Horsemen's Perspective on National Health Care Reform

PART 2

NATIONAL HBPA WINTER CONVENTION January 23, 2014

Disclaimer

This is the yet another chapter in an ongoing series which explores the possible ramifications of the Patient Protection and Affordable Care Act on horsemen, their employees, and HBPA affiliates. The Act is also known as the Affordable Care Act, ACA, The Health Reform Act, or ObamaCare. It is a work in progress. There is still potential for change almost four years after it was signed into law.

Disclaimer continued

2014 will be the year that you will see a great number of requirements go into force. The following general information is not intended to be nor should it be treated as tax, legal, or accounting advice. Your situation may be issue sensitive or subject to your own state's laws. You should seek advice from an independent professional before acting on any information presented.

Let's begin by taking a brief look back at some of the major component that impact horsemen that have been placed in effect since the Health Care Reform was passed in 2010.

Components now in effect

- **Small Business Health Insurance Tax Credits**

  Small businesses and non-profits are eligible for tax credits to help them provide insurance benefits to their workers, this includes racing stables and HBPAs.

- **Allowing States to Cover More People on Medicaid**

  This would also include horsemen who are low-income.

Access to Insurance for Uninsured Americans with Pre-Existing Conditions

- A Pre-Existing Condition Insurance Plan (PCIP) provides new coverage options to individuals who have been uninsured for at least six months because of a pre-existing condition. Do you know any horsemen with pre-existing conditions that would like to have insurance but were turned down?

Components now in effect

- **Extending Coverage for Young Adults to age 26**

  This would also apply to horsemen, their employees, and HBPA employees.

- **Prohibiting Insurance Companies from Rescinding Coverage**

  The new law makes it illegal for insurance companies to search for an error, or other technical mistake, on a customer's application and use this error to deny payment for services when he or she gets sick.

- **Providing Free Preventive Care**

  All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or co-insurance.

  This helps benevolence programs from paying co-pays for these procedures. It also eliminates co-pays at mobile mammography units (health fairs).

Components now in effect

- **Appealing Insurance Company Decisions**

  The law provides consumers with a way to appeal coverage terminations or claims.

  This means less chance of your horsemen, who have insurance, being turned down for a claim and then turning to the benevolence committee for assistance.

- **Eliminating Lifetime Limits on Insurance Coverage**

  With no lifetime limits you may be able to provide chronically ill or injured horsemen with other types of benevolence, financial assistance or aid.

Components now in effect

- **Prescription Drug Discounts**

  Over the next 6 years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.

  Once again, this should help relieve pressure on your benevolence programs.

- **Free Preventive Care for Seniors**

  With free preventative care for seniors, this is another area in which you will find savings for your benevolence programs. It will be your job to recognize these opportunities.

Components now in effect

Health Care Premiums

To ensure premium dollars are spent primarily on health care, the new law generally requires that a high percentage of all premium dollars collected by insurance companies are spent on health care services and health care quality improvement. If insurance companies do not meet these goals because their administrative costs or profits are too high, they must provide rebates to consumers. Your horsemen or HBPA affiliates may have received a refund in 2013.

New Innovations to Bring Down Costs in Medicare

- The Independent Payment Advisory Board began operations to develop and submit proposals to Congress and the President aimed at extending the life of the Medicare Trust Fund.
- The IPAB will have the power to authorize or deny Medicare payments for medical procedures regardless of doctor recommendations.

Components now in effect

- **Uniform Coverage Summaries for Consumers**

  Requires private individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The intent is to help consumers compare health insurance coverage options before they enroll and understand their coverage once they enroll.

- **Medicaid Disproportionate Share Hospital Payments**

  Reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires the Secretary Human Health Services to develop a methodology for distributing the DSH reductions.

Components now in effect

- **Expanded Medicaid Coverage Consumers**

  Expands Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 138% FPL and provides enhanced federal matching payments for the newly eligible. This should will be a great benefit for horsemen who qualify.

- **Individual Requirement to Have Insurance (Individual Mandate)**

  Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions). While the employer mandate deadline has been pushed up to Jan. 1 2015, there is still a mandate which requires all employees to notify their employees of expanded Medicaid and the Insurance Exchanges.

