

# **WORKSHOP**

**PRESENTATION ON THE NEW PATIENT PROTECTION AND  
AFFORDABLE CARE ACT (PPACA), COMMONLY REFERRED  
TO AS HEALTH CARE REFORM,**

**JULIE FREIDUS, VICE PRESIDENT OF BROWN AND BROWN OF FLORIDA, INC.**

**September 14, 2010  
12:00 – 1:30 p.m.**

**Leon County Board of County Commissioners' Chambers  
Leon County Courthouse, 5<sup>th</sup> Floor**





**Board of County Commissioners**  
**Leon County, Florida**

www.leoncountyfl.gov

**Workshop Request**  
**Executive Summary**

August 17, 2010

**Title:**

Presentation on the New Patient Protection and Affordable Care Act (PPACA), Commonly Referred to as Health Care Reform, by Julie Freidus, Vice President of Brown and Brown of Florida, Inc.

**Staff:**

Parwez Alam, County Administrator   
Lillian Bennett, Director of Human Resources

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**Issue Briefing:**

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), commonly referred to as Health Care Reform. PPACA is designed to ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs. Due to the potential impact of healthcare reform on the Leon County Employee Health Insurance Program, the County Administrator requested that Ms. Julie Freidus, Vice President & Manager, Employee Benefits Department for Brown and Brown of Florida, Inc., make a presentation to the Board regarding the new changes (Attachment #1).

**Fiscal Impact:**

There is no current fiscal impact; however, there may be a fiscal impact on the County's Employee Health Insurance program in future years.

**Staff Recommendation:**

Option #1: Accept the Presentation on the Patient Protection and Affordable Care Act (PPACA), commonly referred to as Health Care Reform.

## **Report and Discussion**

### **Background:**

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA), commonly referred to as Health Care Reform. PPACA is designed to ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain cost. The Congressional Budget Office (CBO) has determined that it will provide coverage to more than 95% of all Americans, while bending the health care cost curve and reducing the deficit by \$138 billion dollars, over the next 10 years, with additional deficit reductions in the following years. Staff has included a "Health Care Reform at a Glance" summary prepared by Buck Consultants (Attachment #2).

### **Analysis:**

As a result of the passage of health care reform, the County Administrator requested that Ms. Julie Freidus, Vice President and Manager, Employee Benefits, for Brown and Brown of Florida, Inc, make a presentation to the Board on the potential impacts of the new health care reform legislation. At the July 13, 2010 meeting, Ms. Freidus was scheduled to make a presentation to the Board on the Health Care Reform Act; however, due to the lengthy meeting agenda, the Board requested that Ms. Freidus reschedule the presentation for a September 14, 2010 Board Workshop. The workshop is designed to discuss the potential impact of healthcare reform on Leon County's Employee Health Insurance Program. Ms. Freidus is to make a complete presentation on the PPACA and to answer questions about the Act.

The presentation/workshop will include the following:

- The five major components of the health reform legislation
- Health Reform 2010
  - Grandfathered Status (Attachment #3)
- Health Reform 2014
- Questions

Ms. Freidus is available to provide consulting services to Leon County specifically related to the preparation required to determine plan change requirements and fiscal impact of the new health care reform legislation (Attachment #4). Staff has requested \$50,000 for consulting services in the 2011 tentative budget to assist with the implementation of health care reform legislation and incorporate changes into the issuance of a Request for Proposal for the 2012 Plan Year.

### **Options:**

1. Accept the presentation on the Patient Protection and Affordable Care Act (PPACA), commonly referred to as Health Care Reform.
2. Board Direction.

### **Recommendation:**

Option #1.

Workshop Title: Presentation on the New Patient Protection and Affordable Care Act (PPACA), Commonly Referred to as Health Care Reform, by Julie Freidus, Vice President of Brown and Brown of Florida, Inc.

September 14, 2010

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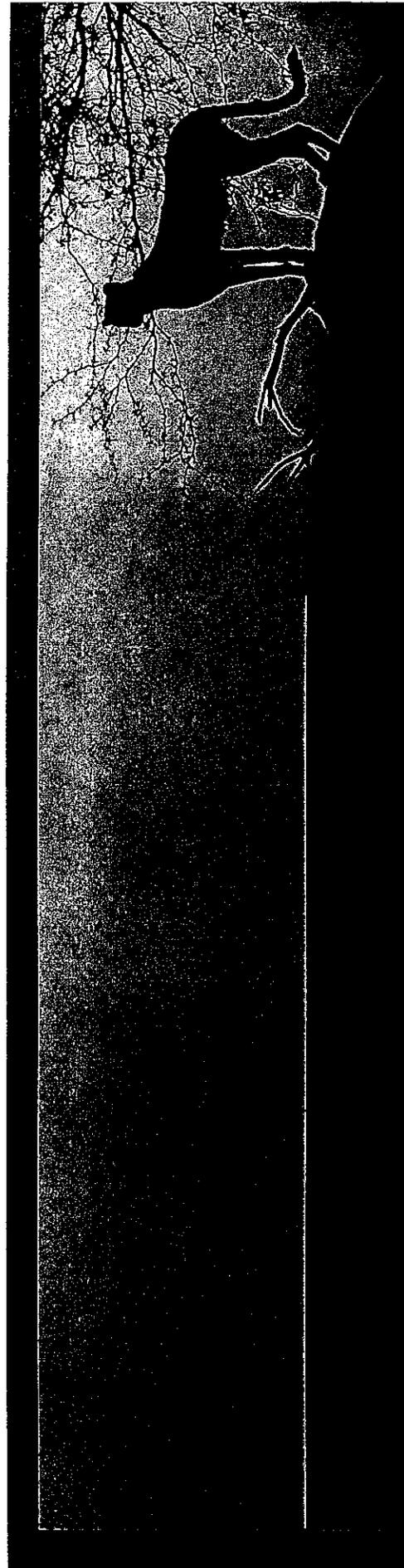
Attachments:

1. Presentation on Health Care Reform by Julie Freidus, Brown and Brown of Florida, Inc.
2. "Health Care at a Glance" Summary prepared by Buck Consultants
3. Impact of Grandfathered Status
4. Letter to County Administrator from Brown and Brown of Florida, Inc.



