PPACA Handbook

Business Guide

Understanding & Shopping for Health Insurance

By

Antonio Paulo Pinto

PPACA Handbook: Business Guide
Understanding & Shopping for Health Insurance
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1st Edition

Forward

This book is intended to serve as an educational and purchasing guide for business owners that are thinking of purchasing insurance for themselves or their employees. The hope is that after reading this book, a business owner can have a better understanding of health insurance and the types of health insurance plan options available for purchase. Reading this book should help a business owner to be able to have a better discussion with a sales representative from an insurance agency or an insurance company. Being able to have a better discussion will help a business owner make a better choice on what health insurance plan best meets their needs and those of their employees.

The health plan benefit examples and the examples of typical purchasing situations with possible purchasing options provided in this book are intended as a guide to help in the discussion of the common options and solutions currently available to small business owners that are buying health insurance for themselves or their employees.

It is recommended that a business owner buying health insurance should work with a health insurance advisor or an experienced health insurance sales representative and ask all of the questions they need to ask when shopping for health insurance. Please remember that many of the ideas and examples in this book have been simplified in the hope of creating a better understanding of health insurance plans and options.

This book does not include or explain any type of Medicare or Medicaid Plan.

Preface

The History of This Book

The author of this book has over twelve years of experience selling health insurance plans to individuals and business owners. In most situations, a lot of time was spent explaining the basics of health insurance and how it worked to those individuals that were shopping for health insurance plans for themselves, their families or their employees. The idea for writing this book was born at that time.

It is hard to help a person choose a health insurance plan when everyone involved is speaking a different language; meaning the person that is buying health insurance, the insurance agent and the insurance company. Everyone has their own way of explaining the benefits that are paid for by a health insurance plan which makes buying a health insurance plan very confusing for most people.

It is very easy for an insurance sales representative to over-simplify the explanation of the benefits that are covered by a health insurance plan, the application process and the underwriting process to a person shopping for health insurance. Often times, people do not end up having a benefit that was needed but not included in the health insurance plan that was purchased by the person. This is why it is important to be able to understand the available health insurance plan options and the pros and cons of the shopping process. It is very important that a person asks many questions and understands what health plan benefits they are getting with their health plan; and that the person knows what the potential out-of-pocket expenses could be if the person goes to the hospital for an emergency or is diagnosed with a serious illness.

The Patient Protection and Affordable Care Act (PPACA) has many changes scheduled to take effect on January 1, 2014. Some of these changes are explained in this book; but in this book, the discussion is primarily about those changes that affect a business owner that has to decide if they want to offer a health insurance plan or what type of health insurance plan they should offer to their employees and their families.

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Part One

The Basics of Health Insurance

Chapter 1

A Brief History of Health Insurance

In talking about insurance, and only insurance, we are usually talking about coverage for large unforeseen expenses. Basically, coverage just in case something happens. This is what insurance is designed and intended to provide, a safety net. No one wants to file a claim against their homeowners insurance or auto insurance. However, when we talk about health insurance, a person thinks that they pay enough for their health insurance; so they either want to get their money back by using it as much as possible; or, they have no choice but to buy it because they are sick and need to get treatments. Therefore, when we talk about wanting better health insurance, what we really mean is that we want a better health plan or a healthcare management program that gives us the health care benefits we need at an affordable price and with reasonable co-payments when we go to the doctor and the hospital. This is why health insurance is different from other kinds of insurance; it's not just about catastrophic coverage.

Health insurance works best when large groups of people are grouped together to allow for the costs of treating and maintaining the health of all the individuals in the group to be spread out across the group, including both the healthy and the unhealthy individuals. This is accomplished by having a large group of healthy individuals in a group that has unhealthy individuals in order to help divide the expenses of the unhealthy individuals across the entire group. Otherwise, if only unhealthy individuals wanted health insurance coverage, it would be too expensive for them to buy it and the co-payments would most likely be unaffordable. For this reason, it is important that groups of people with health insurance not be too small; so that the cost of the health insurance and the day-to-day co-payments can be kept affordable.

The benefits that are included in a health insurance program have changed over the last few decades. The changes have primarily followed the demographic changes of the country over the last few generations and change with every generation. Health insurance first became a benefit offered by employers during World War II because companies needed to hire workers to manufacture all the equipment that was needed for the war; and the government froze wages in order to keep companies from taking other companies employees by offering them more money. Today, most people are familiar with the health insurance plans that have been offered in the last 40 to 50 years. There are the Indemnity plans (popular in the 1970's and 1980's), the HMO plans (popular in the 1980's and 1990's), and, currently popular, Consumer Driven or High Deductible Health Plans (CDHPs and HDHPs), with the most popular being the HSA (Health Savings Account) Qualified health plans (starting in 2004). Ironically, HSA plans, were originally the Archer MSA program started in 1997; and are very similar to the Indemnity plans of the 1970's, except that they allow a person to be able to open a bank account that is tax-deductible in order to pay for their medical expenses.

The old Indemnity plans generally had an individual pay for the doctor's office visit and their prescription drugs out of their pocket and had a very low hospital deductible or co-payment. However, keep in mind that this was at a time when the doctor's office visit cost was not expensive, and there were not as many prescription drugs as there are today and there were very few expensive prescription drugs. The average person in the country at this time also helped keep the costs of healthcare low as the largest group of people in

the country was all children, the Baby Boomers. What this means is that not many people were using the hospital because the country was made up of many young people that were generally healthy. This means that the nation's health care system was not used as much as it is today. Back then, the parents of the baby boomers and the baby boomers themselves were not people that liked to go to the doctor.

The next main change after the Indemnity plans was the change to HMO (Health Maintenance Organization) types of plans, at a time when new medical tests and new prescription drugs were just starting to become available; and the costs of these new tests and drugs were very expensive. The HMO's tried to control costs by managing them through a primary care doctor. For those that remember; there were many issues in the first few years of these HMO plans. The HMOs were able to manage costs while the costs were just starting to increase rapidly by mainly limiting care. For example, if your primary care doctor would not give you a referral to a specialist, you could not go to the specialist unless you paid for it yourself. As time went on, the need for a referral went away, and many primary care doctors would just give referrals to avoid complaints and other issues. The average age of the country made HMO plans good options at the time, the early 1980's, as most of the country was in their mid-to-late 20's. The majority of the Baby Boomers were born between 1957 and 1961 even though the birth years for the Baby Boomers are between 1946 and 1964. Therefore, the nation was still relatively young and healthy, and not rushing to have kids.

Overall, HMOs created a "Free Healthcare" mentality by disconnecting people from the true cost of healthcare services by saying to people; pay the premium and get as much care as you need or want for what were then very small co-payments, typically $5 for a doctor's office visit. The HMOs were not expecting people to use medical care or prescription drugs four times as fast as they did when people paid the whole expense out of their own pockets. The HMOs also did not expect all the new medical tests and new prescription drugs that became available and how much the tests and drugs would cost. The end results created what we have now, very high usage of our nation's healthcare system with quickly increasing health care costs.

This brings us to the plans of the late 1990's through today, CDHPs (Consumer Driven Healthcare Plans); mainly talking about HSA plans (Health Savings Accounts) which are qualified HDHP's (High Deductible Health Plans) and non-qualified HDHP's which are better known as CDHPs. HSAs offer a tax break if you pay the first few thousand dollars out of your pocket before the health plan pays for any of your covered medical expenses. The CDHPs or HDHPs are plans that have a blend of co-payments and deductibles without the option of getting a tax break. Most common of these are plans that have co-payments on prescription drugs but a deductible on medical services, such as paying the first couple of thousand dollars at the hospital before the health plan pays any expenses. These health plans look very similar to the old Indemnity plans. The expectation is that people will do a better job of taking care of themselves and shop around for their medical services and prescription drugs; so, that they will spend less money on the medical services and prescription drugs.

The fact that individuals spend their own money first should make healthcare providers compete on the prices of their medical services, medical tests, and prescription drugs. The idea is that it should help to lower the rate at which prices rise and people will not use as many medical services or prescription drugs; since people have to think about whether or not they want to spend their money first. The thinking that people will not use as much medical care because they have to spend their own money first has not turned out that way over the last decade. As it turned out, the reality is that if people need medical care; they cannot wait. People have to go the doctor or hospital when they get sick; and they have to take their prescription drugs.

A major reason that can be assumed for why CDHPs, HDHPs and HSAs did not actually slow the costs of medical care is that the average age of a person in the country is now much older than it was a generation ago. The Baby Boomers are now primarily in their 50’s and 60’s; and most people now have a real need for medical care. Plus, many younger people have medical issues that need to be treated. As more illnesses are found by doctors, there is more of a need for medical care.

There are some changes we are currently in the middle of and more that should come in the next few years. The largest change being that the largest age group in the country, the Baby Boomers, is just starting to really use the nation’s health care system. They are already leaving the commercial health insurance marketplace and entering the government managed Medicare program; so Medicare covered people will increase significantly over the next ten years. This is one of the reasons that for the first time in two generations; we are seeing a major change with the passage and implementation of the very controversial (PPACA) Patient Protection and Affordable Care Act, also known as Health Care Reform.

There is some hope that the kids of the Baby Boomers, the generation primarily in their Teen’s and 20’s today, will help even out the rising cost of health insurance. Even though this young group is not the healthiest generation; they are still young, and that has its own benefits. However, and more importantly, they will only help slow the rising cost of health insurance if they actually have health insurance, whether or not they need it today.

