2013

Medicare Tax on Wage Income

What It Is
A 0.9 percent surtax on wage income above $200,000 for individuals and $250,000 for couples.

How It Works
The employee portion of the Medicare payroll tax rate for high income earners increases by 0.9 percent, from 1.45 percent to 2.35 percent, effective January 1, 2013. Employers are responsible for collecting the additional withholding.

What It Means to Manufacturers
Although targeted to individuals, small business owners who file as pass-through entities are affected. The tax is not indexed for inflation, so the number of businesses paying the tax will increase each year.

Medicare Tax on Investment Income

What It Is
An additional 3.8 percent Medicare tax on investment income.

How It Works
The new surtax applies to income from capital gains, interest, dividends, annuities, royalties and rent earned by individuals with income above $200,000 and couples with income above $250,000.

What It Means to Manufacturers
Another tax targeted at individuals, this will also affect small businesses filing as subchapter S-corporations and other pass-through entities. The tax is not indexed for inflation, so the number of businesses paying the tax will increase each year.
Medical Device Excise Tax

What It Is

A new medical device excise tax on medical device manufacturers in 2013 slated to raise up to $30 billion.

How It Works

A 2.3 percent medical device excise tax applies to the sale of any taxable medical device by its manufacturer, producer or importer, effective for sales after December 31, 2012. The manufacturer, producer or importer of the taxable medical device must report and remit the medical device excise tax.

What It Means to Manufacturers

This industry-specific fee will stifle innovation and job growth in the medical device industry by eliminating resources without additional market gains. These fees will translate to higher healthcare costs for all manufacturers.

Employer Retiree Coverage Deduction

What It Is

The elimination of a tax deduction for employers that sponsor retiree health plans covering prescription medicines.

How It Works

The retiree drug subsidy was created when Medicare began covering prescription drugs to encourage employers that sponsor group health plans to continue providing prescription drug benefits to retirees. If employers terminated these retiree prescription drug benefit plans, retirees covered by these plans would turn to Medicare, at a significant cost to taxpayers. Under current law, certain employers receive a subsidy equal to 28 percent of covered prescription drug costs for their retirees. Employers are also entitled to an income tax deduction and are permitted to take into account this deduction when accounting for their retiree prescription drug expenses. The Affordable Care Act retains the retiree drug subsidy but eliminates employers' ability to deduct the subsidy amount from their income.

What It Means to Manufacturers

An employer's income tax liability and the cost of providing prescription drug coverage to retirees increases. How much an employer's tax liability will increase depends on the total subsidy amount and the employer's applicable corporate tax rate. In addition, if the cost of providing this benefit becomes too expensive for employers, additional burdens will be placed on Medicare and taxpayers, who will have to assume the cost of providing coverage to retirees.
Flexible Spending Account (FSA) Funding Limits

What It Is
A cap on the amount an individual can contribute to a tax-favored FSA.

How It Works
The 2010 healthcare law limited the maximum annual contribution that an employee can make to a health FSA to $2,500. The $2,500 limit will be indexed for cost-of-living adjustments for plan years beginning after December 31, 2013.

What It Means to Manufacturers
To reduce employees’ medical costs, many employers provide FSAs that allow employees to pay for medical expenses not covered by insurance with pre-tax dollars. This helps curb increases in healthcare costs. Limiting the amount employees can contribute to FSAs will increase their healthcare costs.

2014 Employer Mandate

What It Is
Fines associated with not providing affordable healthcare for employees.

How It Works
If a firm with at least 50 full-time or full-time equivalent workers has a full-time employee who is getting a premium tax credit or a cost-sharing subsidy through an exchange, then that employer must pay a penalty for not offering that worker acceptable insurance on the job. Workers who are offered qualified coverage by an employer are ineligible for the new insurance subsidies provided in the exchanges. The penalties increase each year to mirror the growth in insurance premiums.

- If no insurance is offered: Employer must pay a penalty of $2,000 per employee, after excluding the first 30, not just those who are subsidized.
  
  o Example: If your company has 51 employees, you pay the penalty for 21 employees or $2,000 (fine) x 21 (employees) = $42,000 in fines.

- If insurance is offered, but it is not deemed affordable for certain employees: The penalty is the lesser of $2,000 for every employee (after exempting the first 30) or $3,000 for every employee receiving a subsidy.
Example 1: If your company has 51 employees and the insurance is unaffordable for 5 employees, you pay the $3,000 penalty for each employee whose insurance is deemed unaffordable or $3,000 (fine) x 5 (employees) = $15,000.

However, the amount of the per-employee fine reaches its maximum when the fine reached what you would be paying for $2,000 for each employee.

Example 2: If your company has 51 employees but the insurance is unaffordable to 45 employees, you would pay $42,000, or the same as if the insurance was not offered.

What It Means to Manufacturers

Manufacturers must provide insurance at an affordable rate to their employees or face a penalty. Previously, employers had the option of purchasing insurance, and more than 90 percent of NAM membership provided that benefit. However, now it is mandated, increasing burdens on employers.

Note: The individual mandate—the subject of the 2012 Supreme Court decision—also takes effect in 2014.

Essential Health Benefits

What It Is

All policies in the individual and small group market—inside and outside of the exchange—must include coverage in 10 categories deemed by the Affordable Care Act as essential.

How It Works

The Affordable Care Act defines the following 10 categories as essential:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

However, it does not define what coverage means in the context of those categories. In 2011, the Department of Health and Human Services (HHS) issued a “bulletin,” which moved much
of the decision-making associated with essential health benefits (EHB) to the state level. It outlines that states should choose a benchmark plan from one of four types of plans:

- One of the three largest small group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the state’s commercial market by enrollment

**What It Means to Manufacturers**

Mandated benefits raise costs. In states with a robust number of state mandates, the benchmark plans will not allow employers to control their costs. Small manufacturers are affected by this most directly. However, it is expected that the mandated benefits will likely become standard and in a short time affect all fully insured plans.

