SBAM GUIDE

To the New Health Care Reform Law

for Michigan's Small Business Community

SMALL BUSINESS
Association of MICHIGAN
Focusing the power of small business.

Table of Contents

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July 2010
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Dear Member:

As a small employer or insurance agent, **there is nothing that you need to do immediately to comply with the new laws.** But you do need to be aware of the changes that are coming over the next months and years.

This guide is designed to give you the high-points of the new law. Because the Small Business Association of Michigan has spent many years at the intersection of small business, health care and government relations, you can bet we understand the impact this new law has on you and your small business.

We are your trusted resource for the most accurate and up-to-date information on health care reform. Visit our Web site **www.sbam.org/healthcarereform** frequently for the latest updates and engage with our community discussions to voice your concerns.

Also, feel free to call us at (800) 362-5461 with any questions you may have. We will do our absolute best to provide an answer.

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>> TIMELINE

2010

>Medicare Drug Rebates: Medicare patients who face a gap in prescription drug coverage will receive a one-year, $250 rebate to help pay for medication.

>Temporary Reinsurance Program: A $5 billion program will be created for employers to provide coverage for retirees over the age of 55 who are not eligible for Medicare. Effective date—June 2010 (expires Jan. 1, 2014)

>Temporary High-Risk Insurance Pool: A $5 billion pool will be created to provide health insurance to individuals with pre-existing medical conditions who have been uninsured for at least six months. Effective date—June 2010 (expires Jan. 1, 2014)

>Insurance Reform: Bars insurance carriers from recissons, from denying coverage to children with pre-existing conditions, and removes lifetime caps on coverage.

>Dependent Coverage: Requires insurers to allow people to stay on their parents' policies until they turn 26.

>Preventive Services: Insurers are required to cover preventive services such as immunizations for children and cancer screenings for women, etc.

2010-2014

>Small Business Tax Credits - Businesses with 10 or fewer full-time-equivalent employees earning less than $25,000 a year on average will be eligible for a tax credit of 35% of health insurance costs if the employer contributes at least 50% of the employee-only premium. (Companies with between 11 and 25 workers and an average wage of up to $50,000 are eligible for partial credits.)

>Tanning Tax – 10% tax on indoor tanning services.

2011

>Insurance Carrier Loss Ratios - Requires individual and small group market health insurance plans to spend at minimum 80 percent of premium dollars on medical services. Large group plans would have to spend at least 85%.

>Tax changes on Health Care Savings Accounts: The federal tax on individuals who spend money from health-care savings accounts on ineligible medical expenses would double to 20%.

>Flexible Spending Accounts: Excludes over-the-counter drugs from being reimbursed by either a Flexible Spending Account or Health Reimbursement Account.

>Annual Fees on Pharmaceutical Manufacturers: $2.5 billion in 2011 and $16 billion from 2011 – 2019. Annual fee of $2.8 billion thereafter.

>Long-term Care: A voluntary long-term care program called CLASS would be created. After at least five years of contributions, enrollees would be entitled to a $50-a-day cash benefit to pay for long-term care.

DELAYED/REPEALED

>Medicare "doughnut hole": Drug companies would provide a 50% discount on brand name prescription drugs for seniors who face a gap in drug coverage. More subsidies would be phased in through 2020, when the coverage gap would be closed.

>Medical Malpractice Demonstration Grants: Funding appropriated for five years allowing states to develop, implement and evaluate alternatives to current malpractice system.

>Wellness Program Grants: Funds appropriated for five years to provide grants to small employers to establish wellness programs.

>W2: Aggregate cost of employer sponsored health benefits must be included on W2 form.

DELAYED/REPEALED

2013

>**Contribution Limits on Section 125 Flexible Spending Accounts**: The limit on how much individuals could contribute to flexible spending accounts would be set at $2,500. Currently, employers set the limit.

>**Itemized Deductions for Unreimbursed Medical Expenses**: The threshold for deducting medical expenses would increase from 7.5% of adjusted gross income to 10%.