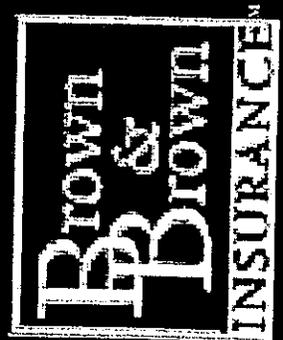
**Brown and Brown of Florida, Inc.**  
**Health Reform 101**  
**September 14th, 2010**

Presented by:  
Julie Freidus, Vice President

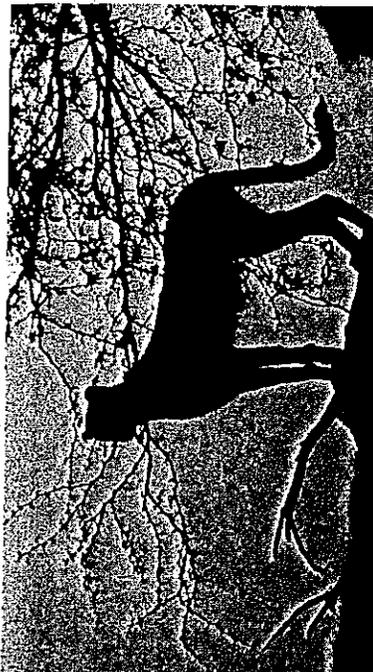


# Meeting agenda

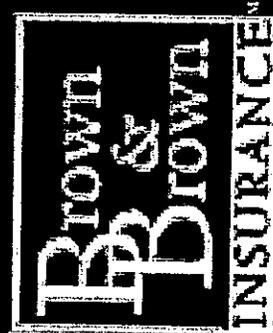
- ◆ The five major components of the health reform legislation
- ◆ Health Reform 2010
- ◆ Health Reform 2014
- ◆ Questions



# Health Reform



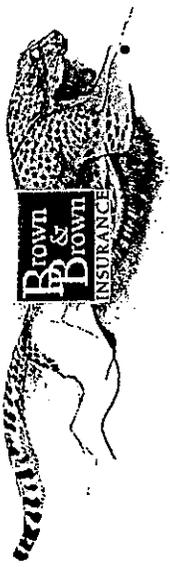
- ◆ On March 23<sup>rd</sup>, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The PPACA was passed by the Senate on December 24<sup>th</sup>, 2009 and by the House on March 21<sup>st</sup>, 2010.
- ◆ This bill constitutes a massive overhaul of the United States health care system.
- ◆ Awaiting clarification on a number of items from the IRS, Department of Labor and Health and Human Services.





# Five Components

- ◆ Insurance market reform
- ◆ Changes to Medicare / Medicaid
- ◆ Improving access to coverage by state based exchanges
- ◆ ER / EE mandates as of 2010
- ◆ Revenue raisers



# Health Care Reform 2010

# Reform 2010



◆ Lifetime limits – Lifetime limits will be prohibited on essential health benefits such as:

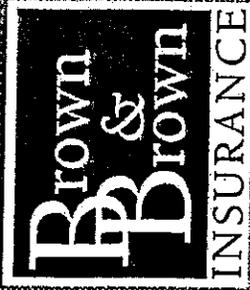
- ◆ Emergency Services
- ◆ Hospitalization
- ◆ Maternity and newborn care
- ◆ Rx services
- ◆ Mental health and substance abuse treatment
- ◆ Laboratory Services
- ◆ Preventive Services

## Health Reform 2010



- ◆ This change is effective as of the first day of the first plan year beginning at least six months after the PPACA became law (March 23<sup>rd</sup>, 2010). Similar restrictions will apply to annual limits.

# Health Reform 2010



- ◆ Eligibility of Dependent Children – Plans must allow unmarried and married dependent children to be eligible until the age of 26
- ◆ Plans are not required to provide coverage to the child of a child
- ◆ Applies to all fully-insured and self-insured plans
- ◆ Provided on a tax-free basis

# Health Reform 2010



## ◆ Pre-existing Condition Exclusions

- ◆ Pre-existing condition exclusions will be prohibited for all fully-insured and self-insured group health plans effective as of the first day of the first plan year beginning on or after January 2014
- ◆ However, there is an acceleration of this prohibition (beginning October first and beyond) with respect to children under age 19.

# Health Reform 2010



- ◆ Preventive Care – All plans must offer first dollar coverage with respect to certain preventive care services including immunizations, screenings and mammograms

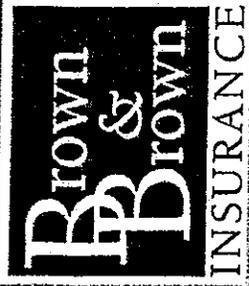
# Health Reform 2010



## ◆ Nondiscrimination Rules for Fully-Insured Plans

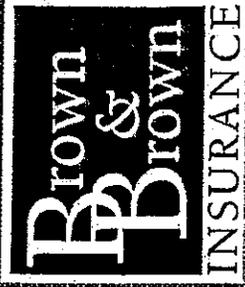
- ◆ Currently self-funded group health plans are subject to nondiscrimination rules prohibiting the plan from favoring the highly compensated with respect to eligibility and benefits. Fully-insured group health plans will now be subject to the same IRS nondiscrimination rules.

