Federal Health Reform Update

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BEFORE THE
INTERIM COMMITTEE ON
INDUSTRY, BUSINESS & LABOR
NORTH DAKOTA STATE LEGISLATURE

The Acts

- H.R. 3590 (P.L. 111-148)– Patient Protection and Affordable Care Act (Senate bill, as amended by the "Manager's Amendment" which appears in H.R. 3590 as a separate title at the end of the Act)
- H.R. 4872 (P.L. 111-152)- Health Care and Education Reconciliation Act of 2010 (amends P.L. 111-148)

Note: The changes made by the manager's amendment and the reconciliation bill are not integrated into the enrolled version of P.L. 111-148.

Some Notes……

- Because the reconciliation process was used, many technical and perfecting amendments were not in order. As a result, in part because the legislation was drafted assuming a Fall 2009 enactment…….
  - Some effective dates occur prior to enactment
  - Some drafting errors could not be addressed
  - Many effective dates will require very aggressive action to implement
  - Technical corrections could not be made because they were not in order and were subject to a point of order

The Law - Coverage

- Maintains an employer-based health care system
  - Imposes a penalty on employers that fail to provide coverage or whose employees go to the health insurance exchange for coverage
- Expands and modifies the Medicaid to become the foundation for the reformed health care system
  - All individuals with incomes at or below 133% of the federal poverty level (FPL) are eligible
- Requires individuals to obtain qualified coverage
  - Imposes a tax on individuals who fail to comply
- Establishes subsidies for premiums and cost-sharing for individuals with incomes between 133% and 400% of the federal poverty level (FPL)

The Law – Coverage cont.

- Establishes health care exchanges to help individuals and small businesses (initially) to purchase qualified coverage

Medicaid Expansion

- Establishes a national minimum eligibility level at 133% of FPL ($14, 400)
- Eligibility based on income (SSI, child welfare, SSDI, medically needy, Medicare Savings Programs beneficiaries are exempt)
- Adds new **mandatory** categories of Medicaid-eligibles
  - Single, childless adults who are not disabled
  - Parents
  - Former Foster Care Children (aged-out of foster care)

Distribution of Population by Income - ND

Distribution of Total Population by Federal Poverty Level, North Dakota (2007-2008); United States (2008)			
	North Dakota #	North Dakota %	United States #
Under 100%	78,600	12.7	18.3
100 - 133%	37,100	6.0	6.4
134 300%	193,700	31.4	28.9
301 - 400%	89,400	14.5	12.3
Over 400%	218,700	35.4	34.0
Total	617,600	100.0	100.0

Health Insurance Coverage for Adults with Income Up to 133% of FPL

Health Insurance Coverage of Adults with Incomes Up to 133% of FPL-- North Dakota (2007-2008)

	Employer	Individual	Medicaid	Uninsured	Total
North Dakota#	12,700	9,600	12,700	**21,400**	57,600
North Dakota%	22.5%	17%	22.5%	**38%**	100%

Enhanced FMAP for Newly Eligibles

- Enhanced FMAP for Newly Eligibles 2014 – 2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

Medicaid Expansion Features

- Temporary Maintenance of Effort/Eligibility
  - Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
  - Expires in 2014 when the health care exchanges become effective
- State Financial Hardship Exemption from Maintenance of Effort
  - Governor must certify that state is in deficit or will be in deficit to qualify for the hardship exemption
- Medicare Rates for Medicaid Primary Care Physicians for 2013 and 2014
  - 100% federal match for the increment above current rate

New Medicaid Mandates

- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) for 2013 and 2014 only
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Quality measures for adult beneficiaries
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- State use of National Correct Coding Initiative (NCCI)
- Background checks for direct patient access employees of long term care facilities and providers

New Medicaid Mandates

- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women

Demonstrations Projects

- Demonstrations
  - Evaluate Integrated Care (bundled payments) around a Hospitalization
  - Medicaid Global Payments
  - Pediatric Accountable Care Organization (ACO)
  - Medicaid Emergency Psychiatric Care

Prevention and Wellness

- Incentives for Coverage of Preventive Services
- Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women
- Incentives for the Prevention of Chronic Diseases
- Medical Home – State Option

