SMALL BUSINESS MAJORITY

Small Business Healthcare Tax Credit and Shared Responsibility Requirements

Patient Protection and Affordable Care Act (Public Law 111 - 148) and Healthcare and Education Reconciliation Act (Public Law 111 - 152)

QUALIFYING REQUIREMENTS FOR THE TAX CREDIT

Who is eligible for the tax credit?

Small employers that provide healthcare coverage are eligible (a "qualified employer") if:

- They have fewer than 25 full-time equivalent employees (FTEs)* for the tax year
- The average annual wages paid are less than $50,000** per FTE
- The employer pays at least 50% of the premium cost under a "qualified arrangement"

* FTEs may be calculated in any of three ways to maximize the tax credit. See "How is the number of employees determined for eligibility?" below.

** Wage limits will be indexed to the Consumer Price Index for Urban Consumers (CPI-U) for tax years beginning in 2014.

A "qualified arrangement" means: The employer pays 50% or more of the cost of the employee-only premium for coverage through a state-licensed company for traditional health insurance. This contribution requirement also applies to add-on coverage including vision, dental and other limited-scope coverage.

Is a tax-exempt organization a qualified employer?

Yes. The same definition of qualified employer applies, but the amount of the tax credit is lower and special rules apply.

CALCULATING THE TAX CREDIT

How much is the tax credit?

There is a sliding-scale tax credit of up to 35% of the employer's eligible premium expenses for tax years 2010–2013. Employers with 10 or fewer full-time employees, paying annual average wages of $25,000 or less, qualify for the maximum credit.

Beginning in tax year 2014, the maximum tax credit increases to 50% of premium expenses and coverage must be purchased from a state health insurance exchange. This tax credit is available for a total of any two years.

For tax-exempt employers, the same employee and wage requirements apply, but the maximum tax credit is 25% of eligible premium expenses for tax years 2010 – 2013, increasing to 35% in 2014.

The amount of the tax credit cannot exceed the total income and Medicare tax the employer is required to withhold from employees' annual wages, plus the employer's share of the Medicare tax.

What expenses are counted in calculating the credit?

- Only the employer contribution to the premium amount counts as an eligible expense, subject to the limit described below. If an employer pays 80% of the premium, then 80% of the premium expense is counted. The premium contribution counted includes traditional health insurance, vision, dental and other limited-scope coverage.
- An employer's eligible premium contribution is capped at the average cost of health insurance for the small group market in their state (or an area of the state). If an employer pays 80% of the premium, then the amount that counts is limited to the same portion—80% of the average cost of health insurance in the state. This provision is designed to avoid an incentive to choose a high-cost plan.
- Any premium paid through a salary reduction arrangement under a section 125 cafeteria plan is not counted in determining the premium expense.

Note: Premium contributions for owners and family members are not eligible expenses for the tax credit.

How is the average premium for the small group market in the state determined?

The Department of Health and Human Services (HHS) will determine the rate for a state (or within a state) and the information will be published on the IRS website (IRS.gov). The 2010 rates are available in an easy-to-read table (PDF).

Example: **Calculating the credit for an employer (non–tax-exempt)**
For tax year 2010, an employer has 9 FTEs with average annual wages of $23,000 per employee. The employer pays $72,000 in premiums for those employees (which does not exceed the benchmark premium) and meets the requirements for the credit. This employer's credit for 2010 equals $25,000 (35% X $72,000).

Example: **Calculating the credit for a tax-exempt employer**
For tax year 2010, a tax-exempt employer has 9 FTEs with average annual wages of $23,000 per FTE. The employer pays $72,000 in premiums for those employees (which does not exceed the benchmark premium) and meets the requirements for the credit. The total for the employer's income tax and Medicare tax withholding, plus the employer's share of the Medicare tax withholding, equals $30,000.

Here's how the credit is calculated:
1) The initial amount of the credit is determined before any reduction: (25% X $72,000) = $18,000
2) The employer's withholding and Medicare taxes are $30,000
3) Total tax credit for 2010 is $18,000

How soon can the tax credit be taken?

Eligible small businesses can claim the credit beginning in tax year 2010. The credit may be included in determining estimated tax payments for the year in which the credit applies, following regular estimated tax rules.

For tax-exempt organizations, the IRS will provide information at a later date on how to claim the tax credit.

Do premiums paid by an employer in 2010, before healthcare reform was enacted, count toward the tax credit?

Yes. All qualified premium expenses paid beginning January 1, 2010 may be counted for that tax year.

Does the state tax credit or subsidy I receive reduce my federal tax credit?

No. Small businesses can receive both a federal and state tax credit for providing health insurance to their employees. The new federal tax credit will not be reduced by state healthcare tax credits or subsidies (except in limited circumstances to prevent abuse of the credit) and it will be based on the entire employer contribution as long as the federal credit does not exceed the employer's net contribution.

Will there be any transition relief for tax years beginning in 2010 to make it easier to meet the requirements for a qualifying arrangement?

Yes. The IRS and Treasury have issued formal guidance on this. To begin with, under transition rules:

- As long as an employer pays at least 50% of the premium for each enrolled employee, s/he will still qualify for a tax credit even if s/he doesn't pay a uniform percentage of the premium for each employee.
- The 50% employer premium contribution requirement applies to an employee-only premium rate. For those with family or employee-plus-one coverage, the employer contribution is met if the contribution is equal to 50% of the employee-only rate, not 50% of broader coverage.

How can non-profits take advantage of this resource?

Tax-exempt organizations can claim the small business healthcare tax credit on a revised Form 990-T. The Form 990-T is currently used by tax-exempt organizations to report and pay the tax on unrelated business income. The 990-T will be revised for the 2011 filing season to enable eligible tax-exempt organizations—even those that owe no tax on unrelated business income—to also claim the small business healthcare tax credit.

Can non-profits take a health insurance credit that is larger than their payroll taxes?

