

HEALTHCARE PLAYBOOK

A step-by-step guide to
Healthcare Reform



REFORM TIMELINE

When the president signed the healthcare bill into law, the clock started to tick on a variety of changes. Whether it's the new taxes or the changes to the insurance you buy in the small group and individual insurance markets, this timeline provides a quick glance at changes you can expect in coming years.

2010

A temporary small business tax credit is available for six years for some firms that provide qualified health coverage. The rules include:

- 1) Only firms with 10 or fewer employees receive the full credit. For firms with 11 to 25 employees, the credit is reduced. Firms with more than 25 employees get no credit.
- 2) Only firms that pay their workers an average of \$25,000 or less are eligible for the full credit. The credit is reduced as the wage goes up, phasing out at \$50,000.
- 3) Only firms covering 50 percent or more of insurance costs will be eligible. Beginning in 2014, if you qualify for the employer tax credit, you must purchase your plan in the exchange.

A 10 percent excise tax on indoor tanning services begins July 1.

Insurance reforms begin. In June, temporary high-risk pools are created for uninsured adults with pre-existing conditions. For plan years beginning in late September, there will be prohibitions on lifetime and annual benefit spending limits, non-group plans will not be allowed to cancel coverage, plans must cover most preventive care and dependents will be allowed to stay on parents' policies until age 26.

2011

Employers will be required to report employee health benefits on W-2s.

Manufacturers and importers of brand-name drugs will begin paying a \$2.5 billion tax.

Consumer-driven account limits begin on over-the-counter medications. The penalty for using HSAs for non-qualified purchases doubles to 20 percent.

Employers may voluntarily participate in federally subsidized long-term care programs. Participating firms' employees will be automatically enrolled and subject to payroll deductions unless they opt out.

2012

Businesses will have to send Form 1099s for every business-to-business transaction of \$600 or more.

Brand-name drug tax is \$3 billion per year through 2016.

2013

2.3 percent excise tax on medical devices begins.

Threshold at which medical expenses as a percentage of income, are deductible, increases to 10 percent, from 7.5 percent.

Medicare payroll tax on wages and self-employment income in excess of \$200,000 (\$250,000 joint) will increase.

Medicare investment tax imposes 3.8 percent tax on investment income for higher-income taxpayers.

Cafeteria plan Flexible Spending Accounts will be limited to a maximum of \$2,500.

2014

An \$8 billion tax will fall on the majority of plans that small businesses purchase, but not on self-insured plans.

Health insurance exchanges open to individuals and small businesses with up to 50 employees.

Premium credits kick in, and the government begins subsidizing individuals up to 400 percent of the poverty line.

Federal officials must define an essential benefits package with which all insurance policies must comply.

Individual mandate begins. Individuals without government-approved coverage are subject to a tax.

Employer mandate begins, requiring growing firms to provide insurance. The penalties are based on the number of full-time employees, whether the firm offers coverage and whether employees qualify for government subsidies. An employee qualifies for a subsidy if his or her household income is below 400 percent of the federal poverty line. Here are some scenarios:

- 1) More than 50 full-time employees and company does not offer insurance, with one or more employees receiving premium subsidies. The penalty is \$2,000 per full-time employee (minus the first 30 employees).
- 2) More than 50 full-time employees and offers insurance with one or more employees receiving premium subsidies. Penalty is the lesser of \$3,000 per subsidized employee or \$2,000 per full-time employee (minus the first 30 employees).
- 3) More than 50 full-time employees and offers insurance, with no employees receiving premium subsidies.

No penalty on employer. All non-grandfathered and Exchange health plans are required to meet federally mandated levels of coverage.

4) 50 or fewer full-time employees: No penalty or requirement to offer insurance. Those who qualify for the employer tax credit must purchase a plan from the exchange.

5) New counting requirements for part-time: Part-time employees' hours will be converted into full-time equivalents for calculations of compliance and determination of penalties. For example, if six employees each work five hours per week, they will count as if the firm had one additional full-time employee.

Insurance reforms take effect, and insurers cannot impose coverage restrictions based on pre-existing conditions. Modified community rating standards go into effect for individual or family coverage based on geography, age and smoking status. Insurers must offer coverage to anyone. The law also limits out-of-pocket cost-sharing and insurance plans must include government defined "essential benefits" and coverage levels.

2015

Small business health insurance tax is \$11.3 billion.

Individual mandate penalty increases to \$325 or 2 percent of income, whichever is greater.

2016

Small business health insurance tax is \$11.3 billion.

Individual mandate penalty increases again, to \$695 or 2.5 percent of income, whichever is greater.

2017

Brand-name drug tax increases to \$3.5 billion.

Small business health insurance tax increases to \$13.9 billion for 2017.

Individual mandate penalty is based on 2016 levels and will rise according to a cost-of-living adjustment.

2018

Cadillac tax begins on high-cost plans.

Brand-name drug tax increases to \$4.2 billion.

Small business health insurance tax is \$14.3 billion.

Individual mandate penalty is based on 2016 levels and will rise according to a cost-of-living adjustment.

MANDATES

VOLUNTARY EMPLOYER PARTICIPATION IN CLASS PROGRAM PREMIUM COLLECTION

The 'CLASS' acronym stands for Community Living Assistance Services and Supports. The provision is found in Title VIII of the new healthcare law.

Specifically, the CLASS program is a long-term care insurance program that takes effect in 2011. Benefits will depend on a person's degree of impairment, but will not be less than \$50 per day (paid on a daily or weekly basis). Eligibility guidelines for benefits associated with the CLASS program require that an individual must pay premiums for at least five years before qualifying for benefits. There is no lifetime limit on the funds available.

