AGENDA

- Health Insurance
  - Who must be covered
  - Tax consequences
- Flexible Spending Account Rules
- Health Reimbursement Arrangements
- Health Savings Accounts
- Health Care Reform
- Q&A
Group Health Plans

OVERVIEW

What is ERISA?
- The Employee Retirement Income Security Act of 1974

When does ERISA apply?
- ERISA § 3(1): “any plan, fund, or program …
- Employee benefit plan or plan - ERISA § 3(3)…
- Applies to “employee welfare benefit plans”
  - Covers retirement plans and some other type of plans
  - Focus on welfare benefit plans

To whom does it apply?
- All private employers—profit and non-profit
- Church and governmental plans exempt
Who can participate in an ERISA plan

- Participants and beneficiaries
  - Those who benefit from ERISA plans must be:
    - Employees or former employees and their beneficiaries

- Who can NOT participate?
  - Directors
  - Independent contractors
  - Household help
  - Vendors
  - Relatives
  - Executives of "related" companies – may NOT participate in ERISA plan

ERISA does not dictate eligibility and participation requirements

- Full-time, part-time, salaried, hourly

Non-ERISA plans may establish eligibility and participation requirements

- Self insured plans (ERISA and non-ERISA plans)
  - IRC section 105(h) states a plan cannot discriminate in favor of highly compensated employees as to eligibility and benefits
    - Discrimination results in taxable income to the highly compensated employee

- Fully insured plans must comply with state insurance laws
  - State insurance laws are not pre-empted by ERISA
  - May require coverage be provided to a domestic partner

- Fully insured plans (ERISA and non-ERISA plans)
  - PPACA provides a nongrandfathered fully insured plan cannot discriminate in favor of highly compensated employees as to eligibility, benefits and premiums
    - Watch for salaried vs. hourly, managers vs. staff
    - Discrimination results in penalty of $100 per day per affected individual – paid by the employer
    - Regulations not yet provided so in a period of nonenforcement
WHO MUST BE COVERED

PPACA provision
- If plan provides for dependent coverage, it must cover dependent child up to age 26
  - Grandfathered plan can limit eligibility based on child’s employment related coverage

2014 pay or play provision
- Excise tax may apply to large employers – 50 or more full-time employees (30 hours/week)
  - Each employee working ≥30 hours/week = 1 FTE
  - Each employee working <30 hours/week = fraction of an FTE
  - Seasonal employees excluded if working <120 days/year
- No excise tax applies to –
  - Employers that are not large employers or that have 30 or fewer employees who work ≥30 hours/week
  - Employers offering “affordable” medical coverage with ≥60% actuarial value
  - Affordable = full-time employee’s required contributions for self-only coverage ≤9.5% of household income

TAXATION

Exclusion from employee’s gross income
- Coverage under employer sponsored health plan and amounts paid or reimbursed for medical care expenses of
  - Employee
  - Employee’s spouse
  - Employee’s dependents
  - Employee’s child who has not attained age 27 as of the end of employee’s taxable year

Not an employee, spouse or dependent so exclusion does not apply
- Sole proprietors, partners and more than 2% shareholders in Subchapter S are self-employed, they are not employees
  - Attribution rules are applicable to spouses and dependents of partners and 2% shareholders
- Imputed income
  - Domestic partner or same sex marriage is not a spouse under federal law
  - Child of domestic partner unless the child is a tax dependent of employee
  - Based on Fair Market Value

IRC sections 104, 105(b), 106 and 125
- Benefits and reimbursements provided by employer not taxable to employee
- Coverage can be provided on a pre-tax basis
- Expenses reimbursable under health FSA/HRA
IRS Notice 2010-38
- Provides guidance on tax-free benefits for federal tax purposes
  - State tax law may provide for a different result
- Makes employer-paid coverage for adult child nontaxable until the end of the year in which the child turns 26
- Child defined as son, daughter, stepson, stepdaughter of employee
  - Includes child placed for adoption with employee and eligible foster child (placed with employee by authorized placement agency or by order of court)
- Tax dependency tests do not apply for purposes of determining whether adult child’s benefits non-taxable

