

Health Care Reform

Creative Benefits, Inc.

Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. On June 28, 2012, the Supreme Court upheld the constitutionality of the ACA (for the most part). The provisions within the ACA started to take effect in 2010 and will continue to become effective through 2020.



| | <u>Page</u> |
|--|-------------|
| Individual Mandate | 2 |
| The State Health Insurance Marketplaces | 3-6 |
| Notice of Health Insurance Marketplaces | 7 |
| Additional Medicare Tax Withholding | 8 |
| W-2 Reporting of Total Cost of Health Coverage | 8 |
| Other Key Provisions of Health Care Reform | 9-10 |

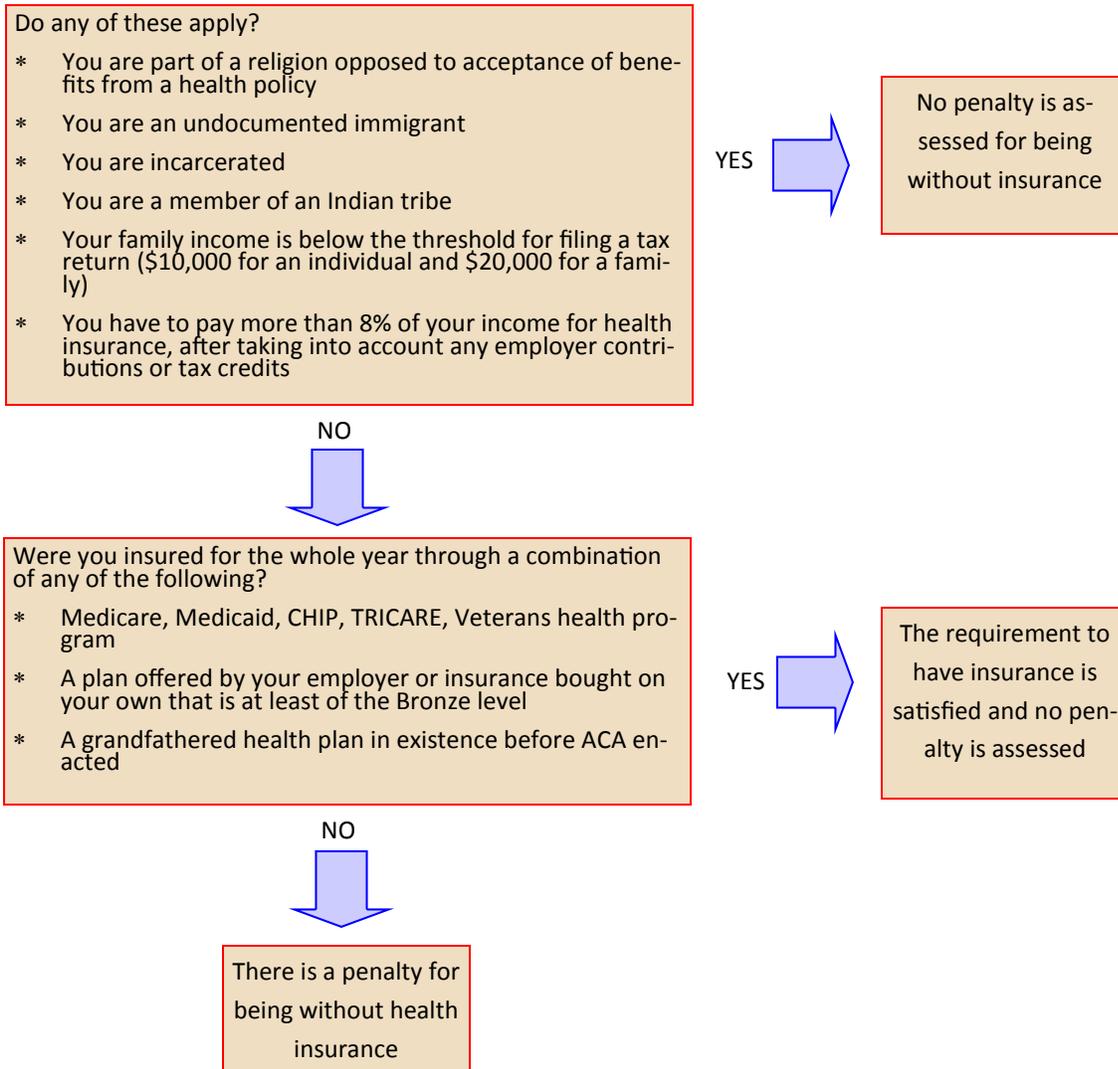
How are you affected?