The Secretary of Health and Human Services (HHS) has not yet set premiums for the CLASS program. The Congressional Budget Office estimated in 2009 that premiums would begin at \$123 per month, with fewer than 10 million persons enrolling in the program over a 10-year period.

The program itself is voluntary, but employees of participating firms would be auto-enrolled. That is, under Section 3204(a), employers that choose to participate must enroll workers automatically and become responsible for making automatic payroll deductions on a monthly basis for each of the employees enrolled in the program. A separate section of the law, Section 3204(b) states that workers may choose to opt out of the CLASS program.

You can read about the CLASS program beginning on Page 710 of the Patient Protection and Affordable Care Act.

INDIVIDUAL MANDATE

Starting in 2014, all individuals are required to demonstrate and maintain proof of insurance coverage that either meets the definition of minimum essential coverage or that is part of an approved grandfathered health plan. Qualified plans include: government-sponsored health insurance programs (e.g., Medicare, Medicaid), grandfathered group health plans, employer-sponsored plans and plans purchased in the individual market. The Secretary of Health and Human Services will provide guidance through the regulatory process to further define what will be considered minimum essential coverage.

For those unable to afford coverage, an individual, depending on their income, will either apply for premium assistance credits or government programs will be made available so that individual can gain access to coverage.

Failure to demonstrate and maintain qualified coverage will leave the individual subject to financial penalties. For an individual, the penalty begins in 2014 at the greater of \$95 or 1% of household income. In 2015, it grows to \$325 or 2%. In 2016, it reaches \$695 or 2.5%. (For families, the figure will be \$2,085 in 2016.) After 2016, the amount will rise by a cost-of-living adjustment.

Aside from the financial penalty, the law specifically prohibits the IRS from imposing civil or criminal penalties on individuals who do not comply with the individual mandate.

EMPLOYER MANDATE AND NEW EMPLOYER PENALTIES

The healthcare law requires employers with 50 or more full-time equivalent employees to either provide insurance, pay penalties or both. For purposes of defining a full-time employee, the new healthcare law defines a full-time employee as anyone who is employed an average of at least 30 hours per week. Anyone who works an average of less than 30 hours per week is considered a part-time employee.

An employer with fewer than 50 full-time equivalent employees is not subject to this provision. That does not mean that those small employers are exempt from the healthcare law in its entirety. Rather, they are only exempt from this single provision.

It is important to note one area that remains unclear—how seasonal workers will be defined under the new healthcare law. Under the new law, an employer is not considered "large" (and thus, subject to the

new employer mandate) if the employer has 50 full-time employees for 120 days or fewer during the year, and the employees that go above that 50-FTE threshold are seasonal workers. The federal government will provide guidance through the regulatory process to determine who is deemed to be a seasonal worker.

How Does the Employer Mandate Affect Your Business?

How the employer mandate affects a particular business depends on a number of factors, including: (1) the number of full-time (or part-timers counted as full-time equivalent); see the section "Part-time Employee Counting Requirements"; (2) whether or not the firm offers coverage; and (3) whether or not one or more employees qualify for government subsidies toward the purchase of health insurance. An employee qualifies for a subsidy if his or her household income is below 400% of the federal poverty line (\$88,000 for a family of four today).

HERE ARE SOME OF THE RULES:

Non-Offering Firms: More than 50 full-time employees. Does not offer insurance. One or more employees receiving premium subsidies. Penalty = \$2,000 per full-time employee (minus the first 30 employees).

§ For example, in 2014, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee over the 30-employee threshold, the employer owes \$2,000, for a total penalty of \$140,000 (100 employees - the 30 threshold = 70, multiplied by \$2,000 each). This penalty is assessed on a monthly basis.[i] Therefore, the employer would pay a monthly portion of the total penalty (1/12 of the total each month). In the example of Employer A, that would amount to \$11,666.66 per month.

Non-Offering Firms: 50 or fewer full-time employees. Does not offer insurance. No penalty.

Offering Firms: More than 50 full-time employees. Offers insurance that meets the standards for affordable minimum essential coverage. One or more employees receiving premium subsidies. Penalty equals lesser of \$3,000 per subsidized employee or \$2,000 per full-time employee (minus the first 30 employees).

§ For example, in 2014, Employer A offers health coverage and has 100 full-time employees, 20 of whom receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee receiving a tax credit, the employer owes \$3,000, for a total penalty of \$60,000 (20 employees x \$3,000). The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, or \$140,000 (\$2,000 multiplied by 70 (100-30)). Since the calculated penalty of \$60,000 is less than the maximum amount, Employer A pays the \$60,000 calculated penalty. This penalty is assessed on a monthly basis.[ii] Therefore, the employer would pay a monthly portion of the total penalty (1/12 of the total each month) amounting to \$5,000 per month.

Offering firms: More than 50 full-time employees. Offers insurance. Has no employees receiving premium subsidies. No penalty on employer.

Part-time employee counting requirements: Part-time employees' hours will be converted into full-time equivalents for purposes of determining whether the employer is a large employer and subject to the employer mandate. This is done by adding up all of the hours worked by employees who are not full-time and dividing by 120. For example, if 6 employees each work 5 hours per week, they will count as if the firm had one additional full-time employee, calculated monthly (6 employees x 5 hours per week each = 30 hours per week x 4 weeks = 120 hours/120 = 1).

Employers will not be required to provide coverage to part-time employees, but their hours will be used to determine whether the employer is subject to the requirements of the employer mandate.

Other factors Affecting "Large" Employers Subject to the Employer Mandate

Waiting Periods: There are extra penalties for firms who have a waiting

period of more than 90 days before employees are eligible for insurance.