>**Medicare Taxes**: The Medicare tax rate would increase by 0.9 percentage points—from 1.45% to 2.35%—on earnings over $200,000 for individuals and $250,000 for families. Also, for the first time, a 3.8% Medicare tax would be imposed on investment income.

>**Excise Tax:** 2.9% on the Sale of any Taxable Medical Device.

2014

>**Individual and Employer Mandates:** Requirement that U.S. citizens and legal residents have qualifying health coverage. Those without coverage are subject to a tax penalty. Employers with 50 FTE or more employees must offer coverage or be subject to a "free rider" penalty fee.

>**Small Business Tax Credit (part 2):** For small businesses that purchase through the Exchange and pay at least 50% of the premium, a tax credit up to 50% of the employer's contribution to premium. Full credit available to companies with 10 or fewer employees with average annual wage of less than $25,000. The credit phases out as company size and wages increase. The credit is available for two years.

>**Free Choice Voucher:** Requires employers that offer coverage to their employees to provide a "free choice voucher" to employees with household incomes [illegible] of federal poverty level whose share of premium exceeds 8% but less than 9.8% of their income and choose to enroll through the Exchange. Voucher is equal to what the employer would have paid had the employee enrolled in employer's plan.

REPEALED

>**Federal Subsidies Based on Income:** Federal government will provide refundable and advanceable premium credits to eligible individuals and families with incomes between 133% and 400% of federal poverty level.

>**Restrictions on Insurance Carrier Rate Setting:** Insurers will no longer be able to set rates or exclude coverage based on pre-existing conditions, and can vary premiums only by geographic location, age, and tobacco use.

>**Guarantee Issue Insurance Policies**: Insurance carriers may no longer deny coverage based on health factors.

>**Essential Benefits Package**: Creation of an essential health benefits package (what must be covered and how).

>**Deductible Limits**: Health insurance plan deductibles are limited to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts (i.e., HRA contribution).

>**Waiting Periods:** Insurance waiting periods limited to 90 days.

>**Health Insurance Exchanges:** Creates state based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) where individuals and small businesses with up to 100 employees can purchase qualified coverage through an exchange (states can limit to 50 employees until 2016)

>**Medicaid Expansion**: The program for low-income Americans under the age of 65 would expand by increasing the income eligibility to 133% of federal poverty, or $29,327 for a family of four.

>**Annual Fee on Insurance Companies**: Annual fees totaling $8 billion in the first year and $47.5 billion from 2014 - 2019 will be imposed on health insurance companies (2018 fee indexed to rate of inflation thereafter).

>**Wellness Programs:** Allows employers to offer employees rewards (premium discounts, etc.) or benefits for participating in a wellness programs.

2018

>**Cadillac Tax:** Excise tax on insurers or employer health insurance plans with aggregate values that exceed $10,200 for an individual and $27,500 for a family – then indexed to CPI-U beginning in 2020. Tax is 40% of the value above the threshold.

>>INDIVIDUAL MANDATE AND EMPLOYER "MANDATE"/FREE RIDER PENALTY

Individual Mandate

Beginning in 2014, every U.S. citizen and legal resident will be required to have qualifying health coverage or face a penalty. Those without coverage will pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.

The penalty will be phased in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 or the flat fee or 1% of taxable income in 2014, 2% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

Employer "Mandate"/Free Rider Penalty

Employers That Do Not Offer Coverage

Employers with more than 50 full-time equivalent employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit will face a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment.

Employers That Do Offer Coverage

Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees. (Effective January 1, 2014)

what you need to do:

Remember that businesses with fewer than 50 employees are not required to provide health insurance to their employees.

Understand what the individual mandate means to your employees and your business. Is offering health insurance making it easier to attract and retain your work force?

what you need to know:

>>HEALTH INSURANCE EXCHANGES, CO-OPS AND ACTUARIAL VALUES

Exchanges

The new law creates state-based **American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges**, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. States are permitted to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.

Restricts access to coverage through the Exchanges to U.S. citizens and legal immigrants who are not incarcerated.