Which plans affected as to adult child taxation? Broader than coverage mandate under PPACA
- Includes all IRC Section 105(b) health plans
  - Medical
  - Dental
  - Vision
  - HRA
  - Health FSA
- Excludes
  - Life
  - Disability
  - AD&D
  - HSA (just the account, not the underlying HDHP)
    - Child must be a tax dependent for distributions
Group Term Life
- Employer can provide employees up to $50,000 of group term life without cost to employee
  - Taxable value in excess of the exclusion amount is determined under Table I rates
  - If plan is discriminatory, exclusion is not available to key employees
    - Taxable value is higher of actual cost or cost under Table I
  - Death benefit is generally excludable from beneficiary’s income
  - Subject to Social Security tax, but not withholding
- Exemption does not include coverage on the lives of an employee’s spouse or dependent
  - Coverage can be tax-free if benefit does not exceed $2,000
- Coverage provided to domestic partners, cost is not excludable from income
  - Use Table I cost of coverage for taxable income

Disability Coverage
- If employee pays for benefit on a post-tax basis, then amount attributable to employee contributions is not subject to FICA
- If employee pays for benefit on a pre-tax basis, or if employer provides then:
  - Benefit is subject to FICA and FUTA for the first six calendar months after the last month in which the employee worked
- Revenue Ruling 2004-55: Employer may allow employees to elect on an annual basis whether to have premiums included in their income for that year
  - Employee is not taxed on disability benefits beginning in that tax year
  - Election is irrevocable
  - Cannot be hybrid—either benefit is taxable or non-taxable
TAXATION FOR EMPLOYER

Group Term Life
- Employer can deduct all premiums of group term life as a business expense
  - Even if plan discriminates in favor of key employees

Accident and Health Insurance
- Employer can deduct premiums as a business expense
- Limitations when contributions are made to a “welfare fund”

PAYROLL TAXES
- Coverage and reimbursements of group health plan for employee’s child under age 27 not wages for FICA or FUTA purposes
  - Exempt from income tax withholding
- Check with state law to see if it follows Federal law for taxation of benefits for child up to the year in which they turn 27
  - All except for WI according to Business Insurance
Flexible Spending Accounts

What are they?

- They are self-insured medical reimbursement plans (subject to certain Internal Revenue Code (Section 105) requirements).
- They are flexible spending arrangements (subject to additional requirements contained in IRS regulations).
- They are group health plans (subject to COBRA, HIPAA, health care reform, and other federal mandates affecting group health plans).
- They are employee welfare benefit plans (subject to ERISA).
- They are subject to Code requirements affecting cafeteria plans generally.
**HEALTH FLEXIBLE SPENDING ACCOUNTS**

Employer-sponsored option under a cafeteria plan — usually funded with pre-tax employee contributions

Usually offered in conjunction with a comprehensive employer-sponsored medical plan

- Reimburse Code Section 213 Expenses
- Maximum reimbursement available during entire period of coverage
- "Use it or lose it" rule
- Expense must be incurred during period of coverage
- Uniform coverage rule
- Irrevocable election is for 12 month plan year, unless IRS reason for a permitted change
- Substantiation requirements

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Employees generally elect the amount of coverage they want each year and contribute that amount

- All amounts paid into and from account are tax-free to the employee
  - Currently, no statutory limit on contributions

**Not a good vehicle for CDHP**

- No carryover of unused balances to future years — "use it or lose it"
  - Exception: Plans can allow a 2½ month grace period after end of year to use remaining balance
- Entire election amount available throughout year — employer must be "at risk" for election amount
- Account must be used only for health care expenses — no cash-outs
**HEALTH FLEXIBLE SPENDING ACCOUNTS**

**Who can participate**
- Employees
- Former employees

**Who cannot participate**
- Sole Proprietors, partners, more than 2% shareholders in subchapter S corp

**Whose expenses can be reimbursed**
- Employee
  - Spouse and tax dependents
  - Employee’s child who has not attained age 27 as of the end of employee’s taxable year
    - Pursuant to PPACA