Vouchers: If an employee's household income is below 400% of the federal poverty line and his or her insurance premium falls between 8% and 9.8% of household income, the employer must offer the employee a voucher (equal to the amount the employer contributes toward an employee's premium) to purchase insurance in the exchange. An employee meeting these characteristics will not trigger the employer penalties.

Auto-Enroll: Employers with more than 200 employees will be required to auto-enroll employees in the employer's health plans, though the employee may opt out.

Factors Affecting All Employers Offering Health Insurance, Whether or not They Are Subject to the Employer Mandate

INDIVIDUAL AND SMALL GROUP MARKET CHANGES

Note: The degree to which you may be affected by insurance market reforms depends on whether:

You have a grandfathered plan. (*see page 8*)

You are newly insured.

You changed plans after March 23, 2010.

You are self-insured

There are currently several changes being made in the individual and small group marketplace. Over the next few years and in 2014, you will see significant changes in both of these markets.

There are currently many differences in how the individual market and small group market functions. The rules dictate how insurers can determine their expected costs and therefore, price your premium. The changes created by the new healthcare law will adjust these differences, making the two marketplaces somewhat more similar.

The following changes apply to new markets, including:

Individual, small group, large group and self-funded and grandfathered plans in the individual and group market

Pre-existing conditions

Changes to pre-existing conditions apply to all plans except grandfathered individual market plans. Beginning September 23, 2010, children under the age of 19 cannot impose exclusions from coverage based on pre-existing conditions.

Annual and Lifetime Limits

Beginning September 23, 2010 new plans will be prohibited from placing lifetime limits on the dollar value of coverage. For example, some policies today have a \$1 million dollar cap on the amount the insurance company will pay out on a policy. The prohibition on lifetime limits takes full effect January 1, 2014. Until then, lifetime limits on coverage are allowed at discretion of the secretary of Health and Human Services. The new rules on lifetime limits will apply to all plans. The rules on annual limits will apply to all plans except for individual market plans that maintain grandfather status.

Rescissions

Beginning September 23, 2010, Insurers are prohibited from rescinding coverage except in cases of fraud. This will apply to all plans.

Dependent Coverage

Beginning September 23, 2010 all plans are required to provide dependent coverage for children up to age 26.

If you do not have a grandfathered plan or you purchase a new plan you will also be subject to are requirements related to preventative coverage.

Coverage of Preventative Services

Beginning September 23, 2010 all new plans that are not grandfathered plans are required to provide 100% coverage (no cost-sharing – deductibles or co-pays) for:

Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task

Force ("USPSTF");

Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration ("HRSA"); and

Preventive care and screening for women provided for in guidelines supported by the HRSA (to be issued no later than August 1, 2011).

To learn more about services of the US Preventative Task Force (A and B) see: <http://www.healthcare.gov/center/regulations/prevention.html>

Deductible Limits

Effective January 2014, deductibles in the small group marketplace will be limited to \$2,000 for individuals and \$4,000 for families.

Insurance Rating Reforms

Effective January 2014, all plans in the individual and small group markets (including those in the exchange) will be required to have guaranteed issue and renewability. The rating factors that insurance carriers will be allowed to use are:

Premiums may only vary by:

Age (3:1 maximum)

Tobacco (1.5:1 maximum)

Geographic rating area

Individual or family coverage (family composition)

The states, along with the Secretary of HHS will be responsible for developing standards for geographic rating areas. The Secretary of HHS, in collaboration with the National Association of Insurance Commissioners (NAIC) will develop the "age bands" used for the age rating process.

To obtain more information on how these changes affect your health insurance plan, please contact your agent or broker, or call your health insurer. There is also more helpful information on your state insurance commissioner's website. See: http://www.naic.org/state_web_map.htm

HEALTH INSURANCE EXCHANGES

New State Health Insurance Exchanges

The new healthcare law requires states to set up health insurance exchanges. If the state chooses not to participate, the federal government will create an exchange in that particular state. There are federal rules that set the foundation for these exchanges but beyond that, states have flexibility to design them in ways that meet the needs of their own population. Two state exchanges have already been created—the Utah Health Exchange and the Massachusetts Health Connector.

The exchange model was created to assist mostly the individual and small group markets. Beginning in 2014, the law requires that states establish an exchange to sell private health plans to individual and small group coverage. You will be able to purchase them directly through the exchange or through an agent of your choice.

There is a cap on the size of businesses that may purchase plans in the exchanges. For the first two years, the exchanges will be available to individuals and small businesses with up to 50 employees. Beginning in 2017, exchanges can open up to businesses with more than 100 employees, at state discretion.

Many states currently separate the individual and small group markets. That is, the two pools operate as separate risk groups. Under the new healthcare law, states have the option of merging these two markets.

The exchanges will not be the only place where you can purchase

coverage. In addition to the new exchanges, there will continue to be a marketplace outside the exchange marketplace. The rules governing the health plans are the same in both marketplaces. However, it is critical to note that the exchanges will be the only marketplace for individuals and small businesses that are eligible for certain kinds of financial assistance.

These new exchanges will house premium and cost-sharing credits (*see page 8*) to individuals and families with incomes between 133% and 400% of the federal poverty level. You cannot access premium credits outside of the exchanges. Access to premium credits are not allowed by individual employees if there is an offer of coverage from the employer, except in certain cases. These exceptions include: if the employer plan does not have an actuarial value of at least 60% (if you are fully insured, your carrier will certify the plan meets this value) or if the employee's share of the premium exceeds 9.5% of their income.

There is also a tax credit available to small businesses that purchase health insurance in the exchange. A maximum credit equal to 35% of the employer contribution is available from 2010 to 2013.

