ADAIR COUNTY COMMUNITY VOICE

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HEALTH CARE REFORM Special Report

How Penalties, Cost Share Affect You

Preparing for new mandates

THE AFFORDABLE CARE ACT

Law covers 2,500 pages; 40 agencies write new regs

The full impact of federal health care reform will be felt by all Americans in January 2014 when the law requires that everyone have health insurance or face penalties.

The law, signed by Pres. Obama on March 23, 2010, covers 2,500 pages and gives an unprecedented 40 agencies a mandate to write new regulations to implement the legislation.

Business representatives from across the commonwealth attended two separate seminars in May hosted by the Kentucky Chamber of Commerce, The Lane Report and The Iasis Group developed to help them make informed decisions as the law goes into full force.

Some portions of the Affordable Care Act are already in effect. In other areas, rules are still being written and details are still missing. Even so, attorney Vickie Yates Brown serves as the chair of the Health and Life Sciences Practice group at Frost Brown Todd. She served as moderator and provided an overview of the new law during the four-hour seminar originally held in Lexington and repeated in Louisville.

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>
> Vickie Yates Brown
> Attorney, Frost Brown Todd

Brown encouraged businesses to look at what information is already available and begin trying to determine how they will be affected.

"If you wait too long, there's too much to catch up with," she said.

Brown and other speakers agreed that health insurance would cost more for individuals and small groups when mandates go into effect in January. They also predicted that many young, healthy people would decide to pay a penalty rather than pay for individual insurance if they hold jobs where insurance is not provided.

Experts believe more unhealthy people will enroll in health coverage, and health care plans for 2014 are being priced with that in mind.

"Large groups have less impact," Brown said. "If you have a well group…you are probably going to see a greater impact."

Additional taxes, penalties and fees are already being put into place. Some affect all employers while others are directed at specific industries. For instance, medical device companies will pay a 3.8 percent fee based on their gross revenue.

> 'I don't know how you do that unless you ration care.'
>
> Vickie Yates Brown, Attorney, Frost Brown Todd

"Insurance is going to be subject to huge new taxes. Pharmaceutical companies–huge new taxes," Brown said. "There are penalties on people who don't comply and there's going to be all these new taxes on gross proceeds. These are going to be passed on to, who do you think? Employers."

The $938 billion health care bill will be financed through $416.5 billion in cuts to Medicare, $210 billion in increased Medicare tax on high-income taxpayers, and another $107 billion from fees on insurers and medical producers. Other funds come from an excise tax on premium health plans, penalties and other spending cuts.

"It has to be paid for some way," Brown said.

Brown questioned how the federal government intends to make

See **ATTORNEY**, page 2

Penalties, cost sharing all part of mandate

In January 2014, all Americans will be required to have health coverage on themselves and their dependents. The Affordable Care Act sets tax penalties on individuals who do not have health coverage.

Speakers during a Health Care Reform Seminar hosted in part by the Kentucky Chamber of Commerce speculated on how many people would choose the penalty over paying for health care coverage, at least initially.

The penalty on an individual in 2014 is 1 percent of the person's income or a minimum of $95. In 2015, the penalty increases to 2 percent or a minimum of $395. In 2016, the penalty increases to 2.5 percent or $695. A maximum penalty will be based on the average cost of what is called a "bronze" level coverage plan, which is expected to be around $8,000 to $9,000 a year.

There are no criminal penalties for not paying the tax nor is there any enforcement authorization for the IRS.

"The IRS cannot take your house, garnish your wages or throw you in jail," said Alison Stemler, an attorney with Frost Brown Todd who works with employers on employee benefit issues.

However, large businesses that will be required to provide coverage in 2015 for their employees face a different set of penalties should they decide to defy the law.

Individuals and small employers will be able to shop for insurance through an "exchange." Kentucky is setting up its own exchange and is expected to have open enrollment beginning in October for health coverage that will take affect in January 2014.

Insurance providers are submitting their plans and prices and getting approval to provide coverage through the exchange.

Qualified individuals will also be able to see what assistance they will receive as a subsidy or Medicaid when they shop in the ex-

See **PENALTIES**, page 2

Tax Subsidies for Exchange Coverage

FACT

Premium tax credits and some reduced cost-sharing is available for individuals with household income of less than 400 percent of the Federal Poverty Level (FPL), but more than 133 percent (or 100 percent) of FPL.

- $15,417: estimated 134 percent of FPL for a single person in 2014
- $93,465: estimated 399 percent of FPL for a family of 4 in 2014
- Subsidy not available if employer provides affordable minimum value coverage to individual
- Dependents of eligible employees will not be eligible for subsidy even if employer's family coverage is unaffordable as long as self-only is affordable. (However, no obligation to offer coverage to spouses, so spouses could still be eligible for premium tax credit)

Cost-sharing assistance on exchange coverage

- Reduction in out of pocket limits under policies on Exchange by one-third to two-thirds, depending upon percent of poverty level.

Provided during the Kentucky Health Care Reform Seminar by Frost Brown Todd

2014 – Tax Penalties on Individuals

FACT

Penalties:
•2014 – $95 per adult up to $285 or 1 percent of household income, whichever is higher.

• 2015 – $395 per adult up to $885 or 2 percent of household income, whichever is higher.

•2016 – $695 per adult up to $2,085 or 2.5 percent of household income, whichever is higher.

Individuals will be required to have minimum essential coverage beginning Jan. 1, 2014.

Allowed exemptions: Cost of coverage is more than 8 percent of household income, religious objection, or financial hardship.

The IRS is prohibited from filing liens or charging interest for penalties. No fines or criminal charges can be filed for nonpayment.

Provided during the Kentucky Health Care Reform Seminar by the Kentucky Department of Insurance

Attorney warns businesses may cut jobs

Continued from front page

such a substantial reduction to Medicare funds. She mentioned Sarah Palin, who has argued that the legislation would lead to "death panels" that would ration health care.

