the inside track

Better benefits at work.

The price of reform
Funding America's health care reform package

- The tax, revenue and enforcement provisions of the law
- The financial impact on employers and individuals
- The excise tax exemption for non-medical benefits

Unless health care costs can be mitigated, more than 60% of large employers' health plans will be subject to the federal "Cadillac" tax.†

These non-medical benefits are **excluded** from the tax:

- Dental and vision coverage offered through "stand-alone" plans
- Voluntary benefits when premium is paid with post-tax dollars
- Any accident plan (paid with pre- or post-tax dollars)
- Life and disability coverage
- Long term care

Paying the piper

The Patient Protection and Affordable Care Act will bring health benefits to millions of uninsured Americans. According to the Congressional Budget Office, the health care reform package will cost $940 billion over the next ten years.[1]

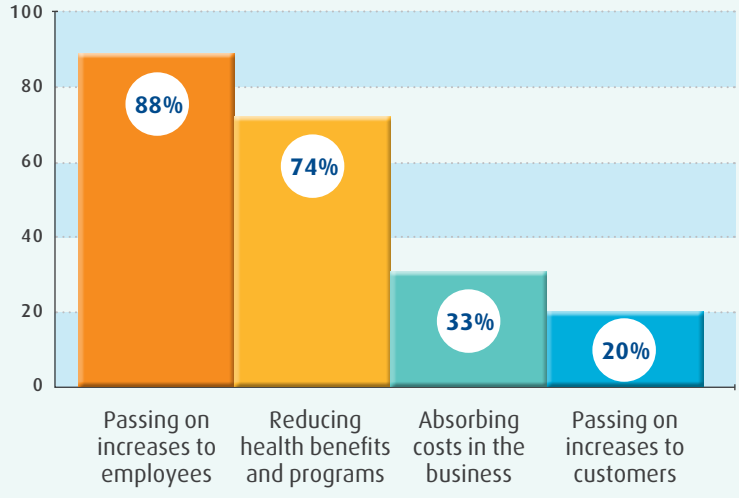
Where will the funding come from?

For the most part, medical insurers, pharmaceutical manufacturers, medical device makers and affluent Americans are designated to foot the bill. Perhaps of most interest to employers is a 40% excise tax that is designed to provide revenue and an incentive for insurers to lower premiums.

Government analysts predict that this decrease in premiums will be sufficient to free up more employer dollars for wages and other benefits.

There is some speculation, however, that health insurance providers may pass along some of the financial burden associated with the excise tax to employers, who in turn may trickle down the increased costs to employees.[2]

In fact, a Towers Watson survey shows that many employers are already planning to do so.[†]



[†] *Towers Watson, "Health Care Reform: Looming fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards," May 2010.*

How far-reaching an impact?

Some industries, such as manufacturing and retail, have voiced concerns that the financial impact of some elements of health care reform may reach beyond their company coffers. They say these financial measures could hamper job growth and place U.S. businesses at a disadvantage when it comes to global competition.[3]

How will health care reform impact your business financially? Will it affect you personally?

Some of these provisions will impact employers and employees directly. Others, such as levies on medical device manufacturers and tanning bed use, will have a limited direct impact on certain companies or individuals.

This white paper provides a framework for evaluating the repercussions of the tax, revenue and enforcement provisions. The taxes and enforcement practices that will fund health care reform will be implemented gradually between now and 2018. As a result, the provisions in this report are presented in a chronological timeline.

2010

Small business tax credits

This tax credit for businesses with fewer than 25 full-time employees is designed to make health care coverage more affordable for employers who may have found it cost-prohibitive to offer medical benefits.

The tax credit equals up to 35% of the employer-paid health premium for small businesses that meet these guidelines:

- Workforce of no more than 25 full-time employees
- Employees' average annual wages must be less than $50,000. (To calculate average wages, see the steps outlined on page 6.)
- The maximum credit goes to smaller businesses, particularly those who:
  - Employ 10 or fewer full time equivalent workers
  - Pay average annual wages of $25,000 or less
- The number of employees does not include:
  - An employee of a subchapter S corporation who owns more than a 2% share
  - An employee who has an ownership of 5% or more in the business
  - Any employees who are related to these owners
  - Seasonal workers employed fewer than 120 days per year
  - Any "leased" employees (contracted from another firm)

Subchapter S corporation
This is a corporation that, for tax purposes, is treated as if it were a partnership. This approach allows profits and losses to pass through individual shareholders.

