exempt qualified employer is 25 percent of the employer’s qualified premium expenses. In addition, the amount of the credit cannot exceed the total amount of income and Medicare tax the employer is required to withhold from employees’ wages for the year plus the employer share of Medicare tax on employees’ wages.

*Credit reductions for the # of FTEs* - If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise maximum eligible credit amount by a fraction. The numerator is the number of FTEs in excess of 10. The denominator is 15.

*Credit reductions for average wages* - If average annual wages exceed \$25,000, the reduction is determined by multiplying the otherwise maximum eligible credit amount by a fraction. The numerator is the amount by which average annual wages exceed \$25,000. The denominator is \$25,000.

*There are no reductions for state health care tax credits or subsidies*, if applicable in your state so long as the federal tax credit does not exceed the employer's net cost..

Subtract the results of each calculation from the otherwise applicable credit. For an employer with both more than 10 FTEs and average annual wages exceeding \$25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers even if they have fewer than 25 FTEs and average wages of less than \$50,000.

**Determining the number of FTEs:** The number of an employer's FTEs, is determined by dividing (1) the total hours for which the employer pays wages to employees during the year, (but not more than 2,080 hours for any employee) by 2,080. The result is rounded to the next lowest whole number. Because the limitation on the number of employees is based on FTEs, an employer with 25 or more employees could qualify for the credit if some of its employees work part-time. The employer may choose to base hours worked on actual hours worked or by using one of two approved alternative methods to estimate hours.

**How to determine the amount of average annual wages:** The average annual wages is determined by dividing the total wages paid by the employer to employees, during the employer's tax year, by the number of the employer's FTEs for the year. The result is rounded down to the nearest \$1,000. For this purpose, wages means wages as defined for FICA purposes (without regard to the wage base limitation).

**Disregarded workers:** *Seasonal workers* are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the tax year. *A sole proprietor, a partner in a partnership, a shareholder owning more than two percent of an S corporation and any owner of more than five percent of other businesses* are not considered employees for purposes of the credit. Thus, the wages or hours of these business owners and partners are not counted in determining either the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit. A family member of any of the business owners or partners member of such a business owner's or partner's household, is also not considered an employee for purposes of the credit. A family member is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

**Controlled groups:** Members of a controlled group (e.g., businesses with the same owners) or an affiliated service group (e.g., related businesses of which one performs services for the other) are treated as a single employer for purposes of the credit. Thus, for example, all employees of the controlled group or affiliated service group, and all wages paid to employees by the controlled group or affiliated service group, are counted in determining whether any member of the controlled group or affiliated service group is a qualified employer.

**Claiming the credit:** The credit is claimed on the employer's annual income tax return. IRS says it will provide further information on how tax exempt organizations are to claim the credit. An unused credit amount can generally be carried back 1 year and carried forward 20 years. An unused credit amount for 2010 can only be carried forward. IRS says that the credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules. For a tax-exempt employer, the credit is a

refundable credit, so that even if the employer has no taxable income, the employer may receive a refund so long as it does not exceed the income tax withholding and Medicare tax liability.

The employer can claim the credit for up to 6 years, 2010 – 2013 and for any two years after 2013.

**Effect on employer’s deduction for health insurance premiums:** In determining the employer’s deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

**Transition relief for tax years beginning in 2010:** IRS expects that transition relief will be provided for tax years beginning in 2010 to make it easier for taxpayers to meet the requirements for a qualifying arrangement. IRS says that guidance will provide that, for tax years beginning in 2010, an employer that pays at least 50 percent of the premium for each enrolled employee will not fail to maintain a qualifying arrangement merely because the employer does not pay a uniform percentage of the premium for each employee. Accordingly, if the employer otherwise satisfies the requirements for the credit, it will qualify for the credit even though the percentage of the premium it pays is not uniform for all such employees.

The requirement that the employer pay at least 50 percent of the premium for an employee applies to the premium for single (employee-only) coverage. Therefore, if the employee is receiving single coverage, the employer satisfies the 50 percent requirement if it pays at least 50 percent of the premium for that coverage. If the employee is receiving coverage that is more expensive than single coverage, the employer satisfies the 50 percent requirement if the employer pays an amount of the premium that is at least 50 percent of the premium for single coverage even if it is less than 50 percent of the premium for the coverage the employee is actually receiving.

#### **Characteristics of this tax credit include:**

CA average premiums cause disallowance of premiums for workers over age 40 on \$20 copay plans and over age 50 on others

CA average premiums cause disallowance of premiums on plans that include the more expensive clinics

CA average premiums cause disallowance of premiums at all age groups who have both spouse and one or more children

The credit is very complicated and expensive to calculate.

It may discourage employers from adding employees by lowering the tax credit for every full time equivalent employee over 10

It may discourage use of overtime as the tax credit reduces for average wages over \$25,000. Only the first 2080 hours worked per employee is used to calculate the number of full time equivalent employees. Total wages, including wages for time worked over 2080 hours, is used for purposes of calculating average wages.

Generates little or no extra tax credit for dental or vision unless the insured population for medical is significantly younger than average or the medical plan(s) is/are primarily low premium health plans

The HHS table of average costs for California are unrealistically low for the small group market. This may erroneously alarm employers that their premiums are not reasonable and possibly motivating benefit reductions or even eliminations in the case of dental and vision coverage

positive change. The tax credit penalizes employers if they hire more workers, promote workers or increase salaries.

For more information:

<http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6>

and

[http://images.magnetmail.net/images/clients/NAHU\\_2/attach/WH\\_NEW\\_GUIDANCE\\_ON\\_SMALL\\_BUSINESS\\_HEALTH\\_CARE\\_TAX\\_CREDIT.pdf](http://images.magnetmail.net/images/clients/NAHU_2/attach/WH_NEW_GUIDANCE_ON_SMALL_BUSINESS_HEALTH_CARE_TAX_CREDIT.pdf)

[http://images.magnetmail.net/images/clients/NAHU\\_2/attach/IRS\\_Small\\_Biz\\_Tax\\_Credit\\_Guidance\\_May\\_10.pdf](http://images.magnetmail.net/images/clients/NAHU_2/attach/IRS_Small_Biz_Tax_Credit_Guidance_May_10.pdf)

## New Nondiscrimination Requirements

### Expansion of Non-Discrimination Rules to Insured Benefits in the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) imposes a new requirement for fully insured health/medical plans. For plan years beginning on or after September 23, 2010, they must comply with nondiscrimination benefit rules that previously only applied to self-funded employer plans.

Rules provide that a plan cannot discriminate in favor of highly compensated individuals as to eligibility to participate. In addition, the benefits provided under the plan may not discriminate in favor of participants who are highly compensated individuals.<sup>1</sup> For purposes of these tests, highly compensated employees are the highest paid 25% of employees.

This does NOT apply to “grandfathered” health plans.

Though compliance regulations are expected from the Department of Labor, IRS and other federal agencies, rules similar to those for self-funded plans are expected to be applied to insured group health plans, including rules for eligibility, benefits and controlled groups. Violations of these requirements result in the taxation of some or all of the benefits provided to highly compensated individuals (Code section 105(h)(7)), and can also result in draconian tax penalties under the nonqualified deferred compensation rules of Code section 409A in the case of retiree benefits. Violations of these requirements result in the taxation of some or all of the benefits provided to highly compensated individuals (Code section 105(h)(7)), and can also result in draconian tax penalties under Code section 409A in the case of retiree benefits.

The law adds new section 2716 of the Public Health Service Act (“PHSA”), and also are incorporated into chapter 100 of the Code (the group health plan requirements) as new Code section 9815 and into the group health plan rules in part 7 of the Employee Retirement Income Security Act of 1974 (“ERISA”) as new ERISA section 715.

**It follows that violations of these new nondiscrimination rules will result in a \$100/day excise tax under Code section 4980D that applies to violations of the chapter 100 group health plan requirements.** As of January 1, 2010, there is a new reporting requirement (Form 8928) that requires an employer to report any violations of Code sec. 4980D and to pay associated excise tax to the IRS. Note, however, that there is a small employer exception under Code section 4980D(d), which provides that an employer who employs an average of 2-50 employees during the preceding calendar year is not liable for this tax. The ERISA remedial rules also would likely be available to participants (e.g., a participant might be able to sue to enjoin a plan from discriminating in favor of the highly paid).

Grandfathered plans are not subject to this new provision. Therefore, existing plans and policies that cover highly compensated individuals should not be considered discriminatory as long as they remain grandfathered.