Beginning in 2014, a 50% credit is available for an additional two years, but only if the small business purchases health insurance through a health insurance exchange. See "Tax Information" on page 6 for more information on whether your business qualifies for the small business tax credit.

Exchanges will be required to maintain a call center and establish procedures for enrolling individuals and businesses. Agents and brokers will be able to sell plans inside and outside the exchanges.

Exchanges will offer four benefit categories and offer a separate catastrophic plan for certain qualified individuals. The four benefit categories and catastrophic plans will be available based on eligibility and will be sold inside and outside the exchange.

The plans will be identified as either bronze, silver, gold, or platinum level. The levels of coverage, as described in a summary of the new law provided by the National Association of Insurance Commissioners (NAIC) are defined in the following way.

Bronze level-Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan.

Silver level-Must provide coverage that provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan.

Gold level-Must provide coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan.

Platinum level-Must provide coverage that provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan.

An individual who is either under 30 years old or is exempt from the individual mandate because of lack of affordability or hardship may purchase a catastrophic plan. That plan provides the essential benefits package with a deductible equal to the total limitation on cost-sharing above and first-dollar coverage of at least three primary care visits.

As exchanges are developed, more information will be available here. Check back often for updates.

MINIMUM ESSENTIAL COVERAGE

Individuals will be required to have qualified health insurance by 2014 or face penalties. This is the individual mandate requirement in the new healthcare law. You can either meet this requirement by maintaining your grandfathered plan or by purchasing a plan that meets the new minimum essential coverage standards.

If you or your business is able to maintain your grandfathered plan (i.e., plans that were in existence on March 23, 2010, when the law was signed), you will be deemed as meeting your obligations for the

individual mandate. For all other health plans following March 23, 2010, there are new minimal essential coverage requirements.

Minimum essential coverage has not been fully defined yet by the Department of Health and Human Services (HHS). Defining regulations will be released by HHS throughout 2010 and 2011.

However, the law does outline the types of benefits that are required to be included in any package deemed to meet minimum essential coverage. Section 1302 of the new healthcare law specifies that all plans meeting these requirements will include at least the following categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

This will be a floor of required services and the states can go above this floor.

Employers who offer coverage will be required to offer minimum essential coverage to their employees worth at least 60% of the actuarial value of the covered benefits the insurance carrier pays out or face penalties. For the policyholder, that means paying no more than 40% of costs.

There will be limits on annual cost sharing and they are tied to current HSA limits (\$5,950 for individual and \$11,900 for a family). The HHS Secretary will be allowed to review and update the minimal essential coverage annually beginning in January 2014.

All plans inside and outside the exchange (including those in the individual and small group market) will be required to meet or exceed the new coverage requirements set forth in the new healthcare law.

For more information, including updates from the HHS process, please go to <http://www.regulations.gov>.

To access the timeline for overall implementation of the healthcare law, please see "Reform Timeline" on page 2.

EXPANDED 1099 INFORMATION REPORTING

Beginning in 2012, businesses will be required to provide Form 1099-MISC for additional business-to-business transactions. Currently, a 1099 is issued to unincorporated (sole proprietor, partnership) businesses that provide services valued at \$600 or more. The expanded information reporting requirement includes services from incorporated businesses, as well as purchases of property of \$600 or more from both incorporated and unincorporated businesses. In addition, the reporting business must include on the 1099 the service-providing business's taxpayer identification number. If the TIN is inaccurate or no TIN is provided, the reporting business is required to withhold 28% of the total contract. The IRS is currently working on additional guidance, including an exemption for certain credit card transactions, and will update the form 1099-MISC.

For additional information about the 1099 reporting requirement, see NFIB 1099 Fact Sheet at <http://www.nfib.com/LinkClick.aspx?fileticket=Pt0JfX3cLXg%3d&tabid=1232>.

[i] Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act" (JCX-18-10), March 21, 2010. Page 39

[ii] *Ibid*, p. 40

TAX INFORMATION

SMALL BUSINESS HEALTH CARE TAX CREDIT

A temporary tax credit is available for some small businesses that provide qualified health insurance. A maximum credit equal to 35% of the employer contribution is available from 2010 to 2013. Beginning in 2014, a 50% credit is available for an additional two years, if the small business purchases health insurance through a health insurance exchange. The business must pass a series of tests to determine if they qualify and how much credit they may receive. Businesses with 10 or fewer employees paying \$25,000 or less in average wages are potentially eligible for the full credit. Businesses with between 11 to 24 employees and average annual wages of less than \$50,000 may be eligible for some credit. Businesses with more than 25 employees and/or \$50,000 in average annual wages are not eligible for any credit.

The rules and calculations to determine eligibility for the credit are complicated. There are a number of tools to help you determine if you receive a credit and how much it is worth. Also, please be sure to consult an accountant or tax professional to determine your eligibility.

For NFIB Background information on the small business health insurance tax credit visit

<http://www.nfib.com/issues-elections/issues-elections-item/cmsid/51232>

For NFIB tax credit calculator visit

<http://www.nfib.com/issues-elections/healthcare/credit-calculator>

For IRS guidance on the tax credit visit

<http://www.irs.gov/newsroom/article/0,,id=223666,00.html>

TANNING SALON TAX

Beginning July 1, 2010, a 10% tax is imposed on certain indoor tanning services. Specifically, the tax applies to the use of tanning devices utilizing ultraviolet lamps. Certain businesses, such as qualified physical fitness facilities, are exempted. The tax is collected from the purchases of tanning services and remitted quarterly to the IRS on a Form 720.