The tax credit begins in 2010 and remains in effect at its initial rate through 2013. In 2014, the credit amounts will be adjusted.

2010 continued

To determine the average annual wages of a small business:

1
Total the aggregate amount of wages paid by the employer to employees during the taxable year.

2
Divide this total by the number of full-time equivalent employees for the taxable year.

3
If the number is not an even thousand, round the amount to the nearest $1,000.

Impact on employers

This affordability measure may encourage small employers to offer their employees medical insurance or retain insurance already in place.

Impact on individuals

If more employers choose to offer coverage as the result of these credits, an increased number of employees at small businesses are likely to have access.

- This would also give individuals access to preventive care and health screenings that can diagnose serious problems early on, resulting in better health outcomes and less expensive treatment.

Large employer auto-enroll

Although this is not specifically a revenue-generating provision, it's important for employers to take note of it. Those companies with more than 200 workers are required to automatically enroll employees in their medical plans, but employees have the option to opt-out of coverage.

According to health care reform regulations, this provision will be effective as of March 2010. However, employers are awaiting guidance from the U.S. Department of Labor, which may delay the actual implementation date.

Impact on employers

Employers with 200 or more employees will need to incorporate auto-enrollment and opt-out functions for employees in their enrollment process.

Impact on individuals

Individuals will need to determine if they want to remain enrolled in their employer's plan or choose other coverage that may be available through a spouse, parent, government program or Health Insurance Exchange.

Health Insurance Exchange

a marketplace where employees or individuals can shop for health insurance. The exchange is scheduled to be developed by 2014. It will be created to foster a more organized and competitive market for health insurance. An exchange must include:

- Choices in coverage
- Common rules regarding the offering and pricing of insurance
- Information to help consumers better understand the options available to them

Early retiree reinsurance program

This establishes a temporary reinsurance program to help employers affordably provide insurance for early retirees (over age 55 and not eligible for Medicare), their spouses, surviving spouses and dependents.

Employers who offer these plans can submit claims for reimbursement to the U.S. Department of Health and Human Services (HHS). They will need to provide documentation of the actual costs of the items and services for which each claim is being submitted. This program has been allocated $5 billion in funding and it will be available on a first-come, first-serve basis. According to the Employee Benefits Research Institute (EBRI), funds will likely run out in 2011.[4]

Health benefits that qualify for relief include:

- Medical services
- Surgical procedures
- Other benefits that may be specified by the Secretary of HHS
- Prescription drugs
- Mental health services
- Hospital confinement

Once someone in an early retirement plan has accumulated $15,000 in health care claims in one plan year, the government will pay the plan sponsor for 80% of those claims, up to $90,000. These figures will be:

- Adjusted to the Medical Care Component of the Consumer Price Index for all urban consumers
- Rounded to the nearest multiple of $1,000

Employers are to use these reimbursements to lower costs for the retiree plan, such as:

- Premium costs
- Premium contributions
- Other out-of pocket costs for plan participants
- Copayments
- Deductibles
- Co-insurance

2010 continued

The program ends on January 1, 2014 when early retirees will be able to choose from the additional coverage options that will be available in the Health Insurance Exchange described on page 7 of this report.

Impact on employers

Employers who receive these funds will see a decrease in the cost of providing insurance for early retirees and, as a result, may be likely to continue to offer or add early retiree coverage.

Impact on individuals

Many Americans who retire before they are eligible for Medicare do not have access to affordable employer-sponsored health insurance. In many cases, they drain their life savings trying to pay for individual insurance and expensive medical care.[5]

This provision will increase their chances of retaining employer-sponsored retiree coverage at an affordable cost, which can help protect their retirement savings.

Indoor tanning tax

Beginning July 2010 there will be a 10% excise tax on indoor tanning services. This tax is similar to the "vice" tax on cigarettes. It is intended to raise revenue while making it more expensive for individuals to engage in behavior directly linked to skin cancer.[6]

This tax is estimated to raise $2.7 billion over ten years.[7]

Skin cancer

is the most common cancer in the U.S., with more than 3.5 million diagnoses each year. Tanning beds have been shown to significantly increase the risk of skin cancer, including deadly melanoma.[8]

Impact on employers

No direct impact, except to owners of tanning salons.

