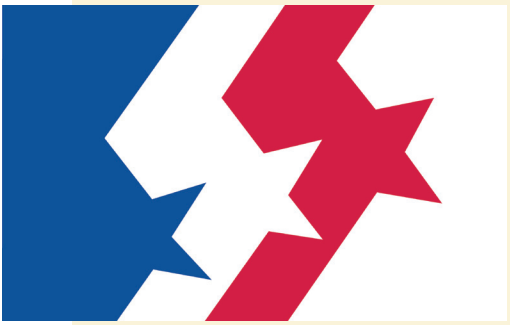
Small Business Council
OF AMERICA

Health Reform *in a* Nutshell:

What Small Businesses Need to Know Now.



With the passage of the most significant reform of America's modern-day health care system, many small business owners and human resources professionals are trying to assess what the Patient Protection and Affordable Care Act (PPACA) means for their organizations.

An Employer's Guide to Health Reform

Some aspects of the law became effective immediately, and others will be phased in over the next several years.

This guide seeks to provide you, as a decision-maker for a small business, with an easy-to-understand overview of the most important things you need to know today about health reform. For example:

- If you already offer major medical coverage to your employees, your existing plan may be grandfathered.
- If you offer a new or non-grandfathered major medical health plan, it must meet strict non-discrimination rules.
- Beginning next year, all employers must adhere to new reporting requirements.
- Health reform does not regulate excepted benefits, which include stand-alone vision, dental, cancer, accident and disability insurance that make payments directly to the individual.

Of course, it would be impossible to cover every aspect of health care reform in an overview piece such as this, but the information we've included is a great starting point to ensure you and your business are ready to follow the new rules.

DISCLAIMER: This material is intended to be informational and does not constitute legal advice regarding any specific situation.

2010

March 23

- Small business tax credit is established

September 23

Grandfathered Health Plans

- Prohibition of lifetime benefit limits
- No rescission except for fraud or intentional misrepresentation
- Children, who are not eligible for employer-sponsored coverage, covered up to age 26 on family policy
- Pre-existing condition exclusions for covered individuals younger than 19 are prohibited
- Restricted annual limits for essential benefits

New and Non-Grandfathered Health Plans

- Prohibition of lifetime benefit limits
- Restricted annual limits for essential benefits
- No rescission except for fraud or intentional misrepresentation
- No cost-sharing for preventive services
- Children covered up to age 26 on family policy
- Internal appeal and external review processes
- Discrimination based on salary is prohibited
- Internet portal to facilitate consumer and small-employer shopping
- Emergency services at in-network cost-sharing level with no prior authorization
- No exclusions for pre-existing conditions for covered individuals younger than 19

2011

January 1

- Aggregate costs of employer-sponsored health plans required on employees' W-2s.
- FSAs/HRAs/HSAs: Over-the-counter drugs not allowed as an expense without a prescription.

2013

January 1

- Contributions to health flexible savings accounts will be limited to $2,500 per year, indexed by the Consumer Price Index in subsequent years. The cap does not apply to employer contributions.

2014

January 1

- All Americans must have insurance or pay a fine
- Health Insurance Exchanges for individuals and small employers
- Essential benefits established
- No lifetime or annual limits for essential benefits
- Guaranteed issue is required
- No exclusions for pre-existing conditions
- Rating restrictions will apply for age and tobacco use
- Individual affordability tax credits and expansion of small-employer tax credits
- Employer fines for employees receiving affordability tax credits for coverage

Grandfathered Health Plans

- No exclusions for pre-existing conditions
- Prohibition of annual benefit limits

2018

January 1

- "Cadillac Tax" on high-cost insurance

What You Need to Know Now

Grandfathered Health Plans

A grandfathered health plan is one in which at least one employee was enrolled on March 23, 2010. If your company's plan(s) are grandfathered, you may continue to add new participants to them, as well as remove employees who terminate employment. Your plan(s) may lose grandfathered status if your business reduces benefits or increases deductibles and co-pays; or if you increase the percentage of premium paid by employees. Beginning September 23, 2010, grandfathered plans must:

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- Cover children up to age 26 on family policies, unless the children have access to employer-provided coverage.
- Prohibit pre-existing condition exclusions for covered individuals younger than age 19.
- Prohibit lifetime policy limits and restricted annual limits on essential benefits.
- Prohibit policy rescissions (retroactive terminations), except in cases of fraud or misrepresentation.

New and Non-Grandfathered Health Plans

Health care plans with effective dates after March 23, 2010, and plans that lose their grandfathered status must meet certain new guidelines to be considered qualified health insurance, including:

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- Prohibition of discrimination based on salary to prevent highly compensated employees from having more generous benefits than non-highly compensated employees.
- Prohibition of lifetime policy limits and restricted annual limits on essential benefits.
- Prohibition on policy rescissions except in the case of fraud or misrepresentation.
- Coverage of preventive services and immunizations without co-payments.
- Coverage for children up to age 26 on family policies.
- Internal appeal and external review processes for disputes.
- Coverage of pre-existing conditions for covered individuals younger than age 19.

