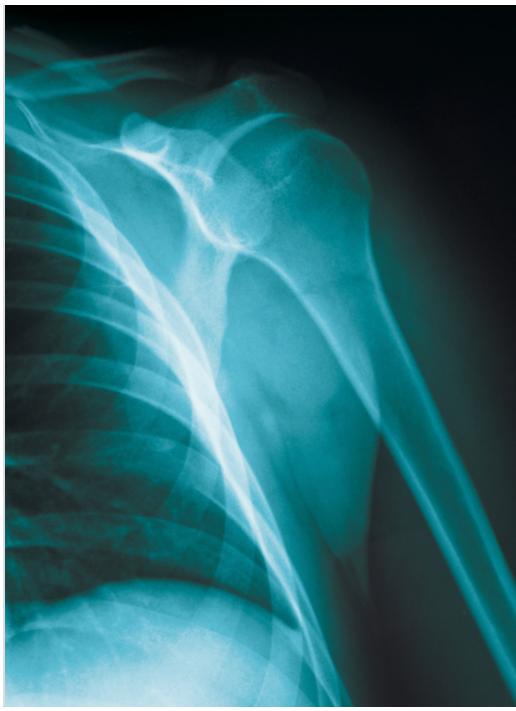
PLANNING STRATEGIES



Helping to Decipher Obamacare

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

The Blind Men and the Elephant

The ancient parable of the blind men and the elephant has been used for centuries to illustrate how we describe, perceive, and process the world. In the parable, each man explains his perceptions based on the part of the elephant he touches. When the first man touches the ear, he exclaims that it's a fan. The next man concludes that the trunk is a snake. One claims the leg is a pillar, and last but not least, the man on the side of the elephant is certain it's a wall. None of them agree, and none of them can envision the big picture. Not unlike Obamacare.

In analyzing the new federal government system created by the Patient Protection and Affordable Care Act (also known as Obamacare and the PPACA), we are a lot like the blind men. We know Obamacare is law, and we have many of the elements setting forth what the law is supposed to look like. But we certainly don't have a comprehensive picture of how it will work or how Obamacare will affect professionals, providers, or consumers.

That said, we do know that the PPACA includes provisions affecting individuals, businesses, insurance, and taxes.

INDIVIDUALS ***are required to purchase insurance and are given new options for insurance plan purchases through insurance exchanges.***

CERTAIN EMPLOYERS ***are required to provide health coverage and may be required to make "shared responsibility payments."***

INSURANCE COVERAGE ***has new federal mandates, such as coverage for dependents and those with preexisting conditions.***

TAXES AND FEES ***at the federal level will be used to help fund parts of the PPACA.***

What Is Obamacare?

In 2010, President Barack Obama signed the PPACA into law. His signature was meant to conclude a controversial political battle. However, the conflict continues in Congress, as certain members are still discussing full or partial repeal, and in the courts, where several challenges to one part of the law or another are still pending. Like the elephant in the room, the scope of the PPACA is broad, and individuals may come away with differing opinions depending on what aspect of the law they are reviewing.

The Congressional Research Service states,

> "The primary goal of the ACA (Affordable Care Act) is to ***increase access to affordable health insurance*** for the millions of Americans without coverage and ***make health insurance more affordable*** for those who are already covered."[1]

To accomplish this goal, the PPACA will be implemented over the course of several years, with full implementation due to occur at the end of 2017. The effects of the PPACA are being felt now through new taxes, while the main insurance sections of the law come into effect starting in 2014.

In an attempt to get a glimpse of the elephant, let's review some relevant parts.

[1] Congressional Research Service, "ACA: A Brief Overview of the Law, Implementation, and Legal Challenges," *CRS Report for Congress*, pg. 1, July 12, 2012. http://fpc.state.gov/documents/organization/195390.pdf

The Individual Mandate

One of the most talked-about (and litigated) pieces of the PPACA is known as the individual mandate. The individual mandate requires almost all individuals in the United States to secure minimum health insurance coverage or pay a shared-responsibility penalty for not having coverage. For many people, this insurance will be provided by an employer or through Medicaid or Medicare. Individuals exempt from the individual mandate include prisoners, members of an Indian tribe, individuals illegally residing in the U.S., and individuals who are opposed to accepting such benefits due to their religious beliefs.

