

Dunedin Chamber of Commerce
Luncheon Series Presents

The New Federal Health Care Law:
Impacts and Opportunities
for Individuals
and
Small Businesses

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We've spent a lot of time preparing for this presentation and hope we can convey to you the information, and the sources for detailed follow-up information, you need to take full advantage of what this new and very significant law offers to you.

This presentation is based on the collection of information, insights, and clarifications gathered from the development of this law since its introduction, from the guidance publications of organizations focused on health care, from the regulations and notices issued by the federal agencies responsible for implementation of this law. We have tried to assimilate all of it and make sense out of it, and we hope we can convey to you at least a bird's eye view that is useful and meaningful.

By the way, during this presentation you will see references to insurance or health plans. The law applies generally to health care arrangements, whether a classic health insurance policy, an employer's self-insurance arrangement, or a health plan offered by a local health care network (e.g., a plan sponsored by a hospital or network of physicians).

The New Federal Health Care Law Our Presentation's Focus Will Be

On the new law *as it is*

How the new law affects small businesses
& owners in the near term (2010-2011)

Highlight major provisions 2010-2011

Highlight how the health exchanges will
work in 2014

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1. This presentation is based on the law itself and the implementing regulations issued as of June 24, 2010. It accepts the law *as it is* and not what it might have been, and the presentation seeks to explain, at a high level, what the law offers and how to take advantage of its provisions.
2. With a law that affects so many parts of our economy (e.g., insurance, employment benefits, medical care, taxes, etc.), it is easy to become overwhelmed. In fact, surveys conducted by the Kaiser Family Foundation report that 44% of Americans remain confused about the law and its meaning for them.
3. Our Scope today for more detailed attention is how the law affects small businesses of 10 or fewer employees and those people who are essentially working alone. Our focus is on the near term of this and next year because we can expect to see more regulations and tools clarifying the law for later years.
3. Nevertheless, we will offer a cursory highlighting of all the major provisions that will be put into effect in 2010 and 2011. The web resources listed in the presentation have detailed materials on the provisions which interest you.
4. Finally, because they are the heart of the affordable coverage and will play such a major role in reshaping how small businesses and individuals get health insurance, we will discuss what we know now and can expect from the Health Insurance Exchanges that will be effective in January 2014.

The New Federal Health Care Law (PPACA for short)

Patient Protection and Affordable Care Act,
Public Law 111-148 (March 23, 2010)

Health Care and Education Reconciliation
Act of 2010, Public Law 111-152 (March
30, 2010)

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1. These are the formal titles and public law numbers of the two laws that together constitute the new health care law. If you want to be able to answer affirmatively if asked “have you read the law”, you now know what to look for and where to find it: (<http://thomas.loc.gov/home/LegislativeData.php?&n=PublicLaws>)

However, do not feel surprised if they are difficult to read. It isn't you; rather it is the way legislation is written. Rarely is new law written to compose a whole new title in the US Code; rather, the legislation is written to be incorporated into existing titles and both adds sections and text and deletes old sections and subsections and text. Also, legislation frequently makes cross-references to other parts of the existing Code so that the only way to make sense of the change is to know that existing law as well.

Needless to say, that makes it difficult and time-consuming for even expert lawyers to learn the new law from the legislation. Fortunately, both private and governmental sources, which have an interest or a duty in implementation of the law, publish explanatory and clarifying materials that pull it all together and make it understandable without a law degree, a pile of books, and a good word processor!

2. Regulations implementing the law are starting to come out, with a number issued in May and June. More regulations can be expected soon to flesh out the law's application for the rest of this year and for next year.

The New Federal Health Care Law: PPACA High Level View – Effective in 2010

Health Insurance Consumer Protections
Temporary Pre-Existing Condition Pool Program
Adult Children's Coverage
HHS Web Portals for Insurance Comparison
Independent Appeals Process & Assistance
Small Business Health Care Plan Tax Credit
Insurer Premium Hikes Review Process by States
Medicare "Donut Hole" Relief
Health Coverage Support for Early Retirees

