The Montgomery County Department of Health and Human Services, Asian American Health Initiative (AAHI) hosted a free training workshop entitled The Affordable Care Act in Montgomery County – What You Need to Know as a part of the Empowering Community Health Organizations (E.C.H.O.) Project 2013. AAHI launched this series of practical and professional training workshops in 2011 aimed to build the capacity and sustainability of community organizations that serve Asian Americans in Montgomery County.

This workshop followed AAHI’s Grants 101, Grants 102, and Tackling Grant Budgets workshops held November 2011, May 2012, and December 2012, respectively. The Affordable Care Act in Montgomery County – What You Need to Know invited leaders of community- and faith-based organizations to learn how the new healthcare law will impact County residents.

AAHI invited speaker Uma Ahluwalia, Director for the Montgomery County Department of Health and Human Services, to lead the workshop. The workshop included a presentation of the demographic profile in Montgomery County, the implementation of the Affordable Care Act at the County level, and audience questions and answers. There were 53 attendees representing 27 organizations from the community.

**Speaker Contact Information:**
Uma S. Ahluwalia
Director
Montgomery County Department of Health and Human Services
[Uma.Ahluwalia@montgomerycountymd.gov](mailto:Uma.Ahluwalia@montgomerycountymd.gov)
240-777-1266
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A Presentation to the:
Asian American Health Initiative
Empowering Community Health Organization
Health and Human Services and
Preparing for Healthcare Reform

By
Uma S. Ahluwalia, Director
Department of Health and Human Services

May 28, 2013 | Silver Spring, Maryland

Who Do We Serve …
A Demographic Analysis
Ethnic | Racial Minority Seniors More Likely to Have Inadequate Income
Annual Household Income Below $25,000

- African American: 26%
- Asian: 26%
- Hispanic: 36%
- Non-Hispanic White: 15%

Limited English Proficiency High Among Ethnic Older Adults

- Hispanic: 44.1%
- Asian: 47.6%
- Indo-European: 26.5%
FY2010 Public Mental Health System Clients Versus 2010 Census County Population

Number of Individuals Oriented | Screened: 9385

Criminal Justice | Behavioral Health Services Clinical Assessment and Triage Services (CATS) FY 2011 Program Data
Crisis Services
FY11 Client Encounters by Race and Ethnicity
(N=2973)

Maternity Partnership Program Serves a Diverse Population
A number of clients enrolled in the Maternity Partnership Program Area Health Center Staff only captured ethnicity, Hispanic and Non-Hispanic.

Maternity Partnership Program Serves a Diverse Population
A number of clients enrolled in the Maternity Partnership Program Area Health Center Staff only captured ethnicity, Hispanic and Non-Hispanic.
Montgomery Cares Serves a Diverse Population

Provides primary health care to medically uninsured low-income adult County residents. The program is funded in part by the County to help support a network of independent nonprofit clinics.

Montgomery Cares Patient Demographics by Race

**Note: 55% of all patients also identified themselves as Hispanic**

<table>
<thead>
<tr>
<th></th>
<th>American Indian or Alaska Native</th>
<th>Asian</th>
<th>Black or African American</th>
<th>Native Hawaiian or Other Pacific Islander</th>
<th>White</th>
<th>Other</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY11</td>
<td>3% N = 806</td>
<td>11% N = 2,956</td>
<td>20% N = 5,375</td>
<td>&lt;1% N = 269</td>
<td>18% N = 4,838</td>
<td>41% N = 11,020</td>
<td>6% N = 1,613</td>
</tr>
<tr>
<td>FY10</td>
<td>&lt;1% N &lt;262</td>
<td>13% N = 3,415</td>
<td>21% N = 5,516</td>
<td>&lt;1% N &lt;262</td>
<td>20% N = 5,254</td>
<td>39% N = 10,244</td>
<td>7% N = 1,839</td>
</tr>
</tbody>
</table>

Racial and Ethnic Breakdown for SNAP Participants

**Racial Breakdown**
- 42% African American
- 39% White
- 12% Asian
- 6% American Indian
- 1% Pacific Islander

**Ethnicity**
- 27% Latino
### Racial and Ethnic Breakdown for Child Care Subsidy Participants

**Racial Breakdown**
- African American | 65%
- White | 22%
- Mixed Races | 6%
- Asian | 2%
- American Indian | 4%
- Pacific Islander | 1%

**Ethnicity**
- Latino | 28%

*Data Source: Maryland State Department of Education; Data available only for State Purchase of Care Program, but is representative of Working Parents Assistance caseloads.*

### Racial and Ethnic Background of Linkages to Learning Families

**Race**
- 39.5% White/Caucasian
- 16.5% Black/African American
- 1.6% Asian
- 0.5% American Indian/Alaska Native
- 0.2% Native Hawaiian or Pacific Islander
- 41.7% Not Captured/Client declined to provide*

**Ethnicity**
- 70.9% Hispanic
- 16.8% Non-Hispanic
- 12.3% Not Captured*

*The Department of Health and Human Services does not offer a “Mixed Race” category; as such, these figures apply to all clients who identify as mixed race or who otherwise do not identify with one of the proscribed categories.*
Population Served

- Services targeted to vulnerable, low-income households including homeless, elderly, disabled, and families with minor children.
- County Rental Assistance Program: 38% aged 62 or older | 20% disabled.
- Homeless Services and Permanent Supportive Housing Programs:

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;18</th>
<th>32%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-61</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>62+</td>
<td>3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>28%</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66%</td>
<td>Black/African American</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>American Indian/Alaska Native</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>Native Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td></td>
<td>3%</td>
<td>Multiple Races</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>51%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>49%</td>
</tr>
</tbody>
</table>

| Ethnicity          | Non-Hispanic | Non-Latino | 85% |
|                   | Hispanic | Latino | 15% |

Population by Race and Hispanic Origin Montgomery County, Maryland (2000 to 2010)

<table>
<thead>
<tr>
<th>Race and Hispanic Origin</th>
<th>2000 Number</th>
<th>Population Share</th>
<th>2010 Number</th>
<th>Populatio</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>519,318</td>
<td>59.5%</td>
<td>478,765</td>
<td>49.3%</td>
<td>-40,553</td>
<td>-7.8%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>100,604</td>
<td>11.5%</td>
<td>165,398</td>
<td>17.0%</td>
<td>64,794</td>
<td>64.4%</td>
</tr>
<tr>
<td>Black</td>
<td>129,371</td>
<td>14.8%</td>
<td>161,689</td>
<td>16.6%</td>
<td>32,318</td>
<td>25.0%</td>
</tr>
<tr>
<td>Asian and Pacific Islander</td>
<td>98,632</td>
<td>11.3%</td>
<td>135,104</td>
<td>13.9%</td>
<td>36,472</td>
<td>37.0%</td>
</tr>
<tr>
<td>Other</td>
<td>25,416</td>
<td>2.9%</td>
<td>30,821</td>
<td>3.2%</td>
<td>5,405</td>
<td>21.3%</td>
</tr>
<tr>
<td>TOTAL POPULATION</td>
<td>873,341</td>
<td>100%</td>
<td>971,777</td>
<td>100%</td>
<td>98,436</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

