WHAT IS HEALTHCARE REFORM?

Healthcare Reform (HCR) is a law passed by Congress that provides many different requirements. A very important aspect of the law is that it is designed to provide individuals greater *access* to health care coverage.

It goes by many names: Patient Protection and Affordable Care Act (PPACA) or ACA or Obama Care or simply Healthcare Reform.

WHAT ARE THREE THINGS I NEED TO KNOW?

1. Beginning in 2014, the law requires *everyone* to have health care coverage! You may choose to purchase it on your own, enroll in your Employer sponsored plan, or if eligible, be covered by a government program such as Medicaid or Medicare. If you decide to go without coverage, you will likely face a financial government penalty.
2. The law has created a "Health Insurance Marketplace," often referred to as the "Exchange." Think of the Health Insurance Marketplace as a one-stop information site where you can compare all your health care coverage options, learn about different plans and purchase the health care coverage that you need. You cannot be turned down for coverage on the Marketplace for any reason, including having pre-existing conditions. The Marketplace is meant to give people a place to compare and understand health plans from different insurance companies so that you can choose one that works the best for you.
3. The law has created many new taxes and fees. Some of these additional taxes and fees may be required of you, your employer or both. You must remember that should you choose to go without coverage, you will pay increased costs due to additional taxes. For most individuals, this new law will NOT provide free health care coverage.

WHAT DO I NEED TO DO NOW?

Read, learn and ask questions! As your Employer, we will continue to provide you with key updates about HCR. You should read these updates and familiarize yourself – *and your eligible dependents* – with this legislation. It is up to you to make an informed decision about your 2014 *federally mandated* health care coverage!

For more information you may visit www.healthcare.gov

The intent of this analysis is to provide general information regarding the provisions of current health care reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

FREQUENTLY ASKED QUESTIONS?

1. **I cannot afford health insurance. Will the new law help?**

   Maybe. If you are single and earn between $14,000 and $35,000, you may get government help to pay for your health plan. You can apply for help if you cannot get a health plan from your employer. How much help you get depends on your income and the cost of your health plan.

2. **Will the new law cost me more?**

   It depends on what kind of health coverage you have right now. However, starting in 2013, people who make more than $200,000 (and couples who make more than $250,000) will pay about one percent more in Medicare taxes. They'll also pay an extra 3.8 percent in income taxes. While this sounds like a lot, it affects a small number of people.

3. **Who pays for the extra screenings and other benefits included in the new law?**

   In many cases, your employer pays. By finding things like cancer and diabetes earlier through preventive screenings, the hope is that people will stay healthier – and avoid more costly health care services later. However, it is possible that more costs will be passed along through premium increases.

4. **Will health coverage be required?**

   Beginning in 2014, people who do not buy health insurance will be subject to fines. There are exceptions. Some people may be exempt for religious reasons from the requirement to buy health coverage. And if you cannot afford a health plan, you may not have to pay a fine. If you are single and earn between $14,000 and $35,000, you may get government help if you can't get a health plan through your employer.

   How much help you get depends on your income and the cost of your plan. In general, however, anyone without a health plan will be fined about $95 a year beginning in 2014. The fine goes up to $325 a year in 2015, and up to $695 a year in 2016.

5. **Can I still get health insurance for my children?**

   Yes. Before health care reform, college graduates were usually not eligible for their parents' health plan. But, beginning with new plans or renewing plans effective on or after Sept. 23, 2010, the law lets children up to age 26 stay on their parents' plan.

6. **What about people who cannot get health coverage because of a pre-existing condition?**

   Beginning with new plans or renewing plans effective on or after September 23, 2010, plans will not be able to apply pre-existing conditions limits to anyone under the age of 19. In 2014, this new rule will apply to everyone. Until then, people older than 19 who have not had health coverage for six months and have a pre-existing medical condition may be able to get a health plan through the pre-existing condition insurance plan.

GLOSSARY

1. Affordable Coverage

Coverage is affordable if the cost to the employee of self-only coverage does not exceed is 9.5% of the employees "household income." This is true regardless whether he or she qualifies for some other level of coverage (e.g., self-plus dependents, family). Thus, despite that family coverage might require a larger employee premium, affordability is determined based on the cost of self-only coverage. The Act defines "household income" to mean "modified adjusted gross income of the employee and any members of the employee's family (including a spouse and dependents) who are required to file an income tax return." Recognizing the employers would generally not know or care to know their employees' household incomes, the proposed regulations permit employers to instead use W-2 earnings.

2. Employer Mandate

The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.

3. Essential Benefits

A set of health care service categories that must be covered by certain plans, starting in 2014.

The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: 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; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014. Self-funded group health plans are not required to cover essential benefits.

4. Exchange or Health Insurance Marketplace

A transparent and competitive health insurance market where individuals, families, and small businesses can learn about their health coverage options, compare health insurance plans based on costs, benefits, and other important features, choose a plan, and enroll in coverage. The Marketplace also includes information on programs that help people pay for coverage, including ways to save on monthly premiums and out-of-pocket costs, and other programs like Medicaid and the Children's Health Insurance Program (CHIP). Individuals and families can apply for coverage online, by phone, or with a paper application.

5. **Federally Mandated Health Care Coverage or Shared Responsibility**

The PPACA ensures that all Americans will have access to affordable health care coverage through shared responsibility among individuals, businesses, and the government. Individuals will be responsible for purchasing health insurance coverage, and most employers will be responsible for offering coverage. Individuals, employers, and the government are all responsible for contributing to the cost of coverage.

6. **Federal Poverty Level**

A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits.

7. **Individual Mandate**

Beginning in 2014, the Affordable Care Act includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. Individuals will be required, to maintain minimum essential coverage for themselves and their dependents. Some individuals will be exempt from the mandate or the penalty, while others may be given financial assistance to help them pay for the cost of health insurance.

8. **Minimum Essential Coverage**

Minimum essential coverage is defined as:

- Coverage under certain government-sponsored plans
- Employer-sponsored plans, with respect to any employee
- Plans in the individual market,
- Grandfathered health plans; and
- Any other health benefits coverage, such as a state health benefits risk pool, as recognized by the HHS Secretary.

Minimum essential coverage does not include health insurance coverage consisting of excepted benefits, such as dental-only coverage.

9. **PPACA**

The Patient Protection and Affordable Care Act (PPACA) – also known as Obama Care, the Affordable Care Act or ACA – The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

10. Qualified Health Plan

A qualified health plan is coverage offered through a state insurance exchange, which will be open to individuals and small groups in 2014.

Under the PPACA, qualified health plans may not have pre-existing condition limitations or lifetime maximums or annual limits on the dollar amount of essential health benefits, which the Secretary of Health and Human Services will define.

Each state exchange's qualified health plans must cover essential health benefits at five levels: bronze (60 percent), silver (70 percent), gold (80 percent), platinum (90 percent) and young adult. Only an insurer or health maintenance organization with a license and in good standing in the state may offer exchange plans.