The PPACA states that the minimum coverage requirement can be satisfied through:

- Medicare part A
- Medicaid
- Children's Health Insurance Program (CHIP)
- TRICARE and the TRICARE for Life program
- Veterans healthcare program
- The Peace Corps program
- Other government-sponsored plans
- Employer-sponsored plans, with respect to any employee
- State plans
- Plans established by an Indian tribal government
- Plans in the individual market

Individuals who do not comply with the mandate will be subject to the shared-responsibility penalty. The amount of the penalty involves a complex calculation that finds the greater of a flat amount or a percentage of the individual's income over the income tax filing threshold. The flat rate penalty is phased in beginning in 2014 at $95, rises to $325 in 2015, then increases to $695 in 2016. After 2016 the penalty is indexed for inflation. The penalty amount is limited to the bronze-level insurance plan premiums of health insurance plans offered on the national health insurance exchanges. The penalty must be included on the individual's federal income tax return for the year.

Insurance Coverage Changes

The PPACA now requires health insurance plans to:

- Provide coverage for dependent children under age 26.
- Cover children under the age of 19, even if they have preexisting health conditions. (Starting in 2014, insurance companies may no longer refuse coverage based on preexisting conditions regardless of the individual's age.)
- Eliminate lifetime dollar limits on essential health benefits (EHBs) in plans that provide major medical coverage. (EHBs are defined in the State Exchanges section.)
- Provide coverage for preventive care with no cost-sharing.
- Rescind coverage only in cases of fraud.
- Limit the medical loss ratio. (The MLR is the ratio of premiums spent on administrative costs compared to medical costs.)

State Exchanges

A key element under the PPACA is the establishment of health insurance exchanges to provide access to health insurance plans for individuals and small businesses. Each state must establish an exchange by 2014—however, if a state opts out of creating the exchange, the federal government will operate a federal exchange in place of the state exchange. The American Health Benefit Exchange (AHB Exchange) will be available for individuals, and the Small Business Health Options Program (SHOP Exchange) will be available for small businesses.

The particulars of the SHOP Exchanges are still being determined. The AHB Exchanges, however, are designed to:

- Oversee federal regulations as applied to private health insurance.
- Make certain that health coverage offered in the exchange is standardized.
- Take responsibility for the new federal healthcare subsidies.
- Enroll additional individuals in state Medicaid programs.

Plans within these exchanges must cover essential health benefits (EHBs), and these plans must be equal to the scope of benefits provided under a typical employer plan. The PPACA defines essential health benefits as:

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

Any individual who is eligible to use the exchange plans may receive a premium credit and a cost-sharing subsidy. Eligibility requirements include:

- Ineligibility for any other affordable coverage providing essential health benefits.
- Income that is generally above 100% and no more than 400% of the federal poverty line.

Individuals may only use the premium assistance credit at an American Health Benefit Exchange to assist with the purchase of insurance through the exchange. Although the individual must claim the credit by filing a federal income tax return, the credit itself goes directly to the insurer that provides the exchange insurance.

While plans in the exchange must have similar coverage, provisions (including premiums) may vary due to an individual's age, family size, geographic area, and tobacco use. Exchange plans must sell and renew policies to all individuals and may not discriminate based on a person's health status.

Within the exchange, the plans will be broken into levels:

LEVEL	ACTUARIAL VALUE OF THE COVERAGE
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

The PPACA establishes a minimum of 60% (actuarial value for coverage) for all plans in or outside of an exchange. The only exceptions to the minimum value are for people under age 30 or people unable to obtain affordable coverage. The actuarial value is based on coverage for EHBs. This lets purchasers compare plans in an "apples to apples" fashion.

Employers and the PPACA

Beginning in 2014, employers with more than 50 employees who do not offer health insurance may be subject to federal penalties under the shared responsibility provisions. These penalties will apply when the employer:

- Does not offer its full-time employees a plan to cover essential health benefits for both employees and dependents.
- Offers a plan to cover EHBs, but the plan does not provide the required 60% coverage or is not affordable for employees based on the household income calculation (costs that exceed 9.5% of income).

An employer who fails to provide the required coverage must pay a penalty of $2,000 per full-time employee. If the company's employees qualify for the federal premium assistance credits to help with the purchase of insurance, then the employer must pay a $3,000 penalty per employee.

New Tax on Investment Income

Individuals

Beginning January 1, 2013, the PPACA imposed a new tax on net investment income for individuals with more than $200,000 in income ($250,000 for a married couple filing jointly). This tax has been called the investment income tax or the Medicare contribution tax. A taxpayer who is above these thresholds and who has net investment income will pay an additional tax of 3.8% on net investment income or the excess of modified adjusted gross income over the threshold amount (whichever amount is less).