Census Bureau 2010
### Food Stamp Caseload by Regional Office

<table>
<thead>
<tr>
<th>Regional Office</th>
<th>Fiscal Year 2019 Year to Date*</th>
<th>Percent of Total</th>
<th>Fiscal Year 2012</th>
<th>Fiscal Year 2011</th>
<th>Fiscal Year 2010</th>
<th>Fiscal Year 2009</th>
<th>% Increase from FY09 to FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rockville</td>
<td>10,292</td>
<td>34%</td>
<td>9,407</td>
<td>8,506</td>
<td>6,232</td>
<td>5,268</td>
<td>79%</td>
</tr>
<tr>
<td>Silver Spring</td>
<td>8,492</td>
<td>28%</td>
<td>7,680</td>
<td>7,224</td>
<td>5,201</td>
<td>4,218</td>
<td>82%</td>
</tr>
<tr>
<td>Germantown</td>
<td>10,917</td>
<td>36%</td>
<td>10,222</td>
<td>9,478</td>
<td>7,576</td>
<td>6,020</td>
<td>70%</td>
</tr>
<tr>
<td>Suburban Washington Resettlement Center</td>
<td>436</td>
<td>1%</td>
<td>352</td>
<td>346</td>
<td>259</td>
<td>260</td>
<td>35%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>30,137</td>
<td>100%</td>
<td>27,661</td>
<td>25,554</td>
<td>19,268</td>
<td>15,766</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Caseload Numbers are as of June 30 of that Fiscal Year (Except for FY13)*

*As at December 2012

### Poverty Map of Montgomery County

Source: U.S. Census Bureau, American Community Survey 2007-2011

[Map showing poverty distribution in Montgomery County, MD]
<table>
<thead>
<tr>
<th>Year to Date</th>
<th>FY13 Unduplicated Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY13 Projected Patients</td>
</tr>
<tr>
<td>CCACC – PAVHC</td>
<td>600</td>
</tr>
<tr>
<td>Community Clinic, Inc.</td>
<td>3,585</td>
</tr>
<tr>
<td>CMR – Kaseman Clinic</td>
<td>2,250</td>
</tr>
<tr>
<td>Holy Cross Hospital Health Centers</td>
<td>6,131</td>
</tr>
<tr>
<td>Mary’s Center</td>
<td>888</td>
</tr>
<tr>
<td>Mercy Health Clinic</td>
<td>2,128</td>
</tr>
<tr>
<td>MobilMed</td>
<td>6,000</td>
</tr>
<tr>
<td>Muslim Community Center Clinic</td>
<td>2,500</td>
</tr>
<tr>
<td>Proyecto Salud — Wheaton and Olney</td>
<td>5,000</td>
</tr>
<tr>
<td>Spanish Catholic Center</td>
<td>1,100</td>
</tr>
<tr>
<td>The People’s Community Wellness Center</td>
<td>875</td>
</tr>
<tr>
<td>General Medical Clinic Sub-totals</td>
<td>31,057</td>
</tr>
<tr>
<td>Montgomery Cares FY13 Budget</td>
<td>32,250</td>
</tr>
<tr>
<td>CCI – Homeless</td>
<td>535</td>
</tr>
<tr>
<td>CMR — Kaseman Clinic – Homeless</td>
<td>273</td>
</tr>
<tr>
<td>Homeless Medical Clinic Sub-totals</td>
<td>808</td>
</tr>
<tr>
<td>Medical Clinic Totals</td>
<td>31,865</td>
</tr>
</tbody>
</table>
Why Health Care Reform Occurred?

- Unaffordable to Individuals
- Excessive Growth to Overall Costs
- Quality and Safety
  - Uneven and Inconsistent
  - Disparities in Outcomes
  - Preventable Medical Errors
- Access
  - Rising Uninsured/Underinsured Population
  - Decreasing Provider Availability
- Clinical Information
  - Program Management
- Inadequate Use of Health IT
- Primary Focus on Disease … Not Wellness
- Under-investment in Public Health

The Patient Protection and Affordable Care Act requires each state to establish a “health insurance exchange” by 2014

- Expands Medicaid to include individuals with incomes up to 138% of the federal poverty level – effective January 2014
- Establishes tax credits for individuals with incomes between 138% - 400% of the federal poverty level – effective January 2014
- Establishes tax credits for small businesses that provide health insurance to employees – effective January 2014
- Creates both **Individual** and **Small Business Health Options Program** (SHOP) Exchanges
- Provides determination of qualified Health plans to participate in the Exchange — four “Metal” levels: Platinum, Gold, Silver, and Bronze

---

**Continued**

- Several key provisions of the Patient Protection and Affordable Care Act include:
  - Coverage extended to adults with pre-existing medical conditions – in effect today
  - Parents can continue to provide health insurance coverage for children until the age of 26 – in effect today
  - Insurance companies are now prohibited from cancelling policy coverage when an enrollee is sick – in effect today
  - All new insurance plans must cover preventive care and medical screenings – in effect today
  - All new health plans must cover certain preventive services (such as mammograms and colonoscopies) without charging a deductible, co-pay or co-insurance – once HIX is operational – January 2014
- Women’s Preventive Services will be covered without requiring a deductible, co-pay or co-insurance – in effect today and will impact Qualified Health Plans in the HIX on January 2014.
- Individuals affected by the Medicare Part D coverage gap have received a $250 rebate:
  - 50% of the gap was eliminated in 2011
  - The gap will be completely eliminated by 2020
- All health insurance companies must inform the public when a rate increase of 10% (or more) is requested for individual or small group policies – in effect today.
Maryland Health Connection is the state’s health insurance Exchange

The State is developing its Exchange to be an accessible and competitive marketplace for Marylanders to search for and enroll in affordable health insurance plans as well as determine eligibility for Medicaid and Federal tax credits.

Maryland Health Connection will provide a “no wrong door” approach to help Marylanders determine health insurance eligibility – online October 2013.

Individuals, families and small businesses will be able to:
- Compare health insurance options
- Calculate total out-of-pocket costs based on eligible subsidies or tax credits
- Enroll in the health plan that addresses his/her coverage needs
- Connect to a Connector Entity who, along with a Call Center, will assist with enrollment within the Exchange.
Maryland Health Connection will expand access to the 730,000 residents who are currently without health insurance.

- 147,000 statewide enrollees projected in the first year
- 52% expansion in the HIX and 48% expansion into Medicaid

Establishes the requirements for “qualified plans” authorized to provide services within the Exchange – currently the selection process under review by the Exchange board.

- Provides federal subsidies & tax credits to individuals up to 400% of the federal poverty level to assist with insurance premiums.
- Lowers uncompensated care costs in the health care system; resulting in lower insurance premiums across the state.