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1. The top six items will be addressed in separate slides momentarily. So let's look at the last three now.
2. Moderating health insurance premium increases is one of the main goals of the new law. Generally, it hopes to do this via competition-enhancing web sites, standardized policy presentations, mandated medical loss ratios, and encouragements to medical providers for more cost-effective delivery models. However, the most direct impact on rate hikes is formal reviews of the justification for those hikes. The law demands state reviews of unreasonable rate hikes, and provides funding for the states to do so. Some states have already begun reviewing rate proposals and even denying them. In Florida, our state insurance department will be responsible for conducting the reviews. It is up to us to make them do it.
3. Briefly, the "Donut Hole" is that point in the Medicare Part D prescription drug program where insurance payment is zero and the participant buys the full cost of drugs until a certain amount is spent. The law will close the "Donut Hole" but only over a number of years. The 2010 Donut Hole relief is a single \$250 payment to each Medicare Part D participant paid when they enter the "Donut Hole".
4. Some employers, especially those with union contracts, cover the health care of early retirees until they are eligible for Medicare. But it is a real burden for those companies. The new law softens the blow by giving health coverage support through a reinsurance program until 2014 to offset the cost of expensive claims when an employer's health insurance program covers retirees 55 and older who are not eligible for Medicare.

The New Federal Health Care Law: PPACA New Consumer Protections

Prohibits rescinding coverage except for fraud*

Prohibits excessive waiting periods (>90 days) for coverage*

Prohibits insurers from placing lifetime limits on dollar value of coverage*

Limits annual limits on coverage to those defined by HHS (annual limits banned entirely in 2014)*

Prohibits benefit limitations and coverage denials for children <19 due to pre-existing conditions*

Mandates coverage of preventive care and immunizations, without cost-sharing or deductibles, in new health plans

*Applicable to Grandfathered Plans as well

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1. Effective in September 2010 all policies issued (or renewed) must comply with a set of basic health insurance consumer protection designed to ensure the real value of coverage is not denied or diminished by common policy provisions that impact millions of insureds.
2. Rescissions of coverage on the basis of incomplete info on applications or non-material errors or omissions will be prohibited. Rescission is only allowed if the insured application is a fraud or contains intentional misrepresentations of material facts relating to the coverage in question.
3. Waiting periods before a specific coverage kicks in will now be limited to no more than 90 days after the policy is in effect.
4. Lifetime limits currently apply to millions of people, but they will be barred in all health plans.
5. Annual dollar limits on what a health insurer will pay are phased out; for plans issued or renewed from 9/23/10 the max annual limit is \$750,000, then on 9/23/11 rises to \$1.25 Million, then on 9/23/12 rises to \$2 Million, and is removed entirely for plans issued or renewed after 1/1/14.
6. Each of the asterisked protections apply to all new plans, and even “grandfathered” plans (see next slide for explanation of “Grandfathered Plans”).
7. The new law recognizes the value of preventive care by mandating that all new plans issued cover preventive care without imposing any cost-sharing or limits on accessing this care.

The New Federal Health Care Law: PPACA “Grandfathered Plans”

As part of the “If you like it you can keep it” promise, plans in effect on 3/23/10 are exempt from *some* new requirements

Grandfathered plans may make routine plan changes but will lose this exemption and be subject to all the new provisions if they:

- Significantly cut or reduce benefits, significantly raise co-payments, or significantly raise deductibles
- Raise co-insurance charges
- Lower employer contributions by more than 5%
- Add or tighten annual limits on what it pays

But even grandfathered plans cannot impose lifetime limits, cannot make policy rescissions except for fraud, and must extend children coverage, if offered, to children up to age 26

If your plan changes, or you choose a new plan then all the new law’s provisions apply to it

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1. The preservation of existing health plans in the individual and employer market, without major adjustments resulting from its new provisions during the transitional period until the Exchanges is assured. Existing plans that will largely remain unaffected by the law’s new requirements are termed “Grandfathered plans”.
2. To be treated as a “grandfathered plan”, the plan must avoid the bulleted actions above, and must incorporate (by no later than 9/23/10) some of the basic consumer protections created by the law.
3. In addition a plan can lose “grandfathered” status and become subject to all the law’s rules If: you or your employer move from one insurer to another, or if you stay with the same insurer but go to a different plan structure with that insurer (e.g., moving to a high deductible plan), then that changed plan is deemed a new plan and must comply with all the law’s provisions. Merely adding dependents or adding or removing employees or from an existing plan does not cause it to lose grandfathered status.
4. **However, keep in mind that having to comply with all the law’s provisions imposes no burden on insureds since those provisions are designed to provide greater rights, better benefits, and more consumer-friendly premiums. Nor should they result in any but minor changes in premiums.**