Components now in effect

- **Health Insurance Exchanges**

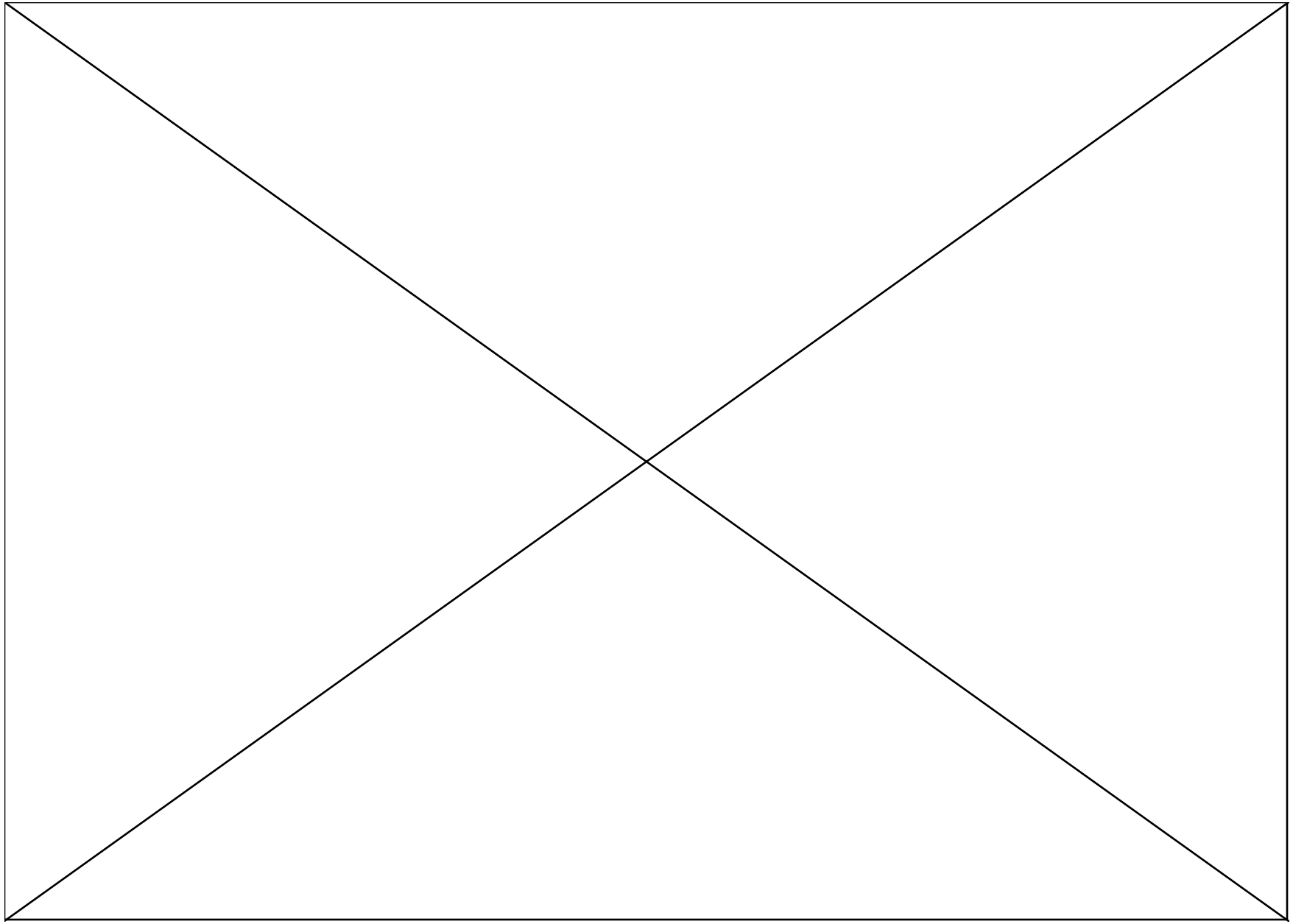
  Individuals can purchase qualified coverage. Exchanges have a single form for applying for health programs, including coverage through the Exchanges and Medicaid and CHIP programs.

- **Essential Health Benefits**

  Creates four categories of plans to be offered through the Exchanges, and in the individual and small group markets, varying based on the proportion of plan benefits they cover. HBPA benevolences, trust benevolence, health and welfare benefits are not considered insurance and do not meet the requirements of a qualified health insurance plan.

Just like HIPAA, the ACA will be felt by everyone in this country who works in the medical field or who will receive professional health care.

