Benefits, requirements of Affordable Care Act will roll out over 3-year period

By ALAN J. ORTBALS

Guess what? The Affordable Care Act is complicated, and provisions of it roll out over several years. The specifics have been left up to a variety of government agencies to figure out. And, on top of everything else, 14 states have filed suit challenging the law's constitutionality - and Republicans, now in control of the House come January, are vowing to repeal, amend or block implementation. What's a business owner to do?

The first set of provisions became effective on Sept. 23. One is that companies that offered health insurance coverage - not only for their employees but also spouses and children - must now cover those children up to age 26. In the case of grandfathered plans, those already in existence when the Act was passed on March 23, 2010, those plans can still exclude children between the ages of 19 and 26 if they have access to health care through their own employment.

A non-grandfathered plan doesn't have that option. The parents have the right to add their children regardless if they're working elsewhere or are eligible for separate coverage.

"If it's a non-grandfathered plan," said Tom Berry, shareholder with the law firm of Sandberg Phoenix & von Gontard P.C., "then they could be working at Boeing with the best health plan imaginable, and if the parent still wants to add their child to their plan, the non-grandfathered plan has to allow their addition. After 2014, even a grandfathered plan would have to cover a child under the age of 26 - regardless of whether or not they are eligible for coverage, either as a full-time college student or work, or if they're married and their spouse has coverage. But a grandfathered plan could theoretically exclude a child under the age of 26 for the next couple of years," Berry added.

Any company healthcare plans that begin after Sept. 23 are also subject to several other changes. Those plans will have to accept all preexisting conditions of children below the age of 19. A plan cannot set any annual or lifetime limits on coverage. And new plans will have to cover preventative care without any co-pays or deductibles, according to Doug Neville, an officer with the law firm of Greensfelder, Hemker & Gale P.C.

"Our theory is these state exchanges will inject more - rather than less - competition into the marketplace, and obviously more competition means more effective and more efficient and presumably less expensive health insurance. Now again, that is something that a lot of people will debate vigorously one way or another, but that is the philosophical design behind the Affordable Care Act that was passed this year."

Tom Berry

Shareholder, Sandberg Phoenix & von Gontard P.C.

"The idea is that in the end that it will save money because you'll catch things earlier - 'an ounce of prevention is worth a pound of cure,' sort of thing," Neville said.

With the Sept. 23 date, insurance companies also lost the ability to rescind coverage unless the insured purposely withheld pertinent information on their application or have not paid their premiums.

Beginning Jan. 1, 2011, insurance companies will have to show that 85 percent of premiums collected from large company plans are being spent on actual health care, and at least 80 percent of premiums collected from small business plans.

The next big changes come in 2014, according to Neville. First of all, everyone is going to have to show that they have insurance coverage or pay a fine. Secondly, employers with 50 or more employees are going to have to provide coverage to their employees or pay a $2,000 per employee, non-deductible penalty to the government.

To assist both companies and individuals in shopping for insurance, states will be required to create health insurance exchanges.

"What we're thinking is that the exchanges will be Web sites where consumers will be able to go and compare and contrast various insurance products," Neville said. "These will still be private insurance companies. It's not like the government's taking it over. Private insurers will design their plans to be compliant with the law and submit them to these exchanges."

Which is a good thing, according to Berry.

"Our theory is these state exchanges will inject more - rather than less - competition into the marketplace, and obviously more competition means more effective and more efficient and presumably less expensive health insurance," Berry said. "Now again, that is something that a lot of people will debate vigorously one way or another, but that is the philosophical design behind the Affordable Care Act that was passed this year."

The question of whether employers will drop their healthcare plans in favor of paying the $2,000-per-employee fine is an open one. Some say it's illogical, as employers currently provide health insurance programs without threat of fine. Why would they stop when a fine becomes the alternative?

But Neville says that if the system works well, some employers may do just that. One, individuals will have much greater and much easier access to health insurance. Two, by forcing people to buy insurance, it will expand the pool and spread the risk, holding down cost. Three, insurers will not be able to deny coverage.

"I'm not necessarily saying I agree with this, but the theory is the marketplace is going to change for individuals," Neville said. "My view is that if employers see that it actually works, they may take a different view. They may say, 'In the past we had to do this because our employees had no other choice and we want our employees to be happy and healthy. But now, they've got a choice. They can go out and get their own health care and it's affordable for them, so we don't need to do this anymore.'"

While the law is being challenged both in Congress and in the courts, Berry and Neville agree that today it's the law - and businesses need to follow the law as it is today, not how it may be next year.

"You need to make sure that whoever you're getting your coverage from is updating the plan documents in terms of expanding now what's included or what was formerly excluded, and also make sure the plan procedures for appeals are otherwise also updated," said Berry. "The Department of Labor, to their credit, has put together a number of model policies and model notice provisions that are available through the Department of Labor Web site to at least try to help employers through this process. A chart that summarizes what a grandfathered plan has to do, or not do, and what a non-grandfather plan has to do, and not do, in the interim. There are still a number of enhanced benefit rights that even a grandfathered plan has to change even though it may not have been in the plan before the law went into affect."