**Discrimination testing**
- Self insured plan subject to section 105(h)
  - Cannot discriminate in favor of highly compensated employees as to eligibility and benefits
  - An HCE is any employee who, for the prior year (or current year if a new employee) is an officer, 5% shareholder, or an employee who received compensation greater than $110,000 in 2011(indexed for inflation) and is among the top 20 % of the employees ranked by compensation
  - Discrimination leads to taxability of benefits for highly compensated employee
- Subject to cafeteria plan nondiscrimination requirements in section 125
HEALTH FSA AND PPACA

December 31, 2010
Over-the-counter medicines can no longer be reimbursed, unless for insulin or prescribed by physician
Based on tax year, even if FSA plan year runs off calendar cycle
Amend plans to reflect OTC limitations

January 1, 2013
Maximum contribution limited to $2,500 under PPACA
Regulations not yet provided on details
- Applicable to each individual or family
- Applicable if different employers
  Amend plans to reflect new contribution limits

SIMPLE CAFETERIA PLANS UNDER PPACA

Relaxes nondiscrimination requirements
- Small employers---less than 100 employees in previous two years
- Eligibility and minimum contribution requirements
- Eligible participants
- Ineligible participants
  - Sole proprietors, partners, more than 2% shareholder in Subchapter S
DCAPs can fall into several highly regulated plan categories:

- They are dependent care assistance programs subject to certain Code 129 requirements;
- They are flexible spending arrangements subject to additional requirements contained in IRS regulations;
- A DCAP offered under a cafeteria plan is subject to Code requirements affecting cafeteria plans.

Employer-sponsored option under a cafeteria plan — usually funded with pre-tax employee contributions

- “Use it or lose it” rule
- Must be incurred (i.e., dependent care must have been provided) during the coverage period.
- No uniform coverage rule (reimbursements only up to amounts deducted)
- Irrevocable election is for 12 month plan year, unless IRS reason for a permitted change
- “Spend-down” of remainder of the DCAP for qualified dependent care expenses incurred after termination permitted
- Substantiation requirements
DEPENDENT CARE SPENDING ACCOUNTS

Reimburse employment-related expenses for care of qualifying dependents

- “Employment-related means expenses incurred for services that allow the participant and spouse (if any) to be gainfully employed
- “Qualifying individual” means
  - A dependent under age 13 who has the same principal place of abode as the employee for more than one-half of the tax year
  - A dependent, including a spouse, who is physically or mentally incapable of self-care and who has the same principal place of abode as the employee for more than one-half of the tax year

DEPENDENT CARE SPENDING ACCOUNTS

Employees generally elect the amount of coverage they want each year and contribute that amount

- All amounts paid into and from account are tax-free to the employee
- Employee can participate in DCAP or use dependent care tax credit
  - No double dipping
- Statutory limit for contributions
  - $5,000 ($2,500 in the case of a separate return by a married individual) or the employee’s or spouse’s earned income, if lower.
**DEPENDENT CARE SPENDING ACCOUNTS**

**Nondiscrimination testing**

- DCAP must not discriminate in favor of HCEs or their dependents as to eligibility to participate;
- A DCAP must not discriminate in favor of HCEs or their dependents as to contributions and benefits received under the plan;
- Not more than 25% of the amounts paid or incurred by the employer for dependent care during a year may be provided to shareholders or owners (or their spouses or dependents) who own more than 5% of the stock or of the capital or profits interest in the employer; and
- The average DCAP benefits provided to non-HCEs under all plans of the employer must be at least 55% of the average benefits provided to HCEs under all plans of the employer.

