For better or for worse...

Health-care reform kicks in

By Steven G. Cosby
Special to Piedmont Business Journal

Reasonable, prudent people can disagree on the effectiveness of our new health-care law, but barring significant changes to our government, health-care reform is here to stay.

As a business owner, it is critical that you know what to expect.

The new law, Patient Protection and Affordable Care Act (PPACA), has several phases to provide gradual reform, giving us all an opportunity to get accustomed to this new system.

For the average business, health-care reform can be put into nine categories: grandfathering, exchanges, reporting requirements, financial assistance, mandates, discrimination testing, benefits requirements, market reforms, and long-term care insurance.

Grandfathering (2010)

A grandfathered health plan is one that was in existence prior to March 23, 2010.

Grandfathering was a conciliatory promise to those who did not want to change. It makes some provisions for businesses and individuals to retain their existing plans and shields them from some reform.

Grandfathered plans will be required to adopt some reforms, including those related to annual and lifetime limits, dependent children coverage to age 26, rescission of coverage, pre-existing condition

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SIZE MATTERS: Health-care reform makes a distinction between large businesses, like Smith-Midland Corp.in Fauquier County, and small businesses, which have fewer than 25 workers.

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exclusions on children under 19, waiting periods, employer mandates, 4-page written plan summaries, and waiting periods.

You will have to report and maintain records of your grandfathered status. In addition, you will be restricted in any changes you make to your plan. Increase premiums, employee cost sharing, or change another significant feature of your plan, and you will likely lose your grandfathered status.

The monetary value of maintaining grandfathered status is a savings of about 2 percent. However, it is unlikely, in the long run, that insurers will maintain two sets of insurance products, one set that is grandfathered and another set of products that is not.

In three to five years, most analysts believe, the majority of plans will be non-grandfathered plans.

Exchanges (2014)

You will be hearing a lot about insurance exchanges, and the government will require that you give notices to your employees about them.

Exchanges are intended for those individuals lacking access to affordable health care. Individuals who receive government premium assistance will be able to purchase coverage only through the exchange.

Exchanges are a relatively new organizational structure for providing health-care plans. Think of them as insurance megamalls for the purpose of bringing together buyers and sellers of health-insurance plans.

These megamalls will be Web-based and will have a navigator tool to help consumers select the best plan for them.

Issuance of these health plans will be guaranteed, heavily regulated by the federal government and typically managed by the states.

While health plans can be sold outside of the exchanges, those plans will have to abide by the same rules as plans within the exchange.

The exchanges are modeled after the federal government's system for its employees, where dozens of different health plans are offered.

Massachusetts and Utah have health insurance exchanges, but they are significantly different in their approaches. Virginia's approach will likely be different, as well.

Shop exchanges are to be set up by the states for small businesses of less than 100 employees. By 2017, states may allow large groups to purchase health-care coverage through the Exchange.

Notices and reporting requirements

All employers will be required to give their employees written notices that describe the exchanges, how they work, and their benefits.

Employers will have to provide annual group-level reports to the U.S. Treasury, information about the employee-sponsored plan that includes premium costs, employer contributions, number of employees, waiting periods, and when employees were covered.

In addition to this group-level reporting, the U.S. Treasury will also require employers to report on the individual employee's health plan, effective dates, and costs. Individual statements are to be given to each employee before Jan. 31 for the preceding year.

Financial assistance (2010)

One of the goals of health-care reform is to cover more people by making coverage more affordable. PPACA includes financial assistance to some employers, and to some individuals.

If you are considered a smaller employer with fewer than 25 workers who each makes less than $50,000 per year on average, you may

receive a tax credit up to 35 percent of the premiums paid in 2010.

These tax credits will increase to 50 percent in 2014, but will only be available for coverage purchased through the exchange.

Employers who pay a portion of the health-plan cost for their employees must make the same amount available in a voucher to eligible employees to purchase coverage in the exchange.

This voucher system will not be for all of your employees, only those whose premium contribution exceeds 8 percent of the employee's household income and whose household income does not exceed 400 percent of the federal poverty level.

The amount of the voucher must be the highest amount made available to employees, single or family coverage. If the amount of the voucher exceeds the cost of coverage purchased through the exchange, the employee may pocket the excess.

The government will make other subsidies available to eligible individuals.