Find out by reading pages 2-10.

Creative Benefits has assembled a team of experts to help you navigate through health care reform. See page 11 for contact information.

The Individual Mandate

Individual Mandate. The individual mandate requires most US citizens to be covered by adequate health insurance beginning in January 2014 or pay a penalty. The following chart shows how the mandate works.



2014 Penalties

\$95 per adult,
\$47.50 per child up to \$285 for a family or 1% of income

2015 Penalties

\$325 per adult,
\$162.50 per child up to \$975 for a family or 2% of income

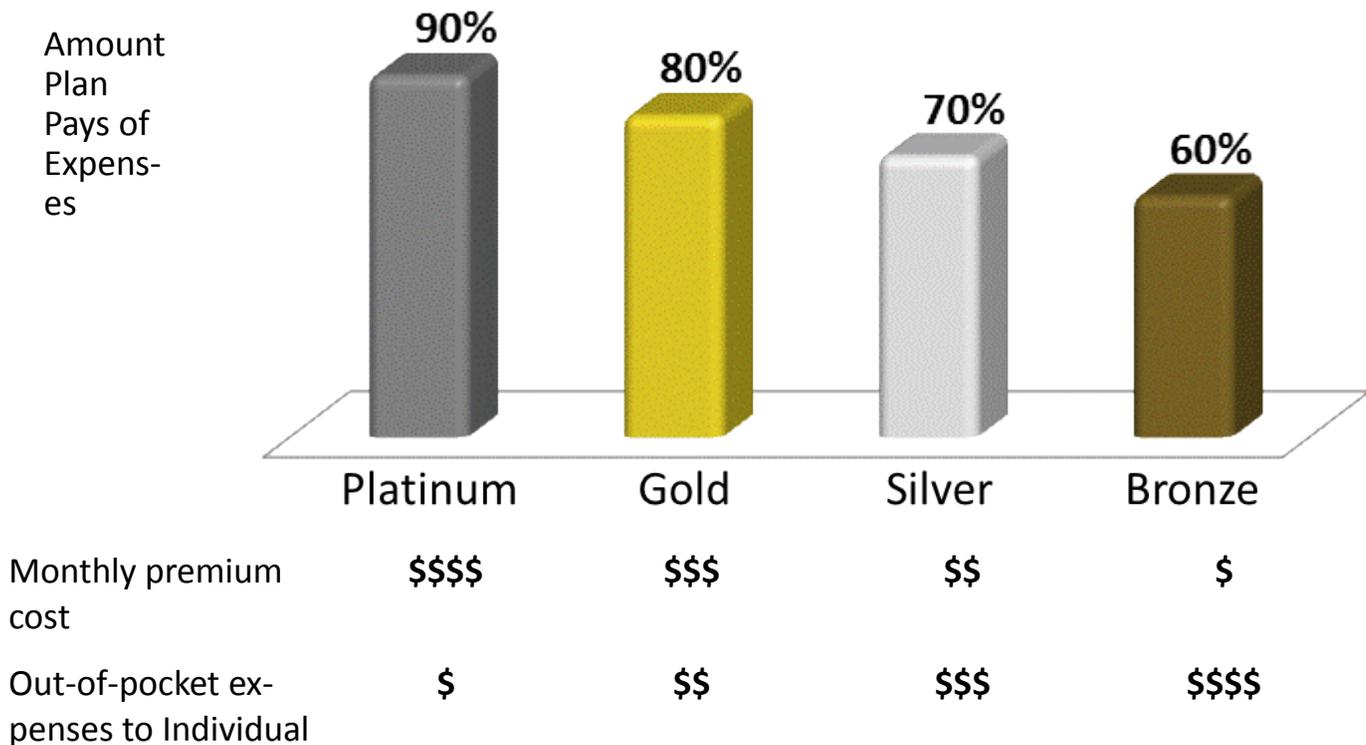
2016 Penalties

\$695 per adult,
\$347.50 per child up to \$2,085 for a family or 2.5% of income

The State Health Insurance Marketplaces

To date, the Marketplaces (f/k/a Exchanges) are still scheduled to open on October 1, 2013. Though many industry experts and political pundits question whether the Marketplaces will be ready to handle open enrollment by then, the government is not giving any indication that they are going to delay this key milestone of health care reform. Individuals may purchase health insurance on the Marketplace that is in their state of residence.