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**Health Reimbursement Arrangements**
OVERVIEW

Employer-sponsored program — must be 100% employer-paid with no pre-tax employee contributions

- Typically offered in conjunction with high-deductible health coverage
- Employer sets the amount it will add to HRAs each year
- All amounts paid into and from account are tax-free to the employee
- No statutory limit on contributions
- Unused balances can carry over to future years — “use it or keep it”
- Expenses from prior years can be reimbursed from current year’s additions
- Additions to account need not be available throughout the year — employer need not be “at risk” for entire annual amount
- Can reimburse insurance premiums including Medicare and Medicare Supplement
- Reimbursement can be allowed before other coverage (e.g. HFSA) exhausted

OVERVIEW

- Account must be used only for health care expenses — no cash-outs
  - Unless funded through a trust or insurance, unused amounts are an employer liability
- Other issues
  - Adjudication of claims required
  - Non-employees cannot participate
  - Discrimination in favor of highly compensated employees prohibited
  - Subject to ERISA, COBRA, HIPAA privacy and security, HIPAA portability and nondiscrimination
  - Subject to Medicare Secondary Payer (MSP) reporting requirements if benefit is $1,000 or more per year
OVERVIEW

HRAs are group health plans subject to PPACA

- If integrated with an underlying plan, then if underlying plan complies with PPACA, HRA complies
- If HRA is stand alone, must comply with PPACA
- Waiver of restrictions on annual dollar limits on essential health benefits available under HHS program
  - Approved 95% 1,315 including 225+ mini-meds
  - Participant notice requirement applies
  - To obtain waiver through end of 2013 plan year, apply by September 22, 2011 and comply with follow-up requirements
  - August 19, 2011 class exemption for all HRAs that were in effect prior to September 23, 2010—comply with follow-up requirements

Health Savings Accounts
OVERVIEW

For CDHP purposes, HSAs have many of the best features of both health FSAs and HRAs

- Both employer and employees can contribute to the HSA, and cafeteria plan can provide for pre-tax employee contributions
- Amounts paid into and from account can be tax-free to the employee
- Unused balances can carry over to future years — “use it or keep it”
- Expenses from prior years (but after HSA established) can be reimbursed from current year’s additions
- Additions to account need not be available throughout the year — employer need not be “at risk” for entire annual amount
- Reimbursement can be allowed before other coverage (e.g. health FSA) exhausted

HSAs also have some unique advantages

- HSAs are portable — owned by employee
  - Can be established without employer plan
  - Unused balances are not employer liability
    - Contributions are paid into IRA-like account
- HSA amounts can be used for any purpose — even cashed out
  - Income and excise tax consequences vary depending on use of funds
  - No claims adjudication required — employee determines tax consequences of distributions
- Most will not be subject to ERISA, COBRA, or HIPAA portability and nondiscrimination
If properly structured, HSAs are tax jackpot

Deductible/excludible contributions
- Tax deductible if contributed by the individual
- Excluded from individual’s taxable pay if contributed by the employer
- Can be contributed on a pre-tax basis by an employee through a cafeteria plan (no double tax benefit)
  Earnings grow tax free
- Individual can direct investment of account (but it cannot be invested in life insurance)
  Distributions are tax free — if used for qualified medical expenses
- Under PPACA—distribution for nonqualified medical expenses pay 20% penalty

WHAT MAKES HSAs SO DIFFICULT TO WORK WITH?

Eligibility, only eligible individuals qualify for tax-favored HSA contributions

Four requirements for being an eligible individual
- Must not be someone who can be claimed as a tax dependent
- Must not be someone who is entitled to Medicare (meaning both eligible for and enrolled in Medicare)
  - Does not mean that everyone over age 65 is ineligible
  - Some individuals under age 65 may be entitled to Medicare
- Must be covered under a high deductible health plan (HDHP)
- Must not be covered by any plan that is not an HDHP (non-HDHP)
  - Eligibility for non-HDHP coverage is not a problem — only actual coverage eliminates eligible individual status
Several limits apply to HSA contributions for an eligible individual:

- 2011 maximum contribution amount: Single $3,050 Family $6,150
- 2012 maximum contribution amount: Single $3,100 Family $6,250
- Catch up contribution for anyone 55 years of age--$1,000
- Eligibility for HSA contributions generally determined on a monthly basis:
  - If employee makes contributions through a cafeteria plan, elections can be changed monthly on a prospective basis
  - Full year contributions may be made by someone who was an eligible individual for only part of the year
  - Must maintain HDHP coverage as of December 1 of current year, and for the next calendar year
  - If HDHP coverage not maintained, then eligible contribution is based on HDHP months of coverage
  - Any excess contributions must be distributed and taxed as taxable income plus 10% tax penalty

WHAT MAKES HSAs SO DIFFICULT TO WORK WITH?