Investment income that may be subject to the additional tax is defined as the sum of gross income from:

- Interest
- Dividends
- Annuities
- Royalties
- Rents
- Capital gains

While this list clearly includes many passive income items, it does not include retirement plan distributions. Nor does it include income from a Subchapter S corporation or partnership subject to self-employment contributions tax.

Estates and Trusts

An estate or trust must also pay investment income tax. For an estate or trust, the tax is 3.8% of undistributed net investment income or the excess of adjusted gross income over the amount at which the highest tax bracket of an estate or trust begins (for 2013, that amount is $11,950). Adjusted gross income for estates and trusts is defined under IRC Sec. 67(e).

Congress, however, carved out an exception for some trusts. The following are not currently subject to the investment income tax:

- Charitable remainder trusts
- Trusts exempt under IRC Sec. 501
- Trusts for which all unexpired interests are devoted to charitable purposes

It is vital to remember that the investment income tax is an additional tax on top of any capital gains tax. With the maximum capital gains tax rate increased to 20% in 2013, the sale of capital gain property may be subject to a maximum capital gains tax rate of 23.8%.

Investment Income Tax

Derek and Stephanie are married physicians and have a combined salary of $400,000 with $100,000 in net investment income. They file their income taxes as married filing jointly.

Wages	$400,000
Net Investment Income	$100,000
Modified Adjusted Gross Income	**$500,000**

Threshold	($250,000)
Excess Over Threshold	**$250,000**

Lesser of	Net Investment Income	$100,000
	or	
	Excess Over Threshold	$250,000
Investment Income Tax		**3.8% x $100,000**

Total Investment Income Tax **$ 3,800**

Additional Medicare Payroll Tax

Like investors, wage earners will also pay more under the PPACA. Individuals with more than $200,000 in income (and married couples filing jointly with more than $250,000 in income) will pay an additional tax of 0.9% on wages and compensation income in excess of the threshold amount. This tax is added to the existing Medicare/Medicaid tax of 1.45% for all wage earners. This means high income earners will pay a tax of 2.35%. However, while employers must match the 1.45%, they are not required to match the additional 0.9% tax.

Medical Device Tax

Another PPACA tax of interest to the healthcare community is the 2.3% excise tax on the sale of certain medical devices. Beginning January 1, 2013, this tax applied to items such as stents, pacemakers, artificial limbs, and more. However, the tax does not apply to eyeglasses, contact lenses, hearing aids, or other medical devices generally available to the public at retail.

Change in Deduction of Medical Expenses

The PPACA not only raises certain tax rates, it also reduces certain tax breaks. Beginning in 2013, the threshold for claiming medical expenses as itemized deductions increased from 7.5% to 10%. This means taxpayers who itemize their deductions will need to accumulate more medical expenses before they can claim a deduction for them. (For taxpayers age 65 and older, the lower threshold of 7.5% remains in place from 2013 through 2016.)

"Cadillac" Employer Health Plans

The PPACA also includes a tax on employers who offer high-value health plans with coverage that exceeds $10,200 per individual or $27,500 per family. These "Cadillac" plans typically provide coverage for a number of medical services and may have low co-payments, low deductibles, or minimal coverage limitations.

The tax is 40% of the policy premiums over the threshold and is indexed for inflation. This means that if medical costs rise more quickly than the Consumer Price Index (CPI), the tax will gradually apply to policies with lower coverage. More people may end up with these plans than the law's creators realized. Although this tax was intended to "penalize employers with excessively rich health benefit plans," Towers Watson's analysis of 2010 survey data found that without making any changes, over 60% of large employers will have one or more plans exceeding the excise tax threshold by the 2018 effective date.[2]

[2] Towers Watson, "Cadillac Health Plan Tax to Penalize Majority of Employers by 2018," May 19, 2010. www.towerswatson.com/press/1895

PPACA Tax Effects

The new taxes imposed under the PPACA can have a surprising cumulative impact. Here is an example:

In 2013, Felix (a biomedical engineer) and his wife Sherri (an orthopedic surgeon) have combined wages of $485,000 and investment income of $150,000. They also have a small custom orthotics business with a 2013 gross sales of $225,000, resulting in business income of $65,000 (which is included in their investment income). They file a joint income tax return. How will the PPACA taxes affect them?

