Compliance Advisory:

Health Care Reform Impact During the First Year of Enactment

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What Group Health Plans and Health Insurers Must Prepare for Immediately

PART II

Part I of our series on the immediate impact of the Patient Protection and Affordable Care Act (the "Act") and the Health Care and Education Reconciliation Act of 2010, H.R. 4872 (the "Reconciliation Act") focused on those provisions of the Act, that we felt had the most significant financial impact on group health plans and health insurers during the first year of enactment. Part II focuses on the remaining provisions that will impact group health plans and health insurers in 2010 and include: Development and Utilization of Uniform Explanation of Coverage Documents and Standardized Definitions; Health Insurance Consumer Information; Reinsurance for Early Retirees; Immediate Information That Allows Consumer to Identify Affordable Coverage Options; and Administrative Simplification. We also address the "Medicare Donut Hole" provision and the Tax Credit for Small Business.

> "Group health plans and health insurers will have to work fast to insure that benefit booklets and Internet sites are updated to comply with the new federal requirements once they are finalized by HHS."

SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

The Secretary of Helath and Human Services (hereinafter referred to as "HHS" or the "Secratary") must develop within 12 months from the enactment of the Act, standards for use by a group health plan and a health insurance issuer in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In addition, the Secretary must periodically review and update, as appropriate, the standards. The new federal standards preempt any related state standards that require a summary of benefits and coverage to the extent they are less stringent than federal law.

In developing the summary of benefits, the Secretary is required to develop standard definitions for insurance-related and medical terms. For example, insurance-related terms include those related to premiums, deductibles, co-insurance, co-payments, out-of-pocket limits, preferred provider, non-preferred provider, out-of-network co-payments, usual, customary and reasonable fees, excluded services, grievance and appeals. Medical terms to be addressed are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, and emergency medical transportation.

Beginning twenty-four months after the date of enactment of the Act, health insurance issuers and plan sponsors of group health plans must provide the summary of benefits that meet the standards adopted by HHS to applicants at the time of application; enrollees prior to the time of enrollment or reenrollment and policyholders or certificate holders at the time of delivery of policy or certificate. The summary of benefits and coverage may be provided in paper or electronic form. Failure to provide the information required under the Act is subject to a fine of not more than $1,000 for each failure per enrollee.

The standards for the summary of benefits and coverage developed must be based on the following requirements:

APPEARANCE- The summary of benefits and coverage must be in a uniform format that does not exceed 4 pages in length and does not include print smaller than 12-point font.

LANGUAGE- The summary must be presented in a culturally and linguistically appropriate manner and utilize terminology understandable by the average plan enrollee.

CONTENTS- The standards shall ensure that the summary of benefits and coverage includes—

1. uniform definitions of standard insurance terms and medical terms understandable by the basic consumer;

2. a description of the coverage, including cost sharing for each of the categories of essential health benefits required by the

Act;

3. the exceptions, reductions, and limitations on coverage;

4. the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

5. the renewability and continuation of coverage provisions;

6. a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing, each scenario to be based on recognized clinical practice guidelines;

7. a statement of whether the plan or coverage (a) provides minimum essential coverage and (b) the plan or coverage share of the total allowed costs of benefits is not less than 60 percent of the costs;

8. a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

9. a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

Notice of any material modification in any of the terms of the plan or coverage must be given to enrollees not later than 60 days prior to the date on which the modification will become effective.

SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

Not later than July 1, 2010, HHS, in consultation with the States, must establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State. To the extent practicable, the Internet website must provide information to residents on certain coverage options that include: (1) health insurance coverage offered by health insurance issuers; Medicaid coverage; Medicare coverage; State health benefits high risk pools; and (2) Coverage under the temporary high risk pool established by the Act.

Not later than 60 days after the Act's enactment date, HHS must develop a standardized format to be used for the presentation of information relating to the coverage options to be described on the Internet website. The format must be consistent with certain provisions of the Public Health Service Act and must include information on the percentage of total premium revenue expended on administrative costs, eligibility, availability, premium rates, and cost sharing with respect to the coverage options.

SEC. 1102. REINSURANCE FOR EARLY RETIREES.

Through the Department of the Treasury, HHS will appropriate 5 billion dollars to fund a reinsurance program for employer sponsored health benefits offered to early retirees. Within 90 days after the date of enactment, HHS must establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of the retirees). The temporary program terminates on January 1, 2014.

Participating employment-based plans are ERISA, multi-employer and governmental plans that offer comprehensive health insurance benefits to early retirees between the age of 55 to until the time the employee is eligible for Medicare. Plan sponsors must submit an application to HHS for participation in the program. However, HHS has the authority to stop taking applications for participation in the program based on the availability of funding.