Prescription Drug Provisions

- Rebates
  - Increases the brand name drug rebate amount from 15.1% to 23.1%
  - Increases the generic drug rebate amount from 11% to 13%
  - Extends the rebate program to Medicaid managed care organizations (MCOs)
  - **The federal government collects the difference between the previous law rebate and the increase in the Act**
  - **New rebates are effective January 1, 2010!**

Prescription Drug Provisions

- Changes the status of some formerly excludable drugs
  - Removes barbiturates and benzodiazepines from the Medicaid excluded drug list. (Effective January 1, 2014)
- Changes to Average Manufacturer's Price (AMP)
  - Changes the Federal upper payment limit (FUL) to no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recent AMPs for pharmaceutically and therapeutically equivalent multiple source drugs available nationally through commercial pharmacies.
  - Clarifies what transactions, discounts, and other price adjustments were included in the definition of AMP.
  - Clarifies that retail survey prices do not include mail order and long term care pharmacies.

Medicaid & Long-Term Care

- Community First Option (October 1, 2011)
- Home & Community-Based Services
- Home & Community-Based Incentives (2011)
- Money Follows the Person Rebalancing Demonstration
- Treatment of Spousal Impoverishment in Home & Community-Based Programs (January 1, 2014)
- Funding for Aging and Disability Resource Centers
- Waiver Authority for Dual-Eligible Demonstrations
- Establishes a Federal Coordinated Health Care Office within CMS (for dual-eligibles)

Reduction in DSH Payments

- Directs the HHS Secretary to reduce DSH payments to states by $14.1 billion between FY 2014-FY 2020

Fiscal Year	Reduction
2014	$500 million
2015	$600 million
2016	$600 million
2017	$1.8 billion
2018	$5 billion
2019	$5.6 billion
2020	$4 billion

Reductions will be made quarterly in equal installments

Reduction in DSH Payments

- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
  - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
  - Do no target their DSH payments on: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).

What Happens to CHIP?

- **Authorization**
  - Extends the current reauthorization period for two years, through September 30, 2015.
- **Maintenance of Effort**
  - Requires states, upon enactment, to maintain current income eligibility levels for CHIP through September 30, 2019.
  - Prohibits states from implementing implement eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), with the exception of waiting lists for enrolling children in CHIP.
  - **Conditions future Medicaid payments on compliance with the maintenance of effort provision**.

What Happens to CHIP?

- **Enhanced Federal Matching Payments**
  - Provides that from FY 2016 to FY 2019, states will receive a 23 percentage point increase in the CHIP match rate, subject to a cap of 100 percent.
- **Eligibility for Tax Credits in the Health Insurance Exchange**
  - Provides that CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible for CHIP and will then be eligible for tax credits in the exchange.

What Happens to CHIP?

- **Treatment of Enrollment Bonuses**
  - Provides that the Medicaid and CHIP enrollment bonuses included in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) will not apply beyond September 30, 2013.
- **CHIP Eligibility Standards**
  - CHIP eligibility will be based on **existing income eligibility rules, including the use of income disregards**.

CHIP & the Exchange

- **CHIP and the Health Insurance Exchange**
  - Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
  - Requires the Secretary to no later than April 1, 2015 to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange.
  - Requires the Secretary to certify (certification of comparability of pediatric coverage) plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP.

CHIP - State Employee's Children

- **Exceptions to Exclusion of Children of State and Local Government Employees**
  - **Maintenance of Effort with Respect to Per Person Agency Contribution for Family Coverage** – Requires the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent state fiscal year is not less than the amount of such expenditures made by the agency for the 1997 state fiscal year, increased by the percentage increase in the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average) for two preceding fiscal year.
  - **Hardship Exception** – A child qualifies for a hardship exemption if the State determines, on a case-by-case basis, that the annual aggregate amount of premiums and cost-sharing imposed for coverage of the family of the child would exceed 5 percent of such family's income for the year involved.

Employer Responsibility

- Requires employers with more than 200 employees to automatically enroll new full-time equivalent employees in coverage (subject to any waiting period authorized by law) with adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in.

Employer Responsibility

- **Penalties for Failure to Provide Coverage**
  - Requires an employer with more than 50 full-time equivalent employees that does not offer coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of $2000 per full-time equivalent employee.
  - Excludes/disregards the first 30 full-time employees.
  - Requires an employer with more than 50 full-time equivalent employees that offers coverage and has at least one full-time equivalent employee receiving the premium assistance tax credit to make a payment of $3000 per full-time equivalent employee.
  - Excludes/disregards the first 30 full-time employees.
- **Large Employers with Waiting Periods**
  - Amends the employer shared responsibility policy such that a large employer requiring a waiting period before an employee may enroll in coverage of longer than 60 days will pay a fine of $600 per full-time equivalent employee.