Establishes a core set of benefits that are “essential” for every health insurance plan offered in Maryland:

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity & Newborn Care
- Mental Health and Substance Use Disorder Services
- Prescription Drugs
- Rehabilitative and Habilitative Services and Devices
- Laboratory Services
- Preventive, Wellness Services and Chronic Disease Management
- Pediatric Services (Including Oral and Vision Care)
OPEN ENROLLMENT

- Begins **October 2013** and will continue through **March 2014**
- Enrollment assistance will be provided:
  1. Online
  2. In Person; or,
  3. Via Telephonic support to residents seeking coverage

*120,000* Montgomery County residents are currently uninsured

*45,000* residents will remain uninsured despite health care reform provisions – hence the need for Montgomery CARES, Care for KIDS and Maternity Partnership with County General Fund Support will continue

- An additional *20,000* residents will be ineligible if Maryland does not enact the *Basic Benefit Plan Option*
  - Highly unlikely at this time – adding total number of uninsured to 65,000 in the County
  - Legal immigrants (persons with less than five years of legal residency) will be negatively impacted

Altogether, *55,000* Montgomery County residents will be eligible for coverage as a result of health care reform – 52% will join in the HIX and 48% will add to Medicaid – full expansion expected over three years.

- **Concern:** the anticipated impact on the County’s network of social services is unknown at this time
Impact of Health Care Reform within Montgomery County?

Health Care Reform Related Activities

- October 2010 conference held in Montgomery County
- 100-plus healthcare professionals, advocates, and policy makers attended
- **Objective:** Develop priority areas and strategies to move Montgomery County towards the goal of universal health care and maximize opportunities under the Patient Protection and Affordable Care Act
Department of Health and Human Services

- Departmental Response to Health Care Reform
  - Monitor federal and state decisions/regulations
    - Advisory Committee Membership
  - Expansion of Primary Care
    - Prevention and Continuity of Care Services
  - Continuation of Service Integration Activities
    - Behavioral Health
    - Social Services
  - Received award for Connector Entity designation for Capital Region – Montgomery And Prince George’s County. Navigator and Assister staff will be trained and ready to offer services effective October 1, 2013
Department of Health and Human Services

(continued)

- Procurement of Electronic Health Records System as well as other departmental technology upgrades
  - Establishing a **No Wrong Door** approach to service delivery

- Healthy Montgomery
  - **Mission**: achieve optimal health and well-being for Montgomery County’s residents
  - The Healthy Montgomery process is based upon an ongoing sustainable community and consensus-driven approach that identifies & addresses key priority areas that ultimately improve the health and well-being of our community

**POLICY**

- Montgomery County elected to apply for Capital Region Connector Entity designation

- Expanding School Based Health Centers and High School Wellness Centers to accept parents, siblings and neighbors in the school community and not just the students in the school – Having very productive conversations with our Public Schools for a January 1, start date

- Build policies to integrate all Eligibility on the HIX platform

- How to create a true “No Wrong Door” – role of our PTM effort

- New staff roles created and supported as health reform is implemented

- How to support Behavioral health and primary care integration
Connector Entity Program
Capital Region
Montgomery and Prince George’s Counties

Maryland Connector Entity Regions

REGIONAL CONNECTOR ENTITIES
- central: Health Care Access Maryland (HCAM)
- southern: Calvert Healthcare Solutions
- upper eastern shore: Seegto
- lower eastern shore: Worcester County Health Department
- western: Healthy Howard
- capital: Montgomery County Department of Health & Human Services
Why:

- These organizations possess the capacity to serve the Capital Region.

- The partners bring diverse strengths and assets required to support the goals of the Connector Entity Program.

- The resources and expertise housed within the Montgomery County Department of Health and Human Services, the Prince George's County Health Department and Department of Social Services will be leveraged to maximize the regional engagement and enrollment activities.

- Collectively, we will combine our knowledge and personnel to meet the year-one Connector Entity targets.
Outreach and Engagement Strategy

- Navigators and Assisters will provide outreach and engagement services throughout the Capital Region with a particular focus on hard-to-reach populations

- Mobile Teams
  - On-the-spot assistance (including enrollment) will be available within the Capital Region

- Leverage Existing Expertise within Community Outreach Workers
  - Capacity within MCDHHS Office of Community Affairs
  - Outreach capacity within Prince George’s County Departments
  - The Training Source, Inc.

- Data-driven Deployment of Connector Entity Staff

- Data-driven Identification of Outreach and Engagement Sites
  - Central to the Capital Region proposal is the flexibility to quickly reassign staff and adjust outreach and engagement sites as dictated by data

- Capital Region Calendar
Outreach and Engagement Strategy | continued

- Outreach and engagement sites will include the following:
  - Montgomery and Prince George's County Government Sites
  - Partner Organization Sites
  - Hospitals
  - Recreation Centers and Libraries
  - Places of Worship
  - Community Clinics
  - Community Events/Fairs
  - Events Sponsored by the Local Chambers of Commerce and the Local Departments of Economic Development
  - Non-Traditional Community Gathering Places

---

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Montgomery County, Maryland
Department of Health and Human Services
401 Hungerford Drive
Suite 500
Rockville, Maryland 20850

240.777.1266
uma.ahluwalia@montgomerycountymd.gov

RESOURCES:
www.montgomerycountymd.gov
www.marylandhealthconnection.gov
www.dhmh.maryland.gov

---

Thank You
**WORKSHOP FEEDBACK**

Responses from the workshop evaluation forms received. Note: “n”=the number of participants; the percents may not add up to 100 due to rounding.

**Please rate this workshop (circle one):**

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Fair</th>
<th>Average</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Value of topic</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>21%</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=7)</td>
<td>(n=26)</td>
</tr>
<tr>
<td>b. Quality of content</td>
<td>0%</td>
<td>3%</td>
<td>6%</td>
<td>29%</td>
<td>62%</td>
</tr>
<tr>
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<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=2)</td>
<td>(n=10)</td>
<td>(n=21)</td>
</tr>
<tr>
<td>c. Quality of speaker</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>35%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=12)</td>
<td>(n=21)</td>
</tr>
<tr>
<td>d. Usefulness of handouts</td>
<td>0%</td>
<td>0%</td>
<td>3%</td>
<td>41%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=14)</td>
<td>(n=19)</td>
</tr>
<tr>
<td>e. Length of workshop</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>47%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=16)</td>
<td>(n=17)</td>
</tr>
<tr>
<td>f. Time for questions and answers</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>41%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=0)</td>
<td>(n=14)</td>
<td>(n=17)</td>
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<tr>
<td>g. Overall rating of workshop</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
<td>38%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=1)</td>
<td>(n=13)</td>
<td>(n=19)</td>
</tr>
</tbody>
</table>

**Please rate the following (circle one):**

<table>
<thead>
<tr>
<th>After attending this workshop:</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Undecided</th>
<th>Somewhat Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I feel more knowledgeable about the ACA</td>
<td>0%</td>
<td>3%</td>
<td>6%</td>
<td>35%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>(n=0)</td>
<td>(n=1)</td>
<td>(n=2)</td>
<td>(n=12)</td>
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</table>
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5 things to know about health insurance

1. There are many kinds of private health insurance policies. Different kinds of policies can offer very different kinds of benefits, and some can limit which doctors, hospitals, or other providers you can use.

2. You may have to pay coinsurance or a copayment as your share of the cost when you get a medical service, like a doctor’s visit, hospital outpatient visit, or a prescription. Coinsurance is usually a percentage amount (for example, 20% of the total cost). A copayment is usually a set dollar amount (for example, you might pay $10 or $20 for a prescription or doctor’s visit).

3. You may have to pay a deductible each plan year before your insurance starts to pay for care you get. For example, let’s say you have a $200 deductible. You go to the emergency room and the total cost is $1250. You pay the first $200 to cover the deductible, and then your insurance starts to pay its share.

