



# Health Reform Summary

## IMPACT ON SMALL BUSINESS

### OVERVIEW

The federal health reform legislation is made up of two parts: a bill that passed the Senate on Christmas Eve, passed the House on March 21, and was signed into law by the President on March 23, and a second piece of legislation: the House's reconciliation bill, which makes changes to the original law, passed both chambers on March 25, and was signed by the President on March 30.

Many of the provisions included in this legislation will not take effect for several years. At the earliest, provisions that affect employer-sponsored health plans will take effect six months from the date of enactment – in late September. Even then, those early provisions will not affect plans until they renew for the next plan year.

The health reform law has thousands of pages and hundreds of provisions. So it's important to remember that before many of those provisions are put in place, additional laws and regulations will need to be developed. That could be a lengthy process. Here are some highlights of the major provisions.

### SMALL BUSINESS TAX CREDITS

Beginning in 2010, small businesses with fewer than 25 employees and average wages of less than \$50,000 are eligible for a tax credit for their contributions to purchase health insurance for employees. The tax credit starts at up to 35 percent and increases to 50 percent in 2014 when the exchange is operational. The full tax credit (35%) is available to small businesses with 10 or fewer employees and average wages of less than \$25,000 per employee.

Details regarding these tax credits:

- Employers must pay at least 50% of the cost for Employee Only coverage to be eligible.
- Business owners and their family members/relatives do NOT COUNT in computing the number of employees or the average annual wages.
- Company contributions to the cost of health coverage for business owners/family members are not eligible for reimbursement under the tax credit.
- The amount of an employer's premium payments that counts for the purposes of the credit is capped by average premiums in their state for small group coverage.
- This tax credit offsets only an employer's actual federal income tax liability for the year. If the employer does not have a tax liability for the year, the unused tax credit can generally be carried forward for up to 20 years. It is not a REFUNDABLE CREDIT.
- The amount of the health premiums that can be deducted by the employer as business expenses is REDUCED by the amount of the credit.

To estimate the amount of tax credit your firm may be eligible for, first you must calculate the number of Full Time Equivalent employees (FTEs):

- Pro-rate part time employees based on 2,080 hours/year = 1 FTE, round down to the nearest whole number, seasonal workers are not included in this calculation.
- Not included in this calculation of FTEs are owners, defined as: sole proprietor, partner, 2% or more owner if employer is an S-corporation, a 5% or more owner of a C-corporation, and relatives and household members of the owners.
- Relatives that are not to be included as FTEs are: spouse, child, descendent of child, sibling or step-sibling, a parent or ancestor of parent, a step-parent, a niece or nephew, an aunt or uncle, a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law.



# Health Reform Summary

## IMPACT ON SMALL BUSINESS

Then, calculate the average wages for these employees:

- Calculate total wages for employees used in the FTE calculation
- Divide total wages by the number of FTEs and round down to the nearest \$1,000 to get average wages

Next, calculate employer health care contributions ONLY for those employees counted in the FTE calculation and verify the employer is paying at least 50% of the premiums for those employees.

If the FTEs are 10 or fewer and the average wage is \$25,000 or less, the employer is eligible for the full tax credit of 35% in tax years 2010 through 2013, and a 50% tax credit for the first two years of coverage offered on the state health insurance exchanges starting in 2014. If the number of FTEs is between 11 and 24, or the average wage is between \$25,000 and \$50,000 the amount of the tax credit is reduced proportionally.

See sample calculations below:

### Healthcare Tax Credit Calculation - Example 1:

Acme Steel Erection Company has 10 Employees and \$250,000 annual payroll (not including owners and family). If the company pays \$100,000 per year in health insurance premiums in total, and pays 70% of the cost of health insurance for these employees, their contribution to the employee's health insurance premiums is \$70,000 per year. Because they have 10 or less employees and average wages of \$25,000 or less, they are eligible for the full credit of 35%.