The Marketplaces will offer four levels of plans: Platinum, Gold, Silver and Bronze. The Platinum plans will pay 90% of the eligible expenses for the services rendered and the individual will only pay 10% of the expenses out-of-pocket; however, the individual premiums will be the most expensive for the Platinum plans. Gold plans will pay 80% of the eligible expenses, Silver 70% and Bronze plans will pay 60% of the eligible expenses. The less the plan pays of the eligible expenses for the services, the more the individual has to pay out-of-pocket but the lower the individual monthly premiums. There will also be a category of Catastrophic plans for young adults under 30. These plans will only cover catastrophic events, will have very high deductibles, and minimal preventive care.



The State Health Insurance Marketplaces

Each of the plans on the Marketplaces will cover ten essential health benefits, as shown in the below.



The State Health Insurance Marketplaces

Individuals not offered health insurance from their employers or, if insurance is offered, such coverage is not affordable or does not provide minimum value, may apply for premium tax credits and cost-sharing subsidies on the Marketplaces. Eligibility for the tax credits will depend on household income. The chart below illustrates that individuals and families who have a household income up to 400% of the Federal Poverty Level may be eligible for tax credits. *However, you cannot receive a tax credit or cost-sharing subsidy if you are offered affordable health coverage that provides minimum value from your employer.*

The following chart and example shows the **premium tax credits**.

| Household Income Level | Premium as % of Household Income |
|------------------------|----------------------------------|
| Up to 133% of FPL | 2% of Income |
| 133-150% of FPL | 3-4% of Income |
| 150-200% of FPL | 4-6.3% of Income |
| 200-250% of FPL | 6.3-8.05% of Income |
| 250-300% of FPL | 8.05-9.5% of Income |
| 300-400% of FPL | 9.5% of Income |

If an individual has a household income that is 250% of the Federal Poverty Level (for example annual household income is \$28,725) and the cost of the second lowest Silver plan (the government's measuring point) is \$7,500, this individual would not have to pay more than 8.05% of his or her income or \$2,312 (which is 8.05% of \$28,725). The tax credit that would be available to this individual would be \$5,188 (the difference between \$7,500 and \$2,312).

The State Health Insurance Marketplaces

The **cost-sharing subsidy** will lower out-of-pocket expenses. The general maximum out-of-pocket expense for individual plans on the Marketplaces will be \$6,350 for individuals and \$12,700 for families. The cost-sharing subsidy reduces these general maximums for qualifying individuals and/or families.

| Income Level | Reduction in Out-of-Pocket Liability |
|-----------------|--------------------------------------|
| 100-200% of FPL | 2/3 of the maximum |
| 200-300% of FPL | 1/2 of the maximum |
| 300-400% of FPL | 1/3 of the maximum |

If an individual has a household income of 250% of the Federal Poverty Level and is purchasing on the Marketplace, they would have the limit on their out-of-pocket expense reduced by 50% of the general applicable maximum value. That would mean that his or her individual maximum out-of-pocket expense would be \$3,175 (which is half of \$6,350).

Premium tax credits will be paid directly to the insurance company to offset the cost at the time an individual purchases insurance on the Marketplace, but...if an individual receives a raise during the year that changes the amount of credit they would have received, they must repay some of the subsidy at the end of the year. Similarly, if an individual's out-of-pocket expenses are incorrectly being subsidized because of an increase in household income, that individual will have to repay amounts at the end of the year.

May apply on-line, by mail or in-person. Issuers will accept prepaid debit cards, cashier's checks, money orders, paper checks and bank account transfers. Telephone help and online chat are available 24/7 to help you complete your application.

The Notice of State Health Insurance Marketplaces

By October 1, 2013, employers must provide to all employees a notice about the new Health Insurance Marketplaces. The notice is required to be given to new employees within 14 days of hire thereafter.

The notice must inform employees:

- About the existence of the Health Insurance Marketplaces, the services they provide, and directs employees to HealthCare.gov to get more information concerning the Marketplace in their state.
- That employees may be eligible for a premium tax credit if they purchase a health plan through a Marketplace and the employer's plan provides less than 60 percent minimum value.
- That employees will lose any employer contribution and tax savings if they purchase a health plan through the Marketplace.



Additional Medicare Tax Withholding

Additional Medicare Tax. Beginning in 2013, employers must withhold an additional 0.9 percent Medicare tax (known as the Additional Medicare Tax) on wages paid to an employee that exceed \$200,000 in a calendar year. Amounts must be withheld in the pay period in which an employee's wages are first in excess of the \$200,000 threshold. The employer is responsible only for withholding the tax and there is no employer match.