No. The IRS has now clarified that non-profits are taking the credit against their payroll taxes, clearing up any confusion on whether non-profits qualified for this credit before. It's important to note that non-profits cannot take a credit greater than their payroll taxes. Line 25 of the form informs tax-exempt organizations on how to determine the impact of this requirement.

CALCULATING NUMBER OF EMPLOYEES, AVERAGE ANNUAL WAGES

How is the number of employees determined for eligibility?

Only employers with fewer than 25 FTEs are eligible for the tax credit; the full credit goes to employers with 10 or fewer full-time equivalent employees (FTEs).

Employers may choose to count hours in one of three different ways, to maximize the credit and minimize their bookkeeping burden. These include:

- Actual hours of service: Divide the total hours for which the employer pays wages to the employees during a taxable year by 2,080. No more than 2,080 hours (equivalent to a 40-hour work week) should be counted for any employee.
- Estimate hours based on total days or service
- Estimate hours based on total weeks of service

  Example: For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

  The employer's FTEs would be calculated as follows:
  1) Total hours (not exceeding 2,080 per employee) is the sum of:

a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 X 2,080) b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 X 1,040) c. 2,080 hours for the 1 employee paid for 2,300 hours (hours limited to 2,080)

Total: 15,600 hours

2) FTEs: 7 (15,600 divided by 2,080) = 7.5, rounded down to the next-lowest whole number).

Can an employer with 25 or more employees qualify for the tax credit if some of its employees are part-time?

Yes. The limit on the number of employees applies only to FTEs. Full-time employees are those who work 30 hours or more; part-time employees work less than 30 hours per week, figured on a monthly basis. This takes weekly fluctuations into account.

> **Example**: An employer with 46 half-time employees has 23 FTEs and may qualify for the credit.

Are seasonal workers counted in determining FTEs and average annual wages?

Generally, no. They are only counted for FTE equivalents and average annual wages if they work for the employer more than 120 days during the tax year.

Does the owner of a business count as an employee for purposes of the tax credit if s/he also provides services? Do family members of a business owner who work for the company count as employees?

An owner is not counted if s/he is a sole proprietor, a partner in a partnership, a shareholder owning more than 2% of an S corporation or an owner of more than 5% of other businesses.

Family members are not counted if they are children or grandchildren; siblings or step-siblings; parents or grandparents; step-parents; nieces or nephews; aunts or uncles; sons- or daughters-in-law; fathers- or mothers-in-law; or brothers- or sisters-in-law.

This means their hours and wages do not apply to the FTE count, the amount of average annual wages or the amount of premium costs paid.

How are annual average wages determined?

Average annual wages are calculated by dividing total wages paid by the employer to employees during a taxable year (box 5 of W-2 wages) by the number of FTEs for the year. The result is rounded down to the nearest $1,000.

> **Example**: For the tax year 2010, an employer pays $224,000 in wages and has 10 FTEs.
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> The employer's annual average wage would be: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000).

How is the tax credit calculated for employers with more than 10 FTEs and/or average annual wages over $25,000?

As long as the employer has fewer than 25 FTEs and pays annual average wages under $50,000 (and meets other specified requirements) they are eligible for a tax credit on a sliding scale basis. A standard formula is used to reduce the full tax credit.

If there are more than 10 FTEs: The reduction is determined by multiplying the full credit amount by a fraction: the numerator is the number of FTEs over 10 and the denominator is 15.

If average annual wages exceed $25,000: The reduction is determined by multiplying the full credit amount by a fraction: the numerator is the amount by which average annual wages exceed $25,000 and the denominator is $25,000.

The amount calculated using the formula above is then subtracted from the full tax credit to determine the final credit the employer qualifies for. If the employer has both more than 10 FTEs and average annual wages over $25,000, the credit is determined by adding both reduction amounts together and subtracting that sum from the full credit amount.

> **Example**: **Calculating the sliding-scale tax credit**
> For the 2010 tax year, a qualified employer has 12 FTEs and average annual wages of $30,000. The employer pays $96,000 in healthcare premiums for those employees (which does not exceed the benchmark premium) and otherwise meets the requirements for the credit. The credit is calculated as follows:
>
> 1. Initial amount of credit determined before any reduction: (35% X $96,000) = $33,600
> 2. Credit reduction for FTEs in excess of 10: ($33,600 X 2/15) = $4,480
> 3. Credit reduction for average annual wages over $25,000: ($33,600 X $5,000/$25,000) = $6,720
> 4. Total credit reduction: ($4,480 + $6,720) = $11,200
> 5. Total 2010 tax credit: ($33,600 - $11,200) = $22,400.

HOW TO CLAIM THE TAX CREDIT

How does an employer claim the tax credit?

The credit is taken on the annual tax return. The IRS will provide information on how tax-exempt employers can claim the new credit.

Does taking the tax credit affect an employer's deduction for health insurance premiums?

Yes. The amount taken for the tax credit must be subtracted from the deduction.

May an employer reduce employment tax payments during the year in anticipation of the tax credit?

No. The credit applies against income tax, not employment tax (i.e. withheld income tax, social security tax, and Medicare tax).

Can an employer (other than a tax-exempt employer) claim the credit if it has no taxable income for the year?

Generally, no. Except in the case of a tax-exempt employer, the credit for a year offsets only an employer's actual income tax liability (or alternative minimum tax liability) for the year. However, as a general business credit, an unused credit amount can generally be carried back one year and carried forward 20 years. Because an unused credit amount cannot be carried back to a year before the effective date of the credit, though, an unused credit amount for 2010 can only be carried forward.

Can a tax-exempt employer claim the tax credit if it has no taxable income for the year?

Yes. The tax credit is a refundable credit and the employer is eligible for a refund as long as it's not more than the income tax withholding and Medicare tax liability.

Can the tax credit be counted in determining estimated tax payment for a year?