Individual Responsibility

- Requires individuals to maintain minimum essential coverage beginning in 2014.
- **Penalties for Failure to Maintain Coverage**
  - Failure to maintain coverage will result in a penalty that is the greater of a flat fee $95 in 2014; $325 in 2015; and $695 in 2016 **OR** the following percent of the excess household income above the threshold amount required to file a tax return----1% of income in 2014; 2% of income in 2015; 2.5% of income in 2016 and subsequent years.
  - For those under the age of 18, the applicable penalty will be one-half of the amounts listed above.
  - Families will pay half the amount for children up to a cap of $2,250 for the entire family.
  - After 2016, dollar amounts will increase by the annual cost of living adjustment.

Individual Responsibility

- **Exceptions** to the individual responsibility requirement to maintain minimum essential coverage are made for:
  - religious objectors;
  - individuals not lawfully present; and
  - incarcerated individuals.
- **Exemptions** from the penalty will be made for those who:
  - cannot afford coverage (where the lowest cost premium available exceeds 8% of income) , thereby qualifying for a “hardship waiver”;
  - taxpayers with income under 100 percent of the federal poverty level;
  - members of Indian tribes; and
  - individuals who were not covered for a period of less than three months during the year.

Health Insurance Reforms - **Now**

- Temporary high-risk pools
  - Directs the HHS Secretary to establish a temporary high risk pool program to provide coverage to individuals with pre-existing medical conditions who have been uninsured for more than 6 months. Eligible individuals must be citizens or legally present.
  - States must **declare intention to participate by April 30, 2010.**
  - States can: (1) keep existing pool with certain conditions; (2) create new pool to comply with statutory requirements; (3) create an alternative program; or (4) permit HHS to establish an alternative program.
  - Effective Date – June 21, 2010 (90 days post enactment)
  - Funds to be distributed to states by July 1 2010

Health Insurance Reforms – Now cont.

- Reinsurance for early retirees (applies to state and local government plans)
  - Temporary $5 billion reinsurance program designed to partially reimburse employers (including state and local governments) for costs associated with health plans for retirees between ages 54 and 65 and their dependents.
  - Employers will receive 80% of claim costs that between $15,000 and $90,000.
  - **Effective date – June 21, 2010 (90 days post enactment)**
  - Program ends January 1, 2014

Health Insurance Reforms – Now cont.

- Minimum medical loss ratios
- Prohibition on rescissions (exception for fraud)**
- Extension of dependent coverage for young adults (expires at the 26th birthday)**
  - Includes young adults who are married, but does not include their dependents
  - Some insurers are voluntarily providing coverage effective in May 2010
- Limits preexisting condition exclusions for children**
- Limits lifetime and/or annual caps
- ***Note: Most of these provisions are effective for "plan years" beginning on or after September 23, 2010 (6 months post enactment)***

** ***Applies to all plans***

Health Insurance Reforms - Later

- Prohibition on preexisting condition exclusions
- Guaranteed issue/Guaranteed renewal
- Premium rating rules
- Non-discrimination in benefits
- Mental health and substance abuse services parity
- Prohibits discrimination based on health status
- Prohibits annual and lifetime caps
- Preventive services provided with no cost-sharing
- Implement both internal and external appeals process for coverage determinations and claims

Health Insurance Exchanges

- **American Health Benefit Exchanges**
  - Requires states, by 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and includes a Exchange for small businesses.
  - Requires a state to decide whether or not it will establish an exchange by the end of 2012.
  - State planning grants will become available March 23, 2011

Health Insurance Exchanges

- Requires the Secretary to:
  - Establish certification criteria for qualified health plans, requiring such plans to meet marketing requirements, ensure a sufficient choice of providers, include essential community providers in their networks, be accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures.
  - Develop a rating system for qualified health plans, including information on enrollee satisfaction, and a model template for an exchange internet portal.
  - Determine an initial and annual open enrollment period, as well as special enrollment periods for certain circumstances.

