

The Buzz for Your Biz on the New Health Care Reform

Independent Insurance Agents and Brokers of Arizona

September 29, 2010

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PATIENT PROTECTION AND
AFFORDABLE CARE ACT OF 2010
(P.L. 111-148)
("the Affordable Care Act")
March 23, 2010

HEALTH CARE AND EDUCATION
AFFORDABILITY RECONCILIATION
ACT OF 2010
(P.L. 111-152)
("the Reconciliation Act")
March 30, 2010

Together, "the Act"

REQUIREMENTS FOR ALL (INCLUDING GRANDFATHERED)

1. Dependent adult children – until 2014, coverage to 26 unless have available, own employer-sponsored insurance; after 2014, coverage for all up to 26
2. No lifetime restrictions
3. Restrictions on annual restrictions
4. Rescission restrictions
5. Preexisting conditions prohibitions
6. Limitations on waiting rules
7. Distribution of 4-page highlight summaries – including 60 days pre-modification

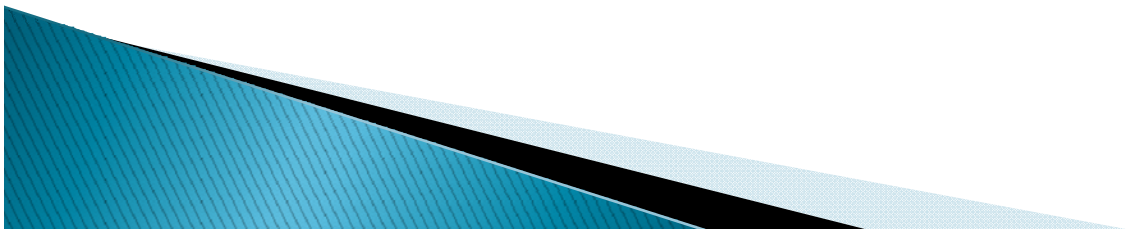
ADULT CHILDREN

Effective plan years beginning on or after 9-23-10:

1. Health Plans and issuers must offer coverage to an enrollee's adult child who is 25 and under
2. Does not have to live with parents
3. Does not have to be in college
4. Can be married (but the spouse and any children are not covered)
5. Does not have to be a dependent on the parent's tax return
6. Tax-deductible business expense for employer and tax-free to the parent enrollee through the year the adult child turns 26

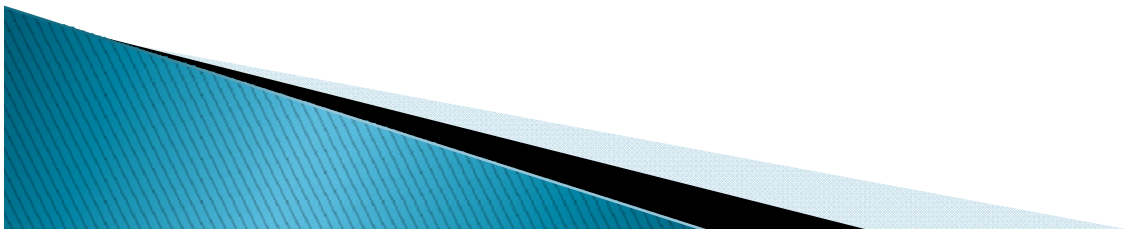
ADULT CHILDREN IF GRANDFATHERED

1. Don't have to provide the coverage unless the adult child cannot obtain other coverage
2. This exception ends with plan years beginning on or after 1-1-14



LIFETIME BENEFITS LIMITS

1. Effective plan years beginning on or after 9-23-10
2. Plans and issuers must eliminate lifetime limits on the dollar value of “essential health benefits” under all plans



LIFETIME BENEFITS LIMITS (cont'd.)

3. Essential health benefits will fall within these categories:
 - a. ambulatory patient services
 - b. emergency services
 - c. hospitalization
 - d. maternity and newborn care
 - e. mental health and substance use disorder services (including behavioral health treatment)
 - f. prescription drugs
 - g. rehabilitative services
 - h. laboratory services
 - i. preventive and wellness services and chronic disease management
 - j. pediatric services (including oral and vision care)

ANNUAL BENEFIT LIMITS

1. Effective plan years beginning on or after 9-23-10
2. Plans and issuers will be reasonably or tightly restricted in placing annual limits on the dollar value of benefits under all plans
3. All annual limits will be banned in 2014 when the State Insurance Exchanges are operational