Chapter 2

The Roles of the Interested Parties

Person with Insurance

As a person with health insurance, you may not think that there are things that are expected of you. However, there are two basic expectations that are expected of most people. The first is that you take care of yourself; and the second is that you get your needed medical care. These two points will be clarified in the next two paragraphs in order to create a common understanding of the two points.

Taking care of yourself may seem like a simple statement; but when talking about your health insurance, it is a little more specific in some of the things that are expected of you. The idea is that you will live a healthy lifestyle by maintaining a healthy diet, exercising regularly and not smoking, drinking alcoholic beverages in excess or using non-prescription drugs. Of course, this idea is different for each person; and most importantly, is something that should be discussed with a doctor.

The other expectation is that you go to the doctor for your annual check-ups and take your prescription drugs as directed by the doctor. In getting annual check-ups and physicals, doctors can more easily detect changes to your health and start treating your medical condition when it is a small issue and help avoid it from turning into a big issue. The same is true for making sure you take your prescription drugs that help maintain a medical condition and keep you from getting sicker. There are times when the costs can be a problem; but, there are many organizations now that a person can ask for help from that try and help people with the costs in order to help keep them healthier.

Health Care Provider

The primary role of health care providers is to detect, treat and manage your personal health issues for you and with you. There are many types of providers of health care related services; such as doctors, urgent care clinics, surgical centers, hospitals, nursing homes, medical equipment vendors and pharmacies. One important thing to remember is that health care providers are also businesses, meaning they need to make money in order to pay for the costs of providing you with the health care services you need or the costs of the prescription drugs that you need in order to address your health issues. It does not matter if the provider is for-profit or not-for-profit; they still have to pay their operating expenses and the salaries of the people that work for them.

Health care providers are the people that work with you in order to find out what medical conditions you may have and develop a treatment plan for those medical conditions. They will also give you advice on how to get healthy and stay healthy in order to help you not get sick or develop a medical condition. However, as we all know, some people will develop medical conditions due to family history or from the environment in which they live or work; and it is important for the people that fall into this category to work closely with their health care providers to limit their chances of getting sick or to treat illnesses as quickly as possible from when they start.

An item of concern with health care providers these days is the question of how they bill people they provide medical care for; and if they are trying to make too much money from providing medical services, equipment or prescription drugs. This is a major debate in the country at this time and one that will not be addressed here in this book. However, it is one that people should pay attention to and follow as it will help one in negotiating with health care providers over payments for medical services.

Employer

In today's environment, employers struggle with the decision of whether or not to offer health insurance benefits to their employees; and if they do offer health insurance to their employees, how much of the cost the employer will pay. Many people believe that employers should offer health insurance to their employees; however, there is no requirement today that employers offer health insurance to their employees. Starting in 2014, under health care reform, small employers with fewer than 50 full-time equivalent employees are not penalized for not offering health insurance to employees. However, larger employers, with over 50 full-time equivalent employees, will be subject to a penalty if they do not offer health insurance or affordable health insurance to their employees. If the employer decides not to offer health insurance; they will just need to pay a penalty.

An employer or the representative of an employer who is shopping for health insurance benefits for themselves and their company's employees needs to decide, in advance, what the goal of the health insurance program is going to be and what the employer may be willing to trade off to accomplish that goal. Many employers would say that the number one goal is to keep the cost of the health insurance plan as low as possible; since, health insurance is one of an employer's largest expenses. However, and in most cases, the health insurance plan is also an important part of a strong benefits package; and an overall business operations issue when considering the need to Recruit, Motivate, and Retain the key employees of the business. At the end of the day, the insurance sales representative will show an employer options and service the account; but the sales representative is not an employee and is not there to help run the business or deal with the fall-out if an employer chooses the wrong health insurance program for their employees.

It is very important for an employer to understand their employees, their employee's needs, and their business needs when shopping for a health insurance plan. The cost of a health insurance plan is a major factor in the purchasing decision, but not the only factor when deciding what is best for their business and their employees. After all, a business does not operate without employees; and employees are not as productive when they are not happy, out sick on a regular basis, or worried about paying for medical care for themselves or their immediate family members. This is why it is important to work with a sales representative that is both knowledgeable and diligent in helping an employer achieve the goals of the business by helping the employer choose the appropriate health plan design and by properly servicing your account.

Insurance Agent

The primary role of the insurance agent is to help you find and purchase the health insurance plan that is the best fit for you, your family or your business. The insurance agent is also the person that can be the point-of-contact for your questions on the health plan you purchased. The agent can occasionally even help you resolve claim issues with the insurance companies. Most insurance agents work with multiple insurance companies and can show you many different options. It is important to know that many insurance agents specialize or focus on specific market segments. What this means is that it is important to work with an agent that has a good understanding of the type of product you are looking to buy. For example, if you are buying health insurance for yourself, you should be looking for an agent that has a very good understanding of the Individual health insurance plans available in the state in which you need health insurance coverage.

Another role of the insurance agent is to teach you about health insurance. An insurance agent should be able to teach you what the health insurance policy that you are buying is going to have for benefits and co-payments. This is something that the agent will be able to do for you as long as you are working with them. Agents also have direct contacts at the insurance companies whose products they sell, meaning that they can usually help get an issue resolved faster than you can on your own. If you are working directly with an insurance company, the insurance company provides you with this service; but you are usually calling into a customer service center. This is a very important service that you should think about when buying health insurance, especially since you are already paying for it as part of your monthly health insurance bill payment.

Insurance Company

The insurance companies have many things that they do, but there are two main things that they have to do when it comes to health insurance. One thing they do is process all the claims payments between everyone involved when a person uses the doctor, the pharmacy, the hospital, etc. The other thing that they do is risk management, which is basically managing the costs of medical care and grouping together very large groups of people, so they can best manage the total amount of money they collect and pay out to providers of medical services.

The pooling of insured's allows for the costs of the medical treatments of the insured individuals in a group to be evenly divided among the group. By having a large group of individuals paying for health insurance, including healthy individuals, it helps to make health insurance more affordable for all individuals. Otherwise, if only unhealthy people purchased health insurance, the price would be completely and totally unaffordable, since the insurance company would have to collect enough in health insurance premium payments to cover all the incurred medical expenses, plus cover their overhead or go out of business. This is actually one of the issues we have today, as many healthy individuals are not buying health insurance, and therefore; are not helping keep the premium costs down; and are forcing those that do need health insurance to pay more and more each year. Both young individuals and healthy individuals do not buy health insurance because they do not feel they need it and because they do not understand that uninsured medical claims are extremely expensive.

Another thing that insurance companies do is to help create and run programs that help people take care of medical conditions they have that may need to be treated regularly. The most common of these types of programs that many people are familiar with are Wellness Programs and Disease Management Programs; for medical conditions such as Diabetes and High Blood Pressure. The reasons that these programs are important is that it is much easier to help a person manage their medical conditions than it is to have them keep getting sicker and needing even more medical care. For example, the cost of helping a person manage their high-blood pressure using medication is probably around $2,000 per year, instead of not helping the person treat their condition and the person has a heart attack or stroke and goes to the hospital for treatment that could easily cost $100,000 or more. The best thing about helping keep a person healthier with these programs is that it is better for everyone! The person with insurance can expect to live a longer, healthier and more productive lifestyle; and the healthcare system in the country runs smoother.

Government

The role of government in healthcare is very complicated and every single person you talk to is going to have a different opinion about what it should be now and in the future. In order to keep things simple, it is best to give a recap of the government's general system and some general program summaries. With the passage of the Patient Protection and Affordable Care Act (PPACA), the national discussion has become even more opinionated; and PPACA is discussed further in Part Two of this book avoiding opinion as much as possible.

When you look at health insurance, you suddenly realize that we are still a Nation of Individual States. Health insurance programs, mandates or required coverage's are completely different in each and every State. There are National guidelines, but they are not as specific as each State's guidelines. Therefore, it makes it difficult to have a discussion on a National program when different States have different required benefits in their State specific health insurance plans. However, PPACA has created a basic list of medical treatments that are the minimum required health insurance benefits offered by all health insurance plans nationally starting in 2014.

Another thing that many States do is provide programs for the uninsured, typically through Medicaid for children and the poor, usually with some financial aid from the Federal Government. These programs fill a much needed gap in our healthcare system by focusing on individuals who either cannot afford to take care of themselves, or in the case of children, who need a lot of preventative care. The preventative care for children is very important as it helps keep future medical expenses down by immunizing them and finding and treating any medical issues they may have before those medical issues become serious. Providing basic coverage to the poor is important because helping them manage their health issues is less expensive than having them use hospitals like they are a doctor's office.

In every State, the State Insurance Department usually has a web site with information on the available programs and how a person can find out if they can get help. It is important to know what help is available in your State, as not all insurance sales agents know about all of the available programs in every State. It is very important to see what programs are available in your State, as an available program may be able to help you with a medical condition when an insurance company may not be able to help you.

Chapter 3

Health Plan Review

Provider Networks: PPO, POS, HMO

These are the three types of health insurance plan names most people are familiar with; Preferred Provider Organization (PPO), Point-of-Service (POS) and Health Maintenance Organization (HMO). The main things that these names do is tell you how big the doctor's network is and if you have any benefits if you go out of the health insurance plans doctors network. Historically, they were very different and the benefits they covered were more difficult to understand. However, today, there are not as many differences as many health insurance plans no longer make you go to your primary care doctor to get a referral to go to a specialist; and most health insurance plans today make the doctor get pre-approval for a medical test. None of these health insurance plans usually cover dental benefits, unless it is due to an accident; or vision benefits, other than maybe an annual check-up or an accidental injury.