# Health Reform 2010



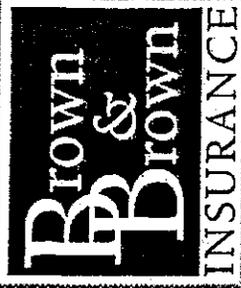
- ◆ **Medical Loss Ratio Reporting and Premium Rebates**
  - ◆ Beginning in 2010, health insurers must publicly report the percentage of their total premium revenue spent on claims, activities that improve health quality and non-claim costs
  - ◆ Beginning with the 2011 plan year health insurers will be required to provide a premium rebate. In the case of larger groups if more than 15% of the premium revenue for group coverage is expended on non-claim costs (excluding taxes) the insurer will be required to provide a rebate. 20% for small groups.

## Health Reform 2010



- ◆ No later than 90 days after the enactment of PPACA the IRS will establish a temporary reinsurance program to provide reimbursement to employer retiree health plans through January 2014.
- ◆ The temporary reinsurance program will provide reimbursement for early retirees age 55 and older who are not yet eligible for Medicare and their dependents with respect to 80% of claims in excess of \$15,000 but less than \$90,000 per year.

# Health Reform 2010



- ◆ **Small Employer Tax Credit**
- ◆ Starting in 2010, certain small employers who provide health coverage to their workers will be eligible for a tax credit
- ◆ To qualify, an employer must have no more than 25 full-time employees with annual average wages of less than \$50,000.
- ◆ For tax years through 2013, the tax credit is up to 35% of the employer's contribution toward health coverage provided the employer is contributing at least half the cost. For tax years 2014 and later, the maximum tax credit increases to 50%.

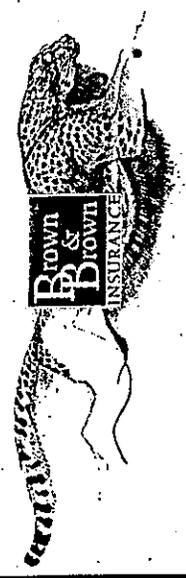
## Health Reform 2010



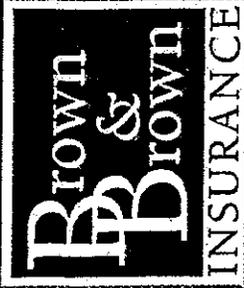
- ◆ **Pre-existing Condition Exclusions**
  - ◆ **Pre-existing condition exclusions will be prohibited for all fully-insured and self-insured group health plans effective as of the first day of the first plan year beginning on or after January 2014**
  - ◆ **However, there is an acceleration of this prohibition (beginning October first and beyond) with respect to children under age 19.**



Health Reform 2014



# Health Reform 2014



- ◆ **State Based Exchanges**
  - ◆ Each state is required to establish an American Health Benefit Exchange (for individuals) and a Small Business Health Options Programs or “SHOP Exchange” (for employer groups) by 2014
  - ◆ Each exchange will be similar to a gateway or clearinghouse to help individuals and groups shop for health coverage in a more efficient and comprehensive manner

# Health Reform 2014



- ◆ Health Plans offered on the exchange will be required to offer minimum essential coverage at one of four levels of “actuarial value” (the percentage of covered expenses paid by the plan)
  - ◆ Bronze (60% of actuarial value)
  - ◆ Silver (70% actuarial value)
  - ◆ Gold (80% actuarial value)
  - ◆ Platinum (90% actuarial value)

# Health Reform 2014



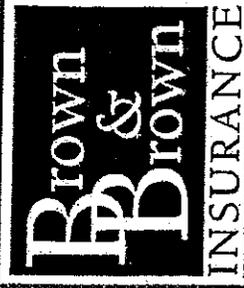
- ◆ **The out-of-pocket limits**
  - ◆ The out-of-pocket limits for these health plans can not exceed the maximum out-of-pocket limits for H.S.A's (which are \$5,950/single and \$11,900/family for 2010)
  - ◆ Exchanges will initially offer coverage to individuals and certain small groups
  - ◆ Before 2016, states can limit exchange availability only to small employer groups with 50 or fewer employees
  - ◆ Before 2017, exchanges may only cover small employer groups with 100 or fewer employees
  - ◆ Beginning in 2017, states can open up their exchanges to large employers

# Health Reform 2014



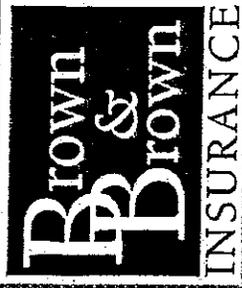
- ◆ **Individual Mandate**
  - ◆ Individuals must obtain health insurance with minimum essential coverage or pay a penalty
  - ◆ The penalty is the greater of a flat dollar amount or a percentage of household income. The flat dollar amount is \$95 for 2014, \$325 for 2015 and \$695 for 2016. For later years, the flat dollar amount will be increased for changes in the cost of living
  - ◆ The percentage of household income is .5% for 2014, 2% for 2015 and 2.5% for 2016 and later years

## Health Reform 2014



- ◆ However, no penalty applies for a year if the taxpayer's household income is below the threshold for filing a federal income tax. The penalty will also not apply to the following individuals:
  - ◆ Individuals who can not afford coverage because the lowest cost option would exceed 8% of their household income
  - ◆ Individuals who do not maintain coverage for qualifying religious reasons.