For additional information visit

<http://www.nfib.com/issues-elections/issues-elections-item/cmsid/51910>

For IRS guidance and copies of Form 720 visit

<http://www.irs.gov/businesses/small/article/0,,id=224600,00.html>

BRAND-NAME DRUG TAX

Beginning in 2011, the manufacturers and importers of brand-name prescription drugs will face an annual tax based on their share of the total brand-name drug market.

FSA LIMITATIONS UNDER CAFETERIA PLANS

Health FSAs are a qualified benefit that may be offered to employees under a cafeteria plan. Beginning in 2013, for a Health FSA to qualify as a benefit under a cafeteria plan, the maximum amount available for reimbursement cannot exceed \$2,500. A cafeteria plan that includes a Health FSA which exceeds the maximum limitation will fail to qualify as a cafeteria plan.

INCREASED HSA PENALTY FOR NON-QUALIFIED DISTRIBUTIONS

Distributions from an HSA can only be used for qualified medical expenses and a nonqualified distribution amount is subject to a penalty. The penalty for making nonqualified distributions from an HSA will be increased from 10% to 20% in 2011.

CAFETERIA PLAN SAFE HARBOR RULES

Beginning in 2011, application of nondiscrimination rules will not apply to cafeteria plans established by certain small businesses. Cafeteria plans are currently subject to nondiscrimination rules to ensure that benefits are not disproportionately allocated to highly-compensated employees. Many smaller businesses struggle to meet

the nondiscrimination tests because of the employee size calculation in the test.

An eligible small employer is provided a safe harbor from the nondiscrimination rules if the cafeteria plan satisfies minimum eligibility and participation requirements and minimum contribution requirements. An eligible small employer is an employer who employed an average of 100 or fewer employees during either of the two preceding years. A cafeteria plan satisfies the eligibility requirements if all employees are eligible to participate and able to elect any benefit available under the cafeteria plan. The minimum contribution requirement is met if the employer provides a minimum contribution for each employee who is not highly compensated, equal to not less than two percent of each eligible employee's compensation for the plan year.

EXPANDED 1099 INFORMATION REPORTING

Beginning in 2012, businesses will be required to provide Form 1099-MISC for additional business-to-business transactions. Currently, a 1099 is issued to unincorporated (sole proprietor, partnership) businesses that provide services valued at \$600 or more. The expanded information reporting requirement includes services from incorporated businesses, as well as purchases of property of \$600 or more from both incorporated and unincorporated businesses. In addition, the reporting business must include on the 1099 the service-providing business's taxpayer identification number. If the TIN is inaccurate or no TIN is provided, the reporting business is required to withhold 28% of the total contract. The IRS is currently working on additional guidance, including an exemption for certain credit card transactions, and will update the form 1099-MISC.

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To request a TIN or for additional information about TINs

<http://www.irs.gov/businesses/small/international/article/0,,id=96696,00.html>

MEDICAL DEVICE TAX

Beginning in 2013, manufacturers and importers of certain medical devices will face a 2.3% excise tax.

LIMITATION OF DEDUCTION MEDICAL EXPENSES

Currently, an individual may deduct the cost of medical expenses exceeding 7.5 percent of the taxpayer's adjusted gross income on their individual tax return. Beginning in 2013, the deduction is limited to 10% of the taxpayer's AGI.

DENIAL OF THE USE OF CERTAIN MEDICAL ACCOUNTS FOR THE PURCHASE OF OVER-THE-COUNTER DRUGS

Beginning in 2011, the cost of over-the-counter drugs may not be reimbursed with funds from a Health FSA, HRA, FSA, HSA or Archer MSA, unless the medicine is prescribed by a physician, except for insulin.

MEDICARE PAYROLL TAX INCREASE

Beginning in 2013, the employee portion of the Medicare payroll tax (specifically the Hospital Insurance portion of the tax) is increased by .9% from the current 1.45%. The increase only applies to wages over \$250,000 for joint return filers, \$200,000 for individual filers and \$125,000 for married individuals filing separate returns. The tax increase also applies to the Medicare portion of SECA taxes for self-employment income.

MEDICARE INVESTMENT INCOME TAX

Beginning in 2013, a new 3.8% Medicare tax will be assessed on certain investment income. The tax is assessed on the lesser of net investment income or the modified adjusted gross income over the threshold amount of \$250,000 for a joint filer, \$200,000 for an individual filer or \$125,000 for a married individual filing a separate

return. Net investment income includes income from interest, dividends, annuities, royalties, and rents. Income in these categories derived from a trade or business is not subject to the tax, unless ownership in the trade or business is considered passive.

SMALL BUSINESS HEALTH INSURANCE TAX

Beginning in 2013, an annual fee will be assessed on health insurance providers based on their market share of health insurance policies in the small group and individual markets. The fee will not be assessed based on their share of self-insured plans. The fee will raise \$8 billion in 2014, rising to \$14.3 billion by 2018.

Check out additional information about the impact this fee will have on small business health insurance plans at <http://www.nfib.com/issues-elections/issues-elections-item/cmsid/51231>.

TAX ON CADILLAC HEALTH INSURANCE PLANS

Beginning in 2018, insurers providing employer-sponsored health insurance coverage that exceeds a threshold amount will be charged an excise tax. The threshold amounts are \$10,200 for individual coverage and \$27,500 for family coverage.

COMPLIANCE

VOLUNTARY EMPLOYER PARTICIPATION IN CLASS PROGRAM PREMIUM COLLECTION

CLASS stands for Community Living Assistance Services and Supports. The provision is found in Title VIII of the new healthcare law.

Specifically, the CLASS program is a long-term care insurance program which takes effect in 2011. Benefits will depend on a person's degree of impairment, but will not be less than \$50 per day (paid on a daily or weekly basis). Eligibility guidelines for benefits associated with the CLASS program require that an individual must pay premiums for at least five years before qualifying for benefits. There is no lifetime limit on the funds available.