The Kaiser Family Foundation has updated their short video that gives a concise overview of what is immediately ahead and how the Act is supposed to work.



Questions and Answers from Horsemen's Perspectives

1. Trainer
2. Owner
3. Employee of Owners and Trainers
4. HBPA Affiliates
5. HBPA Employees

Q. What is expanded Medicaid?

A. A key feature of the Affordable Care Act is the expansion of Medicaid to millions of low-income Americans, many of them uninsured This has been one of the most controversial parts of the new health care law, and some states are still deciding whether to take part in the expansion. Beginning in 2014, the health care law could bring up to 20 million additional people into the program, including many who have never had health insurance. Some states have refused participation in the expansion, however for those states that got on board the federal government will pick up 100 percent of the extra costs a state incurs to expand its program. That will begin phasing down in 2017 and level off at 90 percent in 2020.

http://www.aarp.org/politics-society/government-elections/info-03-2013/whats-the-medicaid-expansion.html

16 HBPA States that have expanded Medicaid as of December 11, 2013

Arizona

Arkansas

Colorado

Illinois

Iowa

Kentucky

Massachusetts

Michigan

Minnesota

New Mexico

Ohio

Oregon

Texas

Virginia

Washington

West Virginia

What a horseman who lives in a state that has expanded Medicaid should know

a. Must be a resident of that state to apply.
b. Income must be below 138% Federal Poverty Level($15,856 for an individual as of 2013 – limit increases for families).
c. Must not be eligible for Medicare.
d. Apply through state or federal insurance exchanges or contact state Medicaid Office.
e. If horseman has a primary care doctor chose a Medicaid insurer which that doctor accepts.
f. If horseman does not have a primary care doctor he should chose one that is on his plan as soon as possible.
f. May be responsible for a small co-pay or deductible.
h. Cannot be eligible for Medicaid in more than one state.
i. Coverage may not be portable from state to state.

10 HBPA States that *do not* have expanded Medicaid as of December 11, 2013

Alabama

Florida

Idaho

Indiana

Kansas

Louisiana

Montana

Nebraska

Oklahoma

Pennsylvania

What a horseman who lives in a state that does not have expanded Medicaid should know

a. Must be a resident of that state to apply.
b. Income must be below that states guidelines and must meet other requirements which are particular to state of residency.
c. Apply through state Medicaid office.
d. Can only apply for Medicaid in one state, state of residency.
e. Coverage may not be portable from state to state.
f. May be able eligible for health insurance through state or federal health insurance with aid of a federally funded premium subsidy.

Q. January 1, 2014 is the date that kicked off the requirement for having health insurance. Who is required to have insurance?

A. U.S. Citizens and legal residents must obtain and maintain coverage for themselves and their dependents, or pay a small penalty. The individual and any dependents shall be covered each month under minimum essential coverage. Cornell University Law School http://www.law.cornell.edu/uscode/text/26/5000A

Q. Are there exemptions to this rule?

A. Yes, several including: having income below 100 percent of the federal poverty level; not being required to file income taxes; if the purchase of insurance would cause financial hardship; having religious objections; having a coverage gap shorter than three months; or being an American Indian, undocumented immigrant, or incarcerated person.

Cornell University Law School
http://www.law.cornell.edu/uscode/text/26/5000A

Q. How small is the penalty?

A. The penalty will be the greater of a flat fee or a percentage of income ($695 or 2.5 percent of taxable income for an individual, capped at three times that amount for a family) and it will be phased in over 2014-2016. In 2015 you will be assessed for 2014. The applicable dollar amount is $95 for 2014 and $325 for 2015. It will be assessed as part of peoples' income taxes.

(American Public Health Association apha.org)

Q. What is the enrollment period?

A. This a another type of penalty aimed at the procrastinators. The limited open enrollment is insurer-speak for “you can only sign up for exchange plans during certain months”. You just can’t buy insurance whenever you fall ill. The initial enrollment period has been extended, from October 2013 through March 2014. But in subsequent years, enrollment will only last from October to December. There are special exceptions, like losing employer-based coverage during an off month.

http://www.newrepublic.com/article/114163/limited-enrollment-periods-obamacare-means-young-people-cant-wait

Q. I am a trainer who has 10 employees. Am I required to carry health insurance for my employees?

A. No – There is no mandate that requires employers with less than 50 employees to carry health insurance.

(Health Care Special Report – The Kiplinger Letter)

Q. I am a trainer who employs 50 employees, when will I have start providing insurance benefits?

A. The Obama administration announced that employers will have until January 1, 2015 before reporting requirements mandated by the Patient Protection and Affordable Care Act go into effect. The unexpected policy decision comes in response to employer concerns about the complexity of data.

http://www.healthleadersmedia.com/content/HEP-293874/White-House-Extends-Employer-Mandate-Deadline##

Q. I am a trainer who employs 50 employees, are there any exceptions?

A. Yes – An employer does not have to offer coverage to:

- Part-time employees
- Seasonal or temporary workers;
- or new employees during a 90 day waiting period.