A committee is responsible for making sure Medicare does not spend more than 1 percent more than the rate of growth in health care across the country.

"That has never happened. Medicare always is way above any of the other factors," Brown said. "What that group has been mandated to do...they are having to go back and cut the reimbursements to providers, they have to cut benefits to recipients, and they essentially have to decide...I don't know how you do that unless you ration care."

'We are picking up the views…that folks are deciding they are not going to hire, or they are going to hire part time people.'

Vickie Yates Brown, Attorney, Frost Brown Todd

MANDATED COVERAGE

The new law requires a business with 50 or more full-time employees to provide health benefits for employees. On Tuesday, July 2, the Obama Administration postponed the January 2014 mandate until January 2015. Business groups complained to the IRS about the complex requirements and said they would not have time to implement them.

A mandate that everyone has health insurance or pay a penalty beginning January 2014 remains in place, however.

According to figures provided by Frost Brown Todd, 57 percent of small businesses with 50 or fewer workers currently offer health benefits to employees, compared to 92 percent for businesses with 51 to 100 employees and 97 percent of businesses with 101 or more workers.

Under the Affordable Care Act, certain benefits must be provided and individuals can no longer be denied coverage because of medical conditions. Rates cannot be set based on a person's gender, health status or occupation. Eligibility waiting periods cannot exceed 90 days.

Businesses that employ large numbers of part-time and seasonal employees will likely be the most impacted group. While businesses will not be required to pay insurance for part-time employees, the number of hours part-time employees work will help determine if a business meets the 50-employee (full-time equivalent) standard.

"We are hearing more and more that this is going to be sticker shock," Brown said.

Brown urged businesses to evaluate their situation now.

"You need to evaluate the effect on your business and you need to quantify...make sure you know what you need to do to comply and secondly know what it's going to cost you," she said.

Businesses are already making decisions that could greatly impact the job market.

"We are picking up the views...that folks are deciding they are not going to hire, or they are going to hire part time people. I think that makes perfect sense. You may not be able to do things retrospectively. Prospectively, why would you hire someone full-time when you have to pick up their insurance and insurance of their dependents in 2015."

In addition, the mandate does not affect company jobs overseas.

"You don't have to pay for the people that are offshore...why are we driving good jobs from our own country?" Brown said. "I think we are shooting ourselves in the foot several ways."

By Sharon Burton
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Penalties, cost sharing all part of mandate

Continued from front page

Cost-sharing is available for individuals with income between 133 percent and 400 percent of the federal poverty level. Stemler estimated an income level of $15,417 for a single person in 2014 at the 134 percent level.

Assistance will not be available, however, if an individual is employed by a company that provides minimum value coverage to an individual. In addition, dependents will not be eligible for a subsidy even if the employer's family coverage is unaffordable.

TAXES ON EMPLOYERS

Employers with 50 plus full time employees who work 30 or more hours or full-time equivalents must provide health benefits for employees in 2015 or face a penalty tax. The original law called for a 2014 deadline but the Obama Administration delayed the mandate last week.

All full-time and part-time employees are considered when determining if a business falls in the large business category. However, penalties only apply to people who work 30 hours a week or more.

Employers should consider that the health coverage is tax-deductible while the penalties are not, Stemler said.

There are two levels of penalty taxes employers could face. The first is a $2,000 penalty for every employee who is not provided benefits after the first 30. The penalty is assessed if the health plan is not offered to at least 95 percent of full-time employees.

There is a rule that you can exclude five people, so if you are close to that 50 you can exclude five people," Stemler said.

If any of the employees who are excluded go to the exchange to buy subsidized coverage then the company will face a $2,000 penalty for every employee, even the ones that are being provided coverage.

"That is the reason this is so important. You can provide coverage to a good many of your employees and mess this up and still end up paying $2,000 times all of your 30 hour-plus people even though you are providing coverage to 80 percent of them," Stemler said.

'You can provide coverage to a good many of your employees and mess this up and still end up paying $2,000 times all of your 30 hour-plus people.'

Alison Stemler, JD
Frost Brown Todd

A second penalty level kicks in even if an employer is providing coverage to 95 percent of its full-time employees. If an employee goes to the exchange and gets a tax subsidy or if minimum value coverage is not offered, the employer pays a $3,000 penalty.

Employers will pay more fees, including a reinsurance fee of $63 per person per year. Some coverage included as part of the minimum value coverage are also costly, Stemler said.

Health care reform will also add administrative costs to businesses, Stemler said. She showed a slide with five responsibilities for businesses prior to health care reform. The list now extends to 12 items.

All employees will have to provide a notice to employees of the exchange. Those rules are not yet complete.

COMPANY STRUCTURE

Employers will not be able to break up companies into separate entities to avoid falling into the large business category. Stemler used an example of a farm owner who also had ownership in a restaurant and the number of employees at each location determined if owners were required to pay for benefits.

Special rules apply for seasonal workers. Seasonal workers who stay fewer than 120 days are not counted when determining if a business falls in the large business category.

Educational organizations also fall under a special rule. If employees work 30 plus hours on average during active portions of the academic year, then they must be considered to average 30 plus hours during break periods.

Large businesses must pay at least 60 percent of the cost of benefits. There are also guidelines on the amount an employee must pay based on the employee household income.

Employees considered high-earners who receive wages over $200,000 will pay an additional .9 percent Medicare tax. Those same people will also pay 3.8 percent on non-wage income such as interest, dividends, and capital gains income.