The Secretary of Health and Human Services has not yet set premiums for the CLASS program. The Congressional Budget Office estimated in 2009 that premiums would begin at \$123 per month, with fewer than 10 million persons enrolling in the program over a 10-year period.

The program itself is voluntary, but employees of participating firms would be auto-enrolled. That is, under Section 3204(a), employers that choose to participate must enroll workers automatically and become responsible for making automatic payroll deductions on a monthly basis for each of the employees enrolled in the program. A separate section of the law, Section 3204(b) states that workers may choose to opt out of the CLASS program.

You can read about the CLASS program beginning on Page 710 of the Patient Protection and Affordable Care Act.

W-2 REPORTING PROVISIONS

Starting in 2011, Section 9002 of the healthcare law requires employers to calculate and report the aggregate cost of employer-sponsored health insurance coverage on employees' Form W-2s. Healthcare benefits continue to be a tax-free benefit; the new reporting requirement is simply for information purposes.

Reportable employer-sponsored costs include:

- Medical plans
- Prescription drug plans
- Health reimbursement accounts (HRAs)
- On-site medical clinics
- Amounts contributed by the employer to a health savings account (HSA) or medical savings account (MSA)
- Medicare supplemental coverage
- Employee assistance programs
- Dental and vision plans unless they are stand-alone plans

Flexible spending accounts, long-term care coverage, workers' compensation insurance, coverage only for accidents, health savings accounts and specific disease or hospital/fixed indemnity plans are excluded from the reporting requirement.

INDIVIDUAL PREMIUM ASSISTANCE

Beginning in 2014, tax credits will be available for people under age 65 who purchase coverage on their own and are not covered through an employer, Medicare or Medicaid.

The premium assistance credits are available on a sliding scale for individuals and families with household incomes between 100 and 400% of federal poverty level to help offset the cost of health insurance premiums. In 2009, 400% of the federal poverty level was \$43,320 for an individual or \$88,200 for a family of four. The sliding scale as outlined in the PPACA is included here.

Premium Assistance Caps as Percentage of Income

Income Range (% of poverty level)	Premium Assistance Credit Cap on Percentage of Income
100% through 133%	2.0
133% through 150%	3.0
150% through 200%	4.0
200% through 250%	6.3
250% through 300%	8.05
300% through 400%	9.5

To determine eligibility for premium assistance, you can use the Kaiser family Foundation Premium Assistance Calculator at <http://healthreform.kff.org/SubsidyCalculator.aspx>.

(1) FAMILY SIZE—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

Premium assistance credits may only be used to purchase a plan offered in the exchange, which will become operational and available in 2014. The value of the premium assistance will be tied to the lowest-cost silver plan, but can be used to purchase any plan purchased in an exchange including bronze, silver, gold and platinum level plans and, for those eligible, catastrophic plans. The IRS will be responsible for determining eligibility for premium assistance credits.

FACTORS AFFECTING ALL EMPLOYERS OFFERING HEALTH INSURANCE, WHETHER OR NOT THEY ARE SUBJECT TO THE EMPLOYER MANDATE

Paperwork Reporting Requirements: Any "offering employer" will be responsible for reporting certain information about health insurance coverage to both the IRS and their full-time employees. § The information required to be reported includes: (1) name, address and employer identification number of the employer; (2) certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; (3) the number of full-time employees of the employer for each month during the calendar year; (4) name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year; and (5) such other information as the government may require.

§ Employers who offer the opportunity to enroll in "minimum essential coverage" must also report: (1) in the case of an applicable large employer, the length of any waiting period with respect to such coverage; (2) the months during the calendar year during which the coverage was available; (3) the monthly premium for the lowest-cost option in each of the enrollment categories under the plan; (4) the employer's share of the total allowed costs of benefits under the plan; and (5), in the case of an offering employer, the option for which the employer pays the largest portion of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under each option.[1]

GRANDFATHERED PLANS

Grandfathered plans are plans that were in existence on March 23, 2010, when the PPACA was signed into law. This includes plans in the group market, self-insured plans and individual plans. The purpose of the "grandfather" status is to shield those plans in existence on or prior to March 23 from many of the requirements in the new law affecting insurance plans.

It's not clear what might cause a plan to lose its grandfather status. In

the summer of 2010, the Department of Health and Human Services and the Department of Labor issued an Interim Final Rule to outline what changes an employer or individual could make to their plan and still retain their grandfather status, and invited organizations to make comments on the rule. The Interim Final Rule outlined what might be considered changes that would result in a loss of grandfather status, as well as changes that would not result in a loss of grandfather status. Samples include:

Changes that would cause a plan to cease being a grandfathered plan:

Elimination of Benefits for Diagnosis and Treatment of Particular Conditions

If a plan eliminates a benefit to diagnose or treat a particular condition (e.g., if a plan stops offering coverage of cystic fibrosis) this will cause a plan to lose its grandfathered status.

Changing Insurers

If an employer offering a fully insured plan changes insurers, the plan will lose its grandfathered status.

Changes to Cost-Sharing Requirements

a.) A plan will lose its grandfathered status if it increases, from its March 23 amount, the fixed-amount cost-sharing for expenses other than co-payments (e.g. out-of-pocket-limits or deductibles) by a total percentage that is greater than the maximum percentage increase (i.e., medical inflation—from March 23, 2010—plus 15 percentage points).

b.) A plan will lose its grandfathered status if it increases, from its March 23 amount, the copayment (e.g., an office visit co-pay from \$30 to \$50) by an amount that exceeds the greater of (A) the maximum percentage increase or (B) \$5 increased by medical inflation.