The main difference between these health insurance plans today is the size of the network of doctors, hospitals and other medical providers that you can go to in order to get care at a lower cost. PPO health plans tend to have large national networks and include coverage for out-of-network services. POS health plans tend to have regional provider networks and also include coverage for out-of-network services. HMO health plans are typically local networks that do not have coverage for out-of-network services. It is important to know when you are trying to decide which type of health plan you want to buy that you know where you will be going to get your medical care. Emergency Care in the Emergency Room is typically covered by all health plans whether or not the emergency care takes place in-network or out-of-network; however, it actually needs to be emergency care and not a cold if you are outside of the health insurance plans network of hospitals and providers.

The other thing you need to think about when buying a health insurance plan is how much it will cost you. One thing to consider is that the larger the network of providers you want to be able to go and see and the more benefits you want the health plan to cover; the more you will pay for the health insurance plan. The easiest way to think about this is that the more you want, the more you pay for health insurance.

Consumer Driven Healthcare Plan (CDHP)

Consumer Driven Healthcare Plans (CDHPs) is the catch phrase for the most recent types of health insurance plans being sold today that are expected to control the increasing cost of health insurance and how many times people use the doctors, etc. The catch-phrase and original program actually started around 1997, when the Archer Medical Savings Account (MSA) program was approved by the government, but only as a test program. The MSA program is the program that became today's Health Savings Account (HSA) program. The most recognized of these types of health insurance programs is the Health Savings Account (HSA) Qualified Plan, which is a specific High Deductible Health Plan and will be explained in the following section.

The idea behind consumer-driven-healthcare is that if you have a financial incentive to take care of yourself; you will take better care of yourself; and, in theory, you will not have to go to the doctor, hospital or other health care providers as much as you do now. By not using these medical services as much as you do today, the overall cost of providing healthcare services nationally will not go up as fast as it has been; and therefore, the future cost of health care should increase slower than it has the last few years. Since you are spending your own money before the insurance company starts to pay for any of the medical services that you use, you are more likely to shop around for your healthcare services. This assumes that you can get actual prices from the health care providers for the medical service you need, so that you can compare prices. Basically, you are being asked to be in charge of how you work with your doctor and figure out the best way to spend your money on medical services. In thinking about CDHP health plans, how much you use the health care system for medical services is very important for you to think about before you buy this type of health insurance plan.

Health Savings Account (HSA) Qualified Plans

HSA Qualified High Deductible Health plans can be explained as a specific group of CDHP health plans that have an up-front deductible and that allow you, if you want to, to pay for your health care expenses with tax free money. The money becomes tax free if you set up a special personal bank account, usually a checking account, which is called an HSA account; and pay your medical bills from that account. However, before you can open an HSA account, you must first have an HSA qualified health plan. In an HSA qualified health plan, the plan deductible applies to just about everything; doctor's office visits, prescription drug costs and hospital expenses. All HSA health plans include Wellness Care as a benefit, meaning that you will not have to pay for recommended wellness visits, such as physicals when you get them.

Many people confuse HSAs with other types of accounts, like Flexible Spending Accounts (FSAs), which many refer to at work as use-it or lose-it accounts. This is not the case with HSAs, as HSA accounts are personal accounts, and if you do not use the money during the year, it stays in your bank account until it is used tax free for medical expenses in the future. Because the HSAs are personal accounts, the bank accounts belong to you and not your employer; so if your employer puts any money in your account, it becomes your money.

The most confusing thing about HSA plans is all of the marketing materials about HSA programs talk almost exclusively about the HSA bank account; and talk very little about the health plan that you have to buy that makes you pay all your medical expenses before the health plan pays any medical expenses. When shopping, you need to look at the health plan that is the HSA Qualified health insurance plan, and decide if you can afford all the medical expenses that you have to pay first. The good things about HSA health plans are that they are less expensive and that you can pay for your expenses with tax free money.

Chapter 4

Universal or Single-Payer

Healthcare Systems

The Universal or Single-Payer Healthcare System is once again a major item of discussion when talking about the affordability of health insurance in this country. It will not be answered in this Chapter or this Book as it is a very complicated discussion.

Many look at the idea of a single-payer healthcare system as the “only” solution to all of the problems with our current health care system. It is important to know that there still exists a “Private Pay” health care system in many of the countries that have single-payer healthcare systems for those people that can afford to pay for services out-of-pocket instead of having to wait for care.

The idea that these single-payer systems work by limiting access to care, meaning longer waiting times for all medical treatments and the potential closing and consolidation of hospitals and clinics, is only partially true. In fact, today, in this country, many people wait a long time to get their medical care or see a specialist doctor. The reasons that these things happen is not just because the government runs the programs; otherwise our current system would be much better than it is today; and we would not be waiting as long as we do for many of the medical services that we need when we need those medical services.

The overall thing to consider is that a single-payer system is a “system” in these other countries. If you go to a public university to become a doctor, for free, you don’t have huge student loans to pay when you actually become a doctor. You then go to work for a government run hospital which means you do not need to worry about running an office or being sued, because you are working in a government provider network. The thing to think about is that we need to understand that single-payer systems are about more than just negotiating for better prices and guaranteeing everyone health insurance coverage. We need to look at “our system” and look at all the parts of our system if we decide to create a Single-Payer “system” in this country.

A current issue in this country is how much Medicare and Medicaid health care providers are paid by the government. Providers usually get paid a lot less than what it costs them to provide the medical service. The issue is that the private sector, meaning people with their own private insurance and people that get insurance from their employer, have to pay a lot more for their medical services in order to make it so that medical providers do not go out of business. This is a thing we need to make sure we pay attention to or the quality of care in our healthcare system will get worse, and doctors, clinics and hospitals will go out of business. It has become so bad in our country that some healthcare providers in this country are starting to not take health insurance anymore and are now “cash-only” providers of healthcare services. However, the other side of the argument being debated today is if the providers of health care services and products are making too much profit, or operating revenue in the case of non-profit institutions.

Part Two

Patient Protection & Affordable Care Act

"PPACA"

Overview

This section of the book is here to help you understand the basics of health care reform and how it will affect you and your business. It is important to note that many changes have already taken effect since 2010; and that the cost of medical care does not change much at this time. Health care reform is not a cure for health care cost control, just a step forward to try and control the cost increases of medical expenses; and a way to make coverage more affordable so that more people can have health insurance.

The greatest impact of health care reform will be on the middle class, meaning the average person that makes under $45,000 per year, or the 4-person family making less than $90,000 per year in Income. Health care reform will also significantly impact "Main Street" businesses, meaning the local "Mom-n-Pop" or local employer, especially Independent Contractors, because health insurance will be Guaranteed Issue and Federally Subsidized. Health care reform is not government insurance! Health care reform is private insurance that a person gets help in paying for when they buy it, based on their family income.

Individual States have the option of setting up their own Health Insurance Marketplaces, basically call centers and web sites where you can buy your health insurance; or letting the federal government set one up in their own State. Since you will have to purchase your health insurance through the Health Insurance Marketplaces in order to be able to get tax credits for your business and for your employees to get financial assistance to buy health insurance from the federal government, if they do not buy their health insurance through your company; it is important that you pay attention to how your State decides to set up its own Health Insurance Marketplace.

Chapter 5

Health Plan Benefits Overview

PPACA became a new law back in 2010 and it started a series of changes in the way health insurance will be purchased by businesses, individuals, families and everyone else in the country. The biggest changes will take effect on January 1, 2014; which is when everyone is guaranteed to be able to buy health insurance whether they are sick or healthy; and that individuals and families may even be able to get help paying for their health insurance from the federal government. Small business owners with fewer than fifty (50) employees have also had a tax credit available to them if they provide health insurance to their employees through 2015. The health insurance plans available will be offered under simpler and new “Metal Plan” categories, such as Silver & Gold. The goal of PPACA is to get everyone health insurance at a price that each person or family can afford to pay based on their own or their family’s income.

One important thing that seems to be lost in the debate is that you will be purchasing a “private” health insurance plan, just as you do today. You are not buying a health insurance plan from the government. The main difference is that you will have another place where you can buy health insurance, a Health Insurance Marketplace. You may even receive a tax credit for providing your employees with a health insurance plan. The tax credit has been available since 2010; but starting in 2014, it will only be available if you purchase your health insurance plan for your employees through the Government Health Insurance Marketplace.

Federal government assistance for purchasing insurance is not a new concept; as most farmers’ today buy federally subsidized crop insurance from private insurance companies with financial assistance from the federal government; so that if they lose their crops, they can still get some money from their insurance company and hopefully not lose their farm to debt collectors.

There are other major changes to health insurance plans that will be sold in the country. The federal government has created a list of minimum medical benefits that must be covered by a health insurance plan anywhere in the country; and added many other options that help people get and keep health insurance coverage. Some examples of new changes are; 1) everyone is guaranteed to be able to purchase a health insurance plan no matter how healthy they are at the time; 2) kids can stay on their parents health insurance plans until they are 26 years old; 3) health insurance plans will be sold on a “community rate” basis, which means no more different rates for men and women; and age brackets will be in one-year increments; and 4) if a state allows it, an insurance company can charge a smoker up-to 50% more for their health insurance than the rate they charge a non-smoker.

A very important new change is the creation of Essential Health Benefits. Basically, Essential Health Benefits (EHB’s) are a list of medical services that the federal government says must be covered in every health insurance plan that someone buys after January 1, 2014, which are the minimum required medical benefits covered by a health insurance plan. A health insurance plan can cover more than these minimum covered benefits, but the health insurance plan cannot cover fewer than these minimum covered benefits. In addition, each State can decide whether or not they want more

benefits to be covered before an insurance plan is sold in their state. Therefore, it is important that each state decides early if they are going to require health insurance plans sold in their state to cover any additional benefits or medical services for the people that live in their state.