NO (ALMOST) RESCISSIONS ON COVERAGE

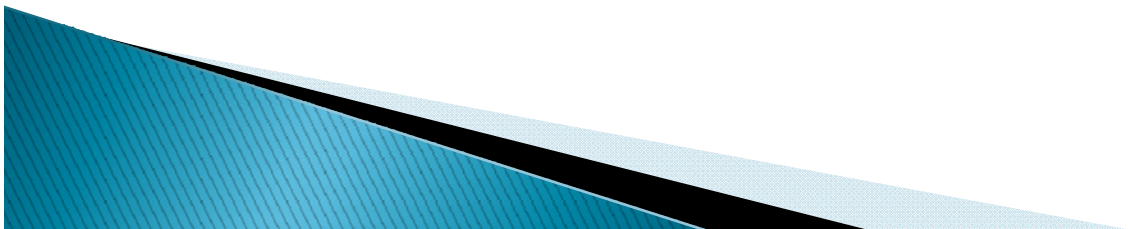
1. Effective plan years beginning on or after 9-23-10, plans and issuers cannot rescind individual coverage once the coverage is in place
2. Exception: fraud or intentional misrepresentation of a material fact as provided by the plan

PREEXISTING CONDITION EXCLUSIONS FOR CHILDREN

1. Effective plan years beginning on or after 9-23-10, plans and issuers cannot impose preexisting condition exclusions to an enrollee's child who is 18 and under
2. Extends to adults (all ages under 65) for plan years on or after 1-1-14

RESTRICTIONS ON WAITING PERIODS

Effective plan years beginning on or after 1-1-14, plans and issuers cannot impose a waiting period for coverage in excess of 90 days



HEALTH COVERAGE AND W-2s

- Beginning in the 2011 tax year
- Employers must report the “aggregate cost” of the employer-sponsored health insurance coverage
- Includes both employer and employee costs
- Excludes salary reduction for flexible spending arrangements
- For reporting purposes only – not taxable
- For purchases made after 12-31-11, 1099s must be generated to vendors for services over \$600 annually
- Applies regardless of grandfathering

2011: NOTICES TO EMPLOYEES

Beginning in 2011, employers must report:

1. The cost of employer-provided coverage (employee plus employer portion) on their employees' Form W-2
2. To new employees, information regarding the availability of the Exchange (for current employees, this is by 3-1-13)
3. An employee's eligibility for subsidy if the employer's contribution is less than 60% of the Benefits
4. If the employee purchases through the Exchange, the employee will lose the employer's coverage contribution

UNIFORM NOTICE OF COVERAGE TO PARTICIPANTS

1. Different from ERISA's Summary Plan Description
2. By 3-23-12, notice must be given by plan administrators, plan sponsors, and insurers to enrollees and participants
3. Describes benefits and coverage for participants prior to enrollment
4. Must state whether the plan provides Minimum Essential Coverage and pays less than 60% of the total cost of the plan's benefits
5. Can be provided electronically in no more than four pages, and must be in a "culturally and linguistically appropriate manner"
6. Potential fines of \$1,000.00 per enrollee
7. Notice of any material modifications must be given 60 days in advance or fines up to \$1,000.00 per enrollee

HOW NOT TO BE GRANDFATHERED OR TO LOSE GRANDFATHERED STATUS

1. Enter into a new policy, certificate, or contract of insurance with an insurance company after 3-23-10
2. Eliminate the benefits for a necessary element to diagnose or treat a condition
3. Increase a percentage cost-sharing requirement (such as coinsurance)
4. Increase fixed-amount cost-sharing requirements other than copayments, such as deductibles or out-of-pocket limits, by a total percentage that is more than the sum of medical inflation and 15 percentage points
5. Measuring from 3-23-10, increase copayments by more than the greater of (1) a total percentage that is more than the sum of medical inflation plus 15 percentage points, or (2) \$5 increased by medical inflation
6. Measuring from 3-23-10, decrease the contribution rate by more than five percentage points

GRANDFATHERED STATUS AND BENEFIT LIMITS

Measuring from 3-23-10,

1. If there was no overall annual or lifetime limit on the dollar value of all benefits, do not impose an overall annual limit on the dollar value
2. If there was an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value, do not adopt an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit
3. If there was an overall annual limit on the dollar value of all benefits, do not decrease the dollar value of the annual limit

ACTIONS THAT WILL NOT IMPAIR GRANDFATHERED STATUS

1. Renew an insurance policy
2. Increase benefits
3. Add new employees and dependents as participants
4. Change third-party administrators
5. Adopt voluntarily other consumer protections

INFORMATION AND DATA TO HEALTH AND HUMAN SERVICES

1. Effective plan years beginning on or after 9-23-10, group plans must provide the Secretary of Health and Human Services with information and data
2. Examples:
 - a. claims payment policies and practices
 - b. enrollment and disenrollment data
 - c. number of denied claims
 - d. rating practices
 - e. non-network cost sharing information
 - f. enrollee and participant rights
3. Grandfathered plans do not need to comply

