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CHLEBINA CAPITAL

Health-Care Reform





One primary goal of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the 2010 health-care reform legislation) is to ensure that all Americans and legal residents have access to a minimum level of affordable health care.



Health-Care Reform

The primary goals of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act (collectively, the 2010 health-care reform legislation) are to ensure that all Americans and legal residents have access to a minimum level of affordable health care, and to help contain the burgeoning costs of our health-care delivery system. The health-care reform legislation invokes a shared responsibility between both state and federal governments, as well as employers and individuals, to contribute toward those ends.

In general, the legislation mandates that most individuals have minimum health insurance. While employers are not required to offer health insurance to their employees, those that choose not to offer coverage may face a penalty. The legislation creates new public programs and expands Medicare and Medicaid to include more beneficiaries, while mandating that all health plans extend coverage to all individuals, regardless of health status. Revenue provisions are also included, not only to help fund the cost of these programs, but to extend the viability of Medicare.

How does health-care reform affect individuals?

While some portions of the law became effective in 2010, other provisions are phased in over time. Nevertheless, it is almost certain that at least some of these reforms will have an effect on you and your family.

Changes to private health insurance

The health-care reform law contains

provisions that expand benefits, improve access to health care, and protect the rights of consumers. Here are some of the changes that will apply to most private health plans (although some will apply only to new, not existing, coverage).

- Plans must fully cover certain wellness and preventive care benefits (e.g., immunizations, cancer, diabetes, heart disease screenings, and smoking cessation programs)
- Plans can no longer charge more for out-of-network emergency care
- Plans can't impose annual or lifetime limits on health coverage
- Children can remain on a parent's health plan up to age 26
- Health coverage can't be rescinded due to illness (only for fraud or intentional misrepresentation)

Individual health insurance

If you don't have insurance, or you've found coverage too expensive to obtain, the reforms may make it easier for you to get and keep health insurance. Insurers will have to accept you regardless of your health history, and premiums can only vary based on tobacco use and age, not on health status or gender. If you don't have access to affordable health insurance through an employer, you'll be able to purchase coverage through state-based American Health Benefit Exchanges. Premium and cost-sharing subsidies will be available to individuals and families to help reduce the cost of insurance purchased through an exchange. In addition, Medicaid availability was expanded in some states to include nondisabled individuals who meet minimum income standards.





Considerations for Seniors

The health-care reform legislation enacted in 2010 contains some provisions that directly affect our nation's older population. If you're a senior, you may be concerned about how these reforms could affect your access to health care and the benefits you are currently receiving.

Medicare spending cuts

At the outset, the legislation does not affect Medicare's guaranteed benefits. However, two goals of the health-care legislation is to slow the increasing cost of Medicare premiums you pay, and to ensure that Medicare will not run out of funds. To help achieve these goals, some cuts in Medicare spending will occur over a ten-year period, beginning in 2011, particularly targeting Medicare Advantage programs--Medicare programs provided through private insurers but subsidized by the federal government. These cuts could reduce or eliminate some of the extra benefits your Medicare Advantage plan may offer, such as dental or vision care, and your insurer may choose to increase your premiums to offset the decrease in government reimbursements. But Medicare Advantage plans cannot reduce your primary Medicare benefits, nor can they impose deductibles and co-payments that are greater than what is allowed under the traditional Medicare program for comparable benefits. And, you may have access to more doctors because some of the federal funds previously earmarked for Medicare will be reallocated to doctors and surgeons as an incentive to treat Medicare patients.

Medicare Part D drug program changes

If you're a Medicare Part D beneficiary, you have to pay for the entire cost of prescription drugs out-of pocket after reaching a gap in your annual coverage, referred to as the "donut hole." Medicare generally pays for your medications up to a certain annual dollar limit,

after which you have to pay more of the cost for your prescriptions. But the amount you have to pay within the coverage gap decreases each year until 2020, at which time a combination of federal subsidies and a decrease in co-payments reduces your out-of-pocket costs for medications in the gap to 25%. However, if your annual income is greater than \$85,000 (\$170,000 for couples), you will see your Part D premiums increase as the federal subsidy offsetting some of the cost of Medicare Part D premiums is reduced.

Benefits added to Medicare

The legislation also improves some traditional Medicare benefits. For example, Medicare beneficiaries receive free wellness and preventive care benefits.

Increased access to home-based care

People facing a long-term disability or illness often prefer to receive care at home instead of at a hospital or nursing home. The health-care reform law provides for programs and incentives enabling greater access to in-home care. The Community First Choice Option is available for states to add to their Medicaid programs. This option provides benefits to Medicaid-eligible individuals for community-based care instead of placement in a nursing home. In addition, the State Balancing Incentive Program provides increased federal funds to qualifying states that offer Medicaid benefits to disabled individuals seeking long-term care services at home, or in the community, instead of in a nursing home. In an attempt to reduce costs associated with multiple emergency room visits and hospital readmissions for the same chronic illness, the Independence at Home demonstration program will provide Medicare beneficiaries with chronic conditions the opportunity to receive primary care services at home.