Essential Health Benefits

1. Ambulatory Services, like Out-Patient Surgery.
2. Emergency Services, like Emergency Room Care.
3. Hospital Care.
4. Maternity and Newborn Care.
5. Mental Health and Substance Abuse Care, including Behavioral Care.
6. Prescription Drugs.
7. Rehabilitative and Habilitative Care.
8. Laboratory Services.
9. Preventive and Wellness Care, including chronic disease management.
10. Pediatric Services, including Dental and Vision Care for kids.

Medicaid Changes

Medicaid is also expanded by PPACA. For Medicaid; the major change is the expansion of Medicaid Eligibility from 58% of Federal Poverty Level (FPL) income to 133% of FPL income. The 100% level of 2012 FPL for a family of 4 is approximately $23,000 in income, and for an individual, it is approximately $11,000 in income. This will also mean that people that are eligible for both Medicaid for Medicare will now qualify for additional financial assistance through Medicaid. Medicaid will also begin to cover Preventative Care; such as Annual Physicals and Immunizations at no cost.

Individual Federal Medicaid Eligibility Annual Income:

Currently Maximum Annual Income (est.) $ 6,400
New Maximum Annual Income (est.) $ 14,600

Family of Four (4) Federal Medicaid Eligibility Annual Income:

Currently Maximum Annual Income (est.) $ 13,300
New Maximum Annual Income (est.) $ 30,600

Important: If your state provides Medicaid to people with higher incomes than above, you need to check and see if your state is planning to change to the new Federal income level in the table above; or, what the state plans on doing after January 1, 2014 when the above changes go into effect. Some states that allow for people to make more money than the current Federal income level above are actually considering making the Medicaid eligibility income the same as the new Federal incomes.

What this would mean is that if some of your employees currently have Medicaid, they could lose their Medicaid coverage and may then have to enroll in the health insurance plan that is offered to them through your business; and you may end up with more people enrolled in your business health insurance plan than you have today. However, if your business health plan is still too expensive for your employees; your employees may still be able to get financial assistance to purchase their own health insurance plan through the employee's home state Health Insurance Marketplace.

Chapter 6

Metal Tier Health Plans

Explanation

The types of health insurance plans you will purchase are being renamed and placed into categories based on how good the health insurance benefits are in each category or "Metal Tier". They are called Metal Tiers because the tier names are based on the names of actual metals; Platinum, Gold, Silver and Bronze; just like the Olympic Medals. The health plans with the lowest copayments and the best benefits are placed into the Platinum Tier; and the basic plans that have a lot of out of pocket expenses on your part and cover the minimum required benefits, will be the plans on the Bronze Tier.

The health plans you purchase today will be placed into one of these tiers along with the many health insurance plans that will be offered in the future. The tiers are based on something called "Actuarial Value" (AV), which is a term comparing how much a person is expected to spend every year on medical services and how much of the medical expenses a person pays out of their pocket. You can think of it as, if you are expected to have $10,000 in medical expenses in a year; a Gold Plan will pay for 80% meaning $8,000 of your medical expenses and you will pay for the other 20%, meaning $2,000.

What does all this mean in actual dollars; no one is really sure at this point in time. This is one of those items that will be figured out between now and October 1, 2013, by states and their Health Insurance Marketplace's. Basically; the general description is:

Metal Tier is based on Actuarial Value (AV)

Platinum Tier Plans pay 90%
Gold Tier Plans pay 80%
Silver Tier Plans pay 70%
Bronze Tier Plans pay 60%

There will also be a limit as to how much each person and each family will spend on Out-of-Pocket expenses based on In-Network medical expenses. The maximum annual out-of-pocket expenses during the year for individuals and families that have a health insurance plan is based on each persons and each family's annual income and is limited to the current HSA health plan limit: estimated at $6,500 for a person and $13,000 for family in 2014.

The minimum required health plan that a small business owner can offer their employees will be a Bronze Tier health plan. The Bronze Tier plan appears to be the most similar to what people have today based on general market research. The Bronze Tier plan may actually be better coverage than most people have today because the new health insurance plans have minimum required Essential Health Benefits (EHB's).

Special Silver Tier Alternative Plans

There will be three additional Actuarial Value health plan options for people that have incomes of between 100% of the FPL and 250% of the FPL. These additional options are available so that people with lower incomes can get a better health insurance plan and still get the federal subsidy when they are buying a health insurance plan through the Health Insurance Marketplace; because a person needs to buy a Silver Tier health plan or better in order to get financial assistance to help them pay for the health insurance plan. These three alternate health insurance plan options are only available for people with lower incomes. These health insurance plan options have lower cost-sharing or lower co-payments; and lower maximum annual out-of-pocket expenses.

The Alternate Silver Plans are cost-reduction health plans and are as follows:

100-150% of FPL = 94%, similar to Platinum Plan
150-200% of FPL = 87%, similar to Gold Plan
200-250% of FPL = 73%, similar to Silver Plan

Basically, these three alternate Silver Tier health plan options give people with lower incomes a lower amount of money that they have to spend out-of-pocket on their medical expenses. If you refer to Appendix A and the page titled “Examples of Alternative Silver Tier Plan Benefits”, you will see examples that were created using the Actuarial Value Calculator available online from CCIIO (The Center for Consumer Insurance & Information Oversight). A link to the CCIIO web site and Calculator is provided in Appendix B.

Chapter 7

The Individual Mandate, Penalty & Your Employees

A major part of PPACA is the requirement that everyone must purchase health insurance or pay a penalty, or a tax as it has been renamed. The simplest point, and one example, that can be made in this extremely complicated area of health care reform and the mandate to buy health insurance is this: when we talk about covering cancer treatments as a mandated health insurance benefit; it is not the treatments we are talking about, but the fact that the treatments are saving people's lives, including children. Currently, there are many mandates placed on health care providers; such as hospitals having to treat uninsured patients and Medicare enrollees having to purchase Medicare Part D. If all mandates were to be eliminated; health insurance companies would realistically only offer health insurance plans that covered only very low risk health issues and all healthcare would be pay-as-you-go non-covered benefits. The reason is that health insurance is really not "insurance" as we think of insurance, which is normally just a back-up in case something goes wrong as in the case of a car accident or a home fire. Health insurance as we think of it today is really a health care program that provides benefits that we plan on using on a regular basis.

The "penalty" for not buying health insurance is what many people are talking about at this time. The penalty looks at how much the lowest cost Bronze Tier health insurance plan will cost, since it is the minimum level of health insurance plan that one is required to buy. If the cost of the minimum available Bronze Tier health insurance plan is more than 8.05% of household income, one does not have to pay a penalty.

Important: If one is eligible for a Subsidy, financial assistance, that makes it so that one can buy a health insurance plan through a Health Insurance Marketplace for less than 8.05% of household income, one will most likely be subject to the penalty. This means that if household income is 250% of Federal Poverty Level or below; one will probably have to pay a penalty if one does not buy health insurance.

The annual penalty is "the greater of" 1% of family income or $95 per adult and $47.50 per child, up-to $285, in 2014. In 2015, it is the greater of 2% of family income or $325 per adult, up-to $975. Beginning in 2016, it is the greater of 2.5% of family income or $695 per adult, up-to $2,085.

It is important to note that the penalty is calculated and charged when one does their taxes for the year one was supposed to have health insurance coverage. For example, when one does their taxes for 2014 at the beginning of 2015; that is when one will be charged the penalty, if one owes a penalty.

Chapter 8

Government Subsidies & Your Employees

{For employees that buy Individual health insurance plans.}

The goal of health care reform is to get everyone to be covered by a health insurance plan at an affordable price, so that everyone is paying their fair share based on their own or their family's income. If one makes between 133% and 200% of FPL (Federal Poverty Level); each State has the option of offering what is called a BHP (Basic Health Plan) that is run by the State. It is not expected that most States will offer BHPs unless they are low healthcare cost States because the State may have to pay for some cost of the offering the BHP. The 100% adjusted gross income based on the FPL for a family of 4 is approximately $23,000 in income, and for an individual it is approximately $11,000 in income; both are based on 2012 income standards. This means that a family of 4 with annual income under $46,000 could qualify for the BHP, if the State in which they live offers a BHP. Otherwise, they can buy a health insurance plan through a Government Health Insurance Marketplace and get help from the federal government to pay for part of the monthly cost of the health insurance plan.

The following table provides a guideline on how the Premium Credit subsidy will be calculated, and is based on household income. Basically, this means that it shows approximately what one will pay for a health insurance plan through a Health Insurance Marketplace. The subsidy is based on the 2nd lowest cost Silver Plan that one can buy on their State's Health Insurance Marketplace. There is also a Cost Sharing subsidy based on what one actually spends that will help a person or a family that has income that is between 100% and 250% of FPL, so that the annual maximum Out-of-Pocket expenses will be even lower than the standard Silver Tier plan. *In order to get the federal subsidy that helps one pay for their health insurance, one must purchase their health insurance plan through a Government Health Insurance Marketplace!*

What will one pay for health insurance? It depends on household income.

Family Income		Maximum Cost of Health Insurance
100% - 150% FPL	=	2.00% - 4.00%
150% - 200% FPL	=	4.00% - 6.30%
200% - 250% FPL	=	6.30% - 8.05%
250% - 300% FPL	=	8.05% - 9.50%
300% - 400% FPL	=	9.50%*

*The 9.5% number is important for Employer and Financial Assistance Eligibility.