2010 Tax Credit for Acme: **\$24,500** credit (35% x \$70,000 – maximum available)

2014 Tax Credit for Acme: **\$35,000** credit (50% x \$70,000 – maximum available)

### Healthcare Tax Credit Calculation - Example 2:

Tri-State Erection Services has 12 full time employee equivalents and pays them an average wage of \$30,000. The company pays a total of \$120,000 in premiums for the year, and covers 80% of the employee costs, therefore they pay \$96,000 in health care premiums for their employee's coverage (assume this does not exceed the average small group premiums in the state).

### Tax Credit Calculations:

1. Initial amount of the FULL credit before reductions: (35% x 96,000) = **\$33,600**
2. Credit Reduction for FTEs over 10 ( 2 in this case, always divided by 15 in the calculation):  
 $\$33,600 \times 2/15 =$  **\$4,480**
3. Credit Reduction for average wages in excess of \$25,000 (\$5,000 in this case, always divided by \$25,000 in this calculation):  $\$33,600 \times \$5,000/\$25,000 =$  **\$6,720**
4. Add together to Calculate Total Credit Reductions: **\$4,480 + \$6,720 = \$11,200**
5. Total 2010 Tax Credit = **\$33,600 - \$11,200 = \$22,400**

Please note the health insurance premiums that may be taken into account when calculating the tax credit are limited to the AVERAGE premium for coverage in the state or rating area in which coverage is offered. The Department of Health and Human Services will publish these average premium amounts by the end of April, 2010.

We advise that you consult a tax professional to calculate the exact amount of the premium credit for your firm.



# Health Reform Summary

## IMPACT ON SMALL BUSINESS

### INDIVIDUAL RESPONSIBILITY

Starting in 2014, everyone must have qualifying health coverage or pay a penalty, which will be enforced by the Internal Revenue Service. The penalties will be phased in over time:

- In 2014, an individual without insurance must pay \$95 or 1% of their income, whichever is greater,
- In 2015, an individual without insurance must pay \$325 or 2% of their income, whichever is greater,
- For 2016 and beyond, that penalty rises to \$695 or 2.5% of income, whichever is greater (the \$695 is indexed from 2016 on).
- Families will pay half the penalty for uninsured children, with a cap of \$2,085 per family.
- There will be exemptions to this requirement, such as in cases of financial hardship and other limited circumstances.

Subsidies to buy insurance in new state exchanges will be available in the form of tax credits and cost-sharing assistance for people above Medicaid eligibility but below 400% of the federal poverty level. Medicaid eligibility will be increased to 133% of the federal poverty level (\$24,252 for a family of 3).

### EMPLOYER RESPONSIBILITY

#### *New employer penalties and obligations*

Starting in 2014, employers ARE NOT REQUIRED to offer their employees health insurance coverage, but most of them with more than 50 employees will pay an assessment if they don't, or if they offer coverage that isn't affordable. Full-time and part-time employees are included when determining whether an employer has 50 employees (based on current full-time employee equivalency rules).

- Employers with 50 or more employees that do not offer "minimum essential coverage" will pay \$2,000 for each employee over the first 30 employees if one of their employees gets a tax subsidy to buy insurance under an exchange.
- Employers with 50 or more employees that do offer minimum essential coverage but have at least one full-time employee receiving subsidized coverage under an exchange will pay whichever is less: \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee.

Employers with 50 or more FTEs must provide "free choice" vouchers to employees with incomes below 400% of the federal poverty level if the employee's contribution to coverage is between 8% and 9.8% of income and the employee chooses to purchase coverage in the exchange. No penalties will be imposed on employers with respect to employees who receive these vouchers.

#### *New employer reporting requirements*

Beginning in 2011, employers will be required to disclose the value of health care benefits on an employee's annual W-2.

Employers will be required to notify employees:

- About the availability of the exchange – for new employees, at the time of hiring; for current employees, by March 1, 2013;
- They may be eligible for a subsidy under the exchange if the employer's contribution to the plan is less than 60% of total allowed costs of the benefits;
- If the employee purchases coverage in the exchange, he or she will lose the employer's coverage contribution.



