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# Health-Care Reform





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## Health-Care Reform

The primary goals of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the 2010 health-care reform legislation) are to ensure that all Americans and legal residents have access to a minimum level of affordable health care, and to help contain the burgeoning costs of our health-care delivery system. The health-care reform legislation invokes a shared responsibility between both state and federal governments, as well as employers and individuals, to contribute toward those ends.

In general, the legislation mandates that most individuals have minimum health insurance. While employers are not required to offer health insurance to their employees, those that choose not to offer coverage may face a penalty. The legislation creates new public programs and expands Medicare and Medicaid to include more beneficiaries, while mandating that all health plans extend coverage to all individuals, regardless of health status. Revenue provisions are also included, not only to help fund the cost of these programs, but to extend the viability of Medicare.

### How does health-care reform affect individuals?

While some portions of the law become effective in 2010, other provisions are phased in over time. Nevertheless, it is almost certain that at least some of these reforms will have an effect on you and your family.

#### ***Changes to private health insurance***

The health-care reform law contains provisions that expand benefits, improve access to health care, and protect the rights of consumers. Here are some of the changes that will apply to most private health plans (although some will apply only to new, not existing, coverage).

- Plans must fully cover certain wellness and preventive care benefits (e.g., immunizations, cancer, diabetes, heart disease screenings, and smoking cessation programs)
- Plans can no longer charge more for out-of-network emergency care
- Plans can't impose lifetime limits on health coverage (annual limits will be gradually phased out, and will be fully phased out by 2014)
- Children can remain on a parent's health plan up to age 26
- Health coverage can't be rescinded due to illness (only for fraud or intentional misrepresentation)

#### ***Individual health insurance mandate***

By 2014, you'll be required to have health insurance or face a tax penalty (some exceptions apply). If you don't have insurance, or you've found coverage too expensive to obtain, the reforms may make it easier for you to get and keep health insurance. By 2014, insurers will have to accept you regardless of your health history, and premiums can only vary based on tobacco use and age, not on health status or gender. If you don't have access to affordable health insurance through an employer, you'll be able to purchase coverage through state-based American Health Benefit Exchanges. Premium and costsharing subsidies will be available to individuals and families with incomes at or below 400 percent of the Federal Poverty Level (FPL), which will help reduce the cost of insurance purchased through an exchange. In addition, Medicaid availability will be expanded to include nondisabled individuals under age 65 with incomes up to 133 percent of the FPL. Prior to 2014, if you're unable to get insurance for at least six months due to a pre-existing condition, you will be able to purchase insurance through temporary high-risk pools.



## Considerations for Seniors

The health-care reform legislation enacted in 2010 contains some provisions that directly affect our nation's older population. If you're a senior, you may be concerned about how these reforms could affect your access to health care and the benefits you are currently receiving.

### Medicare spending cuts

At the outset, the legislation does not affect Medicare's guaranteed benefits. However, two goals of the health-care legislation is to slow the increasing cost of Medicare premiums you pay, and to ensure that Medicare will not run out of funds. To help achieve these goals, some cuts in Medicare spending will occur over a ten-year period, beginning in 2011, particularly targeting Medicare Advantage programs--Medicare programs provided through private insurers but subsidized by the federal government. These cuts could reduce or eliminate some of the extra benefits your Medicare Advantage plan may offer, such as dental or vision care, and your insurer may choose to increase your premiums to offset the decrease in government reimbursements. But Medicare Advantage plans cannot reduce your primary Medicare benefits, nor can they impose deductibles and co-payments that are greater than what is allowed under the traditional Medicare program for comparable benefits. And, you may have access to more doctors because some of the federal funds previously earmarked for Medicare will be reallocated to doctors and surgeons as an incentive to treat Medicare patients.

### Medicare Part D drug program changes

If you're a Medicare Part D beneficiary, you have to pay for the entire cost of prescription drugs out-of-pocket after reaching a gap in your annual coverage, referred to as the "donut hole." In fact, you may pay up to an additional \$3,610, out-of-pocket, for medicines after reaching an initial threshold of \$2,830 in total prescription drug costs (including Part D

payments, beneficiary co-pays, and deductibles). But, in 2010, beneficiaries falling in the donut hole received a \$250 rebate, and, in 2011, these beneficiaries received a 50 percent discount on brand-name drugs. By 2020, a combination of federal subsidies and a reduction in co-payments will completely eliminate the donut hole. However, if your annual income is greater than \$85,000 (\$170,000 for couples), you will see your Part D premiums increase as the federal subsidy offsetting some of the cost of Medicare Part D premiums is reduced.

