What General Counsel Need to Know Before Updating Their Company’s Health Care Plan

Presented By Craig B. Garner
About the Webinar Speaker

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Craig is an attorney and health care consultant, specializing in issues pertaining to modern American health care and the ways it should be managed in its current climate of reform.

Craig’s law practice focuses on health care mergers and acquisitions, regulatory compliance and counseling for providers. Craig is also an adjunct professor of law at Pepperdine University School of Law, where he teaches courses on Hospital Law and the Affordable Care Act.

Between 2002 and 2011, Craig was the Chief Executive Officer of Coast Plaza Hospital in Norwalk, California. Craig is also a Fellow Designate with the American College of Healthcare Executives, a Member of the State Bar of California, Business Law Section, Health Law Committee, and a Vice Chair of the Healthcare Reform Educational Task Force of the American Health Lawyers Association.

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Introduction
Modern American Health Care

- Employment has been the foundation upon which health care in the United States has rested since the creation of the modern day hospital. However, the changing landscape created by the Affordable Care Act now threatens to unravel what has for decades been considered status quo in the field of health care.

- Modern American health care has introduced viable options for health care insurance that are separate and apart from employer-sponsored plans. While the Federal Government has delayed the so-called “employer mandate” until 2015, the migration has already begun.
Challenge to General Counsel

- Notwithstanding, General Counsel should remain mindful that there is much more to employment than just health insurance, and likewise, the value of a company’s health care plan can never be measured by costs alone.

- Now more than ever General Counsel must expand their knowledge beyond the basic elements of the Company’s health care plan, and delve into that uncharted abyss we have come to know as “Obamacare.”
In today’s health care climate, the most effective approach to updating a company’s health care plan includes the following:

- Understanding how the Affordable Care Act (ACA) impacts the Company’s employees.

- Identifying upcoming deadlines for the significant changes brought by health care reform.
What Else to Know

- Examining the impact these new laws will have on the Company.
- Researching the different options available now and in the near future for both the employee and the Company.
- Being prepared to answer any and all questions the Company’s employees may have.
Health Care Reform at Work
Employee Impact

1. Essential Health Benefits
2. “Nearly” Essential Health Benefits
3. Individual and Group Market Reforms
4. Levels of Coverage
5. Individual Mandate
6. The “Penalty”
Essential Health Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services / chronic disease management
- Pediatric services, including oral and vision care
“Nearly” Essential Health Benefits

- Emergency room visits
- Ambulance services
- Diabetes care management
- Kidney dialysis
- Physical therapy
- Durable medical equipment
- Prosthetics
- Infertility treatment
- Organ and tissue transplantation
Individual and Group Market Reforms

- Fair Health Insurance Premiums
  - Individual or Family
  - Rating Area (states will decide)
  - Age (but not more than 3 to 1 for adults)
  - Tobacco Use (but not more than 1.5 to 1)

- End of Preexisting Condition Exclusion
- Coverage for Adult Child Until the Age of 26
- Guaranteed Availability of Coverage
Levels of Coverage

- Bronze (60% of the full actuarial value of the benefits)
- Silver (70% of the full actuarial value of the benefits)
- Gold (80% of the full actuarial value of the benefits)
- Platinum (90% of the full actuarial value of the benefits)
- Catastrophic (29 years old or younger or exempt)
The Individual Mandate

How to Maintain Minimum Essential Coverage

- Government sponsored programs (Medicare, Medicaid, CHIP, Tricare, Veterans, Peace Corps)
- Employer-sponsored plans
- Plans in the individual market (Exchange, Basic Health Program, etc.)
- Grandfathered health plans
The “Penalty”

NEW WAYS TO QUALIFY (1/30/13)

1. Self-funded student coverage
2. Foreign health coverage
3. Refugee medical assistance
4. Medicare Part D
5. State high risk pools
6. AmeriCorp volunteers

Minimum Essential Coverage?

Yes

Exception?

Yes

1. Religious?
2. Not Present?
3. In Jail?
4. Low Income?
5. Hardship?
6. Indian Tribe?

No

No

PENALTY (in 2013) the greater of

$695 (or less)

or

2.5% of household income

not to exceed

Bronze Level of Coverage

What General Counsel Need to Know
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As of 2013, the 0.9% Additional Medicare Tax applies to income that exceeds a threshold amount of $250,000 for married taxpayers filing jointly and $125,000 if filing separately.