# Health Reform Summary

## IMPACT ON SMALL BUSINESS

### HEALTH PLAN CHANGES

Under the new law, employers/employees have the right to keep the coverage they had as of March 23, 2010 and are exempt from many reforms. These plans are considered “grandfathered plans.”

#### CHANGES IN 90 DAYS:

- **Internet portal.** By July 1, an Internet portal will be created for consumers and small businesses to shop for health insurance.
- **High-risk pool.** \$5 billion has been appropriated to create a temporary high-risk insurance pool to help adults with pre-existing conditions get coverage if they have been uninsured for at least six months. The program will be effective through 2013.
- **Reinsurance for early retirees.** A temporary reinsurance program will be established for employers providing coverage to early retirees over age 55 who are not eligible for Medicare. The federal government will provide \$5 billion to fund the program. Participating employers or insurers will be reimbursed 80 percent of retiree claims between \$15,000 and \$90,000. The program will be effective through 2013.

#### CHANGES WITHIN SIX MONTHS:

**Effective for new plans or plans renewed six months after the enactment date unless otherwise noted (includes “grandfathered plans”):**

- **Lifetime and annual limits.** Plans may not impose lifetime limits on the dollar value of essential benefits. Annual limits will be restricted (to be determined by HHS).
- **Rescissions.** No rescissions are permitted, except in cases of fraud or intentional material misrepresentation.
- **Coverage for adult children.** Children may stay on their parents’ policies until age 26 if coverage isn’t available through their work, regardless of their marital or student status. Any employer contribution toward the premium is a tax-deductible business expense for the employer and not taxable income for the employee.
- **Pre-existing conditions.** Plans may no longer impose pre-existing condition exclusions for children under 19.

**Effective for new plans or plans renewed six months after the enactment date (does not include “grandfathered plans”):**

- **Preventive services.** New policies must cover the full cost of preventive care as recommended by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children and adolescents, and additional preventive care for women.
- **Appeals.** New minimum requirements for internal and external claims appeals processes.
- **Patient protections.** Plans that require or provide for a primary care provider (PCP) designation must allow each member to designate any in-network PCP, or pediatrician for children, accepting new patients. Plans may no longer require an authorization or referral to an Ob-Gyn. Prior authorization or increased cost-sharing for emergency services is also prohibited.
- **Nondiscrimination rules.** Nondiscrimination rules that apply to self-funded health plans are expanded to group fully insured health plans. Plans cannot base an employee’s eligibility for coverage or continued eligibility on hourly or annual salary, job title, or position in the firm.



# Health Reform Summary

## *IMPACT ON SMALL BUSINESS*

### CHANGES IN 2011:

- **Medical loss ratio (MLR).** An insurer must publicly report on its MLR and spend at least 80 percent of small group premiums on medical services or provide rebate payments to enrollees.
- **Spending accounts.** Health savings accounts (HSAs) and flexible spending accounts (FSAs) may no longer be used to purchase over-the-counter drugs unless prescribed by a doctor. Increases tax for nonqualified HSA withdrawals from 10 percent to 20 percent, and for Archer MSA withdrawals from 15 percent to 20 percent.
- **HHS studies.** HHS is required to study the group health plan markets to compare employer characteristics and determine whether the new insurance market reforms are likely to cause adverse selection in the large group market or to encourage small and midsize employers to self-insure. HHS and the Department of Labor must also collect information on self-funded plans. These studies could lead to additional employer reporting requirements.
- **Uniform explanation of coverage.** Within 12 months of the law's enactment, HHS, in consultation with the National Association of Insurance Commissioners, will develop uniform standards and definitions for summaries of benefits and coverage explanations. Within 24 months of enactment, group health plans must provide enrollees and applicants with coverage documents that meet these standards.