### Benefits added to Medicare

The legislation also improves some traditional Medicare benefits. For example, Medicare beneficiaries will receive free wellness and preventive care beginning in 2011.

### Increased access to home-based care

People facing a long-term disability or illness often prefer to receive care at home instead of at a hospital or nursing home. The health-care reform law provides for programs and incentives enabling greater access to in-home care. The Community First Choice Option is available for states to add to their Medicaid programs, beginning in 2011. This option provides benefits to Medicaid-eligible individuals for community-based care instead of placement in a nursing home. In addition, the State Balancing Incentive Program, also beginning in 2011, provides increased federal funds to qualifying states that offer Medicaid benefits to disabled individuals seeking long-term care services at home, or in the community, instead of in a nursing home. In an attempt to reduce costs associated with multiple emergency room visits and hospital readmissions for the same chronic illness, the Independence at Home demonstration program will provide Medicare beneficiaries with chronic conditions the opportunity to receive primary care services at home.




## Tax Changes for Individuals

The health-care reform legislation contained a number of tax changes. Some of these changes take effect immediately; others won't have an impact for a few years. Here's a year-by-year breakdown of some of the changes worth taking note of.

### Changes taking place in 2010

Bad news if you frequent tanning salons--there's a new 10 percent tax assessed on amounts paid for indoor tanning services after July 1, 2010.



***The health-care reform legislation contained a number of tax changes. Some of these changes take effect immediately; others won't have an impact for a few years.***

Bad news for adoptive parents, though--the maximum tax credit for qualified adoption expenses, and the maximum amount of employer-provided adoption assistance that can be excluded from income, each decrease from \$13,360 in 2011 to \$12,650 in 2012. The tax credit is also made refundable.

In addition, if you're covered by an employer health plan, the tax benefits (i.e., the ability to exclude the value of the benefits from income) associated with the health coverage and any reimbursements you receive for medical care expenses are extended to children who have not reached age 27 by the end of the year. Similarly, self-employed individuals can deduct the costs associated with health-care coverage for any child who doesn't reach age 27 by year-end.

### **2011 through 2013**

If you have a flexible spending arrangement (FSA), health reimbursement arrangement (HRA), health savings account (HSA), or Archer medical savings account (Archer MSA), it's important to note that, beginning in 2011, over-the-counter medications (except for insulin and medications that are prescribed by a physician) will no longer be considered qualified medical expenses for purposes of reimbursement and tax-free distributions. And, starting in 2011, the additional tax that applies to HSA and Archer MSA distributions that aren't made for qualifying expenses increases to 20 percent. In 2013, health FSAs that are part of a cafeteria plan will be capped at a \$2,500 reimbursement limit.

Do you itemize your deductions on Schedule A? For many, it's going to get a little more difficult in 2013, because unreimbursed medical expenses will be deductible on Schedule A only to the extent that they exceed 10 percent of adjusted gross income (AGI), instead of the 7.5 percent threshold that applies now. Until 2017, however, if you or your spouse turns age 65 before the end of the taxable year, the 7.5 percent AGI threshold will continue to apply. Beginning in 2017, the 10 percent AGI threshold will apply to individuals who have reached age 65 as well.

### **2013 Medicare taxes**

If you receive a paycheck, you probably have some familiarity with the Federal Insurance Contributions Act (FICA) employment tax; at the very least, you've probably seen the tax deducted on your paystub. The old age, survivors, and disability insurance (OASDI) portion of this FICA tax is equal to 6.2 percent

of covered wages (up to \$110,100 in 2012). The hospital insurance (HI) portion of the tax (commonly referred to as the Medicare payroll tax) is equal to 1.45 percent of covered wages, and is not subject to a wage cap. FICA tax is assessed on both employers and employees (that is, an employer is subject to the 6.2 percent OASDI tax and the 1.45 percent HI tax, and each employee is subject to the 6.2 percent OASDI tax and the 1.45 percent HI tax on wages as well), with employers responsible for collecting and remitting the employees' portions of the tax.

Self-employed individuals are responsible for paying an amount equivalent to the combined employer and employee rates on net self-employment income (12.4 percent OASDI tax on net self-employment income up to the taxable wage base, and 2.9 percent HI tax on all net self-employment income), but are able to take a deduction for one-half of self-employment taxes paid.