The laws requires the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more restrictive age rating rules. These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

Insurers with plans participating in the Exchange must meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information

Actuarial Values

The law creates four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets. The plan you buy must meet one of these categories:

- **Bronze plan** represents minimum credible coverage and provides the essential health benefits, covers 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010)
- **Silver plan** provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits
- **Gold plan** provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits
- **Platinum** plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of-pocket limits

Catastrophic plan made available to those up to age 30 or to those who are exempt from the mandate to purchase coverage. It provides catastrophic coverage only with the coverage level set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

what you need to do:

While the Exchange does not begin until 2014, if you are curious to what one is visit the Massachusetts Community Connector at www.mahealthconnector.org, click on the “find insurance” button and follow the prompts.

Speak with your independent insurance agent to make certain your health insurance meets, at a minimum, the Bronze Plan value.

what you need to know:

>>TAX CREDITS AND THE "CADILLAC" TAX

The new healthcare reform law allows some small businesses to receive a credit for providing health insurance to their employees. There are two separate credits. The first credit is available in 2010, prior to the health insurance exchanges being up and running, and the second is available beginning in 2014 to coincide with the scheduled start up of the Exchanges.

Is your company eligible to receive a tax credit? That is a good question, best answered by your accountant. Here are the basic requirements:

Small Business Tax Credit (2010) – Tax credit equal to 35% of the employer's health insurance costs, if:

- >> You have 10 or fewer full-time equivalent employees
- >> An average annual wage of less than $25,000 (not including owner's or owner's family's wages, or any seasonal employee working fewer than 120 hours per year.)
- >> As an employer, you pay 50% or more of the premium

Small Business Tax Credit (2014) – Tax credit equal to 50% of health insurance costs – lasts 2 years

To qualify for the full credit, the business must have:

- >> The three requirements previously listed, and
- >> You must purchase coverage through the state based Exchange

Cadillac Tax

Today a business can spend as much or as little as they desire on health care for their employees and it is not taxed, so there is an incentive for some to load up on health care versus wages. The Cadillac Tax is an excise tax on insurers or employer health insurance plans with aggregate values that exceed $10,200 for an individual and $27,500 for a family. The idea behind this is to encourage businesses and individuals to buy only the coverage that they need and not to be "over–insured."

The Cadillac Tax is indexed to the CPI-U beginning in 2020 and is 40% of the value above the threshold. Don't think this will not apply to your health care plan. A plan that costs an individual $500 per month now, with medical inflation at 10% for the next 9 years, will cost over $14,000 by 2020!

SOME IMPORTANT NOTES:

- Companies with between 11 and 25 workers and an average wage of less than $50,000 are eligible for partial credits. The credits phase out as firm size and or average wage increase.
- Employers with more than 25 employees or an average wage above $50,000 receive no tax credit.
- The first tax credit is available between 2010 and 2013 and applies to all employers regardless of whether or not health insurance was offered previously
- Starting in 2014 the tax credit is only available for 2 years.
- The tax credit is allowed as part of the general Business Credit against taxable income and against the Alternative Minimum Tax for for-profit companies and payroll taxes for tax-exempt organizations.

what you need to do:

Talk with your accountant today about whether your small business qualifies for any or all of the tax credits available.

Calculate what your premium cost may be in 2018 when the 'Cadillac Tax' begins. Use 10% as a good inflation-based number.

what you need to know:

>>CHANGING INSURANCE REGULATIONS

The health care reform law calls for changes that will affect insurance companies six months after the bill was signed into law (March 23, 2010). These changes apply to the rules and regulations that insurance companies will be required to comply with beginning in September 2010.

2010 Changes

Health insurance companies will be prohibited from denying coverage to children with pre-existing conditions. As a result of this new law, children will longer be declined coverage when applying for coverage as a family unit. Also, insurance companies will be banned from engaging in practices that include insurance "riders," which exclude specific injuries or illnesses from receiving coverage.

Health plans are prohibited, in the future, from placing lifetime caps on spending for individuals.

Private plans will now be required to cover preventive services and impose no co-payments or cost sharing for preventive care. Items covered are preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations; preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

Please note that the child does not have to live with the parent, be financially dependent upon the parent or be a student.