- Possible savings in overall long term health care costs if occurrence of skin cancer is reduced.

Impact on individuals

A direct tax will be imposed on those receiving services.

- If the tax results in a desired reduction in individual tanning bed visits, this provision is expected to reduce the occurrence of skin cancer and save lives.[9]

2011

Health Savings Account/Archer Medical Savings Account distributions

Sometimes, individuals take distributions from Health Savings Accounts that are not for qualified medical purposes. This practice is considered counter to good health care management, since individuals could use the money to purchase non-medical goods or services and then be unprepared to pay medical bills if a crisis arises.

Prior to this legislation, these individuals were required to pay a 10% tax on those distributions, with an even higher tax of 15% levied on Archer MSAs. Starting in 2011, the tax on those non-qualified distributions is increased to 20% for both HSAs and Archer MSAs.

In a related measure, the law no longer allows individuals to be reimbursed from an HSA or Archer MSA for over-the-counter drugs not prescribed by a doctor. Insulin is excluded from this provision.

Health Savings Account

A tax-advantaged medical savings account for individuals enrolled in a qualified High Deductible Health Plan.

Archer MSA

A Medical Savings Account that allows funds to be used tax free for health care expenses. Archer MSAs have been used by small business or self-employed individuals as a way to pay for health care services to employees.

Impact on employers

This is very limited, since employers are not responsible for how employees spend distributions from HSAs or MSAs. However, they may want to communicate this benefit change to workers.

Impact on individuals

Any individual who takes a non-qualified distribution from HSAs or MSAs will face the 20% penalty at income tax time.

2011 continued

Flexible Spending Accounts

There are two provisions that impact health care Flexible Spending Accounts (FSAs).

According to the first provision, which takes effect in 2011, individuals will no longer be permitted to purchase over-the-counter (OTC) medications with FSA dollars unless they have a prescription for the medication. Insulin is excluded from this provision. As mentioned earlier, this restriction also applies to HSAs, as well as HRAs (Health Reimbursement Accounts).

Impact on employers

- Employers that administer their company's FSAs will need to adapt their practices to deny claims for OTC medications obtained without a prescription.
- This could increase health care costs over time if individuals increase utilization of primary health providers to obtain prescriptions for medicines they previously purchased over the counter.
- Employers will also need to communicate these changes to employees.

Impact on individuals

Employees may need to budget differently based on these changes and may be more prone to lose funds left in their FSAs.

- Prior to the new law, individuals could over-estimate how much money they would need for prescriptions, co-pays and other eligible expenses. At the end of the year, they could use the leftover funds to purchase approved over-the-counter medicines and health supplies to avoid "use it or lose it" loss of funds. This option will no longer be available.
- In addition, employees will need to determine if they should pay for over-the-counter drugs with post-tax dollars or obtain a prescription for these medicines in order to pay with pre-tax dollars — if their health plans allow this.

The second provision, which restricts the amount of money employees can put in FSAs, is outlined in the 2013 section of this report on page 15.

Pharmaceutical manufacturer levy

A $2.5 billion tax levy will be imposed on branded pharmaceutical manufacturing companies beginning in 2011, which will gradually increase over a period of seven years, before leveling off in 2019.

Calendar year	Annual tax on pharmaceutical industry
2011	$2,500,000,000
2012	$3,000,000,000
2013	$3,000,000,000
2014	$3,000,000,000
2015	$3,000,000,000
2016	$3,000,000,000
2017	$3,500,000,000
2018	$4,200,000,000
2019 and thereafter	$2,800,000,000

The Secretary of the Treasury will calculate the amount of each covered entity's fee based on the entity's branded prescription drug or biological product sales.