By Sharon Burton
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Examples of Tax-Subsidized Coverage

Age	Level of Coverage	Household Income	Total Expected Cost on Exchange	Estimate of Subsidized Premium	Tax Penalty if Not Covered (2014-2016)
60	Family (4)	$93,465 (est 399% of FPL)	$24,042	$8,879	$778-$2,085
30	Family (4)	$93,465 (est. 399% of FPL)	$10,108	$8,879	$778-$2085
60	Single	$15,417 (est. 134% of FPL)	$10,172	$472	$115-$695
30	Single	$15,417 (est. 134% of FPL)	$3,440	$472	$115-$695
		FPL = Federal Poverty Level			

Provided during the Kentucky Health Care Reform Seminar by Frost Brown Todd

Health Care Reform

FACT

- If your plan covers dependents and your adult children do not have employer-sponsored insurance, you can include them on your insurance policy until they turn 26.

- Starting in 2014, no one can be denied health insurance because of a pre-existing condition.

KY. ALREADY SHORT OF DOCTORS, DENTISTS

How state will handle expansion of Medicaid, private insurance

In the wake of Gov. Steve Beshear's decision to expand Medicaid under federal health reform, there is concern that Kentucky's health-care system will not be able to care for the newly insured.

Health reform means that an estimated 308,000 new Kentuckians will qualify for Medicaid, and 332,000 more will qualify for subsidies to buy private insurance through the state insurance exchange that will start taking enrollments Oct. 1.

But Kentucky already has a health care provider shortage, especially in rural areas. A study for the state estimates that it needs 3,790 more doctors just to meet current demand, to say nothing of what will be needed to care for those who haven't been a regular part of the health-care system, reports Laura Ungar of The Courier-Journal.

The report by Deloitte Consulting made 11 recommendations, including authority for nurse practitioners to prescribe less risky drugs without a written agreement with a doctor, and one that would be even more controversial, putting limits on medical malpractice awards, said Ungar.

The report also recommended expanding and increasing Medicaid reimbursements in rural areas, to encourage more physicians to take Medicaid patients.

It did not mention complaints by health-care providers about getting paid by the managed-care Medicaid system that the state began in November 2011; Gov. Steve Beshear said when he announced Medicaid expansion that those problems are being worked out.

"Consultants said 61 percent of the 3,790 'full-time equivalent' physicians needed (which includes primary care doctors and specialists) were in rural counties," reports Ungar. Jonathan Felix of Deloitte said, "Primary care, dental care and behavioral health are all big needs in the state."

> 'We can't grow physicians fast enough to meet the need, in the rural areas especially.'
>
> Susan Zepeda
> President, CEO
> Foundation for a Healthy Kentucky

The report said the state needed 183 more primary-care doctors, even before Medicaid expansion, but a 2012 Kentucky Physician Workforce Needs Assessment report by the University of Kentucky said the state needs 557 more primary-care physicians and 1,655 more total physicians to meet the national ratios for physicians to population.

The consultants said the state already needs 612 more dentists. It now has 1,711.

No Easy Answer

About 192 federally identified areas in Kentucky — including 47 counties — have shortages of health professionals, Ungar reports. Kentucky counties who will have the most non-elderly residents eligible for Medicaid often have fewer primary-care doctors per person, according to data analyzed by The Courier-Journal. Ungar notes that Casey County, for example, ranks in the bottom third for doctors per capita, but it has the highest portion of newly eligible residents at 13.5 percent.

"We can't grow physicians fast enough to meet the need, in the rural areas especially," Susan Zepeda, president and chief executive officer for the Foundation for a Healthy Kentucky, told Ungar.

Nationally, there is a primary-care shortage, partly because such doctors make less money than most, and low reimbursement rates exacerbate that. A 2012 study in the journal Health Affairs said 21 percent of office-based physicians in Kentucky did not accept new Medicaid patients in 2011, Ungar notes.

The health reform law will raise the Medicaid fees to match what Medicare pays primary-care doctors, but only for two years.

Kentucky's Medicare rates are about 72 percent of the Medicare rates, compared to a national average of 59 percent, says an Urban Institute study. But the time limit leaves some practitioners wary.

"If I choose to increase the number of Medicaid patients, and two years down the road that payment drops back to two-thirds, all of a sudden I'm going to have an awful lot of trouble keeping my doors open," Reid Blackwelder, a family practitioner and incoming president of the American Academy of Family Physicians, told Michael Ollove of Stateline.

A report last year by the non-partisan Center for Studying Health System Change said the temporary nature of the pay raise could limit its effectiveness, particularly in Kentucky and other states that are expecting the largest percentage increases in Medicaid enrollees and that have low numbers of primary-care physicians.

"I'm not sure who's going to pick up all those patients into their practices," Julianne Ewen, a nurse practitioner in Lexington and president of the Kentucky Coalition of Nurse Practitioners and Nurse Midwives, told Ungar. Legislation to let nurse practitioners prescribe non-scheduled drugs without a doctor agreement failed in the state Senate this year.

While some policy analysts have touted nurse practitioners as a solution to the rural primary-care shortage because they often provide primary care in rural and isolated areas that do not have doctors nearby, they would not be covered by the two-year reimbursement increase. Ewen said the reimbursement is only $23 for a lower-level visit by an established patient.

A possible long-term solution includes greater reliance on community health centers, some say. And hospital officials said they plan to continue expanding primary care and employ telemedicine. Ruth Brinkley, president and chief executive officer of KentuckyOne Health, said her system is looking to open new primary care offices and hire more staff.

Dr. David Dunn, vice president for health affairs at the University of Louisville, said the university is increasing physician training in such areas as family medicine and geriatrics and using funds from its new partner, KentuckyOne, to expand the nursing work force with professionals, such as advanced nurse practitioners.

Health providers and advocates agree that getting more people insured should produce a healthier population in the end. But they said much remains unknown, including how many of those eligible for coverage under health reform will sign up for it. The state estimates that 188,000 of the 308,000 newly eligible will enroll, but some think that estimate is low.

By Molly Burchett and Al Cross, Kentucky Health News.

Provided by Kentucky Health News, an independent news service of the Institute for Rural Journalism and Community Issues at the University of Kentucky, with support from the Foundation for a Healthy Kentucky.

BETHANY HOUSE

'What happens if I go to court?'