2011 Changes

The law will start requiring plans in the individual and small group market to spend 80 percent of premium dollars on medical services, and plans in the large group market to spend 85 percent. Insurers that do not meet these thresholds must provide rebates to policyholders.

2014 Changes

Starting with the establishment of the Health Insurance Exchanges, new regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. This is known as guaranteed issue. Rates will be limited to allow only variations based on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange. This means that people will no longer get a different price because they have been unhealthy.

All insurance plans must offer the "Essential Benefit Package," which must cover the following items: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. The Health and Human Services agency will review this list annually.

In addition, all future insurance plans must cover at least 60% of the actuarial value of the covered benefits and limit annual out-of-pocket cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010). Waiting periods for coverage will be limited to 90 days for both employers and insurers.

Deductibles will be limited for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. Waiting periods are limited to 90 days from the date of hire or eligibility.

what you need to do:

Speak with your agent to make sure the plan you offer meets the new requirements.

Check on, and adjust your plan's waiting period and adjust your summary plan description if needed.

>>CHANGES TO FLEXIBLE SPENDING ACCOUNTS, HEALTH SAVINGS ACCOUNTS AND OTHER DEDUCTIONS

Flexible Spending Accounts (FSA)

FSAs are designed to pay for medical expenses not covered by insurance and offer several financial benefits. When employees set aside a portion of their salary through pre-tax deduction to pay for medical, dental, vision or dependent care for themselves, a spouse and dependents, they reduce their out-of-pocket expenses. Your company reduces your FICA tax liability and your employees reduce their federal income taxes, state income taxes and Social Security taxes, and they can budget for known out-of-pocket expenses over a 12-month period.

In 2011, non-prescription over the counter drugs, with the exception of insulin, are excluded from eligibility for Section 125 flexible spending accounts.

In 2013, Section 125 flexible spending account contributions are limited to $2,500 per year.

Simple Cafeteria Plan

Available in 2011 there is a new vehicle for small businesses to provide tax-free benefits to their employees by lowering the administrative hurdles of sponsoring a cafeteria plan. This provision also exempts employers who make contributions for employees under a "Simple Cafeteria Plan" from nondiscrimination requirements. The SIMPLE Cafeteria Plan will be available to companies with fewer than 100 employees

Please Note: *Just like regular 125 plans, SIMPLEs cannot cover a sole proprietor, 2% or greater shareholder in an S Corp, partnerships or LLCs treated as a partnership.*

Health Savings Accounts (HSA)

A Health Savings Account (HSA) is a tax-exempt trust or custodial account established exclusively for payment of current and future qualified medical expenses. To have an HSA, you must first have a qualified high-deductible health plan.

In 2011, the tax on HSAs increases to 20% of distribution for non-eligible expenses.

In 2011, non-prescription over the counter drugs, with the exception of insulin, are excluded from eligibility for Health Savings accounts.

Itemized Deductions

In 2013, the threshold for deducting unreimbursed medical expenses from federal taxes increases from 7.5% to 10%.

what you need to do:

Inform your employees of the change impacting over-the counter drugs.

Speak with your agent or FSA administrator to make certain that no over the counter drugs will be allowed in the FSA.

Make sure Section 125 contributions are limited to $2,500 per year in 2013.

>>TAXES AND PAPERWORK - 1099-MISC AND OTHER PAPERWORK NIGHTMARES

Medicare Tax Rate Increase

For individuals who earn $200,000+ (family $250,000+), the Medicare tax rate will increase by .9% (1.45% - 2.35%) – for employee share only

W2 – New Information Required

Beginning in 2011, all employers must include on their employees W2s the aggregate cost of employer sponsored health benefits.

CHANGED

The Benefits Values Calculation: If an employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs. This new rule applies to benefits provided during taxable years after December 31, 2010. No longer applies to companies that issue fewer than 250 W2s.