Affordable Care Act lays 1099 mess on the doorstep of small business

By ALAN J. ORTBALS

On Nov. 12, U.S. Sen. Max Baucus, a Democrat from Montana and Chairman of the Senate Finance Committee, announced that he would introduce legislation to repeal the 1099 provisions of the Affordable Health Care Act. As of press time, such action has not been taken.

Passed March 23, 2010, the 2,400-page law carried a hidden provision that would require all businesses to issue 1099 Forms to every individual and business with which they spend $600 or more in a calendar year - regardless of whether it's for goods or services, incorporated or not.

Up until now, businesses needed to only issue 1099s to unincorporated vendors from whom they purchased services in excess of $600 during a calendar year. But this provision of the Health Care Act, which takes effect on Jan. 1, 2012, is far more expansive.

"Not only services but it's going to include property and that's really the big thing that's catching a lot of people," said Cory Gallivan, a tax manager with the accounting firm of Scheffel & Co. P.C. "Take an accounting firm like us, for example. You buy paper from Office Depot and you spend $1,000 on that paper. That's a physical product. You never had to issue a 1099 for that. Well now the new rule says that if it's over $600 you have to issue a 1099. And, it's cumulative over the year, so something as simple as sometimes we do office lunches and we'll order out to SUBWAY. Well if we do enough of those, all of a sudden we're issuing SUBWAY a 1099. It's a major burden on these small businesses - really any business, for that matter - but especially the smaller businesses," Gallivan added.

"Give me a break. All it does is put thousands of hours of work on businesses, especially small businesses that will now have to figure a way to track whether you paid them $600 or more."

Ken Diel

Principal, Diel & Forguson Financial Group

Ken Diel, principal of Diel & Forguson Financial Group, says he thinks it was put into the bill to help offset the cost of the healthcare expansion, but that it just doesn't make sense.

"It's supposed to help justify repayment or help justify the cost because now these 1099s are going to go out and these businesses are going to have report all this unreported income," said Diel. "Give me a break. All it does is put thousands of hours of work on businesses, especially small businesses that will now have to figure a way to track whether you paid them $600 or more."

Diel says that on top of creating a huge amount of paperwork, there is absolutely no way to match up 1099s with income because individuals don't have to issue 1099s.

"The fallacy of 1099s all along has been that there's no way to match them to anything that businesses do," said Diel. "In my business, I tell all of my business clients that they have to send my firm a 1099 for services because I'm not a corporation. I'm an LLC, so therefore you have to send me a 1099. I do 600 individual tax returns. They don't have to send me a 1099. So if the Feds ever add up the 1099s, I guarantee they're not going to be close to my income. My income's going to be more. Now is it $5,000 more or $500,000 more? Who knows? So we're out here making all of this work for businesses for what purpose?"

And, in order to be able to issue a 1099, the payer has to get the vendor to fill out a W-9 and supply either the vendor's social security number or federal employer identification number. Companies will be required to collect these from every vendor, from Wal-Mart to the lawn service.

"Normally, if someone refuses to issue or provide you with a Federal ID number or social security number, you're supposed to do back up withholding," Gallivan said. "You withhold a certain percentage of the money, send it off to the IRS and tell the person to claim it on their return. The IRS always talks about this tax gap - the amount of tax that they collect versus the amount of tax they should collect. I think they're just trying to force taxpayers to help them police this unreported income."

But none of this does anything to nab the real culprits: people who are operating businesses on a cash basis.

"Most businesses do their best to comply with the law," Diel said. "There are those out there that have a pick-up truck and a hammer, call themselves carpenters and don't report all their income, but most small businesses do their best to comply with the law."

On top of everything else, the law also increased the penalty from $60 to $100 per incident for not filing a Form 1099 when required to.

Hospital administrators support universal care but say 'the devil is in the details'

By ALAN J. ORTBALS

Hospitals are finding both good and bad in the Affordable Care Act. But, as with others impacted by the law, the devil is in the details and there are thousands of details that are yet to be determined.

"All of these things are still yet to be worked out because the regulations haven't been written," said Danny Chun, spokesman for the Illinois Hospital Association. "Most of these are going to be written by the Department of Health and Human Services on the federal level and then every state - state by state - will have to come up with their own regulations to implement the insurance exchanges. You're going to have 50 different versions. It's very complicated because it's a 2,000-page bill," Chun added.

One point that it seems the hospital industry in general agrees on is that universal health care is a good thing. Mark Turner, chief executive officer of Memorial Hospital in Belleville, says the act is projected to cover about 95 percent of the population when fully implemented - and that's a plus. Chun agrees.

"The Illinois Hospital Association and hospitals across Illinois, for many years, have supported expanding coverage - expanding access to health care - because we all recognize what a serious problem the uninsured is," Chun said. "It's not just the cost issue. It's also people's health and well being because the uninsured tend not to get the care when they need it in the right place at the right time. And, when they do show up at the ER, they're usually sicker or chronically ill and it's much more costly to treat them. It's not good for the person, but here's the theoretical benefit. With increased coverage, theoretically, the number of uninsured should drop substantially...and about 50 percent of those who are currently uninsured in Illinois should be able to get coverage."

