Beginning in 2014, the Affordable Care Act includes a mandate for most individuals to have health insurance or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves and their dependents. Some individuals will be exempt from the mandate or the penalty, while others may be given financial assistance to help them pay for the cost of health insurance.

**Panelists**

**John L. Green**
Partner - Thompson Hine

John is a partner in the firm’s Corporate Transactions & Securities and Health Care practice groups. John’s health care practice consists of representation of a wide array of health care providers, which include community hospitals, management service organizations, physician hospital organizations, home health agencies, long term care facilities and physician practice corporations.

**Jarrod B. McNaughton**
Corporate Vice President of Missions and Development - Kettering Health Network

In his role, Jarrod is responsible for marketing, communications, government relations, community relations, church relations, mission integration, and network alignment. Previously, Jarrod served as the Vice President of San Joaquin Community Hospital (SJCH), a 254-bed medical center in Bakersfield, California for over five years.

**Valerie Bogdan-Powers**
Vice President, Employee Benefits Services - HORAN

Valerie leads HORAN’s employee benefits team, developing customized solutions to meet the business goals and benefit objectives of their clients. She is responsible for client relations and works with the Account Management Team to deliver proficiency and education while advising clients in this rapidly changing health care environment.

**Marcus A. Taylor**
Regional Vice President, Southern Ohio Sales - Anthem Blue Cross and Blue Shield

Marcus is accountable for the sales and renewal activities for Anthem Blue Cross and Blue Shield’s large group business. He and his team partner with clients to develop benefit strategies that are tailored to the unique cultural and financial goals of each client organization. Additionally, he has oversight for both employer and broker/consultant relationships.

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KETTERING Health Network.
Perhaps we could start with a quick overview of the Patient Protection and Affordable Care Act. Of course, the Act is often referred to as the Affordable Care Act. For the sake of avoiding a political discussion, let’s refer to it today as the Affordable Care Act or Health Care Reform. Can you explain the major elements of the Act?

Jarrod: This was a bill that was signed into law by President Obama back in 2010 on March 23rd. It was about 2,300 pages. The bill is quite complex. It hits a variety of topics that are not being brought up to the House or Senate for discussion. It includes provisions for small groups, it actually also indirectly impacts large groups. Large groups are not required to cover EHBs but in the event that they do cover one of those EHBs, they are still held to that same inability to put on a limit on those things. They can’t put dollar limits in but they can use other limits. You can put visit limits in, per occurrence limits, day limits and per episode or service limits in. Minimal Essential Coverage is more commonly tied to the employer mandate. It is defined as a group health plan under the Employee Retirement Income Security Act. What that means is that there are some plans out here right now that won’t meet that definition – mini med plans, limited benefit plans, critical illness plans and accident plans. Minimal Essential Coverage is also tied to having a 60% coverage value meaning that the plan you are on has to cover at least 60% of the cost of expected coverage throughout the year.

What is the Health Insurance Marketplace?

Jarrod: The Health Insurance Marketplace, also known as exchanges, is one of the more interesting pieces of this legislation, specifically because you can think of this as a virtual store for folks to be able to visit and review different health insurance plans that might be available to them, and then to sign up for a plan. These exchanges are set up in two different ways; the federal government said the states could either do it and have these virtual stores or the federal government would actually do it for states that chose not to. Think of a travel site like Expedia, where you can go on and put in a little bit about yourself, and your destination. All these different airline options pop up, different costs and it even gives you options for things like car rental. That’s the exact same thing that these Health Insurance Marketplaces will do. They will actually give you tiered plan options that are tailored to you depending on what your needs are, everything from a platinum plan which is the very top, all the way down to a bronze plan and everything in between. It gives people the opportunity to look at the different plans online and be able to say “I might be curious about what this particular insurance offering is versus this one.” You can compare them against each other and find something that works for you.

With this web site, is that only for the people who will not be insured through an employer plan or is it for anybody?

Valerie: It’s for anybody. Anyone can purchase on the Health Insurance Marketplace, setting. All of this results in a greater integration of providers and the delivery of services. Providers, previously independent, are now coming together to provide the entire continuum of care under one roof.