# Health Reform 2014



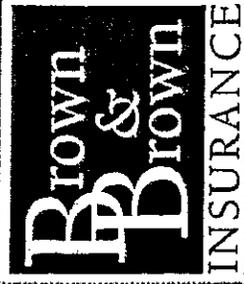
- ◆ US Citizens residing outside the country
- ◆ Illegal aliens
- ◆ Incarcerated individuals
- ◆ American Indians

# Health Reform 2014



- ◆ Individuals with income no greater than 400% of the federal poverty level will be provided with assistance to obtain and maintain health coverage.
- ◆ Medicaid: Individuals with income less than 133% of the federal poverty level will be eligible for Medicaid

# Health Reform 2014



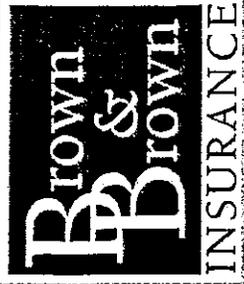
- ◆ **Vouchers**
  - ◆ Where the individual is eligible for employer-provided health coverage, the employer must make its employer contribution for coverage available to the individual as a voucher to purchase coverage on the exchange
  - ◆ However, this option is only required for employees with income no greater than 400% of the federal poverty level where the employee's premium share would be between 8% and 9.8% of the employee's income

## Health Reform 2014



- ◆ **Employer Mandate – The employer must offer health coverage to its employees or pay a “free rider” penalty**
- ◆ **The penalty only applies to employers with more than 50 full-time employees**
- ◆ **A full-time employee is an employee who works on average, 30 or more hours per week**

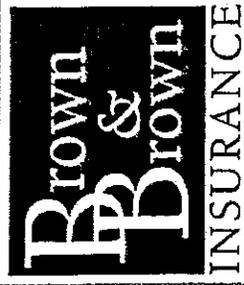
# Health Reform 2014



## ◆ Employer Mandate

◆ If the employer does not offer a plan and has at least one full-time employee who enrolls in health coverage through the exchange and becomes eligible for the premium credit, the employer must pay a penalty of \$2,000 per year per full-time employee. The penalty is determined and assessed on a monthly pro rata basis (i.e. 1/12 of \$2,000).

# Health Reform 2014



## ◆ Notice of Availability of Exchange and Premium Tax Credits

- ◆ At the time an individual is hired, the employer must notify the employee of the existence of the exchange, that the employee may be eligible for assistance in purchasing coverage under the exchange and that if the employee purchases a policy through the exchange, he or she will lose the employer contribution toward health benefits offered by the employer except as otherwise provided under the voucher program.

# Health Reform 2014



- ◆ Increased Reporting Requirements
- ◆ Large employers with 50 or more employees must report the following to the IRS

Whether full-time employees are eligible for minimum essential coverage

The length of any waiting period

The number of months during the calendar year for which coverage under the plan is available.

The monthly premium for the lowest option

Employer contribution share

The number of full time employees

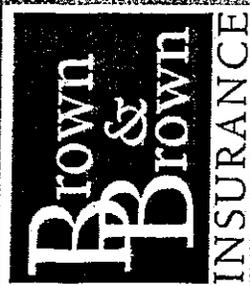
The name, address and SS# of each full-time employee enrolled in the plan and the months during the year they were covered