Estimated Monthly Health Plan Cost
(Based on 2012 FPL Income)

Monthly Health Plan Cost for an Individual:

100% or $ 11,000/yr = $ 20
150% or $ 16,500/yr = $ 90
200% or $ 22,400/yr = $ 120

250% or $ 28,000/yr = $ 190
300% or $ 33,500/yr = $ 265
400% or $ 45,000/yr = $ 355

Monthly Health Plan Cost for a Family of Four:

100% or $ 23,000/yr = $ 40
150% or $ 34,500/yr = $ 185
200% or $ 46,100/yr = $ 240
250% or $ 57,600/yr = $ 390
300% or $ 69,150/yr = $ 550
400% or $ 92,200/yr = $ 730

In addition, all of these qualified health insurance plans will have Maximum amount of Out-of-Pocket expenses for Individuals and Families that are covered by the health insurance plan and it will based on the HSA limits for you or your family. In 2014, the HSA limits are expected to be $6,500 for Individuals and $13,000 for Families. However, individuals and families with lower incomes will have lower out-of-pocket maximum expenses. In the table below, an estimate of those Maximum-Out-of-Pocket or MOOP expenses is listed by income level.

Family Income and Estimated MOOP
(Based on 2012 Income Limits)

100%-200% FPL = $ 1,983 Individual / $ 3,967 Family
200%-300% FPL = $ 2,975 Individual / $ 5,950 Family
300%-400% FPL = $ 3,987 Individual / $ 7,973 Family
Over 400% FPL = $ 5,950 Individual / $ 11,950 Family

IMPORTANT: If a person is eligible for Medicaid; they will probably have to enroll in Medicaid; and not be able to get a subsidy!!! In addition, if a person applies for a subsidy, their children may have to enroll in Medicaid. Otherwise, they buy a full price health insurance plan.

If an Employer Offers a Health Insurance Plan

If an employer offers a health insurance plan and the cost of the health insurance plan, based on the employee-only cost of the health insurance plan, is less than 9.5% of an employee's income, see table above; the employee cannot get a federal subsidy to help them pay for a health insurance plan for themselves or their family through a government health insurance marketplace. *{IRS Safe Harbor Rule – ask CPA}*

If an employer offers a health insurance plan and the cost for the employee-only portion of the health insurance plan, based on the employee-only cost of the health insurance plan, is more than 9.5% of an employee's income, see table above for 400% of FPL income; an employee does not have to buy their health insurance plan through an employer. This means that an employee can turn down the employer's health insurance plan, and still go to the government health insurance marketplace and get financial assistance from the federal government to buy a health insurance plan for themselves and their family.

Example:

Employee Only Health Plan Cost = $ 400 per month
Employee Only Cost Share of Employee Only Health Plan = $ 200 per month
Employee Only Monthly Income = $ 2,000
Cost of Employee Only Health Plan based on Employee Only Income = 10.00%

Result:

Employee is Eligible to buy a health insurance plan ***for themselves and their family*** through a government run health insurance marketplace and get financial assistance from the government because the cost of the health insurance plan to the employee through the employees employer is more than 9.5% of the employees income.

Important: If the cost was less than 9.5% of the employees income for the employee own health plan option; neither the employee or their family could buy a health insurance plan through a government health insurance marketplace and get financial assistance to purchase the health plan based on the family household income.

The Smoker versus the Non-Smoker *(Optional)* Charge

The law allows for insurance companies to charge smokers up-to 50% more than what a non-smoker pays for the exact same health insurance plan, as long as the state allows it; and most states are allowing the 50% mark-up.

The financial assistance that you get to buy insurance from the government is based on the non-smoker rate; so the 50% mark-up is 100% paid by you.

Chapter 9

Small Business Tax Credit & The Employer Mandate

Small Business Tax Credit

Small Employers have been eligible for a "tax credit" since 2010, and continue to be eligible in 2014 and in 2015. However, starting in 2014, in order to get the tax credit, an employer will have to purchase their health insurance plan through a Government Health Insurance Marketplace. The tax credit can be filed for in arrears or as a carry- forward; and you should discuss this with your accountant. Non-Profit organizations also qualify for special tax credits and rebates and should discuss this with their tax advisor; and their tax credit is refundable through payroll tax, and can be up-to 35% of the non-profit's cost-share of the health insurance plan cost.

For small employers, the tax credit can be up-to 50% of the employer's cost-share of the health insurance plan cost. It is on a sliding scale with the credit being eliminated once an employer has more than 25 employees and/or the average wage of the employees is $50,000 or higher. For example; an employer with fewer than 10 full-time equivalent (FTE) employees and an average wage that is under $25,000 is eligible for the full tax credit. This is something that you need to discuss with your tax advisor.

Important Definition: In calculating the average wage; ALL the owners and their Family members are excluded from the average wage calculation.

The tax credit is based on the number of Full-Time Equivalent (FTE) employees. Therefore, you should work with your CPA and/or payroll service to calculate your actual number of FTE's. In general, a rough estimate for converting part-time employee hours to full-time equivalent employees is to divide the total number of hours worked by part-time employees in a year by 2,080 hours.

The Employer Mandate

This section of the book only provides a general overview of the Employer Mandate. It does not get into all the nuances of the mandate and its impact on employers. The goal here is to provide a general overview of the mandate and allow you to have a discussion with your advisors about how to best address the business issues associated with the mandate. As a business owner, you are fully aware that offering health insurance benefits is not just a black-and-white financial decision for your business. Employers invest a lot of time and money in recruiting, retaining and motivating employees that help you operate and grow your business. However, what will become immediately noticeable to you is that you and your CFO, along with your HR manager and health insurance advisor, will most likely now become an integral part of the decision on whether or not to offer health insurance and how you will actually structure the health insurance program.

In a simplistic explanation; the employer mandate states that any employer with over 50 Full-Time-Equivalent (FTE) employees must offer "Affordable" health insurance coverage to their full-time employees or pay a "Penalty" for not offering their full-time employees affordable health insurance coverage at work.

A small employer with fewer than fifty (50) full-time-equivalent employees is *exempt* from the employer mandate of having to offer health insurance coverage to employees *and* the associated penalties. This means that these employers do not pay penalties if they do not offer employees affordable health insurance through their business.

Definitions: *(please verify with CPA as things may change)*

Full Time Employee = 30 hours per week for over 6 months of the year
FTE Conversion for Part Time Employees = (Total # of PT Hours Worked) / 1,440
FTE Calculation = # of FT Employees + # of Full-Time Equivalent Employees

Affordable Health Insurance Coverage

- A Bronze Tier Level (60% AV) or higher qualified health insurance plan.
- Employee cost-share is less than 9.5% of employee income
    - Cost-share is based on EE Only Cost of the EE Only Plan Option
        - See Chapter 8 for an Example
        - Speak with your CPA about the IRS Safe Harbor Rules

The Penalties

In July 2013, it was announced that there would be no enforcement of the Employer Mandate in 2014; meaning employers will not have to pay penalties in 2014. However, the Employer Mandate still exists.

For employers, there are two scenarios that are being widely discussed by the media and health insurance advisors. Generally speaking, most have probably heard of the "Pay-or-Play" acronym. This scenario is simply an extreme analysis of the financial decision that an employer must make under health care reform due to the employer mandate. However, as mentioned earlier, employers have businesses to operate and grow, and employees and employee benefits are not solely a financial decision.

As an employer, generally speaking; you have two penalties that you will be analyzing when you make the decision as to whether or not to offer health insurance benefits to your employees; and how you will offer those health insurance benefits.

An employer will have to pay *"the lesser-of"* one of the two penalties explained below; and please keep in mind that these are subject to change, so please confirm with your CPA and other advisors. The penalties are listed as *Annual* penalties; however, it is expected that they will be enforced on a *Monthly* basis, starting in 2015.

If an Employer does NOT offer affordable coverage:

If just one (1) Full Time employee purchases health insurance through a Government Health Insurance Marketplace ***and*** receives financial assistance, the Employer will have to pay a penalty. The penalty will be $2,000 per FT employee, less the exemption for the first 30-employees.

Sample Calculation: {# of FT employees – 30} x $2,000 = Annual Penalty

If an Employer Offers affordable coverage:

For *each-and-every* Full Time employee that purchases health insurance through a Government Health Insurance Marketplace ***and*** receives financial assistance, the Employer will have to pay a penalty. The penalty is the *"lesser-of"* $3,000 per employee; or the maximum penalty for not offering affordable health insurance.

Sample Calculation: *{Employer pays the lesser-of the two calculations; tentatively, on a monthly basis.}*

Penalty A: {# of FT employees – 30} x $2,000 = Annual Penalty
Penalty B: {# of FT employees getting financial assistance} x $3,000 = Annual Penalty

Chapter 10

Health Insurance Marketplaces

{Originally referred to as Health Insurance Exchanges}

Government

Individual States are in the process of setting up what are called Health Insurance Marketplaces. Basically, Health Insurance Marketplaces will be call centers and web sites where one can buy their health insurance. They will simply be another store one can go to where one can compare and buy health plan insurance plans knowing that all the health plans cover the same minimum required medical benefits. The main difference in the price that one pays for the health insurance plan will be what one pays when you use the health insurance plan at the doctor, hospital, pharmacy, etc.

One will still be able to work with an insurance agent or sales representative to purchase a health insurance plan like many people do today. There will also be newly created types of certified people that will be able to help one on a local level sign up for the new programs that will be called Navigators and In-Person Assisters (IPAs).