4. Health insurance plans contract with networks of hospitals, doctors, pharmacies, and health care providers to take care of people in the plan. Depending on the type of policy you buy, your plan may only pay for your care when you get it from a provider in the plan’s network, or you may have to pay a bigger share of the bill.

5. You may see products that look and sound like health insurance, but don’t give you the same protection as full health insurance. Some examples are policies that only cover certain diseases, policies that only cover you if you’re hurt in an accident, or plans that offer you discounts on health services. Don’t mistake insurance-like products for full comprehensive insurance protection.

Insurance helps pay costs when you need care
Insurance protects you from high costs when something bad happens. No one plans to get sick or hurt, but most people need to get treated for an illness or injury at some point, and health insurance helps pay these costs. You buy health insurance to protect you when you need medical care.

What is health insurance?
Health insurance is a contract between you and your insurance company. You buy a plan or policy, and the company agrees to pay part of your medical expenses when you get sick or hurt.

A standard health insurance policy also gives you access to preventive care to keep you healthy, like vaccines and check-ups. Many plans also cover prescription drugs.

Health insurance helps you pay for care
Did you know the average cost of a 3-day hospital stay is $30,000? Or that fixing a broken leg can cost up to $7,500? Having health insurance can help protect you from unexpected costs like these.

Your insurance policy will show what types of care, treatments and services are covered, including how much the insurance company will pay for different treatments in different situations.

What you pay for health insurance
You’ll usually pay a premium every month for health insurance, and you may also have to meet a deductible once each year before the insurance company starts to pay its share. How much you pay for your premium and deductible is based on the type of insurance you have.

Just as important as the premium cost is how much you have to pay when you get services. Examples include:

- How much you pay before your insurance coverage starts (a deductible)
- What you pay out-of-pocket for services after you pay the deductible (coinsurance or copayments)
- How much in total you’ll have to pay if you get sick (the out-of-pocket maximum)

What your policy covers is often directly related to how expensive the health insurance policy is. The policy with the cheapest premium may not cover many services and treatments.
7 things you can do to get ready now

1. **Learn about different types of health insurance.** Through the Marketplace, you’ll be able to choose a health plan that gives you the right balance of costs and coverage.

2. **Make a list of questions you have before it’s time to choose your health plan.** For example, “Can I stay with my current doctor?” or “Will this plan cover my health costs when I’m traveling?”

3. **Make sure you understand how insurance works, including deductibles, out-of-pocket maximums, copayments, etc.** You’ll want to consider these details while you’re shopping around. Visit [www.HealthCare.gov](http://www.HealthCare.gov) to learn more about how insurance works.

4. **Start gathering basic information about your household income.** Most people will qualify to get a break on costs, and you’ll need income information to find out how much you’re eligible for.

5. **Set your budget.** There will be different types of health plans to meet a variety of needs and budgets, and breaking them down by cost can help narrow your choices.

6. **Find out from your employer whether they plan to offer health insurance,** especially if you work for a small business.

7. **Explore current options.** You may be able to get help with insurance now, through existing programs or changes that are in effect already from the new health care law. Visit [www.HealthCare.gov](http://www.HealthCare.gov) for information about health insurance for adults up to age 26, children in families with limited incomes (CHIP), and Medicare for people who are over 65 or have disabilities.

**Better health insurance choices**

When key parts of the health care law take effect in 2014, there’ll be a new way to buy health insurance: the Health Insurance Marketplace. The Marketplace is designed to help you find health insurance that fits your budget, with less hassle.

Every health insurance plan in the new Marketplace will offer comprehensive coverage, from doctors to medications to hospital visits. You can compare all your insurance options based on price, benefits, quality, and other features that may be important to you, in plain language that makes sense.

You’ll know you’re getting a quality health plan at a reasonable price, because there’s nothing buried in the fine print.

**Insurance plans run by private companies**

When you shop at the Marketplace, everything you need is laid out for you. All your costs are stated up front, so you’ll get a clear picture of what you’re paying and what you’re getting before you make a choice.

Under the health care law, there will also be new protections for you and your family. Health insurance companies can’t refuse to cover you or charge you more just because you have a chronic or pre-existing condition, and they can’t charge more for women than for men.

**Watch for more information in October 2013**

Starting on October 1st, you’ll be able to get information about all the plans available in your area. You’ll be able to enroll yourself and your family, directly through the website, or call a toll-free phone hotline.

If you’re having difficulty finding a plan that meets your needs and budget, there’ll be people available to give you personalized help with your choices. These helpers aren’t associated with any particular plan, and they aren’t on any type of commission, so the help they give you will be completely unbiased.

Coverage via the Marketplace starts in January 2014.

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**3 things to know about the Health Insurance Marketplace**

1. **It’s an easier way to shop for health insurance.**
   The Health Insurance Marketplace simplifies your search for health insurance by gathering all your options in one place. One application, one time, and you and your family can explore every qualified insurance plan in your area, along with any free or low-cost insurance programs you may qualify for.

2. **Most people will be able to get a break on costs.**
   Programs that lower costs are available for almost everyone. You may be eligible for a free or low cost plan, or a new kind of tax credit that lowers your monthly premiums right away. New rules and expanded programs mean that even working families can get help paying for health insurance at the Marketplace.

3. **Gives you control over your options with clear, apples-to-apples comparisons.**
   All health insurance plans in the Marketplace present their price and benefit information in simple terms you can understand, so you don’t have to guess about your costs. You get a clear picture of what you’re paying and what you’re getting, before you make a choice.
7 things you can do to get ready now

1. **Make sure you understand how insurance works.** For example, you’ll want to understand the difference between premiums and out-of-pocket costs, like deductibles and copayments. You’ll want to compare these details to help determine which plans are right for you and your employees. Visit [www.HealthCare.gov](http://www.HealthCare.gov) to learn more about how insurance works.

2. **Learn about different types of health insurance.** Through the Marketplace, you’ll be able to choose a level of coverage that gives you and your employees the right balance of cost and benefits.

3. **Start thinking about when to begin coverage.** You’ll need to choose a month to start coverage. Consider what timing would work best for you and your employees.

4. **Set your budget.** Think about how much money you’re able to spend for group coverage. You’ll also need to consider how much your employees can spend for their coverage.

5. **Get organized.** You’ll want to have basic information about your business organized and available, like a list of employees you plan to cover and your tax ID number.

6. **Make a list of questions you have before it’s time to choose which health plans you’ll offer.** Consider what’s most important for your budget and your employees.

7. **Look for help.** If you already use a health insurance agent or broker, they’ll be able to help you figure out your options. Brokers sell many different insurance products and are usually paid by insurance companies. Agents work for just one insurance company.

A new way to buy health insurance for your small business

Today, small employers like you have a tough time finding and affording coverage that meets the needs of your employees. Starting in 2014, you’ll have more choice and control over your health insurance spending through the Small Business Health Options Program (SHOP), a new program designed to simplify the process of buying health insurance for your small business.

You control the coverage you offer
You choose the level of coverage you’ll offer, and define how much you’ll contribute towards your employees’ coverage.