If you are a large employer (50+ employees), it is these subsidies that will cause you penalties. A contribution policy regarding these employees is worthy of your attention if you want to minimize your exposure to these fines.

(It is important to note that health-care reform amends the Fair Labor Standard Act (FLSA) by adding whistleblower protection for any employee who triggers the employer's penalty by receiving a premium tax credit or subsidy for a health plan.)

Mandates and penalties (2014)

Officially, there is no mandate to have health insurance coverage, and according to a Nov. 29 press release from Virginia Attorney General Ken Cuccinelli's office, a lawyer for the federal government stated that there is nothing punitive about having to pay a penalty.

But let's not quibble about semantics. As a business owner, you need to know the facts regarding how the mandate could affect you, your business, and your employees.

In 2014, the penalty applies only to "large employers," but since the health-care reform law defines large employers four different ways, it might be worth clarifying it here.

As it applies to the penalty, a large group is one that has 50 or more full-time equivalents (FTE) during the preceding year.

To calculate FTE, both full-time and part-time employees are counted. A full-time employee is one who works at least 30 hours per week. The hours worked by part-time employees, those less than 30

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HEALTH-CARE REFORM TIMELINE

2010

- High-risk pool program to begin funding for health insurance coverage for eligible individuals until Jan. 1, 2014, when the insurance Exchanges begin.
- Insurance reforms imposed: no denial of coverage to children with pre-existing conditions; adult children permitted to remain on parents' policies until age 26; prohibits lifetime limits on dollar value of coverage; no rescission of coverage unless fraud occurs.
- States must establish and implement process for reviewing premium increases.
- For tax years 2010-13, employer tax credit Phase I.
- Imposes 10 percent tax on indoor tanning services.
- Requires insurance companies to report medical loss ratios.
- $250 rebate to Medicare beneficiaries reaching Part D coverage gap in 2010.
- Prohibits lifetime limits on the dollar value of benefits for any participant or beneficiary for all fully insured and self-insured groups and individual plans, including grandfathered plans.
- All group and individual plans, including self-insured plans and grandfathered plans, will have to cover specific preventive-care services with no cost-sharing. They also will have to cover emergency services at the in-network level, regardless of provider, allow enrollees to designate any in-network doctor as their primary care physician (if they require a primary care physician designation already) and have a coverage appeal process.

2011

- Excludes costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an H.S.A. or Archer Medical Savings Account.
- Increase tax on distributions from H.S.A. or Archer MSA not used for qualified medical expenses to 20 percent.
- Requires insurance companies to begin providing rebates related to medical loss ratios.
- Develop standards for insurers to use in providing information on benefits and coverage.
- Rules adopted by July 1 for simplifying health insurance administration by adopting a single set of operating rules for eligibility verification and claims status.
- All employers have the option to include on W2s the aggregate cost of employer-sponsored health benefits, for informational purposes. Mandatory after 2011.
- All employers may be required to enroll employees in a new national public long-term care program, unless the employee opted out.

2012

- All group plans and group and individual health insurers (including self-insured plans) will have to provide a summary of benefits and a coverage explanation that meets specified criteria. There is a $1,000-per-enrollee fine for willful failure to provide the information.

2013

- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.
- F.S.A. contributions for medical expenses will be limited to $2,500 per year, with the cap annually indexed for inflation.

2014

- All U.S. citizens and legal residents required to have coverage.
- Penalty phased in: $95 per year in 2014, phasing in to $695 per year by 2016, or 2.5 percent of taxable income. Exempts low-income individuals.
- Penalty of $2,000 per employee per year for employers with 50+ full-time employees who do not offer coverage.
- Requirement to offer employees vouchers to obtain coverage through the Exchange.
- Premium and cost-sharing subsidies to individuals.
- Employer mandate begins. Companies with 200+ employees must auto-enroll all employees.
- For tax years 2014 and beyond, employer tax credit Phase II begins.
- Imposes fee on insurers.
- State-based Exchanges required to be operating.
- Creates essential health benefits package. All health plans except grandfathered individual and employer-sponsored plans, required to offer at least the essential health benefits package.
- Grandfathered group plans may impose annual limits only as determined by HHS. Must eliminate pre-existing condition exclusions for adults.
- Limits waiting periods for coverage to 90 days.
- Requires guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges.
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Premium assistance tax credits for individuals and families making up to 400 percent of FPL begin. These subsidies are available only for individual coverage purchased through the Exchange, not employer-sponsored coverage or coverage outside the Exchange.
- Expansion of the Medicaid program for all individuals, including childless adults, making up to 133 percent of the FPL begins. States can also create a separate non-Medicaid plan for those with incomes between 133 percent and 200 percent of FPL that do not have access to employer-sponsored coverage.