Exchange Benefit Plans

- For the individual and small group markets, requires one of the following levels of coverage, under which the plan pays for the specified percentage of costs:

Plan	Percent of Plan Costs
Bronze	60
Silver	70
Gold	80
Platinum	90

- **Child-Only Plan**
  - If an insurer offers a qualified health plan, it must offer a child-only plan at the same level of coverage.

Exchange Benefit Plans

- **Catastrophic Coverage Plan**
  - In the individual market, a catastrophic plan may be offered to **individuals who are under the age of 30 or who are exempt from the individual responsibility requirement because coverage is unaffordable to them or they meet the requirements for a hardship exemption**.
  - A catastrophic plan must cover essential health benefits and at least 3 primary care visits, and must require cost-sharing up to the HSA out-of-pocket limits.

HSA Out-of-Pocket Limits

- **Out-of-Pocket Spending Limits for 2010**
  - The maximum annual out-of-pocket amount for self-coverage is $5,950 and the maximum annual out-of-pocket amount for family coverage is twice that, $11,900.

Exchange Benefits

- Defines an essential health benefits package that covers essential health benefits, limits cost-sharing, and has a specified actuarial value (pays for a specified percentage of costs), as follows:
  - For the individual and small group markets, requires the Secretary to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
  - For all plans in all markets, prohibits out-of-pocket limits that are greater than the limits for Health Savings Accounts.
  - For the small group market, prohibits deductibles that are greater than $2,000 for individuals and $4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums.

Key Issues - Health Insurance Exchange

- State Options
  - Cooperatives
  - Interstate Compacts – Requires state legislation
  - Basic Health Plan
  - Waiver (available in 2017) – Requires state legislation
- Creating a seamless Exchange/Medicaid connection
  - **Financing**
  - Technical Assistance
- Essential benefits/Affordability
  - Treatment of state mandated benefits
    - States must **pay (individuals or plans)** for mandated benefits not included in the essential benefit package

Health Insurance Exchange

- Establishes Multi-State Plans modeled after Federal Employees Health Benefits Program (FEHBP) and administered by the federal Office of Personnel Management (OPM).
  - This was adopted in lieu of the “Public Option”.
- Provides premium and cost-sharing assistance to individuals, who obtain coverage through the exchange, with incomes up to 400% of FPL.

Exchange Premium Credits

- Provides affordability premium credits and cost-sharing credits to eligible individuals with incomes at 100% - 400% of the federal poverty level (FPL). Bases credits on the lowest cost "silver plan".

Income as % of FPL	% of Income Premium Contribution
Up to 133	2
133-150	3-4
150-200	4-6.3
200-250	6.3-8.05
250-300	8.05-9.05
300-400	9.5

Exchanges – Cost-Sharing Limits

- Establishes the health plan's share of out-of-pocket costs as follows:

Income as % of FPL	% of Plan 's Share
100-150	94
150-200	87
200-250	73
250-400	70

CLASS Program

- Creates a new national insurance program, **Community Living Assistance Supports and Services (CLASS)**, to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities.
- Financed through voluntary payroll deductions (**with opt-out enrollment** similar to Medicare Part B), this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living.
- Could result in Medicaid savings.

Other Provisions of Note

- Grants to Support School-Based Health Clinics
- Increased Community Health Center Funding
- National Health Service Corps Improvements
- Workforce Grants/Initiatives
- Public Health Initiatives
- Medicare Improvements for Rural Areas
- Medicare Rate Improvements/Medicare Rate Reductions
- Indian Health Service Reauthorization

Maternal & Child Health

- **Maternal, Infant, and Early Childhood Home Visiting Programs**
  - Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
  - Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
  - Establishes competitive grants appropriated at $100 million in 2010, $250 million in 2011, $350 million in 2012, $400 million in 2013 & 2014
  - A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.

2009 Poverty Guidelines

- The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
- Persons in family — Poverty guideline
  - 1 — $10,830
  - 2 — 14,570
  - 3 — 18,310
  - 4 — 22,050
  - 5 — 25,790
  - 6 — 29,530
  - 7 — 33,270
  - 8 — 37,010
  - For families with more than 8 persons, add $3,740 for each additional person.
  - **2009 guidelines remain in effect through May 31, 2010**

SMALL BUSINESS HEALTH CARE TAX CREDIT

FREQUENTLY ASKED QUESTIONS

The new health reform law gives a tax credit to certain small employers that provide health care coverage to their employees, **effective with tax years beginning in 2010**. The following questions and answers provide information on the credit as it applies for 2010-2013, including information on transition relief for 2010. An enhanced version of the credit will be effective beginning in 2014. The new law, the Patient Protection and Affordable Care Act, was passed by Congress and was signed by President Obama on March 23, 2010.

