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INSURANCE Agency INC.

Making Sense of Health Care Reform

Seven Basics for Small-Business Owners

Executive Summary

The Affordable Care Act signed into law in 2010 includes provisions that affect how companies administer and report health care information for employer-sponsored health plans.[1] While it may take some time to become familiar with the new regulations, it is important now for small-business owners to understand the effect of health care reform on their companies and their employees. This white paper explains seven primary components of the Act:

1. Small-business tax credits
2. The grandfather provision
3. Non-discrimination
4. FSA, HSA, and HRA plans and over-the-counter medicines
5. Coverage for young adult dependents
6. W-2 reporting
7. The CLASS Program

While it may take some time to become familiar with the new regulations, it is important now for small-business owners to understand the effect of health care reform on their companies and their employees.

1. Small-Business Tax Credits

Generally, employees in small businesses have had to pay higher health-care insurance premiums than their large-company counterparts. That is because smaller employer groups could not take advantage of the larger risk pool enjoyed by major employers.

Under the reform law, federal tax credits will help small businesses pay for employee health-care insurance. The credits may be claimed on the employer's 2010 tax return using IRS Form 8941 – Credit for Small Employer Health Insurance Premiums. To be eligible, a business must fulfill three criteria:

- employ fewer than twenty-five people;
- pay less than $50,000 in average annual wages; and
- contribute at least 50% of the single rate for each employee's health care insurance premium.

Not all businesses that qualify will receive credit. The maximum credit is phased out as wages increase beyond $25,000 and number of employees increase beyond 10.

It is best for business owners to work with their CPA to determine whether or not they meet these qualifications for the tax credit. Taxable and not-for-profit organizations qualify for this credit, which can save a small business as much as 35% (maximum of 25% for not-for-profit organizations) of what it spends on premiums. In 2014, the tax credit for small businesses increases to 50% (maximum of 35% for not-for-profit organizations) for businesses that purchase insurance through small business health options programs in their states. (These are new exchange marketplaces for small businesses to purchase health insurance mandated by the Affordable Care Act). After 2014, the credit will be limited to two consecutive years.

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2. The Grandfather Provision

Small businesses that want to keep their current employee health care coverage because of its lower cost or because of the benefits the plan offers can take advantage of the "grandfather provision." Grandfathered plans are not subject to some aspects of the Affordable Care Act requirements including:

- coverage of preventive health services at no cost to plan participants;
- non-discrimination of health benefits in favor of highly compensated employees;
- certain appeals and external review procedures; and
- coverage of emergency services without authorization.

Grandfather status applies only to plans that were in place before March 23, 2010. Companies that enrolled in health care plans after that date will likely need to change their coverage. Nevertheless, all plans, regardless of their grandfathered status, must prohibit annual and lifetime benefit caps and allow coverage of dependents to age 26. Grandfathered plans may delay the dependent-age requirement until January 1, 2014, if the dependent is eligible for employer-sponsored health coverage.

All plans also must prohibit rescissions of health insurance coverage, meaning that employees may not lose their benefits because of any medical condition or benefits used. The only cause for rescission would be fraud. Employers are also

able to switch health care providers and not lose grandfather plan status, if they maintain similar coverage levels.

Pre-existing condition exclusions for participants younger than 19 may not be grandfathered.

Small-business owners should take special note that some changes to plans may cause them to lose their grandfathered status, so it is best to work closely with a licensed agent when making adjustments to the insurance offered employees.

3. Non-Discrimination

The Affordable Care Act is intended to prevent policies that previously caused people to lose insurance because of their health status, and eliminate coverage that favors highly compensated individuals.

These non-discrimination measures take a number of approaches. For example, new or non-grandfathered plans may not drop individuals from coverage if they get sick; deny coverage to children under age nineteen with pre-existing conditions; or impose lifetime or unreasonable annual limits on essential health benefits, including doctors visits, hospitalizations, and prescriptions.

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In the case of highly compensated employees, the Act states they may not receive preferred health care insurance benefits. Highly compensated employees may be defined in any of three ways:

1. one of the five highest paid officers of a company;
2. a shareholder of more than 10% of the company's shares; or
3. among the highest paid 25% of the company's employees

In addition, employers may not give highly compensated employees health-care benefits that are unavailable to other employees, and the plan must benefit a majority of eligible employees.

Penalties for non-compliance are costly. Violations of this law are subject to an excise tax of one hundred dollars per day, subject to caps and limitations, for any individual who is discriminated against. Additional civil penalties of one hundred dollars per day under the Public Health Service Act. Civil liability under ERISA could also apply. The non-discrimination provisions affect all health plans established on or after September 23, 2010.

The non-discrimination provision was originally to take effect January 1, 2011. However, the federal government has advised that it will delay enforcement of the part of the provision that focuses on discrimination in favor of highly compensated individuals, until further regulatory guidance is provided.