Access to tax benefits
You’ll also have exclusive access to an expanded Small Business Healthcare Tax Credit. This tax credit covers as much as 50% of the employer contribution toward premium costs for eligible employers who have low- to moderate-wage workers.

When you buy insurance through the SHOP, it makes it easy for you to take advantage of other tax breaks, too, including the chance for you and your employees to use pre-tax dollars to make your premium payments.

New consumer protections
You and your employees will also benefit from new protections that help you get real value for your premium dollars. There are new limits on the higher premiums insurers can charge businesses with older employees, and an employee with high health care costs no longer increases your group’s premium. There are also new limits on the share of premiums going to insurers’ profits and administrative costs.

Insurance plans run by private companies
The health insurance plans available in the SHOP will be run by private health insurance companies, the same way small group plans are run now. All plans will offer the same benefits as a “typical” employer plan, including real protection against financial catastrophe.

Plans will present their cost and coverage information in a standard format, using plain language that’s clear and easy for you to understand. You and your employees will be able to easily compare plans based on price, coverage, quality and other features that are important to you.

Use your broker, or shop on your own
You can use your existing insurance broker to access the SHOP, or you can shop for plans yourself, without a broker. You can review pricing and coverage in apples-to-apples comparisons, complete a single application, and choose the level of coverage that works for your budget, your business, and your employees.

Watch for more information in October 2013
Starting in October, you’ll be able to get information about all the plans available in your area. You and your employees will be able to enroll through your broker, directly through the website, or by calling a toll-free phone hotline.
Health Care Reform Timeline

Small Business Tax Credit | January 2010
Small businesses with less than 25 employees may now qualify for a tax credit to help offset the cost of providing health insurance. The tax credit covers up to 35% of the employer’s contribution to the employee’s health plan.

Affordable Care Act Becomes Law | March 2010
On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law. The law aims to improve access to quality, affordable health care for Americans and will be implemented leading up to 2018.

Pre-Existing Condition Health Insurance Plan | June 2010
Marylanders who have been denied coverage because of a pre-existing condition may qualify for coverage through the Maryland Health Insurance Plan.

Indoor Tanning Tax | July 2010
A 10% tax for indoor tanning services took effect.

External Review of Insurance Decisions | September 2010
Marylanders can appeal insurance decisions through an external review process.

Insurers Cannot Revoke Coverage | September 2010
Health plans cannot deny or revoke coverage if you make a mistake on an application, except in the case of fraud.

No Denials for Children with Pre-Existing Conditions | September 2010
Children up to age 19 can no longer be denied health coverage because of a pre-existing condition, like asthma or diabetes.

Phasing out Annual Limits | September 2010
Health plans are beginning to raise their annual dollar limit on the amount of care that is covered in one year. By 2014, annual limits will not be allowed on most health plans.
Increased Access to Preventive Services | September 2010
Employer and individual health plans that started after March 23, 2010 now cover preventive care services, such as cancer screenings and vaccinations, at no cost to you.

Young Adults Covered | September 2010
Young adults who don’t have access to employer coverage can stay on their parents’ health insurance plan until age 26.

No Lifetime Limits | September 2010
Health insurance plans issued or renewed on or after September 23, 2010 can no longer place dollar limits on the amount of care that is covered in your lifetime.

Maryland Consumer Assistance Program | October 2010
The Maryland Consumer Assistance Program will help consumers whose insurance plan has refused to cover a medical procedure or to pay for a medical service that has already been provided.

Flexible Spending Account Change | January 2011
Over-the-counter medication that is not prescribed by your health care provider is no longer reimbursed through an FSA.

Community Care Transitions Programs | January 2011
The CCTP will coordinate care and connect Medicare patients with services to help avoid hospital readmissions.

Medicare Advantage Payment | January 2011
Extra payments to Medicare Advantage plans often result in higher premiums for people in Medicare. The law will gradually remove these extra payments. Medicare plans will still provide all guaranteed Medicare benefits, but some plans might reduce optional benefits. Medicare Advantage plans that provide high-quality care could receive bonus payments.

Medicare Part D Income | January 2011
Premiums for Medicare Part D coverage will be increased for higher-income individuals and couples. This will affect individuals making more than $85,000 per year, and couples in Medicare Part D making more than $170,000 per year.

Medicare Part B Income | January 2011
The cap for income-related Medicare Part B premiums will be kept at 2010 levels ($85,000 per year for individuals and $170,000 per year for couples) until 2019.

Medicare Preventive Services | January 2011
Medicare patients have access to certain preventive services, like wellness visits and cancer screenings, at no cost to them.
Medicare Part D Prescription Discounts | January 2011
Seniors who receive prescription coverage through Medicare Part D will receive a 50% discount on brand-name prescription medicines when they reach the coverage gap or “donut hole.” The “donut hole” will close completely in 2020.

Spending Your Premium Health Dollars | January 2011
Insurers must spend at least 80% of your premium dollars on health care services or improving the quality of care.

Accountable Care Organizations | January 2012
Incentives are available for health care providers that form Accountable Care Organizations (ACOs) to help coordinate care and reduce unnecessary hospital admissions. ACOs that reach certain quality standards can share in cost savings they achieve in Medicare.

Reducing Health Care Disparities | March 2012
Ongoing and new programs will help collect and report on racial, ethnic and language data to help identify and reduce health disparities.

Extension of MCHP | January 2013
The Maryland Children’s Health Insurance Program (MCHP) will receive two more years of funding to cover children not eligible for Medicaid.

Flexible Spending Account Limits | January 2013
Flexible Spending Account contributions used to pay for medical expenses will be limited to $2,500 per year.

Medical Assistance Preventive Care | January 2013
Medical Assistance will provide preventive care services at no cost to enrollees.

Maryland Health Benefit Exchange | October 2013
Marylanders who don’t have access to affordable health insurance will be able to find health plans through a new Maryland Health Benefit Exchange. The Exchange will allow individuals and small business owners to compare and shop for affordable health plans. All health plans offered on the Exchange will cover a set of essential health benefits.

Requirements for Employers | January 2014
Businesses with more than 50 employees that do not offer full-time employees health insurance and whose employees receive a tax credit to buy insurance through the Maryland Health Benefit Exchange will pay a fee.

No Denial for Pre-Existing Conditions | January 2014
Insurance plans will not be able deny coverage for anyone because of a pre-existing condition.
No Annual Limits | January 2014
Insurance plans will no longer be able to put a dollar limit on the amount of care that is covered in one year.

Individual Tax Credits | January 2014
Marylanders who cannot afford health insurance may qualify for tax credits to help them purchase a plan through the Exchange. Individuals and families with incomes between 133 – 400% of the Federal Poverty Level will qualify for a tax credit. Today, that would mean an individual making about $15,000 to about $44,500 or a family of four making about $30,500 to about $92,000 would be eligible.

Medical Assistance Expansion | January 2014
Medical Assistance will expand to cover more Marylanders. If an individual or family makes less than 133% of the Federal Poverty Level they will qualify for Medical Assistance. Today, that would mean an individual earning up to about $15,000 a year or a family of four earning up to about $30,500 a year would be eligible.

Maryland Health Benefit Exchange | January 2014
Marylanders who don’t have access to affordable health insurance will be able to find health plans through a new Maryland Health Benefit Exchange. The Exchange will allow individuals and small business owners to compare and shop for affordable health plans. All health plans offered on the Exchange will cover a set of essential health benefits.