3 Small-Business Tax Credit

Starting in 2010, if your business has 24 or fewer full-time equivalent (FTE) employees (excluding owners, certain family members and seasonal employees) whose average annual compensation is less than $50,000, your business is eligible for a tax credit for employer-paid health insurance premiums. The credit is largest for employers with 10 or fewer counted employees whose average compensation does not exceed $25,000. The credit is phased out and no longer applies when the average wages of an employer's counted employees exceed $50,000 per year or the number of counted employees is 25 or more.

4 W-2 Reporting

Beginning in 2011, all employers, regardless of company size, will be required to track health benefits received by each employee. The value (i.e., the COBRA cost) of both the employer and employee contributions for health insurance coverage must be reported on each employee's W-2. Although the value must be reported, it is not taxable to the business or to the employee under PPACA.

5 SIMPLE Cafeteria Plans

SIMPLE cafeteria plans allow employees to pay their portion of health insurance premiums and other eligible benefits, such as contributions to Flexible Spending Accounts, with pre-tax dollars. They are available for businesses with 100 or fewer employees. Employees' pre-tax contributions are not subject to federal, state or social security taxes. As an employer, you'll save on the employer portion of FICA, FUTA and workers' compensation insurance premiums.

6 2014 and Beyond

- All Americans are required to have a qualified health insurance plan or pay a penalty.
- Individuals and businesses with fewer than 100 employees may purchase coverage through a state insurance exchange.
- Individuals who can't afford coverage may qualify for premium subsidies.
- Employers of 50 or more may pay fines for employees who purchase coverage through exchanges and receive premium subsidies.

Q: What are grandfathered plans, and why does grandfathered status matter?

A: A grandfathered health plan is one in which at least one employee was enrolled on March 23, 2010. They are exempt from most of the new qualified health plan mandates. Grandfathered plans may stay in effect indefinitely, as long as they meet certain conditions. Beginning September 23, 2010, all grandfathered plans must comply with the following plan provisions:

- No lifetime limits.
- Reasonable annual limits.
- No rescissions (retroactive terminations).
- Coverage for children up to age 26 on family policies, unless they have access to employer-provided coverage.
- No pre-existing condition exclusions for covered individuals younger than 19.

If your business has a grandfathered plan, you can continue to add new participants and cease to cover employees who terminate employment. You can also transfer employees to another plan or plan option if there is a bona fide employment-based reason for the transfer. Grandfathered plan status is lost if your business changes health insurance companies, even if the coverage, deductibles and co-pays remain exactly the same. In addition, grandfathered plans cannot do any of the following without losing their status:

- Significantly cut or reduce benefits to diagnose or treat a particular condition (i.e. diabetes, AIDS/HIV).
- Raise co-insurance percentage to any extent.
- Lower the employer-provided contribution as a percentage of total cost by more than 5 percent.
- Lower annual limits, or add new annual limits, on what the insurer pays.
- Raise deductibles by more than the rate of medical inflation (plus 15 percent).
- Raise co-payment charges by more than $5 or, if greater, the rate of medical inflation (plus 15 percent).

Q: Our carrier plans to increase our current plan premiums by 20 percent next year. My company and our employees cannot afford this increase. What are our options?

A: Because of the narrow range of changes that may be made to a grandfathered plan, many employers whose health insurance costs will increase may face a dilemma. If deductibles, co-pays or the percentage of employer contribution is increased by more than the amounts allowed under the new law, the plans will lose grandfathered status. If the plans lose grandfathered status, you may choose to offer a qualified health plan, which could be more expensive than keeping the grandfathered plan. If a new qualified health plan is offered, it must comply with all new insurance market reforms, including the new IRS non-discrimination rules (see below). You may also choose to terminate coverage altogether. If coverage is terminated, business owners and key employees will lose the benefit of having health coverage paid with pre-tax dollars.

Q: What are the new IRS non-discrimination rules for qualified health plans?

A: PPACA now imposes non-discrimination rules on all employer-sponsored health plans, except grandfathered plans. In general, the purpose is to prevent highly compensated individuals from receiving better benefits or more generous employer contributions for those benefits than are available to other employees. As a general guideline, if your business covers 70 percent or more of your eligible workforce and charges all employees the same rate, the rules will be met. An excise tax — $100 per affected person per day — will be imposed on employers whose plans do not meet the non-discrimination rules.

Q: Does health care reform affect my ability to offer voluntary worksite benefits to my employees?