Wages		$485,000
Additional Medicare Payroll Tax (0.9% on wages above $250,000)		**$2,115**
Net Investment Income	$150,000	
Investment income tax (3.8%)		**$5,700**
Medical device sales (not income)	$225,000	
Medical device tax (2.9%) on gross sales		**$5,175**
Total amount of NEW taxes because of the PPACA		**$ 12,990**

This amount does not include taxes due from:

- Federal income tax for individuals up to a top rate of 39.6%
- Capital gains tax up to a top rate of 20%
- State and local income taxes for individuals
- Federal income tax attributed to the business

Frequently Asked Questions

Is the PPACA currently in effect?	Many of its provisions are currently in effect, but others will take effect over the next few years. Congress passed the PPACA in 2010. Many people waited on the results of the U.S. Supreme Court case decided in June 2012 and the 2012 presidential election to see if the law would remain. Both the court ruling and the election went in favor of the PPACA. For now, even those still hoping for a full or partial repeal must deal with the implementation of the initial aspects of the PPACA.
What is the biggest change the PPACA will bring to the healthcare industry?	The first and greatest change will be the millions of new patients who will be receiving care—an estimated 32 million new nonelderly individuals will have health insurance by 2016.[3] This will certainly put a strain on doctors, nurses, and other caregivers working in medicine, especially as many previously uninsured individuals are likely to seek attention for medical conditions that have been neglected over a long period of time. *Physicians News* reports: "In reality, many physicians around the country are already fully occupied in providing patient care. They are not missing the patient volume, but they are being squeezed by reduced reimbursement for those patients and increased cost of care. The increased demand for access to doctors may only bring more criticism as patients experience long delays for appointments or as doctors are forced to limit their practices as they struggle with increased demand."[4]
Will physicians see significant additional revenue along with the increase in volume?	There is that possibility. In fact, the PPACA provides a 10% bonus on Medicare payments for primary care physicians and general surgeons from 2011 to 2016. However, with federal budget items being a constant source of congressional conflict, and with Medicare reimbursements under the ongoing threat of reduction, the healthcare industry has justified concerns about future revenue. A significant worry in the medical field is whether providers will be adding large numbers of new patients for little to no additional income. In addition, the PPACA is instituting a value-based payment system instead of allowing fee-for-service payments for Medicare patients. These payments will be based upon the quality and cost of care as determined by a formula created by the Department of Health and Human Services (HHS).

[3] Congressional Budget Office, "CBO's Analysis of the Major Healthcare Legislation Enacted in March 2010," Testimony of Douglas W. Elmendorf, director of the Congressional Budget Office, March 30, 2011. www.cbo.gov/sites/default/files/cbofiles/ftpdocs/121xx/doc12119/03-30-healthcarelegislation.pdf

[4] David W. Hilgers and Sidney S. Welch, "Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet (Part 1 of 2)," *Physicians News*, March 15, 2012. www.physiciansnews.com/2012/03/15/physicians-post-ppaca-not-going-bust-at-the-healthcare-buffet-part-1-of-2/#_ftn1

Will physicians still provide the same care under the PPACA, or will it be different?	Physicians will provide care as they always have, but under the PPACA, the focus of the care will shift. The PPACA emphasizes "patient/family centered care, prevention, and wellness" rather than responsive care to a particular illness.[5] This will mean more people visiting primary care physicians and may result in a shortage of these doctors compared to the number of patients.
The PPACA is also increasing the regulatory burden on physicians, right?	Yes, the PPACA brings new regulations on the practice of medicine, particularly related to cost savings, while increasing scrutiny of the healthcare industry's use of federal dollars. Here are just a couple of examples: ***Limits on physician-owned hospitals*** PPACA section 6001 limits Medicare reimbursement payments to hospitals owned by physicians, unless the hospital was licensed prior to December 31, 2010, or unless the HHS Secretary grants an exception. Commentators have noted that this "effectively bars future physician investment in specialty hospitals."[6] ***Required supplier lists*** Another section of the PPACA requires that each time a physician refers a patient for additional tests (such as an MRI, CT scan, or other services designated by the HHS Secretary), the physician must furnish the patient with a written list of suppliers who provide such services in the area where the patient lives.
What happens to physicians who fail to meet all the regulations?	Unfortunately, the PPACA also provides additional grounds for financial penalties, including penalties for: • Making false statements on supplier enrollment applications • Knowingly ordering or prescribing a medical item or service during a period of exclusion • Knowingly failing to report and return an overpayment • Knowingly submitting false statements material to a false claim submitted for payment • Delaying inspections[7]

[5] Joseph J. Felties and Justin Vrabel, "One Bit at a Time: PPACA's Immediate Impact on Physicians," *MD News*, October/November 2010. www.mdnews.com/news/2010_11/05788_octnov2010_one-bite-at-a-time

[6] Sidney Welch and Jennifer Blakely, "Health care reform: What every physician should know," *Medical Association of Georgia Journal*, July 2010. www.agg.com/media/interior/publications/Welch_Blakely-MAGJournal-HealthCareReform-072010.pdf

[7] Ibid.