The New Health Care Law: PPACA Pre-existing Condition Insurance Plan (PCIP)

Beginning in 2014, coverage denials, and charging higher premiums, for pre-existing condition are barred as to **all** persons (bar as to children under 19 is effective in 2010)

Until 2014, those with a pre-existing condition (other than children under age 19) who have been without insurance for six months can apply to a PCIP in their state

HHS will carry out the FL PCIP program

Premiums will be set to equal a standard rate for a standard population (i.e., not exceed 100% of standard non-group rate) and not vary by age more than 4 to 1

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1. Addressing coverage and benefit denials and higher premiums for pre-existing conditions is a major concern of the law. Now no insurer can deny coverage or benefits to, or charge a higher premium for, a child under age 19 on account of a pre-existing condition. For the rest of the population, that protection will kick-in on January 1, 2014.

2. Until then, people with pre-existing conditions who cannot obtain insurance coverage, or who have been without coverage for six months, will be able to sign up for coverage through a federal high risk pool, or a PCIP (a Pre-existing Condition Insurance Plan).

While it can be expected that the PCIP rates will be higher than those for people without pre-existing conditions, there is some good news. The rates are projected to be 10%-40% lower than in current high risk pools, and federal assistance in the form of subsidies will be available. The federal pools will be available soon, so keep your eyes peeled for reports in the press or check www.healthreform.gov from time to time.

3. Suppose you are *currently* covered and don't want to go without coverage for six months? You can consider checking with your insurer and moving to a high deductible health plan that is Health Savings Account compatible. Then you can set money aside tax free to cover any expenses not covered by the high deductible plan. Once the PCIPs are up and running there will be advice from HHS on handling the six-month hiatus rule.

The New Health Care Law: PPACA Adult Children's Coverage

If a plan offers dependent coverage, then it must cover parent's adult children until age 26, even if the child is not dependent or is married

Effective for policy years from 9/23/10

Plans must provide these adult children with notice & opportunity to enroll in plan

Applies to all plans (even grandfathered plans)

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1. Health insurance plans that offered dependents coverage typically cut off coverage for children of the insured after the child turned a certain age, or left home, or married. Unfortunately, this left those young adults with no health coverage at the same time that their ability to buy insurance was limited.
2. The new law requires any health insurance plan that has dependent coverage to extend that coverage to these young adults on their parent's policy until the child attains age 26. This is so whether the child is a birth, adopted or step-child of the parent; whether the child is still a dependent of the parent; and whether the child is single or married.
3. The premium for this extended coverage is not to be more than the premium would be for adding a non-adult child to the coverage, and since most plans's premiums for dependent coverage are a flat fee there may be no additional premium at all. The parent of the adult child may pay the premium or the adult child him/herself can elect the coverage and pay the premium.
4. However, the law does not require a health plan to offer dependent coverage, and does not require an employer whose plan offers dependent coverage to pay for that coverage. It simply requires that notice of the opportunity for coverage be provided and, if accepted by the parent or young adult, to continue the coverage until the child attains age 26.

The New Health Care Law: PPACA Web Portals for Insurance Comparisons

HHS will develop interactive web portals for each State so residents and small business can see affordable health insurance coverage options for their areas

Basic Web Portals set to start 7/1/10

Comprehensive Web Portals set to start 10/1/10

October 2010 version to include data on premiums, cost-sharing, services covered, limitations and exclusions

Later versions will include insurer performance ratings

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1. Health plans are often anything but easy to understand and outline for comparison shopping. As a result, people and businesses seeking health insurance often turn to brokers for selection information. The new law seeks to make it easier for all health care consumers to see just what each health plan available offers, presented in an accessible, concise and meaningful way, so that competition can do its work and help make coverage affordable.
2. To do this, the law requires HHS to create user-friendly web sites (called “web portals”) where the collected information from health plans is presented in a standardized format. The web portals are the beginning of smart shopping for health care consumers.
3. Currently there are two rollout dates set. The initial one is in July 2010, and it will let you know about the health plans available in your area for individuals and employers. An expansive version will start in October 2010 and should be *very* helpful since there will have been time for HHS to collect, abstract, and present a lot more information about the plans available in your area.
4. The law also provides for grants to the states to provide for persons to act as advisors and guides to the health plan materials for those who need assistance in sorting through and making sense of the information on the portals.
5. The web portals will also contain information for small businesses to take advantage of the small business tax credit for health plan.