This levy could be largely equalized on pharmaceutical companies' balance sheets due to the additional 32 million individuals who will be added to medical insurance plans. Pharmaceutical revenue is expected to grow as these individuals use their coverage to pay for prescriptions they could not afford without health care coverage.[10]

Impact on employers

- As pharmaceutical manufacturers face increased taxes, they may build this increase into their pricing models for their products, which could affect employer costs down the road if they absorb additional costs for pharmaceuticals. It is also possible that the increased revenue these companies receive due to an increased insured population may hold down any price increases.
- Ultimately, the levy could increase insurance premiums as pharmaceutical companies look to pass on costs.

Impact on individuals

Employers could pass along all or a portion of any increased premium to employees.

2012

W-2 reporting

Employers will be required to provide employees with the aggregate value of their health coverage on their W-2 forms.

Aggregate values are based on the COBRA premium rate. Employers then subtract out any premiums paid with post-tax dollars.[11] This value excludes any health care FSA or HSA contributions and is specific to the coverage elected by the employee.

Employers will have to make their first W-2 reporting in 2012, reflecting the value of the health benefits provided for the 2011 tax year.

Impact on employers

- This will mean increased administrative responsibility for employers and third-party vendors who complete company W-2s.
- This also will help employers — and the government — to track the value of tax free health insurance premiums.

Impact on individuals

Individuals are not required to do anything with this information and the benefits reported on their W-2s will not increase their taxable income.

1099 requirement

Beginning in 2012, all businesses will be required to file 1099 forms with the IRS every time they purchase more than $600 in goods or services from a store, vendor or other supplier during a calendar year. This is a change from the current state where these forms were typically provided only to freelancers and independent contractors. Under current rules, no 1099s are required if the business is a corporation or it sells a product rather than providing a service.

Impact on employers

Employers will need to generate the additional 1099s and will need to obtain the required tax information from all vendors with whom they spend $600 or more.

Impact on individuals

None anticipated.

2013

Comparative effectiveness fee

The funds generated by this fee will be used by the government to fund a Patient-centered Outcomes Research Trust Fund. This will be used to establish a non-profit corporation, which will not be considered an agency or establishment of the U.S. Government, to study patient outcomes.

The purpose is to help patients, clinicians, purchasers and policymakers make better evidence-based decisions to determine the most effective ways to diagnose, prevent and treat health conditions. It is designed to increase patients' engagement in their own health care.[12]

This fee will be charged to the medical insurance providers of fully insured plans and to the "plan sponsor" of self-insured plans, according to a stepped schedule:

- Plans ending during 2013 will pay $1 per covered individual
- Plans ending 2014 — September 2019 will pay $2 per covered individual

This provision will "sunset" after policy years ending September 30, 2019. A sunset provision is commonly used when lawmakers wish to act quickly on an issue, but the long-term repercussions of the act are not yet foreseeable. A law with a sunset provision expires at a pre-scheduled date, but Congress can push the date out at any time.

2013 continued

Impact on employers

Faced with this fee either directly or embedded in increased insurer premiums, employers may choose to absorb the cost or pass it on to employees. This fee will have a greater direct impact on self-funded employers or plan sponsors.

Impact on individuals

Employees could see increased premiums if employers choose to pass along all or some of the cost.

Medical device manufacturer levy

The manufacturers of taxable medical devices will be assessed a 2.9% tax. For the purposes of the law, a taxable medical device is defined by section 201(h) of the Federal Food, Drug, and Cosmetic Act, as medical equipment intended for use by humans. Some devices are excepted from the levy, including:

- Eyeglasses
- Contact lenses
- Hearing aids
- Any other medical device determined by the Secretary of Health and Human Services to be of a type which is generally purchased by the general public at retail for individual use.
  - These excepted items include tongue depressors, exam gloves and personal hygiene supplies.

Taxable medical devices

Some examples of devices the levy applies to are:

- Pacemakers
- X-ray machines
- Other medical test equipment

Impact on employers

This may indirectly affect employers if medical device manufacturers decide to build the cost of the levy into their pricing models, which could raise health care expenses. These higher medical costs could also push premiums upward.

Impact on individuals

- Employers could decide to pass along all or a portion of any increased premium to employees.
- Employees who need to purchase medical devices — such as pacemakers — may see higher costs passed on by their medical insurers.

Flexible Spending Accounts (FSAs)

Beginning in 2013, health care FSA contributions will be limited to $2,500 and indexed for inflation. Prior to this new legislation, there was no limit on contribution maximums. However, many employers set a cap of between $3,000 and $5,000 in order to avoid discrimination testing issues.

