HEALTH CARE REFORM:
Compliance Strategies for Employers

Follow Up Panel Discussion

August 17, 2010
Timeline: NOW

- Early retiree reinsurance
- Small business tax credit
- Recognition of taxation of retiree drug subsidy
- Nursing mothers
- High risk pools
- Automatic enrollment ??
Timeline: Plan years beginning on or after September 23, 2010

• Dependent coverage for adult children under the age of 26
• Restrictions on rescission
• Changes to appeals process
• First dollar coverage required for certain evidence based preventative care
Timeline: Plan years beginning on or after September 23, 2010

- Elimination of the pre-existing condition exclusion for children under age 19
- Elimination of lifetime limits related to essential health benefits
- Reasonable annual limits related to essential health benefits
Timeline: Plan years beginning on or after September 23, 2010

- Participants can select primary care provider
- No preauthorization or increased cost-sharing for emergency
- No preauthorization or referral requirement for OB/GYN services
- Nondiscrimination requirements apply to fully insured plans
Timeline: 2011

- Over the counter medications are no longer eligible for reimbursement under a health flexible spending account, health reimbursement arrangement or health savings account
- CLASS ACT: National voluntary employee funded long term care benefit
- Insurance rebates required to the extent that more than 20% of the premium revenue is spent on costs other than benefit claims
Timeline: 2011

- W-2’s issued for 2011 must disclose cost of employer provided health benefits
- Simple Section 125 cafeteria plans are available for companies with less than 100 employees
- Tax on distributions from a health savings account is increased from 10% to 20%
- Adoption assistance limits increased and extended
Timeline: 2012

• 1099 reporting requirements expanded to require a 1099 to be issued to any corporation, other than a tax exempt, for any property or services over $600

• Report health care quality and wellness initiatives to HHS
Timeline: Plan years ending on or after September 30, 2012

- Fee of $2 per average number of enrollees/lives ($1 for policy/plan years ending during fiscal year 2013)
Timeline: 2013

- Additional 0.9% Medicare tax on wages in excess of $250,000 for joint return filers, and $200,000 for others
- 3.8% tax on unearned income for joint filers with modified AGI in excess of $250,000, $200,000 for singles, $120,000 for married filing separately
- Effective January 1, 2013 the maximum amount that can be made available through a health flexible spending account is limited to $2,500, indexed
Timeline: 2013

• Employer notice about state health care exchanges to be established in 2014
• 60-day advanced notice of plan material modifications
Timeline: 2014

- Establishment of state health insurance exchanges for individuals and small businesses with 100 or less employees
- Individual mandate requiring all individuals to have health insurance
- Employer mandate regarding health coverage
Timeline: 2014

- Elimination of pre-existing condition exclusions for all participants
- No annual dollar limits
- Waiting periods cannot exceed 90 days
- No cost sharing in excess of the limits on high deductible health plans
- Limit on wellness incentives is increased from 20% to 30%
- Cover routine costs of patients who are part of clinical trials
Timeline: 2018

• Cadillac plan tax becomes effective
Previously Addressed Guidance

- Small Business Tax Credit
- Early Retiree Reinsurance
- Grandfathered plans
- Dependent coverage for adult children
- Prohibition on lifetime and annual limits
- Preexisting condition exclusion
- Rescissions
- Patient protections
New Guidance

- Internal claims and appeals processes
- Coverage of preventive care
- High risk pools
- Privacy, security and enforcement rules under the HITECH Act
Appeals Procedures

• Interim final regulations issued on July 23 apply to all non-grandfathered plans for plan years beginning on or after September 23, 2010

• Existing claims procedures are expanded and extended to non-ERISA governmental and church plans

• In applying these rules, immediate coordination with a health plan’s third party administrator or insurer is essential
Appeals Procedures

- Eligibility and rescissions are subject to the claims and appeals procedures.
- Urgent care claims response time shortened to 24 hours from 72 hours.
- The hiring, compensation, promotion and termination of the parties involved in the appeals process must be impartial (cannot be based upon the likelihood that the party will support decisions to deny benefits).
Appeals Procedures

- Claimants must be allowed to review the claim file and present evidence.
- A claimant must be provided any new evidence considered and an explanation of any new or additional rationale for a denial sufficiently in advance of a final decision to give the claimant a reasonable opportunity to respond.
Appeals Procedures

