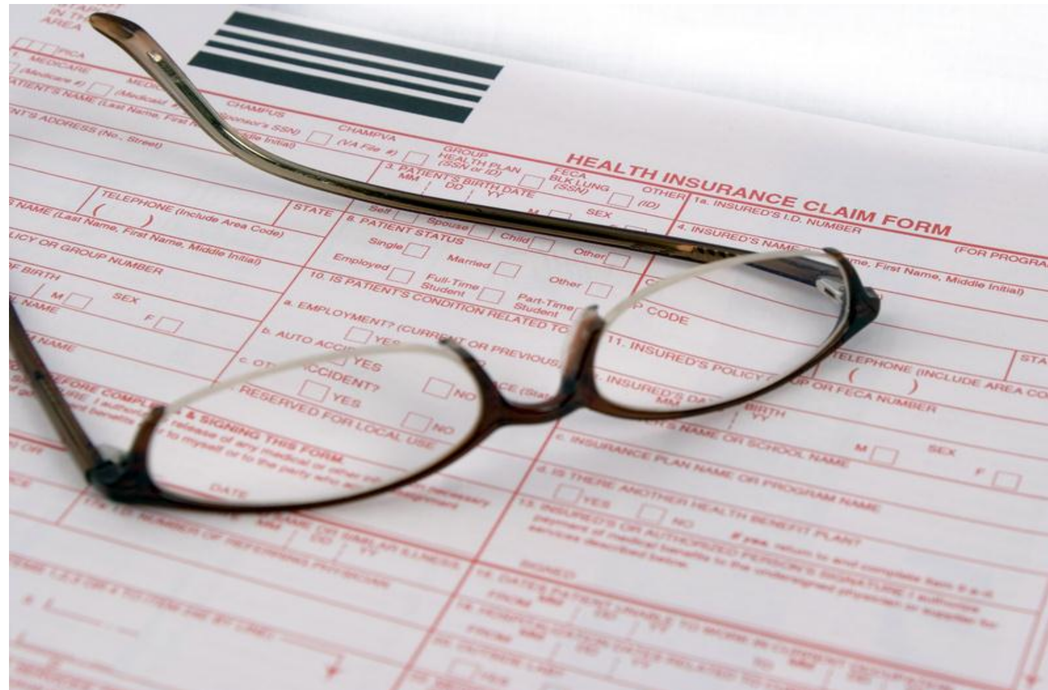
EXPLAINING HEALTH CARE REFORM: WRAP UP FOR 2011 AND WHAT TO EXPECT IN 2012



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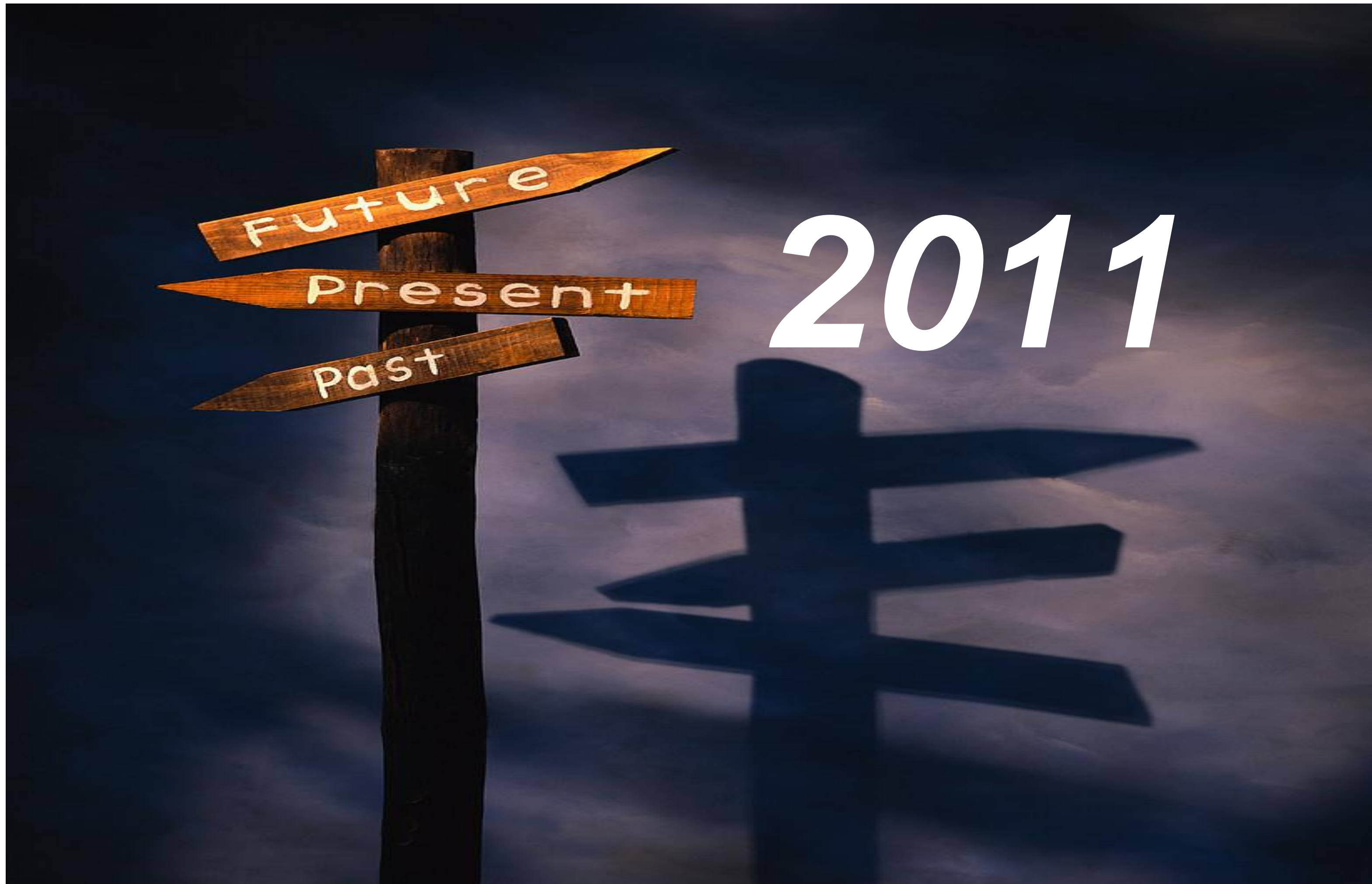
Provisions Already in Effect Related To Health Coverage