Jarrod: For us, operationally and practically you’re seeing changes on reimbursement structures to health care providers that are focusing us more on outcomes, on patient satisfaction, on quality issues. You’re seeing many more resources being spent in those areas within the hospitals and health care providers. John alluded to the continuum of care. We’re looking at health care now from literally before you ever get into the hospital, all the way through to after the hospital episode of care, through your home care, and any follow up care in a rehab facility you might need, whatever that might look like. That full continuum is much broader and part of that is because as we look forward, something likely to happen and is already being tried out in some markets is this concept of bundled payments. There is one payment for one episode of care that gets dispensed to all of the providers that were in contact with the patient during that episode of care. So hospitals and healthcare providers have to be much more attuned to the idea that we are caring for this patient for the entire episode that they are with us. It’s not just for that one surgical intervention, maybe a knee replacement but for everything from the pre knee replacement, what we have done on the physical therapy side to help prevent it, and all the way through to the after care.

People most motivated to purchase early will be the people who don’t have insurance but anyone can begin on October 1.

How can the models of healthcare delivery changed as a result of health care reform?

John: The ultimate outcome is to have a more consumer-centric delivery system that focuses on improved quality outcomes at reduced cost. As a result, the new models which we are starting to see, some of which were included in the Affordable Care Act, for example, Accountable Care Organizations, are models that are focused on population health management with concurrent reimbursement centered on patient outcomes as opposed to the fee for service. Another example is patient-centered medical homes. New access points include telehealth, and consumers receiving medical services in a retail setting, which think that you are going to see a much more heightened effort. We are already doing this at Kettering with cost control, making sure that we are doing everything that we possibly can to work with national organizations for purchasing power, making sure that we are looking at every single implant that we provide and getting the best pricing. You are going to see a shift to both cost issues as well as a heightened push towards patient satisfaction and quality because as the country gets better in those areas it spares down the percentage. Everyone is running after those goals so you have to be on your game.

Are there changes with regard to how providers will be reimbursed change on January 1 or is that further out?

Jarrod: Some of that has already changed. It was part of this legislation and others enact. There is the IRD10 conversion, which takes codes for how we get paid as a hospital. It used to be called IC99 and there were about 15,000 codes you could bill for. Everyone in the country is moving to IC10, which has about 150,000 codes that we all have to know and learn. You also have situations where people can go on different web sites and look at how providers are doing with regards to patient experience, with quality issues. The government payers like Medicare and Medicaid are actually starting to shift payments based on how well we do. That shifting of payments isn’t a bonus for hospitals that do well, it’s all about a takeaway. The 100% payment is whole but you can be docked a percentage point or two if you’re not meeting certain threshold holds. That system is already being implemented today.

I’m sure that Kettering Health Network is very immersed in improving quality and patient service. Can you please share with us which of these you have implemented now, and which you will roll out in the future?

Jarrod: This area is quite blessed with phenomenal healthcare providers. The quality here in this market is exceptional. This region is nationally known for quality outcomes and is unlike any other market. On the Kettering front, we were out ahead with electronic medical records to try and help with some of those quality issues. Right now, we are in the middle of something called One Best Practice, which takes all of the different hospitals and health providers in our network,
metrics will be forthcoming.

for patients, based on definable and objective
that are solely focused on quality outcomes
emphasis on quality. New payment methods
ditions will occur. The goal is that people
health care providers. Things like medication
ers is a work in progress, but it are happening
of care and communication between provid-
izations so that health care delivery is a
are becoming a part of similar provider orga-
number of independent medical practices
become part of a larger delivery model. The
their providers, previously independent,
integration?

What about a situation involving two
different hospital systems? Will there
be a sharing of that patient information
across systems?