A victim of domestic violence can petition the court for a protective order to keep her abuser away from her. Let's follow one (fictitious) victim as she reaches out for help.

Sarah had been married to Claude for three years. The first six months were wonderful and then he started being verbally abusive. He would yell at her and the kids when things didn't go his way. He told Sarah that she was stupid and that no other man would ever want her. The physical abuse began slowly and then escalated. This time he choked her until she nearly passed out. Neighbors called the police, who took her husband to jail and suggested that Sarah get an EPO (Emergency Protective Order).

The next morning Sarah went to the Circuit Clerk's Office in the courthouse. (She could have gone to the Sheriff's office the night before. EPOs are available 24/7.) On the EPO petition she wrote what had happened the night before and that her husband had been abusive in the past. Sarah went back home and packed her personal belongings and went to Bethany House Abuse Shelter. She knew her husband would be angry when he got out of jail and she was afraid of what he might do.

Once she signed the petition, the clerk took the petition to a judge. The judge reviewed it and signed it. For a judge to sign an EPO petition there has to be words or actions that are threatening enough to cause a reasonable person to be afraid.

> The petition is not in effect until it is served.

After the petition was signed by the judge, it went to the Sheriff's department to be served upon her husband (the "respondent" in legal terms). The petition is not in effect until it is served. Her husband was served the same day and they were both given a court date. Sometimes service takes much longer, as when the respondent actively tries to avoid being served. The EPO is only good for 14 days but can be renewed if it has not been served. In the EPO the judge ordered Claude to remain at least 500 feet away from Sarah and also gave Sarah temporary custody of the children.

On the court date both Sarah and Claude were required to be present. Going to court is generally a scary time, and the victim may be especially nervous because this is the first time she has seen her abuser since the abusive incident. One of the Court Advocates from Bethany House took Sarah to court and answered her questions and stood with her during the proceedings.

A victim who is not a resident at the shelter may also contact Bethany House before the EPO hearing and ask questions or speak with the court advocate. Court advocates cover all 10 counties served by Bethany House and accompany victims to court and provide information. They are not attorneys and do not give legal advice. Appalachian Research and Defense Fund (Legal Aid) provides free legal advice to low-income victims (800-866-7313).

Claude and Sarah (along with the Court Advocate) were called in front of the judge, who read Sarah's petition and asked both of them if they had anything further to say. Claude tried to explain that he didn't mean to hurt Sarah and just wanted her to come back home.

Sarah told the judge that she did not want to go home. The judge granted Sarah a DVO (Domestic Violence Order) that was good for one year. (DVOs can be for up to three years.)

In the DVO the judge ordered Claude to remain 500 feet away from Sarah and to have no contact (phone, mail, or third party) with her at all. Sarah was granted temporary custody of the children with Claude having visitation.

Claude was ordered to pay temporary child support. Sarah felt safer after she had the DVO.

If you are a victim of domestic violence and need help, call Bethany House at 679-8852 or 800-755-2017. Bethany House serves Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne County.

From left to right Brandy Loy, Keri Rowe, Tanner Caldwell, Ashley Coomer, David Eubank, Karen Darnell, Kevin Miller, Jennifer Melson, Susan Pollard, Mike Bryant, Marie Tupman and Ashley Adams.

ANTHEM REP: Expect rate shock

When a ranking employee in a top insurance firm says the Affordable Care Act is difficult to understand, you know problems are inevitable.

"This makes advanced calculus (look) easy," said Lawrence Ford, director of government relations at Anthem Blue Cross Blue Shield of Kentucky.

Ford talked about health care reform in May during a conference sponsored in part by the Kentucky Chamber of Commerce.

Ford openly voiced concerns about where rates will stand when they are presented for 2014. He even joked that anyone who thought rates would go down should see about health care coverage for mental health issues.

Ford detailed how insurance companies determine rates. The new federal law prohibits insurance providers from refusing a customer and determines what factors can be used in determining prices.

Community ratings will continue to be a rate driver but a person's current health cannot be used to set rates.

> 'We will be accepting a lot more risks than we would normally have accepted.'
>
> Lawrence Ford
> Director of Government Relations,
> Anthem Blue Cross Blue Shield of Kentucky

"We will be accepting a lot more risks than we would normally have accepted," he said. "You've got to balance all these things out."

Age is still a determining factor but its affect is limited. While there is currently a 5:1 variation for age now, the new law will limit that to 3:1. This means that there can only be a 3 to 1 difference in how age impacts rates from an 18-year-old to a 63-year old, Ford said.

"That drives rates up for the most desirable risk, the 26-year-old male," Ford said. "That's going to push rates up for him."

For people whose rates have been on top, they will likely not increase.

But Ford, and others in the industry, believe the new rules will bring a lot of new people on insurance that have existing health problems. Preparing for that is going to cause "rate shock," he said.

As a result, there is little incentive for young, healthy people to purchase insurance. They may face a small penalty but young people new in the job market will probably choose to pay the penalty, he said.

"What's to keep them from going in and out when they need it?" he asked.

Open enrollment for 2014 health coverage begins Oct. 1.