Employee Vouchers | January 2014
Employees who cannot afford their employer-sponsored insurance may take the funds their employer would have contributed and use that money to purchase a more affordable plan.

Requirement to Have Health Coverage | January 2014
Most Marylanders will be required to have health coverage through their employer, a public health insurance plan or a plan they purchase on their own. Individuals who have trouble affording a health plan may qualify for a tax credit, and individuals who choose not to purchase a health plan will be required to pay a fee.

Physicians Payments and Quality Care | January 2015
Physician payments will be tied to the quality of care they provide. Physicians who provide higher value care will be paid more than those who provide lower quality care.

Tax on High Cost Plans | January 2018
Insurance companies that offer expensive employer health insurance plans may have to pay a High-Cost Excise Tax.
Health Reform:
Frequently Asked Questions

Insurance

**Will everyone have to buy health insurance? What happens if they don't? How will people prove they have health insurance?**

Starting in 2014, most people will be required to have health insurance or pay a penalty if they don't. Coverage may include employer-provided insurance, coverage someone buys on their own, or Medicaid.

Several groups are exempt from the requirement to obtain coverage or pay the penalty, including: people who would have to pay more than 8% of their income for health insurance, people with incomes below the threshold required for filing taxes (in 2012, $9,750 for a single person and $26,000 for a married couple with two children), those who qualify for religious exemptions, undocumented immigrants, people who are incarcerated, and members of Indian tribes.

The penalty for people who forego insurance is the greatest of two amounts: a specified percentage of income or a specified dollar amount. The percentages of income are phased in over time at 1% in 2014, 2% in 2015, and 2.5% starting in 2016. (Income is defined as total income in excess of tax filing thresholds.) The dollar amounts are also phased in at $95 in 2014, $325 in 2015, and $695 beginning in 2016 (with annual increases after that). The Congressional Budget Office projects that 3.9 million people will pay the penalty in 2016. The total penalty for the taxable year will not exceed the national average of the annual premiums of a bronze level health insurance plan offered through the health insurance Exchanges.

Health insurance plans will provide documents to people they insure that will be used to prove that they have the minimum coverage required by law.

**What is a health insurance exchange?**

Exchanges are new organizations that will be set up to create a more organized and competitive market for buying health insurance. They will offer a choice of different health plans, certifying plans that participate and providing information to help consumers better understand their options.

Beginning in 2014, Exchanges will serve primarily individuals buying insurance on their own and small businesses with up to 100 employees, though states can choose to include larger employers in the future. States are expected to establish Exchanges--which can be a government agency or a non-profit organization--with the federal government stepping in if a state does not set them up. States can create multiple Exchanges, so long as only one serves each geographic area, and can work together to form regional Exchanges. The federal government will offer technical assistance to help states set up Exchanges.
How will the new provision allowing young adults to remain on a parent's insurance work?

The health reform law contains a provision that requires private insurers to continue dependent coverage of children until age 26. Department of Health and Human Services regulations specify that a young adult can qualify for this coverage even if he or she is no longer living with a parent, is not a dependent on a parent's tax return, or is no longer a student. Both married and unmarried young adults can qualify for the dependent coverage extension, although that coverage does not extend to a young adult’s spouse or children. For employer plans that were in place prior to March 23, 2010, young adults can only qualify for dependent if they are not eligible for another employer-sponsored insurance plan. Insurers that do not offer coverage to dependent children will not be required to offer this coverage to young adults.

The extension of dependent coverage to age 26 will go into effect on September 23, 2010, but plans will not be required to comply with the regulations until the first plan year beginning on or after that date. However, some insurers have said that they will begin to make the extension of dependent coverage available prior to September 2010 for young adults who would otherwise lose coverage.

Regulations also state that young adults who gain dependent coverage under the health reform law cannot be charged more for coverage than similar individuals who did not lose coverage due to the end of their dependent status. Young adults newly qualifying as dependents under the health reform law must also be offered the same benefits package as similar individuals who were already covered as dependents.

Currently, some states require that private insurance extend coverage to young adults in their twenties. These state requirements do not extend to self-funded insurance plans, but the new federal health reform law is designed to apply to these self-funded plans.

What protections are there in the new health reform law for people with pre-existing conditions?

Starting in 2014, all health insurers will have to sell coverage to everyone who applies, regardless of their medical history or health status. At that time, insurers will not be allowed to charge more to individuals with pre-existing conditions, nor will they be able exclude coverage of those conditions from the insurance plans they sell.

The law provides new protections for children with pre-existing conditions that will take effect on September 23, 2010. Insurers will not be permitted to deny coverage to children due to their health status, or exclude coverage for pre-existing conditions.

While adults will not have the same protections as children in the years prior to 2014, some adults may be eligible for a temporary national high-risk pool open to all U.S. citizens and legal residents who have had trouble buying insurance due to a pre-existing condition and have been uninsured for at least six months. This federally subsidized coverage, officially known as the Pre-existing Condition Insurance Plan, will provide temporary coverage until the broader coverage provisions take effect in January 2014. States can operate their own high-risk pool or have the federal government carry out the program. The federal government began accepting applications for enrollment in their high-risk pool on July 1, 2010, with coverage beginning on August 1, 2010. Premiums for this coverage will be based standard premiums for the general population, and therefore will not be higher due to the health problems faced by the high-risk pool beneficiaries. In addition, the amount that premiums can vary based on age will be limited. The high-risk pool insurance must cover 65% of medical costs and the maximum cost sharing is set at the Health Savings Account limits ($5,950 for an individual and $11,900 for a family of four).
How will existing employer health plans be affected by health reform?

Employer plans that were in place on March 23, 2010, the date the new health reform law was enacted, are referred to as "grandfathered plans" and are subject to some of the new rules but exempt from others. Beginning on September 23, 2010, grandfathered employer plans are required to eliminate any lifetime limits on coverage and restrict any annual limits on coverage, eliminate pre-existing condition exclusions for children, and if the plan provides dependent coverage, extend that coverage to adult children up to age 26. Beginning in 2014, grandfathered employer plans will be required to eliminate any annual limits on coverage, eliminate pre-existing condition exclusions for adults, and limit waiting periods for coverage to no more than 90 days. Grandfathered employer plans will not, however, be required to alter their benefits to meet the new minimum benefit standards nor will they have to limit enrollee cost sharing or provide coverage for preventive services with no cost-sharing. In order to maintain its grandfathered status, a plan cannot reduce or eliminate benefits to treat particular conditions, increase employee cost-sharing (including deductibles, co-insurance, and co-payments) above certain thresholds, reduce the employer share of the premium cost, or change insurers. Once a plan loses its grandfathered status, it will have to comply with all the new rules.

What preventive services will be covered?

Since July 2010, any new plans offered by employers or insurers — not including so-called "grandfathered" coverage that people already have — have to provide coverage for a range of preventive services, including: services recommended with a rating of "A" or "B" from the U.S. Preventive Services Task Force, immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, and additional services for women contained in guidelines issued by the Health Resources and Services Administration (including routine mammograms for women over age 40). In addition, plans are required to cover these preventive services without any cost-sharing for patients.

Employers

How are small businesses affected by health reform?