Yes. The credit may be included in determining estimated tax payments for the year in which the credit applies, following regular estimated tax rules.

Can a small employer claim the credit after they have already filed their taxes?

Yes, after the taxes have been filed a small business owner can file a correction to claim the credit. If you failed to claim the credit on your 2010 taxes but are eligible, you can still get the credit! Simply fill out an amended return, Form 1040x, and attach the Form 8941 to complete the process. For more information, contact your local IRS office.

If a small business files an extension on their federal income taxes, can they still claim the credit?

Yes, a credit can still be claimed on an extension.

HEALTH INSURANCE EXCHANGES

When are health insurance exchanges going to be available?

The health insurance exchanges will be available beginning January 1, 2014. (Some states have expressed interest in trying to make them available earlier.)

Beginning in 2017, states will have the flexibility (for up to 5 years) to make changes related to the exchange, qualified health plans, cost-sharing reductions, tax credits and individual and employer responsibility requirements.

What's the difference between the exchange for individuals and SHOP for small businesses?

The law provides for a separate exchange for small businesses (Small Business Health Options Program, SHOP) and one for individuals. The small group market is defined as employers with 1-100 employees. However, a state may limit small group participation to employers with 50 or fewer workers from 2014 through 2016. Beginning in 2017, all employers with 100 or fewer employers may participate in the exchange. States may allow businesses with more than 100 employees to participate after 2017. States can also choose to combine the individual and small business exchanges—an option with many proponents, because expanding the pool would lead to more competition among insurers, which would mean more choice and should result in better pricing for consumers.

Is it true that only standardized benefit packages will be offered through the exchange? What are they?

Yes. The exchange will provide a choice of four standardized benefit packages that must offer essential minimum benefits. This will allow easier comparison among plans. The employer will decide what level of coverage to offer, and employees may pick any plan offered within the exchange at that level.

The law established broad benefit categories of typical employer coverage, including ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care). The HHS secretary will define specific services that must be covered within these categories. This provision is designed to make sure coverage is comprehensive.

The four standardized options are based on the specified percentage of costs the plan will cover:

- Bronze = 60%

- Silver = 70%
- Gold = 80%
- Platinum = 90%

Also, if an insurer offers a qualified health plan, they must also offer a child-only plan at the same level of coverage.

The standardized options must also limit cost-sharing:

- Out-of-pocket costs can't exceed Health Spending Account (HSA) limits.
- Annual deductibles are limited to $2,000 for individuals and $4,000 for families in the small group market. The limit is indexed to the percentage increase in average per capita premiums.
- No cost-sharing for preventive services.
- No annual or lifetime caps on the dollar value of services.

Are there new tools or information sources for small businesses and individuals to explain options and help with decision-making? For example, to compare benefits and prices?

Yes. A new website (www.healthcare.gov) will provide information about coverage options in their state, including eligibility, availability, premium rates, cost-sharing, and how much is spent on medical care vs. administrative costs. The site will also help people determine whether they're eligible for a variety of programs, including existing or new state high-risk pools, Medicaid, Medicare and CHIP.

The site will launch on July 1, 2010; more detailed information will be available in October 2010.

By July 1: In addition to educational content and details on small business tax credits and the early retiree reinsurance program, the site will provide information that will enable consumers to evaluate their options in the private market (they'll be able to search for options by zip code, for example). Private health plan information will include:

- Plan names and types (e.g. HMO, PPO)
- Summary of services provided
- List of network providers
- List of prescription drugs covered, if available
- Links to plan websites
- Consumer contact information to learn more or enroll

The site will provide links to existing Medicare websites and call centers.

The following will be available on the site for Medicaid and CHIP:

- Eligibility information
- Summary of services available in states through core programs and waiver programs
- Links and contact information to get more details on benefits, determine eligibility on an individual basis, and enroll

Consumers will be able to get the following information on high-risk pools in their states:

- Eligibility criteria for enrolling
- Name and contact information to determine individual eligibility and enroll
- Coverage limitations

By October: The website will provide more detailed pricing and benefit information on private insurance options. It will show cost-sharing per service, deductibles and premiums and will have a tool to help compare plans.

It will also have more detailed information on services covered by the state Medicaid and CHIP programs, and on the federal and state high-risk pool program, including premiums and cost-sharing.

States will also receive funding this year to establish health insurance consumer assistance offices or ombudsman programs. This resource will be available to answer questions and handle complaints.

The HHS secretary is developing procedures for the exchanges to help consumers. For example:

- Each exchange will have an electronic calculator to help consumers figure out plan costs, including the impact of tax credits and subsidies, if eligible.
- The exchange will help determine eligibility for coverage and tax credits, whether an individual is exempt from the requirement to purchase coverage and whether their employer coverage is deemed "unaffordable."
- Each exchange will also maintain a call center for customer service.
- Plans will be required to provide an explanation of benefits and policies using a standard format, which will help make comparisons easier.

What happens if my state doesn't establish an exchange by 2014?

The HHS secretary will step in. If the secretary determines before 2013 that a state is not going to have an operational exchange by 2014 or implement the required standards, the secretary will establish the state exchange and implement the standards in the state.

How will administrative complexity be reduced for employers and individuals through the health insurance exchanges?

There are a number of provisions designed to reduce administrative complexity. These include:

- The exchange will establish procedures to enroll small businesses and individuals; one simple enrollment form will be used.
- The exchange will offer standardized benefit packages, and require insurers to describe benefits and policies in a standardized format that allows for easy comparison.
- Individuals will be able to apply for coverage through the exchange, and will be informed if they qualify for Medicaid, CHIP or any other state or local public health program through one state-sponsored website. The exchange will determine whether an individual qualifies for a tax credit and/or subsidy to reduce cost sharing.
- HHS is creating a single website where small businesses and individuals can find detailed information about coverage options in their state.