The New Federal Health Care Law: PPACA Health Insurance Appeals & Assistance

Beginning in September 2010, all new health plans (individual as well as group) will have to have a clear and effective process for appeals (both internal and external) of coverage decisions and claims

States must set up independent external appeals process for fair & objective review of health coverage disputes

Grants are being made to States to set up health plans consumer assistance or ombudsman offices to inform and assist in appeals by consumers

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1. Benefit decisions by health plan administrators can be very frustrating but until now the consumer's appeals have been limited. Employment plans were governed by ERISA and required an internal appeal process and for dissatisfied employees, the right to file a lawsuit to review the plan's decision. However, ERISA lawsuits are not simple matters so ERISA lawsuits were usually pursued only by unions or by class actions.
2. The new law introduces a new external review step in every state, and requires each state to provide health plan consumers with assistance in filing and pressing their appeals, and to set up an independent appeals process with an independent decision maker. The law gives federal funding to the states to provide these services.
3. This reform preserves existing ERISA remedies but makes them more viable for most employees. And this reform gives those in non-ERISA plans the opportunity for an independent review and assistance in filing and pressing the appeal.

The New Federal Health Care Law: PPACA Small Business Health Plan Tax Credit

- ❑ An income tax credit is available to a small business providing health care coverage for employees
- ❑ A small business with ≤10 FTE employees & average annual wages ≤\$25,000 & that contributes at least 50% of health care premiums, gets a tax credit of 35% of the small business's premium contribution
- ❑ Percentage contributed by employer must be uniform
- ❑ Countable premium capped at average premium for small group market in state: \$5,161 & \$12,453 in FL in 2010
- ❑ Tax credit reduces as number of employees approaches 25 and as average annual wage increases; phased out at 25 employees and \$50,000 per year
- ❑ 35% credit applies thru 2013; then in 2014, a 50% credit can be claimed for two consecutive tax years

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1. This tax credit can be a major assist to small businesses, especially those finding themselves losing employees because of the lack of a health plan. No small business is **required** to offer health insurance, but if it wants to do so the tax credit certainly makes it easier to bear the cost.

2. What kind of health plan must be offered? Plans for medical care primarily; however plans for dental, vision, long-term care, nursing home care, home health care, or any combination thereof; coverage of a specific condition; hospital or other fixed indemnity insurance, Medicare supplemental insurance can also qualify. The key thing is that for *each* such plan the 50% of premium rule has to be met if a tax credit is sought for that premium. The employer must pay at least 50% of the premium for coverage or the credit isn't available.

2. For 2010 a transitional rule permits unequal contribution percentages as long as the total contribution percentage is at least 50% of total premiums of countable FTEs.

3. The countable premium for calculating the credit is capped at the average premium for the small group market in Florida, which is \$5,161 for a single person and \$12,453 for family coverage. So, if an employer's share of the plan premium is 50%, then the premium s/he can count is only 50% of the FL average (i.e., 50% of \$5,161 or \$2,580.50 for single coverage and 50% of \$12,453 or \$6,226.50 for family coverage). Suppose the employer's share is 80%? Then the countable premium is 80% of what it pays up to 80% of the FL average (i.e. 80% of \$5,161 or \$4,129 for single coverage and 80% of \$12,453 or \$9,962 for family coverage). Cap applies to total credit for all plans offered.

The New Federal Health Care Law: PPACA Small Business Health Plan Tax Credit

- Who counts towards total employees?
- What about part-timers?
- What about seasonal workers?
- What if wages vary among staff?
- What if average premium is over \$5,161 for single & \$12,453 family?
- What if taxable income is too low to absorb the full credit?

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1. Owners or family members of owners do not count. Who is an owner? A sole proprietor, a partner in a partnership, a shareholder owning more than 2% of an S corporation, and any owner of more than 5% of the company. Who is a family member of the owner? A child/grandchild, sibling/step-sibling, parent/grandparent, step-parent, niece/nephew, aunt/uncle, in-laws (i.e., son, daughter, father, mother, brother, sister), and any other person who qualifies as a dependent of the owner under Sec. 152.