# Health Reform 2014



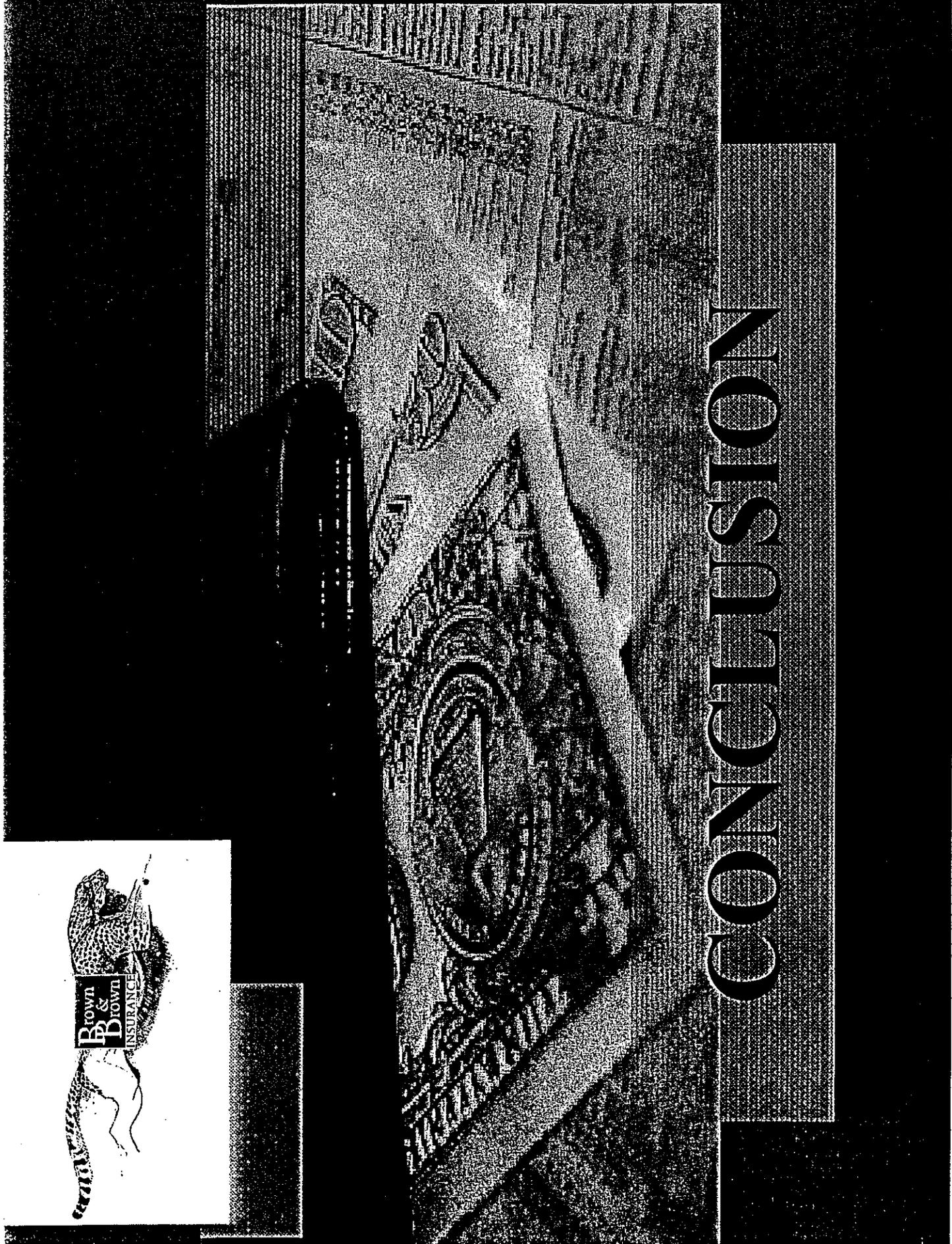
- ◆ **Wellness Incentives**
  - ◆ Currently, under the HIPAA non-discrimination rules, employers may provide incentives to employees to participate in a wellness program based on a health-status factor provided certain requirements are met. The key requirement is that the total incentive may not exceed 20% of the cost of coverage under the employer's health plan. This 20% limit is being increased to 30%. Further, the IRS and DOL and HHS are provided with the discretion to increase the 30% limit to as high as 50%.

# Health Reform 2014

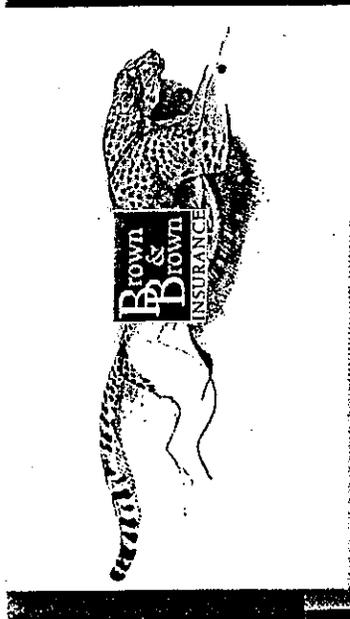


## ◆ Waiting Period

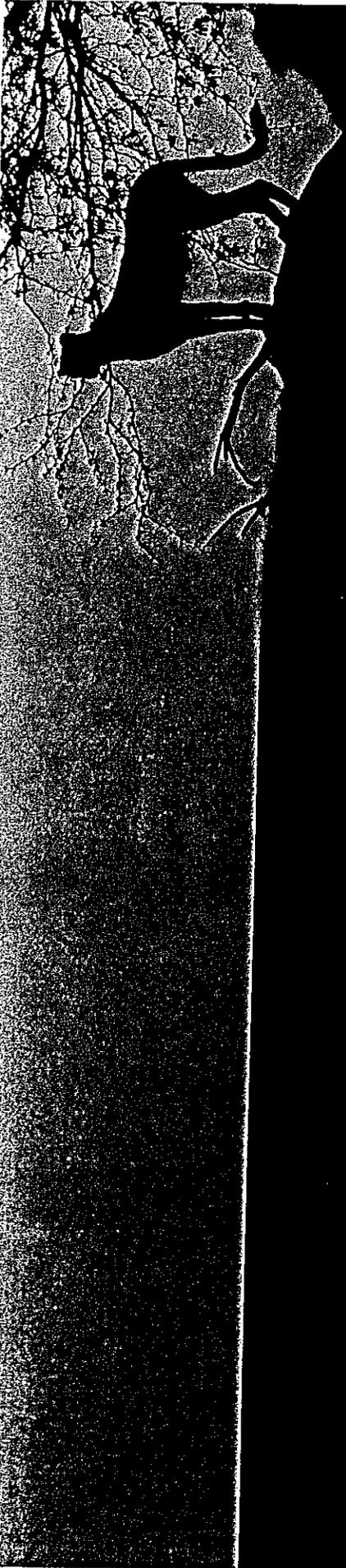
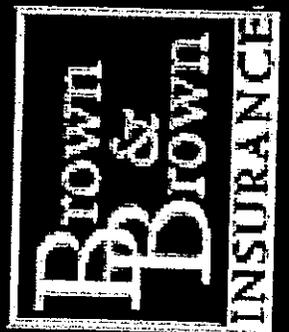
- ◆ Employers will no longer be permitted to impose a waiting period of longer than 90 days in order for a new hire to become eligible to participate in the employer's group health plan.