Discrimination testing

The Internal Revenue Service (IRS) requires that cafeteria plans, through which flexible spending accounts are offered, pass a series of discrimination tests each year. These tests are designed to show that eligibility and plan benefits are applied fairly and consistently, which in turn allows the plan sponsor to avoid unfavorable tax consequences.

Impact on employers

- With the new limit on FSA contributions, employers may need to amend their plans to the new, lower level.
- Employers will also need to communicate these changes to employees.

Impact on individuals

Employees will have to adjust their allocations according to the new regulations. Individuals may not be able to cover all their qualified expenses with pre-tax dollars.

Prescription drug subsidy rollback — Medicare Part D

In 2003, President Bush signed into law a bill that provided a 28% tax-free subsidy for employers providing retirees with a prescription drug benefit. This benefit remains in the new law, however, the provision that allowed employers to deduct the amount of the subsidy from their taxable income has been removed.[13]

The American Benefits Council, an association representing 300 large corporations, has voiced concern that this provision could exert enough financial pressure on corporate profits to discourage companies from hiring more workers.[14] Some large companies report that the loss of this tax deduction will cost them millions of dollars each quarter.

Impact on employers

Employers will likely face increased costs associated with offering retiree prescription drug coverage. Some may reconsider offering this benefit.

Impact on individuals

Some individuals may lose access to employer-provided prescription drug coverage when they retire.

2013 continued

Investment income tax

This is the provision that creates funding for health care reform by taxing affluent Americans, who will pay a new surtax of 3.8% on investment income. For the purposes of this law, affluent individuals are defined as:

- Individuals who make more than $200,000 annually
- Couples making more than $250,000 annually

Impact on employers

Some employees may ask for increased tax withholding, which would entail some added administrative processing time.

Impact on individuals

Individuals in this income bracket may look to revisit their investment choices and may choose to adjust payroll tax withholding.

Itemized medical deductions

The threshold for itemizing medical deductions will increase from 7.5% of income to 10% of income. Those age 65 and older are exempt from this provision until 2017, and will remain at the 7.5% threshold.

Impact on employers

No direct impact.

Impact on individuals

This will mean an increased tax liability for individuals younger than age 65 who have medical expenses between 7.5% and 10% of income.

Medicare tax increase

The Medicare payroll tax will increase from 1.45% to 2.35% for:

- Individuals making over $200,000 annually
- Couples making in excess of $250,000 annually

Impact on employers

Employers will need to adjust tax withholding for individuals in this income bracket. It is unclear how employers will be able to determine family income.

Impact on individuals

This will mean an increased tax liability for individuals in this income bracket.

2014

Employer responsibility

There are three major considerations for employers for 2014. They must decide:

- Whether to offer medical coverage or potentially face a financial penalty
- Whether their coverage is considered "affordable" enough to avoid a potential financial penalty
- Whether they need to issue free choice vouchers to certain low-wage employees

Although employers will not be required to provide health insurance coverage to employees, there will be a penalty levied on some employers who do not provide coverage, or those who provide coverage that is not considered affordable.

This provision applies ONLY to employers who have an average of 50 full-time workers for the prior calendar year. For the purposes of this provision, full time equals 30 hours per week.

It is interesting to note that by 2018, employers will have to analyze carefully both the affordability and the richness of their health insurance plans. Beginning on page 23, this report looks at the so-called "Cadillac" tax for plans that are determined to offer high-end benefits exceeding a determined threshold.

To qualify for this premium assistance, individuals must earn less than 400% of the federal poverty guidelines established for 2014. To put those salary levels in perspective, below are the income levels that equal 400% of the federal poverty guidelines for 2009:*

- $43,320 for an individual
- $88,200 for a family of four

**Amounts differ for Alaska and Hawaii. The 2009 federal poverty guidelines has not been updated by the government and remains in effect in 2010.*

Premium assistance

When the new Health Insurance Exchange is in operation in 2014, the federal government will offer a subsidy to help low-income Americans better afford medical coverage.

2014 continued

Financial penalties

For employers who do not offer coverage:

If any employee receives premium assistance from the federal government, an employer fee of $2,000 is assessed for each employee (excluding the first 30 employees).