2. Part-time workers count; FTE worker count is a calculation of total worker hours (not to exceed 2080 per worker) divided by 2080.

3. Seasonal workers are not part of the count at all unless they work at least 120 days in year.

4. Average wages are focus; take total employee wages divided by FTEs.

5. If average premium is over \$5,161 or \$12,454 respectively per FTE, then the credit is calculated as follows: percentage of employer's contribution X \$5,161 for single coverage and percentage of employer's contribution X \$12,453 for family coverage.

6. Credit offsets actual tax liability and it is not refundable (i.e., it is not payable regardless of tax liability), however, as a general business credit it can be carried forward 20 years. There is calculation tool on IRS website to figure FTEs and average annual wages.

3 SIMPLE STEPS

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the **Small Business Health Care Tax Credit** by following these three simple steps:

1 Determine the total number of your employees (not counting owners or family members):

Full-time employees: _____
(enter the number of employees who work at least 40 hours per week)

+

Full-time equivalent of part-time employees: _____
(Calculate the number of full-time equivalents by dividing the total annual hours of part-time employees by 2080.)

= total employees

If the total number of employees is fewer than 25 **GO TO STEP 2**

2 Calculate the average annual wages of employees (not counting owners or family members):

Take the total annual wages paid to employees: _____

÷

Divide it by the number of employees from STEP 1: _____
(total wages ÷ number of employees)

= average wages

If the result is less than \$50,000, **AND**

3 You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then

» you may be able to claim the **Small Business Health Care Tax Credit**.
Find out more information at IRS.gov

This is what the calculation chart on the IRS web site looks like. It guides you through the calculation to determine FTEs and average annual wages to qualify for the tax credit.

We can expect that IRS will automate the calculation tool so that you can input and run the numbers on line.

Small Business Health Care Tax Credit Scenarios

Examples of Employers Receiving the Credit

Example 1: Auto Repair Shop with 10 Employees Gets \$24,500 Credit for 2010

Main Street Mechanic:

- *Employees:* 10
- *Wages:* \$250,000 total, or \$25,000 per worker
- *Employee Health Care Costs:* \$70,000

2010 Tax Credit: \$24,500 (35% credit)

2014 Tax Credit: \$35,000 (50% credit)

This is one of several scenarios presented on the IRS web site to illustrate the calculation of the small business tax credit.

In the slide the Employer has paid at least 50% of the total of the health care plan costs for its employees. Here it came to \$70,000 for the year. Since the employer had no more than 10 FTEs and the employees' average annual wages did not exceed \$25,000, the employer was able to claim the full amount of the tax credit ($\$70,000 \times 35\% = \$24,500$).

In 2014 the maximum credit rises to 50% of the employer's share of the health plan costs.

The New Federal Health Care Law: PPACA Small Business Health Plan Tax Credit

Table I. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms in 2010-2013 and Nonprofit Firms in 2014+

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

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This table shows you how the tax credit is reduced from the maximum at ≤10 FTEs and \$25,000 average annual wages.

Notice that the percentage of the credit declines with increases in the number of FTEs and with increases in the average annual wage.

While the law provides for the credit to be available for up to 25 FTEs employees, and for up to \$50,000 average annual wages, we have focused on the impacts for employers with 10 or fewer FTEs.

At 25 FTEs & \$25,000 average annual wage the credit is eliminated.

At even 10 or fewer FTEs, at \$50,000 average annual wage the credit is eliminated.

The New Federal Health Care Law: PPACA High Level View – Effective in 2011

- ❑ Employers must report value of health coverage provided to employee on employee's W-2 form
- ❑ National voluntary insurance program for community living assistance services and support (CLASS)
- ❑ Medicare: Brand name & biologic drugs will be discounted by 50% for those in "Donut Hole"
- ❑ Medicare: annual physical & proven preventive services will be covered without cost-sharing
- ❑ HSAs: No expensing for OTC drugs unless prescribed; 20% penalty for non-medical spending from HSAs
- ❑ Health insurers spending <80-85% of premiums on clinical services and quality measures (i.e., the medical loss ratio) must pay rebates to their insureds

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1. Reporting on the value of health care plans provided to an employee begins with tax year 2011. "Value" will be amount of premium employer contributed. By the way, this reporting of the value of health care plan contributions is **not** taxable income to the employee. Health care provided as an employment benefit remains non-taxable.

