

# Health Care Reform Update

## What Employees Should Know About Health Care Reform

The *Patient Protection and Affordable Care Act* and the *Health Care and Education Affordability Reconciliation Act of 2010* together create the most comprehensive health insurance reform undertaken in recent history.

Beginning this year, you will see significant changes in health plan coverage, with many additional changes phased in over the course of the next eight years. This summary is intended to help you understand some of the key changes that may impact you and your family.

### IMMEDIATE CHANGES TO YOUR COVERAGE

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Effective with the first plan year that begins on or after September 23, 2010, health plan coverage provided by your employer will change in the following ways:

- Your health plan will no longer be permitted to place lifetime limitations on essential health benefits, or unreasonable annual limitations on those benefits.<sup>1</sup>
- Your health plan may no longer cancel your contract if you get sick, except in cases of fraud or misrepresentation by you.
- If your health plan provides coverage for dependents, you will be allowed to enroll your dependent children up to age 26. If your plan is considered grandfathered,<sup>2</sup> eligibility to age 26 is only extended if your child is not eligible for his or her own employer-provided coverage.
- Effective March 30, 2010, you may use pre-tax dollars and avoid imputed income on the value of group health plan coverage provided to children who do not attain the age of 27 in the taxable calendar year.

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#### <sup>1</sup> Essential Benefits

The general category of *essential health benefits* will undergo further definition by the Secretary of Health and Human Services (HHS). The general category includes:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services;
- Prescription drugs;
- Rehab services and devices; and
- Preventive and wellness services and chronic disease management.

The regulations that provide further definition of these general categories will also confirm that the scope of essential benefits reflects what is provided under a typical employer-sponsored health care plan.

<sup>2</sup> A health plan in effect on March 23, 2010 is considered "grandfathered coverage." It retains this status until a benefits change is made; merely enrolling new hires or adding/dropping dependents will not cause a plan to lose its status.

This includes reimbursement of eligible medical expenses through the health flexible spending account (FSA) or health reimbursement arrangement (HRA).

- Your health plan is no longer permitted to discriminate against, or deny coverage to, children up to age 19 with pre-existing conditions.
- If your employer's plan is not a grandfathered plan, the plan may not require cost-sharing for certain preventive services.<sup>3</sup>
- Your employer may not encourage you or provide you with incentives to drop coverage through the group health care plan to obtain coverage through the new state-created high-risk pool program.

## **CHANGES IN 2011**

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There are a few additional changes that apply effective January 1, 2011:

- Expenses for over-the-counter (OTC) medicines or drugs may no longer be reimbursed from your health FSA, HRA and/or HSA, unless you obtain a prescription from your doctor. This change is effective as of January 1, 2011, regardless of your plan year. Thus, any OTC medicines or drugs purchased on or after January 1, 2011 will not be eligible for reimbursement unless you have a prescription. This will also likely impact your ability to use a flexible spending debit card to purchase these expenses.
- Your employer will be required to report the value of health care coverage on your W-2. This value does not include dental or vision plans, or contributions to your health FSA, your HSA or to an Archer medical savings account (Archer MSA). W-2 reporting is for informational purposes only and is not treated as taxable income.
- You may contribute to a new voluntary, publicly financed, long-term care program (the CLASS Act) through your employer. If your employer elects to participate, then you will automatically be enrolled in a salary reduction program, unless you opt out. If your employer does not participate, but you would like to contribute to the program, government agencies will be providing more information on an alternative participation option.
- Distributions from an HSA for non-medical expenses will be subject to a 20% penalty.

## **CHANGES IN 2012**

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- Plans will be required to provide you with a summary of benefits that is understandable and no more than four pages long. The summary may be included with other plan information that you already receive on an annual basis.

## **CHANGES IN 2013**

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- There will be a new cap on the amount that you, an employee, may contribute to a health care FSA (the limit will be \$2,500 and adjusted annually for inflation).
- High-income individuals (\$200,000/single, \$250,000/married filing jointly) will see an increase in taxes, including an increase in the Hospital Insurance Tax part of FICA from 1.45% to 2.35% and the imposition of a 3.8% tax on passive investment income.

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<sup>3</sup> Preventive services may include immunizations, newborn and well-baby/child visits and screenings for women.