Example

An employer has 60 workers, **does not** offer coverage and has one employee who receives premium assistance from the government

To determine the financial penalty:

- Deduct the first 30 employees
- Multiply remaining 30 employees by $2,000 per person

Employer pays $60,000

	60	total employees
–	30	first employees
	30	remaining employees
x	$2,000	fee for each
	$60,000	penalty

For employers who do offer coverage

If any employee receives premium assistance from the government, the employer will be assessed the *lesser* of a $3,000 fee for each employee receiving premium assistance *or* a fee of $2,000 for each full-time employee.

Example

An employer has 60 workers, **does** offer coverage and has 15 employees who receive premium assistance from the government

To determine the financial penalty:

- Deduct the first 30 employees
- Multiply remaining 30 employees by $2,000 each
- Employer assessed penalty of $60,000

or

- 15 employees receiving premium assistance x $3,000
- Employer assessed penalty of $45,000

Employer pays $45,000

	60	total employees
–	30	first employees
	30	remaining employees
x	$2,000	fee for each
	$60,000	penalty

	15	employees with assistance
x	$3,000	fee for each
	$45,000	penalty

Employer pays the lesser amount

Impact on employers

Employers will need to determine if they will offer medical insurance or pay the penalty. In addition, those who do offer coverage will need to determine whether the coverage is affordable enough to avoid penalties.

Impact on individuals

These provisions may result in more individuals having access to medical insurance through the workplace, but the outcome at this point is unknown. This will depend on whether employers choose to offer coverage or absorb the penalties.

Free choice vouchers

In 2014, employees who are offered health benefits through the workplace will be able to choose to participate in those plans and pay the set premium contribution established by the employer or purchase coverage on their own through the Health Insurance Exchange described on page 7 of this report.

In some instances, employers will be required to provide employees with vouchers to help them pay for medical insurance. The voucher amount would be equal to the most generous employer contribution to coverage that the employer makes. This would be the amount for single or family coverage, depending on which option the employee chooses.

Individuals qualify for vouchers if they meet each of these criteria:

- Household income is less than 400% of the federal poverty guidelines (as described on page 17 of this report)
- Employee contributions toward coverage are greater than 8% but less than 9.8% of the employee's taxable income, with both values indexed to reflect premium growth
- The employee is not enrolled in the employer's health plan

Employees can use these vouchers to pay for coverage purchased through the Health Insurance Exchange, and if there are funds left over, the difference is payable to the employee. These leftover funds will not be treated as taxable income to the employee. They also can be deducted by the employer as compensation for personal services actually rendered.

If an employer does provide a free choice voucher, it will not trigger a financial penalty.

2014 continued

Impact on employers

Employers will need to comply with the voucher requirements for those employees who qualify.

- There is some concern that the demographics of an employer risk pool could change if some employees opt out of employer coverage to purchase alternative coverage through the Health Insurance Exchange.

Impact on individuals

Individuals who qualify for vouchers will need to determine if they want to use a voucher to access coverage through the Exchange or remain on the employer's plan.

Individual mandates

By 2014, most individuals will be required to have health insurance that meets minimum essential standards established by the Department of Health and Human Services.

Examples of coverage that is considered acceptable include:

- Employer-sponsored coverage, when requirements are met
- Grandfathered employer-based coverage
- Individual coverage offered within a state
- Government-sponsored coverage
  - Tricare
  - VA coverage
  - Medicare Part A
  - Medicaid
  - CHIP

Coverage must include benefits for:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Annual individual penalty for not having coverage:

Year	Individual† annual penalty is the greater of:
2014	$95 per uninsured adult or 1% of household income
2015	$325 per uninsured adult or 2% of household income
2016	$695 per uninsured adult or 2.5% of household income

† Amounts shown are for adults over age 18. Minors would be assessed a charge that is half that amount. The penalty for not having coverage is prorated monthly. After 2016 the penalty will be adjusted for inflation.

The penalty assessed to a household may not exceed:

- 300% of the adult penalty, or
- The national average annual premium as the minimum level of health coverage (referred to as the "bronze" level) offered through the Exchange.
- It is unclear if 300% of the adult penalty will become the de facto penalty if it is below the applicable percentage of household income.