- Comparability or nondiscrimination limits on employer contributions:
  - Employer contributions outside of a cafeteria plan must be comparable (same dollar amount or same percentage of deductible) for similarly situated individuals
    - Single versus family coverage
    - Can discriminate in favor on non-highly compensated
  - Employer contributions through a cafeteria plan do not have to meet comparability requirements
    - Can do matching contribution
    - Can run into nondiscrimination testing requirements under cafeteria plan
- Employers who fail to meet comparability requirements:
  - Excise tax of 35% on all contributions
  - IRS requires self reporting as of January 1, 2010
### OTHER ISSUES

**Rollovers**
- Rollover contributions may be made to an HSA from another HSA without being subject to the annual contribution limitations.
  - A rollover contribution is any amount distributed from an HSA to an HSA account holder that is then deposited into an HSA for the benefit of that individual within 60 days after the distribution is received.
  - Rollover exception is only once every 12 months

**Qualified distributions**
- Limited time (from December 20, 2006 to December 31, 2011), may be directly rolled over, tax-free, from HRAs or health FSAs into HSAs.
  - Only one qualified distribution per HRA or health FSA of an individual
  - The individual must have had a positive (i.e., greater than $0) balance on September 21, 2006 in his or her HRA or health FSA
  - Distributions are treated as rollover contributions to HSAs, and are not deductible and do not count against HSA contribution limit or additional catch-up contribution limit.
  - Individual must have HDHP coverage as of the first day of the month during which the qualified HSA distribution occurs, and must otherwise be an HSA-eligible individual.
  - If the individual is not HSA eligible on the first day of the month in which the qualified HSA distribution occurs or if the individual fails to remain HSA eligible during the remainder of the relevant "testing period" the amount of the rollover will be included in his or her gross income and subject to an additional 10% tax.

### OTHER ISSUES

**Establishment of HSA**
- Expenses can only be reimbursed that are incurred after the establishment of an HSA
  - Based on state trust laws, usually requires contribution be made

**Employee who does not establish HSA in calendar year**
- Employer must still make contributions plus interest (notice requirement gives some relief)
- Provide notice to employees by January 15th that employees have until February 28th to establish HSA
- Contributions for prior calendar year must be made by April 15th of following year
Health Care Reform

EMPLOYER HCR TIMELINE

2010
- Coverage reforms (plan years on or after September 23, 2010)
- Early retiree reinsurance program
- Small employer tax credit
- Children’s coverage nontaxable
- No incentives to opt out and go to high-risk pool
- Automatic enrollment (enforcement delayed, probably until 2014)
- 60 days' notice of changes (enforcement delayed, probably until 2012)

2011
- OTC drug restrictions
- Increased penalties for non-medical HSA withdrawals
- Uniform explanations of coverage (use not required until 2012)

2011 (continued)
- “Simple” cafeteria plans
- CLASS program (authorized, but will not be effective for 2011)

2012
- Required use of uniform explanations of coverage
- 60 days' advance notice of changes required
- Report value of coverage on W-2s
- $1 per capita fee applies to years ending after 9/30/12
- Refunds for medical loss ratios <85% or 80% for small plans
- Reporting on heath improvement benefits standards (date for reporting unclear)
- Transparency reporting standards (date for issuance/report unclear)
**EMPLOYER HCR TIMELINE**

<table>
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<th>Year</th>
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| 2013 | Health FSA salary reduction contributions capped at $2500  
Per capita fee increases to $2  
Medicare Part D subsidy no longer deductible  
Notice of state exchanges and premium assistance availability  
Medicare payroll tax increases to 2.35% on pay over $200k/$250k |
| 2014 (continued) | Insurance exchanges open for individuals and small employers  
Wellness incentives up to 30% (50% possible with agency rules)  
Employers offering exchange plan may allow pre-tax premiums  
Early retiree reinsurance program ends  
2014 (continued)  
Additional coverage reforms  
First applicability of penalties for not providing coverage (free-rider)  
Individual mandate  
Employer reporting to IRS re: individuals' coverage  
Automatic enrollment required |
| 2014 | Insurance exchanges open for individuals and small employers |
| 2015 | Wellness incentives up to 30% (50% possible with agency rules)  
Employers offering exchange plan may allow pre-tax premiums  
Early retiree reinsurance program ends |
| 2016 | Insurance exchanges must open to employers with <100 employees  
States may open insurance exchanges to any size employer |
| 2017 | Excise tax on high-cost plans |
| 2018 | Per capita fee sunsets |
EFFECTIVE DATES OF COVERAGE REFORMS