Jarrod: Yes. The good thing is that in
this market, both of the hospital systems actually
utilize the same platform for their behind the
scenes IS infrastructure and that’s called Epic,
a medical record program. They are a little bit
different but there are crosswalks available;
the ideas being that they can go in and look
into the system. Where the concern comes in
is in other markets where you have a number of
different medical record platforms. We do
have some here, too. Some providers may
not be on that electronic medical record and
it may be more challenging for them because
they have to learn something new. We have
some work yet to be done but it’s progressing
in the right way.

It sounds like there are many advan-
tages to healthcare reform for patients.
Can you comment further on how you see
this will positively impact Americans in
healthcare systems like yours?

Jarrod: The idea for hospitals and provid-
ers to improve their game as best as they can,
drive to be the best is certainly a big part of
this. You are going to have some providers
check out of this system and we’re seeing
some of that already where you might have a
physician that does what we call concierge
or boutique medicine and they say ‘We don’t
want to deal with any payers at all. You pay
me cash and I will come to your home.’ That
exists to a small extent but for the most part,
you’re seeing the providers and hospitals in
the country have a huge push to improve
their patient experience, to improve their
quality, to drive down costs, to look at patients
like much more than someone just coming in
for a procedure and rather looking at them as
coming across the entire continuum of care.
That is so important because that idea for
hospitals, where we were paid on the basis
of if a person is sick, is starting to change.
Those reimbursement structures and what
they look like have not been identified yet but
that idea of population health, making sure
that the full wellness component is there, is a
win-win for both the hospital industry as well
as consumers. The goal is to have Americans
be as healthy as they can possibly be.

There have been a number of delays
announced with health care reform. What are some the provisions that
have been delayed?

Marcus: To clarify, it’s only the enforce-
ment of penalties that are imposed on
employers and some of the related reporting
requirements that are being delayed. There
are two major ones that are most recent
and topic de jour for most employers. First
is the notice of coverage options. Basically,
by October 1st of 2013, employers had to
send out a notification to their employee base
that there were options out there, primarily
through the Health Insurance Marketplace
or the exchanges. They had to send that to
the current base and then going forward,
that provision required that within 14 days
of hire, they also had to notify new hires
that those options were out there. That was
recently delayed and that will go into effect
on October 1st of 2014, more than likely. The
second one, probably the one most impor-
tant to employers, is the actual delay of the
employer mandate. That has been delayed
until January 1st of 2015. This is the provision
that said that employers must offer Minimal
Essential Coverage, they must offer a 60%
minimum value plan, and they must offer
coverage that is affordable or not in excess
of 9.5% of household income. If they didn’t
meet those requirements, then a fine would
be imposed on those employers on a per
employee basis, depending on whether it was
the affordability test that they didn’t pass or
the offer test. Those are the two with the most
financial impact, which impact how employ-
ers report and change their own systems
internally to be compliant with the law.

Was the individual mandate impacted
with this delay?

Valerie: The individual mandate is still
in place. Starting January 1st, 2014, most
Americans, with those few exceptions point-
ed out, need to have insurance. They are
allowed no more than three consecutive
months without insurance and insurance for
one day of the month counts. The interesting
thing that our employers are thinking about is
that employers aren’t required to offer insur-
ance but everyone has to have insurance.
We now have a population in America that’s
going to need to make sure they have insur-
ance. How will they get that insurance is
a seismic change. Whether they choose to
go to an exchange, purchase it from their
employer, go to a mall kiosk, or go to a bro-
er agency, there will be many more outlets
emerging and people will have to pay atten-
tion to that. One of the elements we counsel
our employers on, especially because about
80% of employers renew their plans on the
first of the year, is thinking about who is
coming onto the plan that may not have
been on the plan before because they are
required to have insurance. When they think
of who is waiving, are they waiving because
they are on a spousal plan, are they waiving
because they choose not to buy insurance?
How are they going to make sure that they are budgeting for that? As we think about consumers, October 1st will be that first day that the exchanges are open and people will lift their heads up and say, ‘I have to buy insurance. How do I get it? Where do I get it?’ There are a lot of questions, we’re helping arm our employees to help their employees through this.

Why did the administration approve the delay?