#### **Non-Discrimination Rules and IRC Sec. 105(h) for Self-Insured Plans:**

Internal Revenue Code (IRC) Sec. 105 and Sec. 106 permit employers to offer certain health benefits on a tax-free basis. However, these rules can be different for highly compensated employees (HCEs) if the eligibility for benefits or benefits payable to the HCE is discriminatory. For purposes of IRC Sec. 105(h), an HCE (determined in the plan year for which the reimbursement was made) is:

- One of the five highest-paid officers;
- A shareholder owning (actually or constructively) more than 10 percent of the company’s stock;

- Among the highest paid 25 percent of all employees.

These requirements are not mutually exclusive. The five highest paid officers may also be among the highest paid 25% of all employees. However, if one of the top five officers is not in that pay range, that officer still needs to be included in the highly compensated individual category.

IRC Sec. 105(h) applies to all employment-based health plans (medical, dental and vision) in which the risk has not been shifted to an insurance company, including administrative services only (ASO) and cost-plus arrangements, possibly minimum premium plans and medical reimbursement plans provided through an IRC Sec. 125 plan (collectively referred to as “self-insured health plans”).

<sup>1</sup> Sec. 1001 of the PPACA as amended by Sec. 10101; new Sec. 2716 of the Public Health Service Act

If such a self-insured health plan discriminates in favor of HCEs, the affected HCEs must include some or all of the value of the benefits received in their taxable income. This imputed income is subject to federal income taxes (but not to Social Security or Medicare taxes) and state tax liability, if such liability is calculated pursuant to federal rules.

**Eligibility Test**—For a plan to be considered nondiscriminatory, with respect to eligibility to participate, it must pass one of the three coverage tests:

- 70 percent of all employees benefit under the plan;
- The plan benefits 80 percent of eligible employees and 70 percent of all employees are eligible;
- The plan benefits a nondiscriminatory classification of employees.

The IRS regulations indicate that the plan must provide the same benefits for both highly compensated and non-highly compensated employees. If a plan provides different benefits to different groups of employees (e.g., differences in waiting periods), each benefit structure is treated as a separate plan for purposes of the eligibility test described above.

A self-insured health plan discriminates as to benefits unless all benefits provided for participants who are HCEs are also provided to all other participants. All benefits for dependents of HCEs must also be available on the same basis for the dependents of all other employees. The self-insured health plan will also be considered discriminatory as to benefits if it covers HCEs and the type or amount of benefits subject to reimbursement is offered in proportion to compensation. The nondiscrimination test is applied to the benefits subject to reimbursement under the medical program and not to the actual payments or claims made. Further, a self-insured plan is not considered discriminatory just because HCEs utilize benefits to a greater extent than other participants.

If there are optional benefits available (e.g., vision and dental), these benefits will also be considered nondiscriminatory if all eligible employees can elect any of the benefits and either there is no required premium by the employee or the premium charged is the same for all employees.

Certain employees may be excluded from the eligibility tests, including:

- Those that have less than three years of service at the beginning of the plan year;
- Those that are younger than age 25 at the beginning of the plan year;
- Part-time or seasonal employees; Seasonal is defined as working less than 7 months per year;
- Those that are covered under a collective bargaining agreement;
- Nonresident aliens who receive no income from a U.S. source.

In addition to the eligibility rules, all benefits provided to highly compensated employees must be provided to all other participants.

Since the discrimination rules for self-funded plans were issued in 1980, employers have adopted fully insured plans to provide executives and key employees with tax-free reimbursements for out-of-pocket medical, dental and vision expenses. The new PPACA prohibitions against discrimination in fully insured plans will compel employers to consider other methods in compensating higher earning employees.

## New Employee Legal Rights Against Employers

The act creates new legal rights for employees to charge their employers with discrimination having to do with health benefits, based upon federal laws such as the Age Discrimination Act, the Rehabilitation Act, the Civil Rights Act, the Fair Labor Standards Act and others. The act's amendment of the Fair Labor Standards Act prohibits an employer from discriminating in any way against an employee who has received a premium subsidy or reduced cost-sharing under the act, while another provision protects individuals from discrimination in terms of exclusion from participation in or denial of benefits under any health program or activity.

These provisions also provide whistleblower protections for employees who provide information to or cooperate with federal or state government authorities concerning alleged violations of the act. These new rights apply regardless of whether the employer's health benefits plan is fully insured or self-funded.

## Long Term Care – The CLASS Act

“The Community Living Assistance Services and Supports (CLASS) Act is a provision in the new health care reform bill (Public Law 111-148) that provides a small cash benefit of \$50 – \$75 a day with a lifetime benefit period depending on the level of impairment (needing help with 2 Activities of Daily Living vs. 4 ADLs). It is proposed to be effective 1/1/2011 and all employees would pay through payroll deduction unless they opt out. Employers do not have to offer the plan.

**Effective Date:** The act takes effect Jan. 1, 2011, but the health and human services secretary has until October 2012 to present the full rules. Experts expect enrollment to begin in 2013 if the bill survives.

**Benefits:** After participation for at least 5 years, eligibility for benefits is based on the existence of a functional or cognitive impairment that lasts for at least 90 days and that is certified by a licensed health care practitioner. Benefits also vary based on the degree of the beneficiary’s functional or cognitive impairment. Benefit details are not yet available. The law says the average minimum benefit must be at least \$50 a day, indexed for inflation. Once you qualify, those benefits continue as long as you need care. Cash benefits may be deferred month to month but may not be rolled over from year to year. The plan also provides advocacy services, and advice and counseling services.

**Premiums:** Premium must be paid for at least five years before benefits could be claimed. Premiums are yet to be determined and will be based on keeping the program solvent throughout a 75 year period. Premiums are age banded with the youngest participants locking in very low rates. People who drop out for more than 90 days will have to re-enter at attained age. Even so, the premium can be recalculated in the future and rate increases applied except to enrollees who are age 65 and have paid premium for at least 20 years. PPACA includes premium subsidies for workers with incomes below the federal poverty level and full-time students aged 18-21 who are working.

The plan must be fully supported by premiums. Premium estimates by the CBO project a monthly premium in 2011 of \$123 per month with premiums for new enrollees increasing for inflation in later years. They based rates on an assumed participation rate of 3.5% which compares to a 4% participation rate in the current employer-sponsored private LTC insurance market.

CMS, However, estimates that the initial average premium would need to be about \$240 per month. Premium estimates from CMS are higher than CBO’s, largely reflecting assumptions about increased adverse selection and an assumed 2% participation rate. CMS states that:

in general, a voluntary, unsubsidized, and non-underwritten insurance program such as CLASS faces a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases.

The problem of adverse selection would be intensified by requiring participants to subsidize the \$5 premiums for students and low-income enrollees.

**Eligibility:** Those who are working and who are age 18 or older, including the self-employed are eligible. You are not eligible if you are already retired unless you continue to work part time. The unemployed and nonworking spouses are also not eligible. Part-time workers are eligible if they earn enough to pay Social Security taxes, approximately \$1,200.

What if you already have an illness or disability? You can still enroll, as long as you can work for three years and pay premiums for 5 years. You cannot be denied for pre-existing conditions. However, the plan has a 5 year waiting period for any benefit whether pre-existing or not.

**Tax Treatment:** Under PPACA, LTC insurance policies purchased through the CLASS program are treated for tax purposes similarly to current tax-qualified LTC insurance contracts. Under current law, benefits from a “qualified” LTC insurance policy are excluded from the gross income of the taxpayer (that is, they are exempt from taxation). The exclusion for LTC insurance benefits paid on a per diem or other periodic basis is limited to the greater of (1) \$280 a day (in 2009) or (2) the cost of LTC services. Employee contributions to LTC insurance premiums are not deductible except as itemized deductions to the extent they, and other unreimbursed medical expenses, exceed 7.5% (soon to be 10%) of adjusted gross income (AGI). Employer contributions, however, are not considered as taxable income to the employee. LTC insurance premiums are subject to age-adjusted limits. In 2009, these limits ranged annually from \$320 for persons aged 40 or younger to \$3,980 for persons over aged 70 and older. In addition, under current law, employer contributions toward the cost of tax-qualified LTC insurance policies are excluded from the gross income of the employee. Self-employed individuals are allowed to include LTC insurance premiums in calculating their deductions for health insurance expenses. Only amounts not exceeding the age-adjusted limits can be deducted or excluded from taxable income.

**What Critics Believe:** Critics believe that the plan will be underfunded and eventually will have to become tax subsidized. The plan could be subject to extreme adverse selection as healthy individuals can find coverage at competitive rates without a 5-year pre-existing condition exclusion and with better guarantees.