First group of coverage reforms effective for most plans in 2011
- Effective for plan years starting on or after September 23, 2010
- Regulations issued for most of the 2010-2011 coverage reforms
- Several enforcement delays, waiver programs, modifications
  - Nondiscrimination rules for insured coverage remain on hold
Second group of coverage reforms will be effective for plan years starting on or after January 1, 2014
- Grandfather rule does not change effective date of any provision
- Makes some coverage reforms inapplicable for as long as plan remains grandfathered
- Until 2014, allows exclusion of children who have coverage available from their own or their spouse’s employer

COVERAGE REFORMS

First group of coverage reforms applies to most plans in 2011
- No lifetime dollar limits on essential health benefits
- Restricted annual dollar limits on essential health benefits
- Rescission of coverage prohibited except in cases of fraud or intentional material misrepresentation
- No preexisting condition exclusions for enrollees under age 19
- Minimum limiting age on dependent child coverage is 26
- Preventive health services covered with no cost sharing (GF)
- Nondiscrimination rules apply to insured coverage (GF)
- Patient protections regarding access to certain providers and emergency services (GF)
- Standards for internal claims and appeals and external review (GF)
- Wellness programs may not require disclosure of information relating to, and no incentives can be based on, legal use or possession of firearms (GF)
COVERAGE REFORMS

Recent developments re: 2010-2011 coverage reforms

Waiver of restrictions on annual dollar limits on essential health benefits available under HHS program
- Approved 95% 1,315 including 225+ mini-meds
- Participant notice requirement applies
- To obtain waiver through end of 2013 plan year, apply by September 22, 2011 and comply with follow-up requirements
- August 19, 2011 class exemption for all HRAs that were in effect prior to September 23, 2010—comply with follow-up requirements
- Age 26 mandate applies only to employees' biological, adopted, placed for adoption, step and eligible foster children
- Preventive health services include items supporting women's health
- Applies to non-grandfathered plans for plan year starting on or after August 1, 2012
- Includes contraceptives
  - Nondiscrimination rules for insured coverage still on hold
  - Standards for internal claims and appeals and external review updated

Information

Second group of coverage reforms applies to 2014 plan years

- Waiting periods longer than 90 days prohibited
- Preexisting condition exclusions prohibited for all enrollees
- All annual dollar limits on essential benefits prohibited
- Exclusion of employees' children who are under 26 based on eligibility for other employment-based coverage no longer allowed
- Coverage of routine care for participants in clinical trials (GF)
- No discrimination against providers acting as licensed (GF)
- Out-of-pocket maximum can be no greater than allowed for a high-deductible health plan offered in connection with an HSA (GF)
- Deductibles cannot exceed $2,000 for single coverage and $4,000 for family coverage (applicability to larger plans unclear) (GF)
- Wellness incentives up to 30% of individual COBRA rate permitted (federal agencies may allow additional increases up to 50%) (GF)
SUMMARY OF MAJOR TAX CHANGES

2010 – 10% federal excise tax for using indoor tanning facility
2010 - Coverage for child up to year turning 27 on a tax favored basis
2010 – Small business tax credit
2011 – Over-the-counter limitations and additional tax on HSA/MSA distributions
2011 – Simple cafeteria plans
2011 - W-2 reporting of health insurance---IRS made this optional for 2011
2012 – Reporting of payments to corporations (Repealed—a d d e s s e d on later slide)
2012 - $1 per capita fee applies to years ending after 9/30/12, in 2013 per capita fee
    increases to $2—not a tax but might as well be
2013 – Medicare tax increase for high income earners
2013 – New 3.8% Medicare tax on investment income