Additional Medicare Tax

\$0.9%

to be withheld on
wages over
\$200,000

Note that the withholding must take place regardless of an employee's filing status or whether the employee will ultimately be responsible for the tax liability. For example, an employee may not be required to pay the tax because combined wages with the employee's spouse do not exceed \$250,000. In such a case, the employee can file for a refund on his or her tax return.

Net Investment Income Tax. The ACA also imposes a 3.8 percent tax on net investment income above specified thresholds for high-income individuals. However, this is not a payroll tax and will be paid by the individual on his or her tax return. Employers have no responsibility for withholding this tax on behalf of employees.

Creative Benefits Note: High-income individuals will want to take a proactive approach to tax planning in order to minimize the impact of both of these new taxes. Tax experts should be consulted now to discuss what strategies can be utilized.

W-2 Reporting of Total Cost of Health Coverage

Employers that issued 250 or more W-2s in 2012 are required to provide the total cost of health coverage provided to employees on their 2013 W-2s due in January 2014. (The first time this reporting was required was on 2012 W-2s, which employees received in January 2013.)

The amount reported is for information only and is not taxable. The calculation is made on an employee-by-employee and calendar-year basis. If the cost of coverage changes during the year for an employee, the reportable cost must reflect the change in cost, e.g., an employee has a baby midyear, so changes tiers to family coverage from husband/wife coverage, thus increasing the premium rate. Or, if an employee commences, changes, or terminates coverage during the year, the reportable cost must consider the change in coverage.

Other Key Provisions of Health Care Reform

Please contact Creative Benefits for more detailed information about any of the following topics or any others not covered here.

Coverage of preventive health services (expanded in 2012). Since the ACA was passed in 2010, group health plans began covering certain recommended preventive services provided by in-network providers with no cost sharing (such as deductibles, copays, coinsurance, etc.). Health plans that began on or after August 1, 2012 incorporated eight additional preventive services for women that are covered at 100 percent, including generic contraceptives and other contraceptive methods. Certain religious organizations are temporarily exempted from the contraceptives coverage mandate.

Summary of Benefits and Coverage, and the Uniform Glossary, September 2012. Beginning with plan years on and after September 23, 2012, insurers and group plan sponsors are required to provide members with the SBC, which is a document that outlines a plan's key services and the amount of cost sharing required by the member versus the plan for those services.

The purpose of this document is to allow individuals and families shopping for coverage to easily review and compare different plans, and to provide them a reference to use once a plan has been chosen.

A website address is included on each SBC that directs individuals to the Uniform Glossary, which explains in simple language common health insurance terms.

\$2,500 flexible spending account limit, January 1, 2013. Employees participating in an employer's FSA are limited to an annual contribution of \$2,500. This limit does not include employer contributions. The cap applies on a per-employee basis. Thus working spouses can each contribute up to \$2,500 in a health FSA even if both work for the same employer and participate in the same plan.

Essential health benefits, 2014. Individual and small group health plans sold inside and outside of the Health Insurance Marketplaces must include a core package of items and services in ten categories, called "essential health benefits" (as described on page 4). Large employers and self-insured plans are not required to cover the ten EHBs. However, for EHBs that are covered, no annual limits can be imposed.

Deductible limits, 2014. Beginning in 2014, small group plans will be limited to a \$2,000 deductible for individuals and \$4,000 for families. Regulations allow for some flexibility in these limits to allow a plan to meet a certain actuarial value.

Out-of-pocket maximum limit, 2014. For small and large group plans beginning in 2014 that offer the EHBs, out-of-pocket costs must not exceed the amounts allowed for high-deductible health plans coordinated with health savings accounts. In 2013, these amounts are \$6,250 for individuals and \$12,500 for families. For 2014 these amounts will be \$6,350 and \$12,700 respectively. Deductibles, coinsurance, and copayments must be counted towards the out-of-pocket maximum.

Other Key Provisions of Health Care Reform

Elimination of pre-existing condition exclusion, 2014. The law already prohibits pre-existing condition exclusions for children under the age of 19. For plan years beginning on or after January 1, 2014, the law expands to cover everyone.



* Based on group size, renewal date and if a plan is self-insured or fully-insured, the above listed provisions may or may not be applicable to your health plan or may affect various health plans differently.



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