The head actuary at CMS thinks the participation will be only 2%.\* Most of them will likely be people who have health issues, which will drive up the number of claims which ultimately leads to the program being underfunded. Therefore I think it will fall way short of the revenue generator it is expected to be.

The Academy of Actuaries including the head actuary at CMS (the government branch that runs Medicare and Medicaid) thinks that the premium should be more like \$240 per month. “I just can't see employees accepting that much premium for so little benefit. We know how hard it is to educate employees to buy private long-term care insurance for much less premium than that and it doesn't look like there are dollars budgeted to educate the public at all. “

The concern about this program is two-fold: that it will cost much more than is projected and that it will lull Americans into a false sense of security that they are truly protected for long-term care. A \$50-\$75 a day benefit seems very small vs. current costs of \$150+ per day for 8 hours of home care, the cost of which could triple in the next 20 years.

An additional consideration for high income individuals is that if the plan becomes underfunded, Congress may solve the problem via means testing of benefits. There already is precedent for this in both Medicare and Social Security.

Participants have to pay into this plan for 5 years before they can collect benefits. For this 5-year period, **Congress looked at it as a revenue generator to help fund the overall health care reform bill** because it was designed to have no claims for 5 years. The expected surplus was estimated at \$70 Billion. It was necessary as a part of health reform to balance the finances to show that the health reform bill was fully funded.

\*Source: Richard Foster, Chief Actuary for CMS, 11-13-09 (p. 11) more at:  
<http://www.ltconsultants.com/articles/2010/classactposition/index.shtml>

Employers could offer a voluntary group long-term care plan as an option to CLASS Act coverage, assuming that when rules are issued doing so will remain permitted.

**Grandfathering:** The new law provides that, under very limited circumstances, an employer may continue to maintain the employer-sponsored health plan it had in effect on the date of the act's enactment (March 23, 2010), without having to comply with some of the otherwise mandatory benefit and other plan changes the act requires. Maintaining current coverage is called "grandfathering" in the act.

New Proposed Regulations have just been issued explaining how to maintain "Grandfathered" status. Look in the Table of Contents under "Grandfathered Plans".

Grandfathered plans will not have to comply with the following provisions of PACA:

- The requirement to offer preventive health benefits without cost sharing
- Coverage of adult children eligible for other employer-sponsored coverage
- Annual reports on health care quality and care coordination
- Prohibition against discrimination as to coverage, eligibility or contributions
- New internal and external review and appeals procedures
- Choice of participating specialists as PCPs
- No prior approval for or higher out-of-network cost sharing for emergencies
- No denials of pre-existing conditions for children (primarily applies to individual plans)

In addition, Grandfathered plans are exempt beginning 1/1/2014 from the following:

- Restriction of annual limits (individual coverage only)
- Plain language disclosure of data on health plans
- Review of premium increases
- Modified community rating
- Restrictions on annual out-of-pocket limits
- Cover clinical trials
- Guaranteed access/renewability rules

## New Taxes Summary

### *Additional Medicare Tax on Wages*

- **The new law imposes a new .9% Medicare surtax on earned income** over a threshold (Effective 1/1/2013); Specifically, PPACA would impose an additional payroll tax of 0.9% on high-income workers with wages over \$200,000 for single filers and \$250,000 for joint filers effective for taxable years after December 31, 2012. Married taxpayers filing separately are subject to a \$125,000 threshold. The additional payroll tax only applies to wages above these thresholds. Thus, the portion of the payroll tax will increase from 1.45% to 2.35% for wage income over the threshold amounts. Additional revenues from this provision are transferred to the Medicare Hospital Insurance Trust Fund (Part A). According to the JCT, the increase in the Medicare payroll tax is projected to raise \$86.8 billion over a 10-year period.

### *Additional Medicare Tax on Investment Income*

- Effective 1/1/2013 the bill imposes a tax equal to 3.8% of the *lesser* of (1) net investment income for such taxable year or (2) the excess of MAG over \$250,000 for joint filers (\$125,000 for married filing separately and \$200,000 for all other returns). It is important to note that if an individual has net investment income but does not have MAGI over these thresholds they will not pay the tax. Estimated taxes would be required to be paid to avoid penalties.

#### **The new law defines net investment income to be:**

- interest
- dividends
- non-qualified annuities
- royalties
- rents
- passive activity business income
- income from estates and trusts
- taxable net capital gains
- income from commodity trading
- Proceeds from the sale of a principal residence (subject to a partial exclusion from tax under current law).
- gains from the sale of a partnership interest or shares in an S corporation (only to the extent the assets had built in gains)

#### **The new law excludes from tax:**

- distributions from a qualified annuity from a pension plan
- The K-1 active income from trade for self-employed and S-corporations
- Tax-exempt interest

The investment income provision is projected to raise \$123.4 billion in revenues over a 10-year period.

#### **The tax on Home sales:**

a 3.8% tax on home sales, surrender of life insurance policies and annuities...

Middle-income people must pay the full tax even if they are "rich" only for one day - the day they sell their house and buy a new one. Homeowners with significant equity who are considering downsizing or who anticipate needing to move for health or other reasons should plan carefully.

## *Expiration of Bush Tax Cuts*

In 2003, the capital gains tax rates were reduced from 20% to 15%.

In 2003, “qualified dividend” tax rates were reduced from ordinary income tax rates to a 15% tax rate.

These lower rates will, absent any change, expire on December 31, 2010.

## *Modification to Tax-Advantaged Accounts*

- **Health FSAs will be limited to \$2,500 per year, beginning 1/1/2013.** FSAs are employer-established benefit plans that reimburse employees for specified health care expenses (e.g., deductibles, co-payments, and non-covered expenses) as they are incurred on a pre-tax basis. About one-third of workers in 2007 had access to an FSA. Currently, each employer may set their limits on FSA contributions. In 2008, the average FSA contribution was \$1,350. PPACA will limit the amount of annual FSA contributions to \$2,500 per FSA. According to JCT, this provision is projected to increase revenues by \$13 billion over 10 years.
- **HSA penalties for nonqualified distributions are increased from 10% to 20%.** HSAs are also tax-advantaged accounts that allow individuals to fund unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a pre-tax basis. Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan (with some exceptions). HSAs may be rolled over and the funds accumulated over time. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. While distributions that are not used for qualified medical expenses are taxable as ordinary income and, under current law, an additional 10% penalty tax is imposed for those under the age of 65. PPACA will raise this penalty on nonqualified distributions from 10% to 20% of the disbursed amount. According to the JCT, this provision would raise \$1.3 billion over 10 years.
- **The definition of qualified medical expenses are modified.** Under current law, qualified medical expenses for FSAs, HSAs, and HRAs can include over-the-counter medications. The bill restricts this practice and excludes over-the-counter medications (except those prescribed by a physician) as a qualified medical expense effective 1/1/2011. According to the JCT, this provision would increase revenues by \$5 billion over 10 years.
- **Reduces the deduction for medical expenses.** Currently, taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI). Medical expenses include health insurance premiums paid by the taxpayer, but also can include certain transportation and lodging expenses related to medical care as well as qualified long-term care costs, and long-term care premiums that do not exceed a certain amount. About 7% of tax returns for tax year 2007 reported a deduction for medical expenses. Taxpayers with AGI below \$50,000 accounted for 52% of those taking this itemized deduction for medical expenses. PPACA will increase the threshold to 10% of AGI for taxpayers who are under the age of 65, this effectively further limits the amount of medical expenses that can be deducted. Taxpayers over the age of 65 will be temporarily excluded from this provision and still be subject to the 7.5% limit from 2013 through 2016.