Valerie: From the perspective of many of our employers, there were a lot of report- ing requirements and they were not ready to report who is eligible and who is not eli- gible. There is a whole piece on measurement periods. For example, if people are working 30 hours on average, are they getting affordable insurance and do they have to report to the government for a subsidy? The systems were not set up. You see a lot of payroll companies coming forward and building systems such as hour management and tracking taxes. They just weren’t readily available to verify what the government needed in order to say that people were eligible. That’s one of the biggest things we’ve seen.

Marcus: The administration, Health and Human Services, spoke about this last year, listened to their lobby and the employer lobby for all those reasons just mentioned. Those voices were very loud and very clear about is a lack of readiness and that’s why I think the administration delayed it.

Is there any sense that the current systems being put in place for the October 1st marketplace launch will not be able to handle the amount of transactions that are being promised? How many uninsured people will need to get insured in a small window of time? Is there any concern about that?

Marcus: Everything that I have read and heard from HHS and the administration states that the exchanges will be ready to go on October 1st. I have not heard of any con- cerns around volume. At a recent presenta- tion, HHS Secretary Sebelius mentioned this, lis- tened to their lobby and the employer lobby for all those reasons just mentioned. Those voices were very loud and very clear about is a lack of readiness and that’s why I think the administration delayed it.

Valerie: The first day they did extend how long people can enroll. You can enroll from October 1st to March 31st, 2014, whereas in the second year, you will only have until December, which is more consistent with the Ohio Department of Insurance here in Ohio suggested that some things may not be ready in a timely manner, like information verification. But as the process of the exchange evolves, you will start to see that become more automated and effi- cient. Again, everything that I have seen says that the administration and exchanges across Ohio will be up and running on October 1st.

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health plan for the employees but they also want to follow that up with some tax credits. The small business is going to see that while they don't have a free ride on this, they will get some assistance.

**Do penalties apply to employers with part-time employees?**

Marcus: The penalties apply to large employers with 50 or more full-time equivalent employees. The law says that a full-time employee is someone who works 30 or more hours per week but part-time employees are aggregated together on a pro rata basis to equal full-time equivalent employees. The answer is yes. It just depends on the amount of part-time employees you have, how many hours they are working and whether or not once you run that calculation, they become a full-time equivalent.

Valerie: There are different counting methodologies you can use. In a simple way, you can take the amount of hours that your aggregates, part-time employees worked, divide it by 120, and that's your full-time equivalent for the month of part-time employees. If that's the counting method you chose, you would then count that plus your full-time employees, which equals a number. If that number is above 50, you are now a full-time employer and are subject to penalties like any other full-time employer. You don't have to offer every one of those part-time employees insurance because some may be working less than 30 hours but you are counted as a full-time employer. We have groups that are full-time employers, that are going to be subject to penalties but based on how they offer insurance, because some of their part-timers might work 10 or 20 hours, they actually fall into the small group market and are being underwritten as small groups. We call that Double Jeopardy.

**What if an individual cannot afford coverage? What are the penalties?**

Valerie: There are standard penalties for not having insurance. In the first year, it's 1% of household income or $95 and it accelerates each year. What people are confusing is thinking they have a penalty of $95 but in fact, that penalty is 1% of household income. So unless you make $9,500 a year, which would probably make you eligible for Medicaid, you are going to have a greater penalty than $95. Also, the penalty is for every adult in your household and half the amount for a dependent, up to three times of the individual penalty. So it's a household penalty and it comes on your tax return. There is one caveat for a person whose income is 8% or less of the lowest silver plan cost. They will not have to pay a penalty. How you get a subsidy is very different. You can get a subsidy if you are not eligible for employer coverage that is affordable, 9.5% of your income, or Minimal Actuary Value, which is 60%. Seventy-five percent of Americans do have that so if you do, you are not eligible for a subsidy. The second thing that qualifies you for a subsidy is that you have to be between 100 and 400% of the poverty level. If you qualify under both of those, you would receive a subsidy, which is based on your household income. So if you are at a certain poverty level, you may have to pay up to 2% of your household income and then the rest comes in a subsidy based on the cost of the plan. The scale is between 2% and 9.5% so if you're at 400% of the poverty level, you will be expected to pay 9.5% of your income against health insurance and the rest will be covered by the government subsidy, which is in the form of an advanced tax credit so you don't actually receive it. It goes right to your insurance carrier. The biggest piece for most employers offering insurance is that people will be ineligible if you offer insurance to get a subsidy.