There are also a number of new requirements for insurers on standardized operating rules to simplify elements of health insurance administration such as eligibility verification, service authorizations, claims status, payment procedures, and referrals. These changes should reduce waste, administrative cost and hassle; they must be adopted by July 1, 2011 and fully implemented by January 1, 2013.

GRANDFATHERED PLANS

What makes a plan "grandfathered?"

One important aspect of healthcare reform allows employers who like their current coverage to keep it, as long as the plan was in existence before reform was enacted on March 23, 2010. These plans are often referred to as "grandfathered" plans.

Keeping a health plan's grandfathered status

Small businesses are allowed to keep their grandfathered plans as long as they don't make any significant changes in coverage. If any of the following changes are made, the plan can no longer keep its grandfathered status—which means that all the new consumer protections introduced with reform will apply.

- **Increase medical costs to employees.** An increase in cost-sharing above medical inflation (usually 4-5% annually) plus 15% (changes in premiums are not taken into account):
  - 1) Raises copayment charges more than $5 (adjusted annually for medical inflation) or a percentage equal to medical inflation plus 15%
  - 2) Raises deductibles (an allowable range is 19-20% from 2010 to 2011; 23-25% from 2011 to 2012); grandfathered plans can only increase these deductibles by a percentage equal to medical inflation plus 15%
  - 3) Increases coinsurance charges; for example, if coinsurance for a hospital stay is 20% (usually requires the patient to pay a fixed percentage of the charge), it cannot be increased to 25%
- **Reduces the employer contribution**. Many small business owners pay a portion of their employee's insurance premium and this is usually deducted from workers' paychecks. If an employer decreases the percent of premiums it pays by more than 5%, the plan loses its grandfathered status.
- **Significantly cuts or reduces benefits.** For example, if coverage for a specific condition, like diabetes, HIV/AIDS or cystic fibrosis is reduced or eliminated.
- **Adding or tightening an annual limit.** As of 2010, annual limits are restricted and will be phased out. To keep grandfathered status, an annual dollar limit may not be made more restrictive; if the plan had no annual dollar limit on March 23, 2010, a new one can't be added. There's one exception: If there was a lifetime cap, it could become the annual dollar limit, so long as it is at least as high as the lifetime cap. Annual limits requirements are as follows:
  - Plan years: Sept. 23, 2010 to Sept. 23, 2011: not less than $750,000
  - 2011-2012, not less than $1.25 million
  - 2012-2013, not less than $2 million

The limits apply only to essential benefits, not yet defined.

Loss of grandfathered status

If an employer inadvertently triggers the loss of grandfathered status by violating one of the below rules, s/he may request a delay and make any necessary changes to coverage in order to retain the status.

Reforms that DON'T apply to grandfathered plans

The new law exempts grandfathered plans from certain requirements:

- **Preventive health coverage.** Group health plans and health insurance issuers offering group or individual coverage must cover certain preventive health services (mammograms, colonoscopies, etc.) without passing the cost on to consumers.
- **Patient protections.** The following rules offer additional safeguards for patients and apply to group health plans and health insurance providers offering group or individual coverage:

- Plans that require designation of a participating primary care provider must allow each participant, beneficiary and enrollee to select any available participating primary care provider (including pediatricians for children).
- No preauthorization or increased cost-sharing requirements for emergency services (in our out of network).
- Obstetrical and gynecological care offered through the plan may not require preauthorization or referral of a participating primary care provider for such services.

- **Restrictions on insurance premiums**. Plans may not charge discriminatory premiums for health insurance in the individual or group market, and may only differ by individual or family coverage, rating area and age and tobacco use, subject to certain restrictions.
- **Guaranteed issue and renewal of coverage**. Health insurance providers offering coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage and must renew or continue the coverage at the option of the plan sponsor or the individual.
- **Nondiscrimination rules.** New rules protect consumers from discrimination:
  - Fully insured plans must satisfy the requirements of IRC section 105(h)(2) that requires a plan to not discriminate in favor of highly compensated individuals when considering eligibility and for the benefits provided under the plan.
  - Plans may not establish eligibility or continued eligibility rules based on health status-related factors and wellness programs must meet nondiscrimination requirements.
  - Group health plans and health insurance issuers offering group or individual coverage can't discriminate against any provider operating within their scope of practice. However, this provision doesn't require a plan to contract with any willing provider or prevent tiered networks. Individuals cannot be discriminated against based on whether they receive subsidies or cooperate in a Fair Labor Standards Act investigation.

Other provisions of the new law that don't apply to grandfathered plans include quality of care reporting, effective appeals processes, limits on cost-sharing and coverage for clinical trials.

Reforms that DO apply to grandfathered plans

The following provisions apply to both grandfathered and new health plans under the healthcare reform law:

- **Extension of dependent coverage.** Group health plans must provide coverage for adult dependent children up to the age of 26 if the child isn't eligible to enroll in other employer-provided coverage (other than the grandfathered plan). Coverage provided to adult children is tax-free to employees.
- **Elimination of lifetime and annual limits.** Plans may not establish lifetime caps on the dollar value of essential benefits and group health plans may not establish unreasonable annual limits. By 2014, all annual limits will be abolished.
- **Elimination of preexisting condition exclusions.** Children cannot be denied coverage for preexisting conditions; this will apply to all enrollees in 2014.
- **Limits on rescissions.** Coverage may not be rescinded except in the case of fraud or intentional misrepresentation of facts. Policyholders must be notified prior to cancellation.

Additionally, plans cannot require a waiting period of more than 90 days beginning in 2014, and on March 23, 2012, insurers and sponsors of self-funded plans must provide a summary of benefits to participants and applicants. Health insurance providers must report the percentage of premiums spent

on non-claim expenses on an annual basis, and in 2011, insurers must provide rebates if more than the applicable percentage is spent on these costs.

Collectively bargained plans

Plans that are maintained pursuant to a collective bargaining agreement that was in place before March 23, 2010 are considered grandfathered until the termination of the agreement, even if a change in insurers or a change that terminates the plan's grandfathered status occurs.