## *Additional Industry Taxes/Fees*

The new reform bill also contains new taxes or fees on certain sectors of the health care industry that add up to either a direct cost or a cost that will be passed through in form of higher health insurance rates. These are:

- **A new 40% tax on high-cost health insurance plans** – (plans costing more than \$10,200 for single coverage and \$27,500 for family coverage in 2018);
- **A new annual fee on pharmaceutical manufacturers** and importers of branded drugs, including biological products and excluding orphan drugs beginning in 2011;  
The fee structure will be based on annual sales and will be set to reach a certain revenue target each year. Annual revenues collected by the fee would total \$2.5 billion for 2011, \$2.8 billion per year for 2012 and 2013, \$3.0 billion for 2014 through 2016, \$4.0 billion for 2017, \$4.1 billion for 2018, and \$2.8 billion for 2019 and thereafter. PPACA specifies that these additional revenues should be transferred to the Federal Medicare Supplementary Insurance (Part B) Trust. Fund. According to the JCT, this fee is projected to raise \$27 billion over a 10-year period.
- **A new 2.9% excise tax on sales by medical device manufacturers**, producers and importers, beginning in 2013; This provision will exempt eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use. The tax will apply to sales made after December 31, 2012. According to the JCT, this excise tax is projected to raise \$20 billion over a 10-year period.
- **A new fee on health insurance providers** (estimated to add up to \$14.3 billion annually);  
PPACA will impose a fee on all health insurers based on their market share of net premiums written, which will be effective beginning in 2014. For example, there will be no fee on the first \$25 million of net premiums of covered entities. For net premiums greater than \$25 million and less than \$50 million, 50% will be taken into account, and 100% of net premiums written in excess of \$50 million will be subject to the fee. The fee will not apply to self-insured plans and federal, state, or other government entities. Only 50% of net premiums for tax exempt insurers will be taken into account when calculating the fee, giving them a cost advantage over for-profit entities. The law would also exempt Voluntary Employee Benefit Associations and nonprofit providers for whom more than 80% of revenues are received from public programs that target low-income, elderly, or disabled populations. The aggregate fee collected across all health insurers will equal \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. After 2018, the fee amount is indexed to the rate of growth in premiums. According to the JCT, this fee is projected to raise about \$60 billion over a 10-year period.
- **Limitation on Deduction for Executive Compensation of Health Insurers;**  
PPACA will impose limits on the amount of executive compensation that is deductible by health insurers. Specifically, health insurance providers where at least 25% of their gross premium income is derived from health insurance plans that meet the minimum creditable coverage requirements (i.e., covered health insurance provider) will not be able to deduct compensation above \$500,000 per year. This income threshold will include deferred compensation. This provision will be effective for compensation paid in taxable years beginning after 2012 with respect to services performed after 2009. According to the JCT, this limitation on executive compensation is projected to raise \$600 million over a 10-year period
- **Eliminate Employer Deduction for Retiree Prescription Drug Plans** Eligible for Federal Subsidy;  
Under current law, employers who provide their Medicare-eligible retirees with prescription drug coverage that meets or exceeds federal standards are eligible for subsidy payments from the federal government. The subsidies were equal to 28% of their actual spending for prescription drug cost in excess of \$250 and not to exceed \$5,000 (in 2006 dollars). These qualified retiree prescription drug plan subsidies are excluded from the employer's gross income for the purposes of corporate income tax. Employers are also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses. PPACA will require employers to coordinate the subsidy and

the deduction for retiree prescription drug coverage beginning in 2013. The amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received. According to the JCT, this provision is projected to raise \$4.5 billion over a 10-year period

Note: The information, opinion forecasts and estimates provided may change at any time and we do not plan to provide further notice to the recipients of this document. This document has been prepared solely for informational purposes and we are not proposing any particular strategy. This document does not address all areas of the new law. We have prepared it using sources of information we believe to be reliable but we cannot be certain as to its accuracy.

## Grandfathered Plans

All group health plans – whether or not they are grandfathered plans – must provide certain benefits to their customers for plan years starting on or after September 23, 2010. These include:

- Elimination of lifetime limits on coverage for all plans;
- Prohibition of rescissions of coverage except in the case of fraud or intentional misrepresentation (applies primarily to individual policies);
- Extension of parents' coverage to young adults under 26 years old;
- No coverage exclusions for children with pre-existing conditions;
- Elimination of "restricted" annual limits (e.g., annual dollar-amount limits on coverage below standards to be set in future regulations and effective 2014).
- Prohibition on excessive waiting periods (effective 2014)
- Prohibition of preexisting condition exclusion or other discrimination based on health status (effective 2014)
- Development and utilization of uniform explanation of coverage documents and standardized definitions (effective 2014)

The new law provides that, under very limited circumstances, an employer may continue to maintain the employer-sponsored health plan it had in effect on the date of the act's enactment (March 23, 2010), without having to comply with some of the new and otherwise mandatory changes the act requires. Maintaining current coverage is called "grandfathering" in the act.

Plans will lose their grandfathered status if they choose to make significant changes that reduce benefits or increase costs to consumers. If a plan loses its grandfathered status, then consumers in these plans must be provided all of the provisions called for in the PACA.

New Proposed Regulations issued June 14, 2010 explain how to maintain "Grandfathered" status. This may be important to Plan Sponsors and employees because grandfathered plans will not have to comply with the following provisions of PACA:

- The requirement to offer preventive health benefits without cost sharing
- Coverage of adult children eligible for other employer-sponsored coverage
- Annual reports on health care quality and care coordination
- Prohibition against discrimination as to coverage, eligibility or contributions
- New internal and external review and appeals procedures
- Choice of participating specialists as PCPs
- No prior approval for or higher out-of-network cost sharing for emergencies
- No denials of pre-existing conditions for children (primarily applies to individual plans)

In addition, Grandfathered plans are exempt beginning 1/1/2014 from the following:

- Restriction of annual limits (individual coverage only)
- Plain language disclosure of data on health plans
- Review of premium increases
- Modified community rating
- Restrictions on annual out-of-pocket limits
- Cover clinical trials
- Guaranteed access/renewability rules

## Maintaining Grandfathered Status:

In order to maintain “Grandfathered” status, plans cannot make significant changes that reduce benefits or increase costs to consumers. The determination is made separately with respect to each benefit package made available under a group health plan. Specifically, compared to their policies in effect on March 23, 2010, grandfathered plans:

- ❑ **Cannot Significantly Cut or Reduce Benefits.** For example, if a plan eliminates all or substantially all benefits to diagnose or treat a particular condition such as diabetes, cystic fibrosis or HIV/AIDS.
- ❑ **Cannot Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
- ❑ **Cannot Significantly Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor’s office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans will be able to increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15 percentage points. For example, if a plan raises its copayment from \$30 to \$50 over the next 2 years, it will lose its grandfathered status. Medical inflation is defined as the medical component of CPI-U.
- ❑ **Cannot Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15 percentage points. In recent years, medical costs have risen an average of 4-to-5% so this formula would allow deductibles to go up, for example, by 19-20% between 2010 and 2011, or by 23-25% between 2010 and 2012. For a family with a \$1,000 annual deductible, this would mean if they had a hike of \$190 or \$200 from 2010 to 2011, their plan could then increase the deductible again by another \$50 the following year.
- ❑ **Cannot Significantly Lower Employer Contributions.** Most employers pay a portion of their employees’ premium for insurance and this is usually deducted from their paychecks. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers’ share of premium from 15% to 25%).
- ❑ **Cannot Add or Tighten an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot tighten any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit (which is more protective of high-cost enrollees).
- ❑ **Cannot Change Insurance Companies.** If an employer decides to buy insurance for its workers from a different insurance company, this new insurer will not be considered a grandfathered plan, even if the benefits from the new insurance company are the same as the replaced plan and or the plan costs less to the employer and employees.

This does not apply when employers that provide their own (self-funded) insurance to their workers switch plan administrators. Plans provided under collective bargaining agreements get a special pass from this provision.

- ❑ Revoking a plan's grandfathered status if it forces consumers to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing as a means of avoiding new consumer protections; or
- ❑ Revoking a plan's grandfathered status if it is bought by or merges with another plan simply to avoid complying with the law.

**New Notice Requirements:**

The new regulation also adds the following requirements in order to maintain grandfathered status:

- ❑ Requires a plan to disclose to consumers every time it distributes materials whether the plan believes that it is a grandfathered plan within the meaning of section 1251 of the Affordable Care Act and therefore is not subject to some of the additional consumer protections of the Affordable Care Act. This allows consumers to understand the benefits of staying in a grandfathered plan or switching to a new plan. The plan must also provide contact information for enrollees to have their questions and complaints addressed;
- ❑ A plan must also maintain records documenting the terms of the plan that were in effect on 3/23/2010 and any other documents necessary to verify, its status as a grandfathered health plan. This could include:
  - certificates or contracts of insurance
  - documentation of premiums
  - documentation of required employee contribution rates

**Specifically Permitted Changes:**

Certain changes will not cause a plan or coverage to cease to be a grandfathered health plan. For example:

- Changes to premiums
- Changes to comply with Federal or State legal requirements
- Changes to voluntarily comply with provisions of the ACA (provided these changes are made without exceeding the standards required)
- Changing third party administrators
- Changes made pursuant to a good faith effort to comply prior to the date proposed regulations were issued