Tax Changes for Individuals

The health-care reform legislation contained a number of tax changes. Some of these changes took effect immediately; others were spread out over several years. Here's a breakdown of some of the changes.

Tanning salons and dependent children

Bad news if you frequent tanning salons--there's a 10 percent tax assessed on amounts paid for indoor tanning services.

In addition, if you're covered by an employer health plan, the tax benefits (i.e., the ability to exclude the value of the benefits from income) associated with the health coverage and any reimbursements you receive for medical care





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expenses are extended to children who have not reached age 27 by the end of the year. Similarly, self-employed individuals can deduct the costs associated with health-care coverage for any child who doesn't reach age 27 by year-end.

Health savings arrangements and medical expense deductions

If you have a flexible spending arrangement (FSA), health reimbursement arrangement (HRA), health savings account (HSA), or Archer medical savings account (Archer MSA), it's important to note that over-the-counter medications (except for insulin and medications that are prescribed by a physician) are no longer considered qualified medical expenses for purposes of reimbursement and tax-free distributions. And, the additional tax that applies to HSA and Archer MSA distributions that aren't made for qualifying expenses is 20 percent. Health FSAs that are part of a cafeteria plan are capped at a \$2,700 reimbursement limit.

Medicare taxes

If you receive a paycheck, you probably have some familiarity with the Federal Insurance Contributions Act (FICA) employment tax; at the very least, you've probably seen the tax deducted on your paystub. The old age, survivors, and disability insurance (OASDI) portion of this FICA tax is equal to 6.2 percent of covered wages. The hospital insurance (HI) portion of the tax (commonly referred to as the Medicare payroll tax) is equal to 1.45 percent of covered wages, and is not subject to a wage cap. FICA tax is assessed on both employers and employees (that is, an employer is subject to the 6.2 percent OASDI tax and the 1.45 percent HI tax, and each employee is subject to the 6.2 percent OASDI tax and the 1.45 percent HI tax on wages as well), with employers responsible for collecting and remitting the employees' portions of the tax.

Self-employed individuals are responsible for paying an amount equivalent to the combined employer and employee rates on net self-employment income (12.4 percent OASDI tax on net self-employment income up to the taxable wage base, and 2.9 percent HI tax on all net self-employment income), but are able to take a deduction for one-half of self-employment taxes paid.

The health-care reform legislation increased the HI tax on high-wage individuals by 0.9

percent (to 2.35 percent). Who will be subject to the additional tax? If you're married and file a joint federal income tax return, the additional HI tax will apply to the extent that the combined wages of you and your spouse exceed \$250,000. If you're married but file a separate return, the additional tax will apply to wages that exceed \$125,000. For everyone else, the threshold is \$200,000 of wages. So, a single individual with wages of \$230,000 will owe HI tax at a rate of 1.45 percent on the first \$200,000 of wages, and HI tax at a rate of 2.35 percent on the remaining \$30,000 of wages for the year.

Employers will be responsible for collecting and remitting the additional tax on wages that exceed \$200,000. (Employers will not factor in the wages of a married employee's spouse.) You'll be responsible for the additional tax if the amount withheld from your wages is insufficient. The employer portion of the HI tax remains unchanged (at 1.45 percent).

If you're self-employed, the additional 0.9 percent tax applies to self-employment income that exceeds the dollar amounts above (reduced, though, by any wages subject to FICA tax). If you're self-employed, you won't be able to deduct any portion of the additional tax.

Also, a 3.8 percent Medicare contribution tax is imposed on the unearned income of high-income individuals (the new tax is also imposed on estates and trusts, although slightly different rules apply). The tax is equal to 3.8 percent of the lesser of your net investment income (generally, net income from interest, dividends, annuities, royalties and rents, and capital gains, as well as income from a business that is considered a passive activity or a business that trades financial instruments or commodities), or your modified adjusted gross income (basically, your adjusted gross income increased by any foreign earned income exclusion) that exceeds \$200,000 (\$250,000 if married filing a joint federal income tax return, \$125,000 if married filing a separate return.)

So, effectively, you'll only be subject to the additional 3.8 percent tax if your adjusted gross income exceeds the dollar thresholds listed above. Interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence that are excluded from gross income are not considered net investment income for purposes of the additional tax. Qualified retirement plan and IRA distributions are also not considered investment income.