Employee notification

Employees must be notified by either their employer or the insurer that their plan will be grandfathered; any material distributed about the plan must also include whether or not the plan has grandfathered status and therefore isn't subject to new consumer protections. If you buy your own insurance, you should ask your insurer if your plan is grandfathered.

Beginning in 2014, insurers must apply to grandfathered plans the same reforms that apply to all other individual and small group plans like those mentioned above.

PREEXISTING CONDITION INSURANCE PLANS (FORMERLY HIGH-RISK POOLS)

How will the new Preexisting Condition Insurance Plan (formerly high-risk pool) work and when will it be available? What if my state already has one?

A temporary national Preexisting Condition Insurance Plan (formerly called the high-risk pool) was established July 1, 2010. Up to $5 billion in federal funding will be provided to cover those who have been denied coverage due to a preexisting condition and who have been uninsured for at least six months prior to applying for enrollment. The secretary of the Department of Health and Human Services (HHS) will determine the benefits that must be included and is considering establishing a minimum standard. HHS will also determine what qualifies as a "preexisting condition."

Each state has now made a decision about whether to establish its own Preexisting Condition Insurance Plan (PCIP). If a state already has a high-risk pool in place, it may combine it with its new PCIP or operate them separately. Thirty-four states currently have a high-risk pool, but eligibility, benefits, premiums, subsidies and other parameters vary widely. Some states have elected to let HHS handle the creation of their Preexisting Condition Insurance Plan.

Thirty states and the District of Colombia have decided to run their own Preexisting Condition Insurance Plan; HHS will run the plan in the other 20 states. Applications should be available on July 1, 2010. For the 20 states where HHS is operating the plan, check healthcare.gov for information. For states that are operating their own plan, check individual state websites (see directions below).

Twenty states will begin accepting applications for their new PCIP in early to mid-July; 10 others are working to resolve issues and will take a little longer. For example, California just passed legislation to create its new Preexisting Condition Insurance Plan and expects to begin accepting applications in August, with coverage starting in September. All states should be able to accept applicants by the end of the summer.

For information about your state's PCIP, find the state Department of Insurance at http://www.naic.org/state_web_map.htm. Those interested in applying for coverage should gather copies of their medical records to demonstrate they have a preexisting condition (it must be one specified by the secretary or the state) and apply as soon as the state or federal government starts accepting applications. You will also need proof of a denial of coverage, or that coverage was offered only with an exclusionary rider.

People already enrolled in a state risk pool will maintain their coverage and won't be able to enroll in the new PCIP. The new federal funding will allow existing state plans to cover more people.

The Preexisting Condition Insurance Plan is a temporary solution and will end January 1, 2014, when the health insurance exchanges are in place. Procedures will be developed to transition PCIP members to the exchange with no gaps in coverage.

Will insurance through the new preexisting condition insurance plan (formerly high-risk pool) be more affordable than that through existing plans?

The new national preexisting condition insurance plan (formerly high-risk pool) will make coverage more affordable; premiums may be 10%-40% less than those available through existing state preexisting condition insurance plans thanks to subsidies from the federal government and new rating restrictions: Premiums will be set for a standard population, not one with higher risk; premiums can only be adjusted for age (limited to a 4-to-1 ratio), geographic area, and family composition. Cost-sharing will be capped at HSA limits: $5,950 for individuals and $11,900 for families in 2010. Premium subsidies will also be available.

> Read about the preexisting condition insurance plan on HealthCare.gov

PREEXISTING CONDITIONS

How are preexisting conditions handled under healthcare reform?

Guaranteed issue—requiring insurers to take all applicants, including people with preexisting conditions—will eventually apply to everyone. Effective immediately, preexisting condition exclusions are no longer allowed for children. For adults, the ban takes effect in 2014. Until then, individuals who have a preexisting condition and have been uninsured for 6 months may obtain coverage through either the new national risk pool or one in their state.

Since being implemented, restrictions have eased and premiums have been lowered in the states where the plan is federally administered. For more information, visit https://www.pcip.gov/.

How does the change in preexisting condition exclusions affect the coverage I offer my employees?

If you currently offer coverage, there is no change now in how preexisting conditions are handled, except for children: Preexisting condition exclusions are prohibited for children effective September 2010, although some insurers may make this change immediately.

Beginning in 2014, qualified health plans will no longer be able to deny coverage or charge a different premium based on preexisting conditions, health status or claims history.

Will waiting periods still be allowed?

Effective January 1, 2014, waiting periods for group coverage will be limited to no more than 90 days. Waiting periods don't apply to the individual market.

COVERAGE OPTIONS FOR THE SELF-EMPLOYED

How does healthcare reform affect the self-employed?

The self-employed will have more affordable coverage options and may qualify for individual tax credits and subsidies on a sliding scale, based on income. Also, there are exceptions for the individual requirement penalty. Information on how specific provisions apply to the self-employed follows.

Temporary risk pool
Immediate coverage will be available through a temporary state-based risk pool as described for those with preexisting conditions who been uninsured for 6 months. As described under "risk pools" there will be limits on premiums, cost-sharing will be capped and premium subsidies will be available to those eligible based on income.

Health insurance exchange
Individuals will be able to purchase coverage through the state's health insurance exchange beginning in 2014. There will be four standardized benefit packages that differ by the percentage of costs the health plan covers, set at 60%, 70%, 80% or 90%. Under the exchange, plans must accept all applicants; there are limits on out-of-pocket costs (deductibles can't exceed $2,000 for individuals and $4,000 for families); and there are no annual limits or lifetime caps on the dollar value of care.

Individuals and families will be eligible for premium and cost-sharing reduction assistance on a sliding scale for those with incomes of up to 400% of the federal poverty level ($43,000 for an individual and $88,000 for a family of four).

How do premium assistance tax credits work and how much will they be?