(Implementing Health Care Reform in the Workplace – American Health Care Association)

Q. I am a trainer with over 50 full time employees. If I chose not to make affordable insurance available to my employees what are the consequences?

A. The penalty is determined by a formula. In the case where just one employee is eligible for the federal subsidy the fine would be $40,000. There are lesser penalties imposed under two other circumstances which involve the employer making insurance available that pays less than the required percentage of covered expenses.

(Health Care Special Report – The Kiplinger Letter)

Q. I am a trainer with 10 employees, I want to make health insurance available for my employees, what's the next step?

A. Starting in 2014 eligible small businesses that purchase coverage through a state-based insurance exchange may qualify for credit up to 50% of the premium cost through 2015.

(What Health Care Reform Means for Your Business – Stanley, Hunt, Dupree, & Rhine Benefit Consultants)

Q. I am an employee of the local H.B.P.A. affiliate, I have no health insurance. How will I be impacted?

A. The same small business rules apply. As an individual, if your employer does not offer insurance and you chose not to purchase a qualified plan and you are not in the exempt group you may have to pay the penalty.

(What Health Care Reform Means for Your Business – Stanley, Hunt, Dupree, & Rhine Benefit Consultants)

Q. I am a trainer and I need to purchase my own health insurance. I travel around to different states during the year. What should I do?

A. You must enroll in the insurance exchange of the state that you claim as your primary residence. If you live in one state and reside in another, you need health insurance that offers multi-state coverage. Before you enroll you should check to make sure that the plan you select has provider networks in the state that you need coverage.

Q. I am an employee of the local H.B.P.A. affiliate, I do have health insurance. How will I be impacted?

A. ACA provides that certain group health plans existing as of March 23, 2010 are subject to only certain provisions. These plans are referred to as "grandfathered" health plans. There are several advantages to being "grandfathered". If not grandfathered, the plan needs to meet a certain level of benefits.

(Closeup: Health Care Reform and Grandfathering HIGHMARK)

Q. There is a lot of talk about Medicaid expansion. How will that impact our benevolence program?

A. It may reduce the demand on your benevolence program or allow you to provide benefits not covered by Medicaid.

Q. I am a trainer and I carry my own individual health policy. Will the Affordable Care Act keep my premiums from increasing?

A. Probably not. The Congressional Budget Office expects premiums to be somewhat higher than they are today. Improvements in minimum coverage such as maternity care, mental health care, guaranteed coverage for pre-existing conditions, and demographic factors will play into premium calculation. Kaiser Family Foundation Policy Insights February 8, 2013

Q. Will ACA make our benevolence programs obsolete?

A. Probably not– Here are 6 reasons why:

6 reasons why your benevolence programs may not become obsolete

1. Even if everyone has health insurance there will still be co-pays and deductibles with which horsemen may need assistance.

6 reasons why your benevolence programs not not become obsolete

2. Even if everyone has health insurance there may be coverage that is not provided under the minimum care levels such as: dental, vision, and some medical appliances with which horsemen may need assistance.

6 reasons why your benevolence programs may not become obsolete

3. Even if a person has Medicaid there are still items that may not be covered. Example: In Kentucky, Medicaid pays dental at the rate of fillings and extractions only, 1 cleaning & 1 x-ray per year. The Ky Racing H&W Fund pays for (within limits) dentures, crowns, bridges, and periodontal procedures in addition to fillings, extractions, x-rays and 2 cleanings per year.

6 reasons why your benevolence programs may not become obsolete

4. If a person has Medicaid they may have a great deal of difficulty finding a provider that will accept Medicaid. Example: The Fund polled 8 of our most heavily utilized doctors; 3 would not accept Medicaid. In another large practice with 5 offices only 1 doctor accepted Medicaid.