- Rescission of Coverage
- Changes to Pre-existing Exclusions
- Extension of Dependent Coverage to Age 26
- Limitations on Lifetime and Annual Limits
- Required Coverage for Preventive Services
- Changes to Emergency Coverage
- Patient Protections/Access to Physicians
- New Internal and External Appeals Processes


Future
Present
Past
2011

Phase In on Restriction on Annual Limits

- Restricted annual limits allowed for a period of time:
  - $750,000 for plan/ policy years beginning on or after September 23, 2010, but before September 23, 2011;
  - **$1.25 million for plan/policy years beginning on or after September 23, 2011, but before September 23, 2012; and**
  - $2 million for plan/policy years beginning on or after September 23, 2012, but before January 1, 2014.
  - No annual limits after January 1, 2004.

Required Coverage for Preventive Services

- Must cover without application of deductibles or coinsurance:
  - Services rated “A” or “B” by the U.S. Preventive Services Task Force.
  - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  - Preventive care and screenings for children as recommended by the Health Resources and Services Administration.
  - Preventive care and screenings for women as recommended by the Health Resources and Services Administration.

Required Coverage for Preventive Services

- On August 1, 2011, HHS adopted the Guidelines for Women's Preventive Services – including well-woman visits, support for breastfeeding equipment, contraception and domestic violence screening.
- The guidelines were recommended by the independent Institute of Medicine.
- The new guidelines go into affect for plan years starting in August 2012.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.* (see note)
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling.)	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	Annual.

New Appeals Requirements

- External Review Process
  - GHPs and insurers must comply with any applicable external review process in states that have implemented such a process if the state's external review process is applicable and binding and includes, at a minimum, the consumer protections set forth in the Uniform Health Carrier External Review Model Act promulgated by the NAIC that was in effect on July 23, 2010.
  - The appeals rules created by the ACA are effective for plan years beginning on or after Sept. 23, 2010, but under a transition rule, a state external review process applicable to a plan or insurer is deemed to meet these requirements for plan years beginning before July 1, 2011.
  - HHS has indicated that Louisiana's MNRO Act does not meet the requirements.

New Appeals Requirements

- Self-insured plans that are not subject to state insurance regulation, and (beginning the first day of the first plan year beginning on or after July 1, 2011) self-insured or fully insured plans that are not subject to a state external review process that meets the minimum standards, must comply with a federal external review process.

Medical Loss Ratios

- Beginning in 2011, health insurers must spend a minimum percentage of each premium dollar on medical care and health quality improvement.
  - If they do not, policy enrollees are entitled to a rebate.

- Under the MLR, the minimum percentage to be spent on permissible expenses is 80% for insurers in the individual and small group markets and 85% for insurers in the large group market.