Premium assistance can be an advance or refundable tax credit that helps reduce the cost of the annual premium. The amount of the credit is tied to the "Silver plan" (this benefit plan covers 70% of costs). The premium subsidy is set as follows:

If your income is:	Your premium assistance will limit your contribution to:
Up to 133% of FPL	2% of income
133% to 150%	3% - 4% of income
150% to 200%	4%- 6.3% of income
200% to 250%	6.3% - 8.05% of income
250% to 300%	8.05 - 9.5% of income
300% to 400%	9.5%

Cost-sharing reduction assistance is also available. These credits reduce out-of-pocket limits for those with incomes up to 400% FPL to the following levels:

- 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
- 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
- 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

The exchange will help individuals and families:

- Determine whether they meet income requirements and are eligible for coverage, including whether their employer coverage is "unaffordable"
- Determine tax credits and cost-sharing reductions
- Get certification of exemption from the individual coverage requirement so that no penalty will apply

Are there other options besides the four benefit packages in the health insurance exchange?

Yes. You can get catastrophic coverage through the exchange if you meet certain requirements, or you may qualify for Medicaid, which many states will use to cover the uninsured.

Catastrophic coverage option
If an individual can't find a plan premium that costs less than 8% of his or her annual adjusted gross income, or qualifies for a hardship exemption from the individual coverage requirement, s/he may purchase catastrophic coverage through the exchange. Catastrophic coverage provides the essential benefits, including three preventive care visits to a primary care physician; the plans come with a high deductible, and cost-sharing is limited to what can be charged under HSAs.

Medicaid
Individuals may also qualify for coverage under newly expanded Medicaid programs. States can modify their Medicaid eligibility requirements immediately, including allowing low-income non-parents to qualify and lowering income requirements for eligibility. States are required to expand Medicaid at least to those with incomes of less than 133% of the poverty guidelines ($24,353 for a family of four) by 2014, when states will receive extra money from the federal government.

What are the penalties for those who don't meet the individual responsibility requirement? And are there exceptions?

If you don't meet the individual responsibility requirement, which takes effect in 2014, the following penalties will apply (note that they'll be phased in over a few years): The greater of $95 or 1% of income in 2014; $325 or 2% of income in 2015; and $695 or 2.5% of income when fully implemented. There is a cap equal to the annual premium for the Bronze plan. These are indexed to the Consumer Price Index.

Individuals are exempt from the requirement if they meet any of the following criteria:

- Can't find a premium for a qualified plan through the exchange that is less than 8% of adjusted gross income
- Income below the tax filing threshold
- Has a hardship waiver
- Not covered for a period of less than three months during the year
- Has a religious objection

SHARED RESPONSIBILITY REQUIREMENTS

Are small employers that don't offer health insurance required to pay a penalty?

Most small businesses are exempt. Employers with fewer than 50 FTEs are not subject to the shared responsibility (or "free rider") provision that takes effect January 1, 2014. If you have at least 50 FTEs but no employee receives an individual premium tax credit or cost-sharing reductions (both based on income), there's no penalty—whether or not you offer health insurance.

How are employees counted under the shared responsibility requirement?

A business is defined as "large" if it has at least 50 FTEs, not counting seasonal workers. Full-time employees are those who work 30 hours or more; part-time employees work less than 30 hours per week, figured on a monthly basis. This calculation involves taking the total number of hours worked divided by 120. Also, the first 30 employees are subtracted from the total when calculating the total amount of the assessment.

How is the shared responsibility payment calculated?

If you have at least one full-time employee who receives a premium tax credit or cost-sharing reductions under the health plan they're enrolled in through the state insurance exchange, the payment assessed depends on whether or not you offer health coverage.

Doesn't offer health insurance
If the employer does not offer coverage, and at least one full-time employee receives a premium tax credit or cost-sharing reductions, the business must pay $2,000 for each full-time employee, not counting the first 30 employees.

> **Example**: An employer with 51 employees who doesn't offer health insurance and has one employee who receives an individual tax credit or cost-sharing reductions will be assessed $42,000 ($2,000 multiplied by 21).

Does offer health insurance
If the employer does offer coverage, and at least one full-time employee receives a premium tax credit or cost-sharing reductions, the employer will be required to pay $3,000 for each employee who receives assistance or $2,000 per full-time employee (not counting the first 30 employees), whichever is less. In this case, the coverage offered to an employee and his or her dependents must meet the criterion of having a minimum essential value (to be determined and defined by the secretary of Health and Human Services) and not be considered "inadequate" or "unaffordable."

- Coverage is considered "inadequate" if it covers less than 60% of the total allowed costs of benefits.
- Coverage is considered "unaffordable" if the employee's share of the premium is more than 9.5% of the employee's household income.

> **Example**: An employer with 51 employees who offers coverage but has one employee who receives an individual tax credit or cost-sharing reductions will be assessed $3,000 ($3,000 x 1).

AFFORDABILITY AND CONTROLING COSTS

Will there be limits on what insurance companies can charge me or my employees?

Yes. There will be a number of limits to what insurers can charge. Beginning in 2014, they may only vary premiums based on scope of coverage (individual vs. family), geography, tobacco use, wellness program participation and age. The latter is limited to a 3-to-1 ratio. Rating can no longer take into account gender, health status, occupation, genetic information or claims history. Deductibles can't exceed $2,000 annually for individuals and $4,000 for families and cost-sharing can't exceed limits for HSAs.

Also, beginning with plan year 2010, the secretary and the states will establish a process for the annual review of premium increases. Insurers will be required to justify "unreasonable" premium increases to the secretary of Health and Human Services and the state, and post the information online.

States will be required to make recommendations to their exchange about whether insurers should be excluded from the exchange due to unjustified premium increases. States will receive up to $250 million from 2010 to 2014 to help them develop or enhance rate review programs.