Employers Eligible for the Credit

1. Which employers are eligible for the small employer health care tax credit?

A. Small employers that provide health care coverage to their employees and that meet certain requirements ("qualified employers") generally are eligible for a Federal income tax credit for health insurance premiums they pay for certain employees. In order to be a qualified employer, (1) the employer must have fewer than 25 full-time equivalent employees ("FTEs") for the tax year, (2) the average annual wages of its employees for the year must be less than $50,000 per FTE, and (3) the employer must pay the premiums under a "qualifying arrangement" described in Q/A-3. See Q/A-9 through 15 for further information on calculating FTEs and average annual wages and see Q/A-22 for information on anticipated transition relief for tax years beginning in 2010 with respect to the requirements for a qualifying arrangement.

2. Can a tax-exempt organization be a qualified employer?

A. Yes. The same definition of qualified employer applies to an organization described in Code section 501(c) that is exempt from tax under Code section 501(a). However, special rules apply in calculating the credit for a tax-exempt qualified employer. A governmental employer is not a qualified employer unless it is an organization described in Code section 501(c) that is exempt from tax under Code section 501(a). See Q/A-6.

Calculation of the Credit

3. What expenses are counted in calculating the credit?

A. Only premiums paid by the employer under an arrangement meeting certain requirements (a "qualifying arrangement") are counted in calculating the credit. Under a qualifying arrangement, the employer pays premiums for each employee enrolled in health care coverage offered by the employer in an amount equal to a uniform percentage (not less than 50 percent) of the premium cost of the coverage. See Q/A-22 for information on transition relief for tax years beginning in 2010 with respect to the requirements for a qualifying arrangement.

If an employer pays only a portion of the premiums for the coverage provided to employees under the arrangement (with employees paying the rest), the amount of premiums counted in calculating the credit is only the portion paid by the employer. For example, if an employer pays 80 percent of the premiums for employees' coverage (with employees paying the other 20 percent), the 80 percent premium amount paid by the employer counts in calculating the credit. For purposes of the credit (including the 50-percent requirement), any premium paid pursuant to a salary reduction arrangement under a section 125 cafeteria plan is not treated as paid by the employer.

In addition, the amount of an employer's premium payments that counts for purposes of the credit is capped by the premium payments the employer would have made under the same arrangement if the average premium for the small group market in the State (or an area within the State) in which the employer offers coverage were substituted for the actual premium. If the employer pays only a portion of the premium for the coverage provided to employees (for example, under the terms of the plan the employer pays 80 percent of the premiums and the employees pay the other 20 percent), the premium amount that counts for purposes of the credit is the same portion (80 percent in the example) of the premiums that would have been paid for the coverage if the average premium for the small group market in the

State were substituted for the actual premium.

4. What is the average premium for the small group market in a State (or an area within the State)?

A. The average premium for the small group market in a State (or an area within the State) will be determined by the Department of Health and Human Services (HHS) and published by the IRS. Publication of the average premium for the small group market on a State-by-State basis is expected to be posted on the IRS website by the end of April.

5. What is the maximum credit for a qualified employer (other than a tax-exempt employer)?

A. For tax years beginning in 2010 through 2013, the maximum credit is 35 percent of the employer's premium expenses that count towards the credit, as described in Q/A-3.

Example. For the 2010 tax year, a qualified employer has 9 FTEs with average annual wages of $23,000 per FTE. The employer pays $72,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit. The credit for 2010 equals $25,200 (35% x $72,000).

6. What is the maximum credit for a tax-exempt qualified employer?

A. For tax years beginning in 2010 through 2013, the maximum credit for a tax-exempt qualified employer is 25 percent of the employer's premium expenses that count towards the credit, as described in Q/A-3. However, the amount of the credit cannot exceed the total amount of income and Medicare (i.e., Hospital Insurance) tax the employer is required to withhold from employees' wages for the year and the employer share of Medicare tax on employees' wages.