- Insurers must submit reports regarding their MLRs to HHS for calendar year 2011 by June 1, 2012.

- Insurers are required to start providing rebates with respect to any MLR failures by August 2012.

Medical Loss Ratios

- For current enrollees, insurers may issue the rebates either in the form of a premium credit or a lump sum payment.

- For former enrollees, only a lump sum payment is permitted.

- In the case of a fully-insured employer group health plan, even though the enrollee may be the employee, the rebate can be provided to the employer.
  - Only permissible if the employer agrees to distribute the rebate on behalf of the insurer; and the insurer maintains records showing accurate distribution of the rebate.

Medical Loss Ratios

- The regulations include a provision whereby a State could request a waiver of implementation of the MRL requirements for the individual market.
- Louisiana sought to lower the threshold to 70 percent in 2011 and 75 percent in 2012.
- HHS took issue with Louisiana's claims that the ACA was already forcing insurers out of the individual market.
  - *The denial letter noted that two insurers in the state that withdrew for business reasons were not active in the individual market.*
  - *Another insurer that blamed the ACA for its withdrawal only had 12 enrollees in the individual market — well below the threshold for triggering compliance with the ACA's MLR standards*.

Rate Review

- The rate review final rule, effective Sept. 1, 2011, requires insurers of individuals and small groups to provide detailed information to the states and/or HHS for any proposed increase equal to or greater than 10 percent (the threshold), along with the reason for the proposed increase.

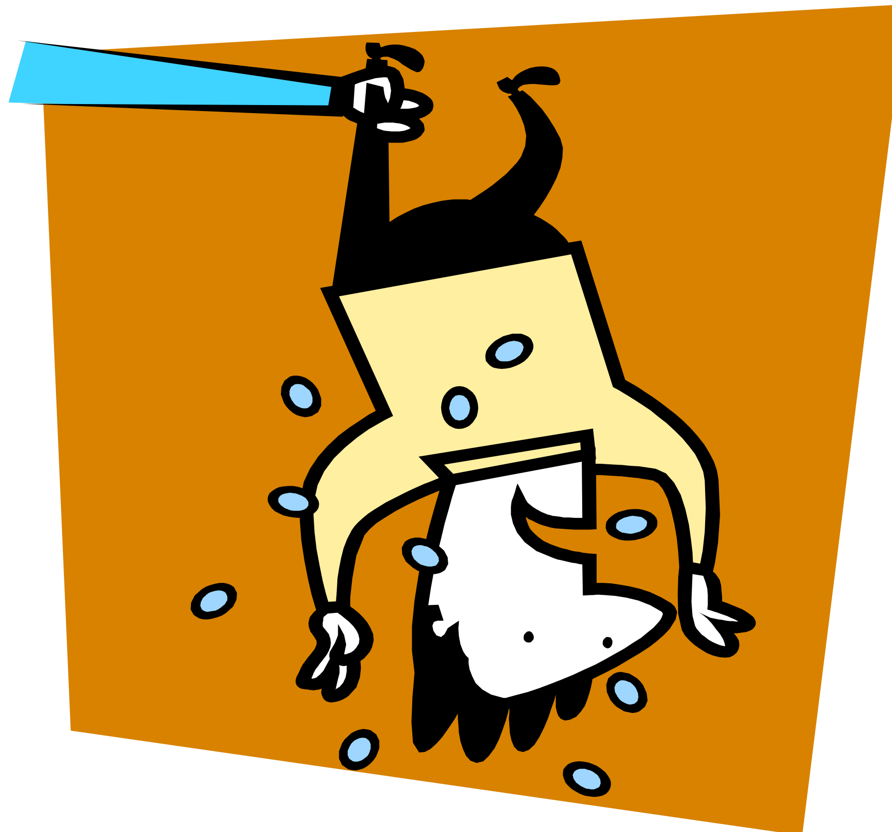
- States deemed to have effective rate review programs will be able to set state-specific thresholds beginning Sept 1, 2012.

- 40 states and the District of Columbia have "effective" rate review programs. Two states have "effective" rate review programs in the individual market only. Six states do not have an "effective" program and will therefore have rate increases that meet or exceed the federal threshold reviewed by HHS.
  - Louisiana does not have an effective rate review process!

Health Exchanges

- Regulations on the "Establishment of Exchanges and Qualified Health Plans" were released on July 11, 2011.
- Regulations provide for the American Health Benefit Exchange (for individuals) and the Small Business Options Program (for small businesses).
- If a state operates an Exchange, it must offer a SHOP Exchange.
- No regulations for a federally run exchange have been promulgated to date.