QUALITY OF CARE REPORT TO PARTICIPANTS

1. At Open Enrollment, the participants must be given a report that describes the health care provider reimbursement rates that improve quality of care
2. Includes wellness activities
3. The data will be collected and put on the internet by the HHS Secretary
4. Reporting requirement will be provided by 3-23-12
5. Grandfathered plans do not need to comply

PREVENTIVE SERVICES

1. Effective plan years beginning on or after 9-23-10, plans and issuers, individual and group, provide first dollar benefits for “Preventive Care Services”
2. All ages 64 and under
3. Grandfathered plans do not need to comply
4. Some of the Services:
 - Immunizations, infant care, and infant care screenings
 - Regular well-baby and well-child visits from birth to age 21
 - Screening for abdominal aortic aneurysm
 - Screening and counseling to reduce alcohol misuse
 - Aspirin to prevent CVD

PREVENTIVE SERVICES (cont'd.)

- Screening for bacteria
- Screening for high blood pressure
- Mammography
- Chemoprevention of breast cancer
- Interventions to support breast feeding
- Screening for cervical cancer
- Screening for chlamydial infection
- Screening for cholesterol abnormalities
- Screening for colorectal cancer
- Chemoprevention of dental caries
- Screening for depression
- Screening for diabetes
- Counseling for a healthy diet
- Supplementation with folic acid
- Screening for gonorrhea

PREVENTIVE SERVICES (cont'd.)

- Screening for hearing loss
- Screening for hemoglobinopathies
- Screening for hepatitis B
- Screening for HIV
- Screening for congenital hypothyroidism
- Screening for anemia
- Iron supplements in children
- Screening and counseling for obesity
- Screening for osteoporosis
- Screening for PKU
- Screening for Rh incompatibility (during pregnancy)
- Counseling for STIs
- Screening for syphilis
- Counseling for tobacco use
- Screening for visual acuity in children

CHOICE OF PRIMARY CARE PHYSICIANS AND OB-GYNS

1. Effective plan years beginning on or after 9-23-10:
 - a. Plans that require participants to designate a Primary Care Physician, must be allowed to select any participating provider as the participant's PCP;
 - b. Plans that require participants to designate a Primary Care Physician for the child must be allowed to select any participating provider (allopathic or osteopathic) who specializes in pediatrics as the child's PCP
 - c. Plans must give women direct access to participating OB-GYNs without a referral
2. Grandfathered plans do not need to comply

EMERGENCY CARE

1. Effective plan years beginning on or after 9-23-10, plans must offer coverage for emergency services at the in-network level and cost-sharing without requiring prior approval or use of specified or participating facilities
2. The cost-sharing requirements for benefits out-of-network emergency must equal to the greatest of the following three amounts:
 - a. the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance
 - b. the amount the plan generally pays for out-of-network services without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - c. the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
3. Grandfathered plans do not need to comply

I.R.S. CODE § 105(h) PROVIDES FOR NON-DISCRIMINATION IN FAVOR OF HIGHER-WAGE EMPLOYEES

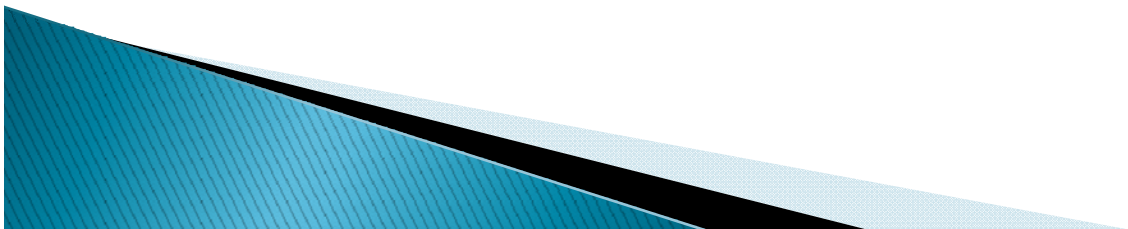
1. Previously applied to only self-funded plans
2. Effective plan years beginning 9-23-10, group fully-insured plans must comply
3. Plans and employers cannot establish any eligibility rules that have the effect of discriminating in favor of higher-wage employees
4. Plans and employers must provide the same benefits to all participants
5. The plan must benefit (a) at least 70% of all employees; (b) 80% of all those eligible if at least 70% of all employees are eligible; or (c) a non-discriminatory classification of employees

I.R.S. CODE § 105(h) PROVIDES FOR NON-DISCRIMINATION IN FAVOR OF HIGHER-WAGE EMPLOYEES (cont'd.)