2018

- Excise tax on "Cadillac plans" valued at more than $10,300 for individual coverage and $27,500 for family coverage.

This document is an outline and not meant to replace qualified tax and legal advice from your qualified expert. Seek tax and legal advice only from your qualified expert.

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hours per week, are added together monthly, then divided by 120.

Add this number, plus the number of your full-time employees, to get your FTE number of employees.

If your FTE is 50 or greater, then your company is subject to the penalty.

The penalty will trigger when one or more of your employees receives a government premium credit for exchange coverage.

So what is the penalty? Two different scenarios define it.

One is if you have an employer-sponsored plan, the second is if you do not offer a plan.

Employers that offer a health plan pay a penalty that is the lesser of $2,000 per full-time worker, or $3,000 for each full-time employee receiving the credit, whichever is less; the first 30 full-time workers are subtracted from the monthly calculations.

For employers that do not provide a health plan, the penalty is $2,000 per full-time employee.

The employer will be allowed to subtract the first 30 full-time workers from the penalty's monthly calculation. Part-time employees will not be used to calculate the penalty.

Employers should be aware that each of their employees will be mandated to maintain health insurance coverage starting in 2014. (Pending the final rule of the U.S. Supreme Court.) Most workers will look to their employer to solve this problem, or to at least provide them with some professional guidance.

An individual's annual penalty for not having insurance will be between $95 and $695, depending on his or her income. Providing employees with essential coverage and helping them avoid the federal penalty may pay off as a retention and recruiting tool.

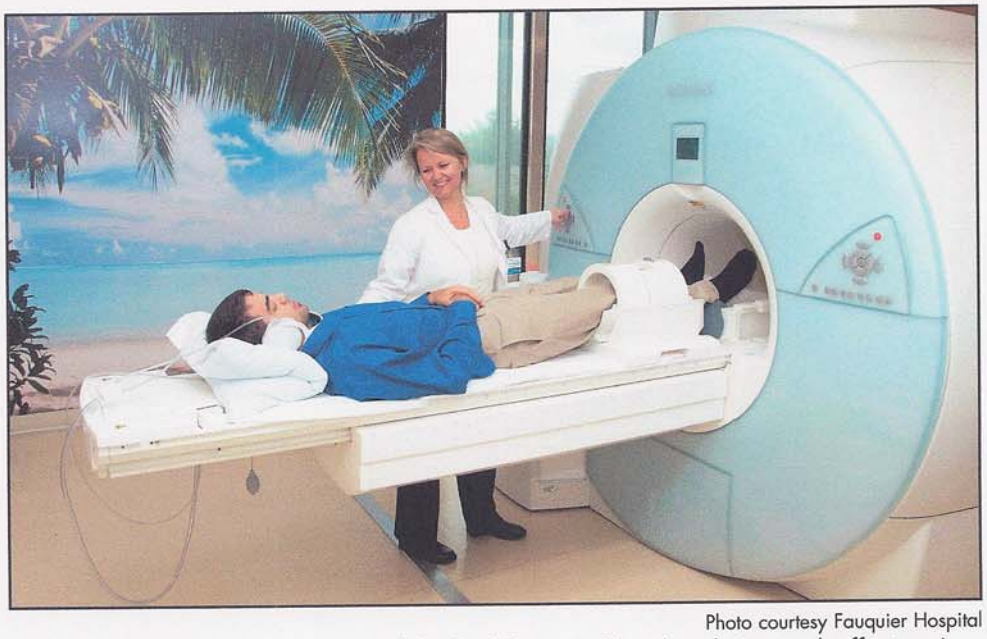

Photo courtesy Fauquier Hospital

STARTING NOW: Many aspects of the health-care reform legislation took effect on Jan. 1. The new Republican-controlled House has vowed to repeal the legislation, though it is unlikely that repeal will make it through the Democrat-controlled Senate.