By Sharon Burton
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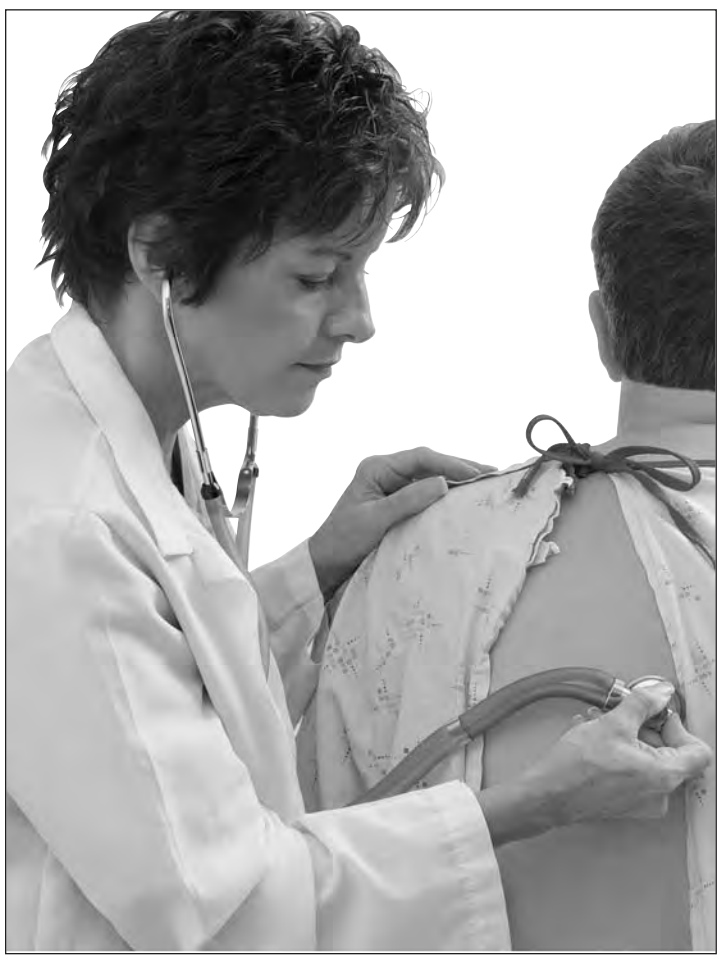
Health Care Reform

FACT

For individual and small group markets:

- No rating based on health status
- Maximum age variation of 3:1 (ages 19-64)
- Maximum variation based on tobacco use of 14:1
- Actuarially justified variation based on geographic areas (Kentucky will continue with its existing 8 rating regions based on Medicaid regions)
- Family rates built up based on age and tobacco use of each member.
- Each group has its own pool, ie., the large group (employers with 50+) is a risk pool, small group is its own pool. Kentucky has chosen not to combine its individual and small group market.

*Provided by the Kentucky Department of Insurance



Cuts in primary care physician training a cause for concern

Facing an already-existing shortage of primary care in the country and state, the American Academy of Family Physicians sent a letter to U.S. Rep. Harold Rogers, R-Ky., chairman of the House Appropriations Committee, saying the committee's 2014 funding allocations could damage the nation's primary-care infrastructure by cutting primary-care physician training and research programs.

In the June 18 letter, AAFP Board Chair Glen Stream wrote, "We are concerned that the House-proposed allocation will be inadequate to make the necessary investment in vital primary care research and physician workforce training."

The proposed allocation would reduce funding for the only federal program that provides funds specifically to academic departments and programs that increase the number of primary-care health professionals, says an AAFP release.

There are not enough primary-care physicians being trained to meet the demand for services, and a recent study shows only a fourth of newly educated doctors actually go into this field. Even worse for Kentucky, which faces a critical doctor shortage amid Medicaid expansion, less than 5 percent go on to practice in rural areas, says a study by researchers at the George Washington University School of Public Health and Health Services.

The study's lead author wrote, "If residency programs do not ramp up the training of these physicians the shortage in primary care, especially in remote areas, will get worse."

How can Kentucky meet the critical demand for new doctors when Congress has proposed to make additional cuts to training programs? Kentucky needed to increase its number of doctors and other medical professionals even before the state decided expand Medicaid, says a recent review by Deloitte Consulting. The review found that the state needs 3,790 additional physicians, including primary-care doctors and specialists, and the doctor shortage is worse among rural communities.

Provided by Kentucky Health News, an independent news service of the Institute for Rural Journalism and Community Issues at the University of Kentucky, with support from the Foundation for a Healthy Kentucky.

KENTUCKY SPIRIT DEPARTS

Judge refuses to stop exodus, other companies will provide managed care

A Kentucky Court of Appeals judge refused last week to stop Medicaid managed-care firm Kentucky Spirit from leaving the state on Friday, July 5.

Chief Court of Appeals Judge Glenn E. Acree denied the Cabinet for Health and Family Services' emergency motion to require the company to stay through August.

The previous week, a Franklin Circuit Court judge said the state can't require Kentucky Spirit to keep serving Medicaid beneficiaries two months beyond its July 5 exit date.

When filing the emergency motion last week, Cabinet officials said that if Kentucky Spirit leaves the state without a two-month transition plan, it will "jeopardize the health" of 125,000 people.

However, Acree said the cabinet has had plenty of time to prepare for the company's departure, reports Beth Musgrave of the Lexington Herald-Leader.

> Circuit Judge Thomas Wingate said the state has "been repeatedly cautioned by this Court to prepare for this contingency…'

Furthermore, Kentucky Spirit said the state has refused to work with it to ensure an "effective" transition, and Franklin Circuit Judge Thomas Wingate said the state has "been repeatedly cautioned by this Court to prepare for this contingency, and a lack of preparation at this junction does not warrant a grant of the extraordinary remedy of injunctive relief" requested by the state.

The cabinet argues that Kentucky Spirit did not communicate its intentions to leave, despite Wingate's May 31 ruling until the cabinet took Kentucky Spirit back to court earlier this month, reports Musgrave. However, Kentucky Spirit said in October 2012 that it was pulling out of Kentucky's managed-care system because it was losing too much money covering the 125,000 Medicaid enrollees contracted to the company.

So what will happen now? The cabinet has argued that the two other Medicaid managed care companies — Coventry Cares and WellCare — would take on the Kentucky Spirit beneficiaries and letters have been sent to Kentucky Spirit's clients and to health care providers.

Kentucky Spirit argued in its lawsuit that the state rushed to privatize Medicaid in 2011 and provided incorrect cost information to the bidders, causing the firm to lose about $120 million. It made the lowest bid, and on average, gets about $100 less per month for each patient than the other two MCOs, Coventry Cares and WellCare.