1099-MISC

REPEALED

The law makes a couple of changes to how 1099s are issued. These changes will end up requiring businesses to distribute millions of additional 1099s each year; no wonder the IRS says it will need an extra 16,000 agents to deal with our new healthcare laws. The two changes that go into effect in 2012 expand the scope of 1099s by using them to track payments not only to individuals, but now also to corporations, and it expands the use from services to services and tangible goods. So, beginning in 2012, all companies must issue a 1099 to any individual or corporation if they buy more than $600 in goods in a year from that person or corporation.

Think about what this change could mean for your business on both the sending and receiving end of 1099s.

Free Choice Voucher

REPEALED

Employers that offer coverage to their employees are required to provide a free choice voucher to employees with **household** incomes less than 400% of Federal Poverty Level whose share of the premium exceeds 9.5% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective 2014)

Benefits Summary

All group plans and group and individual health insurers (including self-insured plans) will have to provide a summary of benefits and a coverage explanation that meets specified criteria to all enrollees when they apply for coverage, when they enroll or reenroll in coverage, when the policy is delivered and if any material modification is made to the terms of their coverage.

Beginning on March 23, 2012, the summary and explanation can be provided electronically or in written form, and it must be no more than 4 pages in length with print no smaller than 12 point font written in a culturally linguistically appropriate manner.

There is a $1,000 per enrollee fine for willful failure to provide the information.

Employer Notice

In 2013, all employers must provide notice to their employees informing them of the existence of the state based exchanges.

what you need to do:

Stay tuned to SBAM for more information and contact your member of Congress to explain what the 1099 change means to your business.

what you need to know:

>>GRANDFATHERED PLANS

The new health care reform law provides that certain provisions of the law will not apply to group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, the date the legislation was signed into law. The law refers to these plans as "grandfathered health plans," and states that a "grandfathered plan" will retain its status even if the covered individual renews the coverage after March 23, 2010. Both new family members and new employees (and their families) are allowed to enroll in this "grandfathered plan".

Please Note: *Significant changes in plan design could take a health care plan out of the "grandfathered" status. These changes could include deductible, co-pay, and re-insurance changes, among other possible changes. The Department of Labor, IRS and Department of Health and Human Services will be providing further guidance in the coming months. Employers should be cautious with changes until further information is available.*

New Rules That Do Apply to Grandfathered Plans

There are a number of new regulations and requirements that even "grandfathered plans" will have to comply with in the future. Keep in mind these are only the major provisions that affect health plans, not an exhaustive list of how health care reform might affect your company.

New Reform Rules That Do Not Apply to Grandfathered Plans

The "grandfathering" provision of the health care reform law specifically exempts "grandfathered plans" from certain regulations and requirements of the law.

Visit www.sbam.org/healthcarereform for more detailed information on grandfathered plans.

Special Effective Date for Collectively Bargained Plans

Collectively bargained multi-employer and single-employer plans in effect on March 23, 2010 are not subject to the health care reform rules described above until the termination date of the last of the collective bargaining agreement relating to the coverage. There is some debate as to whether the exemptions for "grandfathered plans" will continue to apply after that date. The health care reform law provides, however, that a collectively bargained plan is allowed to be amended early for some or all of the new rules. This voluntary amendment will not be treated as a termination of the collective bargaining agreement that might otherwise subject the plan to an earlier compliance deadline.

Please Note: *Covered under Section 1251 "Preservation Of Right To Maintain Existing Coverage" with exclusions and waivers under each regulation's section.*

what you need to do:

Speak with your agent about your plan, what "grandfathering" means, and if you should care.

what you need to know:

>>PRESSURE ON PRICES

A thought and a question:

In our opinion, health care reform that doesn't get at the root cause of the problem is not reform. Within the new law, the root cause of the nation's issue with health care – **cost** - was almost completely ignored. As far as SBAM is concerned, the issue of cost containment is critical, and the reality is that this bill does next to nothing to reduce the cost of health care, which is of course the driver of health insurance costs.

What is likely to happen when demand is increased by some 32 million people, but supply and cost containment have not been effectively dealt with? The Patient Protection and Affordable Care Act and those in Washington who voted for it are hoping that increasing preventive care services and increasing the number of insured will have a long term positive impact on cost and reduce uncompensated care now paid for by insured Americans. Only time will tell if they are correct.