**Exchanges**

**What It Is**

States are designing Small Business Health Options Program (SHOP) exchanges in assisting small businesses with purchasing health insurance. In addition to the SHOP exchange, exchanges are also being developed in the individual market.

**How It Works**

In many markets across the country, small businesses have very few insurance options, and it is often difficult to determine how those limited options compare with one another. The goal of these state-based insurance exchanges is to improve competition and provide clarity. According to HHS, “Exchanges will allow individuals and small businesses to compare health plans, get answers to questions, find out if they are eligible for tax credits for private insurance or health programs like the Children’s Health Insurance Program (CHIP) and enroll in a health plan that meets their needs.” The exchanges organize coverage and cost-sharing options, such as co-insurance and out-of-pocket limits to make it easier for consumers to choose a plan.

HHS has begun to issue rules so states can create the exchanges, but the states are where most of the activity will happen. Much of HHS’s regulatory decision-making remains uncertain; thus, many states have opted not to move forward and are choosing a federally facilitated exchange (FFE). The following information is necessary for FFES:

- Responsibility needs to be delineated between states and HHS for federal-state exchange partnerships.
- States will need details on the “plan management” partnership to avoid dual regulation.
- It needs to be determined what data HHS will require from states for the FFE exchange Internet portal.
- States do not know the standards HHS will apply for a mandatory “assistor” program that HHS will implement for the FFE, and states will be required to implement if they elect the “consumer assistance” partnership.
For those states that are moving forward, additional details are necessary to ensure functioning exchanges and robust competition.

- Whether employers will select a single plan for employees through the federal SHOP exchange
- Coordination of premium payments within mandated premium aggregators
- Transaction standards for enrolling employees into qualified health plans
- Details for the small employer tax credit

**What It Means to Manufacturers**

SHOP exchanges are an opportunity for fully insured manufacturers to have a greater choice and clearer options when choosing healthcare plans. However, the exchanges must be designed in a manner that promotes competition. In certain jurisdictions, such as Washington, D.C., the exchange rules could be damaging to small businesses by requiring all small employers to participate in the exchange and combining it with the individual market. It is essential for manufacturers to engage in the process and be aware of how these new entities will affect their healthcare plan choices.

**Health Insurance Tax**

**What It Is**

A new excise tax on fully insured plans provided by healthcare insurers.

**How It Works**

The tax is assessed on health insurance companies based on their “net premiums” written. A health insurance company is defined in statute to specifically exclude employers that self-insure. Thus, the only fully insured plans are affected by the health insurance tax. It is expected that this tax will be passed on to purchasers of fully insured products.

**What It Means to Manufacturers**

The tax will raise $8 billion starting in 2014 and $14.3 billion in 2018 and increase each year. This tax could increase costs for companies that are fully insured through an insurance company, primarily smaller employers.

**Reinsurance Fee**

**What It Is**

A very large and burdensome fee designed to fund a reinsurance program for the individual market for three years. Although the focus is the individual market, employers—both fully insured and self-insured—will bear the burden of paying the fee.

**How It Works**

The Affordable Care Act authorizes states to establish a “transitional reinsurance program” with a goal of stabilizing premiums in the individual market during the first three years that the
state health insurance exchanges are operational. As is the case with other facets of the law, if a state chooses not to establish a reinsurance program, HHS will do so.

The law states that fund contributions should total $25 billion over three years: $12 billion for 2014, $8 billion for 2015 and $5 billion for 2016.

**What It Means to Manufacturers**

HHS has stated that the first-year assessment will be $63 per participant. This means that for a company of 400 employees there will be an assessment of $25,200.

**Affordability Tax Credit**

**What It Is**

A health insurance premium tax credit for individuals and families who cannot obtain affordable health insurance through their employers or certain government-sponsored plans.

**How It Works**

According to the Affordable Care Act, employer-provided health coverage is not considered affordable if the employee’s required contribution to the plan exceeds 9.5 percent of the applicable taxpayer’s household income for the year.

The IRS has stated that the affordability would be determined by payments for self-only coverage, even if the individual would be purchasing family coverage or other coverage for multiple individuals. This, however, is only guaranteed until the end of 2014; thus, the IRS reserves the right to readdress this calculation.

**What It Means to Manufacturers**

There was significant concern that the law would require employers to collect “household income” to determine if insurance was affordable. This would mean an employer would need to collect salary information from other household members, as well as information from other employers, if a person in the household has multiple jobs. This is a significant logistical burden that may also violate an employee’s privacy rights.

Instead, HHS chose to base the affordability on the data available, allowing affordability to be calculated based on self-only coverage. HHS also has reserved the right to modify this to become more compliant with the statute.
2018

Tax on “Cadillac” Healthcare Plans

What It Is

A tax on expensive healthcare plans.

How It Works

The Affordable Care Act imposes a 40 percent excise tax on high-cost health insurance plans, defined as $10,200 for an individual and $27,500 for a family. The tax will be levied on insurers and self-insured employers. The cost of plans subject to the tax will be adjusted upward annually based on inflation, and for retired individuals 55 and older who are not eligible for Medicare, for employees engaged in high-risk professions and for firms that may have higher healthcare costs because of their workers’ age or gender.

What It Means to Manufacturers

This tax may be of immediate concern to employers that offer benefit-rich plans to their employees. Although the average cost of employer-sponsored care is significantly lower than the identified amounts, the targets are adjusted according to the rate of inflation, not medical inflation. Historically, medical inflation increases at a much higher rate than overall inflation, which means that so-called “high-cost” plans will likely make 40 percent tax the norm, instead of the outlier.