There are exceptions to the mandate for some groups, including:

- Those who decline coverage for religious reasons
- Incarcerated individuals
- Those for whom coverage is unaffordable (defined as >8% of household income)
- Individuals below the government's income tax filing threshold
- Those who receive a hardship waiver
- Those who have a lapse in coverage of less than 3 months
- Members of Native American Indian tribes

Impact on employers

No direct impact is anticipated. Employers may see some changes in enrollment levels in their employer-sponsored medical coverage as workers decide whether to:

- Accept coverage and pay any associated premium, or
- Choose not to have coverage and pay the penalty

Impact on individuals

Individuals will need to choose whether to enroll in medical coverage or pay the penalty associated with not having coverage.

2014 continued

Health insurer levy

A levy will be imposed on health insurers, with exclusions for insurers that meet certain criteria. The levy is based on market share.

Year	Total levy on health insurers
2014	$8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion

After 2018, the levy will be increased by the rate of premium growth for the prior calendar year.

There are some exemptions to this provision, such as 501(c) not-for-profit health insurance providers who meet the criteria defined by the law.

Impact on employers

As health insurers face increased taxes, they could choose to increase their pricing models to absorb the levy. This may be passed on to employers through higher premiums.

Ultimately, the levy is likely to raise premiums.

Impact on individuals

Employers could pass along all or a portion of any increased premium to employees.

2018

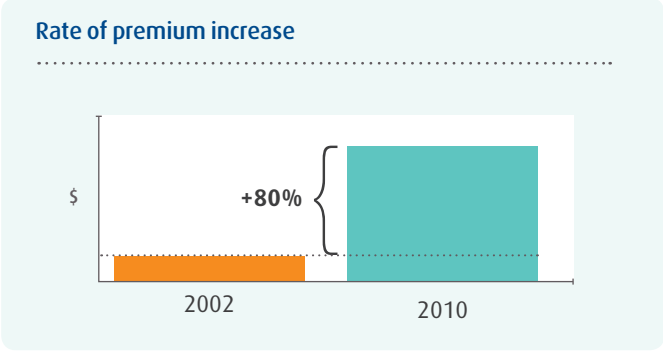
Excise Tax or "Cadillac" Tax

This provision has attracted a great deal of attention. It levies a 40% excise tax on any health insurer (or self-insured employer) if the plan's premium exceeds standards set by the Department of Health and Human Services.

This substantial tax would apply if the annual aggregate value† of a medical insurance plan is higher than:

- $10,200 for single coverage
- $27,500 for family coverage

Some opponents of this provision have suggested that this tax should more accurately be called a "Chevrolet" tax, because many plan premiums may likely exceed those limits by 2016. As a benchmark, consider that in 2009, the average median medical coverage cost for a family topped $15,000. And since 2002, many plan sponsors have experienced an increase of nearly 80% in health insurance premiums.[15]



AON Consulting, "2009 Benefits and Talent Survey: Focused on Recovery," 2009. Survey of 1,300 employers.

†The aggregate value includes both employer- and employee-paid premium for employer-provided coverage.

2018 continued

Employers will be required to complete the calculation at a per-employee level and provide notice of any amount applicable to each insurance carrier (for medical coverage, voluntary benefits, etc.) and to the IRS. These figures will be adjusted annually based on the Urban CPI rather than the rate of medical cost inflation.

The calculation of the value of the medical plan **includes**:

- Medical insurance premium (employer- and employee-paid)
- FSA and HSA contributions
- On-site medical clinics (not "wellness centers")
- Voluntary benefits when premium is paid with pre-tax dollars (except accident plans)

The calculation **excludes** non-medical ancillary benefit plans, including:

- Dental and vision coverage offered through "stand-alone" plans
- Voluntary benefits when premium is paid with post-tax dollars
- Any accident plan (paid with pre- or post-tax dollars)
- Life and disability coverage
- Long term care

Certain groups, such as qualified retirees and employers in high-risk professions, will have higher limits. Those limits also may be increased by characteristics such as age and gender.