The Cabinet for Health and Family Services replied that Kentucky Spirit had breached its contract with the state. Wingate said it had not, because it gave notice of early termination, but it will be subject to fines if it pulls out of the state before July 2014, Beth Musgrave of the Lexington Herald-Leader reported on June 1.

> Kentucky Spirit argued in its lawsuit that the state rushed to privatize Medicaid in 2011 and provided incorrect cost information to bidders, causing them to lose about $120 million.

Kentucky Spirit had argued that its contract allows it to be terminated with six months notice. The six-month provision could only be interpreted to mean six months prior to the end of the three-year contract, said Wingate, because there has to be enough time for the state to move hundreds of thousands of Medicaid patients from Kentucky Spirit to another managed-care provider.

Kentucky Spirit's legal battles are part of ongoing tensions between health-care providers and managed-care companies, and providers have repeatedly complained that the companies are delaying payments for services. The cabinet is hosting a series of forums across the state designed to help providers resolve such issues with the managed care companies.

Provided by Kentucky Health News, an independent news service of the Institute for Rural Journalism and Community Issues at the University of Kentucky, with support from the Foundation for a Healthy Kentucky.

STATE OFFICIALS: Health care providers, managed care companies should meet

At one of a series of forums on Medicaid managed care, state officials said the new system has improved the quality of care, but you could cut the tension with a scalpel in the packed auditorium at the University of Kentucky as they fielded complaints and questions and urged the providers to work out the problems with managed-care companies themselves.

Gov. Steve Beshear and the Cabinet for Health and Family Services say the forums are designed to improve relations between providers and the managed-care organizations, but reactions from capacity crowd of health care providers and staff — reactions that included a roomful of laughter about the MCOs' low count of transferred phone calls from providers — suggested that the state's solutions to providers' problems with the companies aren't quite the solutions sought by providers.

> About 20 percent of providers' claims have either been denied or suspended.

Kentucky's transition to Medicaid managed care

In 2011, Kentucky was faced with spiraling Medicaid costs that gave the state two options: cut reimbursement rates to providers by a third or moving from a fee-for-service model to a managed-care system, in which MCOs get a specified fee for each patient they manage and use the money to pay providers, said Lawrence Kissner, commissioner of the Department for Medicaid Services.

The change is driving improvements in health for Medicaid clients while saving the state money, said Kissner: It has increased well-child visits for children aged 3-6 from 2 percent to 53 percent, has increased diabetes testing from 6 percent to 59 percent, and has improved adult access to preventative and ambulatory health services.

MCOs also have numerous quality initiatives underway, said Kissner, including one in improving anti-depressant medication management and compliance. One company, Wellcare, has worked to improve oral health through a campaign that offered $10 gift cards for dental visits, but no one hears about this, he said.

What we've heard are complaints from physicians, hospitals, pharmacies and other health-care providers who aren't getting some claims paid in a timely manner, or at all.

Providers say manage care's complicated pre-approval process, designed to limit costs, delays critical treatment for patients and adds unsustainable administrative burdens.

State officials' response: meet with the MCOs

Kissner said the new system denies 6 percent of providers' requests for pre-authorization, compared to the fee-for-service model that only denied 1 percent of such requests, but he says that's about the same as other states that use managed care.

About 20 percent of providers' claims have either been denied or suspended. In the first 14 months of managed care, 22 million of the 28.3 million claims, or 78 percent, were paid within 30 days. Kissner said 4.9 million (17 percent) were denied in 30 days and 1.2 million (4 percent) were suspended; he did not mention the monetary amount of the denied or suspended claims.

Kentucky Health News is an independent news service of the Institute for Rural Journalism and Community Issues at the University of Kentucky, with support from the Foundation for a Healthy Kentucky.

Health Care Reform

FACT

• Insurance companies can no longer drop your coverage if you get sick. Your health insurance is guaranteed, as long as you pay your premiums.

•Insurance companies can no longer place lifetime or annual dollar limits on your health coverage. This change will make sure that your benefits won't run out when you need them the most. The ban on lifetime limits started in 2010. The ban on annual limits begins in 2014.

Lack of bank account could keep millions from health coverage

'I've not seen any specific guidance that says you have to be able to accept these types of payments.'

Ray Smithberger, Cigna

A new study says that if corrective action isn't taken, health-insurance companies could exclude 27 percent of qualifying Americans now eligible for premium-assistance tax credits under the health-reform law because they plan to require customers to pay premiums automatically through a bank account.

Denying coverage to the more than 8 million "unbanked" Americans will undermine efforts to expand health coverage and equalize access to health care, says the report from tax service firm Jackson Hewitt.

Another 20 percent are "underbanked," meaning they have accounts but prefer to use payday loans and other non-bank financial services. One in five households use check-cashing stores and money lenders instead of a traditional bank, says the Federal Deposit Insurance Corp.

Most health plans accept a credit card for the first month's premium payment and thereafter require monthly payment from a checking account. Federal officials are wary of taking action that might discourage insurance companies from participating in the state insurance exchanges, Varnet heard from current and former state health officers who have pressed the Department of Health and Human Services for a ruling.

"I think there is a dawning awareness that this is a large problem," Brian Haile told Sarah Varney of Kaiser Health News. Haile is senior vice president for health policy at Jackson Hewitt and has called on federal officials to set a uniform standard requiring all insurers to accept all forms of payment. Alternative forms include credit cards or pre-paid debit cards that people without bank accounts often use.

While health insurance companies are evaluating these options, no law requires them to accept all forms of payment, notes Varney. "I've not seen any specific guidance that says you have to be able to accept these types of payments," Ray Smithberger, Cigna's general manager of individual and family plans, told Sarah Kliff of The Washington Post.

Insurance carriers take a risk by accepting credit cards and pre-paid debit cards because transaction fees can run as high as 4 percent and pre-paid cards are popular among low-wage workers, Haile told Varney. "If you accept reloadable debit cards, are you in fact getting folks with lower health status?" he said. "That's a real risk when you're in the insurance business. So you can't be the only one picking up those risks."