• All notices of decision must include the following:
  – Reasons for denial, including the denial code and its corresponding meaning, as well as a description of any plan standard that was used in denying the claim (e.g., medical necessity)
  – A description of internal appeals and external review process
  – The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman
Appeals Procedures

- Except for claims regarding eligibility or rescission, a notice of decision must also include:
  - The date of service, the health care provider and the claim amount
  - The diagnosis code and its corresponding meaning
  - The treatment code and its corresponding meaning
Appeals Procedures

- Government intends to publish model notices
- Notices must be culturally and linguistically appropriate
  - If the lesser of 10% or 500 participants are literate only in the same non-English language, English-language notices must include a prominent notice of the availability of notices in the other language
  - If plan covers fewer than 100 participants, the threshold is 25%
  - Upon request, all future notices along with customer service must be provided in the other language
Appeals Procedures

• Must provide continued coverage pending the outcome of an appeal
  – Open issue: Will this only apply to those already receiving coverage or also to those who were deemed ineligible?

• Strict compliance: Any mistake in meeting these requirements would allow the claimant to proceed to court
Appeals Procedures

- Plans and issuers must comply with either a state external review process or the Federal external review process for adverse benefit determinations.

- State external review processes:
  - For insured health coverage, insurers are generally required to comply with state insurance law mandates on external review.
  - For plan years starting on or after July 1, 2011, compliance with state insurance law on external review will be sufficient only if state insurance law provides equivalent consumer protections as those included in the “NAIC Uniform Model Act”
Appeals Procedures

– If state law complies with the NAIC Model Act, the issuer of the insurance policy—not the plan—would be required to comply

– In limited cases the state external review process may apply to self insured plans (e.g. MEWAs, church plans and nonfederal governmental plans)
Appeals Procedures

– For a state review process to apply it must include the following:
  
  • Review an issuer’s decision based on medical necessity, appropriateness, level of care or effectiveness of a covered benefit
  • Require issuers to provide claimants notice of their right to a written external review of an adverse benefit determination
  • Allow for exceptions to requirement for exhaustion of internal claims and appeals process
  • Provide that an issuer pay the cost of the external review
  • Not impose a minimum dollar limit on claims eligible for external review
### Appeals Procedures

- Allow at least four months to file a request for external review.
- Provide that reviews will be randomly assigned to ensure impartiality and independence of the reviewer.
- Provide that the reviewer not have a conflict of interest.
- Provide for a list of approved reviewers.
- Allow a claimant at least 5 days to submit additional information.
- Provide that the decision of the reviewer is binding on the issuer and the claimant and shall be made within 45 days from receipt of the request for external review.
- Provide for expedited review if the adverse determination concerns an admission, availability of care, continued stay, care following emergency services, or concerns a condition for which the standard time frame would jeopardize the life or health of the claimant.
Appeals Procedures

• Federal external review process
  – Generally applies to insurers, if the state process does not meet the standards above, and to self insured plans
  – Standards will be established that detail the following:
    • How to initiate and determine eligibility for an external review
    • Minimum qualifications for independent review organizations (IROs)
    • Process for approving IROs
    • Process for random assignment of external reviews to approved IROs
    • Requirements for plans to turn over records to IROs
    • Standards for IRO decision making
    • Provision of expedited external review processes
    • Consumer protections for experimental or investigational treatments
    • Notice requirements
Appeals Procedures

• An IRO decision is binding on the plan but the claimant still has the right to bring suit after the external review

• Disputes related to an individual’s eligibility for coverage (e.g., worker classification or employment status) are not subject to external review
Preventive Care

• Effective for plan years beginning on or after September 23, 2010, non-grandfathered plans may not impose any cost-sharing requirements (co-payments, co-insurance or deductibles) on certain in-network recommended preventive health services, including
Preventive Care

– Screening tests or evidence-based items or services currently recommended (with a rating of A or B) by the United States Preventive Services Task Force such as

  • Breast and colon cancer screenings
  • Screenings for vitamin deficiencies during pregnancy
  • Screenings for diabetes, high cholesterol and high blood pressure
  • Tobacco cessation counseling
Preventive Care

– Immunizations for routine use in children, adolescents, and adults currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
Preventive Care

– Preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents including including

• Regular pediatrician visits
• Vision and hearing screening
• Developmental assessments, and
• Screening and counseling to address obesity
Preventive Care

– Preventive care and screenings for women provided for in the comprehensive guidelines currently being developed by the HRSA. These guidelines are expected to be issued by August 1, 2011
Preventive Care

- A complete list of recommended preventive services is available at http://www.healthcare.gov/center/regulations/prevention/recommendations.html

  - The list will be updated periodically but plans will not have to apply the rules to recommended preventive services until the first plan year following the date that is one year from the date the service is added to the list.
Preventive Care

• If a service that was previously recommended as a preventive service is no longer recommended as such, a plan is no longer required to provide the service (subject to other requirements for advance notice to participants), and may impose cost-sharing on the service if it does.