**Outstanding Questions About Other Items That May Trigger Loss of Grandfather Status:**

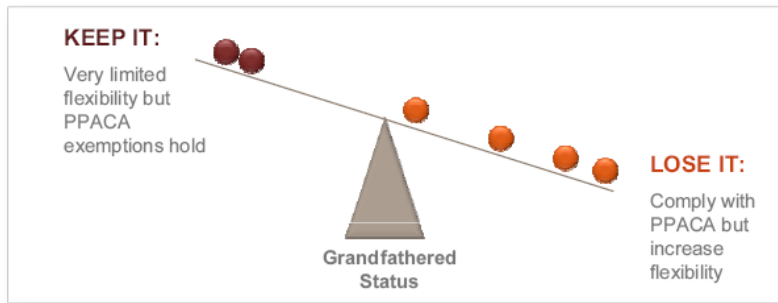
- Change in networks
- Change in formularies
- Change in funding arrangements

**You can keep your own health plan revisited:**

The DOL, IRS and HHS collectively estimate that worst case 80% of smaller plans will lose their grandfathered status by the end of 2013. The real number will be close to 100% and it will occur within 2 years. Any employer who does any of the following will lose grandfather status:

- Contributes a fixed premium contribution and cannot significantly increase it every year will
- Changes Carriers to save money
- Raises office visit copays more than \$5 (when only \$10 increments are sold)
- Stays with the same insurer who changes the plan designs that are offered
- Raises a deductible by more than 20% when only changes in excess of 20% are offered
- Raises coinsurance even when the out of pocket maximum does not change
- Lowers premium contributions even if it means saving jobs or the company
- Misses a notice requirement

“You can keep your own health plan.” Despite the rhetoric, it is not true due to practical realities. In the cold war years they called this propaganda.



<b>Grandfathering avoids the following near-term costs:</b>	
No cost-sharing on Preventive Care (if preventive care is not currently covered)	3% - 4%
Remove existing cost-sharing from preventive care	1% - 2%
Remove lifetime maximum	0.1% - 0.5%
Remove pre-existing for enrollees under 19	immaterial

## SIMPLE Cafeteria Plans – Effective for years beginning in 2011

Small employers, especially small employers with richer benefits for key employees, will want to take a close look at the new SIMPLE Cafeteria Plan.

Small employers are defined as any employer that employed on average 100 or fewer employees during either of the two preceding years, i.e. 2009 or 2010 for plans established in 2011. Once the plan is established the employer may maintain the plan as long as employment remains below an average of 200 employees in subsequent years.

Employers who establish a SIMPLE Cafeteria Plan is treated as meeting the nondiscrimination requirements of a classic cafeteria plan, including IRC Sections: 79(d) – group term life insurance, 105(h) – accident and health plans, 125(b) – cafeteria plan limitation for highly compensated and key employee participants, and 129(d)(2) – dependent care. Therefore, a SIMPLE Cafeteria Plan should pass testing if it offers all eligible employees the same benefits. Establishing a SIMPLE Cafeteria Plan also eliminates the need to perform discrimination testing and can avoid the time and expense of preparing a 5500 filing.

Prior to PPACA, insured health plans did not have to meet nondiscrimination tests. UNDER PPACA insured health plans must meet the Section 105(h) nondiscrimination tests that previously only applied to self-insured plans. (See the separate section on the new Section 105(h) discrimination testing requirements. By establishing a SIMPLE Cafeteria Plan employers may be able to provide discriminatory benefits for highly compensated and key employees (subject to some restrictions relating to contributions).

All eligible employees would enjoy the significant tax benefits of a cafeteria plan.

**Contribution requirements:** An employer who adopts a SIMPLE Cafeteria plan must make contributions to all eligible employees under one of two approved formulas:

1. a uniform percentage of the employee's compensation (not less than 2%) for the year, or
2. a "match" of 100% of an employee salary reduction contributions, but not more than 6% of the employee's compensation

Under option #2, the matching contribution rate may not be higher for any key employee or highly compensated employee than for any other employee. However, most employers are already contributing at least 2% of pay toward health benefits.

**Eligibility Requirements:** All employees who had at least 1,000 hours of service for the preceding plan year must be eligible to participate, and all employees must have uniform election rights under the plan.

Certain exclusions from eligibility are allowed. For example, employees who are under age 21 before the end of the plan year, employees who have less than one year of service with the employer as of any day during the plan year, employees who are covered under a collective bargaining agreement and certain other employees may be excluded.

As for owner employees, only regular C corporation employees may receive pre-tax benefits under the plan. Sole proprietors, partners of partnerships and 2% shareholders of S Corporations are not eligible.

**Qualified Employees:** The term “qualified employee” means any employee who is not a highly compensated employee or Key employee. The definitions of “highly compensated employee (HCE)” and “key employee” are consistent with the definitions under the classic cafeteria plan provisions.

The definition of a qualified employee is relevant only to the two alternative minimum contribution requirements. HCEs and key employees may participate like everyone else so long as they are “employees” and do not receive disproportionate employer regular or matching contributions.

## Opinion - Cost of health care and health insurance

Proponents of the new law have claimed that it will lower health care costs. Some provisions have the potential to deliver cost savings. Others will likely increase costs. A short discussion follows several of the provisions that will likely impact costs. You decide who is right.

### Provisions that increase costs

**SHOP Exchanges:** These are more likely to increase costs than to reduce them.

California has already experimented with this concept beginning in 1993. California health reform created the "Health Insurance Plan of California" (HIPC). Legislators believed that a purchasing pool (similar to the reform bill's exchange) would allow small employers to band together and negotiate better rates from insurers. The program was an immediate hit in the media. However, enrollment failed to develop due to lack of interest. The HIPC exchange suffered from higher costs than near identical benefit plans obtainable through guaranteed issue directly from the same insurers that participated in the HIPC. The exchange added another layer of cost to the purchase of health insurance without adding efficiency in an already competitive marketplace. By the time California's HIPC failed and was withdrawn from the marketplace, its premiums were generally 10%-20% higher than similar plans available direct.

The premise that the pool could offer savings is highly questionable. Negotiating a better deal implies either that the insurers have large profit margins that can be negotiated lower, or that the pool offers opportunities to reduce administrative cost. In a good year insurers margins are 4-5%, which is very low considering the risk and amount of capital that must be invested to administer plans and back guarantees. In a bad year an insurer can suffer enormous losses. For example, in 2002 (in just one year) Aetna lost 32% of its entire book value from making a misjudgment in its pricing assumptions. That 4% average profit is not waste in the system. It is a required cost to attract the capital required to fund guarantees and invest in efficiency. How much of that 4% could really be negotiated away?

It is true that larger groups have lower administrative cost than smaller groups. However, just calling thousands of smaller groups (each with their own plans, enrollments, billings and collections) one large group saves nothing. Although the new SHOP exchanges have not yet been created and there is no way to know how they will be structured, it looks like they will be modeled very closely to the HIPC model.

Helping to compensate will be slight lowering of administrative costs because plan designs will be more.

**Increased use of emergency facilities:** As the number of insured individuals swell without a corresponding increase in the number of physicians we would expect that the time you must wait for a physician office visit will lengthen. Residents of Massachusetts are experiencing this now, just shortly after passage of a state universal care initiative. Will more people access emergency rooms in order to be seen right away? This is already a problem. For example, at St. Joe's Hospital, a 431 bed nonprofit hospital in LA, 22% of emergency room visits are minor problems and less than 19% warrant an admission (Los Angeles Times 4/5/2010). The overuse is primarily a function of insured members not wanting to wait for an office visit and insurance plans that pay almost all the cost.

**Increased cost shifting:** The new law will increase the number of people covered under MediCal. Because the government health program for the poor pays less than private insurers (approximately 50% of the cost of delivering the care) providers will be pressured to make up losses. While some reimbursement is better than none, as in the case for the uninsured, many of these new MediCal patients may come from the population that is now insured on private plans. To the extent this happens, providers will need to increase prices to private insurers to make up the difference. This "cost-shifting" is already estimated to be \$150 per month per insured individual in the U.S. before health reform.

**Increase in Free-Riding:** The new law is clear, an insurer cannot limit coverage for pre-existing conditions and after regulations are issued, cannot deny coverage for children under age 19. It is also clear that now you can wait to buy insurance until you have known large claims. Coverage for children is very low, especially in the individual market because prior to the new law, when your insured child becomes sick the cost of care is spread over a large population of children who qualified for coverage and have low average costs. After health reform there will be large numbers of high-cost children immediately entering the claim pool, and the high average cost of these children will cause premiums to immediately climb. Of course covering children is important and we are not heartless. Maybe there was a good reason why parents don't buy insurance for their children while they are healthy. But many cash-strapped parents may be even more tempted to delay the purchase of coverage for healthy children knowing they now have guaranteed access. If this happens, it will cause rates to rise ever higher causing more and more parents to be unable to pay the required rates. It can begin an endless cycle that causes rate increases to accelerate until no one can afford coverage.