After January 1, 2014, anyone can buy insurance without having to worry about pre-existing medical conditions either directly from an insurance company or through a Health Insurance Marketplace. In some States, there will be two types of Health Insurance Marketplaces; one for individuals and one for small businesses. Since one will have to purchase their health insurance through the Health Insurance Marketplaces in order to get any type of financial assistance from the federal government; it is important that one pays attention to how their State sets up its own Health Insurance Marketplace.

If your State does not set up its own Health Insurance Marketplace; then the Federal Government has the right to set up its own program in your State. This is important to know because all the States have differences in the medical benefits that they make health insurance plans pay for in the form of additional required State mandated benefits. These additional State mandated benefits are in addition to the federally required Essential Health Benefits; and are usually specific to each and every State and put in place by each State to address local community medical issues.

If a State lets the Federal Government set up and run the Health Insurance Marketplace for them, then the health insurance plans that are sold through that particular marketplace may not cover the same medical benefits as health insurance plans that are sold outside of the marketplace. This means that some people may not be getting some of the State specific health plan mandated benefits that they get today.

Private

Private Health Insurance Marketplaces are fairly common today. A private health insurance marketplace is basically a marketplace for insurance. Private marketplaces are operated by some associations or organizations in order to provide their members with an alternative to buying insurance on the open market.

There are some brokers that set up their own private marketplaces for their clients, and they can be set up for individual or business clients. The idea is that if a group has a lot of people enrolled or enough groups combined have a lot of people enrolled through the private health insurance marketplace; the marketplace may be able to get better pricing or at least offer different health insurance coverage options than are generally available in the open market.

Private health insurance marketplaces should continue to exist and even expand after October 1, 2013, when the government health insurance marketplaces start to open. They are seen as a being able to operate alongside and even support the government health insurance marketplaces. Individuals should even be able to access the government health insurance marketplaces through a private health insurance marketplace, meaning that individuals should still be able to purchase health insurance plans and still get financial assistance from the government for buying their individual health insurance plans as these private marketplaces are expected to be able to work with the government marketplaces.

The main difference will be that the private marketplaces should have more options, including different types of insurance; and be able to show people health insurance plans that are available through the private marketplace as well as the health insurance plans that are available through a government, State of Federal, health insurance marketplace with or without financial assistance from the government.

Part Three

How to Shop for

Small Business Health Insurance

Overview

This section of the book is the shopping guide. In has a brief explanation on how to pick a health insurance plan; some basic situations with possible solutions; and has some sample health insurance benefit plan designs. The sample metal tier benefit plan designs are included in Appendix A that follows the shopping guide. The plan designs are there in order to help you have a talk about the health insurance plan you want to buy or help you better understand the health insurance plan that you want to buy.

In general, the things that you want to think about when you are buying a health insurance plan are; how is this health insurance plan going to affect my employees; can my employees understand and manage the co-payments or deductibles on some or all of the medical services that they will need to use once they have the health insurance plan. The important thing to think about when you make your final decision is to make sure the health insurance plan is affordable for you and your employees. If the health insurance plan is unaffordable for you or your employees, it may not make sense to offer health insurance to your employees. Since you are the buyer, you are the person responsible for making sure you get the right health insurance plan, because you have to live with any issues that it may create between you and your employees. The sales representative is there to help you, but you need to ask the questions.

Remember; the health insurance plan designs and solutions being provided in this book are a guide that can help you; so that you can have a direct talk with a knowledgeable advisor or sales representative when you are shopping for health insurance.

Chapter 11

Overview:

How to Pick a Health Insurance Plan

Buying Insurance under PPACA

As of January 1, 2014, many changes will take effect as part of health care reform, also known as PPACA. These changes will greatly impact your decision on whether or not to offer health insurance through your business to your employees or let your employees purchase their own health insurance plan directly through a Government Health Insurance Marketplace, where they may qualify for financial assistance toward the purchase of their individual or family health insurance plan. The new and the current health insurance plans you offer will also be placed into categories or tiers referred to as "Metal Plans", discussed in an earlier chapter. This chapter of the book assumes an understanding of items discussed in earlier chapters.

An important thing to consider is that you will be buying a "private" health insurance plan as you do today; not a health insurance plan from the government. A major difference is that, currently in some states, an employer can be charged more than the standard rate or denied coverage if they have employees that have health issues like pre-existing conditions. Some other differences are that all new health insurance plans will have to offer a national minimum standard of medical benefits that must be covered by the health insurance plan. The way in which the health insurance plans are priced will also be different than today. Health insurance plans will be "community rated", meaning male and female rates will go away; there will be one-year age bands; the rate between the lowest cost person in a plan to the highest cost person in the same plan is limited to a 3 to 1 ratio; and only a few modifications to the price are allowed, such as regional cost factors and tobacco use. The law does allow for charging smokers up-to 50% more than non-smokers for the same health insurance plan.

If you are a small employer with fewer than fifty (50) full-time-equivalent employees, you are <u>*exempt*</u> from the requirement to provide health insurance coverage to your employees <u>*and*</u> not subject to the penalties. The bottom line is that what basically changes for you is that you will have more options for providing health insurance to your employees or to help them get their own health insurance plan. You will be also able to purchase your health insurance plan from an insurance company or through a Health Insurance Marketplace; and, you should still be able to use a health insurance agent. If you purchase your health insurance plan through a Health Insurance Marketplace, you may be even eligible for a Tax Credit for your 2014 and 2015 tax years.

<u>Note:</u> Starting in 2014, employers will have to pay for each member enrolled in the health insurance plan. For small employers that have been used to EE Only, EE+Sp, EE+Ch and Family rates, this rate structure will no longer be available, unless you can get approval for Composite Rates, typically how large employer plans are priced.

The pricing of health insurance plans will be based on each person enrolled in a health plan by adding up the age-based rate for each person. The way it expected to work is that you would add the rate for the employee based on their age, plus the rate for the spouse based on their age, plus the rates for up-to the three (3) oldest children age 20 and under based on their ages, plus the rate for each and every young adult on the

parents health plan between the ages of 21 and 26. As one can quickly see from this explanation, it will be difficult to calculate health insurance costs for each employee; and, for those with large families, the health insurance plan could be expensive.

For all employers, the main question you will have to answer is will you offer health insurance through your business or let your employees purchase their health insurance on their own? Note that if your employees cost of their portion of the health insurance plan for themselves is greater than 9.5% of your employee's income; the employee can opt-out of your employer plan and still enroll in their own health insurance plan through a government health insurance marketplace and still qualify for financial assistance to help them buy their own health insurance plan. However, if your employee's portion of the cost of the company health insurance plan for themselves is less than 9.5% of their income; they will not be able to get financial assistance for themselves or their families; since you are offering them affordable coverage as their employer.

When you are considering which health insurance plan to pick for you and your employees, you need to think about; how is this health insurance plan going to affect my employees; can my employees understand and manage the co-payments or deductibles on some or all of the medical services that they will need to use once they have the health insurance plan. The important thing to think about when you make your final decision is to make sure the health insurance plan is affordable for you and your employees. If the health insurance plan is unaffordable for you or your employees, it may not make sense to offer group health insurance to your employees. In reality, after January 1, 2014, when individual health insurance plans are guaranteed issue and employees can buy individual health insurance plans with financial assistance from the government; the best solution for you and your employees may be to not offer a group health insurance plan and let your employees buy their own health insurance plans through a Health Insurance Marketplace.

You will also need to consider what benefits your employees may need; how much you and they will pay for the health insurance plan; and how much they will pay when they use the health insurance plan at the doctor, pharmacy, hospital, etc. If you are worried about keeping what you pay for the health insurance plan low, then they must pay more when they go to the doctor, pharmacy, hospital, etc. Basically, the less they pay when they get medical care, the more you pay for the health insurance plan, and vice-versa.

There are examples of health insurance plans that are included at the end of this book; Health Plan A through Health Plan D, and are placed in order from the most expensive plan (Health Plan A – Platinum Tier Plan) to the least expensive plan (Health Plan D – Bronze Tier/HSA Qualified Plan). This should help you to understand that the cost of a health plan is based on how much someone pays when they go to the doctor, pharmacy, hospital, etc. The approximate Metal Tier or category that the health insurance plans may be assigned to is also noted under the title.

The most common health insurance plans that most people are familiar with today are the health insurance plans that have co-payments for all of the medical services that are used on a regular basis, like at the doctor's office and at the pharmacy. Sample Health Insurance Plan A is an example of this type of health insurance plan. In general, the lower the co-payments, the more a health insurance plan costs, and vice-versa.

The CDHP, HDHP and HSA qualified health insurance plans tend to be less expensive because you are buying a health insurance plan that has a person pay a lot of their medical expenses before the health insurance plan starts paying for any part of their medical expenses. Some of these health insurance plans have a person pay all the medical expenses first for only one type of medical service, like at the hospital only; and other types of these health insurance plans have a person pay for all their medical and prescription drug expenses before the health insurance plan pays for any part of the persons medical expenses.

HSA qualified health insurance plans allow a person to set money aside tax free in an HSA bank account for their medical expenses; but these plans require that a person pays almost all of their medical expenses first. A person needs to set up the HSA bank account to get a tax break; and they get the tax break just for depositing the money into the bank account, whether or not they spend it on qualified medical expenses today or in the future; so there is no reason not to set up the bank account.