Changes to Contribution Rates

A plan will lose its grandfathered status if it decreases from its March 23 amount, its contribution rate by more than five percent below the contribution rate (e.g., adjusting the employer-employee contribution of 80-20 to 70-30).

Changes that would not cause a plan to cease being a grandfather plan:

Adding New Employees

You can add new employees without affecting grandfathered status.

Application of Rules to a Collective Bargaining Agreement (CBA)

Collectively bargained agreements are permitted to change their plans up until the last CBA terminates without losing grandfathered status.

Declaration requirement

Any plan wishing to retain its grandfathered status must provide a statement to participants that includes a description of the benefits provided in the plan and that the plan sponsor believes the plan to be a grandfathered plan as defined by the PPACA.

It is important to note that as of September 1, 2010, final guidance codifying these regulations had not been issued. Based on a sensitivity analysis conducted by the government and featured in the Interim Final Rules, the government's own analysis found that, under the proposed Interim Final Rule, upwards of 80 percent of small employers could lose the plan they have today by 2013. In response, NFIB filed comments urging the government to make changes to their Interim Final Rule. Stay tuned for updates.

INDIVIDUAL AND SMALL GROUP MARKET CHANGES

Note: The degree to which you may be affected by insurance market reforms depends on whether:

- You have a grandfathered plan.
- You are newly insured.
- You changed plans after March 23, 2010.
- You are self-insured

There are currently several changes being made in the individual and small group marketplace. Over the next few years and in 2014, you will see significant changes in both of these markets.

There are currently many differences in how the individual market and small group market functions. The rules dictate how insurers can determine their expected costs and therefore, price your premium. The changes created by the new healthcare law will adjust these differences, making the two marketplaces somewhat more similar.

The following changes apply to new markets, including:

Individual, small group, large group and self-funded and grandfathered plans in the individual and group market

Pre-existing conditions

Changes to pre-existing conditions apply to all plans except grandfathered individual market plans. Beginning September 23, 2010, children under the age of 19 cannot impose exclusions from coverage based on pre-existing conditions.

Annual and Lifetime Limits

Beginning September 23, 2010 new plans will be prohibited from placing lifetime limits on the dollar value of coverage. For example, some policies today have a \$1 million dollar cap on the amount the insurance company will pay out on a policy. The prohibition on lifetime limits takes full effect January 1, 2014. Until then, lifetime limits on coverage are allowed at discretion of the secretary of Health and Human Services. The new rules on lifetime limits will apply to all plans. The rules on annual limits will apply to all plans except for individual market plans that maintain grandfather status.

Rescissions

Beginning September 23, 2010, Insurers will be prohibited from rescinding coverage except in cases of fraud. This will apply to all plans.

Dependent Coverage

Beginning September 23, 2010 all plans will be required to provide dependent coverage for children up to age 26.

If you do not have a grandfathered plan or you purchase a new plan you will also be subject to all requirements related to preventative coverage.

Coverage of Preventative Services

Beginning September 23, 2010 all new plans that are not grandfathered plans will be required to provide 100% coverage (no cost-sharing – deductibles or co-pays) for:

Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);

Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (“HRSA”); and

Preventive care and screening for women provided for in guidelines supported by the HRSA (to be issued no later than August 1, 2011).

To learn more about services of the US Preventative Task Force (A and B) see: <http://www.healthcare.gov/center/regulations/prevention.html>.

Deductible Limits

Effective January 2014, deductibles in the small group marketplace will be limited to \$2,000 for individuals and \$4,000 for families.

Insurance Rating Reforms

Effective January 2014, all plans in the individual and small group markets (including those in the exchange) will be required to have guaranteed issue and renewability. Insurers can only vary premiums

based on the following factors:

- Age (3:1 maximum)
- Tobacco (1.5:1 maximum)
- Geographic rating area
- Individual or family coverage (family composition)

The states, along with the Secretary of HHS will be responsible for developing standards for geographic rating areas. The Secretary of HHS, in collaboration with the National Association of Insurance Commissioners (NAIC) will develop the “age bands” used for the age rating process.

To obtain more information on how these changes affect your health insurance plan, please contact your agent or broker, or call your health insurer. There is also more helpful information on your state insurance commissioner’s website at http://www.naic.org/state_web_map.htm.

HEALTH INSURANCE EXCHANGES

New State Health Insurance Exchanges

The new healthcare law requires states to set up health insurance exchanges. If the state chooses not to participate, the federal government will create an exchange in that particular state. There are federal rules that set the foundation for these exchanges but beyond that, states have flexibility to design them in ways that meet the needs of their own population. Two state exchanges have already been created—the Utah Health Exchange and the Massachusetts Health Connector.

The exchange model was created to assist mostly the individual and small group markets. Beginning in 2014 the law requires that states establish an exchange to sell private health plans to individual and small group coverage. You will be able to purchase them directly through the exchange or through an agent of your choice.

There is a cap on the size of businesses that may purchase plans in the exchanges. For the first two years, the exchanges will be available to individuals and small businesses with up to 50 employees. Beginning in 2017, exchanges can open up to businesses with more than 100 employees, at state discretion.

Many states currently separate the individual and small group markets. That is, the two pools operate as separate risk groups. Under the new healthcare law, states have the option of merging these two markets.

The exchanges will not be the only place where you can purchase coverage. In addition to the new exchanges, there will continue to be a marketplace outside the exchange marketplace. The rules governing the health plans are the same in both marketplaces. However, it is critical to note that the exchanges will be the only marketplace for individuals and small businesses that are eligible for certain kinds of financial assistance.