6 reasons why your benevolence programs may not become obsolete

5. If a person has Medicaid from one state coverage may not be honored in another state. Example: A horseman is a resident of Minnesota and is receiving Medicaid coverage there; however he spends 7 months racing in Arizona. He may or may not find a doctor that will accept his Minnesota Medicaid coverage. If that person applies for Medicaid in both states he will be committing fraud.

6 reasons why your benevolence programs may not become obsolete

6. The goal of ACA is to require all U.S. citizens and permanent residents to have health insurance. Through state health insurance exchanges and an expansion of Medicaid, the health care reform law will increase the availability of affordable coverage. But millions of undocumented immigrants are excluded from these programs.

How will ACA impact our affiliate?

1. Depending on your benevolence budget you may need to review your guidelines and benefit structure, and your position on how you will provide benefits for people who have insurance and those that are supposed to have insurance but do not buy it.
2. You may want to revisit your application to make sure its asks the right questions so that you can make an accurate assessment of the horsemen's request.

How will ACA impact our affiliate?

3. You may want to be more vigilant against possible cases of fraud particularly when going through your benevolence program is easier than negotiating through the ACA maze.
4. You may find that opening a health or wellness center or reaching an agreement with a nearby immediate care center is more economical and provides better service to your horsemen than your current program.

How will ACA impact our affiliate?

5. You may want to place a greater emphasis on horsemen's services for your affiliate by preparing yourself and securing resource material for horsemen about ACA.

- The most common question you will encounter is: "Where and how do I apply?" Having the address and phone number for your local Medicaid office may be useful and the web address for your state and federal exchange handy.
- You will have to decide if you have the resources to personally assist horsemen with the website or paper application.
- You may want to contact local organizers or "navigators" to come to your backside.

How will ACA impact our affiliate?

Q. Will our affiliate be doing something unlawful if we provide benevolence to someone who is suppose to have health insurance?

A. Peter?

How will ACA impact our affiliate?

6. Your benevolence program will not take the place of the required insurance. Your benevolence plan may be able to assist as a last resort after insurance or Medicare and Medicaid. The following are policy statements which aid the Kentucky Racing Health and Welfare Fund:

How will PACA impact our affiliate?

Disclaimer

The Kentucky Racing Health and Welfare Fund is a non-profit charitable organization that receives no government funding or public tax revenue. It is not an insurance company and does not assume responsibility for any incurred charges nor does it guarantee approval for any request for assistance.

From our funding statute….

….. (For those) who can demonstrate their need for financial assistance connected with death, illness, or off-the-job injury and are not otherwise covered by union health and welfare plans, workers' compensation, Social Security, public welfare, or any type of health, medical, death, or accident insurance.

Unintended Consequences Kentucky's recent experience

1. The Fund has a maximum benefit of $20,000.
2. We rely heavily on negotiating hospital charges by having hospital charity or other financial assistance to offset the charges. In 2013 we diverted approximately $500,000 in hospital charges that we could have paid to these facilities.
3. With the onset of the individual mandate we were notified by a major hospital chain, that accounts for approximately 50% of the incurred hospital charges, that they believe so strongly that everyone should have health insurance that they would only provide financial assistance to those people **who had health insurance**.
4. That change in their policy would make the Fund responsible for the majority of the hospital charges, approximately $500,000, a large ticket item that is **not** affordable to the Fund.
5. In order for the Fund to stay solvent, in 2014 we kept our maximum benefit of $20,000, but limited all annual hospital charges to $7,000 .

Unintended Consequences Kentucky's recent experiences

6. All hospitals have differing documentation requirements to determine an applicant's eligibility. During 2013 we saw the requirements become more strict. For those financial assistance application that are still in the hospital pipeline the hospital may require: an application, two weeks to three months of payroll stubs, tax return, and proof of citizenship. One hospital requires a credit check on charges over $5,000. Turn around time for a determination is 3 to 6 months if the hospital does not lose the application during the process.
7. The unintended consequence lands on those individuals without insurance who are seeking elective surgeries such as a hernia, knee repair, hip replacement. They will not be able to have their procedures because they will not be able to meet the requirements for financial assistance and cannot afford to pay the hospital charge out of pocket.