The health reform law includes a number of provisions that reform the insurance market and encourage small businesses to offer health insurance. Coverage offered in the small group market and in the exchanges established for small business to purchase insurance, must meet minimum benefit standards; allow premiums to vary only by age, tobacco use, and geographic location; be subject to reviews of premium increases; and comply with other consumer protections.

The provisions to encourage small firms to offer coverage apply only to firms under a certain size.

Fewer than 25 Employees:
Beginning in 2010, business with fewer than 25 full time equivalents and average annual wages of less than $50,000 that pay at least half of the cost of health insurance for their employees are eligible for a tax credit. The full credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. The credit is capped based on the average health insurance premium in the area where the small business is located.
The tax credit will be introduced in two phases. For tax years 2010 to 2013, eligible employers may receive a tax credit of up to 35% of the employer’s contribution toward the employee’s health insurance premium. For tax years 2014 and later, eligible small businesses that purchase coverage through the state Exchange may receive a tax credit of up to 50% of the employer’s contribution toward the employee’s health insurance premium. Employers are eligible to take the tax credit for two years. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer’s contribution toward the employee’s health insurance premium for tax years 2010 to 2013, and up to 35% for tax years 2014 and later.

**Fewer than 50 Employees:**
Businesses with fewer than 50 employees are exempt from penalties faced by larger employers that do not offer coverage. The penalties for larger employers (50 or more employees) do not go into effect until 2014.

**Fewer than 100 Employees:**
Small businesses with fewer than 100 employees will be able to purchase coverage through Small Business Health Options Program (SHOP) Exchanges beginning in 2014. These state-based exchanges are intended to allow employers to shop for qualified coverage and more easily compare prices and benefits. In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through the SHOP Exchanges.

**Will employers that don’t provide health benefits have to pay a penalty?**
The health reform law does not require employers to provide health benefits. However, it does impose penalties in some cases on larger employers (those with 50 or more workers) that do not provide insurance to their workers or that provide coverage that is unaffordable.

Larger employers that do not provide coverage will be assessed a penalty beginning in 2014 if any one of their workers receives a tax credit when buying insurance on their own in a health insurance Exchange. Workers with income up to 400% of the poverty level are eligible for tax credits. The employer penalty is equal to $2,000 multiplied by the number of workers in the business in excess of 30 workers (with the penalty amount increasing over time).

In some instances, larger employers that offer coverage could be subject to penalties as well. If the coverage does not have an actuarial value of at least 60% — meaning that on average it covers at least 60% of the cost of covered services for a typical population -- or the premium for the coverage would exceed 9.5% of a worker's income, then the worker can obtain coverage in an Exchange and be eligible for a tax credit. For each worker receiving a tax credit, the employer will pay a penalty of $3,000 up to a maximum of $2,000 times the number of workers in excess of 30 workers.

**How does the new law apply to companies with self-funded plans?**
Self-funded plans--those where the employer accepts the risk for the health benefits it provides, rather than buying coverage from an insurance company--are generally exempt from state insurance regulations and are instead regulated by the Employee Retirement Income Security Act (ERISA). The new health reform law contains many provisions that apply nationally to both self-funded plans and fully insured plans. Some of these provisions include the extension of dependent coverage until age 26, no cost sharing for preventive services, the limit on waiting periods to no more than 90 days, maximum patient out-of-pocket costs, and no lifetime or annual limits on coverage. However, self-funded plans will not be subject to meeting the minimum essential health benefit requirements. “Grandfathered” plans (i.e., those that were in place on March 23, 2010) are not subject to all the above requirements.
How will the health reform law help people with their out-of-pocket expenses?

The new law has several provisions that are aimed at making private health insurance more affordable that will take effect in 2014. First, premium tax credits and cost-sharing subsidies will be available for U.S. citizens and legal immigrants purchasing coverage on their own in the new health insurance exchanges. The premium tax credits will be available to those with incomes up to 400% of the poverty level (estimated at about $47,000 for an individual or $96,000 for a family of four in 2014) and will limit what a person has to pay toward the premium to a specified percentage of income. The amount people will have to pay will range from 2% of income for those with income up to 133% of the poverty level to 9.5% of income for those with income between 300 and 400% of the poverty level. In addition to premium tax credits, people with incomes up to 250% of the poverty level (estimated at about $29,000 for an individual or $60,000 for a family of four in 2014) will be eligible for cost-sharing subsidies that will reduce what they will have to pay out-of-pocket for covered health services.

Second, the law establishes limits on what people buying insurance in the exchanges and some others will pay out-of-pocket for services covered by health plans. These limits are set initially at $6,400 for an individual and $12,800 for a family, and grow over time. For people purchasing coverage in the exchanges who have incomes at or below 250% of the poverty level, the out-of-pocket limits will be reduced.

Will employers that don't provide health benefits have to pay a penalty?

The health reform law does not require employers to provide health benefits. However, it does impose penalties in some cases on larger employers (those with 50 or more workers) that do not provide insurance to their workers or that provide coverage that is unaffordable.

Larger employers that do not provide coverage will be assessed a penalty beginning in 2014 if any one of their workers receives a tax credit when buying insurance on their own in a health insurance Exchange. Workers with income up to 400% of the poverty level are eligible for tax credits. The employer penalty is equal to $2,000 multiplied by the number of workers in the business in excess of 30 workers (with the penalty amount increasing over time).

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Affordability and Subsidies

Who will be eligible for subsidies to make health insurance more affordable?

Beginning in 2014, tax credits will be available to U.S. citizens and legal immigrants who purchase coverage in the new health insurance exchanges and who have income up to 400% of the federal poverty level ($43,320 for an individual or $88,200 for a family of four in 2009). To be eligible for the premium tax credits, individuals must not be eligible for public coverage—including Medicaid, the Children's
Health Insurance Program, Medicare, or military coverage—and must not have access to health insurance through an employer. (There is an exception in cases when the employer plan does not cover at least 60 percent of covered benefits on average or the employee share of the premium exceeds 9.5% of the employee’s income.)

The premium tax credits will be advanceable and refundable, meaning they will be available when an individual purchases coverage and will be available regardless of whether or not an individual owes any taxes. The premium tax credits will vary with income and are structured so that the premium an individual or family will have to pay will not exceed a specified percentage of income, ranging from 2% for those with incomes up to 133% of the poverty level (about $14,400 for an individual) to 9.5% for those with incomes between 300 and 400% of the poverty level ($32,490 to $43,320 for an individual).

Will members of Congress and their staffs have to buy their health insurance in the new exchanges?

The health reform law requires that in 2014 the federal government only provide health coverage to members of the House of Representatives and the Senate through the new health insurance exchanges that will be created. The same requirement also exists for Congressional staff who are employed by a member of Congress. It appears that Congressional committee staff and certain other Congressional staff members may be excluded from this requirement because they do not work directly for a member of Congress.

Medicaid and CHIP

Who will be eligible for Medicaid?