Requiring that all Americans purchase insurance solves this problem. Unfortunately this new law will not accomplish this. The penalties are so low that vast numbers of individuals will forego insurance because the penalty is far cheaper. See the supplemental tables for more information on this. In addition there are exceptions to the individual responsibility rules for vast numbers of people. For example, illegal immigrants, individuals with income low enough that they are not required to file an income tax return (42% of the U.S. population by some estimates), members of Indian tribes or those whose premium would exceed a specified share of their income (initially 8% in 2014 and indexed over time). Individuals may also be granted waivers from the penalty because of hardship or on the basis of religious beliefs.

Some years ago, the state of New York adopted regulations similar to health reform that required insurers to offer guaranteed issue and permitted only a very limited pre-existing exclusion period. As of January, 2010, the following table illustrates rates in Albany County for an HMO in the individual market. Even if you are young and healthy, the rates below apply. Rapidly increasing rates have made these plans unreachable by most individuals. It is reasonable to expect that the New York experience will become the experience of the Nation. By comparison, the January rate for a Californian under age 30 is about \$280.

	Capital District Physician's Health Plan	GHI HMO Select	MVP Health Plan	Empire Blue Cross	Blue Shield
Individual	\$858	\$2,000	\$1,062	\$877	\$1,295
Family	\$2,230	\$5,101	\$2,973	\$2,632	\$3,368

**PricewaterhouseCoopers** estimated that because of specific provisions, the cost of private health insurance coverage will increase:

- 26% between 2009 and 2013 under the current system and by 40% during this same period if the Senate reforms are implemented
- 50% between 2009 and 2016 under the current system and by 73% during this same period if the Senate reforms are implemented
- 79% between 2009 and 2019 under the current system and by 111% during this same period if the Senate reforms are implemented

The specific provisions are:

- Insurance market reforms coupled with a weak coverage requirement
- A new tax on high-cost health care plans (and as costs rise, more plans become subject to tax)
- Cost-shifting as a result of additional cuts to Medicare, (does not include cost shifting from additional Medicare members) and
- New taxes on several health care sectors

The individual responsibility mandate is supposed to impose a penalty such that individuals who are healthy and are presently uninsured will choose to enroll for insurance rather than pay the penalty. Would a \$95 penalty in 2014 motivate an otherwise healthy and uninsured person to enroll at the premium levels such as exist today, let alone if they rise to the levels in New York?

**Cost – Plus:** The new law requires that insurers must spend 85% of premium revenue on direct medical care (80% for individuals and small groups). This approach transforms the health insurance market from a competitive market mechanism to a cost-plus mechanism. With cost-plus, the more an insurer spends on care, the more it can collect for its markup. The need to control medical spending now becomes less interesting for insurers. The ability to offer plans with high deductibles where administration is necessarily a higher percentage of the premium becomes more difficult or impossible.

On the other hand, investments that insurers can make to increase efficiency, reduce fraud and improve outcomes in order to lower future costs are now more difficult because if the insurer exceeds the 15% administrative threshold, they must refund the difference to consumers. Investments in service could suffer for the same reason. Only rising medical spending enables more to be invested or spent on services.

**Community rates:** Under community rating, everyone pays the same price no matter the quantity or expense of services consumed. The problem here is similar to going out to dinner as a party of 10 and everyone agrees in advance to just split the bill. You could order lobster costing \$50 or chicken costing \$25, but, under this scenario the lobster costs you only \$5 vs. \$2.50 for the chicken because you are splitting the bill with 9 others. The problem is that almost everyone will do the same thing. The economic decision has now changed. In healthcare, the lower the patient's cost relative to the actual cost of care, the more care will be demanded, even if it is not necessary. Before health reform, employers cared about waste in the system because it directly affected their rates. Now it makes no difference at all. Expect that employers with no stake will make less effort to control costs. After all how can you get any credit for your effort? Likewise, patients now have little stake in the costs. Benefits will be mandated to relatively high levels, employers will bear the lion's share of the cost and utilization of services to the extent that it impacts costs will be diluted over millions of people making individual economic decisions pointless.

**New Taxes:** New taxes on drug companies, device makers and insurers begin in 2012. These must be passed along directly to consumers and insurance plans in the form of higher prices to cover the added cost.

**Increased benefits:** No lifetime limits, no internal limits, increased preventive and minimum medical benefits must be paid for with higher premiums. Although coverage will be better when illness or injury arises, the fixed monthly cost will increase. Evidence suggests that even for most preventive services, increased utilization leads to higher, not lower, medical spending.

**Expanded eligibility for children:** Increase in age of eligible dependents will be welcomed by parents with adult children who are not yet independent. It will increase the cost of dependent coverage.

**Regulation:** What is the cost of writing, communicating, reading and complying with the potential 3 million pages of new regulation?

**Employee Advice:** The rules are so complex they will be incomprehensible to many employees. Those employees may make poor decisions which will cost them more and end up causing vast fines for the employer. Employers may need to spend more on communication and possibly individual advice.

**Reporting:** The law will require employers to annually report to the IRS a number of pieces of data, including:

- Whether the employer offers minimum essential coverage to full-time employees;
- Any waiting period for health coverage;
- The monthly premium for the lowest cost option in each enrollment category under the plan;
- The employer's share of the total allowed cost of benefits provided under the plan
- The number of full-time employees covered and not covered month by month
- The name, address and taxpayer identification number of each full-time employee, and the months each employee was covered under the employer's plan, and
- Such other information as the Health and Human Services (HHS) Secretary may require.

**Eligibility:** The law excludes benefits for undocumented workers, thus significantly lowering the cost of the law. The CBO cost estimates are based on this presumption.

It is possible that many undocumented workers will soon become legal and flow into the pool of covered and heavily subsidized workers. If current attempts in Congress are successful, costs will rise significantly. The following link directs you to a CBS news report on the topic.

<http://d.yimg.com/kg/groups/17260182/1610997888/name/ftc-vi26.wmv>

## Provisions that could reduce costs

**Wellness:** The new law includes many provisions intended to address preventable health conditions. Chain restaurants with 20 or more locations will have to provide a calorie count and nutrition information for each standard menu item. Customers may also request a listing of the amount of fat, cholesterol, sodium, carbohydrates and protein in menu items. In New York City where similar regulations have been enacted, consumers appear to be choosing lower-calorie foods, some restaurants have changed their menu offerings, shrinking portion sizes and reducing the fat in pastries or substituting low-fat milk for cream. About 15% of people who come in to chain restaurants say the calorie information makes a difference in their purchasing decisions (NY Times April 4, 2010).

Employers with 50 or more employees must provide "reasonable break time" for nursing mothers to express or pump breast milk. Research shows that children who are breastfed are less likely to be susceptible to illness such as asthma, diabetes and obesity.

Health insurance companies will have to provide recommended screenings, preventive care and vaccines without cost to the consumer.

Medicare beneficiaries will get free annual physicals. Each Medicare beneficiary will be entitled to an "annual wellness visit," in which a doctor can assess the patient's condition, check for signs of Alzheimer's disease and draw up a personalized prevention plan with a screening schedule.

Medicaid will cover drugs and counseling to help pregnant women stop smoking.

A new federal trust fund will reimburse up to \$5 billion over 5 years for more bicycle paths, playgrounds, sidewalks and hiking trails. Supporters claimed this spending could keep people out of hospitals and cut health costs. Many, including the CBO, are skeptical.

There is a great body of evidence that supports the claim that investing in wellness can dramatically lower claims costs. The bill liberalizes rules for wellness plan design and begins a grant program to help small employers establish wellness plans. Insurers can discount rates for participants.

## Opinion – Medical Loss Ratios

### Janet Trautwein: With health care fixed, next Congress turns to kitchen appliances.

**By: Janet Trautwein**  
**OpEd Contributor**  
**April 6, 2010**

Congressional leaders just announced plans to address the mounting lack of affordability in the market for kitchen appliances. "Now that we're finished with healthcare reform, I'll introduce the Kitchen Appliance Affordability and Fairness Act of 2010," Sen. Jim Meddlesome, D-Nannystate, said this week.

The KAAFA would require all kitchen-appliance manufacturers to spend at least 85 percent of their revenues on materials -- not labor, marketing or infrastructure -- by 2014. Proponents of the measure claim that it will prevent profit-driven blender-makers from wasting money on administration and bloated executive salaries -- and thus lead to lower prices for ordinary consumers.