Example. For the 2010 tax year, a qualified tax-exempt employer has 10 FTEs with average annual wages of $21,000 per FTE. The employer pays $80,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit. The total amount of the employer's income tax and Medicare tax withholding plus the employer's share of the Medicare tax equals $30,000 in 2010.

The credit is calculated as follows:

(1) Initial amount of credit determined before any reduction: (25% x $80,000) = $20,000
(2) Employer's withholding and Medicare taxes: $30,000
(3) Total 2010 tax credit is $20,000 (the lesser of $20,000 and $30,000).

7. How is the credit reduced if the number of FTEs exceeds 10 or average annual wages exceed $25,000?

A. If the number of FTEs exceeds 10 or if average annual wages exceed $25,000, the amount of the credit is reduced as follows (but not below zero). If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed $25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000. In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding $25,000, the reduction is the sum of the amount of the two reductions. This sum may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than $50,000.

Example. For the 2010 tax year, a qualified employer has 12 FTEs and average annual wages of $30,000. The employer pays $96,000 in health care premiums for those employees (which does not exceed the average premium for the small group market in the employer's State) and otherwise meets the requirements for the credit.

The credit is calculated as follows:

(1) Initial amount of credit determined before any reduction: (35% x $96,000) = $33,600
(2) Credit reduction for FTEs in excess of 10: ($33,600 x 2/15) = $4,480
(3) Credit reduction for average annual wages in excess of $25,000: ($33,600 x $5,000/$25,000) = $6,720
(4) Total credit reduction: ($4,480 + $6,720) = $11,200
(5) Total 2010 tax credit: ($33,600 – $11,200) = $22,400.

8. Can premiums paid by the employer in 2010, but before the new health reform legislation was enacted, be counted in calculating the credit?

A. Yes. In computing the credit for a tax year beginning in 2010, employers may count all premiums described in Q/A-3 for that tax year.

Determining FTEs and Average Annual Wages

9. How is the number of FTEs determined for purposes of the credit?

A. The number of an employer's FTEs is determined by dividing (1) the total hours for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee) by (2) 2,080. The result, if not a whole number, is then rounded to the next lowest whole number. See Q/A-12 through 14 for information on which employees are not counted for purposes of determining FTEs.

Example. For the 2010 tax year, an employer pays 5 employees wages for 2,080 hours each, 3 employees wages for 1,040 hours each, and 1 employee wages for 2,300 hours.

The employer's FTEs would be calculated as follows:

(1) Total hours not exceeding 2,080 per employee is the sum of:

a. 10,400 hours for the 5 employees paid for 2,080 hours each (5 x 2,080)
b. 3,120 hours for the 3 employees paid for 1,040 hours each (3 x 1,040)
c. 2,080 hours for the 1 employee paid for 2,300 hours (lesser of 2,300 and 2,080)

These add up to 15,600 hours

(2) FTEs: 7 (15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number)

10. How is the amount of average annual wages determined?

A. The amount of average annual wages is determined by first dividing (1) the total wages paid by the employer to employees during the employer's tax year by (2) the number of the employer's FTEs for the year. The result is then rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). For this purpose, wages means wages as defined for FICA purposes (without regard to the wage base limitation). See Q/A-12 through 14 for information on which employees are not counted as employees for purposes of determining the amount of average annual wages.

Example. For the 2010 tax year, an employer pays $224,000 in wages and has 10 FTEs.

The employer's average annual wages would be: $22,000 ($224,000 divided by 10 = $22,400, rounded down to the nearest $1,000)

11. Can an employer with 25 or more employees qualify for the credit if some of its employees are part-time?

A. Yes. Because the limitation on the number of employees is based on FTEs, an employer with 25 or more employees

could qualify for the credit if some of its employees work part-time. For example, an employer with 46 half-time employees (meaning they are paid wages for 1,040 hours) has 23 FTEs and therefore may qualify for the credit.

12. Are seasonal workers counted in determining the number of FTEs and the amount of average annual wages?

A. Generally, no. Seasonal workers are disregarded in determining FTEs and average annual wages unless the seasonal worker works for the employer on more than 120 days during the tax year.

13. If an owner of a business also provides services to it, does the owner count as an employee?

A. Generally, no. A sole proprietor, a partner in a partnership, a shareholder owning more than two percent of an S corporation, and any owner of more than five percent of other businesses are not considered employees for purposes of the credit. Thus, the wages or hours of these business owners and partners are not counted in determining either the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit.

