

HEALTH CARE REFORM

Will it work and how much will it cost us?



Now that the dust has settled with respect to the massive overhaul of your health care infrastructure, we feel it is necessary to inform you of the key issues that may affect you in the near future and not so near future. The jury is still out on whether or not the legislation

passed in the The Patient Protection and Affordable Care Act "The Act" will accomplish the goals it was designed to accomplish. These goals are:

1. To expand coverage to over 30 million individuals that currently do not have health insurance;
2. Reform the current delivery of health care and insurance and improve its quality; and
3. Lower the overall cost of providing health care.

Certain provisions of the Act call for immediate reform, while others will be phased in over the years beginning 2010 through 2020.

Certain of the changes made by the Act are not considered tax provisions. With this being said, these changes do warrant attention as they will affect all current health plans as well as proposed plans in the future. Of immediate concern to employer-sponsored group plans will include changes to existing plans for:

1. Elimination of lifetime and annual limits on benefits;
2. Mandating coverage for preventive services;
3. Extending eligibility for dependent coverage up to the age of 26; and
4. Establishing new internal and external reviews for claims determinations.

From a reform standpoint on the insurance market, the Act will do a number of things, some of which include:

1. Limit the insurers' flexibility to vary premiums;
2. Require guaranteed availability and renewability of health policies;
3. Prohibit exclusion of coverage based upon pre-existing conditions;
4. Prohibit discrimination based on health status;
5. Establish new benefit requirements require plans to pay a minimum of 60% of coverage costs;
6. Create state-based exchanges through which individuals and small business can purchase insurance.

Of course, all of these nuances and reforms will come with a cost to the health care industry, ancillary medical device manufacturers, small businesses, and finally individuals. We have organized our analysis into sections that we hope will make it easier to understand.

Who will bear the brunt of the costs for reform? As you can see, there are a number of revenue taxes and or fees that will be imposed.

INDIVIDUALS

Bush Tax Cuts To Expire - The Bush tax cuts enacted in 2001 and 2003 will sunset at the end of 2010. This means the top ordinary income tax rates of 33 and 35 percent will return to 36 and 39.6 percent. The capital gains rate and qualified dividend rate of 15% for Federal tax purposes will soon become 20%.

Although not expressly included in the Act, the expiration of the Bush cuts will have a dramatic impact combined with the following tax provisions within the Act. High-income taxpayers will also be hit with two big tax hikes under the Act to help offset the cost of providing health insurance to millions of Americans.



Medicare Tax Or Hospital Tax Increase - Under current law, wages are subject to a 2.9% Medicare tax. Workers and employers pay 1.45% each. Self-employed people pay both halves of the tax (but are allowed to deduct half of this amount for income tax purposes). Unlike the payroll tax for Social Security, which applies to earnings up to an annual ceiling (\$106,800 for 2010), the Medicare tax is levied on all of a worker's wages without limit.

Under the provisions of the new law, which take effect in 2013, most taxpayers will continue to pay the 1.45% Medicare tax, but single people earning more than \$200,000 and married couples earning more than \$250,000 will be taxed at an additional 0.9% (2.35% in total) on the excess over those base amounts. Self-employed persons will pay 3.8% on earnings over those thresholds. These earnings limits are not indexed for inflation, so it is likely that more and more people will be subject to the higher tax in coming years.

Employers will collect the extra 0.9% on wages exceeding \$200,000 just as they would withhold Medicare taxes and remit them to the IRS. However, companies won't be responsible for determining whether

a worker's combined income with his or her spouse made them subject to the tax. Because of this, some employees will have to remit additional Medicare taxes when they file income tax returns, and some will get a tax credit for amounts overpaid. Married couples with combined incomes approaching \$250,000 will have to keep tabs on both spouses' pay to avoid an unexpected tax bill.



Medicare or Hospital Tax on Investment Income - Under

current law, the Medicare tax only applies to wages and self-employment income. Beginning in 2013, a Medicare tax will, for the first time, be applied to investment income. A new 3.8% tax will be imposed on net investment income of single

taxpayers with adjusted gross income (AGI) above \$200,000 and joint filers with AGI over \$250,000. Once again, this is not indexed for inflation.

Investment income would include income from interest, dividends, capital gains, annuities, royalties, and rents, other than such income that is derived in the ordinary course of a trade or business. Net investment income is reduced by the deductions that are allocable to that income. However, the new tax won't apply to income in tax-deferred retirement accounts such as 401(k) plans.

Because the new tax on investment income won't take effect for three years, this leaves more time for Congress and the IRS to tinker with it. Needless to say, we can expect lots of refinements and "clarifications" between now and when the tax actually takes hold in 2013.

Both of the Medicare taxes imposed above are expected to generate revenue of approximately \$200 billion over 10 years.