2. The CLASS program is an attempt to help employees save for long term care before it becomes too expensive. Employers decide if they wish to participate in the CLASS program, and if so participating employers will withhold the premium established from the employee's pay **unless** the employee affirmatively opts out of CLASS. The funds collected will be remitted to the federal government with the money held in a separate federal CLASS account.

3. In the second installment of the plan to close the Medicare Part D "Donut Hole", brand name and biologic drugs prescribed for the beneficiary must be discounted by 50%. Also, for Medicare beneficiaries preventive services and an annual physical will be covered without cost-sharing.

4. HSA = Health Savings Accounts; OTC = over the counter.

5. Insurers allocate premiums to medical losses (i.e., payment of medical claims) and expenses (e.g., staff salaries and sales costs). In individual and small group markets the required Medical Loss Ratio is 80% and in the large group market the required MLR is 85% (i.e., 80-85% of premiums must be spent on medical services and quality enhancement measures).

The New Federal Health Care Law: PPACA “Essential Health Benefits Package”

- HHS is to define essential plan benefits for Exchange plans to include at least items/services in following general categories:
 - Ambulatory patient services (e.g., Doctor visits)
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services
 - Prescription drugs
 - Rehabilitative and habilitative services/devices
 - Preventive and wellness services; chronic disease mgmt.
 - Pediatric services, including oral and vision care
- HHS to ensure “essential health benefits package” is at least equal to benefits provided in typical employer plan; data from surveys of employer-sponsored health coverage as basis

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Given the variety of services covered in existing health care plans, it is necessary to spell out exactly what will be the covered services that must be in all health care plans. For purposes of the comparison shopping on the 2014 Health Care Exchanges, HHS is to define the benefits that must be included in all plans. The law sets out the broad categories that must be covered but has left it to HHS to flesh it out.

In defining this “essential health care benefits package”, HHS seeks to include all the services that are included in the typical employer/employee health plan. To do so, HHS will rely on data collected by the DOL in a survey of all ERISA health insurance plans. DOL has jurisdiction over ERISA plans and thus can more easily obtain the information.

The New Federal Health Care Law: PPACA “Essential Health Benefits Package”

- “Essential health benefits package” plans will be offered on Exchanges starting in 2014, but levels of coverage may vary:
 - Bronze (covers 60% of value of package)
 - Silver (covers 70% of value of package)
 - Gold (covers 80% of value of package)
 - Platinum (covers 90% of value of package)
- Same benefits exist at all the different levels; differences relate to amount of cost sharing
- However, there is overall cap on cost-sharing: out-of-pocket costs of \$5,950 for individuals & \$11,900 for family per year
- All plans offered on Exchanges to be presented in standardized format for easy comparison

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Fundamental to the success of the Exchanges is as much consistency as possible. Hence all plans presented for the Exchange must offer the same benefit package, but their cost-sharing (and hence their premiums) are the basic variables.

All Exchange plans will have capped cost-sharing in the sense that annual out-of-pocket costs are limited to \$5,950 for single coverage and \$11,900 for family coverage.

There will be variation permitted by geography and, to a limited extent, by age, and tobacco use.

Plans offering more services than in the required “essential health benefits package” will be present on the Exchange as well.

The New Federal Health Care Law: PPACA Using the Exchanges Starting 2014

- ❑ Each state must establish an American Health Benefit Exchange [AHBE] for individuals lacking access to affordable employer coverage
- ❑ Each state must establish a Small Business Health Options Program Exchange [SHOP] for businesses with up to 50 employees
- ❑ Federal OPM will arrange for at least 2 multi-state plans in each Exchange
- ❑ Each Exchange will have standard rules and disclosures for all participating plans
- ❑ Plans on Exchanges must have uniform Essential Health Benefit Package
- ❑ Each insurer must offer Silver and Gold level plans

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This is the structure of the exchanges for each state. The exchanges will be the place where health care plan shopping will take place. There will be an exchange for individuals and an exchange for small businesses with up to 100 employees in each state; however, if a state chooses not to run an exchange, the federal government will arrange to run it in that state

The Exchanges will have standardized formats, definitions, enrollment applications, consumer satisfaction, and marketing requirements to allow easy comparison of the prices, benefits, and performance of health plans.