A $200,000 threshold applies for all other taxpayers.

An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays in excess of these limits within a calendar year.
Other Taxes

Net Investment Income Tax

As of 2013, the 3.8% Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above threshold amounts.

Indoor Tanning Services Tax

As of July 1, 2010, a 10% excise tax on indoor UV tanning services went into effect.
Employer Impact

1. The Employer Mandate
2. Small Business Health Care Tax Credits
3. Employer W-2 Reporting Requirements
4. Health Flexible Spending Arrangements (FSAs)
5. Premium Tax Credit
The Employer Mandate

- While the Individual Mandate starts January 1, 2014, the Employer Mandate starts in 2015.

- The ACA does not require employers to offer health insurance coverage to their employees.

- However, for "large employers" (those with 50 or more full-time employees), the ACA imposes a penalty of $2,000 per employee if any of their full time employees qualify for and receive federal subsidies.
Small Business Tax Credits

- Must pay average annual salaries below $50,000.
- Must have fewer than the equivalent of 25 full-time workers.
- In 2010 this credit was up to 35% of a small business’ premium costs (25% for tax-exempt employers). On January 1, 2014, this rate will increase to 50% (35% for tax-exempt employers).
- Designed to encourage small businesses to provide qualified health insurance for their employees.
W-2 Reporting Requirements

- For 2012, W-2 forms included the total cost of employer-sponsored health insurance coverage.
- Required by the Affordable Care Act, the disclosures are designed to raise awareness of health care expenses among employees.
- These health benefits are still tax free.
- The new information appears in Box 12 of the standard W-2 form, with the two-letter code DD.
Health Flexible Spending Arrangements

- A Health Flexible Spending Arrangement (“FSA”) is a benefit designed to reimburse employees for medical care expenses incurred by the employee, employee’s spouse, dependents and any children who, as of the end of the taxable year, are under 27 years of age.

- Contributions to an FSA offered through a cafeteria plan do not result in gross income to the employee (subject to other Code provisions).

- As of January 1, 2011, the cost of an over-the-counter medication was no longer reimbursable from FSAs without a prescription, though this does not apply to insulin, medical devices, eye glasses or contact lenses.
The ACA provides for a premium tax credit to help individuals and families afford health insurance coverage through an Exchange.

An employee is not eligible if offered affordable coverage under an employer-sponsored plan that provides minimum value, or if the employee enrolls in an employer-sponsored plan.

An employer-sponsored plan is affordable if the employee’s required contribution does not exceed 9.5% of the employee’s household income.
What Are My Other Options?

Health Insurance Marketplace

- Make comparison shopping easier
- Lower barriers for new competition in the insurance market
- Provide savings and choice through transparency
- Determine individual tax credits/subsidies
- Increase competitive advantage for enrollees
- Focus on the uninsured
What Are My Other Options?

Exchange Transparency

- Exchange Board and Governance Structure
- Stakeholder Consultation Plan
- Outreach and Education Plan
- Role of Agents and Brokers
- Coordination Strategy
- Pre-Existing Condition Insurance Plan
Basic Health Program

Beginning January 1, 2015, states will have an additional option to establish a Basic Health Program (BHP) for certain low-income individuals who would otherwise be eligible to obtain coverage through an Exchange.

- Exists in addition to Exchanges and Medicaid Expansion
- Proposed rules published September 25, 2013
- Regulations encourage coordination between BHP rules and existing rules for Exchanges, Medicaid or CHIP
Creating Solutions
Performance Based Reimbursement

- Hospital Value-Based Purchasing
- Physician Value-Based Purchasing
- Hospital Readmissions Reduction Program
- Hospital Acquired Conditions
- Hospital Associates Infections
Under the Hospital Value-Based Purchasing (VBP) Program, CMS will start paying hospitals Medicare “bonuses” based upon overall performance, adherence to quality measures and patient satisfaction.

This epic change is designed to transform a system that has historically been based on cost into one that focuses primarily on quality and performance.

Funding for value-based purchasing comes from base operating DRG reductions (1% in 2013, 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, and 2% thereafter).
The Program is based on a hospital’s total performance score (TPS), which includes, in part, 12 Clinical Process of Care measures (70% of the TPS).