Individual mandate - The new law contains an "individual mandate". The mandate requires U.S. citizens and legal residents to have qualifying health coverage or be subject to a tax penalty. Under the Act, those without qualifying health coverage will pay a tax penalty of the greater of: (a) \$695 per year, up to a maximum of three times that amount (\$2,085) per family, or (b) 2.5% of household income over the threshold amount of income required for income tax return filing.

The penalty will be phased in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 or the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by a cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, aliens not lawfully present in the U.S., incarcerated individuals, those for whom the lowest cost

plan option exceeds 8% of household income, those with incomes below the tax filing threshold (in 2010 the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples), and those residing outside of the U.S. This fee is known as the "Shared Responsibility Penalty".

Premium assistance tax credits for purchasing health insurance - The centerpiece of the health care legislation

is its provision of tax credits to low and middle income individuals and families for the purchase of health insurance. For tax years ending after 2013, the new law creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an Exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an Exchange. Under the provision, an eligible individual enrolls in a plan offered through an Exchange and reports his or her income to the Exchange. Based on the information provided to the Exchange, the individual receives a premium assistance credit based on income and IRS pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total premium charged for the plan. For employed individuals who purchase health insurance through an Exchange, the premium payments are made through payroll deductions.

The premium assistance credit will be available for individuals and families with incomes up to 400% of the federal poverty level (\$43,320 for an individual or \$88,200 for a family of four, using 2009 poverty level figures) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. The credits will be available on a sliding scale basis. The amount of the credit will be based on the percentage of income the cost of premiums represents, rising from 2% of income for those at 100% of the federal poverty level for the family size involved to 9.5% of income for those at 400% of the federal poverty level for the family size involved.

Floor on medical expenses deduction rose from 7.5% of AGI to 10% - Under current law, taxpayers can take

an itemized deduction for unreimbursed medical expenses for regular income tax purposes only to the extent that those expenses exceed 7.5% of the taxpayer's AGI. The new law raises the floor beneath itemized medical expense deductions from 7.5% of AGI to 10%, effective for tax years beginning after Dec. 31, 2012. The AGI floor for individuals age 65 and older (and their spouses) will remain unchanged at 7.5% through 2016. This floor increase is expected to generate revenue of approximately \$15 billion over 10 years.

Limit on reimbursement of over-the-counter medications from HRAs, HSAs, FSAs, and MSAs -

The new law excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account (HRA) or health flexible savings accounts (FSAs) and from being reimbursed on a tax-free basis through a health savings account (HSA) or Archer Medical Savings Account (MSA), effective for tax years beginning after Dec. 31, 2010.

Increased penalties on nonqualified distributions from HSAs and Archer MSAs -

The new law increases the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount, effective for distributions made after Dec. 31, 2010.

Health flexible spending arrangements (FSAs) are limited to \$2,500 -

An FSA is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Under current law, there is no limit on the amount of contributions to an FSA. Under the new law, however, allowable contributions to health FSAs will be capped at \$2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount will be indexed for inflation after 2013. This limit on FSAs is expected to generate revenue of approximately \$14 billion over 10 years.

Dependent coverage in employer health plans -

Effective on Mar. 23, 2010, the new law extends the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the tax year. This change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. A parallel change is made for VEBAs and 401(h) accounts. Also, self-employed individuals are permitted to take a deduction for the health insurance costs of any child of the taxpayer who has not attained age 27 as of the end of the tax year.

Liberalized adoption credit and adoption assistance rules -

For tax years beginning after Dec. 31, 2009, the adoption tax credit is increased by \$1,000, made refundable, and extended through 2011. The adoption assistance exclusion is also increased by \$1,000.

BUSINESSES

Tax credits to certain small employers that provide insurance -

The new law provides small employers with

a tax credit (i.e., a dollar-for-dollar reduction in tax) for non-elective contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its alternative minimum tax (AMT) liability.



To qualify, a business must offer health insurance to its employees as part of their compensation and contribute at least half the total premium cost. The business must have no more than 25 full-time equivalent employees ("FTEs"), and the employees must have annual full-time equivalent wages that average no more than \$50,000.

However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than \$25,000.

The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a state exchange and is only available for two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014. Thus, an eligible small employer could potentially qualify for this credit for six tax years, four years under the first phase and two years under the second phase.

For tax years beginning in 2010, 2011, 2012, or 2013, the credit is generally 35% (50% for tax years beginning after 2013) of the employer's non-elective contributions toward the employees' health insurance premiums. The credit phases out as firm-size and average wages increase.

The employer is entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost (i.e., in tax years beginning after 2013), the employer can claim a deduction for the other 50% of the premium cost.