This, Chun says, will help hospitals because, right now, care to the uninsured is a big cost and it's provided free.

"What we think we'll see is exactly what Massachusetts saw - and that is a real influx of patients coming into the emergency room to seek that primary care because they can't get in to see a physician. Right now economics drive physicians into the medical and surgical specialties over the primary care practices. We have to make the primary care specialties more appealing to young medical students. And we have to have a way to attract more young people to medical school over other alternatives."

Mark Turner

Chief executive officer, Memorial Hospital, Belleville

Another positive, according to Turner, is that we should eventually see an improvement in the alignment of incentives between hospitals and physicians. As an example, Turner says, the hospital might currently get one payment for a patient's care regardless of how many days they're in the hospital, while the physician may be getting paid per day. So, the physician is not really incentivized to move the patient out of the hospital while the hospital is.

"That's where Medicare is heading over the next decade with healthcare reform," Turner said, "trying to align those incentives and allow organizations like hospitals to work more closely with their physicians, to integrate more fully and share some of those cost savings across the board. And private insurers almost always follow Medicare."

On the negative side, hospitals are going to be taking a hit on reimbursements for Medicare and Medicaid patients, making a bad situation worse. According to Chun, hospitals across the country will see a $155 billion reduction in Medicare and Medicaid payments over the next 10 years - and those cuts actually started this year.

"Medicare and Medicaid both pay less than cost," Chun said. "Medicare is slightly better than Medicaid. If it costs an Illinois hospital $100 to provide a service, Medicare, on average, will pay a hospital $90. Medicaid, which is a combined state and federal program, will only pay about 75 percent of cost. So, on average, every time a hospital treats a Medicare/Medicaid patient, they're actually losing money."

Another problem, according to Turner, is that Medicare/Medicaid is not going to pay for certain types of readmissions to the hospital; and, oftentimes, those readmissions occur because of patient non-compliance. The patient, Turner says, doesn't have any accountability in this process; the hospitals do, but the patient controls his behavior.

"For example," said Turner, "a patient is admitted for heart failure. He's treated, recovers and is sent home. He is told to follow a specific diet, take a particular medication and adopt a regimen of activity. If he doesn't follow that, we know he'll be back in but we can't make him follow that at home. We don't get paid for that readmission under the new law."

The new law also does nothing to address malpractice litigation - and that's disappointing, says Turner. The direct costs of malpractice litigation are fairly easy to determine and are not that dramatic, according to Turner. But what you don't see and what is not figured into the calculations, is the cost of defensive medicine; Turner thinks that's significant.

While a lot of people are complaining about the act for one reason or another, a big problem that no one is paying attention to, Turner notes, is patient access - the fact that there already aren't enough primary care physicians to handle the load and plans call for adding about 50 million people to that weight.

"We just don't have enough physicians in the United States to provide the access to care," Turner said. "If you do a little homework on the Massachusetts plan, that's what you find. Yes, a lot of individuals gained coverage, but they could not gain access to physicians' offices because there weren't enough physicians to go around.

"What we think we'll see is exactly what Massachusetts saw - and that is a real influx of patients coming into the emergency room to seek that primary care because they can't get in to see a physician," Turner said. "Right now economics drive physicians into the medical and surgical specialties over the primary care practices. We have to make the primary care specialties more appealing to young medical students. And we have to have a way to attract more young people to medical school over other alternatives."

IBJ Business News

Brown & James ranked with Best Lawyers as one of top 2010 firms

U.S. News Media Group, in conjunction with Best Lawyers®, has ranked Brown & James P.C. as one of the nation's 2010 Best Law Firms for the St. Louis metropolitan region in their inaugural "Best Law Firms" rankings. The first-tier rankings are published in the October issue of *U.S. News & World Report* and online at www.usnews.com/bestlawfirms.

Brown & James received a First-Tier Metropolitan Ranking for the following practice areas: Insurance Law, Legal Malpractice Law - Defendants, Medical Malpractice Law - Defendants, Personal Injury Litigation - Defendants and Product Liability Litigation - Defendants.

The methodology for choosing the 2010 Best Law Firms included surveying thousands of law firm clients, leading lawyers and law firm managers. Each of whom were asked what factors they considered vital for clients hiring law firms, for lawyers choosing a firm to refer a legal matter to and for lawyers seeking employment.

BJC top exec named to new federal healthcare board

BJC HealthCare president and CEO Steven Lipstein has been appointed by the U.S. Government Accountability Office to serve as vice chairman of the Patient-Centered Outcomes Research Institute Board of Governors. Lipstein is one of 21 board members who will lead PCORI, a federal nonprofit organization established by the Patient Protection and Affordable Care Act of 2010.

PCORI will conduct comparative effectiveness research to provide quality, evidence-based findings on how diseases and health conditions can be effectively prevented, diagnosed, treated and managed appropriately. The group also will consolidate the findings of research being done by various public and private agencies and make those findings publicly available to healthcare decision makers at all levels of government and private industry, including businesses that provide healthcare insurance coverage to their employees. The goal is to assist patients, clinicians, purchasers and policymakers to make informed health decisions.