

Insurance Specialists Newsletter

Feds Face Challenges In Launching U.S. Health Exchange

January 2012

Inside this issue:	
Health Insurance Exchanges	1
CDHPs Continued Growth	2
Health Insurance Exchanges Cont'd	3
IRS Mileage Guidelines	3
Form W-2 Reporting	4
Supreme Court Oral Arguments	4
Smoking Cessation	4

With many states unwilling or unable to get insurance exchanges operational by the health law deadline of January 1, 2014, pressure is growing on the federal government to do the job for them.

But health care experts are starting to ask whether the fallback federal exchange called for in the 2010 health law will be operational by the deadline in states that will not have their own exchanges.

“It will be an enormous uphill battle to get this thing launched on time,” says Robert Laszewski, a consultant and former insurance executive who is watching the effort closely. “They have a Herculean task, even if everyone was cooperating.”

The federal exchange—like the state models—would be a one-stop website where individuals and small businesses could compare insurance policy offerings on price, coverage and quality.

The exchanges also will help applicants determine whether they are eligible for Medicaid or for federal subsidies or tax credits to help offset premium costs. Thus, the exchanges will need to

incorporate a host of state and federal data on income, employment and residency. Enrollment through the state and federal exchanges is scheduled to begin in the fall of 2013.

So how far along are the feds?

It’s hard to assess, because the Obama administration has “been very reluctant to provide any updates on progress,” says Daniel Schuyler, a director at consulting firm Leavitt Partners in Salt Lake City, which is advising states on the establishment of exchanges. HHS did not respond to request for comments.

All but a few states accepted initial federal planning money for exchanges, and 28 of them plus the District of Columbia have received additional grants.

About a dozen have authorized establishment of exchanges, but even those may not be able to meet the deadlines for enrollment. Alaska, Florida and Louisiana have said flat out that they won’t establish exchanges of their own.

That guarantees that a federal exchange will be needed. But those crafting it face enormous technical,

political and financial challenges.

Technically, federal data from a host of agencies needs to be collected in one system, which then must be linked with differing computer systems in 50 states plus the District of Columbia.

Matt Silo, executive director of the National Association of State Medicaid Directors, notes that computer systems in some states are quite old and may need substantial upgrading. While the federal government is putting up 90 percent of the money for the upgrades, Silo says there is some question about whether there is enough “physical capacity in the IT systems world” to get it all done in time.

“Our members have been having conversations with the vendors since the law was passed, and they are coming to the gradual conclusions that no, they don’t have the capacity to do this everywhere in the time frame” says Silo.

Political threats also abound. No one knows whether the Supreme Court will invalidate part or all of the law.

Cont’d Page 3

Consumer-Drive Health Plans Showed Continued Growth in 2011

Enrollment in consumer-driven health plans (CDHPs) continued to grow in 2011, according to the 11th annual EBRI/MGA Consumer Engagement in Health Care Survey. In 2011, 7 % of the U.S. adult population was enrolled in a CDHP, through a group plan or individual policy, compared with 5 % in 2010.

The survey of 4,703 privately insured U.S. adults ages 21-64 was sponsored by the not-for-profit Employee Benefit Research Institute (EBRI) and Mathew Greenwald & Associates (MGA). The survey report was published in the December 2011 EBRI Issue Brief, "Findings from the 2011 (EBRI/MGA Consumer Engagement in Health Care Survey."

During the last decade, in response to rising health costs, employers have turned their attention to CDHPs, which typically combine health plans with deductibles of at least \$1,000 for employee-only coverage with a tax-preferred savings or spending account—such as a health savings account (HSA) or health reimbursement arrangement (HRA) - that workers and their families can use to pay out-of-pocket health care expenses.

Account-based health plans first appeared in 2001, when a small number of employers began to offer employer funded HRAs. In 2004, employers were able to start offering health plans with HSAs, funded by employers, employees or

both.

Overall, 15.8 million U.S. adults ages 21-64 with private insurance were in a CDHP or a high-deductible health plan that was eligible for an HSA in 2011, according to the survey. When their children are included, about 21 million individuals with private insurance, representing about 12 percent of the market, were in a CDHP or an HSA-eligible plan.

Cost Conscious Behavior

As previous versions of the EBRI/MGA survey have found, the 2011 findings suggest that those enrolled in CDHPs tend to have different characteristics than those in traditional health plans. They were somewhat more cost conscious; were more likely to try to find information about their medical service provider's cost and quality from sources other than the health plan; and were more likely to take advantage of a health risk assessment.