A: No. Voluntary worksite benefits, also called supplemental or excepted benefits, include accident, disability and stand-alone vision and/or dental plans, as well as cancer and hospital indemnity insurance. Unlike major medical insurance, supplemental coverage pays cash benefits to the policyholder. The new health insurance reforms are aimed at improving access to major medical coverage and, therefore, don't negate the need for supplemental products or affect your ability to offer them to your employees.

Q: What's so special about a SIMPLE cafeteria plan?

A: SIMPLE cafeteria plans — plans that automatically satisfy the non-discrimination requirements in place for regular cafeteria plans — can only be used by businesses with 100 or fewer employees. For example, in a regular cafeteria plan, no more than 25 percent of the total plan benefit may be for "key employees." This requirement is presumed to be met under a SIMPLE plan. Only employees (including owners of regular C-corporations) will likely be eligible to participate in these plans. Until regulations are issued, some questions remain, such as whether the SIMPLE cafeteria plan will automatically satisfy the health insurance non-discrimination rules that will apply if a plan is not grandfathered. However, it is clear that the SIMPLE cafeteria plan will become a very attractive employee benefits delivery system for all forms of small businesses, especially C-corporations.

Q: What do I need to know about the small-business health care tax credit?

A: ELIGIBILITY RULES

- An employer must provide health care coverage to qualify: A qualifying employer must cover at least 50 percent of the cost of single health care coverage for its workers receiving coverage in 2010, and at least 50 percent of all coverage — whether single or family — beginning in 2011. Beginning in 2014, the credit will only apply to coverage purchased through an exchange, for two consecutive years. It is available for both taxable (for-profit) and tax-exempt firms.
- Firm size: A qualifying employer must have 24 or fewer full-time equivalent (FTE) workers (employers with more than 24 workers may be eligible if they still have fewer than 24 FTEs).
- Average annual wage: A qualifying employer must pay average annual wages of less than $50,000 (owners, their family members and seasonal employees are not counted).

AMOUNT OF CREDIT

- Maximum amount: The credit is worth up to 35 percent (25 percent for tax-exempt employers) of a small business' premium costs in 2010. On January 1, 2014, this rate increases to 50 percent (35 percent for tax-exempt employers) and is available for two consecutive years if coverage is purchased through an exchange.
- Phase-out: The credit phases out gradually for firms with average wages between $25,000 and $50,000, and for firms with between 10 and 25 FTE workers.

The federal tax credit reduces your business' tax if a tax liability exists. If a liability doesn't exist in a given year, then the credit may be carried back one year (although not for a 2010 loss) or carried forward 20 years until it has been used. For tax-exempt entities, the federal tax credit reduces federal withholding and Medicare taxes. Additional information may be found at www.irs.gov.

Q: Is it true that health benefits paid by a company must be tracked in 2011 and reported on employees' W-2s in 2012? Which contributions must be counted?

A: Yes, and perhaps earlier for employees who terminate employment in 2011 and demand their W-2s. The W-2 reporting requirement includes the value (i.e., the COBRA cost) of both employer and employee contributions for health care coverage. The cost of coverage under health flexible spending accounts and vision/dental coverage is excluded from the W-2 reporting requirement. The cost of cancer, hospital indemnity or other supplemental insurance is excluded from the W-2 reporting if paid for by the employee with after-tax dollars, even if it is payroll-deducted. This is merely an informational reporting requirement. The reported amounts are not taxable to employees.

Q: Is there an employer mandate to offer coverage to employees beginning in 2014?

A: Technically no; however, employers with 50 or more full-time equivalent (FTE) employees will pay an assessment if an employee opts to purchase coverage through an exchange and receives a premium subsidy. If you, as an employer, **do not offer coverage,** the fee will be $2,000 times your total number of FTE employees, excluding the first 30. If you **do offer coverage,** you will pay a fee of $3,000 for each employee who actually purchases coverage through an exchange and receives a subsidy. The assessment is limited to $2,000 times the number of FTEs in excess of 30.

Q: Where can I learn more about health care reform and coverage available in my state?

A: The Department of Health and Human Services information portal at **www.healthcare.gov** provides information about reform and gives consumers a place to research and compare currently available major medical health insurance plans.

The Small Business Council of America

The Primary Goal of the SBCA is to enact favorable federal tax and employee benefit laws for small businesses and their owners. The SBCA supports legislation that creates important economic incentives and opposes oppressive and burdensome laws and proposals.

About one-third of our members are advisors for family and privately-owned businesses: lawyers, accountants, actuaries, financial planners, insurance advisors and plan administrators. Our advisory boards are comprised of some of the nation's leading small business experts, including the heads of national and state bar associations, CPA organizations, pension and actuarial and insurance associations and state and local estate planning councils.

We are the most effective voice in Washington for privately owned businesses with respect to income and estate taxes, benefits and health care issues.

For a more detailed discussion about these and other topics related to health reform, please visit us at **www.sbca.net.**

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