14. Do family members of a business owner who work for the business count as employees?

A. Generally, no. A family member of any of the business owners or partners listed in Q/A-13, or a member of such a business owner's or partner's household, is not considered an employee for purposes of the credit. Thus, neither their wages nor their hours are counted in determining the number of FTEs or the amount of average annual wages, and premiums paid on their behalf are not counted in determining the amount of the credit. For this purpose, a family member is defined as a child (or descendant of a child); a sibling or step-sibling; a parent (or ancestor of a parent); a step-parent; a niece or nephew; an aunt or uncle; or a son-in-law, daughter- in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

15. How is eligibility for the credit determined if the employer is a member of a controlled group or an affiliated service group?

A. Members of a controlled group (e.g., businesses with the same owners) or an affiliated service group (e.g., related businesses of which one performs services for the other) are treated as a single employer for purposes of the credit. Thus, for example, all employees of the controlled group or affiliated service group, and all wages paid to employees by the controlled group or affiliated service group, are counted in determining whether any member of the controlled group or affiliated service group is a qualified employer. Rules for determining whether an employer is a member of a controlled group or an affiliated service group are provided under Code section 414(b), (c), (m), and (o).

How to Claim the Credit

16. How does an employer claim the credit?

A. The credit is claimed on the employer's annual income tax return. For a tax-exempt employer, the IRS will provide further information on how to claim the credit.

17. Can an employer (other than a tax-exempt employer) claim the credit if it has no taxable income for the year?

A. Generally, no. Except in the case of a tax-exempt employer, the credit for a year offsets only an employer's actual income tax liability (or alternative minimum tax liability) for the year. However, as a general business credit, an unused credit amount can generally be carried back one year and carried forward 20 years. Because an unused credit amount cannot be carried back to a year before the effective date of the credit, though, an unused credit amount for 2010 can only be carried forward.

18. Can a tax-exempt employer claim the credit if it has no taxable income for the year?

A. Yes. For a tax-exempt employer, the credit is a refundable credit, so that even if the employer has no taxable income, the employer may receive a refund (so long as it does not exceed the income tax withholding and Medicare tax liability, as discussed in Q/A-6).

19. Can the credit be reflected in determining estimated tax payments for a year?

A. Yes. The credit can be reflected in determining estimated tax payments for the year to which the credit applies in accordance with regular estimated tax rules.

20. Does taking the credit affect an employer's deduction for health insurance premiums?

A. Yes. In determining the employer's deduction for health insurance premiums, the amount of premiums that can be deducted is reduced by the amount of the credit.

21. May an employer reduce employment tax payments (i.e., withheld income tax, social security tax, and Medicare tax) during the year in anticipation of the credit?

A. No. The credit applies against income tax, not employment taxes.

Anticipated Transition Relief for Tax Years Beginning in 2010

22. Is it expected that any transition relief will be provided for tax years beginning in 2010 to make it easier for taxpayers to meet the requirements for a qualifying arrangement?

A. Yes. The IRS and Treasury intend to issue guidance that will provide that, for tax years beginning in 2010, the following transition relief applies with respect to the requirements for a qualifying arrangement described in Q/A-3:

(a) An employer that pays at least 50% of the premium for each employee enrolled in coverage offered to employees by the employer will not fail to maintain a qualifying arrangement merely because the employer does not pay a uniform percentage of the premium for each such employee. Accordingly, if the employer otherwise satisfies the requirements for the credit described above, it will qualify for the credit even though the percentage of the premium it pays is not uniform for all such employees.

(b) The requirement that the employer pay at least 50% of the premium for an employee applies to the premium for single (employee-only) coverage for the employee. Therefore, if the employee is receiving single coverage, the employer satisfies the 50% requirement with respect to the employee if it pays at least 50% of the premium for that coverage. If the employee is receiving coverage that is more expensive than single coverage (such as family or self-plus-one coverage), the employer satisfies the 50% requirement with respect to the employee if the employer pays an amount of the premium for such coverage that is no less than 50% of the premium for single coverage for that employee (even if it is less than 50% of the premium for the coverage the employee is actually receiving).

Source: Internal Revenue Service (IRS) website at http://www.irs.gov/newsroom/article/0,,id=220839,00.html.