Among key survey findings:

More focused on costs and quality. Individuals in CDHPs were more likely than those with traditional coverage to exhibit a number of cost-conscious behaviors. **They were more likely to say that they had:**

- * **Checked whether their plan would cover care.**
- * **Asked for a generic drug instead of a brand name.**
- * **Talked to their doctor or other health care**

provider about treatment options and costs.

- * **Talked to their doctor about prescription drug options and costs.**
- * **Developed a budget to manage health care expenses.**
- * **Checked the price of a service before getting care.**
- * **Used an online cost-tracking tool.**

More engaged in wellness programs.

CDHP enrollees were more likely than traditional plan enrollees to report that they had the opportunity to fill out a health risk assessment, and they were more likely to report that they had access to a health promotion ("wellness") program.

More responsive to financial incentives.

When it comes to participating in wellness initiatives, CDHP enrollees were more likely than traditional plan enrollees to take advantage of a health risk assessment but not necessarily the health promotion program. However, when offered a cash incentive or reward to participate in a health promotion program, these financial incentives were more likely to be a factor for CDHP enrollees than for traditional plan enrollees.

In a survey, HR consultancy Mercer revealed that 2011 saw the biggest increase ever in the adoption of high-deductible, account-based CDHPs by large U.S. organizations.

⇒ A CDHP was offered in 2011 by 32% of all employers with 500 or more employees, up sharply from 23% in 2010.

⇒ The largest employers were the most likely to offer a CDHP (47% of those with 10,000 or more employees did so.

⇒ Among small employers, CDHP use grew as well, from 16% to 20% of those with 10-499 employees.

Overall, 13% of all covered employees were enrolled in a CDHP. Enrollment growth has been rapid—five years earlier, CHDHPs enrolled just 3% of covered employees, according to Mercer.

Source: SHRM

Health Exchanges Cont'd from Page 1

It is also not clear how much funding will be available to launch and operate the federal exchange, and the 2012 presidential and congressional elections could delay or derail the entire process if Republicans are victorious.

Still, at this point Schuyler says he is confident that the Obama administration “will be able to provide a federally facilitated exchange” in time to meet the law’s requirements.

Although federal officials are saying very little about their progress, they have signed contracts worth more than \$150 million with several private contractors who are working on creating the federal exchange. The administration is taking a three-pronged approach, says Schuyler.

First, a Federal Data Services Hub is being built to pull together needed information across agencies, such as the IRS and Social Security. States will be able to “plug in” to that data hub if they run their own exchanges. The Department of Health and Human Services has signed a 5-year contract worth roughly \$69 million with Columbia, MD based Quality Software Services to set up the hub.

The second prong is to

beef up the health care.gov site to include more information on health insurers and the health law. While the site already has some information on private insurers by zip code, more is coming.

And finally, the federal government has signed a \$94 million contract with Fairfax, VA based CGI Federal Inc. to build the federal exchange. The firm is also helping with the healthcare.gov site. A company spokeswoman referred questions to the government.

Despite the contracts, some state officials, Medicaid directors and health-care experts are nervous. Many significant questions remain unsettled about the operation of exchanges, they say, whether the marketplaces are managed by the states or by the federal government.

They still don’t know, for example, the final rules on “essential benefits” the federal government will require insurers to offer in all policies sold on the exchanges. Details on what the federal exchange will look like are still lacking. Also not clear are the standards—and the work required—for the states to upgrade their computer systems so they will link with the federal data hub. States will be assessed in January 2013 as to whether they will be ready by the fall of that year.

“There’s an enormous amount to be decided and put together and built before these key milestones can happen,” says Laura Minzer, executive director of the Illinois Chamber of Commerce’s Healthcare Council. “The fact that so little has happened [at the state and federal level] is good cause for alarm.”

What’s happening in Illinois shows that even when a state has authorized an exchange, political disagreements can stymie efforts to move forward.

“A study group met over the summer, but didn’t come up with any clear recommendations,” says Minzer. A big part is politics, she adds. Some lawmakers—both Democrats and Republicans—fear that any movement to implement the law threatens their re-election chances. Others want to wait to see how the Supreme Court rules.

“Even though we are a blue state—the Democrats have a majority in the House and Senate—there’s a nervousness going into the 2012 elections,” she says. “There’s speculation that nothing will happen on the exchange until after the elections.”