Self-employed individuals, including partners and sole proprietors, 2% shareholders of an S corporation, and five percent owners of the employer are not treated as employees for purposes of this credit. Any employee with respect to a self-employed individual is not an employee

of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of full-time equivalent employees or average full-time equivalent wages.

Employer Mandate - To provide or not to provide, that is the question. As is the case with individuals, The Act does not require that a “large employer” provide health coverage to its employees however after 2013, however a business will be penalized



for failing to do so. A large employer (generally, an employer with at least 50 full-time employees, see below) that does not offer health care coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers minimum essential coverage is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. The “applicable payment amount” will be \$166.67 with respect to any month or \$2,000 annually. To illustrate, assume that in 2014, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state Exchange-offered plan. For each employee over the 30-employee threshold, the employer owes \$2,000, for a total penalty of \$140,000 (\$2,000 multiplied by 70 ((100-30)). This has been referred to as “pay or play”. These provisions take effect Jan. 1, 2014.

The “Cadillac tax” on high-cost health plans - The new law places an excise tax on high-cost employer-sponsored health coverage (often referred to as “Cadillac” health plans). This is a 40% excise tax on insurance companies, based on premiums that exceed certain amounts. Although the tax is not on employers themselves, we have purposely included this under the “Business” heading. We have done this because it is expected that employers and workers will ultimately bear this tax in the form of higher premiums passed on by insurers. This provision is expected to generate revenue of approximately \$32 billion over 10 years.

The new tax, which applies for tax years beginning after Dec. 31, 2017, places a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual

premium exceeds \$10,200 for single coverage and \$27,500 for family coverage. An additional threshold amount of \$1,650 for single coverage and \$3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

The tax will apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). Stand-alone dental and vision plans will be disregarded in applying the tax. The dollar amount thresholds will be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office (CBO) estimates in 2010. Employers with age and gender demographics that result in higher premiums can value the coverage provided to employees using the rates that would apply using a national risk pool. The excise tax will be levied at the insurer level. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

Health Care Industry and Ancillary Providers Health Care Industry Fees – There are several new fees that will be levied upon companies which operate in certain health care niches. These fees are assessed by the Secretary of the Treasury and are generally payable no later than September 30 of the following year. These fees are generally contingent upon the market share of each individual payor.

Fee on Pharmaceutical Manufacturers and Branded Prescription Drug Importers - The 2010 Health Care Act and 2010 Reconciliation Act imposes a fee on each covered entity engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program or under coverage under any of these programs for each calendar year beginning after 2010. Fees collected will be credited to the Medicare Part B trust fund. A “covered entity” is any manufacturer or importer with gross receipts from branded prescription drug sales. The aggregate annual fee is based on market share but the total allocable applicable amounts or total fees are as follows:

<u>Calendar year:</u>	<u>Applicable amount:</u>
2011	\$ 2.5 billion
2012 and 2013	\$ 2.8 billion
2014 – 2015	\$ 3.0 billion
2017	\$ 4.0 billion
2018	\$ 4.1 billion
2019 and thereafter	\$ 2.8 billion

Fee on Health Care Insurance Providers - The 2010 Health Care Act, as amended by the 2010 Reconciliation Act, imposes an annual fee on each covered entity engaged in the business of providing health insurance with respect to U.S. health risks. The term "covered entity" means any entity that provides health insurance for any U.S. health risk during the calendar year in which the annual fee is due. This fee is effective for calendar years beginning after 2013.



The aggregate annual fee for all covered entities is the applicable amount or annual aggregate fee and is apportioned among providers based on the above ratio which is designed to reflect relative market share of U.S. health insurance business.

For calendar years beginning before 2019, the applicable amount or aggregate fee is determined in accordance with the following table:

<u>Calendar year:</u>	<u>Applicable amount:</u>
2014.....	\$ 8 billion
2015.....	\$ 11.3 billion
2016.....	\$ 11.3 billion
2017.....	\$ 13.9 billion
2018.....	\$ 14.3 billion

Medical Device Fees - Under pre-2010 Reconciliation Act law, a manufacturer’s excise tax wasn't imposed on sales of medical devices. The Act provides that the sale of a taxable medical device by the manufacturer, producer, or importer will be subject to a tax equal to 2.3% of the price for which it is sold. A device is an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, that is (i) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; (ii) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (iii) intended to affect the structure or any function of the body of man or other animals, and that doesn't achieve its primary intended purposes through chemical action within or on the body of man or other animals and that isn't dependent upon being metabolized for the achievement of its primary intended purposes. Eyeglasses, contact lenses, hearing aids are specifically exempted from the above definition of taxable medical device. This fee is effective for calendar years beginning after 2013.