If you are an employer that has been trying to lower your health insurance plan costs, you may have changed your health insurance program to one of these programs that has deductibles on many of the medical services your employees use in order to save money on the health insurance plan. If you are an employer that has not yet made this type of change, then it is one you should consider when trying to lower your health insurance plan costs. The most common way of transitioning from health insurance plans with low co-payments to health insurance plans with deductibles that cost less than health insurance plans with co-payments is by using a HRA (Health Reimbursement Arrangement) as the method of transition. It is very important that you know your employees; how they will react to switching to a health insurance plan with deductibles; and that you provide them with a lot of education about how the health insurance plan will work; and how it will affect them and their families, before making the change to your health insurance plan.

The HRA transition method is an optional employer plan. In other words, you, the employer, decide how the plan is set up and how it works for your employees. The main thing that most companies do is hire a third-party company to administrate the program at what is usually a nominal fee. The fee is worth it in most cases because of HIPAA regulation and liability issues. Typically, an employer chooses to provide a reimbursement to an employee to help with some medical expenses through the HRA; and it is best that the employer not know what the employee or their family members were treated for at any time.

A newer type of employer health plan that many employers are converting to is called a Defined Contribution (DC) health insurance program that is typically used with a Premium Reimbursement Arrangement (PRA). The way to think about this approach is that it is similar to how Pension funds were converted to 401k's, years ago. As an employer, you decide how much money you will give your employees per month toward the purchase of their health insurance plan; and the employees buy the health insurance plan of their choice through the businesses DC plan. Employees would then decide whether to get health insurance through the business with the pre-set funds or opt-out of the health insurance coverage through the company.

The alternative to offering a group health insurance plan through the business, which will be viable when all Individual health insurance plans are guaranteed issue and there are government subsidies available for people to buy their own health insurance plans through a government health insurance marketplace; is for an employer to let employees buy their own Individual health insurance plans. If employees and their families earn less than 400% of the Federal Poverty Level; they will be able to purchase a health insurance plan through a government health insurance marketplace with financial assistance from the government for themselves and their families. This may actually make the health insurance plan cost less for the employee and their family, even without any employer contribution toward the cost of the health insurance plan.

In essence, if an employer offers health insurance though the business to their employees, an employer may actually be creating a financial hardship for the employee by causing them to lose the government subsidy that would have helped the employee pay less for a health insurance plan than the employer is charging the employee for themselves and their family!

In summary, you need to think about what is best for your business when you are shopping for a health insurance plan. You need to know what, if any, trade-offs you are willing to make when you are ready to buy your health insurance plan. For example; do you want a health insurance plan that makes your employees pay all their medical expenses first; or do you want a health insurance plan that pays most of their medical expenses when they go to the doctor, pharmacy, hospital, etc., so that they have very low co-payments? It is important that you do not rush into a decision, and be honest with the sales representative or person that is certified to help you choose a health insurance plan; because, in the end, you are the one responsible for picking the health insurance plan that your employees will be enrolled in and any issues that may occur later on if the employees or their families are not happy with the health insurance plan.

The last chapter of this book will give you some ideas on how to make a decision to purchase a health insurance plan for your business. However, please keep in mind; they are general situations and your situation is always unique.

Chapter 12

Defined Contribution Health Plans

&

Premium Reimbursement Arrangements

Defined Contribution Plans

Defined Contribution (DC) health insurance plans or programs are a relatively new approach to changing company health insurance programs from employer based health insurance plans to individual health insurance plans. The best way to think of this is by looking at retirement plans. Years ago, companies had Pension plans for their employees to support them in retirement. However, today, most companies have 401k plans and employers usually contribute to each employee's 401k either a fixed amount or some type of matching funds based on what the employee contributes to their 401k plan. The difference is that instead of having to guess how much money needs to be available in the future to pay someone a pension; an employer puts money into the 401k plan today and does not have to worry about a payout in the future. This is basically how the Defined Contribution plans for health insurance work. An employer gives an employee a fixed amount of money, if any, in order for an employee to buy their health insurance through the employer's business.

The DC programs will require that employers create and maintain the proper and necessary legal documentation that must be kept on file, and should probably use a third-party administrator to consult on or administer the DC program. The plan documentation is important as it is defines how the program will operate and makes the program compliant with tax laws which should allow for the pre-tax distribution of the funds. The DC programs can be used with either group health insurance plans or individual health insurance plans.

The impact of DC plans will be seen after January 1, 2014, when health care reform starts and all individual health insurance plans will be guaranteed issue. The reason for this is that once a person can buy a health insurance plan either through an employer or on their own on a guaranteed basis whether or not they are sick; then there will be many more health insurance purchasing options for business owners and individuals.

Premium Reimbursement Arrangements

Premium Reimbursement Arrangements (PRAs) can basically be seen as an employee version of an employer Health Reimbursement Arrangement (HRA). In this case, an employee is paying for part or all of the cost of their own individual health insurance plan on a pre-tax basis just as they do today when paying for their employee portion of their group health insurance plan through payroll deduction. The PRA is an option when an employer offers a Defined Contribution (DC) health insurance plan; and allows for an employee to keep paying for their own individual health insurance plan on a pre-tax basis, which also saves the employee and the employer on payroll taxes such as FICA, FUTA, etc. The main thing to keep in mind is that the individual health insurance plan and the PRA are personally owned employee plans and funds.

One important item to note is that, if an employee buys an individual health insurance plan though a government health insurance marketplace after January 1, 2014, and gets a subsidy, meaning financial assistance, to buy their individual health insurance plan; the employee cannot pay for their individual health insurance plan on a pre-tax basis through a DC-PRA because they are getting a subsidy.

Chapter 13

Examples of Situations

& a Possible Solution

This chapter of the book is here to assist you in your conversations with your health insurance agent, advisor or sales representative when you are purchasing a health insurance plan for your business. The situations presented are example situations and thoughts on a possible solution are provided with the reason why that solution may be a possible solution. These examples are here to help you make a decision, but please be careful and make sure you speak to a professional before making your final decision as these are just examples. Your situation may look like one of these situations, but everyone's situation is unique.

The example situations are for Small Employers with fewer than fifty (50) full-time equivalent employees that normally have a more difficulty getting assistance than larger employers. The possible solutions have their own title in bold and the explanation under the title. Please note, you can read each and every situation on its own; so you can skip around and read them each on their own.

For larger employers, those with over fifty (50) full-time equivalent employees; it is recommended that you consult with your financial and tax advisers, as well as health insurance brokerage firms and brokers that have experience helping larger employers address the more complicated needs of larger employers and their employees.

Important Notes:

(1) The Employer Mandate was not eliminated for 2014. However, there will be no financial penalties issued; meaning it will not be enforced in 2014. Large employers should view 2014 as a test-year, and try to design and implement a program to help them address the penalties in 2015.

(2) Employers should discuss the IRS Safe Harbor Rules issued by the IRS with their appropriate advisors. The rules more clearly define the "affordability" rule and have significant impacts on employees and their families.

(3) If an employer offers a health insurance plan though the business to their employees, an employer may actually be creating a financial hardship for an employee by causing the employee to lose the government subsidy that would have helped the employee pay less for their health insurance plan through a health insurance marketplace than the employer is charging the employee for their and/or their families cost of a health insurance plan through the business.

(4) Employers should consider setting up a Defined Contribution (DC) health insurance plan with a Premium Reimbursement Arrangement (PRA), and let employees buy their own personal health insurance plans through the business before deciding not to offer health insurance at all starting Jan 1, 2014.

We are a Mom-n-Pop and/or Family Business.

If you are a business that employs mainly family, you may want to still purchase your insurance through the business for everyone in order to save on taxes. Otherwise, each person can buy their own health insurance plan; since after January 1, 2014, a person can not be turned down or charged extra for health insurance for being sick or having existing medical issues. However, this is a decision that you will need to make with your accountant, because it depends on the type of business entity that you have in order to be eligible to deduct the expense of the health insurance from your taxes.

If you are a business that has employees that are not family members and you have fewer than 50 full time equivalent employees, you should work with a health insurance advisor as well as your accountant in order to figure out if you should offer health insurance benefits through your business. The law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan that any of you buy must be bought through a Health Insurance Marketplace.

I am an Independent Contractor.

If you are a person that works on their own as an Independent Contractor, you are considered self-employed. This is a very common way that many people work today as many companies have converted some jobs to contract positions in order to save money on the cost of benefits to the company. It is the way in which many real estate agents, insurance agents and other types of sales people work today. As of January 1, 2014, you can buy your own health insurance plan for yourself or your family and not be turned down or charged extra for your health insurance plan, even if you are sick.

Under health care reform you should take into consideration that even people that are sick and have pre-existing medical issues can buy insurance for themselves and their families; and that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for you to be able to buy an Individual health insurance on your own for yourself or your family, and be able to get financial assistance; you must buy the health insurance plan through a Health Insurance Marketplace.

We are a local Retail Store with only a few employees.

If you are a small retail store that has many part-time employees or employees that make just above the minimum wage, and you have fewer than 50 full time equivalent employees; you may not be in a position to be able to afford to offer or provide your employees with health insurance benefits. The law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan you buy must be bought through a Health Insurance Marketplace.

I own a local Restaurant or Bar with only a few employees.

If you are a local or small restaurant that has many part-time employees or employees that make most of their money off of tips or are paid just above the minimum wage, and you have fewer than 50 full time equivalent employees; you may not be in a position to be able to afford to offer or provide your employees with health insurance benefits. The law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan you buy must be bought through a Health Insurance Marketplace.

We are a Small Manufacturer with less than 50 employees.