## **ADDITIONAL HEALTH BENEFITS CHANGES IN EFFECT IN 2014**

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The final changes to health plan coverage go into effect in 2014. They are:

- The health plan may no longer exclude coverage of a pre-existing condition;
- The health plan may not impose more than a 90-day waiting period for coverage;
- Your plan may no longer place an annual limitation on essential benefits;
- Your health plan must allow dependents up to age 26 to enroll in coverage, regardless of the availability of employer-sponsored coverage;
- If your employer's plan is not grandfathered, what you pay out of pocket annually may not exceed the limits imposed on the health plans tied to an HSA (in 2014, these limits are estimated to be \$6,200/single, \$12,300/family).

## **MANDATED COVERAGE**

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Beginning in 2014, all U.S. citizens and legal residents must carry health insurance or pay a penalty. There are two ways to obtain health insurance: through your employer or through an Exchange operated by your state. If you do not obtain coverage, you will face a penalty.

### **If you obtain coverage through your employer:**

- If your employer has more than 200 employees, new employees will be enrolled in the health care plan automatically.
- Your employer must tell you about the availability of coverage through the Exchange.
- Your employer must provide you with a coverage option that is at least as good as the least expensive option on the Exchange (bronze level).

### **If you obtain coverage through an Exchange:**

- The state-operated Exchange will sell insurance policies at certain levels of coverage :
  - **Bronze level**—designed to provide coverage of 60% of the actuarial value of the covered benefits;
  - **Silver level**—designed to provide coverage of 70% of the actuarial value of the covered benefits;
  - **Gold level**—designed to provide coverage of 80% of the actuarial value of the covered benefits;
  - **Platinum level**—designed to provide coverage of 90% of the actuarial value of the covered benefits;
  - **Catastrophic**—available to young adults up to age 30 or those exempt from the individual mandate (additional requirements may apply).
- You may only obtain coverage through an Exchange if you are not participating in your employer's plan.
- If you satisfy certain low income thresholds (household income between 100%-400% of the Federal Poverty Level) and have a contribution toward employer coverage that exceeds 8% but is not more than 9.8% of household income, you may qualify for and obtain a voucher from your employer to purchase coverage through an Exchange, instead of the employer-based plan.
- If you satisfy certain low income thresholds (household income between 100%-400% of the Federal Poverty Level) and do not have coverage through an employer, or have employer-provided coverage that is deemed unaffordable or below certain prescribed thresholds, there is a sliding scale of tax

credits available to help you pay the premiums for coverage purchased through the Exchange. The sliding scale also subsidizes cost-sharing expenses like deductibles and co-pays.

- If you and your family are below 133% of the Federal Poverty Level in 2014, you will qualify for Medicaid.

### Penalties for failing to buy coverage

Penalties for failing to buy coverage are phased in according to the following schedule:

- In 2014, the greater of \$95 or 1% of taxable income;
- In 2015, the greater of \$325 or 2% of taxable income;
- In 2016, the greater of \$695 or 2.5% of taxable income; and
- After 2016, the penalty is indexed for inflation.

Exemptions apply, including:

- Financial hardship
- Individuals with income below the tax filing threshold;
- Individuals without coverage for less than 3 months; and
- Religious objection.

## RETIREE MEDICAL COVERAGE

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### Employer coverage

- If you are an early retiree (55-64) receiving coverage through an employer, the government is providing a reinsurance program to qualified employer-based retiree plans that will reimburse the employer for a portion of the cost of providing coverage. This program will discontinue once the Exchanges are operational or when government funding is exhausted, whichever comes first. Any reimbursements will be used to reduce the costs associated with the plan.

### Medicare, Medicare Advantage & Medicare Part D

- Income thresholds are frozen for income-related Part B premiums from 2011 to 2019.
- Widows and widowers will be able to retain their low-income eligibility more easily beginning in 2011.
- Payment rates from Medicare Advantage plans will be frozen at 2011 levels in a four-year effort to move to new benchmarks.
- Seniors who reach the coverage gap (known as the “doughnut hole”) in Medicare Part D will be eligible to receive a \$250 rebate in 2010. The coverage gap will continue to decrease, closing in 2020.
- In 2011, drug companies must provide a 50% discount on brand-name drugs bought in the coverage gap.
- In 2011, the federal subsidy for premiums for Part D will be reduced for higher-income individuals.



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Please contact us if you have any questions regarding the content of this document.

601 Union St  
Suite 1000  
Seattle, WA 98101  
206.441.6300  
kpc.com

700 NE Multnomah  
Suite 1300  
Portland, OR 97232  
503.224.8390  
usinw.usi.biz

50 California Street  
Suite 650  
San Francisco, CA 94111  
415.273.8700  
usi.biz

2021 W March Lane  
3rd Floor  
Stockton, CA 95207  
209.957.6800  
usi.biz

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