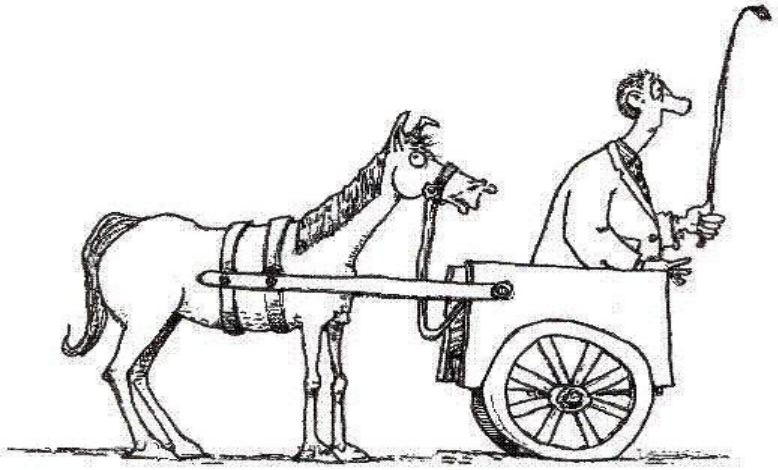
Unintended Consequences Kentucky's recent experiences

1. The Fund sponsors a Health Service Center which handled 1,629 patient visits in 2013. Some of our patients are now eligible for Medicaid. The first patient/family who applied for Medicaid was approved. Unfortunately, the Health Service Center is not an approved Medicaid facility. This means that even though patient is very happy with the nurse practitioners who treat her and the treatment she has been receiving for the past nine years, she can no longer be seen at the HSC.
2. There are several reasons for this:
   a. Medicaid will only provide prescription benefits written by a Medicaid provider.
   b. Should the HSC nurse make a referral to a specialist Medicaid would not provide benefits because the HSC is not an approved provider. The referral must come from Medicaid approved Primary Care Provider.
   c. The Fund, by law, is a last resort payer after insurance, Medicare and Medicaid.

Free for the asking 27 page e-booklet in Q &A Format

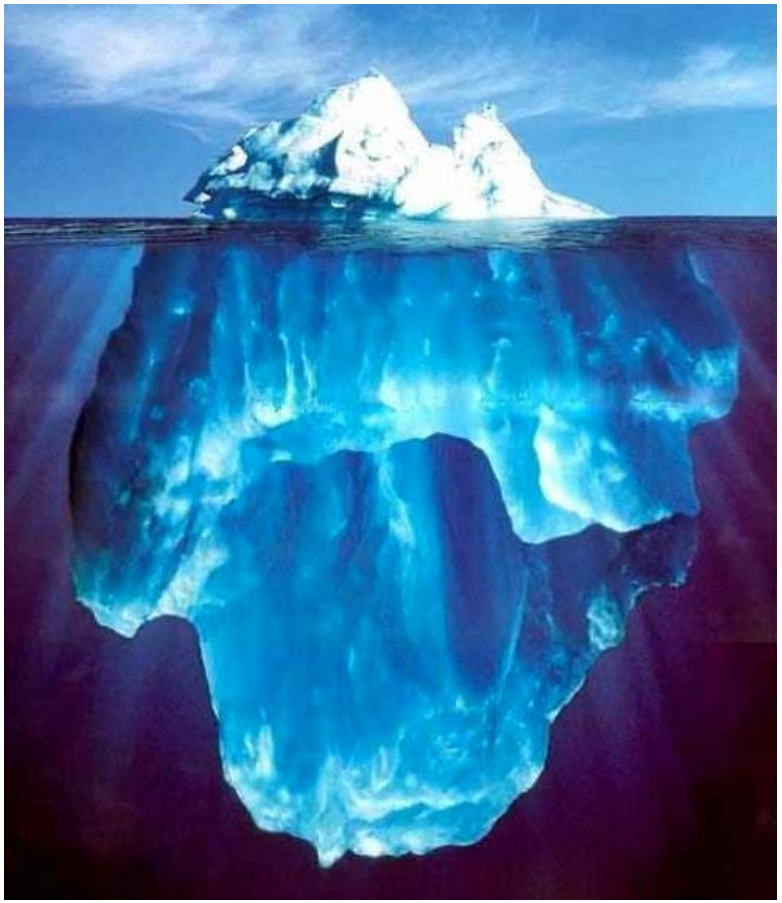
HEALTHCARE REFORM

FOR



WHAT YOU NEED TO KNOW

It’s not the end…



…it’s just the tip of the iceberg!