It is possible to set up exchanges fairly fast, says John McDonough, one of the principal authors of the Massachusetts law that created a similar site, called the Connector. In that state, the exchange was up and running within about six months of the

law’s enactment, he says.

“Massachusetts had a head start because it had already done a modernization of its data system, so it’s not completely analogous,” says McDonough, now director of the Center for Public Health Leadership at Harvard School of Public Health, “but it doesn’t take as much time to get an exchange up as a lot imagine.”

McDonough says in his conversations with Obama administration officials, he has found them **“hell-bent on meeting the January 1, 2014, deadline by hook or crook.”**

Source: Kaiser Health News in Collaboration with The Washington Post



On December 9, 2011, the IRS announced in IRS Notice 2012-1 the 2012 optional standard mileage rates that employees, self-employed individuals and other taxpayers may use to calculate deductible costs of operating automobiles.

Beginning January 1, 2012, the standard mileage rates for cars, vans, pickups or panel trucks will be:

- **55.5 cents per mile** for business miles driven (unchanged from midyear adjustment effective July 1, 2011).
- 23 cents per mile driven for medical or moving purposes
- 14 cents per mile driven in service of charitable organizations

Source: NFP

IRS Notice 2011-28 (W-2 Reporting)

Source: NFP

The Requirement

Under PPACA, employers are required to report the aggregate cost of applicable employer-sponsored group health plan coverage on each employee's Form W-2. The employer must report the cost of coverage on a calendar year basis, regardless of the plan year used for the health plan. The W-2 reporting requirement does not cause the cost of such coverage to be included in the employee's income or otherwise become subject to

federal taxation.

Employers Subject to the Requirement

Generally speaking, all employers, including private companies, governmental entities, church organizations and tax-exempt organizations, are required to provide informational reporting of the value of health benefits provided to employees. There is a small employer exception for employers who filed fewer than 250 Forms W-2 for 2011. Unless changed by future guidance, those

employers who file fewer than 250 Forms W-2 for one calendar year will be exempted for the next calendar year.

Effective Date

According to Notice 2011-28, employers are not required to include the cost of coverage on any Form W-2 required to be issued before January 2013. Thus, the reporting requirement will first apply with respect to coverage provided in 2012 and report that value on W-2 provide in January 2013.



Supreme Court sets oral arguments on health care reform law

The Supreme Court has set aside three days at the end of March to hear oral arguments in lawsuits challenging the legality of the health care reform law. The court announced that it will hear five and half hours of arguments over three days.

Individual Mandate

On March 26, the justices will hear arguments on whether a challenge to the law's individual mandate that requires individuals to enroll in a qualified plan or pay a financial penalty can be imposed before the provision's Jan. 1, 2014 effective date. On March 27, the court will hear arguments on whether the individual mandate is constitutional.

On March 28, the court will hear arguments on whether the entire law can stand if the individual mandate were to be found unconstitutional.

A ruling is expected by the end of the court's term in June.

Source: Business Insurance

Study: Smoking Cessation Ups Happiness

People who quit smoking are happier and more satisfied with their health, compared to those who smoke, U.S. researchers say.

Dr. Megan Piper of the University of Wisconsin School of Medicine and Public Health said smokers hold strong beliefs about how stopping smoking will reduce their quality of life.

Piper and colleagues assessed overall quality of life, health-related quality of life, positive vs. negative emotions, relationship satisfaction and occurrence of stressors—among 1,504 smokers taking part in a U.S. smoking cessation trial. Smoking status and quality of life were assessed at both one year and three years post-smoking cessation.

Quality of life measures

included health, self-regard, philosophy of life, standard of living, work, recreation, learning, creativity, social service, love relationship, friendships, relationships with children, relationships with relatives, home, neighborhood and community.

Some smokers express concerns that their quality of life may deteriorate if they stop smoking, but the study found smokers who quit successfully experience no such deterioration.

If anything, the ex-smokers showed noticeable improvements. The study, published in the Journal Annals of Behavioral Medicine, found quitters scored higher on measures of overall quality of life, health-related quality of life and positive emotions, after one year and three years, com-

pared to those who still smoked.

"This research provides substantial evidence that quitting smoking benefits well-being compared to continuing smoking," Piper said in a statement.

Source: **Untied Press International, Inc.**

The new year is the perfect time to offer an onsite smoking cessation class for your employees

We can help....give us a call today at **HIG WellFit Solutions**. We can provide onsite classes and access to discounted nicotine replacement products. Call Maryellen at 270.793.0367 for details.