# CONCLUSION



# QUESTIONS



# Health Care Reform at a Glance

|  | Provision | Effective Date | Implications for Large Employers |
|--|-----------|----------------|----------------------------------|
|--|-----------|----------------|----------------------------------|

## Employer Mandate

|   |  |  |      |  |
|---|--|--|------|--|
| 1 | Play or Pay Penalty for not offering coverage                            | \$2,000 per FTE, indexed. FTE defined as 30 or more hours per week. No requirement for PTE coverage. No minimum employer subsidy required.   | 2014 | <i>This penalty for not offering coverage might be so low as to encourage some employers to drop coverage.</i>             |
| 2 | Minimum Value of Employer Coverage                                       | If actuarial value of the plan is below 60%, employees under 400% FPL are eligible for subsidized Exchange coverage and if elected, employer is assessed the play and pay penalty. |      | <i>To avoid penalties employers will need to provide plan with actuarial value of at least 60%.</i>                        |
| 3 | Pay and Play Penalty for opt-outs electing coverage through the Exchange | \$3,000 (indexed) for FTEs who enroll in Exchange and receive subsidy; aggregate cap of \$2,000 times total number of FTEs.  |      | <i>Even employers who offer a qualifying plan can be subject to penalties for opt-outs; Limited to low-income waivers.</i> |
| 4 | Employee Vouchers for Exchange   | Employers must offer cash vouchers to employees under 400% of federal poverty level with contributions between 8.0% to 9.8% of household adjusted gross income (AGI).              |      | <i>Increases potential of anti-selection. However, limited number of employees may be eligible.</i>                        |
| 5 | Employer Reporting Requirements  | Reporting to both Secretary and employees regarding minimum essential coverage.  |      | <i>Similar to Part D Creditable Coverage notices; Increased administrative burden.</i>                                     |

## Individual Mandate

|   |  |  |      |   |
|---|--|--|------|---|
| 6 | Play or Pay Penalty  | Greater of 1.0% of AGI or \$95/person in 2014, 2.0% or \$325/person in 2015, 2.5% or \$695/person in 2016; Indexed. Family dollar amount capped at 300% of individual penalty. | 2014 | <i>Employer cost will increase with higher enrollment with fewer waivers.</i>   |
| 7 | Unaffordable Employer Coverage for Employees Under 400% of FPL | If employee contributions are above 9.5% of AGI – the employee is eligible for subsidized Exchange coverage and employer is assessed the play and pay penalty.                 |      | <i>If the required employee contribution is above this limit, employees under 400% FPL are eligible for subsidized Exchange coverage.</i> |

## Provisions Applying to Employer Plans

|    |   |   |  |  |
|----|---|---|--|--|
| 8  | Expansion of Child Coverage                         | Up to age 26 if not eligible for other group coverage.  | Plan years beginning on or after Sept. 23, 2010  | <i>Increased enrollment and costs for covering more dependents.</i>  |
| 9  | Income Tax Exclusion of Employer Health Benefits    | Expanded to include adult children through year in which child turns 26.  |  | <i>Simplifies payroll administration</i>   |
| 10 | Lifetime Limits                                     | Lifetime limits prohibited for essential benefits.  |  | <i>Plans might need to be improved; stop-loss would become more important.</i>   |
| 11 | Restricted Annual Limits                            | Unreasonable annual limits prohibited for essential benefits.   |  | <i>Plans might need to be improved; stop-loss would become more important.</i>   |
| 12 | Cost Reporting and Rebates                          | Rebates to enrollees for insured plans with loss ratio below 85%.   |  | <i>Employers may need to establish refund mechanism.</i>   |
| 13 | Uniform Explanation of Coverage                     | Federally prescribed appearance, content, language and timing. Notice due within two years of enactment.  | 2011   | <i>Will need to be coordinated with other employee communications materials.</i>   |
| 14 | Pre-existing Condition Exclusions for Children      | Pre-existing exclusions prohibited for children under 19.   |  |  |
| 15 | Reporting Plan Value on W-2                         | Yes.  |  | <i>Value of coverage is disclosed but not taxed directly to employees.</i>   |
| 16 | Standardize Definition of Medical Expenses          | Prohibits reimbursement of over the counter drugs from FSAs, HRAs and HSAs.   |  | <i>May require amendments to spending account programs.</i>  |
| 17 | HSA Nonqualified Withdrawals                        | Penalty for increased from 10% to 20%.  |  | <i>Plan sponsors may want to communicate.</i>  |
| 18 | Health FSA Cap                                      | Capped at \$2,500 in 2013; indexed  |  | <i>Employer redesign required.</i>   |
| 19 | Pre-existing Condition Exclusions for all Enrollees | Pre-existing exclusions prohibited for all enrollees.   |  | <i>Reduced job lock might spur higher turnover.</i>  |
| 20 | Annual Limits                                       | Annual limits prohibited for essential benefits.  | Plan years beginning on or after January 1, 2014 | <i>Plans might need to be improved; stop-loss would become more important.</i>   |
| 21 | Auto Enrollment                                     | Auto enrollment required with employee having ability to opt out of coverage. Effective date not clear.   |  | <i>Increased cost due to higher enrollment and more complex administration.</i>  |
| 22 | Waiting Periods                                     | Waiting periods over 90 days not permitted.   |  | <i>A critical provision for high-turnover firms.</i>   |
| 22 | "Cadillac Plan" Excise Tax                          | 40% tax on value above \$10,200/individual and \$27,500/family (Indexed at CPI-U+1% for 2019, CPI-U only after 2019). Higher indexing based on retirees, high risk industry, age and gender. Excludes dental and vision. For multiemployer plans all coverage is considered family. | 2018   | <i>Deferral of excise tax to 2018 mitigates impact. However, in 2018 the tax will apply to many employer plans. Elimination of executive programs.</i> |