6. If the plan has different contribution levels, then each level is tested as though it is a separate plan – same for waiting periods
7. If the plan fails the non-discrimination test:
 - a. Self-funded plans – the highly compensated employees are taxed
 - b. Fully-insured plans – \$100.00 a day (maximum \$500,000.00)
8. Grandfathered plans do not need to comply

TEMPORARY HIGH-RISK POOL

1. For states (like Arizona) without their own high-risk pool
2. For citizens, nationals, or others lawfully present with preexisting conditions who have been uninsured for six months or more because of a medical condition
3. Lasts until 1-1-14, when preexisting conditions end and Exchanges begin, or the appropriated \$5 billion runs out
4. Premiums may vary by age up to a factor of 4:1
5. Individual's cost share cannot exceed 35% of the total allowed cost of benefits provided under the plan



TEMPORARY HIGH-RISK POOL (cont'd.)

6. The out-of-pocket limits cannot exceed those above which a plan qualifies as a “high-deductible health plan”
7. “A high-deductible health plan” is currently \$5,950.00 for self-only and \$11,900.00 for family coverage
8. No compensation for agents who help individuals purchase coverage
9. Links:
 - HHS Secretary Announce the Plan
<http://www.hhs.gov/news/press/2010pres/07/20100701a.html>
 - PreExisting Condition Plan Homepage
<http://www.pcip.gov/>
 - PreExisting Condition Plan Application
https://www.pcip.gov/PreExistingConditionPlan_EnrollmentForm_082310_508.pdf
 - PreExisting Condition Application Homepage
<http://www.pcip.gov/Apply.html>

LONG-TERM CARE

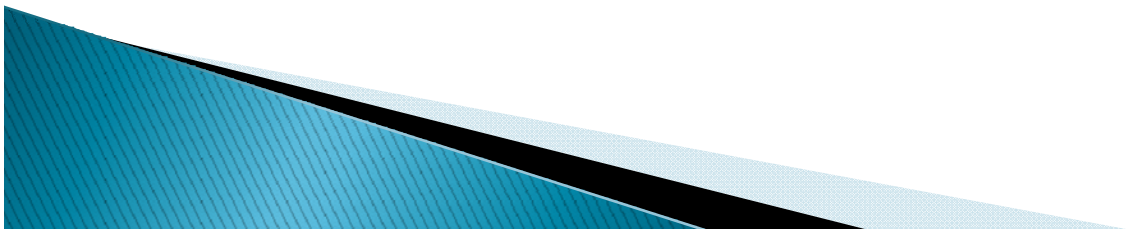
Federal Long-Term Care Insurance Program

1. Effective 1-1-11
2. Available cash benefits for disabled individuals (stay in home or nursing care) that start 5 years after start paying for coverage
3. Employers administer
 - marketing
 - collect premiums
 - remit employee deductions to government
4. Employers can automatically enroll
5. Voluntary for employers

CONSUMER-DIRECTED PLANS

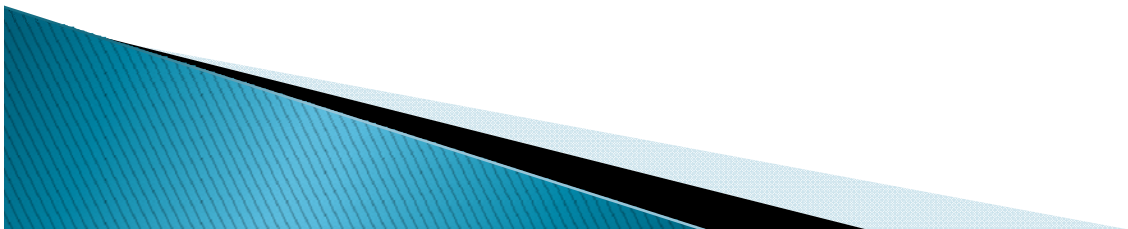
Pre-reform, certain consumers availed themselves of Health Care Flexible Spending Accounts:

1. High-deductible, low-premium health plans
2. Linked to:
 - a. health savings accounts funded by
 - employers
 - employees
 - b. employer-funded health reimbursement arrangements
3. Health care flexible spending accounts with annual “use it or lose it” provisions are also impacted



CONSUMER-DIRECTED PLANS

1. Effective 1-1-11
2. Over-the-Counter Medications:
 - a. No reimbursement through health savings accounts, health reimbursement arrangements, or flexible spending accounts
 - b. Unless physician prescribed



SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES

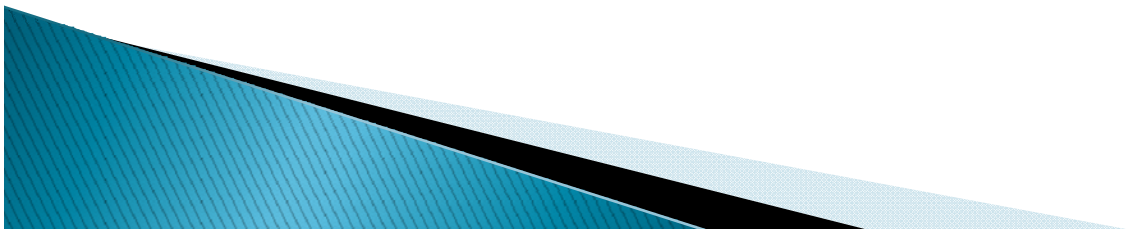
1. Effective 1-1-11
2. Of interest to employers that cannot pass the nondiscrimination tests
3. Average of 100 or fewer employees in either of the preceding two years
4. All employees with at least 1000 hours in preceding year must be eligible to participate
5. Must have employer contributions for each non-key employee of (a) at least 2% of compensation, or (b) lesser of 6% of compensation or two times employee's salary reduction
6. Employee can elect any available, qualified, non-cash benefit

CLAIMS APPEALS

1. Different from ERISA's internal claims appeals process for disputed claims
2. Effective plan years beginning on or after 9-23-10, plans must implement an external claims procedure that will assure the review of disputed claims by a third party
3. Claimants must continue receiving coverage during the appeals process
4. Grandfathered plans do not need to comply

2014: NO ELIGIBILITY DISCRIMINATION BASED ON HEALTH STATUS

1. Effective plan years beginning on or after 1-1-14, both self-funded and fully-insured group plans must provide enrollment without regard to health status factors
2. But geography, age, and smoking will affect cost
3. Grandfathered plans do not need to comply



COST RATIOS REQUIREMENTS AND MINIMUM LOSS RATIOS

1. Effective 1-1-11, health insurers must provide rebates if they do not meet minimum loss ratios
2. Not apply to self-insured plans
3. 100 or more employees – 85% MLR
4. 99 or fewer employees – 80% MLR

COST-SHARING LIMITS

1. Effective plan years beginning on or after 1-1-14, both self-funded and fully-insured plans must limit cost-sharing amounts
2. Cost-sharing amounts: deductibles, coinsurance, and co-pays
3. The limits: those applicable to high-deductible plans under Code Section 223
4. Deductibles cannot exceed \$2,000.00 per single and \$4,000.00 per family
5. Currently, Code Section 223 out-of-pocket limits on a high-deductible plan are \$5,950.00 for single and \$11,900.00 for family
6. Grandfathered plans do not need to comply

CLINICAL TRIALS – MANDATED COVERAGE

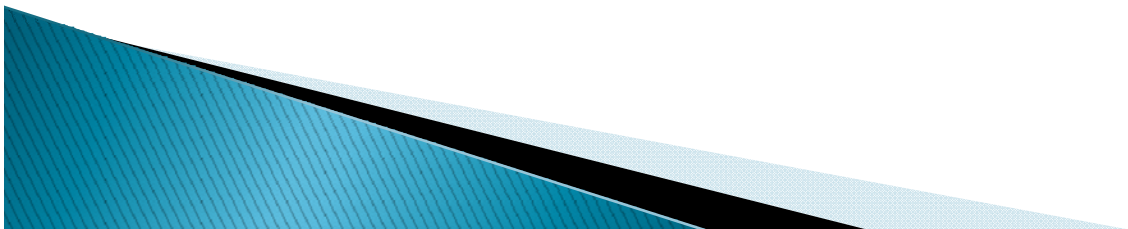
1. Effective plan years beginning on or after 1-1-14, self-funded and fully-insured plans must provide coverage for routine costs associated with clinical trials
2. Coverage if:
 - a. The participating physician deems it appropriate with respect to the protocols of treatment, or
 - b. The insured is eligible according to the trial protocol and the condition is life-threatening
3. Grandfathered plans do not need to comply

BENEFITS OF GRANDFATHERED STATUS

1. Until 2014, not have dependent adult children if own employer-sponsored coverage available
2. Not provide report to HHS of claims policies, practices, denials, etc.
3. Not provide enrollees with quality of care or wellness activity reimbursements and reports
4. Not provide first dollar coverage for preventive services
5. Not provide primary care provider designations or OB-Gyns without referrals
6. Not provide out-of-network emergency room coverage as though in-patient

BENEFITS OF GRANDFATHERED STATUS (cont'd.)

