Obamacare Implementation Information
Fact Checking by Carlyle

Large Employers: 50 or more full-time employees (30 hours a week or more on average)
Requirements:

Large employers that do not offer any health insurance coverage and have at least one full-time employee receiving subsidized coverage (through a health insurance Exchange) are assessed an annual fee of $2,000 per full-time employee, but the first 30 employees are excluded in calculating the assessment. Note: this requirement was due to start in 2014, but it has now been postponed to start in 2015.

Large employers that offer coverage that is either unaffordable or inadequate and who have at least one full-time employee receiving subsidized coverage in the Exchange must pay an annual fee of $3,000 for each full-time employee receiving a premium credit, with a maximum penalty equal to $2,000 for each full-time employee, excluding the first 30 employees from the assessment. Coverage is considered unaffordable if an employee must contribute more than 9.5 percent of their household income for their premium. Coverage is considered inadequate if the plan does not cover at least 60 percent of a person's medical costs on average. Employers do not need to pay the full premium as long as the amount the employee pays is no more than 9.5% of their household income.

Likely impact:
Of the 5.7 million employers in the country, only about 210,000 have 50 or more full time employees. **So more than 96% of employers are not impacted by this requirement in any way.**

The Department of Health and Human Services estimates that fewer than 2% of the large employers (about 4000) will have to pay any assessments. **So fewer than one-tenth of one percent of all employers would pay an assessment.** Over 95% of large employers already provide insurance coverage, and more are likely to provide coverage under Obamacare. Insurance companies are already adjusting their policies to make sure they meet the minimum coverage requirement.

For most large employers there will be very little compliance work involved; their insurance company will do almost of it.

For those few who do not provide insurance now, or who make employees pay most of high-priced coverage, they will have a simple choice: provide acceptable insurance coverage or likely pay the assessment. This is quite easy to understand - no need to learn complicated regulations.

The postponement of this requirement on large employers will have relatively little impact on the overall implementation of Obamacare because it will impact only a small

number of firms, primarily on the low end of the size scale, and the employees of those firms will still be able to purchase insurance on their own in the Exchanges. Many of these employees also will be eligible for subsidies to help cover the cost of their insurance because the employers most likely not to provide insurance are those who pay the lowest wages.

Small Employers: under 50 full time employees

Requirements: None. No requirement for over 96% of all employers.

Benefits Available: Small employers who have fewer than 25 employees, pay average annual wages below $50,000, and contribute at least 50 percent of the self-only premium for an insurance plan in an Exchange, can receive a tax credit of up to 50% (up to 35% for non-profits) of the employer's cost of the insurance, starting in 2014. The full 50% credit applies to employers with 10 or fewer full time employees with an average annual taxable wage of $25,000 or less. The credit declines as the number of employees and/or average salary level increases, up to the maximum of 25 employees and $50,000 average salary.

A 2008 survey of employers found that low-income employees working for small employers are the least likely to receive health benefits from their employer. Only about half (49 percent) of those with 3-9 employees offer health insurance. The tax credit is targeted to encourage more of those firms to offer their employees insurance.

Small businesses with fewer than 100 employees can shop in the Health Insurance Exchanges for their insurance, which should give them better choices and lower prices.

Individuals Without Insurance
Requirements:

Individuals who do not have health insurance coverage (or Medicare or Medicaid) and who have incomc above 133% of the Federal poverty level ($15,282 in 2013), are to purchase insurance or be subject to a tax. Those who can show that they would need to pay more than 8 percent of their household income for their premiums are exempt from the tax. The amount of this penalty is based on the amount of income above the Federal tax filing threshold (which was $9,750 in 2012 for a single person and $19,500 for married filing jointly). For a single person with income of $20,000, the penalty would be $695 a year, or $58 per month, which is the minimum penalty. A single person with income of $100,000 would pay a penalty of about $2,256 a year, or $188 a month (2.5% of income above the tax filing threshold). This is the amount of the penalty when fully phased in by 2016. The penalty is to be collected by IRS from any tax refunds owed the taxpayer.

Premium Subsidy For Low Income Individuals

Individuals with income between 100% and 400% of the Federal poverty level who purchase insurance through an Exchange can receive a refundable tax credit to pay a portion of the premium. The amount of the premium subsidy is reduced on a sliding scale as income increases to 400% of the FPL. Those with income up to 133% of FPL would pay a maximum of 2% of their income for their insurance premium. The maximum amount increases to 9.5% of income at 400% of the FPL. The difference between an established benchmark price of insurance and the maximum amount to be paid by the insured will be paid to the selected insurance company by the IRS. This calculation and subsidy process is all handled by the insurance Exchange. This subsidy is available to those who already have individual insurance coverage as well as those now without insurance.

To put this in dollar terms, a single person with income of $15,282 (133% of 2013 FPL) would pay no more than $306 a year ($25.50 per month) for their health insurance. A single person with income of $22,980 (200% of 2013 FPL) would pay no more than $1,448 a year ($121 per month). A family of four with that same income of $22,980 (less than 133% of FPL) would pay no more than $460 a year ($38 per month). A family of four with income of $47,100 (200% of the FPL) would pay no more than $2,967 a year ($247 a month). A single person with income of $45,000 (392% of 2013 FPL) would pay no more than $4,275 a year ($356 per month).