### CHANGES IN 2013:

**FSA contributions limited.** Contributions to flexible spending accounts are limited to \$2,500 a year.

### CHANGES IN 2014:

The federal definition of a small employer is defined as an employer with 1-100 employees. States can modify the definition to 1-50 employees until January 1, 2016.

- **Pre-existing conditions.** Group and individual health plans can no longer impose pre-existing condition exclusions for any person of any age.
- **Annual limits.** Annual limits on essential health benefits are prohibited.
- **Guaranteed issue.** Health insurers must accept every group/individual who applies for coverage.
- **Rating restrictions.** Rating restrictions go into effect for new fully individual and small group plans. Insurance companies cannot base premiums on health status, claims experience or gender. Premiums can only vary by:
  - Age (no more than 3:1)
  - Geography
  - Family size
  - Tobacco use (no more than 1.5:1)
- **Merged markets.** States are allowed to merge the individual and small group markets.
- **Clinical trials.** Coverage of routine patient care costs is mandated for participation in approved clinical trials (does not apply to grandfathered plans).
- **Exchanges.** State health insurance exchanges are up and running for small businesses and individuals to buy insurance.
- **Cost-sharing limits.** Cost sharing (out-of-pocket limits) imposed under group health plans is limited to current health savings account amounts (\$5,950 for employee coverage/\$11,900 family)



# Health Reform Summary

## IMPACT ON SMALL BUSINESS

- **Essential benefits.** Essential benefit plan is created, which mandates the level of benefits that must be included in plans offered in the exchange, as well as in the individual and small group markets outside the exchange. Deductibles limited to \$2,000 for individuals and \$4,000 for families in the small group market (self-funded plans and grandfathered plans are exempt from this requirement).
- **Waiting periods.** New employee waiting periods cannot exceed 90 days.
- **Wellness.** Expands health plan wellness incentives up to 30 percent of total coverage costs (up to 50 percent with HHS approval).
- **Reinsurance.** A temporary reinsurance program will be established for the individual market and funded by individual and group health plan assessments (\$25 billion in 2014-2016).

### MEDICARE CHANGES

- **Part D donut hole.** Provides a \$250 rebate for Part D Medicare enrollees who enter the “donut hole” coverage gap (2010 only). Beginning in 2011, there will be a 50 percent brand discount on drugs in the gap. Members will pay less for generic drugs in the gap as well: 93 percent in 2011, which phases down to 25 percent by 2020. The donut hole is eliminated by 2020.
- **Retiree drug subsidy.** Beginning in 2013, employers may no longer deduct the retiree drug subsidy when offering qualified coverage under Medicare Part D.
- **Medicaid.** Beginning in 2014, states are required to provide premium assistance and wraparound benefits to any Medicaid beneficiary who is offered employer-sponsored coverage, if it is cost-effective to do so.
- **Medigap.** The National Association of Insurance Commissioners will create new model plans for benefit packages C and F that include nominal cost sharing. The new models will be available in 2015.

### REVENUE COLLECTION/TAXES TO PAY FOR HEALTH REFORM

- Starting July 1, 2010, impose a 10 percent tax on tanning services.
- Beginning in 2011, the pharmaceutical industry will pay annual industry fees. The fee will be phased in and will hold steady at \$2.8 billion a year after 2019.
- Beginning in 2013, manufacturers of medical devices will pay a 2.3 percent excise tax on sales of medical devices.
- Beginning in 2013, the Medicare payroll tax rate will increase by 0.9 percent for individuals who make more than \$200,000 and couples that make more than \$250,000.
- A new 3.8 percent tax will be added on income from interest, dividends, annuities, royalties and rents for those at the same income threshold.
- Beginning in 2014, a non-deductible premium tax will be imposed on insurers (\$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017 and \$14.3 billion in 2018. After that, it will increase in an amount proportional to overall premium growth).
- A new excise tax goes into effect for high-value, “Cadillac” health plans: 40 percent for amounts over \$10,200 for individuals and \$27,500 for family plans, paid by insurance companies and plan administrators.