Jarrod: Right now, there are groups that are exempt, including Native Americans and undocumented immigrants. Some of the estimates are that well over 10 million people in the country will not have some form of health insurance made available to them. It's still a big chunk of people. Not every single person in the land will be covered but a majority will.

**Who will be exempt from this mandate?**

From Bloomberg article: “46 million people didn’t have health insurance in the first quar-

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**Guiding Employers through the Impact of Health Care Reform.**

Valerie Bogdan-Powers and her HORAN colleagues work with employers across the region to help them build benefit strategies as the marketplace adjusts to health care reform changes.

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Health Benefits
ter of the year and 57 million people, or 19 percent of the U.S., were without coverage at some point in the prior 12 months, according to a survey by the Centers for Disease Control and Prevention."

Is it a good idea for companies to reduce benefits and turn their employees over to the state healthcare exchanges to save money?

Valerie: I think the trend you’re going to see is that a lot of employers are looking at this 60% Actuary Minimum and starting to reduce the plans. The average Actuary Value is in the low 80s so people might say, “Okay, this is our base plan, 60%.” Most contributions are far greater than 95%, People don’t pay 95% of their income to health insurance today in an employer plan. And there is also the subject of spouses. There are spousal surcharges and spousal carve outs that are allowed. Employers are asking if they even need to cover spouses. Technically, no. You have to cover employees and dependents. So now, the game around benefits is who are you trying to recruit, who are you trying to retain, and what is the role of your benefit plan? Most benefit plans are fairly equal. That is going to change. In some ways, it can help and in others, it will, in terms of the employers and what they can offer.

Is there a sense that most employees who are currently insured and working for a company that has traditional insurance, their cost will go up?

Valerie: It could potentially if employers end up following suit. Instead, the government has set for them because those are lesser benefits at a higher cost.

How will the healthcare reform law help people with their out of pocket expenses?

Jarrod: For those folks that have no coverage today, it can help them dramatically. It will depend on what plan they choose, whether it’s a platinum plan that covers a catastrophic coverage or whether it’s a platinum plan that covers a catastrophic coverage. Whether it’s a platinum plan that covers the like, the bronze plan, which is much more geared towards catastrophic coverage.

How are people going to prove that they have coverage?

Jarrod: Right now, the language of the law is that insurance cards will be made available just like they are for your auto insurance cards. There will actually be a section on your IRS tax return, which will state whether or not you have insurance.

The new law changes how insurance companies determine premiums. Can you explain those changes? And what is a Modified Community Rating?

Marcus: Many of the premium changes and rating restrictions apply to the small group space, which in Ohio, is defined as 2 to 50 employees. There will be changes in that group beginning in 2014. Those rating changes and restrictions then expand upward in the market to the 51 to 99 space in 2016. So in the small group space right now, there are a number of variables that an insurer can use to determine premiums. In the individual space right now, there are a number of variables that an insurer can use to determine premiums. In the small group space, you can rate on age. This is where you see a restriction. Right now, from an age standpoint, there is an 8:1 ratio so someone who is 1st could be charged eight times as much as someone who is 21 and buying insurance. That is now going to a 3:1 ratio. Carriers can also rate on geographic area and on tobacco usage with a 50% surcharge. There’s a lot of variability in rates so looking at the age restriction, you would expect a typical 64-year-old would have higher deductibles and incur costs differently than a 21-year-old. In many instances, you could demonstrate where an 8:1 ratio would make sense based on that. Now, that will be compressed. The expectations are that for companies that are younger and healthier, you would expect that costs are going to increase for them. But there will be winners and losers in the Modified Community Rating. It really just depends on your socioeconomic demographic within your population. Certainly, some less healthy, older groups will see their rates go down.