Following is a list of items contained in the new law that will put upward pressure on health insurance costs.

>> Annual fees totaling $8 billion in the first year and $47.5 billion from 2014 - 2019 will be imposed on health insurance companies (2018 fee indexed to rate of inflation thereafter). These costs will be passed on to small businesses and individuals.

>> Benefit Caps: Health plans must remove any caps on lifetime benefits

>> Dependent Coverage: Health Plans must allow dependents to remain on their parent's policy until they turn 26

>> Children with Medical Conditions: Health Plans may no longer deny coverage to children with pre-existing conditions

>> Preventive Services: Health Plans are required to cover preventive services such as immunizations for children and cancer screenings for women. This will require short term cost increases, but hopefully long term cost reductions.

>> Annual Fees on Pharmaceutical Manufacturers: $2.5 billion in 2011 and $16 billion from 2011– 2019. Annual fee of $2.8 billion thereafter.

>> Federal premium tax on health plans funding imposes an annual fee on private insurance plans equal to $2 for each individual covered.

>> Waiting periods limited to 90 days

>> Insurers will no longer be able to set rates or exclude coverage based on pre-existing conditions, and can vary premiums only by geographic location, age, and tobacco use.

>> Guarantee Issue Insurance Policies: Insurance carriers may no longer deny coverage based on health factors.

>> Essential Benefits Package: Creation of an essential health benefits package/minimum benefits that must be covered.

>> Deductible Limits: Health insurance plan deductibles are limited to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts (i.e., HRA contribution).

what you need to do:

Speak with your member of Congress and encourage him/her to finish the job and pass healthcare reform that reduces the cost of healthcare.

Visit **www.sbam.org/healthcarereform** for our ideas on the topic.

>>FREQUENTLY ASKED QUESTIONS

Q. How do employers, their employees and dependents access the new Exchange?

A. The new health insurance Exchange in Michigan is not required to be up and running until 2014. At that time, employers with up to 100 employees can take their entire group into the Exchange for coverage (states can choose to limit the size of eligible employers to 50 employees up to 2016). Specifics on how to access and engage the Exchange will be made public by the Department of Health and Human Services and the state of Michigan in the coming years.

Q. Will I really be able to keep my current insurance policy?

A. The notion that you can keep the coverage you have if you like it is slightly misleading. The law does allow for plans to be ""grandfathered"" (i.e., you can keep the coverage you have with respect to the new essential benefit package and certain insurance market reforms). In other words, ""grandfathered"" plans will not have to abide by the new list of mandated benefits and certain insurance market regulations. However, the law requires even "grandfathered" plans to make certain changes, including changes immediately to extend dependent coverage to adult children up to the age of 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage greater than 90 days. Six months after enactment "grandfathered" plans are required to eliminate preexisting condition exclusions for children. By 2014, "grandfathered" plans will also have to eliminate lifetime and annual limits on coverage.

The law allows individuals and groups to keep the "grandfathered" status when you only add or delete new employees and new dependents. Most other changes to your health insurance plan will result in the forfeiture of the '"grandfathered"' protection.