In order to participate in the program, employer based plans must be certified by HHS and must (1) implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions; and (2) provide HHS with documentation of the actual cost of medical claims involved.

In order to be reimbursed for payments, the plan must submit documentation of the actual costs of the items and services for which each claim is being submitted. Claims must be based on the actual amount expended by the participating employment-based plan involved within the plan year for the health benefits provided to an early retiree or the spouse, surviving spouse, or dependent of the retiree. In determining the amount of a claim, the participating plan must take into account any negotiated price concessions (i.e. discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by the plan with respect to the health benefit. In addition, the costs paid by the early retiree or the retiree's spouse, surviving spouse or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan for purposes of determining the amount of claim.

HHS will reimburse participating plans 80 percent of that portion of the costs attributable to each claim that exceed $15,000 but are not greater than $90,000.

Amounts paid to participating employment-based plans under the program must be used to lower costs for the plan. For example payment may be used to reduce premium costs or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. The payments may not be contributed to the plan sponsor's general revenues. However, reimbursement from the program will not be included in determining the plan sponsor's gross income.

HHS is also required to establish an appeals and audit process for the program.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

The Administrative Simplification provisions of the Act require that HHS adopt a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011 and effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012 and effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014 and effective January 1, 2016).

The Act also provides additional compliance and certification requirements for health plans. No later than the effective date of an operating rule, a health plans must provide HHS with adequate documentation of compliance with the standards and operating rules that (1) demonstrates to the Secretary that the plan conducts the electronic transactions in a manner that fully complies with HHS' regulations; and (2) provides documentation showing that the plan has completed end-to-end testing for the transactions with their partners, including hospitals and physicians.

In addition, health plans must include in its contracts with business associates or vendors providing electronic transaction services that the contractor agrees to comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of compliance) under these provisions.

Further, in the event HHS revises standards and associated operating rules or establishes other financial or administrative transactions, a health plan will be required to file a statement with HHS certifying that the data and information systems for the plan are in compliance with any applicable new or revised standards and associated operating rules.

Under the Act, HHS must also conduct periodic audits to ensure that health plans and its contractors are in compliance with any standards and operating rules.

PENALTIES: Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee against a health plan that has failed to meet the requirements with respect to certification and documentation of compliance with--

(i) the standards and associated operating rules;

(ii) a standard and associated operating rules or any other financial and administrative transactions.

HHS is requires to assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements.

A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance will also be subject to a penalty fee that is double the amount that would otherwise be imposed under the penalty provisions.

A penalty fee assessed against a health plan may not exceed, on an annual basis--

(i) an amount equal to $20 per covered life under the plan; or

(ii) an amount equal to $40 per covered life under the plan if the plan has knowingly provided inaccurate or incomplete information.

Administrative Simplification Provisions in the Act also address the following:

(1) UNIQUE HEALTH PLAN IDENTIFIER- Final rules establishing a unique health plan identifier must be promulgated and effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER- Standards for electronic funds transfers must be adopted not later than January 1, 2012, in a manner ensuring that the standard is effective not later than January 1, 2014.

(3) HEALTH CLAIMS ATTACHMENTS- A transaction standard and a single set of associated operating rules for health claims attachments must be adopted no later than January 1, 2014, in a manner ensuring that the standard is effective not later than January 1, 2016.

SEC. 1421. SMALL BUSINESS TAX CREDIT

The Act provides small employers (with no more than 25 "full-time equivalent" employees) and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit.

From 2010 through 2013, the Act provides a health insurance tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium. The credit phases-out as firm size and average wage increases.

For tax years 2014 and later, eligible small businesses that purchase coverage through the state exchange, the Act provides a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium. The credit phases-out as firm size and average wage increases.

SEC 1102 - Closing the Donut Hole

With respect to the Medicare Part D prescription benefit program, the Reconciliation Act reduces the beneficiary conisnurance from 100% to 25% over ten years. For generic drugs, the coinsurance will drop to 93% in 2011, and will continue to be reduced annually until reaching 25% in 2020. For brand name drugs, manufacturers will provide a 50% discount starting in 2011, in addition to federal subsidies that will phase in beginning in 2013.

In addition, the Reconcilliation Act also provides a one-time rebate of $250 for Part D beneficiaries who reach the donut hole in 2010.

Effective January 1, 2013, the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments will be eliminated.

CONCLUSION

Group health plans and health insurers will have to work fast to insure that benefit booklets and Internet sites are updated to comply with the new federal requirements once they are finalized by HHS. In addition, the acceleration of the implementation of HIPAA standard transactions described in the amendments to the Administrative Simplification Act will require a quicker turnaround time for information technology groups. While it appears that the provisions for early retiree reinsurance and small business tax credits will provide some relief to group health plans, the application process and determination of tax credits will be a challenging and time consuming process.

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