TAX

A new premium assistance tax credit will help eligible individuals purchase health-care insurance through one of the newly established state exchanges.

Together, these two new Medicare-related taxes are expected to provide a major source of revenue to finance other parts of health-care reform.

Health insurance credits

A new premium assistance tax credit will help eligible individuals purchase health-care insurance through one of the newly established state exchanges. If you qualify for the credit, it will be paid directly to the exchange insurance plan that you join. Who qualifies? Individuals with household income between 100 percent and 400 percent of the federal poverty level will qualify, with the exact amount of the credit based on income level.

Generally, individuals who are offered coverage through an employer health plan won't qualify for the credit unless the employer health plan doesn't cover an adequate share of benefits (60 percent), or it's considered "unaffordable").

In addition to a premium assistance tax credit, those with household income between 100 percent and 400 percent of the federal poverty level may qualify for a cost-sharing subsidy to help cover out-of-pocket costs, like co-payments and deductibles, when they buy health insurance through an exchange. Like the tax credit, the subsidy will be paid directly to the plan.





The new health-care reform legislation provides a tax credit to small businesses that offer health insurance coverage to their employees.

How Does Health-Care Reform Affect Businesses?

The health-care reform legislation includes new taxes, but there are also some tax breaks available to help small businesses pay for health insurance. Two of the changes getting a lot of attention are: a tax credit available to small businesses that offer health-care coverage to employees, and a tax to penalize employers who do not offer coverage.

Small business tax credit

The new health-care reform legislation provides a tax credit to small businesses that offer health insurance coverage to their employees. The maximum credit is 50 percent.

To be eligible for the tax credit, the following conditions must be met:

- An employer must have the equivalent of fewer than 25 full-time employees for the tax year. Generally, this is determined by dividing the total hours for which wages were paid for all eligible employees during the year by 2,080.
- Average annual wages must be less than \$53,200 (to calculate, total wages paid during the tax year are divided by the number of full-time employees, and rounded down to the nearest \$1,000).
- The employer must contribute at least 50 percent of the premium cost of a qualifying health plan offered to employees.

Special rules apply to seasonal employees and to tax exempt employers. Also, sole proprietors, partners, 2 percent shareholders of an S corporation, and 5 percent owners of an employer generally are not considered employees for purposes of the credit. In addition, family members of ineligible employees are not counted as employees.

The maximum credit is available to qualifying employers with 10 or fewer full-time employees with average annual wages not exceeding \$26,600. The credit is phased out for employers with between 10 and 25 full-time employees, and for employers who have full-time employees with average annual wages between \$27,100 and \$54,200.

The total premium paid by the employer that's eligible for the credit cannot exceed the average premium for the small-group market in the state where the employer offers health coverage. The average premium for each state is published by the IRS. The credit is claimed on the employer's annual tax return

as a general business credit.

The maximum credit is 50 percent; however, qualifying arrangements are restricted to health insurance purchased by the employer through a state-run health exchange. Additionally, the credit can be claimed by the employer for only two years.

Other employer incentives

Small businesses with up to 100 employees may be able to purchase health insurance through Small Business Health Options Program (SHOP) Marketplaces. The marketplaces offer at least four benefit categories of plans based on covering an increasing percentage of benefit costs.

Penalty taxes encourage employers to offer coverage

While employers aren't required to provide health-care coverage to employees, a new excise tax will encourage them to do so. A penalty tax will be assessed on employers who do not offer health-care coverage to at least 95 percent of employees and their dependent children up to age 26 if:

- The employer has 50 or more full-time equivalent (FTE) employees, and
- At least 1 FTE purchases health insurance coverage through a federal or state marketplace, and is entitled to a tax credit or cost-sharing reduction

The tax is assessed monthly and is equal to the number of full-time employees exceeding 30 multiplied by \$2,320 divided by 12.

Even employers (those with at least 50 FTEs) that do offer health-care coverage to employees may still face a tax penalty if at least 1 FTE purchases health insurance coverage through a federal or state marketplace, and is entitled to a tax credit as a result of:

- An employer's coverage consisting of a plan that pays less than 60 percent of the total allowed cost of benefits, or
- An employer's coverage being considered "unaffordable" for an employee (generally, coverage would be considered unaffordable if an employee's portion of the premium exceeds 9.56 percent of the employee's household income)

In this case the tax, assessed on a monthly





basis, equals one-twelfth of \$3,480 for each FTE that buys coverage through a marketplace and receives a premium tax

credit. The tax is capped, however, at the amount that would be due if an employer did not offer health-care coverage to employees.



IMPORTANT DISCLOSURES

Securities offered through Securities Service Network, LLC., Member FINRA/SIPC. Fee-based advisory services are offered through Chlebina Capital Management, LLC., a registered investment advisor.



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