Some states have also introduced or passed legislation to limit annual increases and/or require state approval of premiums. Massachusetts has such a requirement in place and legislation to require approval of premium increases is close to passage in California.

What does the new law do to control costs?

Reform is expected to reduce the deficit by $143 billion over the next 10 years by attacking waste, fraud and abuse and paying for quality over quantity. The law was designed to control and stabilize costs in a variety of ways: Expanding coverage to those previously uninsured will reduce cost-shifting; combining the purchasing power of small businesses and individuals through the exchanges will promote competition; creating standardized benefits options will encourage better consumer decision-

making; and investing in wellness initiatives will prevent some chronic illness, to name a few examples.

The new law also encourages development of more efficient and cost-effective payment and delivery models for the long-term. Examples include the creation of advisory boards to explore ways to lower healthcare costs, promote quality and efficiency and expand access to evidence-based care; testing of different models of paying doctors and hospitals to reward patient outcomes, rather than number of visits and tests ordered; and research into the relative effectiveness of various treatments for specific conditions and illnesses.

Will there be malpractice reform under this new law?

The law establishes a five-year demonstration grant program for states to develop, implement and evaluate alternatives to the current system. The new grants will help states and healthcare systems test models that: (1) put patient safety first and work to reduce preventable injuries; (2) foster better communication between doctors and their patients; (3) ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reduce liability premiums.

ADDITIONAL OPTIONS: MULTI-STATE PLANS, CO-OPS AND MORE

Will state exchanges give small business owners and individuals more choices of insurance plans? And will consumer protections and price limits still apply?

Yes. The law requires that at least two multi-state plans be offered in each state exchange. The HHS secretary and NAIC will issue regulations for multi-state options that can be entered into by 2016. The state and secretary must approve the option.

Private insurers will be able to offer multi-state plans through the exchange. These plans will be subject to the same requirements as other qualified plans offered in the exchange, including the consumer protection laws of the purchaser's state, and the secretary has to be assured that the policy will not weaken enforcement of state consumer protection laws.

The agency that will oversee multi-state plans is the Office of Personnel Management (OPM), the federal agency that runs the Federal Employee Health Benefits Program (FEHBP), which covers federal employees and their families nationwide. It also includes members of Congress and their families. (Once the exchange is operational, members of Congress, congressional staff and their families must purchase their healthcare coverage through the exchange just like small businesses and individuals).

States will also be able to form "healthcare choice compacts" with other states to permit cross-selling of insurance. Insurers would be able to sell in any state in the compact. They would be subject to the laws of each state where coverage is issued or written except for consumer protection, network adequacy, market conduct or unfair trade practices. The compacts may only be approved if they provide coverage that is at least as comprehensive and affordable as any other coverage offered through the exchange. Governing regulations will be issued by July 1, 2013; compacts may not be established before 2016.

When will new nonprofit insurance co-ops be available in my area? How will they work?

The new insurance co-ops are not mandated, but, rather, encouraged. A new program will encourage the development of nonprofit, member-run cooperatives in each state and the federal government will award up to $6 billion in loans for startup costs and grants to help meet solvency requirements through July 1, 2013. An advisory board was recently named to help the government make decisions

on offering loans and grants to start new co-ops; priority will be given to entities that offer statewide coverage.

Co-op health plans have been established in other states and have generally taken a number of years to get set up. These new entities can't be an existing insurer or a government entity. Loans and grants may help speed up the process.

The bottom line: It will be up to parties in each state to take the initiative to set up an insurance co-op with federal support and funding.

ADDITIONAL ISSUES

Does the law affect coverage for early retirees?

There is temporary assistance for employers who provide health coverage for early retirees who are 55 or over but not yet eligible for Medicare. The Department of Health and Human Services (HHS) has established a program that provides re-insurance coverage. The program will pay 80% of eligible claims between $15,000 and $90,000, and program participants will be able to submit claims for medical care going back to June 1, 2010. HHS began accepting applications on June 29, 2010; to get an application or application assistance, visit www.hhs.gov/ociio. The program will expire January 1, 2014.

Are there changes to Health Spending Accounts (HSAs), Flexible Spending Accounts (FSAs) and Archer Medical Spending Accounts (MSAs)?

Yes, there are several:

For FSAs under a cafeteria plan, annual contributions will be limited to $2500, beginning in 2013; the cap is indexed to the Consumer Price Index – Urban (CPI-U) for subsequent years. There is currently no federal limit and employers set the annual cap.

The FSA definition of qualified medical expenses will be the same as those allowed under itemized tax deduction. Currently, employers can be more restrictive than the government for what qualifies as acceptable medical expense. This change, effective January 1, 2011, will no longer allow coverage of OTC items unless directed by a physician.

The additional tax that applies to early distribution for nonqualified medical expenses before age 65 will go up: for HSAs, the tax will increase from 10% to 20% and for Archer MSAs, from 15% to 20%.

The threshold of adjusted gross income for deducting medical expenses is raised from 7.5% of adjusted gross income (AGI) to 10%. Those 65 and over can continue to claim 7.5% of AGI through 2016.

How will the changes in simple cafeteria plans work for small business owners?

The reform law makes it easier for small employers to offer cafeteria plans by carving out a safe harbor from nondiscrimination requirements. This change relaxes participation restrictions so that small employers can provide tax-free benefits, including healthcare coverage, to their employees. The self-employed are also considered qualified employees. The change exempts employers who make contributions for employees under a simple cafeteria plan from pension plan non-discrimination requirements applicable to key employees and those who are highly compensated.

Are there new reporting requirements, such as on the W-2?

Yes. Every employer will be required to report the value of the health insurance benefit for each employee on his or her annual W-2 beginning in 2011. This is to determine whether a) an individual has coverage as required and b) his or her health plan will be subject to the excise tax. Note that there is no new tax associated with this requirement.

Does an employee have to take an employer's insurance if offered?