Beginning in 2013, the health-care reform legislation increases the HI tax on high-wage individuals by 0.9 percent (to 2.35 percent). Who will be subject to the additional tax? If you're married and file a joint federal income tax return, the additional HI tax will apply to the extent that the combined wages of you and your spouse exceed \$250,000. If you're married but file a separate return, the additional tax will apply to wages that exceed \$125,000. For everyone else, the threshold is \$200,000 of wages. So, in 2013, a single individual with wages of \$230,000 will owe HI tax at a rate of 1.45 percent on the first \$200,000 of wages, and HI tax at a rate of 2.35 percent on the remaining \$30,000 of wages for the year.

Employers will be responsible for collecting and remitting the additional tax on wages that exceed \$200,000. (Employers will not factor in the wages of a married employee's spouse.) You'll be responsible for the additional tax if the amount withheld from your wages is insufficient. The employer portion of the HI tax remains unchanged (at 1.45 percent).

If you're self-employed, the additional 0.9 percent tax applies to self-employment income that exceeds the dollar amounts above (reduced, though, by any wages subject to FICA tax). If you're self-employed, you won't be able to deduct any portion of the additional tax.

Also beginning in 2013, a new 3.8 percent Medicare contribution tax will be imposed on the unearned income of high-income individuals (the new tax is also imposed on



*A new premium assistance tax credit will help eligible individuals purchase health-care insurance through one of the newly established state exchanges.*

estates and trusts, although slightly different rules apply). The tax is equal to 3.8 percent of the lesser of your net investment income (generally, net income from interest, dividends, annuities, royalties and rents, and capital gains, as well as income from a business that is considered a passive activity or a business that trades financial instruments or commodities), or your modified adjusted gross income (basically, your adjusted gross income increased by any foreign earned income exclusion) that exceeds \$200,000 (\$250,000 if married filing a joint federal income tax return, \$125,000 if married filing a separate return).

So, effectively, you'll only be subject to the additional 3.8 percent tax if your adjusted gross income exceeds the dollar thresholds listed above. Interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence that are excluded from gross income are not considered net investment income for purposes of the additional tax. Qualified retirement plan and IRA distributions are also not considered investment income.

Together, these two new Medicare-related taxes are expected to provide a major source of revenue to finance other parts of health-care reform.

## **2014**

A new premium assistance tax credit will help eligible individuals purchase health-care insurance through one of the newly established state exchanges. If you qualify for the credit, it will be paid directly to the

exchange insurance plan that you join. Who qualifies? Individuals with household income between 100 percent and 400 percent of the federal poverty level will qualify, with the exact amount of the credit based on income level. Generally, individuals who are offered coverage through an employer health plan won't qualify for the credit unless the employer health plan doesn't cover an adequate share of benefits (60 percent), or it's considered "unaffordable" (the employee portion of the premium is 9.5 percent or more of the employee's household income).

In addition to a premium assistance tax credit, those with household income between 100 percent and 400 percent of the federal poverty level may qualify for a cost-sharing subsidy to help cover out-of-pocket costs, like co-payments and deductibles, when they buy health insurance through an exchange. Like the tax credit, the subsidy will be paid directly to the plan.

Beginning in 2014, if you're a U.S. citizen or legal resident, you'll generally be required to have adequate health-care coverage. If you don't, you'll face a penalty tax. In 2014, the tax will equal the greater of 1 percent of the amount of your household income that exceeds a specific amount (generally, the standard deduction plus personal exemption amounts you're entitled to for the year) or \$95 per uninsured adult (half that for uninsured family members under age 18), with a maximum household penalty of \$285. By 2016, the percentage rate increases to 2.5 percent, the dollar amount per uninsured adult increases to \$695, and the maximum household penalty increases to \$2,085.



**The new health-care reform legislation provides a tax credit to small businesses that offer health insurance coverage to their employees.**

## How Does Health-Care Reform Affect Businesses?

The health-care reform legislation includes new taxes, but there are also some tax breaks available to help small businesses pay for health insurance. Two of the changes getting a lot of attention are: a tax credit available to small businesses that offer health-care coverage to employees, and a tax to penalize employers who do not offer coverage.

### Small business tax credit

The new health-care reform legislation provides a tax credit to small businesses that offer health insurance coverage to their employees. The credit is available in two phases. For the years 2010 through 2013, the maximum credit is 35 percent of the employer's premium expenses. For tax years 2014 and later, the maximum credit increases to 50 percent.