IRS Rules



Limitations on Tax Exempt Accounts

- The cost of over-the-counter medicine (other than doctor prescribed) may not be reimbursed through health FSA, HRA, HSA or Archer MSA.
- Tax years beginning 1/1/2011.

HSA Excise Tax

- The ten percent (10%) excise tax on HSA distributions for non-medical purposes is increased to twenty percent (20%).
- Distributions beginning 1/1/2011.

W-2 Reporting

- IRS Notice 2011-28 provides for reporting of the aggregate cost of employer sponsored coverage must be reported on an employee's W-2.
- Effective for 2012 tax year.
- The amount is not taxed; it is merely reported.
- Exempt if less than 250 employees.

Future
Present
Past

Medicare Advantage Plan Payments

Quality Ratings

“MA plans may feel like they’re seeing stars”

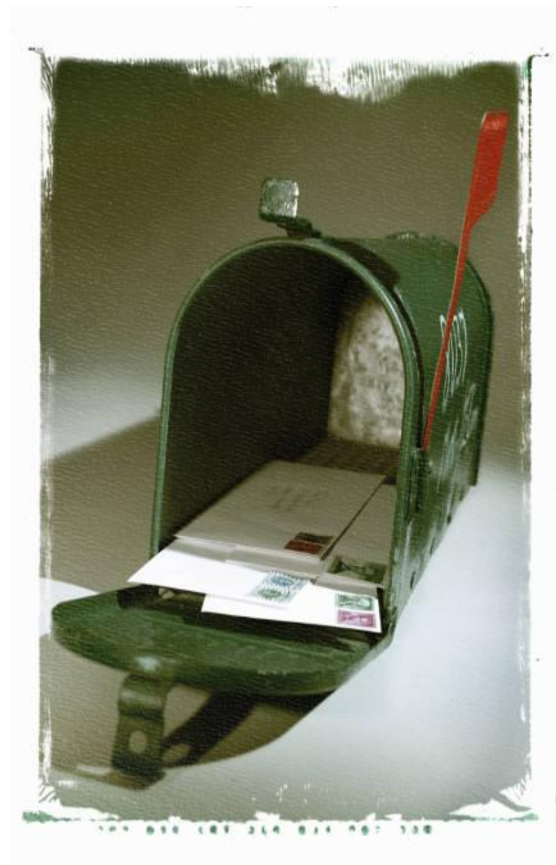
Goal: Tie quality of care to reimbursement

- Beginning in 2012
  - Bonuses paid to plans that achieve 4 or more stars on a 5 star rating system
    - 2012: 1.5% bonus
    - 2013: 3% bonus
    - 2014: 5% bonus

Accountable Care Organizations

- Allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- On April 7, 2011, DHH published a proposed rule defining ACOs setting our requirements for governance, legal structure, transparency efforts and the incorporation of evidence-based medicine and quality efforts.
- The Shared Savings Program which allows ACOs to share in savings to the Medicare program begins January 1, 2012.

New Notice Provisions



Quality Reporting Requirements

- The ACA requires plans to submit annual reports to HHS and enrollees on whether the benefits under the plan:
  - Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management.
  - Implement activities to prevent hospital readmission.
  - Implement activities to improve patient safety and reduce medical errors.
  - Implement wellness and health promotion activities.

- HHS is to develop requirements by March 23, 2012.

Summary of Benefits and Coverage and the Uniform Glossary

- The ACA requires that health insurance carriers and employer-sponsored health plans provide a Summary of Benefits and Coverage ("SBC") to participants and enrollees.

- Proposed regulations and templates on the SBC and Uniform Glossary were published on August 22, 2011.

- The Act originally required that plans begin using the SBC on March 23, 2012.
  - *The proposed regulations recognize that a mid-year communication requirement may be problematic for employers and sought comments on a phased approach to the rule*.

- Employers who sponsor self-funded plans will be responsible for the production and distribution of the SBC.

Summary of Benefits and Coverage and the Uniform Glossary

- The SBC is a written summary of benefits and coverage that is intended to help participants and beneficiaries make health care decisions and comparisons.

- The SBC is intended to assist plan sponsors in comparing and selecting health care coverage for employees.

- Under the proposed regulations, the SBC is a disclosure document that is separate from the SPD.
  - SPDs must continue to be issued for GHPs.

- The Uniform Glossary is a list of health coverage and medical terms, defined by regulatory guidance, that is intended to help participants and beneficiaries understand those terms that are important for understanding their benefits and coverage.

Summary of Benefits and Coverage and the Uniform Glossary

- Generally, the SBC must be distributed when a GHP sponsor or an individual is comparing health coverage options.