SUMMARY OF MAJOR TAX CHANGES

2013 – Flexible spending account contributions limited to $2,500 for medical expenses
2013 – Itemized deduction threshold for health care expenses increased from
    7.5% to 10% of AGI
2013 – Medicare retiree drug subsidy tax deduction eliminated
2013 – Excise tax on certain medical devices
2014 – “Pay or play” provisions begin for certain taxpayers
2014 – Increase of small business tax credit
2014 – Individuals refundable premium assistance credit created; penalty
    for no coverage
2018 – 40% excise tax on a portion of employer-sponsored “Cadillac plans”
CHANGES STARTING IN 2010

Small Business Tax Credit
- Credit established to offset the cost of employer-provided health coverage
- 2010-2013 is transition tax period
- 25 or fewer full time equivalent employees with average annual wages of less than $50,000
  - Tax credit is phased out for employees with wages between $25,000 and $50,000
  - Tax credit is phased out after 10 employees
- Tax credit up to 35% (25% for tax exempt employers) of the employer’s contribution
  - 2010 employer must contribute at least 50% of employee only coverage
  - 2011 employer must make a uniform contribution under a qualifying arrangement
  - Does not count employee pre-tax contributions
- Employer’s premium payment for the purpose of the credit is capped by premium amount the employer would have made under the same arrangement using the average premiums for the small group market in the state (benchmark premium)

CHANGES STARTING IN 2010

Small Business Tax Credit
- Sole proprietor, partnerships, Subchapter S corps
  - Owners, partners and any familial relationship does not count as an employee for determining size of company or payment of health insurance credit
- Member of a controlled group or affiliated service group is treated as a single employer for purpose of the credit
- Status is determined each tax year
- Changes in 2014, more information later
- This is part of IRC Sec. 38 general business credits (for non-exempt credit is refundable credit on income tax and Medicare)
- If no tax liability, then no credit
- IRS to provide further guidance
  - Exception: unused credit amount can be carried forward for 20 years
- Employer’s deduction for health insurance is reduced by the amount of any tax credit.
- IRS Notice 2010-44
  - Clarifies calculations for small business credits and provides many examples as well
**W-2 Reporting**
- 2011 reporting due in January 2012, delayed (2011 reporting is optional)
- 2012 W-2 due January 2013
- Large employer= 250 or more W-2s
- Report in Box 12 using code DD
- “cost of employer sponsored coverage”—does not include
  - HSA contributions
  - Employee FSA contributions
  - Specified disease or illness
  - Dental or vision that is not integrated into a group health plan
  - Long term care
  - Coverage only for accident or disability income
  - Liability, workers compensation, automobile medical payment, credit only insurance
  - Military coverage maintained by a governmental plan
  - Coverage under an HRA
  - Self insured plans not subject to COBRA (church plans)
- Penalty $30 to $100 per W-2

**Information reporting for payments to corporations**
- Act requires businesses to file an information return (e.g., a 1099) for all payments aggregating $600 or more in a calendar year to a single payee, including corporations (other than a payee that is a tax-exempt corporation)
- Effective for payments made after December 31, 2011
- Prior to this act such payments to corporations were exempt from 1099 reporting
- Additional burden to many businesses and IRS who will be forced to process
- Notice 2010-51
  - Requests public feedback on information reporting
- PPACA §9006 application to all vendors of more than $600
- Senate passed repeal as part of the FAA Air Transportation Modernization and Safety Improvement Act (S. 223) – “FAAATMSIA”
**Changes Starting After September 30, 2012**

- Participant fee for comparative effectiveness research
  - $1 per participant for first *plan year ending after September 30, 2012* (2013 for calendar plan years)
  - $2 per participant following year
  - Not applicable to HIPAA exempt benefits
  - Sunsets 1/1/2020