The Jackson Hewitt report calls for immediate action by federal policy makers to ensure insurers cannot discriminate against the 'unbanked' through their payment acceptance policies by creating a system-wide rule requiring all forms of payment must be accepted.

"Given the dilemma presented to insurance companies by the strong financial incentives to discourage non-bank payment mechanisms, insurers are unlikely to resolve this issue without federal action," the report says.

Provided by Kentucky Health News, an independent news service of the Institute for Rural Journalism and Community Issues at the University of Kentucky, with support from the Foundation for a Healthy Kentucky.

FACT

The $938 billion health care bill is financed: $416.5 billion net cuts to Medicare. $210 billion in increased Medicare tax on high-income taxpayers. $107 billion in fees on insurers and medical producers. $149 billion from "other" revenue provisions.

Health Care Reform

FACT

Under the Affordable Health Care Act, plans must include the following coverage:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services including oral and vision services

*Provided by the Kentucky Department of Insurance

Delayed? Now What?

(AP) A few questions and answers:

WHO BENEFITS FROM DELAY?

• Democratic candidates. The employer mandate was set to take effect at the start of a congressional election year, intensifying the focus on one of the Republicans' favorite campaign issues. Postponing the requirement should mean fewer ads featuring business owners saying they're drowning under health care mandates.

• Maybe Republicans, too. They get new ammunition for their argument that the law is an unworkable "train wreck." Voters' complaints and worries about the health law helped the GOP win control of the House in 2010.

• Some low-income workers. When the employer mandate does take effect, some smallish companies have threatened to lay off workers or cut back their hours to stay under the 50-employee threshold. There's debate about how many workers might be harmed by this.

• Some job hunters. Once the mandate kicks in, jobseekers may find fewer openings for unskilled workers. That's because some restaurants and other small companies say the mandate will force them to cut back on staff or freeze hiring. The economy is likely to continue improving, which will help offset the impact by increasing demand for workers.

IS THIS A DOWNWARD SPIRAL?

The delay adds to an appearance of disarray surrounding the law.

It comes after other glitches and angry opposition: Lawsuits reaching all the way to the Supreme Court. Protests by religious employers who say covering contraception is against their beliefs. Repeated votes by House Republicans to repeal "Obamacare."

But the postponement doesn't affect the heart of the law – the requirement that individuals get insurance, and the subsidies to help them pay for it. The Obama administration insists the rest of the law will keep rolling along.

IS THE REST OF THE LAW ON TRACK?

Not for everyone.

Last summer, the Supreme Court said states have the right to opt out of the law's Medicaid expansion.

Eighteen states aren't expanding their programs, including populous Texas and Florida. In nine other states, the outcome remains unclear.

Under the law, Medicaid is the only coverage option for people below the poverty line – $11,490 for an individual or $23,550 for a family of four. People this poor cannot get subsidized private coverage in the new health insurance markets.

The poor will be exempt from penalties for being uninsured, but they also won't get help with their health care.

Medicaid already covers more than 60 million people, including many elderly nursing home residents, severely disabled people of any age and many low-income children and their mothers.

KIDS COUNT

Statistics show health, education, economic data

Conditions have improved slightly for Kentucky children, especially in education and health, and the state's overall well-being ranking has gone up one spot, from 35th to 34th in the nation.

But economic conditions for young Kentuckians have slipped since last year, says the Kids Count report released recently by the Annie E. Casey Foundation.

The annual report measures how the country and its 50 states are doing according to four measures of child well-being – education, health, economic well-being, and family and community. How well Kentucky's children score in each domain paints a picture of Kentucky's future.

The report includes a wide range of data for every county and school district.

The data include current and five-year rates of child poverty; median family income and median household income; infant mortality rate; child death rate; teen death rate; child abuse and neglect cases; foster care cases; births to mothers who are teenagers, who smoke, who are not high-school graduates, and who get early and regular prenatal care; pre-term births; low-weight births; newborns breastfed when they leave the hospital; early childhood obesity, number and percentage of child-support collections; asthma hospitalizations; and recreational facilities.

It also includes number and percentage of children receiving food stamps, Medicaid, child-care subsidies, Supplemental Security Income, and benefits from the Women, Infants and Children nutrition program; and the number and percentage eligible for reduced-price meals at school.

Also included are the number and percentage in publicly funded preschool; the hourly wage needed to pay fair-market rent and the percentage of renters unable to afford such rent; juvenile justice data; percentage of students ready for college and careers; and the six-year college graduation rate.

Statewide, the report shows that Kentucky has made gains in education, and the state ranks 28th on this measure. Since 2005, more children are attending preschool, more fourth-graders are proficient in reading and more eighth-graders are proficient in math, says the report.

Kentucky has also improved in many health measures. There are fewer low birth-weight babies, fewer children without health insurance and fewer teens who abuse alcohol or drugs. Medical coverage should only continue to improve as the state expands Medicaid coverage to households at 138 percent of the poverty line. However, youth advocates say gains in education and health may not be maintained if more children continue to live in poverty.

Unfortunately, Kentucky children continue to struggle economically, weighing in at 32nd in the nation. The report says 37 percent of Kentucky children have parents who lack stable employment, up from 33 percent last year, and 32 percent of children live in households that are burdened by housing costs, up from 27 percent.

The state's lowest ranking is 38th, on the family and community measure. Its constituents: More than 27 percent of children live below the poverty line, compared to the national average of 23 percent, and the number of children in single-parent families has increased from 31 percent in 2006 to 36 percent in 2011. On the bright side, teen births declined during that period.

With the hard work of child advocates, community agencies, educators and policymakers, the report shows progress has been made to improve children's well-being, but there is still much to be done.

The report can be found online at http://datacenter.kidscount.org.