Impact on employers

- Employers will need to determine how their benefits package aligns with the "Cadillac" plan tax and may choose to lessen the aggregate benefit. If the aggregate benefits for an individual exceed the cap, the employer will need to communicate to the insurance provider and the federal government the amount of penalty that applies.
- Companies that "self-insure" their medical coverage would not have a provider to pass along the penalty to — they would be required to pay the excise tax themselves. Many analysts, including those in the Congressional Budget Office, estimate that businesses may respond by changing their benefits to have lower premiums, higher deductibles and copayments and, by terminating employer contributions to HSAs and FSAs. Economists say employers may pass the savings to workers in the form of higher wages.[16]

Impact on individuals

Individuals may see changes to their health benefits if insurers lower premiums to avoid the excise tax.

Business as usual for benefits other than medical

As noted at the beginning of this white paper, the anticipated impact of the tax, revenue and enforcement provisions will be minimal when it comes to other employee benefits — including disability, accident, long term care and critical illness. These HIPAA-excepted benefits are excluded from the tax revenue and enforcement provisions outlined in this document.

It is important to note that a benefits package rich in disability, life, critical illness, accident and long term care benefits would not impact the premium used to determine a "Cadillac" plan.

Excepted and HIPAA benefits

HIPAA refers to the Health Insurance Portability and Accountability Act. For the purposes of health care reform, certain kinds of coverage are designated as "excepted benefits" and are not subject to the Patient Protection and Affordable Care Act.

The Department of Labor defines these as benefits provided under a separate policy, certificate, or contract of insurance, such as voluntary coverage that is supplemental to a group health plan.

Conditions for tax exemption:

Benefit	Conditions
Disability	If HIPAA-excepted
Critical illness	If HIPAA-excepted and paid with post-tax dollars
MedSupport	If HIPAA-excepted and paid with post-tax dollars
Accident	If HIPAA-excepted and paid with pre- or post-tax dollars
Long term care	Always exempt

Unknowns in the road ahead

With $940 billion in the tax and revenue pipeline for health care reform, the most frequently asked question is this: will the expenditures and reform measures lead to lower health care costs for consumers?

The answer is as complex as the law itself. On one hand, a free-choice health insurance market could force premiums downward. But other measures, such as the "Cadillac tax," could potentially result in pass-along costs to employers and higher rates for employees.

It's important to note that the legislation lacks measures that would directly control or push down the actual costs of medical care. So there is no pressure to reduce the cost of a hospital stay, for instance, or to lower the expense of treating cancer.

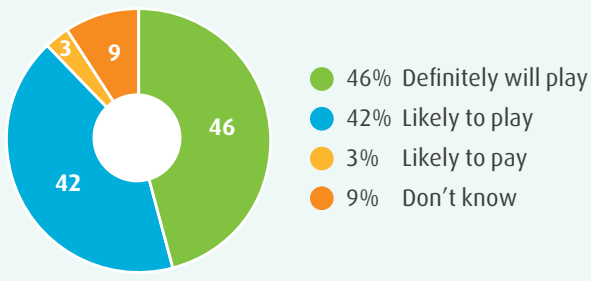
The "pay or play" factor

The financial viability of the reform package as a whole is also difficult to project, due to many variables. One important variable is the actual number of employers and individuals who choose to "play" by offering or buying insurance coverage, or pay the penalty for not participating in a plan, which would generate revenue.

What employers say

A survey by Towers Watson indicates that the vast majority of employers are likely to play — by offering at least the minimum "essential benefits package" mandated by the law — rather than pay.[17]

Likelihood that organization will play or pay†



†From towerswatson.com, May 2010

On an individual level, the Congressional Budget Office projects that 3.9 million people will pay penalties under the law rather than buy insurance.[18]

The single certainty

Without a crystal ball, it's impossible to predict accurately how the financial measures of health care reform will play out. However, as employers take a step back and re-evaluate their benefits offering in light of the Patient Protection and Affordable Care Act, one thing remains certain. More than ever before, it will be important for employers to work consultatively with their brokers and benefits providers to create solutions unique to this new era in employee insurance.

To learn more about the impact on health care reform on your business, or if you have questions about how to plan consultatively for this new era in employee benefits, call your broker or local Unum representative.

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MK-2605 (6-10) FOR BROKERS AND EMPLOYERS