"The manufacturers of blenders and toasters have jacked up prices with impunity for far too long," said Meddlesome. "It's high time we put an end to their abusive practices."

Meddlesome's bill was inspired by a provision in the healthcare reform package that would require insurers to spend a certain percentage of their revenues on medical claims. Supporters of the KAAFA want to extend similar "minimum loss ratios" to the kitchen-appliance industry.

"Insurance companies and appliance-makers alike have devoted too much of their revenue to profit and administration," declared Meddlesome. "With these new rules, we're simply ensuring that every regular John Q. Cuisinart gets a fair deal."

Financial data on the two industries' profits seem to contradict Meddlesome's claims. According to Yahoo Finance, the insurance and appliance sectors are among the least profitable in the U.S. economy, with profit margins of just 4.4 percent and 1.9 percent -- good enough for 87th and 121st, respectively.

Representatives from BlenderCorp USA expressed dismay with the KAAFA proposal, saying that the company's current pricing structure would fall afoul of the law.

BlenderCorp's CEO explains: "Our mid-range blender retails for \$50. We use 75 percent of the sale price to pay for materials, 20 percent to pay for labor and marketing, and 5 percent for profit to fund research into our next wave of blending products.

"By forcing us to spend 85 percent of our revenues on materials, Congress is effectively mandating that we cut jobs, curtail research and development, raise prices -- or enact some combination of all three."

Economists predict that the new minimum-loss ratio would lead to waves of consolidation within the kitchen-appliance industry -- and even the outright failure of many companies.

"Many small manufacturers will not be able to establish the economies of scale necessary to comply with the new regulations," said Joseph Commonsense, a professor of finance at Faber College. "If these firms don't merge with one another, they'll simply go out of business."

Either way, predicts Commonsense, consumers will face fewer choices in the blender market. "The public will have to suffer through several rounds of price hikes -- first when the minimum loss ratios go into effect, and then again after the surviving blender makers capitalize on their lack of competition by jacking up rates," he said.

Meddlesome is undeterred by the prospect of newly expensive home appliances. "I don't care about the blender-makers' threats to raise prices," he said. "This is about taking a stand against greedy profiteering."

Ordinary Americans may pay the price for his crusade. Ironically, Congress's embrace of "minimum loss ratios" as a means of lowering the price of consumer goods seems poised to make blenders -- not to mention health insurance - - unaffordable.

*Janet Trautwein is CEO of the National Association of Health Underwriters.*

Read more at the Washington Examiner: <http://www.washingtonexaminer.com/opinion/columns/OpEd-Contributor/Janet-Trautwein-With-health-care-fixed-next-Congress-turns-to-kitchen-appliances-90001422.html#ixzz0IO4IA5ms>

## Opinion - The Future of Employer-sponsored Plans

**Employees may opt out of employer-sponsored coverage:** The new law permits plan members to leave their group health plan in order to buy coverage on a government-run health-insurance exchange. Members of grandfathered plans or plans that meet minimum benefit requirements will be ineligible to obtain coverage through an exchange. Exchanges could become operational under the law as early as July 1, 2012.

Members who pay less than 8% of their salary on employer-sponsored plan premiums will not be eligible to buy insurance on the exchange until 2014. If, however, an employer plan is deemed “unaffordable” (it costs 8% or more), employees may leave and buy insurance on the exchange, possibly receiving tax credits to do so. In other words, potentially, employees are paid by the federal government to opt out of the employer’s plan.

Employers would have to issue “free choice vouchers” to employees if worker premium shares exceed 8% but less than 9.8% of salary. Workers will use the vouchers to buy coverage on the exchange and vouchers will be equivalent to the employer contribution to the highest cost coverage offered to workers.

**Employers may opt out of employer-sponsored coverage:** Employers could terminate their health plans and instead pay a tax or fine.

Eventually, the cumulative effect of rigid requirements, administrative burdens and added complexity of sponsoring a plan will lead many employers to simply pay the fine rather than deal with it all.

Some employers will find it advantageous to not offer health insurance and just pay the \$2,000 penalty. In addition to the fact that the employer’s share of the cost of coverage may be higher than the penalty, some employers might welcome not having to administer the health benefit plans.

**The insurance market:** You can tell an insurer the rules they will need to play by, but, you can’t make an insurer stay in the healthcare industry. The insurance market will begin to shake up almost immediately. Insurers may decide that certain business lines are no longer attractive. Some will begin pulling out of the individual market, raising rates aggressively and curtailing services in advance of having to face unknown risks. Others who conclude that they cannot achieve the scale necessary to meet new requirements will begin to close or attempt to be acquired. The result is likely to result in an insurance market that has become worse, not better, with higher premiums and more Americans choosing to opt out rather than endure the higher costs and more limited options.

In the end, there may be only two places for consumers to get affordable coverage – through a large employer or union or through the new state-based exchanges that are heavily tax subsidized. Eventually, the federally sponsored exchanges will be the only option.

**The Public Option:** Fear of the public option was primarily due to the intention of government to use it as a way to crowd out private insurance and take over the market. It is possible that sponsors of the public option have still won their cause.

America’s largest companies, such as AT&T, Verizon and others, have already begun the discussion about dropping their employer-sponsored health plans. Follow this link.

[http://money.cnn.com/2010/05/05/news/companies/dropping\\_benefits.fortune/index.htm?cnn=yes&hpt=C2](http://money.cnn.com/2010/05/05/news/companies/dropping_benefits.fortune/index.htm?cnn=yes&hpt=C2)

## What Does Health Reform Mean for Retirement Plans?

- The employer provided benefit system is no longer voluntary. Most employers must offer health care or take a cash payment to the government. Could retirement plans be next?
- If cost of health insurance increases at projected rates under health reform, will both employer and employee resources available to fund retirement plans be diminished?
  - With employer contribution levels and higher health benefits mandated by law, the money may come from other forms of compensation (i.e. lower salary increases, or reductions in other employee benefits such as life insurance, disability insurance and retirement contributions.)
  - With higher health benefits along with higher costs mandated by law and diminishing salary increases and possibly reductions in other benefits will employees have the resources to increase retirement contributions or even maintain them?
  - The end result may be that increase health benefits will come from diminished retirement benefits.
- Early retirees may find relief in obtaining health care as the result of the exchanges, subsidies and the ban on preexisting conditions.
- The new Medicare tax on unearned income for high-income filers will not be assessed on distributions from qualified plans. That is good news, but, will it change in the future if revenues do not cover costs? Over the long run revenues will not cover costs. The bill is approximately revenue neutral over the first 10 years because taxes increase for 10 years while most benefit costs are for the last 6 years of the initial 10-year period.
- Will the new tax structure lead to an increase in small company plan formation because:
  - The expected higher income tax rates will increase the value of the tax deferral?
  - The expected increase in the tax rate on capital gains and dividends will narrow the tax advantage investing outside the plan has over investing in the plan and paying regular income tax rates on plan distributions?
  - The new tax on unearned income and the new increased hospital insurance tax on high wage earners may make a qualified plan more attractive since plan distributions will not be subject to these taxes?
  - Cash balance plans and defined benefit plans still provide significant opportunities for sheltering income on a favorable basis for small employers.

## What Will Health Reform Really Cost?

The Congressional Budget Office calculates that the health care reform bill will cost \$950 billion over the next 10 years. It also estimates that it will lower federal deficits by \$138 billion. Taxpayers are rightfully concerned about the credibility of the numbers and the consequence if they are wrong. Are they trustworthy?

The CBO is required to conduct their calculations based upon the legislation as written. They cannot second-guess the information they are presented with as to accuracy or plausibility. They must perform the calculations using the inputs as presented. Garbage in, garbage out as the saying goes.

N.Y. Times OP-ED contributor, Douglas Holtz-Eakin estimates that if you rework the calculations using realistic inputs, the health reform legislation would raise federal deficits by \$562 billion. The differences of opinion result from the following changes in inputs:

The health care bill front-loads revenues by beginning taxes and fees immediately. Spending called for in the bill is deferred for 4 full years. Therefore, there are 10 years of revenues paying for 6 years of benefit spending.

Some costs are left out entirely. To cover operations costs of the new programs over the first 10 years, future Congresses would need to vote for \$114 billion in additional annual spending. This so-called discretionary spending is excluded from the Congressional Budget Office's tabulation.