## Provisions that do not apply to Grandfathered Employer Plans

|    |  |   |  |   |
|----|--|---|--|---|
| 23 | Preventive Care                        | Preventive care services covered at 100%.   | Plan years beginning on or after Sept. 23, 2010  |   |
| 24 | Discrimination Requirements            | No discrimination in favor of highly compensated employees under insured plans.                         |  |   |
| 25 | OB/GYN, Pediatrician, ER Services      | No preauthorization or referral can be required.  |  |   |
| 26 | Appeals Process                        | Mandatory internal and external appeals process.  | Plan years beginning on or after January 1, 2014 | <i>Similar to current ERISA requirements.</i>   |
| 27 | HIPAA Wellness Incentives              | Codifies HIPAA Wellness Incentives, but with a maximum differential of 30%; Secretary can raise to 50%. |  | <i>May be drafting error that this provision does not apply to grandfathered plans.</i> |
| 28 | Required Service Categories & Coverage | Mandatory statutory list, to be supplemented by Secretary of HHS. Limited to insured plans.             |  |   |
| 29 | Maximum Out-of-pocket Limit            | Cannot exceed the OOP limit for HSA-compatible HDHP; indexed.   |  |   |

# Health Care Reform At A Glance

|  | Provision | Effective Date | Implications for Large Employers |
|--|-----------|----------------|----------------------------------|
|--|-----------|----------------|----------------------------------|

## Retiree Health

|    |   |   |               |  |
|----|---|---|---------------|--|
| 30 | Reinsurance Program for Early Retirees (55-64)    | \$5B to subsidize 80% of costs between \$15K-\$90K. Terminates December 31, 2013 or when funds expended.                            | June 21, 2010 | Temporary bridge to support employer retiree plans until Exchange is effective; administration appears similar to RDS.         |
| 31 | Application of Plan Requirements to Retiree Plans | Review of retiree programs for compliance with plan requirements.   | Various       | Could have significant FAS/GASB implications.  |
| 32 | Phase out of Donut Hole                           | \$250 rebate in 2010 for beneficiaries who reach donut hole. Phases out donut hole by 2020 in combination with brand drug discount. | 2010          | Makes participation in Part D more attractive to employers relative to RDS. May result in plans failing actuarial equivalence. |
| 33 | Brand Drug Coverage in Part D Donut Hole          | Drug manufacturers required to discount brand drugs in donut hole by 50%.   | 2011          | Makes participation in Part D more attractive to employers relative to RDS.  |
| 34 | Means Based Medicare Part D Premiums              | Increased for higher income retirees.   |               | Makes employer-provided Rx that much more attractive to high income retirees.  |
| 35 | Medicare Advantage Plan Funding                   | Payments frozen in 2011; reduced benchmarks starting in 2012.   |               | Increased retiree premiums for Medicare Advantage plans; reduced enrollment.   |
| 36 | Taxability of RDS Payments to Employers           | Yes. While taxability is not effective until 2013, non-public employers will need to reflect impact in first quarter 2010.          | 2013          | Increases retiree plan costs; makes employer Part D (EGWP) plans more attractive.  |

## Insurance Market Reform for Individuals and Small Groups

|    |   |   |  |  |
|----|---|---|--|--|
| 37 | Minimum Benefit Package                 | Bronze, Silver, Gold and Platinum with actuarial values of 60% - 90%.                                 | 2014   | Sponsors would retain some (but not complete) latitude in setting plan design for programs offered through the Exchange. |
| 38 | Guaranteed Issue and Renewability       | Yes. Also includes interim high risk pool for currently uninsured (starting 90 days after enactment). |  | More robust individual market is especially valuable to former employees and retirees.                                   |
| 39 | Community Rating - Limits on Age Rating | 3 to 1 ratio maximum (50% surcharge also permitted for tobacco use).                                  |  | The need for COBRA declines but adverse selection worsens.   |
| 40 | Medical Loss Ratios - Minimum Standards | 80% individual market and small groups; 85% Group market.   | Plan years beginning on/after March 23, 2010 | More robust individual market is especially valuable to former employees, particularly early retirees.                   |
| 41 | Small Employer Subsidies                | Yes, up to 25 employees.  | 2010   | Will some large employers now be at a competitive disadvantage?  |

## Purchasing Exchanges

|    |   |  |      |  |
|----|---|--|------|--|
| 42 | Exchanges                                   | State-based exchanges for individuals and small employers. In 2017 states can make available to large employers. | 2014 | Similar to the Massachusetts Connector. Initially, not available to large employers.                                       |
| 43 | Low Income Premium Subsidy in the Exchanges | Affordability credits up to 400% of the federal poverty level.   |      | With generous subsidies to low income, employers might not want to duplicate these efforts with salary-based cost-sharing. |