- Group insurance issuers must issue an SBC to GHP sponsors, free of charge, in the following instances:
  - Upon request for coverage or request for information about coverage, as soon as practicable but not later than 7 days following the request.
  - If there is any change to the initial SBC prior to the start of GHP coverage, no later than the first day of coverage.
  - Upon renewal or reissuance of the GHP coverage, regardless of whether there have been any changes to the coverage, no later than 30 days prior to the first day of the new policy year (automatic renewal/reissuance), or with the renewal/reissuance materials if a new written application is required.

Summary of Benefits and Coverage and the Uniform Glossary

- GHPs must also issue an SBC to plan participants and beneficiaries, free of charge, in the following instances:
  - Participants and beneficiaries must receive an SBC for each benefit package offered under the plan for which they are eligible, no later than the first date of eligibility.
  - The SBC(s) must be provided with any written application materials for enrollment or, if none, prior to the first date the employee is eligible to enroll in the GHP.
  - Should there be any change to benefits and coverage between enrollment and the first day of coverage, no later than the first day of coverage.
  - Within 7 days of a request for special enrollment.
  - Upon renewal of coverage (*i.e.,* annual enrollment), not later than 30 days prior to the first day of the new plan year.
  - Upon request, as soon as practicable, not later than 7 days following the request.

Summary of Benefits and Coverage and the Uniform Glossary

- The proposed regulations set forth content, appearance, form and language requirements for SBCs.
- Use of the templates satisfies the content and appearance requirements.
- Plan sponsors and insurance issuers/TPAs will need to carefully work with the draft templates to ensure that the descriptions of coverage, cost sharing provisions, and exceptions accurately reflect the plan provisions.

Summary of Benefits and Coverage and the Uniform Glossary

- The SBC must include the following information:
  - Uniform definitions of standard insurance terms and medical terms.
  - Description of coverage, including cost sharing, for each category of benefits identified by HHS.
  - Exceptions, reductions, limitations on coverage.
  - Cost-sharing provisions, including deductibles, coinsurance and copayments.
  - Renewability and continuation of coverage provisions.
  - Coverage examples (currently required in the template are: having a baby, treating breast cancer and managing diabetes, and how the coverage would apply under the plan).

Summary of Benefits and Coverage and the Uniform Glossary

- The SBC must include the following information:
  - Premiums (fully-insured GHPs) or cost of coverage (self-insured GHPs).
  - Contact information for questions and obtaining a copy of the plan document.
  - Internet addresses for participants to obtain a list of network providers, information on prescription drug coverage, & access to the Uniform Glossary.
  - A statement that the SBC is only a summary and the provisions of the plan document or insurance contract govern.
  - Starting January 1, 2014, a statement regarding whether the plan provides minimum essential coverage and whether the plan's share of total allowed costs of benefits meets applicable minimum essential coverage requirements

Notice of Material Modification

- If there is a material change to the benefits or coverage in the SBC during the plan year, insurance issuers and GHP sponsors must provide notice of the change not later than 60 days prior to the date on which the change will become effective.
  - a material change (or modification) is a change that affects the content of the SBC, including enhancements or reductions of covered services or benefits.

- The proposed guidance indicates that notices of material modifications will only have to be provided in situations other than open enrollment, renewal or reissuance.
  - For example, if the material modification coincides with the start of a new plan year, then only the required SBC (that includes the modified information) must be provided to participants and beneficiaries; not the notice.

Comparative Effectiveness Research Fees

- The ACA created a new Patient-Centered Outcomes Research Institute (PCORI), a nonprofit organization, to conduct research evaluating and comparing health outcomes and the clinical effectiveness, risks and benefits of medical treatments.

- The IRS issued Notice 2011-35 which address payment of fees to fund the PCORI.
  - For health insurance policies, fees are paid by the issuers of the policies.
  - For self-insured health plans, fees are paid by the sponsor of the plan.

- IRS Notice 2011-35 states that for calendar-year plans the fee would apply to calendar-plan years 2012 through 2018. For plans that do not operate on a calendar-year basis, the fee would apply to the first plan year that ends on or after October 1, 2012 (*e.g.*, a plan year beginning on November 1, 2011). The fees do not apply to plan years ending after September 30, 2019.

Comparative Effectiveness Research Fees

- In the first year it applies, the fee will amount to $1 multiplied by the average number of lives covered under the plan (including dependents).
- In subsequent years, the multiplier is $2 times the average number of covered lives.
  - This dollar amount will be adjusted, starting in 2014 or 2015 (depending on the plan year), by the percentage increase in the projected per capita amount of National Health Expenditures as most recently published by DHH before the beginning of the fiscal year.

QUESTIONS