7. Not comply with the non-discrimination rules for higher-wage employees
8. Not comply with the new processes for internal and external appeals
9. After 1-1-14, insurers must make coverage available and cannot cancel
10. After 2014, cannot discriminate based on health status factors
11. After 2014, not have to limit cost-sharing amounts
12. After 2014, not have to provide clinical trial coverage



RETIREE-ONLY PLANS

1. If there are fewer than two current employees (one), the new legislation does not apply
2. Reason: The provisions have been incorporated by the portion of ERISA that contains the HIPAA exclusion of group health plans with fewer than two current employees

PRE-65 RETIREES - TEMPORARY REINSURANCE

1. Reinsurance for early retirees (ages 55-64) and their families
2. The plan is reimbursed for 80% of claims between \$15,000.00 and \$90,000.00 expended for each retiree (adjusted annually based on Medicare percentage increases)
3. Payments must be used to lower costs for the plan
4. Lasts until 1-1-14, or the \$5 billion cap runs out (first come, first served)

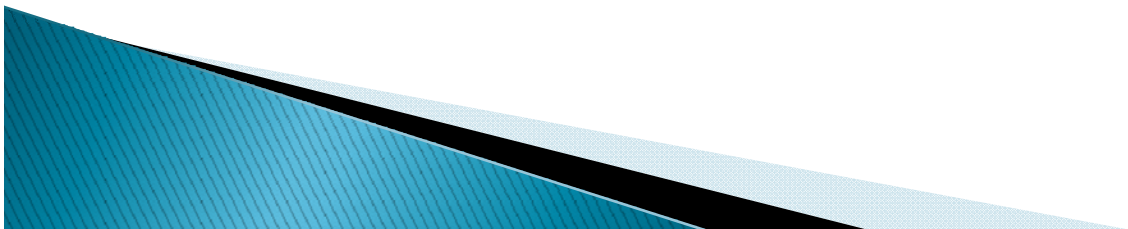
ELIMINATION OF MEDICARE DOUGHNUT HOLE

1. Part D Medicare enrollees pay
 - a. 25% of drug costs until \$2,830
 - b. 100% up to \$4,550 in drug costs
 - c. Then, coverage picks up
2. The doughnut hole is the gap between \$2,830 and \$4,550
3. Reform:
 - a. 2010: \$250 rebate for the gap
 - b. 2011: 50% discount on brand-name drugs and 93% on generic during the gap
 - c. 2020: the discount percentage phases down each year until the gap is closed completely



2013: ELIMINATION OF DEDUCTION FOR RETIREE PRESCRIPTION DRUG SUBSIDY

1. Employers who receive a federal subsidy for maintaining retiree prescription drug coverage can no longer deduct the amount of the subsidy
2. The loss of this deduction, in combination with the elimination of the Medicare Part D "doughnut hole" could lead employers to reevaluate whether they want to continue to provide retiree prescription drug coverage



GRANTS TO SMALL EMPLOYERS TO ESTABLISH WELLNESS PROGRAMS

1. Effective 1-1-11
2. The Secretary of Health and Human Services is authorized to award grants to eligible employers to provide employees with access to comprehensive workplace wellness programs
3. An employer is eligible if it employs less than 100 employees who work 25 hours or greater per week and did not provide a wellness program prior to 3-23-10
4. \$200 million has been appropriated for these grants for fiscal years 2011 through 2015

WORKPLACE GRANTS FOR WELLNESS PROGRAMS

1. Effective 1-1-11
2. Grants from Health and Human Services for up to 5 years
3. ONLY to establish new programs
4. Technical assistance and other resources to evaluate programs
5. Studies and Surveys to assess policies and programs

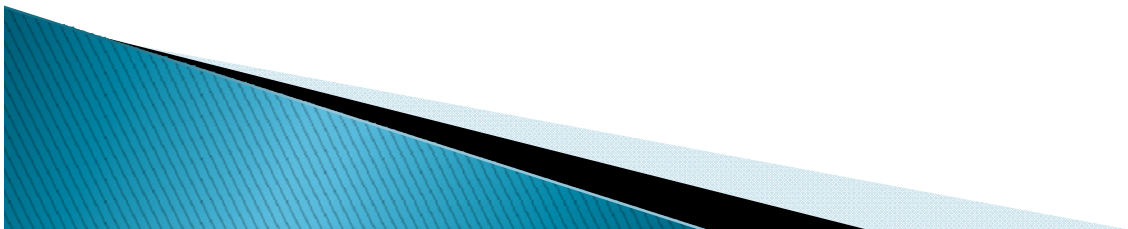
2014: REQUIREMENTS FOR WELLNESS PROGRAMS OFFERED BY AN EMPLOYER

1. Employers can establish wellness programs that provide a premium discount or rebate or other reward for participation without violating the nondiscrimination rules that prevent discrimination based on health status
2. Rewards not based on the participant satisfying a health standard -- the reward must be made available to all similarly situated individuals
3. Rewards based on the participant satisfying a health standard - the reward cannot greater than 30% of the cost of coverage, the program must be reasonably designed to promote health or prevent disease, and eligible and all similarly situated individuals can try to qualify for the reward at least once per year
4. The maximum premium reduction may be increased up to 50% in future regulations