As enacted, the ACA expands state Medicaid programs beginning in 2014 to cover nearly all individuals under age 65 with incomes up to 138% of the federal poverty level ($15,856 for an individual or $26,951 for a family of three in 2013). The ACA establishes a uniform minimum Medicaid eligibility level and income definition across all states and eliminates a prohibition that prevented states from providing Medicaid coverage to adults without dependent children except under a waiver of federal rules. However, while the Supreme Court upheld the ACA, it limited the federal government’s ability to enforce the Medicaid expansion to low-income adults, effectively making implementation of the Medicaid expansion a state choice. This means eligibility for Medicaid for this population will vary depending on whether a state implements the expansion. If all states implemented the expansion, an additional 21.3 million people could be added to Medicaid. Undocumented immigrants are not eligible for Medicaid regardless of their income, and legal immigrants who have resided in the U.S. for less than five years are also not eligible, though states have the option of extending Medicaid coverage to legal immigrant children and pregnant women who are in the 5-year waiting period.

Financing and Taxes

Will employees be taxed for the portion of the health insurance premium that is paid by the employer?

Starting for the 2012 tax year, W-2 forms provided by employers (in the beginning of 2013) show employees how much their health insurance costs. However, the reporting is for informational purposes only; employees will not be taxed on this amount.
A separate provision of the health reform law creates a new tax on so-called "Cadillac" insurance plans provided by employers. Beginning in 2018, plans valued at $10,200 for individual coverage or $27,500 for family policies will be subject to an excise tax of 40% on the value of the plan that exceeds these thresholds. The tax will be levied on insurers and self-insured employers, not directly on employees.

The threshold amounts will be increased for inflation beginning in 2020, and may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The thresholds are also adjusted upwards for retired individuals age 55 and older who are not eligible for Medicare, for employees engaged in high-risk professions, and for firms that may have higher health care costs because of the age or gender of their workers.

**Medicare**

**How does the Affordable Care Act (ACA) of 2010 change the Medicare Part D coverage gap, sometimes called the "doughnut hole"?**

The ACA gradually reduces the amount that Medicare Part D enrollees are required to pay for their prescriptions when they reach the coverage gap. When the coverage gap is fully closed in 2020, beneficiaries will be responsible for paying 25 percent of the cost of their prescriptions under the standard drug benefit. Medicare Part D plans will cover 75 percent of the cost of generic prescription drugs and 25 percent of the cost of brand-name prescription drugs, in addition to a manufacturer discount of 50 percent on brand-name drug prices for prescriptions filled in the coverage gap.

**What will happen to Medicare Advantage plans?**

The health reform law reduces payments to Medicare Advantage plans, gradually bringing them closer to the average costs of traditional Medicare. In 2011, the law froze the maximum county-level payments to plans (called "benchmarks"). In 2012, to reduce payments, based on the Medicare costs in the county relative to other parts of the country. In addition, the law reduces the amount plans are permitted to keep when bids come in below the benchmark (known as "rebates"), which achieves savings for Medicare but also reduces the amount available to plans to provide extra benefits. In 2012, some Medicare Advantage plans began to receive bonuses based on quality ratings, as the result of both the health reform law and a CMS demonstration program.

The effect of the reductions in benchmarks and rebates is expected to vary across counties and by firm. Companies offering Medicare Advantage plans may respond to these payment changes in several different ways, depending on the circumstances of the company, the location of their plans and their historical commitment to the Medicare market. Plans will continue to be required to provide all benefits that are covered by traditional Medicare, but may charge higher premiums, increase cost-sharing, reduce their network of providers, or reduce "extra benefits" such as dental care or eyeglasses.

The law also includes new consumer protections. Plans are subject to new rules that limit cost-sharing that can be imposed on enrollees for certain services. Medicare Advantage plans will also be required to maintain a medical loss ratio of at least 85 percent beginning in 2014, restricting the share of federal payments and premiums that Medicare Advantage companies can use for administrative expenses, including profits.
How does the Affordable Care Act (ACA) affect physician fees?

The ACA provides bonus payments for primary care physicians in underserved areas and increases payments to rural health care providers.

The ACA does not address issues related to the sustainable growth rate (SGR) formula that determines physician payments, which was established by the Balanced Budget Act of 1997. The formula would have required reductions in payments every year since 2002; however, the scheduled reductions have been overridden by various laws, including the American Taxpayer Relief Act of 2012, which postponed the scheduled reduction in physician fees under Medicare through the end of 2013.

How is the Affordable Care Act (ACA) expected to affect Medicare spending?

The ACA includes several changes to Medicare benefits and spending, including some provisions that increase program spending and some that decrease program spending. On net, the Congressional Budget Office (CBO) estimated that the Medicare provisions in the ACA would reduce Medicare spending by $716 billion between 2013 and 2022.

Savings: Medicare savings provisions include phasing down payments to Medicare Advantage plans, reducing updates in payment levels to hospitals and other providers, increasing premiums paid by higher-income beneficiaries, and various delivery system reforms (such as establishing accountable care organizations and creating incentives to reduce preventable hospital readmissions). The ACA also authorized the Independent Payment Advisory Board (IPAB) to recommend policies to reduce Medicare spending if projected spending exceeds specific target growth rates.

Spending: Medicare spending provisions include providing free coverage for some preventive services and closing the coverage gap in the Part D prescription drug benefit (the so-called “doughnut hole”) by 2020. The law also includes higher payments for primary care physicians.

Revenue: The ACA establishes new sources of revenue dedicated to the Medicare program, including an additional payroll tax on earnings of higher-income workers and a fee on the manufacturers and importers of branded drugs.

States

What happens if a state does not implement the health reform law?

If a state does not establish Exchanges or implement the new insurance rules according to the standards in the new law (and subject to further interpretation by federal regulations), then the federal government will step in and perform those functions. The Supreme Court upheld the ACA but limited the federal government’s ability to enforce the Medicaid expansion to low-income adults, effectively making implementation of the Medicaid expansion a state choice. For states that move forward with the Medicaid expansion, the federal government will fund the vast majority of the costs, the number of uninsured will decline and states could see savings related to reductions in uncompensated care costs, shifting other state costs to Medicaid or due to broader economic effects. States that do not move forward with the Medicaid expansion could see large gaps in coverage because individuals with incomes below 100% FPL generally cannot receive subsidies to purchase coverage in the newly established health insurance exchanges and will not gain any new affordable coverage options.
# 2013 Poverty Guidelines

**All States (Except Alaska and Hawaii) and D.C.**

## Annual Guidelines

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<th>133%</th>
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For family units of more than 8 members, add $4,020 for each additional member.

## Monthly Guidelines

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HEALTH CARE REFORM RESOURCES

Centers for Medicare & Medicaid Services
http://www.cms.gov/

HealthCare.gov
http://www.healthcare.gov/

HealthCareandYou.org
http://www.healthcareandyou.org/

Maryland Health Benefit Exchange
http://marylandhbe.com/

Maryland Health Connection
http://www.marylandhealthconnection.gov/

Maryland Office of Health Care Reform
http://www.healthreform.maryland.gov/

Kaiser Family Foundation on Health Reform
http://kff.org/health-reform/

Media Resources

Educational Presentation on the ACA

The Health Care Law and You: In-Language Webinars (Chinese, Korean, Tagalog, Tongan, Vietnamese)

Disclaimer: This list is provided as reference only. A listing does not imply its endorsement or recommendation by the Asian American Health Initiative or the Montgomery County Department of Health and Human Services. For more detailed information, please refer to the respective organizations.
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