No. Employees can join their spouse's coverage or purchase coverage through the exchange or the individual market. However, as of 2014 when individual responsibility requirements take effect, if an employee refuses employer coverage and doesn't obtain coverage on his or her own, the employee will be subject a penalty.

If an employee waives coverage for any reason other than that it doesn't meet the affordability test, s/he can still purchase coverage through the exchange, but will not be eligible for the refundable tax credit.

If an employee's share of the premium for employer-sponsored coverage meets the law's definition of unaffordable (i.e., it exceeds 9.5% of their adjusted gross income), s/he can purchase coverage through the exchange. They can't receive a tax credit unless the employer plan does not have an actuarial value of at least 60 percent (as defined by the DHHS's essential benefits package) or is deemed unaffordable. The exchange will determine if the coverage is unaffordable for the employee.

What is the minimum coverage that everyone is required to carry? Is there a "bare-bones" option?

For most, the minimum coverage will be the standard Bronze benefit package available through the exchange that covers 60% of the costs.

Catastrophic-only coverage is available through the exchange (but only in the individual market) to those under age 30. It's also available to those deemed exempt from the individual coverage requirement due to hardship and/or because they can't find a qualified plan with a premium that costs less than 8% of their adjusted gross income. This option must still cover essential benefits, with at least three annual visits to a primary care physician for preventive care. Catastrophic-only plans will have a large deductible, and cost-sharing will be capped at the out-of-pocket limits under HSAs.

How will I know if my employees are getting premium credits that might subject me to the free-rider penalties? Who validates employees' eligibility?

Many of these details have yet to be determined. The health insurance exchange will determine an employee's eligibility for coverage through the exchange and whether they qualify for premium assistance tax credits. It is assumed there will be a good information flow between the exchange, the IRS and employers.

Does the law offer incentives to create or participate in wellness programs?

Wellness initiatives are encouraged--the law authorizes Congress to appropriate $200 million for small business wellness initiatives and lets employers vary cost-sharing based on employee participation in these programs**.**

Can employees still waive coverage if not covered under another program?

Employees may waive coverage, but they will have to pay the penalty for not having coverage unless they can't afford the employee share of the premium (more than 8% of their adjusted gross income) and qualify for the individual responsibility exemption. Otherwise, they'll have to obtain coverage through a spouse, through the exchange or in the individual market.

What are the details on the excise tax for small businesses?

The federal excise tax, due to take effect in 2018, will apply to insurers and plan administrators in the group and self-insured market. It won't apply to the individual market except for coverage eligible for the self-employment deduction.

The excise tax is set at 40% of the amount in excess of a threshold premium of $10,200 for single coverage and $27,500 for family coverage. The threshold premium is indexed to the Consumer Price Index – Urban (CPI-U) plus 1% in 2019 and the CPI-U only for 2020 and after.

There are several caveats: The threshold premium is increased by $1650 for single coverage and $3450 for family coverage for retirees age 55 and older and for plans that cover workers in high-risk professions. There is also an adjustment for firms with higher health costs due to the age or gender of employees. Finally, there may be an adjustment to the initial premium threshold if there is unexpected growth in premiums before 2018.

By what date must we put kids under 27 back on parents' health insurance?

This is a new option that takes effect September 2010. Note that parents are not required to put their children back on their plans—the provision was intended to ensure coverage for young people who, for various reasons, can't obtain or afford their own insurance. Until 2014, only young people who are not offered coverage by their employer can stay on their parent's coverage until age 27. Beginning in 2014, this provision applies to all young people, whether or not their employer offers them coverage.

- The last day a plan can extend coverage is the day before the 26th birthday;
- The employer can extend coverage through the end of the year of the 26th birthday without adverse tax consequences to the employee;
- Employers may not levy a surcharge for extending adult dependent coverage;

Note that maternity benefits may be excluded in some cases: If an employer currently offers maternity benefits to dependents, the coverage must now be offered to adults up to age 27. Otherwise, maternity benefits may be excluded for this entire group until 2014, when they become part of the essential benefits package and must be covered.

Note: Some insurers are offering to make the dependent coverage provision effective before the required September date so those who are eligible don't have gaps in coverage. The HHS secretary has asked that all health insurers voluntarily comply with an immediate effective date. However, for those with self-insured coverage, it's the employer who must agree to offer an earlier coverage option; recent surveys indicate that many do not plan to offer this coverage earlier than required. The provision is effective September 2010 for the new plan year on the renewal date, which may be January 1, 2011, or later.

> White House fact sheet on the extension of coverage for young adults

Is there a new long-term care benefit?

Yes, the law creates a new government long-term care insurance plan for working adults, the Community Living Assistance Services and Supports program (or Class Act). Employees of businesses that participate will be able to have their premiums deducted from their paychecks. There will also be a mechanism for self-employed individuals to make premium contributions. Enrollment will likely begin in 2013; benefit and premium specifics have yet to be ironed out. The HHS secretary is expected to release details of the program by October 2012.

WHERE CAN I GET ADDITIONAL INFORMATION?

- Check the Small Business Majority website (http://www.smallbusinessmajority.org/) and sign up for our alerts.
- Healthcare.gov, a new portal maintained by the Department of Health and Human Services. The small business site includes information about small business tax credits, coverage options, reinsurance for retirees and more, and will be updated regularly.
- Check the IRS website, http://www.irs.gov/newsroom/article/0,,id=220839,00.html; the new front page at IRS.gov has tips, a detailed FAQ and eligibility worksheets.

Sources:

- Patient Protection and Affordable Care Act (Public Law 111 - 148) and Healthcare and Education Reconciliation Act (Public Law 111 - 152)
- Small Business Health Care Tax Credit – White House Fact Sheet, March 24, 2010
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- Kaiser Family Foundation, http://healthreform.kff.org/
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- CCH Tax briefing, http://taxcchgroup.com/Legislation/Final-Healthcare-Reform-03-10.pdf