The TPS also includes 8 Patient Experience of Care dimensions (30% of TPS) from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
Starting October 1, 2012, the Hospital Readmissions Reduction Program (HRRP) reduces a hospital’s base operating Medicare diagnosis-related group (DRG) payments with respect to readmissions for three conditions, including: (1) acute myocardial infarction (AMI); (2) heart failure (HF); and (3) pneumonia (PN).
The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Severity Diagnosis Related Group (MS-DRG) payments for certain hospital acquired conditions. CMS has titled the provision “Hospital-Acquired Conditions and Present on Admission Indicator Reporting” (HAC & POA).

Hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission).

The case is paid as though the secondary diagnosis is not present.
To reduce patient health care expenditures, the Affordable Care Act must rely upon innovation and prevention, hoping to improve upon the delivery of health care in the United States. Some examples include:

- Center for Medicare and Medicaid Innovation
- Prevention and Public Health Fund
- Education and Outreach Campaign for Preventative Benefits
- Community Transformation Grants
- Patient-Centered Outcomes Research Institute (PCORI)
Challenges
When first announced in August 2011, the inclusion of contraceptive care as a mandatory component in the employer promotion of preventative services sparked a First Amendment debate.

Regulations in February 2012 created a temporary enforcement safe harbor for objecting employers.

The February 2013 regulations set the new threshold, allowing employers to oppose providing coverage for some or all of the previously required contraceptive services on the basis of religious grounds, exist as a nonprofit entity, and represent themselves as a religious entity.
HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act):

- Affect almost 700,000 health care entities
- Breach notifications
- Business associates
- Provide notification to patients of privacy practices
Existing privacy laws require practically every health care related electronic device to employ encryption algorithms, from a home facsimile or copy machine to all institutional servers.

Laptops and other portable devices must default to unreadable ciphertext, a protocol far beyond the ordinary login password.

Physicians’ Medicare incentive payments can be as high as $44,000, but the future penalty for not participating is up to 3% of all Medicare payments, starting in 2017.
The Genetic Information Nondiscrimination Act of 2008 (GINA)

- GINA is the leading federal regulatory protection of genetic information, but it only prohibits genetic discrimination in health insurance and employment.

- GINA does not regulate access, security or disclosure of genetic or whole genome sequence information across all potential users, nor does it protect against discrimination in other contexts.

- State laws vary for similar protections.
Proceed With Caution
The Affordable Care Act increases the Federal Government’s arsenal to combat health care fraud, abuse and waste. Some examples include:

- Mandatory Compliance Programs
- 60 Days to Pay
- Physician Owned Hospitals
- Medicaid RACs
- Physician Payment Sunshine Act
The Affordable Care Act requires all providers and suppliers who participate in Medicare to adopt a compliance program as a condition precedent.

The Office of the Inspector General (OIG) has encouraged the industry “to exercise due diligence to prevent and detect criminal conduct and otherwise promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law” consistent with the Federal Sentencing Guidelines for Organizations (FSGO).
Last year the Federal Government made it clear that health care providers must return federal overpayments **within 60 days** from the time the overpayment was first identified.

Failure to follow this new requirement set forth in Section 6402(a) of the Affordable Care Act throughout any ten-year “look-back” period creates potential liability under the False Claims Act.

Providers are held to a standard of actual knowledge or “reckless disregard or deliberate ignorance” for purposes of identifying an overpayment under the new regulations.
Enacted in February 2013, the Physician Payment Sunshine Act deals primarily with transparency and public disclosure.

It requires disclosures by certain manufacturers of drugs, devices, and biological or medical supplies, as well as group purchasing organizations (GPOs), including but not limited to: (a) certain physician ownership or investment interests; and (b) certain payment information made by these entities to physicians.

The deadline to collect this information was August 1, 2013, and the reporting deadline is March 31, 2014.
“Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.”

— Sir Winston Leonard Spencer Churchill
Hurry Up and Wait
Avoid the Herd
Trust Your Instinct
Be Patient
Remember What’s At Stake

With no end in sight to the partisan rhetoric that follows health care reform like paparazzi, we must consider what the crux of health care reform is all about:

Whether in the form of the ACA or some future legislation, the U.S. has a fundamental obligation to provide health care to those who live within its borders.
The General Counsel’s Top 10
Questions
Contact the Speaker

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