Child Poverty Rate
(% who live below poverty line)

Location	2009	2010	2011
Ky.	25.3	26.1	27.2
Adair	34	35.4	37.6
Casey	40.6	40.8	41.9
Green	34.1	32.4	35.2
Metcalfe	38.2	36.1	38.4
Russell	36.5	37.4	34.9
Taylor	33.1	35	29.5

Data provided by Kentucky Youth Advocates

MEN: Take steps to manage diabetes

If you have diabetes, you know the day-to-day steps needed to manage diabetes can be hard. Managing diabetes isn't easy, but it's worth it. If left untreated, men with diabetes can face serious health problems such as heart attack, stroke, kidney disease, blindness, and even the loss of a toe or foot. Diabetes can also lead to sexual problems such as erectile dysfunction.

An important part of managing your diabetes is knowing your diabetes ABCs – A1C, Blood Pressure, and Cholesterol.

A is for the A1C test. It measures your average blood glucose level over the past three months. The goal for many people with diabetes is below 7. Ask what your goal should be.

B is for blood pressure. If your blood pressure gets too high, it makes your heart work too hard. It can cause a heart attack, stroke and kidney disease. Ask what your goal should be.

C is for cholesterol There are two kinds of cholesterol in your blood: LDL and HDL. LDL or "bad cholesterol" can build up and clog your blood vessels. HDL or "good" cholesterol helps

See **MEN**, next page

Help teens address diabetes

Teens with diabetes and their families often face unique challenges. Teens may sometimes have feelings of sadness, anger, loneliness, and fear, or they may blame themselves or their family for their diabetes. These feelings are normal every now and then. But in order to feel better, teens need to learn to take charge of their diabetes – and families can help. Parents or guardians can encourage their teens to feel good about themselves, seek support from others, and take action to manage their diabetes one step at a time. Follow these tips from the National Diabetes Education Program (NDEP) to help your teen deal with the ups and downs of diabetes:

• Get your whole family involved. It's easier to manage diabetes when your whole family gets involved. Serve your family healthy foods, such as a mix of colorful fruits and vegetables, whole grain breads, and low-fat meats, milk, and cheese. Make healthy snacks, like fruit, highly visible in your home and do not keep a lot of sweets, like cookies, candy, or soda around the house. Encourage your family to be more physically active by planning activities that you can do together, such as riding bikes or going for a walk. Join a community program like the Y to enjoy a variety of low-cost or free activities.

• Encourage your teen to take an active role in his or her diabetes care. Help your teen set goals. Start with small goals, such as cutting back on soda, or riding a bike a couple of times a week. Reward your teen when goals are met, and encourage your teen to make every new goal just a little bit harder.

• Help your teen find other teens who have diabetes. Programs and support groups for teens with diabetes can be found in clinics, health centers, and hospitals. Check your local newspaper. Ask your teen's health care team for more information. Visit www.diabetescamps.org to find diabetes or weight loss summer camps for teens with diabetes.

• Encourage your teen to ask for help from their school and health care team. It's important that teens tell their health care team how they feel and what they need help with to manage their diabetes. Make sure you notify your teen's school that your teen has diabetes. Provide the school staff with your teen's diabetes care plan and meet with them to help plan their diabetes care during the school day.

• Help your teen find a counselor if he or she seems depressed. Suggest people your teen can reach out to for help, such as a family member, friend, school counselor, teacher, doctor, diabetes educator, or psychologist. Encourage your teen to let you know when he or she is feeling down.

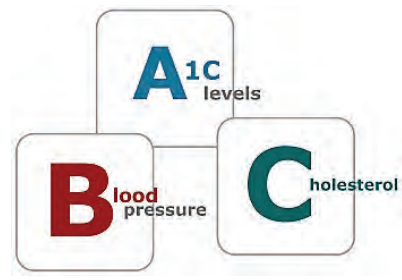
For more information about diabetes, contact your local health department & ask to speak to the diabetes educator or call 1-800-928-4416. You may also visit our website, www.lcdhd.org or become a fan of Lake Cumberland District Health Department on Facebook.

For a free copy of the Tips for Teens: Dealing with the Ups & Downs of Diabetes tip sheet, contact the National Diabetes Education Program at www.YourDiabetesInfo.org or call 1-888- 693-NDEP (1-888-693-6337), TTY: 1-866-569-1162.

By the National Diabetes Education Program.

MEN: Take steps to manage diabetes

Continued from page 9



remove the "bad" cholesterol from your blood vessels. Ask what your cholesterol numbers should be.

If you smoke, get help to stop smoking. Talk to your health care team about your ABC numbers and what you can do to reach your ABC goals.

The NDEP offers tips to help you take action to manage your diabetes. An important first step is to set a goal for yourself.

Choose something that is important to you and that you believe you can do. Then make a plan by choosing the small steps you will take. For example, start working towards getting 30 minutes of physical activity, such as brisk walking, most days of the week. If you have not been very active in the past, start slowly and try adding a few minutes each day. Ask others for help with your plan.

For more information about diabetes, contact your local health department & ask to speak to the diabetes educator or call 1-800-928-4416. You may also visit our website, www.lcdhd.org or become a fan of Lake Cumberland District Health Department on Facebook.

The National Diabetes Education Program has free resources that can help. Order a free copy of 4 Steps to Manage Your Diabetes for Life and get more information about managing diabetes at 1-888-693-NDEP (1-888-693-6337) or www.YourDiabetesInfo.org.The U.S. Department of Health and Human Services' National Diabetes Education Program is jointly sponsored by the National Institutes of Health and the Centers for Disease Control and Prevention with the support of more than 200 partner organizations.

Health care reform helpful websites:

Kentucky Department of Insurance
http://insurance.ky.gov/home.aspx?div_id=17

Health Action Network
www.healthactionnetwork.com

U.S. Department of Health and Human Services
https://www.healthcare.gov/

Anthem (for employers)
MakingHealthCareReformWork.com