



The New Health Care Law Frequently Asked Questions

On March 23rd, President Obama signed into law the Patient Protection and Affordable Care act to completely restructure the nation's health insurance system. A week later he signed into law the Health Care and Education Affordability Reconciliation Act to amend various sections of the Patient Protection and Affordable Care Act. Below is a series of questions and answers detailing the requirements of these new laws.

The new law is only the first step in the process, however. The Department of Health and Human Services and other government agencies will write implementing regulations for many provisions of the law which will determine how these policies will be implemented. This process will be critical to determining the impact of the law and will take place over the next few years. Until these regulations are put in place, many questions regarding how the new law will be implemented will remain unanswered.

Q. What changes will the new law make in the immediate future?

A. The primary changes that come in the next year are a variety of insurance market reforms. The new insurance requirements that take effect October 1st and will impact all plans including those currently in place include:

- Prohibiting limits on lifetime benefits
- Prohibiting rescissions
- Mandating dependant coverage up to age 26
- Prohibiting pre-existing conditions exclusions for dependents

New plans created after March 23, 2010 will face additional requirements including:

- Prohibiting cost sharing for preventive services (first dollar coverage for these services)
- Prohibiting group insurance providers from wage-based coverage eligibility discrimination (does not apply to self insured plans.)
- Additional requirements such as an appeal process and emergency services covered in-network

In addition, a number of additional insurance market requirements will take effect for all plans on January 1, 2014 including:

- Prohibiting pre-existing conditions exclusions for all individuals
- Prohibiting annual benefit limits
- Requiring guarantee issue
- Imposing ratings restrictions
- Creating essential benefit plans
- Mandating coverage for approved clinical trials

Q. Will all Americans be required to have health insurance?

A. Yes, starting in 2014, all U.S. citizens and legal residents must have a qualifying healthcare plan or pay a penalty. The penalty will be phased in over time and will, by 2016, be the greater of \$695 per family member or 2.5% of income.

Also beginning in 2014, the federal government will begin to provide subsidies, known as “premium credits,” to individuals who earn up to 400% of the federal poverty level for the purchase of insurance. The current federal poverty level is \$10,830 for an individual, \$22,050 for a family of four. Therefore if this provision were to take effect today, individuals earning up to \$43,320 or families of four earning up to \$88,200 would be eligible for subsidies. These premium credits are a critical element in determining employer responsibilities.

Q. Are employers required to provide health insurance?

A. While there is not an explicit requirement that employers provide insurance, beginning in 2014 there are penalties that will apply under various circumstances. These penalties are based on 1) the number of full time employees, 2) whether or not the firm offers coverage and 3) whether or not one or more employees qualify for government subsidies to purchase health insurance. A critical element to determining which category a company falls into is the determination regarding the number of full time employees. Part time employees are included in this determination by adding the number of hours worked by part-time employees per week and dividing by 30. That number is then added to the number of full time employees to determine the total number of full time employees for the purposes of these provisions. The three factors listed above then combine to create four major categories of employers.

- 1) Employers with fewer than 50 full time employees
There are no penalties
- 2) Employers with more than 50 full time employees who provide insurance
If one or more employees receives a premium subsidy, the employer pays a penalty equal to the lesser of \$3,000 per subsidized employee or \$2,000 per employee
- 3) Employers with more than 50 full time employees who do not provide insurance
If one or more employees receive a premium subsidy the penalty is \$2,000 times the total number of employees in the company. The first 30 employees are excluded from the calculation.
- 4) Employers with more than 50 full time employees with no employees receiving a premium subsidy regardless of whether they provide insurance or not
There are no penalties

Q. I have heard the bill includes small business health tax credits. What are they?

A. There are extremely limited small business tax credits that begin immediately and can be worth up to 50% of an employer's contribution toward employee's health insurance premium. The full credit is available only to firms with less than 10 employees and is then phased out on a per employee basis. Firms with more than 25 employees receive no credit. In addition, only firms that pay their workers \$25,000 or less are eligible for the full credit which is then reduced as wages increase. Firms with average wages of \$50,000 or more are not eligible for the credit. The credit is only available for a maximum of five years and only two years once the Exchanges are up and running beginning in 2014.

Q. How will the Exchange work and when will it begin?

A. Beginning in 2014, states must establish an American Health Benefit Exchange that will facilitate the purchase of "qualified health plans" for individuals and small businesses. Individuals can enroll in a plan through the exchange and small employers can offer a choice of plans to employees through the Exchange. The federal government will define the essential benefits packages for plans offered through the exchange. Prior to 2016, the Exchange is available only to individuals and businesses with fewer than 100 employees, though states can limit it to employers with 50 or fewer employees. After 2017, states may allow larger employers into the Exchange. Beginning in 2016, states may enter interstate compacts to create Exchanges with plans from multiple states. Insurers would still be subject to the consumer protection laws in the purchaser's state.

Q. What are the tax consequences of the new law?

A. The new law includes a wide variety of new taxes that will take effect over the next few years including:

- Beginning July 1, 2010
 - A 10% tax on indoor tanning services
- 2011
 - Employers are no longer allowed to deduct the value of retiree prescription drug benefits
- 2013
 - 0.9% surtax will be added to the current 1.45% Hospital Insurance (HI) payroll tax for individuals earning more than \$200,000 and joint filers above \$250,000.
 - 3.8% tax imposed on "unearned" income such as capital gains, dividends and rent for individuals above \$200,000 and joint filers above \$250,000.
- 2018
 - A 40% excise tax on high cost insurance plans to be paid by insurers or self-insured firms on policies in excess of \$10,200 for individuals and \$27,500 for families

In addition, the law imposes a number of new fees and taxes on a variety of healthcare industries including:

- Fees on manufacturers and importers of brand-name drugs
 - \$2.5 billion in 2011, \$2.8 billion in 2012 and 2013, \$3 billion for 2014-2016, \$4 billion in 2017, \$4.1 billion in 2018 and \$2.8 billion in 2019 and beyond
- 2.3% excise tax on manufacturers and importers of certain medical devices
- Annual fees on health insurance providers
 - \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, \$14.3 billion in 2018 and indexed to medical cost growth thereafter

All of these fees will simply be passed on to consumers and benefit providers in the form of higher insurance costs.

Q. What other requirements will be placed on employers and how will Flexible Spending Accounts and Health Spending Accounts be impacted?

A. The law creates a number of additional regulatory mandates including:

- Employers will be required to report the value of employees health benefits on W-2's beginning in 2011
- Businesses will have to complete 1099 forms for every business to business transaction of \$600 or more
- Consumers will no longer be allowed to use HSA's and FSA's to purchase over the counter medication, if not prescribed by a doctor, beginning in 2011
- The penalty for making a non-qualified purchase with an HAS increases to 20% beginning in 2011
- FSA contributions will be limited to \$2,500 beginning in 2013

Q. Why are companies like Caterpillar and AT&T taking write downs due to the new law?

A. When Congress created the Medicare prescription drug plan it provided employers with a tax deduction for the cost of providing prescription drug coverage for retirees. This created an incentive for employers to continue to provide this benefit to keep these individuals out of the public program. The new law eliminates this tax deduction effective January 1, 2011. Employers who provide drug coverage to retirees and utilized the deduction, generally larger unionized employers, now must revise their financial statements to account for the new future tax liability. The loss of this deduction is likely to make companies reexamine the cost of providing this benefit, potentially pushing more individuals into the Medicare prescription drug plan.