**Changes for Plan Years on or After January 1, 2013**

- Health FSA cap of $2,500
  - Contributions are capped at $2,500 each year, indexed for Consumer Price Index (CPI) starting in 2014
  - Cap previously left to employer’s discretion ( $4k to $5k)
  - Uncertain how cap is applied, i.e. individual, filing jointly
  - Off calendar health FSA plan years will need to be cautious of employee elections overlapping from one tax year into another
**Medicare Retiree Drug Subsidy (RDS) tax deduction eliminated (Medicare Part D)**
- Employers offering retiree drug coverage have been able to receive a 28% subsidy on the costs
- The RDS has been tax deductible
- Subsidy will no longer be tax deductible
- Mainly impacting very large corporations
- Employer may consider shifting retiree drugs onto Medicare

**Additional Medicare tax on wages and self-employment**
- Individuals making $200,000 a year or couples making $250,000 would have a higher Medicare payroll tax of 2.35% on earned income, up from the current 1.45%
  - Not applicable to employer’s tax
- Not deductible as SE tax on individual’s tax return
- Company’s will need to adjust payroll systems to capture additional tax for those with highly compensated meeting this level

**Medicare contribution tax on unearned income**
- New tax of 3.8% on unearned income, such as dividends/interest, annuities, rent also added. No on retirement or tax-exempt income
- Tax applied on the lesser of net investment income or amount of AGE that exceeds the threshold amount
**CHANGES FOR PLAN YEARS ON OR AFTER JANUARY 1, 2013**

- New 2.9% excise tax on medical devices
  - Contacts, glasses, etc. would be exempt

- Itemized deduction threshold for medical expenses increases from 7.5% to 10% of AGI

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**CHANGES FOR PLAN YEARS ON OR AFTER JANUARY 1, 2014**

- “Pay or Play” provisions enacted for businesses
  - Nondeductible penalty on some employer plans with 50 or more full-time equivalent (FTE) (30 hours/week or more) employees
    - Part time employee equivalents used to determine FTE number
    - First 30 FT employees excluded from tax
  - Tax is $2,000 per FT employee if employer provides no health insurance coverage at all and at least one employee receives tax credit for coverage on an exchange
  - Tax is lesser of $3,000 per FT employee if employer DOES offer health insurance coverage but employee receives tax credit for coverage on an exchange but no more than $2,000 X all employees (minus first 30 employees)
Vouchers

- Employer must offer vouchers to permit certain employees
  - eligible under plan AND
  - required premium is between 8% and 9.5% of income AND
  - total household income does not exceed 400% of FPL
- Voucher can be used to purchase coverage outside of employer plan and retain any excess tax free
  - Must equal the largest portion the employer provides toward type of coverage
  - No free rider penalty for employees receiving vouchers

Free Choice Vouchers—Repealed as part of 2009 Budget Deal

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**CHANGES FOR PLAN YEARS ON OR AFTER JANUARY 1, 2014**

- Increase in small business tax credit
  - Tax credit is increased to 50% (35% for tax exempt employers)
  - Average annual wage dollar limit of $25,000 is adjusted for inflation
  - Credit is only available for two additional years after December 31, 2013 during the credit period
  - Credit is only available if employer provides for coverage through the Exchange
    - Current credit period is 2-consecutive tax year period beginning with first tax year in which the employer or any predecessor offers one or more qualified health plans through the Exchange
    - Credit period cannot start before 2014
  - All other conditions remain the same: 25 FTEs, ER pays at least 50% of employee coverage, definition of employee, ER premium expense capped at "average premium for small market group", tax credit phase-out
Penalty imposed for no coverage with certain exceptions—
individual tax
- $95 in 2014
- $325 in 2015
- $695 in 2016
- Or
- 1.0% of taxable income in 2014
- 2.0% of taxable income in 2015
- 2.5% of taxable income in 2016 and thereafter
- "average premium for small market group", tax credit phase-out

Excise taxes on “Cadillac” plans
- 40% nondeductible tax
- Value of all employer – sponsored medical benefits in excess of:
  - $10,200 for individual coverage
  - $27,500 for more than individual coverage
- High risk occupations* and retirees
  - $11,850 individual
  - $30,950 more than individual
- Indexed at CPI + 1% in 2019, CPI thereafter
- Active and retired employees
- Excludes dental and vision plans
QUESTIONS AND COMMENTS