Health-care reform goes green by recycling an old idea

Steven Cosby

Health-care reform purports to embrace a radically new idea, Accountable Care Organizations (ACO). ACO's are unlike health plans of the past. These are not insurance plans that indemnify for medical costs or preferred provider organization (PPO) plans that reimburse providers for services rendered.

Instead, ACOs create an integrated health-care system with health-care providers coming together to accept one payment method. If the ACO performs well, then all the providers share in their success.

If the ACO sounds a lot like a health maintenance organizations (HMO), that is because it is. HMOs received such negative backlash in the 1990's that a new term needed to be created, hence, ACOs.

ACOs will reward providers for cost-effective, efficient, and efficacious medical care for a specified population of patients.

Theoretically, integrated health-care models that are accountable for their health outcomes are the only realistic solution we have for solving our health-care financial crisis.

However, to date, the only entities that are preparing for such a model are hospitals.

Only the most astute individuals have noticed the gradual power shift that is going on in health care. Hospitals are employing physicians, either through direct hiring or direct acquisitions of physician groups. Hospitals are also merging together through formal affiliations to create more integrated models.

Physicians thus far have not taken the lead on physician-led ACOs.

"I am pleading with physician groups to be willing to be the entity receiving money, with or without a hospital, said Dr. Gail Wilensky, economist and senior fellow at Project Hope. "Pair up with a payer if you want, but don't only be the recipient in a hospital-led ACO, or you will rue the day."

Physicians are currently the lords our feudal health care system (even if they don't realize it). As a new power structure quietly evolves in health care, imperative to their own interest, physicians need to make sure they don't passively wind up as the peasants.

— Steven G. Cosby

Discrimination testing (2010)

Currently, an employer with a fully insured plan may provide benefits to highly compensated individuals without providing the same coverage to other employees.

The new health-care reform law will still allow this, but will make the health plan benefit taxable to these highly compensated employees.

Benefit Requirements (2010)

No longer can employers or insurers make unilateral decisions regarding benefit designs and coverage.

While state mandates may still apply, PPACA will require that all group health plans meet certain benefit levels and cost-sharing limits.

Small groups cannot have individual deductibles greater than $2,000 or $4000 for a family, and an out-of-pocket maximum cannot exceed current levels in high-deductible health plans for health savings accounts.

The government will set minimum standards for coverage and call it essential benefits. All plans will be measured in some way to this essential benefit level.

Market reforms (ongoing)

Probably the most talked about subject with PPACA has been the market reforms.

Promoters say reform will end the worst practices of insurance companies. The White House used these market reforms as the cornerstone of its "Patient Bill of Rights" issued in June 2010.

By 2014, all policies will be guarantee issued, meaning no more medical insurability issues for anyone.

While this sounds good, it inevitably will drive premium costs up significantly. If insurers are unable to price risk appropriately, they must charge everyone more to anticipate the worst possible scenario.

By 2011, insurers must pour at least 80 percent of their premiums back into health care. If not, they will have to refund money back to members based on formulas issued by the government.

States will be given the authority to review premium increases. However, it is not entirely clear what authority they'll have to deny insurers their requested increases.

Already in effect is the rule that a dependent child can remain on a parent's policy up to age 26, and children up to age 19 have to be given coverage on a guarantee issued basis.

The unintended consequence, of course, has stopped many insurance companies from writing child-only policies altogether.

Insurers can no longer issue rescissions of coverage, except in cases involving fraud.

Plans will no longer be able to provide lifetime limits on coverage and annual dollar limits on essential benefits will be removed, such as a $3,000 per year limit on mental and emotional counseling.

It is important to note that while annual dollar-limit coverages are prohibited, insurers may place other types of limits on coverages. For example: visit limits are still permissible.

Long-term Care (2011)

One of the lesser-known aspects of the law is the Class Act scheduled to be effective Jan. 1, 2011. It creates a new federal long-term care program and requires all participating employers to enroll employees, unless the employee elects to opt out.

Until the Department of Health and Human Services releases its final regulation on the Class Act, many details of the program are unknown. The law requires HHS to issue details no later than Oct. 1,2012, so it is unlikely that anyone will be enrolling before this time.