What happens to physicians who fail to meet all the regulations? (Continued)	The PPACA also eliminates certain defenses available to physicians to contest claims of fraud brought by the federal or state government. For example, under current law, physicians are prohibited from receiving kickbacks (e.g., certain discounts, cross-referrals between parties, etc.) for referrals to another medical provider for patients who are covered by any federal healthcare program. The PPACA eliminated the provision in current law that a physician must knowingly violate the statute. This means that physicians may now be charged for unintentionally violating this rule. *Physicians News* reports that physicians are concerned about the current regulatory environment being one where "even technical violations can support both civil and criminal prosecution that is both costly and frightening. For example, the failure to sign a written contract can, and has, resulted in a claim for refund of all Medicare dollars paid to the hospital as the result of referrals from the doctor that didn't sign the contract."[8]
How are physicians handling the expected increased volume, increased regulatory issues, and income that may remain flat?	For the most part, that remains to be seen, as many aspects of the PPACA have just gone into effect or have yet to be implemented. However, physicians already face a high level of professional stress. The addition of new regulatory pressures and economic pressures (including high malpractice costs) is prompting many physicians to leave the practice of medicine.[9] According to a Jackson Healthcare study, 34% of doctors will leave practice within the next decade. While many of these are Baby Boomers who are retiring, many others are planning to leave the profession due to high costs and a desire not to practice medicine in the era of healthcare reform.[10] There is some concern that physician exits coupled with increasing numbers of new patients may stretch remaining practices to the limit.
Is there anything physicians can do to counteract such worry and uncertainty?	Careful planning is always recommended, but planning becomes even more important during times of great change. Retirement planning, estate planning, and business planning are all essential. Perhaps the single most important consideration to attend to, however, is insurance planning—protecting your income and your assets. Life insurance in particular can not only protect your family and your wealth but also play an important role in the other facets of your planning. A financial professional can help you determine your specific goals and examine the most efficient ways to meet those goals.

[8] David W. Hilgers and Sidney S. Welch, "Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet (Part 1 of 2)," *Physicians News*, March 15, 2012. www.physiciansnews.com/2012/03/15/physicians-post-ppaca-not-going-bust-at-the-healthcare-buffet-part-1-of-2/#_ftn1

[9] Aisling Maki, "Survey: 34 Percent of Physicians to Leave Medical Practice," *The Memphis Daily News*, August 8, 2012. www.memphisdailynews.com/news/2012/aug/8/survey-34-pct-of-physicians-to-leave-practice/

[10] Jackson Healthcare, "A Tough Time for Physicians: 2012 Medical Practice & Attitude Report." www.jacksonhealthcare.com/media/137811/physiciantrendsreport_ebook0712-final.pdf

The Elephant in the Room

The elephant in the room will become gradually more apparent. Over the course of the next several years, the statutes and regulations of the PPACA will be more fully developed. As the healthcare industry begins to adapt to the changes, and our economy responds, we will obviously have a better picture of the true effects of Obamacare. However, we are currently left with many questions about this major change—both how various provisions will work and how those in the medical professions will respond.

The Strength of Lincoln Benefit Life

For more than 70 years, Lincoln Benefit Life Company has been protecting policyholders nationwide. In 1984, we became a subsidiary of the Allstate Life Insurance Company. Lincoln Benefit Life and Allstate Life are wholly owned subsidiaries of the Allstate Corporation, a Fortune 100 company that provides insurance protection to approximately 17 million U.S. families.

We pride ourselves on strength, stability, and integrity as well as our ability to provide financial solutions and professional assistance to help families achieve their lifelong dreams.

Let us help you achieve yours.

LINCOLN BENEFIT LIFE
AN ALLSTATE COMPANY

800.525.9287 | UnderstandLifeInsurance.com

The examples presented throughout this brochure are for illustrative purposes only. They may not be representative of the experience of the other customers and are not indicative of future performance or success. Please seek the advice of a professional regarding your specific situation.

Fixed life insurance products are issued by Lincoln Benefit Life Company. All guarantees are based on the claims-paying ability of Lincoln Benefit Life Company, Lincoln, NE, a wholly owned subsidiary of Allstate Life Insurance Company, Northbrook, IL. There is no contractual relationship between you and Allstate Life.

This information is provided for general education purposes and is not intended to provide legal, tax, or investment advice.

Date of first use 4/13

Not FDIC, NCUA/ NCUSIF insured	Not insured by any federal government agency	Not a deposit	No bank or credit union guarantee	May go down in value

LBL8887