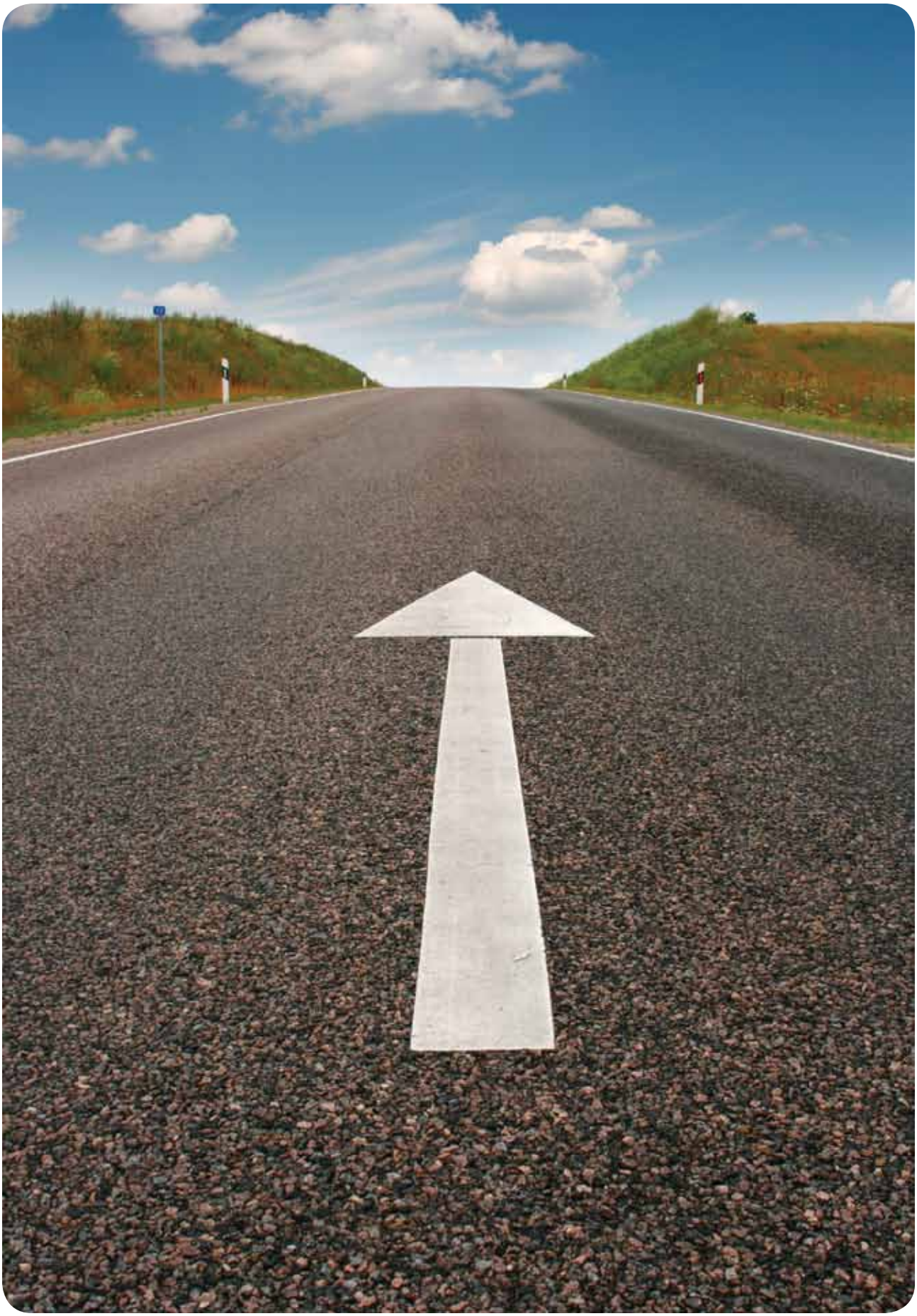
Q. What is meant by an actuarial value of a health insurance policy?

A. The actuarial value of a health insurance plan has several variables, but is generally a percentage of the total covered expenses that the plan would on average cover. For example, the "Bronze" package, or minimum coverage defined by the new health reform law in 2014, has a 60% actuarial value, which means the consumer would pay on average 40% of the cost of health care expenses through features like deductibles and co-payments. Traditionally, there have been several factors that determine an actuarial value of a health insurance policy, including the plan type (HMO, PPO, POS, CDHP), benefits, exclusions, deductible level, co-payment/coinsurance, provider networks, out of pocket maximums and employer health savings account contributions. The general rule is higher premiums mean higher actuarial value; you pay more for more coverage. For purposes of the new health reform law, actuarial values were used to set benchmarks levels of coverage to qualify for minimum coverage and premium subsidies.

Answers to more frequently asked questions are available online at sbam.org/healthcarereform, or by contacting Scott Lyon, SBAM Vice President, Small Business Services at (800) 362-5461 / scott.lyon@sbam.org.

HELPFUL RESOURCES

- www.sbam.org/healthcarereform
- www.kff.org/healthreform
- www.nahu.org



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