CONSUMER-DIRECTED PLANS

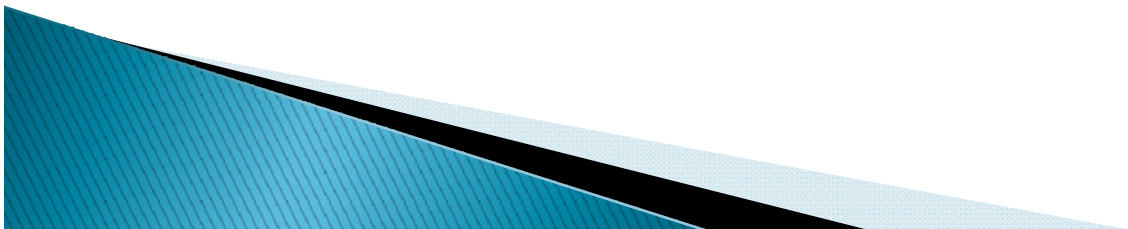
2013:

1. Health Flexible Spending Account Contributions
 - a. Capped at \$2,500 a year
 - b. Indexed annually for inflation
2. Government regulations – forthcoming



2014: INSURERS MUST MAKE COVERAGE AVAILABLE AND CANNOT CANCEL IT

1. Effective plan years beginning on or after 1-1-14, insurers must make coverage available for purchase by employers for employees
2. Insurers cannot cancel an employer's group plan for poor claims experience
3. No guarantee of affordability
4. Grandfathered plans do not need to comply

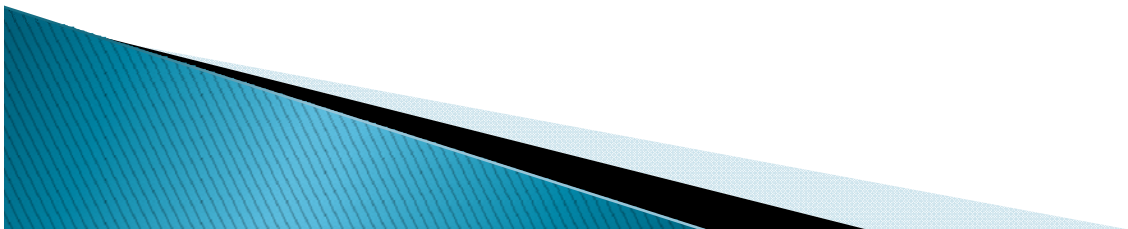


2014: EMPLOYERS WITH 50 OR MORE EMPLOYEES ARE ENCOURAGED TO OFFER COVERAGE

1. Effective plan years beginning on or after 1-1-14, employers with 50 or more full-time equivalent employees are encouraged to offer “minimum essential coverage”:
 - a. Full-time: 30 or more hours a week
 - b. 50 full-time equivalent employees on at least 120 business days during the preceding calendar year
2. Pay a penalty if at least one full-time employee received a subsidy. Subsidy:
 - a. tax credit
 - b. cost-sharing reduction
 - c. not free choice vouchers
3. Penalty: \$2,000.00 a year, prorated by month, for each full-time employee in excess of 30 while one receives a subsidy

WHAT ABOUT PART-TIME EMPLOYEES?

1. Employers are not obligated to provide coverage for part-time employees
2. Part-time: Less than 30 hours a week
3. 2014: To determine if an employer has 50 or more employees, the hours are counted (still have to offer coverage only to full-time)



2014: EMPLOYERS WITH 50 OR MORE EMPLOYEES ARE ENCOURAGED TO MAKE SURE THE COVERAGE IS SUFFICIENT

1. Effective plan years beginning on or after 1-1-14, employers with 50 or more full-time equivalent employees are encouraged to be sure the coverage they offer is sufficient.
2. If there is coverage, but at least one full-time employee receives a subsidy, the employer must pay \$250.00 per month or \$3,000.00 per year for each subsidized employee, but not greater than if no coverage is offered

2014: SMALL EMPLOYERS, INDIVIDUALS, AND THE EXCHANGE

1. Effective plan years beginning on or after 1-1-14, states will have private insurance marketplaces, called Exchanges, under which individuals and Small Employers (1-100 employees in the preceding year) can purchase health insurance at varying cost levels
2. Until 2016, states can limit the small group market to no more than 50 employees. If an employer outgrows the small group market, it can continue through the Exchange until it discontinues coverage
3. Beginning in 2017, states may elect to permit employers in the large group market to offer insurance through an Exchange