The Exchanges will have online eligibility determinations with regard to health care premium tax credits or public programs, and consumers without access to the Internet will be able to enroll through the mail or in person in a variety of locations.

Funding is provided for health coverage Navigators in the states who will conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance.

Each insurer that is qualified to offer plans on an Exchange must offer at least the Silver and Gold versions of the health care plan.

The New Federal Health Care Law: PPACA Exchanges Starting 2014 - Subsidies

- ❑ Subsidies will be available for families and individuals to offset cost of Exchange plan premiums; subsidies will be in the form of refundable and advanceable tax credits
- ❑ Subsidies will be available on sliding scale, based on insured's gross income, ranging from 133% to 400% of the Federal Poverty Level (FPL) for respective family size
- ❑ Only citizens and legal residents can use the Exchanges & qualify for subsidies
- ❑ In general, FTEs with employer coverage meeting specified requirements will not get subsidies unless employee paying more than certain % of his income

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The law requires all individuals to be insured, either through work or individual plans. To do this without hardship, the law creates a variety of subsidies for individuals and families to afford coverage.

People whose income is less than 133% of the FPL can be covered under the Medicaid program of their state.

People whose income is between 133% and 400% of the FPL will receive a subsidy in the form of a tax credit which is refundable (i.e., payable even if there is little or no income taxes due) and advanceable (i.e., it can be used to pay premiums as they arise).

The Kaiser Family Foundation has a subsidy calculator on its web site that permits you to enter variables as to your income and age and get an idea what the premiums and subsidies would be.

People in employer plans will still be able to go to the Exchanges if their premium share is too high.

The Exchanges do not start until January 2014, and in the interim HHS will be issuing notices, guidance, and regulations that will "fill in the spaces" for the Exchanges.

The New Federal Health Care Law: PPACA Exchange Subsidy Examples - Single

- Person, age 35, income \$30,000 =
 - \$3,082 Actual Annual Premium
 - **\$432 Subsidy Amount**
 - \$2,650 Annual Premium Paid by Insured

- Person, age 35, income \$40,000 =
 - \$3,082 Actual Annual Premium
 - **\$0 Subsidy Amount**
 - \$3,082 Annual Premium Paid by Insured

- \$30,000 = 277% of 2010 FPL for one person
- \$40,000 = 369% of 2010 FPL for one person

- Calculator at <http://healthreform.kff.org>

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Examples are drawn from the premium/subsidy calculator which is on the Health Reform page at the web site of the Kaiser Family Foundation.

All the calculations in these examples use 2009 figures for premium and income levels. Also, KFF suggests these caveats about the calculator:

- Specific subsidies for cost sharing and what people might pay out-of-pocket for deductibles and coinsurance are not illustrated on the calculator.
- In many cases coverage will be more comprehensive and accessible than what is typically available today in the non-group market, so premiums cannot easily be compared to what people buying insurance on their own are now paying.
- The calculator does not apply to people with coverage available through an employer, where the firm is generally paying for a substantial portion of the insurance premium.
- Premium subsidies are based on a silver plan, so all premiums shown are for silver coverage. People may be able to pay a lower premium for less comprehensive coverage (i.e., a bronze plan, with an actuarial value of 60%). The tables showing results by age and income also reflect premiums for silver coverage, though the minimum insurance that people will be required to obtain will be bronze coverage.

The New Federal Health Care Law: PPACA Exchange Subsidy Examples - Single

- Person, age 45, income \$30,000 =
 - \$4,362 Actual Annual Premium
 - **\$1,712 Subsidy Amount**
 - \$2,650 Annual Premium Paid by Insured

- Person, age 45, income \$40,000 =
 - \$4,362 Actual Annual Premium
 - **\$562 Subsidy Amount**
 - \$3,800 Annual Premium Paid by Insured

- \$30,000 = 277% of 2010 FPL for one person
- \$40,000 = 369% of 2010 FPL for one person

- Calculator at <http://healthreform.kff.org>

Examples are drawn from the premium/subsidy calculator which is on the Health Reform page at the web site of the Kaiser Family Foundation.