These new exchanges will house premium and cost-sharing credits to individuals and families with incomes between 133% and 400% of the federal poverty level. You cannot access premium credits outside of the exchanges. Access to premium credits are not allowed by individual employees if there is an offer of coverage from the employer, except in certain cases. These exceptions include: if the employer plan does not have an actuarial value of at least 60% (if you are fully insured, your carrier will certify the plan meets this value) or if the employee’s share of the premium exceeds 9.5% of their income.

There is also a tax credit available to small businesses that purchase health insurance in the exchange. A maximum credit equal to 35% of the employer contribution is available from 2010 to 2013.

Beginning in 2014, a 50% credit is available for an additional two years, but only if the small business purchases health insurance

through a health insurance exchange. See <http://www.nfib.com/issues-elections/healthcare/credit-calculator> for more information on whether your business qualifies for the small business tax credit.

Exchanges will be required to maintain a call center and establish procedures for enrolling individuals and businesses. Agents and brokers will be able to sell plans inside and outside the exchanges.

Exchanges will offer four benefit categories and offer a separate catastrophic plan for certain qualified individuals. The four benefit categories and catastrophic plans will be available based on eligibility and will be sold inside and outside the exchange. The plans will be identified as either bronze, silver, gold, or platinum level. The levels of coverage, as described in a summary of the new law provided by the National Association of Insurance Commissioners (NAIC) are defined in the following way.

Bronze level-Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan.

Silver level-Must provide coverage that provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan.

Gold level-Must provide coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan.

Platinum level-Must provide coverage that provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan.

An individual who is either under 30 years old or is exempt from the individual mandate because of lack of affordability or hardship may purchase a catastrophic plan. That plan provides the essential benefits package with a deductible equal to the total limitation on cost-sharing above and first-dollar coverage of at least three primary care visits.

As exchanges are developed, more information will be available here. Check back often for updates.

MINIMUM ESSENTIAL COVERAGE

Individuals will be required to have qualified health insurance by 2014 or face penalties. This is the individual mandate requirement in the new healthcare law. You can either meet this requirement by maintaining your grandfathered plan or by purchasing a plan that meets the new minimum essential coverage standards.

If you or your business is able to maintain your grandfathered plan (i.e., plans that were in existence on March 23, 2010, when the law was signed), you will be deemed as meeting your obligations for the individual mandate. For all other health plans following March 23, 2010, there are new minimal essential coverage requirements.

Minimum essential coverage has not been fully defined yet by the Department of Health and Human Services (HHS). Defining regulations will be released by HHS throughout 2010 and 2011.

However, the law does outline the types of benefits that are required to be included in any package deemed to meet minimum essential coverage. Section 1302 of the new healthcare law specifies that all plans meeting these requirements will include at least the following categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

This will be a floor of required services and the states can go above this floor.

Employers who offer coverage will be required to offer minimum essential coverage to their employees worth at least 60% of the actuarial value of the covered benefits the insurance carrier pays out or face penalties. For the policyholder, that means paying no more than 40% of costs.

There will be limits on annual cost sharing and they are tied to current HSA limits (\$5,950 for individual and \$11,900 for a family). The HHS Secretary will be allowed to review and update the minimal essential coverage annually beginning in January 2014.

All plans inside and outside the exchange (including those in the individual and small group market) will be required to meet or exceed the new coverage requirements set forth in the new healthcare law.

For more information, including updates from the HHS process, please go to <http://www.regulations.gov>.

To access the timeline for overall implementation of the healthcare law, please visit our “Reform Timeline” on page 2.

[1] Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act” (JCX-18-10), March 21, 2010. Page 39

ADDITIONAL RESOURCES

NAIC HEALTH REFORM RESOURCE CENTER

http://www.naic.org/index_health_reform_section.htm

GLOSSARY RELATED TO PPACA

http://www.naic.org/documents/index_health_reform_glossary.pdf

FOLLOW REGULATIONS AT

www.regulations.gov

FOLLOW NFIB'S WORK ON HEALTHCARE REFORM

www.nfib.com/healthreform

Tax Credit Phaseout Information: <http://www.nfib.com/LinkClick.aspx?fileticket=N4UJE19k44w%3d&tabid=1235>

Primer on the Free Rider Provision: <http://www.nfib.com/LinkClick.aspx?fileticket=mYX1cEJXRLk%3d&tabid=1235>

PRIMER ON REFORM

<http://healthreform.kff.org/>

SUMMARY OF REFORM

<http://www.kff.org/healthreform/8061.cfm>

IRS ON THE SUNTAN TAX

For more information on the tax and how it will be administered see:

News Release: <http://www.irs.gov/newsroom/article/0,,id=224313,00.html>,

Video: <http://www.irs.gov/app/scripts/exit.jsp?dest=http%3A%2F%2Fwww.youtube.com%2FIRSVideos%23p%2Fu%2F11%2FGSR1gegvoA4>

Questions and Answers: <http://www.irs.gov/businesses/small/article/0,,id=224600,00.html>

Legal Guidance: http://www.irs.gov/pub/newsroom/td_9486_indoor_tanning_services.pdf

IRS ON SMALL BUSINESS TAX CREDITS

Learn more by browsing our page on the Small Business Health Care Tax Credit for Small Employers at <http://www.irs.gov/newsroom/article/0,,id=223666,00.html>.

IRS ON 1099S

<http://www.irs.gov/newsroom/article/0,,id=225029,00.html>

BREASTFEEDING ALERTS AND GUIDELINES

<http://www.dol.gov/whd/regs/compliance/whdfs73.pdf>

HEALTH REFORM IN THE STATES—STATE LEGISLATIVE ACTION

<http://www.ncsl.org/default.aspx?tabid=20231>