4. FSA, HSA and HRA Plans and Over-the-Counter Medicines

Health Care Reform establishes new guidelines – many effective January 1, 2011 – for FSAs, HSAs, and HRAs. Most of the provisions of these plans remain the same as before, with some notable exceptions. Effective immediately, participants can submit FSA claims for eligible expenses incurred by their adult dependents through the end of the calendar year in which the dependent turns twenty-six. Another provision, starting January 1, 2011, increases the penalty for HSA distributions for unqualified medical expenses from 10% to 20%.

Effective January 1, 2011, over-the-counter medicines or drugs (other than insulin) will no longer be eligible for tax-free reimbursement or distribution under a health FSA, HSA, or HRA unless they are prescribed by a medical practitioner.

The law states:

> *". . . reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or insulin."*[2]

Allergy and sinus treatments, antibiotics, cough, cold and flu remedies, and pain relief medications are just some of the affected categories that will now require a prescription to be reimbursed under the plan. Items such as adhesive bandages, insulin, and contact solution are examples of some of the over-the-counter items that will remain reimbursable without a prescription.

An important future change for FSA holders is that health FSA contributions will be limited to $2,500 or the company maximum, whichever is less. This maximum will be indexed annually for inflation. This provision will take effect January 1, 2013.

Starting in tax year 2012, employers must include the value of health-care insurance on employees' Forms W-2 if 250 or more forms are filed.

5. Young Adult Coverage

The creators of the Affordable Care Act recognized the need for coverage of young adults who, for example, may have finished college and are still looking for a job, or whose job does not provide health insurance. Previously, in some states, children of employees could be covered only up to age nineteen, or twenty-three if they were full-time students. Under health care reform, dependent children may be covered up to age twenty-six, but coverage cannot be extended to the dependent's spouse or children. Young adult coverage applies to plan years that began on or after September 23, 2010.

Grandfathered plans may exclude adult children who have access to coverage under another group health plan until 2014.

6. W-2 Reporting

Starting in tax year 2012, employers must include the value of health-care insurance on employees' Forms W-2 if 250 or more forms are filed. Employees will first receive these expanded forms for use in preparing 2012 tax returns. FSA contributions will not be included in the new reporting.

Employers are not required to issue Forms W-2 to non-employees currently receiving health coverage (such as a retiree, surviving spouse, or COBRA recipient) in order to report the health coverage amounts.

7. The CLASS Program

The Affordable Care Act created the Community Living Assistance Services and Supports Program and called for a voluntary long-term care (LTC) insurance program, which will be available after October 2012. Lawmakers intended for this program to make LTC insurance affordable for all Americans.

Under the terms of the new law, there is no lifetime cap on long-term care benefits, which can include services such as nursing home care, home health care aides, and assistive devices such as wheelchair ramps. An enrollee can collect benefits under these circumstances if he or she:

- has paid premiums for at least five years, and has worked at least three of those years;
- has a functional limitation, as certified by a licensed health care provider, that is expected to last more than 90 days;
- is unable to perform a specified number of activities of daily living, such as eating or bathing, without substantial assistance;
- requires substantial supervision to protect themselves from threats to their own health or safety.

Benefits from LTC insurance may prevent people from relying on Medicaid coverage and the "spend-down" or depletion of personal resources that sometimes is required to qualify for Medicaid. To enroll workers in the system, employers can automatically register employees through payroll deduction. Of course, employees can opt out if they choose to not keep the coverage.

Conclusion

Employers owe it to themselves — to say nothing of their obligation to their employees — to be well-versed in tax, employment, and benefits guidelines. At the same time, complying with state and federal statutes is the first step in avoiding costly penalties. A squeaky-clean record with tax agencies reinforces a company's reputation.

A Work In Progress

Health-care reform is still a work in progress. As its measures go into effect over the next few years, the federal government will continue to adjust provisions that were not specifically spelled out in the legislation. It's not necessary for small-business owners to understand every facet of the complex reform effort, but being aware of these seven basic changes can help them prepare for how their businesses will most likely be affected. Maintaining close contact with an insurance agency is another efficient way to navigate the changes the Affordable Care Act will require.

It's not necessary for small-business owners to understand every facet of the complex reform effort, but being aware of these seven basic changes can help them prepare for how their businesses will most likely be affected.

Notes

[1]The comprehensive health-care reform law was enacted in two parts. The Patient Protection and Affordable Care Act (signed into law March 23, 2010) was amended a week later by the Health Care and Education Reconciliation Act. The final, amended version of the law is officially referred to as the "Affordable Care Act."

[2]Section 9003 of the Affordable Care Act added section 106(f), containing this language, to the Internal Revenue Code, revising the definition of medical expenses as it relates to over-the-counter drugs. Additional IRS guidance on this addition was detailed in Notice 2010-59, and included intent to further amend the regulations under sections 1.105-1, 1.105-2, 1.106-1, 1.125-1 and 1.125-5.

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