The New Federal Health Care Law: PPACA Exchange Subsidy Examples - Single

- Person, age 55, income \$30,000 =
 - \$6,607 Actual Annual Premium
 - **\$3,957 Subsidy Amount**
 - \$2,650 Annual Premium Paid by Insured

- Person, age 55, income \$40,000 =
 - \$6,607 Actual Annual Premium
 - **\$2,807 Subsidy Amount**
 - \$3,800 Annual Premium Paid by Insured

- \$30,000 = 277% of 2010 FPL for one person
- \$40,000 = 369% of 2010 FPL for one person

- Calculator at <http://healthreform.kff.org>

Examples are drawn from the premium/subsidy calculator which is on the Health Reform page at the web site of the Kaiser Family Foundation.

The New Federal Health Care Law: PPACA Exchange Subsidy Examples - Family

- Family of 4, worker age 45, income \$30,000 =
 - \$11,800 Actual Annual Premium
 - **\$10,126 Subsidy Amount**
 - \$954 Premium Paid by Insured

- Family of 4, worker age 45, income \$40,000 =
 - \$11,800 Actual Annual Premium
 - **\$8,902 Subsidy Amount**
 - \$2,178 Premium Paid by Insured

- \$30,000 = 136% of 2010 FPL for Family of 4
- \$40,000 = 181% of 2010 FPL for Family of 4

- Calculator at <http://healthreform.kff.org>

Examples are drawn from the premium/subsidy calculator which is on the Health Reform page at the web site of the Kaiser Family Foundation.

The New Federal Health Care Law: PPACA Federal Poverty Levels - 2010

Family Size	100% of 2010 FPL	133% of 2010 FPL	200% of 2010 FPL	300% of 2010 FPL	400% of 2010 FPL
1	\$11,830	\$14,404	\$21,660	\$32,490	\$43,320
2	\$14,570	\$19,378	\$29,140	\$43,710	\$58,280
3	\$18,310	\$24,352	\$36,620	\$54,930	\$73,240
4	\$22,050	\$29,327	\$44,100	\$66,150	\$88,200

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This table gives you an idea of what the Federal Poverty Level is for different family sizes and at different percentages. Getting a feel for the actual numbers in connection with the FPL is important to understanding the health care assistance options that the law is going to provide. Since the commonly referenced figures are the actual FPL itself and then 133%/200%/300% and 400% of the FPL they are grafted above. Keep in mind that these figures are all based on the FPL in effect for 2010, and it is the FPL in effect for 2014 that is the vital one. The projected rate of growth in the FPL currently is about 1.5% a year until 2014, so you can do some of the projections yourself.

As you can see, the FPL is a pretty low figure. For example, for a single individual it works out to \$227.50 per week; and for a family of four it works out to \$424.03 per week. That's not much to cover everything a family needs.

The multiples of the FPL, which are the reference points for subsidy calculations, have the capacity of reaching many people in our area, especially when you consider that in the 2000 census Dunedin's median household income was \$34,800 and for Pinellas County in 2008 it was \$45,900.

Here is the federal government web site where you can learn about and examine the Federal Poverty Levels:

<http://aspe.hhs.gov/poverty/09poverty.shtml>

The New Federal Health Care Law What It Is & How It Works: Information You Can See on Line

Official Federal Health Reform site: www.healthreform.gov

Internal Revenue Service site: www.irs.gov

Health & Human Services site: www.hhs.gov

Kaiser Family Foundation site: www.kff.org and specifically
<http://healthreform.kff.org>

FamiliesUSA site: www.familiesusa.org

US Chamber of Commerce site: www.uschamber.com

Commonwealth Fund site: www.commonwealthfund.org

New York Times "Prescriptions" Blog site:
<http://prescriptions.blogs.nytimes.com>

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This page has a list of very informative web sites with good, reliable information about the law and its implementation and application.

On the three government sites you can follow the formal actions of the government in interpreting and implementing the law.

On the three "org" sites you can follow studies on the reforms in action, as well as excellent and updated summaries of the key parts of the law. You will also find exemplary tools demonstrating the law in action.

The Chamber's site has a health reform section which offers a different perspective on the law, one that raises caveats and questions even as it provides more detail on the implications of the law on larger employers and on its taxing provisions.

The NYT's site is an on-going discussion of the law's immediate and short term applications. You'll enjoy its extremely practical Q&A to readers emails, and can pose a question yourself. There are links at this site to all the major legislative materials and the organizations interested in the health care law.

Whenever you have a question, or hear something that you want to check for yourself, do a little homework and pass it on!