## Taxes

|    |                                    |  |  |   |
|----|------------------------------------|--|--|---|
| 44 | Tax on Indoor Tanning Services     | 10% tax on indoor tanning services, starting in July, 2010.  | July, 2010                             | Generally will not impact employer plans.   |
|    | Pharmacy Manufacturer Tax          | \$2.5B in 2011 increasing to \$4.2B in 2018; \$2.8B in 2019+   | 2011                                   | Increased cost-shifting.  |
| 45 | Comparative Effectiveness Research | Tax on insured and self-funded plans of \$1/ee/yr first year; \$2 second year; indexed thereafter.   | Plan years ending after Sept. 30, 2012 | Potential for increased or additional taxes in the future.  |
| 46 | Income Tax Provisions              | Itemized medical deduction threshold increased from 7.5% to 10%.   | 2013                                   | Even greater pressure on employers to offer tax-advantaged compensation and benefits.                                     |
| 47 | Medicare Hospital Insurance Tax    | Tax rate increased from 1.45% to 2.35% starting for high income earners. A new 3.8% tax on net investment income. (Income in excess of \$250K joint filers; \$200K others) |  | Payroll tax increase only applies to employees, not employer. Increased interest by high paid employees in tax deferrals. |
|    | Medical Device Excise Tax          | 2.3% excise tax.   |  | Increased cost-shifting.  |
| 48 | Health Insurance Industry Tax      | \$8B in 2014 increasing to \$14.3B in 2018; trended after 2018   | 2014                                   | Increased cost-shifting.  |
| 49 | Exchange Reinsurance Program       | \$25B tax on Insurers and TPAs from 2014 to 2016 for Exchange reinsurance program  |  | Potential for increased cost-shifting.  |

## Collective Bargained Coverage

|    |                               |  |                |  |
|----|-------------------------------|--|----------------|--|
| 50 | Coverage Maintained Under CBA | For coverage maintained under a CBA ratified before March 23, 2010, all new coverage and cost-sharing rules apply upon the termination of the last CBA relating to the coverage. | March 23, 2010 | Provides needed flexibility for CBA plans. |
|----|-------------------------------|--|----------------|--|

## CLASS Act

|    |                                  |  |      |  |
|----|----------------------------------|--|------|--|
| 51 | Voluntary Long-term Care Program | Government run long-term care program. Employers are expected, but not required, to allow for payroll deductions and automatically enroll employees. | 2011 | Employers may want to provide supplemental long term care programs |
|----|----------------------------------|--|------|--|

# Grandfathered Status

- Cannot significantly raise deductibles
  - Significantly is defined as medical inflation + 15%.
    - Example: 8% medical inflation + 15% = 23%
    - Current deductible = \$500 – can raise it to \$615
  
- Cannot significantly lower employer contributions
  - Significantly is defined as 5%
    - Current contribution is 80% - cannot reduce it below 75%
  
- Cannot add or tighten any annual limits on what the plan pays
  
- Cannot change insurance companies

***If any of these actions are taken – your plan will forfeit it's grandfathered status***



Dear P.A.-

June 15<sup>th</sup>, 2010

Brown & Brown can provide to the Board of County Commissioners. We are a full service brokerage firm in business since 1939. In addition, we are the 6<sup>th</sup> largest insurance broker in the United States. Given our size and breadth of experience, we feel capable of providing marketing services, account management, underwriting, actuarial services and guidance with State and Federal Laws.

We have kept our clients apprised of the new HIPAA regulations beginning earlier this year as well the American Relief and Recovery Act. We are experts in the initial details of this legislation and are awaiting the final regulations from the Department of Health and Human Services, the Department of Labor and the Internal Revenue Service. We have hosted countless seminars for our clients over the past few months to educate them on the legislation and to answer any questions they had. I am happy to come to Tallahassee and do the same presentation for the Board of County Commissioners. In addition, we have been retained by many of them to provide guidance on this very complicated and important piece of legislation. For example, one key point to know is if any of the entities that the Board represents has early retirees, under the health reform legislation plan, sponsors that have early retirees on their plan who incur medical claims over \$15,000 are eligible for a reimbursement from the Federal Government. Unfortunately, there is a limited amount of dollars available, and reimbursement is on a first come first serve basis. The financial impact to an employer could be in the millions if the employer is not educated on how to apply for these funds. There are specific applications that need to be completed and submitted to the Department of Health and Human Services. I am happy provide and educate Leon County on completing the applications for reimbursements.

Attached please find a copy of my presentation, my resume, and applicable health care reform documents. We would be happy to attend the scheduled County Commission meeting in July. In addition, we are open to negotiate fee's commiserate with services desired.

Please feel free to call me if you have any questions. I look forward to hear from you regarding my offer of a presentation.

Sincerely,

Julie Freidus

**Julie Freidus, GBDS**  
Brown & Brown of Florida, Inc.  
Vice President & Manager, Employee Benefits Department

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**EXPERIENCE**

**Brown & Brown of Florida, Inc.**  
Vice President & Manager/Employee Benefits Department, 2004 to Present.  
Duties require maintenance of current accounts in addition to new sales, business development, advising and consulting. Additionally, managerial responsibilities include department operations, quality control, account tracking and reporting.

**CUNDY**  
Account Manager, 2002 to 2004.  
Responsible for new business sales and development, marketing, negotiation with vendors, and service for large Fortune 500 companies in the 10,000+ employee market.

**Lincoln Re**  
Reinsurance Underwriter, 2001-2002  
Underwrote reinsurance contracts for self-funded clients. Worked with our Registered Nurses and Utilization review to determine the ongoing nature of large claims.

**Cigna Healthcare**  
Medical Underwriter, 1999 to 2001.  
Underwrote fully insured, minimum premium and ASO accounts for the Chicago market. Also, underwrote dental and short term disability contracts.

**EDUCATION**

215 Licensed for Life, Health & Variable Annuities in the State of Florida  
Designated G.B.D.S – Group Benefits Disability Specialist  
Masters of Public Administration, University of Tennessee, 1998  
Bachelor of Arts Degree, University of Tennessee, 1996

**ACTIVITIES**

Volusia Literacy Council Board Member (2004-2007); Leadership Daytona 2005, Member Board of Trustee's for the Daytona Beach Museum of Arts and Sciences.

**AWARDS**

2006, 2007, 2008, 2009 Brown and Brown Tangle B award winner.