What are you doing to educate consumers about the new products you are offering?

Marcus: Anthem will be using multiple touch points to communicate with and educate consumers in our various geographies. We are also working to reach the underserved and uninsured populations, particularly in rural areas, which is essential to access. For our existing customer base we will be using letters, emails, and in some cases outbound calls to help explain coverage options and advising them of open enrollment for 2014. For prospective consumers we will utilize direct marketing and education campaigns via radio and television advertisements, increase visibility in social media, and even presence in retail and other venues that allow person to person engagement. The retail space opportunity is one I’m especially excited about. In many cases we are using kiosks, provided in partnership with a company called SoloHealth, to engage and educate consumers about their options in 2014. These kiosks have multi-lingual capabilities and began appearing at Wal-Mart and Sam’s Clubs throughout the state beginning in August. There are a number of them available here in the Dayton area already. Finally, I’d like to mention that we have also launched a website called healthcaredermform-foyou.com so that people can use all of these tools and learn about their benefit choices.

How will healthcare reform create a greater transparency with the relationships between physicians and pharma-ceutical companies and medical device companies?

Johns: One of the benefits of the Affordable Care Act is the emphasis on a consumer-centered view of care. The Physician Payment Sunshine Act is a new law that has gotten little play in the popular press. This law requires pharmaceutical and medical device manufac-turers (and others) to publicly report financial relationships that they have with physicians. The purpose of the reporting is to provide transparency to patients regarding the financial relationships that their physicians are prescribing. These financial relationships include payment for things like speaking, trips, honorariums and the like. Starting next year, this information will be publicly available on a government web site that patients may access. Again, it has not received much play in the media but I think as time goes on, it will. As a result, I am sure there will be some candid discussions between patients and their physicians.

Healthcare reform was supposed to make healthcare cheaper – not more expensive. But for most, rates are higher. Why? And how do you expect people to pay for them?

Marcus: First, this is an extraordinary opportunity for our country to get more people insured and it’s certainly transformational for the industry. But in addition to increased access to care, we also have to look at the fact that people who already have benefits are going to get expanded benefits. Using the individual market as an example, many carriers offer health plans that don’t have maternity built into it so if you’re a single male and you don’t plan on getting married, you could see a price break for getting into a plan without maternity coverage. With this legislation, there are benefits that people may not have asked for or didn’t necessarily need in their coverage but because we are mandating certain coverages for all, you are expanding benefits. Even free preventative care, though it’s free to the consumer, someone has to pay for it. That’s the company, it’s the insurance company. So with the expansion of benefits, with the lowering or limiting of out of pocket maximums, having to lower deductibles in the small group and in their place, or rate restrictions in the small group space, the cumulative effect of those things potentially raises costs. Most projections say they do raise costs for people overall. But if you look at this from a greater good standpoint, more bodies, more American consumers are now insured and have access to quality care. We can also look at the overall cost of care because more people will get intervention sooner rather than showing up in ER for a catastrophic incident.

How does health care reform affect the availability and privacy of electronic health records?

Johns: The exchange of information electronic sector is a key component of the healthcare reform effort, be it the exchange of health information for providing care or procuring information on health insurance changes. The Health Insurance Portability and Accountability Act (HIPAA) is designed to create a secure electronic platform to exchange health information. The law has various components but the one that people are most familiar with is how it is designed to protect the privacy of their health information. The goal is that a patient’s providers, wherever they are, may access that patient’s medical information. That is to have a seamless transfer of information so that the patient is getting the right care. Health care reform has added further protections to the privacy and security of electronic health information. If information is inadvertently disclosed, the patient must be notified and the health care entity which allowed a breach of the information may be penalized. The biggest issues that we are seeing is the use of mobile devices. Everyone has notebooks and smart phones. Providers are sending and receiving health information on these devices, as well as on web sites. Because of health care reform, the penalties are now much more severe. The government is taking patient privacy very seriously.

What are some of the fees that have been imposed upon health insurance carriers and employers as a result of healthcare reform?