In addition to the premium subsidy, there will be cost-sharing assistance available to those with income up to 400% of the FPL This will cap a person's maximum out-of-pocket costs, and the assistance will pay the added cost of a lower out-of-pocket cap for low income people.

Impact of the Tax and the Subsidy

For those with low income (up to about $17,000), it would cost less to purchase insurance with the subsidy than to pay a penalty for not having insurance (not even considering the financial advantage of having insurance). For those with income levels above about $17,000, the near-term cost of the penalty would become less than the cost of insurance as income increases (if one wants to risk bankruptcy in the event of a serious accident or illness).

For example, for a person at 133% of FPL, the insurance premium would be only $306 a year, while the penalty would be $695 a year. A person at 392% of FPL could pay up to $4,275 a year for the insurance, while the penalty would be only about $881 a year. It is likely that there will continue to be some higher income individuals who decide to pay a tax penalty to IRS rather than buy health insurance.

In any case, the requirements on individuals are not onerous. There are no complex regulations to learn. They have a simple choice: buy insurance on an Exchange or maybe have the IRS deduct a rather small penalty from their tax refund. For lower

income people, the subsidy of insurance premiums will permit many to afford health insurance for the first time.

Expansion of Medicaid

Obamacare was designed to make Medicaid available to those earning up to 133% of the Federal poverty level ($15,282 for one person in 2013). The law as written made it essentially financially unacceptable for states to not expand Medicaid coverage. However, the Supreme Court ruled that states could not be coerced to expand Medicaid, and now we have possibly up to 20 states where Republican-controlled legislatures or Republican Governors are refusing to expand Medicaid. In many of those states, Medicaid is available only to very low incomc adults under age 65 who have dependent children or are pregnant or disabled, which is essentially what Virginia Medicaid covers. Currently, in Virginia, parents can't earn more than 30 percent of the poverty level, and childless adults don't qualify for benefits no matter how little money they earn, unless they are disabled.

The failure of states to expand Medicaid as planned will result in the lowest-income people in those states not having any insurance coverage. They will not have Medicaid and they will not receive any subsidies to buy insurance, because the subsidy only applies to those at 100% of the FPL or higher. The people who need assistance the most will not have anything under Obamacare if those states continue to refuse to expand Medicaid.

In Virginia, the Republican Governor and many Republicans in the legislature opposed expansion of Medicaid, but as the price of getting their transportation legislation enacted they agreed to establish a Commission on Innovation and Reform of Medicaid, which is tasked with determining whether the Medicaid reform conditions set forth in the budget bill have been met in order to expand Medicaid. The Commission does not have a deadline for making a decision, but expansion can't start before July 1, 2014. The Commission has ten voting members - five House Delegates and five Senators, with seven Republicans and three Democrats. A minimum of three Delegates and three Senators must vote for approval of expansion.

The Speaker of the House, William Howell, has stated that the House members appointed to the Commission are all opposed to expanding the program, and most have expressed opposition to expansion. Senator Emmitt Hanger was elected Chair of the Commission at its first meeting on June 17, and has voiced his support for expansion. The Vice Chair is Delegate Steve Landis, who has expressed strong concerns about expansion. He has stated that he did not see the Commission approving expansion without the support of the General Assembly. And some Republicans have vowed to fight it in court if the Commission approves expansion. Hanger has stated that he would like the Commission to make a decision by the end of December this year, but some Republicans are promoting delay until 2014 when the new General Assembly could change the terms of the Commission or abolish it entirely. Based on the stated positions

of the five Delegates on the Commission, it is very unlikely that three of them will vote to expand Medicaid.

Insurance Exchanges

The insurance Exchanges are to offer high-quality, qualified health plans that meet provider network standards, and offer at least an essential benefits package. The Exchange will categorize levels of coverage into four standard tiers: bronze, silver, gold and platinum. Bronze plans have the least generous benefits and platinum have the most generous. All insurers in the Exchange must offer at least a silver and a gold level plan. Exchanges will also be responsible for determining who is eligible for premium subsidies, and at what level, certifying exemptions for people from the individual requirement to purchase insurance, and sharing information with the IRS. They will also verify whether employees are eligible for premium subsidies through the Exchange because employer-sponsored coverage is not available to them. Exchanges are to be ready by October 1, 2013 to start accepting applications, with insurance coverage available January 1, 2014. Some states are running their own Exchanges and some are leaving it up to the Federal Government to establish and operate the Exchanges. Virginia refused to implement an Exchange but will have a role in reviewing the insurance policies to be offered on the Exchange. As of June, insurance companies have submitted proposed plans to be available on the Exchange, and they are being reviewed to ensure they qualify.

Grandfathered Plans

A health insurance plan that existed on March 23, 2010, and that has covered at least one person continuously from that day forward, is considered to be a "grandfathered" plan. That applies to an individual insurance policy as well as job-based plans. A grandfathered health plan isn't required to comply with some of the consumer protections of the Affordable Care Act that apply to those health plans that are not grandfathered. For example, grandfathered plans do not need to phase out annual dollar limits on key benefits or eliminate pre-existing condition exclusions for children under age 19. So it is advisable to study the provisions of any grandfathered plan and consider the desirability of purchasing a new plan when they are available on the Exchanges.