To be eligible for the tax credit, the following conditions must be met:

- An employer must have the equivalent of fewer than 25 full-time employees for the tax year. Generally, this is determined by dividing the total hours for which wages were paid for all eligible employees during the year by 2,080.
- Average annual wages must be less than \$50,000 (to calculate, total wages paid during the tax year are divided by the number of full-time employees, and rounded down to the nearest \$1,000).
- The employer must contribute at least 50 percent of the premium cost of a qualifying health plan offered to employees.

Special rules apply to seasonal employees and to tax exempt employers. Also, sole proprietors, partners, 2 percent shareholders of an S corporation, and 5 percent owners of an employer generally are not considered employees for purposes of the credit. In addition, family members of ineligible employees are not counted as employees.

The maximum credit is available to qualifying employers with 10 or fewer full-time employees with average annual wages not exceeding \$25,000. The credit is phased out for employers with between 10 and 25 full-time employees, and for employers who have full-time employees with average annual wages between \$25,000 and \$50,000.

The total premium paid by the employer that's eligible for the credit cannot exceed the average premium for the small-group market

in the state where the employer offers health coverage. The average premium for each state is published by the IRS. The credit is claimed on the employer's annual tax return as a general business credit.

Beginning in 2014, the maximum credit will increase to 50 percent; however, qualifying arrangements are restricted to health insurance purchased by the employer through a state-run health exchange. Additionally, starting in 2014, the credit can be claimed by the employer for only two years.

### Other employer incentives

Employers who provide insurance for retired employees who are over age 55, but not yet eligible for Medicare, may receive reimbursement for 80 percent of retiree claims between \$15,000 and \$90,000. This temporary reinsurance program began in 2010 and is available until 2014. On the other hand, employers who currently receive a tax deduction for Medicare Part D drug subsidy payments will see that eliminated in 2013.

Small businesses with up to 100 employees may be able to purchase health insurance through state-based Small Business Health Options Program (SHOP) Exchanges by 2014. The exchanges will offer at least four benefit categories of plans based on covering an increasing percentage of benefit costs.

### Penalty taxes encourage employers to offer coverage

While employers aren't required to provide health-care coverage to employees, a new excise tax will encourage them to do so. Beginning in 2014, a penalty tax will be assessed on employers who do not offer health-care coverage to employees if:

- The employer has 50 or more full-time employees (more specifically, an average of at least 50 full-time employees in the prior year, and part-time employees are factored into the calculation), and
- At least 1 full-time employee purchases health insurance coverage through a state exchange, and is entitled to a tax credit or cost-sharing reduction

The tax is assessed on a monthly basis, and is equal to the number of full-time employees exceeding 30 multiplied by \$166.67 (\$2,000 divided by 12).



***Beginning in 2014, a penalty tax will be assessed on employers who do not offer health-care coverage to employees.***

Even employers (those with at least 50 full-time employees) that do offer health-care coverage to employees may still face a tax penalty if at least 1 full-time employee purchases health insurance coverage through a state exchange, and is entitled to a tax credit or cost-sharing reduction as a result of:

- An employer's coverage consisting of a plan that pays less than 60 percent of the total allowed cost of benefits, or
- An employer's coverage being considered "unaffordable" for an employee (generally, coverage would be considered unaffordable if an employee's portion of the premium exceeds 9.5 percent of the employee's household income)

In this case the tax, assessed on a monthly basis, equals \$250 (one-twelfth of \$3,000) for each full-time employee receiving a premium tax credit or cost-sharing subsidy through a state exchange. The tax is capped, however,

at the amount that would be due if an employer did not offer health-care coverage to employees (i.e., the number of full-time employees exceeding 30 multiplied by \$166.67).

In addition, beginning in 2014, employers that offer employee health insurance must offer a "free choice voucher" to qualified employees who elect to enroll in a state-based exchange plan. The value of the voucher is equal to the amount the employer would have paid to cover the employee under the employer's plan. Employees may enroll in an exchange plan if the employee's total household income is less than 400 percent of the Federal Poverty Level (FPL) and the employee's cost to participate in the employer's plan is greater than 8 percent and less than or equal to 9.8 percent of the employee's income. The voucher can be used to offset the employee's cost to participate in the exchange plan.

## Disclosure Information -- Important -- Please Review

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