The Congress also jury-rigged the cost of the bill by assuming they will collect \$70 billion in Long Term Care premiums. You will recall that beginning 1/1/2011 employers will be required to default enroll employees into the government's new Long Term Care plan. Employees can opt out but the default enrollment will likely enroll huge numbers of people. However, the coverage is written to exclude all claims until you have been insured for at least 5 years. Therefore, the expected \$70 billion in premiums will be counted as deficit reduction. The legislation arbitrarily assumes there will be no costs in the first 10 years, so they appear nowhere in the cost of the legislation. It is certain that huge new unfunded liabilities will be accrued and all the premiums will have been spent.

Another wild manipulation of the numbers is a provision that would use \$53 billion in anticipated higher Social Security taxes to offset health care spending. Social Security revenues are expected to rise as employers shift from paying for tax-free health insurance to paying higher wages. This may or may not happen. But if workers have higher wages, they will also qualify for increased Social Security benefits when they retire. So the extra money raised from payroll taxes is already spoken for. It cannot legitimately be used for lowering the deficit.

A government takeover of all federally financed student loans — which obviously has nothing to do with health care — is rolled into the bill because it is expected to generate \$19 billion in deficit reduction.

And the most unbelievable of all, the CBO estimate assumes that the legislation to trim \$463 billion from Medicare spending. The plan is to use this money to finance the cost of promised insurance subsidies. Unfortunately, Medicare is already in the red and preceding Medicare provider payment cuts are responsible for the current \$150 per individual cost shift to private insurance. The health care bill has no reforms that would enable Medicare to operate more cheaply in the future. Congress is most likely to continue to do what it does every year when Medicare cuts come up and delay or waive scheduled cuts in payments to Medicare providers.

Add it all up and it looks like we are adding another half a \$ trillion to the deficit. After 10 years the numbers get rapidly much worse. Assuming new entitlement programs will be too difficult to eliminate, the inevitable result will be less for other programs such as meeting obligations due to the boomer generation from Social Security, education, national defense and other priorities.

## Revisions:

**April 22, 2010:** The Department of Health and Human Services released on April 22<sup>nd</sup> the "Estimated Financial Effects of the "Patient Protection and Affordability Act" as amended. The Office of the Actuary made the estimates. Their calculations estimate that net of any savings, the cost in excess of revenues is \$251 Billion over the first 10 years before considering the Federal cost of additional administrative expenses or potentially offsetting revenues from the Cadillac tax in years following 2018. You can find the full report here:

[http://johanns.senate.gov/public/?a=Files.Serve&File\\_id=1835930b-9e63-4300-89c7-9051c920d76a](http://johanns.senate.gov/public/?a=Files.Serve&File_id=1835930b-9e63-4300-89c7-9051c920d76a)

**5/11, 2010:** CBO: "The following analysis updates and expands upon the analysis of potential discretionary spending under PPACA that CBO provided on March 13, 2010... The study identifies \$105 Billion in costs not previously included in its analysis. This [new report](#), which was issued at the request of the ranking members of the House and Senate Appropriations Committees, Representative Jerry Lewis (R-CA) and Thad Cochran (R-MS), puts the official estimate as to how much the act will cost the American taxpayer over the next 10 years at over \$1 trillion.

CBO indicates that between \$10 billion and \$20 billion will be needed by various federal agencies on implementation costs (\$1 billion was appropriated by the original legislation for implementation) and about \$86 billion will be spent on funding ongoing programs, including grants to community health centers and Indian health care.

## The Experience of Massachusetts - A Preview to the future of U.S. medicine under PPACA

The top four health insurers in Massachusetts posted first-quarter (2010) losses of more than \$150 million. Most blamed the state's decision to forbid premium increases for individual and small-business policies, when they'd proposed double-digit rate increases to match the soaring costs they've seen under the state's universal-coverage law.

The companies have gone to court to challenge the state's action -- it apparently had no basis for its ruling beyond the political needs of Gov. Deval Patrick. If they win, Bay State health premiums will continue their rapid rise; if they lose, they'll eventually have to stop doing business in Massachusetts -- and the state will be that much closer to a "single payer" system of socialized medicine.

The Massachusetts "health reform" disease means more than just bureaucrats setting prices. It also includes rising government spending and taxes; politicians demonizing doctors, hospitals and insurers -- and patients getting lectured that the restrictions of managed care are good medicine.

It's what's in store for all of America. The Bay State's structure provided the base for Obama Care. "Basically, it's the same thing," says MIT economist Jonathan Gruber, who was a health adviser to GOP Gov. Mitt Romney and President Obama.

Like ObamaCare, RomneyCare includes a government-run exchange (the "Commonwealth Connector"), mandates and fines on individuals and fines on businesses. It expanded coverage mainly by expanding Medicaid. Of the 176,766 insured through the Connector, more than 152,000 are on subsidized plans, most paying nothing.

ObamaCare will follow suit. Richard Foster, chief actuary at the Centers for Medicare and Medicaid, reports that the law will add \$310 billion over 10 years to federal spending and put 18million more Americans on Medicaid. Another similarity: RomneyCare offered no real means to control and ultimately reduce costs. Its backers made airy promises of redirecting monies from state-sponsored charity care to insurance premiums, claiming that an insured

population would be healthier and save money. In fact, the state has begged Washington year after year for money to plug the system's gaps. In the program's first three years, the feds will have spent \$21.2 billion -- \$3,000 per Massachusetts resident.

Actually, ObamaCare's cost-control promises are even more fantastic -- from supposed slashing of Medicare payment rates to politically impossible "Cadillac" taxes. The only real cost control in either plan will be the brute force of government.

A Boston Globe story from earlier in the dispute over rate hikes says it all: "Two of the state's big health insurers face stiff fines after they submitted to the state revised premium rates for individuals and small businesses that differed from what regulators ordered." There's no such thing as a market where bureaucrats set the price. Yet that's what health care has become in Massachusetts under its reform.

"I don't know how much clearer we could have been with them," complained Massachusetts Insurance Commissioner Jack Murphy. He told the Globe: "We communicated four times what rates we expected. We're considering all options. At minimum, both will face significant fines and potentially other penalties."

When insurers then complained that they'd post losses, the Patrick administration lambasted them as "outrageous," "uninterested in alleviating escalating health-care costs" and "in love with the status quo." Government finally caring about the little guy? Hold your cheers -- because the inevitable next step is rationing at the point of consumption.

Massachusetts state Senate President Therese Murray has proposed putting an end to "fee for service" medicine in the next five years and moving to a system of capitated managed care, where doctors receive a flat fee for each assigned patient. This "HMOs for all" approach is designed to lead to soft rationing -- which, in medical terms, means people will have a hard time finding doctors or seeing the ones they have. It's already started. In Massachusetts, one doctor in two is not accepting new patients. Waits for treatment in Boston are the highest in the nation.

And Medicare's chief actuary predicts the same fate under ObamaCare. "It is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet," Richard Foster wrote in a recent report. Get ready, America: If nothing else, ObamaCare will put the patience back in being a patient.

Sally Pipes, president & CEO of the Pacific Research Institute, is the author of "The Top Ten Myths of American Health Care."

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## **The Experience of Germany - Jul 7, 2010**

To close a projected \$13.9 billion deficit in 2011, Chancellor Angela Merkel's government announced plans to raise health care premiums to 15.5% from 14.9% of workers' gross salaries and cut payments to doctors, hospitals and drugmakers. Germany's mandatory health insurance is struggling to cover costlier medical treatments and rising expenses costs tied to an aging population.

## Will Health Reform Deliver on its Promise to Cover More People?

A new report issued April 23<sup>rd</sup> by the Centers for Medicare & Medicaid Services (CMS) on the new health care reform law, estimated that 1.4 million fewer Americans will be enrolled in employer coverage as a result.

Early studies indicate that the total number covered will be higher. The report also concluded that seven million seniors would no longer be covered by Medicare Advantage and that the nation's health care spending would increase by \$331 billion over the next 10 years. Regarding the number of people to be covered by different insurance types, the CMS estimated that as of 2019, 164.5 million would have employer coverage under the new law, compared to 165.9 if the reform law had not been passed.

On the other hand, about 14 million people may lose employer-provided coverage due to a variety of reasons, including more low-wage workers moving to an expanded Medicaid program and some employers, especially smaller companies and those with low average salaries, being "inclined to terminate" coverage, the report said.

Representative Joe L. Barton of Texas, the senior Republican on the House Energy and Commerce Committee, said, "From a financial standpoint, from a purely economic standpoint, many companies would be better off discontinuing health care as a fringe benefit, paying the penalty and pocketing the savings."

The report also says that 23.1 million people will be uninsured in 2019 compared with 56.9 million had the legislation not passed.

The CMS concedes, however, that because the health reform measure will make substantial changes in the way Americans receive health care in coming years, any estimates come with an unusually high degree of uncertainty.