Marcus: There are basically three known fees and hidden fees, which are considered a fourth. One is the insurer fee or the Health Insurance Tax. This doesn’t apply to self-funded clients. It’s an annual fee for the health insurance sector that’s meant to fund exchange subsidies. What the health insurance sector does is pass those along to their clients. That fee is permanent in duration and is 2.46% of premium. The second is the Transitional Reinsurance Fee. That applies to all segments with the exception of individuals
and that’s to stabilize the individual market. It is assessed on a per capita basis, from 2014 to 2016. That amount is $5.25 per member, per month. There is a third fee. Patient Centered Outcomes Research Institute is an organization focusing on advancing the quality of evidenced based medicine. That fee began in 2012 and phases out in 2019. It’s a dollar per member in year one and then it goes up to $2 per member, per year. But there are also hidden fees in terms of business transactions and consultation, be it with your attorney, your broker or your tax advisor around finding out how this law affects you and how do you become compliant. That is an additional cost that will vary by employer and will probably be significant.

How are wellness programs impacted by ACA?

Valerie: We put our clients on what we call a Wellness Continuum because we think every client is in a different stage of wellness. The stages are employers that are informers, ones that are goal setters who are more participation/reward based. They have created a Wellness Continuum because we think that they are participation-based or reward-based. Those variables have actually increased. You can have a 30% differential now for outcome based wellness and you can have a 50% differential if you have tobacco included. The max for those two combined is 50%. So if you had a mix between tobacco and any wellness outcomes, you can only max to 50%. If you had tobacco only, you could do a reward or penalty as high as a 50% differential for that individual. There are non-discrimination pieces to this. You have to provide the plan to similarly situated individuals in a company. You can’t just target certain people; it has to be for everyone. You have to have renewal annually so people can renew to that reward or penalty every year. And you have to have reasonable opt out programs for individuals that would allow them to do something different and still earn that reward or avoid the penalty. So if you have someone with very high cholesterol, you might have to have an outcome. If they don’t change their cholesterol but they went through an opt out, which is maybe a nutrition class or sessions with a health nurse, they would still be eligible for that reward or avoid the penalty based on that opt out.

What is the new paradigm in the delivery of health care?

John: Providers relate to each other and to the government in new ways. For example, new health care payment models reward value instead of volume. These models include: value-based purchasing, gainsharing, and bundled payments. Second, greater integration among providers increases coordination of patient care. Third, the expansion of health information technology results in better quality of services. We find, from a legal perspective, that the current government regulations have not kept up with this new paradigm of health care delivery. Thus there is a tension between the new paradigm and the current regulatory structure. That will ease only as the government addresses the new realities and goals of health care delivery.

You each are approaching Health Care Reform from a somewhat different point of view considering your industries. I’m curious how you are advising our constituents.

Marcus: We do our part in terms of letting people know what we think they need to do to be compliant. What we typically tell them is consult your broker, consult your tax advisor and consult your attorney. Be prepared and stay compliant.

Valerie: We have three things that we are trying to do. One is that you have to comply. We have checklists, we have seminars, we have model notices. You HAVE to comply. The second thing is we have four parties trying to do. One is that you have to comply. You can’t just target certain people; it has to be for everyone. You have to have renewal annually so people can renew to that reward or penalty every year. And you have to have reasonable opt out programs for individuals that would allow them to do something different and still earn that reward or avoid the penalty. So if you have someone with very high cholesterol, you might have to have an outcome. If they don’t change their cholesterol but they went through an opt out, which is maybe a nutrition class or sessions with a health nurse, they would still be eligible for that reward or avoid the penalty based on that opt out.

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Health Care Reform
Giving You a Headache?

We have the cure. Our health care lawyers have been keeping their fingers on the pulse of the evolving health care reform legislation. We help clients develop and implement cost-effective health care strategies in response to the new regulations.

For more information, contact our health care lawyers:

John L. Green
937.443.6864
John Green@ThompsonHine.com

Cori R. Haper
937.443.6856
Cori.Haper@ThompsonHine.com