Excise Tax on Indoor Tanning Services - The Act imposes a new tax on any indoor tanning service, whether paid for by insurance or otherwise. The tax, imposed on tanning service recipients, is equal to 10% of

the amount paid for the services, whether or not the amount will be paid by insurance. The Act defines “indoor tanning service” as a service that uses any electronic product that's designed to incorporate one or more ultraviolet lamps, and that's intended for the irradiation of an individual by ultraviolet radiation, to induce skin tanning. The term “indoor tanning service” excludes any phototherapy service performed by a licensed medical professional.

The tax imposed is paid by the individual on whom the service is performed. Every person receiving a payment for tanning services on which the tax is imposed has to collect the amount of the tax from the individual on whom the service is performed, and has to remit the tax quarterly to IRS at the time and in such manner as IRS will provide. This excise tax is effective for indoor tanning services performed on or after July 1, 2010.

There are other fees included in the Act but above are some of the more notable provisions. Please check with your White, Nelson service provider to see how these other fees may impact you.

Compensation Limit Paid By Health Insurance Providers

– Under current tax law, a publicly-held corporation can't deduct applicable employee compensation in excess of \$1 million per year paid to a covered employee—the principal executive officer (PEO) or someone acting in that capacity and the three highest paid officers other than the PEO or principal financial officer (PFO). Under the current law, compensation doesn't include commissions generated directly by the executive's performance, certain other performance-based compensation, and other items.

Under the new Act, for any tax year beginning after Dec. 31, 2012, no income tax deduction will be allowed for applicable individual who performs services for a “covered health insurance provider” to the extent that the amount of that remuneration exceeds \$500,000. A “covered health insurance provider” means any employer that is a health insurance issuer, and received premiums from providing health insurance coverage.

There are a number of other fees included in this Act. We have included those which are expected to generate the lion's share of revenue. In all, the total revenue expected to be generated is \$142 billion over a 10 year period.

As you can see, the changes that we will experience over the next ten years will be dramatic. It is never too early to start planning or ensuring you are in compliance with this new legislation. We have included a timeline for the effective dates for the above items, as well as, the others that were not specifically addressed in this newsletter.



**HEALTH CARE REFORM
ESSENTIAL TIMELINE**

2010**INSURANCE REFORMS**

- Establish a temporary national high risk pool.
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014.
- Require qualified health plans to provide at a minimum coverage without cost-sharing.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare.
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets.
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases.

MEDICARE

- Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.

MEDICAID

- Creates a state option to cover childless adults through a Medicaid State Plan Amendment.
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals.
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1%; increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.

PRESCRIPTION DRUGS

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

TAX CHANGES

- Impose additional requirements on non-profit hospitals. Impose a tax of \$50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that purchase health insurance for employees.

2011**LONG-TERM CARE**

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

MEDICAL MALPRACTICE

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

MEDICARE

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Reduce annual market basket updates for Medicare providers beginning in 2011.

<ul style="list-style-type: none"> • Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012. • Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
MEDICAID
<ul style="list-style-type: none"> • Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home.
TAX CHANGES
<ul style="list-style-type: none"> • Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. • Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount. • Impose new annual fees on the pharmaceutical manufacturing sector.
2012
MEDICARE
<ul style="list-style-type: none"> • Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care. • Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. • Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
2013
INSURANCE REFORMS
<ul style="list-style-type: none"> • Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. • Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status.
MEDICARE
<ul style="list-style-type: none"> • Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
MEDICAID
<ul style="list-style-type: none"> • Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.
TAX CHANGES
<ul style="list-style-type: none"> • Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016. • Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers. • Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment. • Impose an excise tax of 2.3% on the sale of any taxable medical device. • Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014
INDIVIDUAL AND EMPLOYER REQUIREMENTS
<ul style="list-style-type: none"> • Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage). • Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment.
INSURANCE REFORMS
<ul style="list-style-type: none"> • Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges through which individuals and small businesses with up to 100 employees can purchase qualified coverage. • Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits. • Limit any waiting periods for coverage to 90 days. • Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits. • Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% of the Federal Poverty Level. • Allow states the option of merging the individual and small group markets. (Effective January 1, 2014) • Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
PREMIUM SUBSIDIES
<ul style="list-style-type: none"> • Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% of the Federal Poverty Level to purchase insurance through the Exchanges.
MEDICARE
<ul style="list-style-type: none"> • Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019); • Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. • Require Medicare Advantage plans to have medical loss ratios no lower than 85%.
MEDICAID
<ul style="list-style-type: none"> • Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% of the Federal Poverty Level based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles. • Reduce states Medicaid Disproportionate Share Hospital (DSH) allotments.
TAX CHANGES
<ul style="list-style-type: none"> • Impose fees on the health insurance sector.
2015 AND LATER
INSURANCE REFORMS
<ul style="list-style-type: none"> • Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact.
MEDICARE
<ul style="list-style-type: none"> • Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)
TAX CHANGES
<ul style="list-style-type: none"> • Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018)