2014: ESSENTIAL BENEFITS PLAN

1. The Essential Benefit Plan will come into play in 2014
2. Mandates the level of benefits that must be included in plans offered in the Exchange
3. Mandates the level of benefits that must be included in the individual and small group markets outside the Exchange
4. Deductibles limited to \$2,000 for individuals and \$4,000 for families in the small group market
5. Self-funded plans and grandfathered plans do not need to comply

SMALL EMPLOYER TAX CREDIT

1. Qualifying employer must pay at least half the cost of single-rate coverage
2. Fewer than 25 full-time equivalent employees (not including the owner) with average annual wages of less than \$50,000
3. 2010–2013: maximum tax credit is 35% of employer's paid premiums (tax exempt: 25%)
4. 2014: maximum tax credit increases to 50% of employer's paid premiums (tax exempt: 35%)
5. 10 or fewer full-time equivalent employees (not including the owner) with average annual wages of \$25,000 or less – full tax credit possible
6. The amount of the credit phases out as the number of employees and average wages increase
7. The draft IRS tax Form 8941 was posted 9–7–10 for comments – 30 days (tax exempt: revised Form 990–T). Interactive calculator:
<http://www.smallbusinessmajority.org>

2014: FREE CHOICE VOUCHERS FOR CERTAIN LOW-INCOME EMPLOYEES

1. Employers that offer Minimum Essential Coverage and pay a portion of the premiums are required to provide “free choice” vouchers to eligible employees for coverage in an Exchange
2. An employee is eligible if: (a) the employee’s required premium contribution is between 8 and 9.8 percent of the employee’s annual household income for the year; (b) the employee’s household income does not exceed 400 percent of the federal poverty line; and (c) the employee does not participate in the employer’s plan
3. The employer is required to pay the voucher amounts to the Exchange
4. The voucher amount used to pay for coverage is not taxable to the employee
5. Any amount of the voucher in excess of the cost of coverage is paid to the employee, and is taxable
6. Employers are not required to pay any penalties with regard to employees to whom they provide vouchers
7. The percentages are indexed after 2014

INDIVIDUALS: GET COVERAGE OR BE PENALIZED

1. 2014: If an individual does not have coverage, the penalty is the greater of \$95 or 1% of income
2. 2016: If an individual does not have coverage, the penalty is the greater of \$695 or 2.5% of income
3. After 2016: The penalty is indexed based on the \$695. Families pay half the penalty for children, with a cap of \$2,085 per family.
4. There will be exemptions (i.e., financial hardship)
5. There will be subsidies (tax credits and cost-sharing assistance) for purchases from the new State exchanges

HOW DOES AN EMPLOYEE QUALIFY FOR A SUBSIDY WHEN THERE IS COVERAGE?

Subsidies are available if the employee meets the income requirements for assistance (generally, household income between 133–400 percent of the federal poverty line), and either:

1. The plan's share of the total allowed cost of benefits under the plan is less than 60% of the cost; or
2. The employee's contribution exceeds 9.5% of the employee's household income (indexed after 2014)

BIOGRAPHY

Pamela Kingsley , as a Shareholder of Tiffany & Bosco, P.A., represents a broad base of clients in many diverse areas. Besides helping clients in understanding the impact and consequences of health care reform, Ms. Kingsley's business counseling and advice often includes drafting and analyzing agreements for employment and severance, confidentiality, non-competition, and non-solicitation; policies for sexual harassment and oppressive or violent conduct, drug testing, safety, absences, and disabilities.

In addition to working with management on the adoption and implementation of policies, including employee handbooks and safety manuals, Ms. Kingsley is ready when claims are made to take her clients through the investigation phases to the EEOC and court, when warranted. When advisable, Ms. Kingsley encourages the amicable resolution of disputes through negotiation and mediation. Ms. Kingsley regularly gives seminars for clients and helps them with implementing changes intended to avoid future employee-related claims and litigation.

University of Texas, B.A., with honors, 1971; University of Texas, J.D., with honors, 1975; Member, Texas Law Review; admitted, Texas, Arizona, U.S. District Court of the District of Arizona, U.S. Court of Appeals (Ninth Circuit), and United States Supreme Court; Member: State Bar of Arizona (Member, Sections of Appellate Practice, Business Law, Construction Law, Employment & Labor Law, and Trial Practice), Member: Maricopa County Bar Association, and Member: American Bar Association, (Member, Section of Litigation); Fellow: Arizona Bar Foundation

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