If you are a small manufacturer that has many part-time employees or employees that make just above the minimum wage, and you have fewer than 50 full time equivalent employees; you may offer or provide your employees with very good health insurance benefits in order to recruit, retain and motivate your employees.

If you are not in a position to be able to afford to offer or provide your employees with health insurance benefits, the law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan that you buy must be bought through a Health Insurance Marketplace.

We are a Community Service Organization with fewer than 50 employees.

If you are a community service organization that has some part-time employees or employees earning an average salary, and you have fewer than 50 full time equivalent employees; you may offer or provide your employees with good health insurance benefits in order to recruit, retain and motivate your employees.

If you are not in a position to be able to afford to offer or provide your employees with health insurance benefits, the law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan you buy must be bought through a Health Insurance Marketplace.

We are a small business with unionized employees in our workplace.

If you are a small business with fewer than 50 full time equivalent employees that has a unionized workforce, you will have to review your benefits package with your union and you should work with a health insurance advisor as well as your accountant and CFO in order to figure out how and if you should or should not offer health insurance benefits through your business. You may have blue collar and white collar unions and a non-union workforce working alongside each other in your business; and you will want to figure out a way to offer or provide all your employees with good health insurance benefits in order to avoid labor issues and recruit, retain and motivate your employees.

If you are not in a position to be able to afford to offer or provide your employees with health insurance benefits, the law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, it may be less expensive for your

employees to be able to purchase health insurance for themselves or for their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan that you buy must be bought through a Health Insurance Marketplace.

I own a local service business like an auto dealer or auto repair shop.

If you are a local service business that has part-time employees or employees that are paid just above the minimum wage, and you have fewer than 50 full time equivalent employees; you may not be in a position to be able to afford to offer or provide your employees with health insurance benefits. The law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan that you buy must be bought through a Health Insurance Marketplace.

We are a Personal Services business with fewer than 50 employees.

If you are a local or small service business that has part-time employees or employees that are paid just above the minimum wage, and you have fewer than 50 full time equivalent employees; you may not be in a position to be able to afford to offer or provide your employees with health insurance benefits. The law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

In order for your business to eligible for a tax credit for offering and providing health insurance to your employees or for your employees to be able to buy health insurance on their own and be able to get financial assistance; the health insurance plan that you buy must be bought through a Health Insurance Marketplace.

We are a Professional Services Firm with fewer than 50 employees.

If you are a professional services firm that has part-time employees or employees that are earn good salaries, and you have fewer than 50 full time equivalent employees; you may offer or provide your employees with good health insurance benefits in order to recruit, retain and motivate your employees.

If you are not in a position to be able to afford to offer or provide your employees with health insurance benefits, the law does not require that you provide or offer health insurance to your employees; and you will not be subject to a penalty for not providing or offering health insurance to your employees. However, you should work with a health insurance advisor as well as your accountant in order to figure out if you should or should not offer health insurance benefits through your business; especially since it may be less expensive for your employees to be able to purchase health insurance for themselves or their families on their own after January 1, 2014.

A major difference under health care reform that you should take into consideration is that health care reform makes it so that people cannot be turned down or charged extra for their health insurance, even if they are sick and have pre-existing medical issues. Another major difference is that a person buying health insurance on their own for

themselves or for their family may even be able to get financial assistance from the federal government for buying health insurance for themselves and their family.

Please note that the average salary of your employees may be too high to make your business eligible for a tax credit for offering and providing health insurance to your employees; and that employees with higher salaries will probably not be eligible to buy health insurance on their own and get financial assistance from the federal government.

Appendix Section

Appendix A

Examples of Metal Tier Health Plan Benefits

Sample Plan A – Possible Platinum or Gold Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	$ 500
- Pharmacy Expenses	$ 0
- Combined Medical & Pharmacy	n/a
Out-of-Pocket Maximum Annual Expenses	$ 4,000
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 15
- Specialist Office Visit	$ 30
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 100
- Outpatient Surgery	$ 250 *
- Inpatient Surgery or Hospital Stay	$ 500 *
Pharmacy/Prescription Drugs	
- Generic	$ 10
- Preferred Brand Name Drugs	$ 20
- Non-Preferred Brand Name Drugs	$ 30
- Specialty Drugs, Injectable Drugs, etc.	$ 40

Sample Plan B – Possible Gold or Silver Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	$ 1,000
- Pharmacy Expenses	$ 100
- Combined Medical & Pharmacy	n/a
Out-of-Pocket Maximum Annual Expenses	$ 5,000
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 20
- Specialist Office Visit	$ 40
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 100
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 *
Pharmacy/Prescription Drugs	
- Generic	$ 10
- Preferred Brand Name Drugs	$ 25
- Non-Preferred Brand Name Drugs	$ 50
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You

Sample Plan C – Possible Silver or Bronze Tier

Cost Share Example for Major Medical Services Only

In the Table below, items with a “*” next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	n/a
- Pharmacy Expenses	n/a
- Combined Medical & Pharmacy	$ 2,000
Out-of-Pocket Maximum Annual Expenses	$ 6,500
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 30
- Specialist Office Visit	$ 60
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 150
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)
Pharmacy/Prescription Drugs	
- Generic	$20
- Preferred Brand Name Drugs	$ 40 *
- Non-Preferred Brand Name Drugs	$ 60 *
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *

Sample Plan D – Possible Silver or Bronze Tier
{Potential HSA Plan Option}

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Deductibles	{Per Person – 2x for Family}
- Medical Expenses	n/a
- Pharmacy Expenses	n/a
- Combined Medical & Pharmacy	$ 2,000
Out-of-Pocket Maximum Annual Expenses	$ 6,500
Medical Service	Co-Payment by You
- Primary Care Office Visits	$ 30 *
- Specialist Office Visit	$ 60 *
- Annual Physicals, Preventative Care, etc.	$ 0
- Emergency Room Visit	$ 150*
- Outpatient Surgery	$ 500 *
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)
Pharmacy/Prescription Drugs	
- Generic	$20 *
- Preferred Brand Name Drugs	$ 40 *
- Non-Preferred Brand Name Drugs	$ 60 *
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *

Examples of Alternative Silver Tier Plan Benefits

Cost Share Example for Major Medical Services Only

In the Table below, items with a "*" next to the co-payment amount may not be paid by the insurance company until after you pay the Deductible, meaning what you pay first, is paid first by you. After you pay your deductible, you then pay the co-payments.

Target Actuarial Value	70%	73%	87%	94%
Deductibles {Per Person – 2x for Family}				
- Medical Expenses	$ 2,000	$ 1,000	$ 500	n/a
- Pharmacy Expenses	$ 100	$ 50	n/a	n/a
- Combined Medical & Pharmacy	n/a	n/a	n/a	n/a
Out-of-Pocket Maximum Annual Expenses	$ 6,500	$ 5,000	$ 4,000	$ 2,000
Medical Service	Co-Payment	Co-Payment	Co-Payment	Co-Payment
- Primary Care Office Visits	$ 30	$ 25	$ 10	$ 5
- Specialist Office Visit	$ 60	$ 40	$ 25	$ 10
- Annual Physicals, Preventative Care, etc.	$ 0	$ 0	$ 0	$ 0
- Emergency Room Visit	$ 150	$ 100	$ 75	$ 50
- Outpatient Surgery	$ 500 *	$ 500 *	$ 250 *	$ 100
- Inpatient Surgery or Hospital Stay	$ 500 * (per day)	$ 500 *	$ 250 *	$ 250
Pharmacy/Prescription Drugs				
- Generic	$ 20	$ 15	$ 10	$ 5
- Preferred Brand Name Drugs	$ 40 *	$ 30	$ 20	$ 10
- Non-Preferred Brand Name Drugs	$ 60 *	$ 40	$ 30	$ 20
- Specialty Drugs, Injectable Drugs, etc.	50% Paid by You *	$ 60 *	$ 40	$ 30

Appendix B

Online Calculator and Other Online Information

Online Calculator: www.ppacacalculator.com

The following are links to other web sites that can help you learn more about the changes to Medicaid and Medicare.

The link to the Federal Medicaid web site: http://www.medicaid.gov/

The link to the Federal Medicare web site: http://www.medicare.gov/

If you would like to research and learn more about PPACA; the Henry J. Kaiser Family Foundation has an extensive web site discussing health care reform and will provide you with a wealth of information. It is this author's favorite web site for collaborating information from various sources.

Henry J Kaiser Family Foundation web site: http://healthreform.kff.org/

CCIIO (The Center for Consumer Information & Insurance Oversight)

http://cciio.cms.gov/resources/regulations/index.html#pm

CCIIO Actuarial Value Calculator

http://cciio.cms.gov/resources/files/av-calculator-2-25-13.xlsm

About the Author

Mr. Pinto is an insurance agent with over twelve years of experience specializing in health insurance and health care reform as it relates to individuals and businesses. He started and managed an insurance agency with offices in CT and the Capitol District of NY, which he subsequently sold. He is also a 1st generation American citizen of immigrant parents from Portugal and served in the United States Army National Guard and United States Army Reserve for over twelve years.

Mr. Pinto is an advocate for health care reform and is a member of the "SHOP" Advisory Committee to the Health Insurance Marketplace Board in the State of Connecticut, known as Access Health CT, which is a committee that focuses on helping small businesses access the benefits available to them as part of health care reform.

Mr. Pinto is active in many business groups and charitable organizations; and serves as a volunteer to several charitable organizations and community service groups. He was selected by New Haven Business Times magazine to their 13th Annual “Forty under 40” in 2006; a list of up and coming young professionals in the Greater New Haven Region of CT that serve their communities.