• A plan is not required to provide preventive services if they are delivered by an out-of-network provider. If they are provided on an out-of-network basis, cost-sharing requirements may be imposed.
Preventive Care

• If the preventive service guidelines do not specify the frequency, method, treatment or setting for the service, the plan can use reasonable medical management techniques to determine any coverage limitations.

• If a plan covers preventive services beyond those that are required, the plan can impose cost-sharing requirements on those additional services.
Preventive Care

• Billing for Preventive Care
  – If a recommended preventive service is billed separately from an office visit, the plan may impose cost-sharing requirements with respect to the office visit
  – If a recommended preventive service is not billed separately from an office visit and the primary purpose of the visit is delivery of the preventive service, cost-sharing requirements may not be imposed
  – If a recommended preventive service is not billed separately from an office visit and the primary purpose of the visit is not the delivery of such preventive services, cost-sharing requirements may be imposed
High Risk Pool

• Act requires HHS to set up this temporary high risk insurance program for uninsured individuals with preexisting conditions until 2014
  – Although no preexisting condition exclusion for children starting in plan years that begin on or after September 23, 2010, full preexisting condition exclusion ban and full ban on rate-ups based on health status does not take effect until 2014

• Most states currently have high risk pools in response to HIPAA, but these have low coverage and high premiums
High Risk Pool

• Interim final regulations issued on July 30 set forth standards that entities must use when they submit a proposal to carry a Pre-existing Condition Insurance Plan (PCIP)
High Risk Pool

• Eligibility
  – US citizens or nationals and individuals who are lawfully present in the US
  – Must have had no creditable coverage during the 6-month period prior to the date they apply for PCIP
  – Must reside in the PCIP’s service area
High Risk Pool

– Must have a preexisting condition that can be proven
  • Documented evidence that an insurer refused to issue coverage on a grounds related to the individual’s health
  • Individual offered coverage but with a rider that excludes coverage for a preexisting condition
  • Documented evidence of history of medical condition
  • Other HHS approved criteria
High Risk Pool

• Benefits to be provided
  – Inpatient and outpatient hospital benefits
  – Mental health and substance abuse
  – Professional services for the diagnosis of injury or illness
  – Prescription drugs
  – Preventive care
High Risk Pool

• Cannot impose any preexisting condition exclusion with respect to covered services
  – No denial of coverage, limitation or exclusion of benefits

• Premiums charged under a PCIP
  – May not exceed 100% of the standard individual market rate in the PCIP area
  – May vary by age by a factor not greater than 4 to 1, age band rating to be established
High Risk Pool

- PCIPs must establish procedures for identifying and reporting to HHS instances where insurers or group health plans have discouraged high-risk individuals from remaining enrolled in their current coverage (referred to as “dumping”)
  - Insurer or group health plan will be responsible for expenses of dumped employee
  - “Other enforcement action” – perhaps health status discrimination
HITECH Act Guidance

- Health Information Technology for Economic and Clinical Health Act was part of the American Recovery and Reinvestment Act of 2009
- Recently published proposed rules
- New obligations on business associates
- Additional clarification of some HIPAA provisions
HITECH Act Guidance

• Prior to HITECH Act, business associates were not directly regulated under HIPAA and a violation of a business associate agreement merely led to possible contractual damages.

• Now, with HITECH Act, new privacy and security obligations for business associates, who can be subject to criminal and civil sanctions for violating HIPAA.
HITECH Act Guidance

• Business associate definition expanded to include subcontractors
• Business associates must comply with the HIPAA security rule’s administrative, technical, and physical safeguards and implement security policies and procedures, just like a covered entity
HITECH Act Guidance

• With respect to privacy, business associates mandated to comply with business associate agreement
• No privacy policy necessary
• Business associate agreements may need to be amended
• Sample language will be coming soon
Questions
This presentation is made available by Hill Ward Henderson for educational purposes only to provide you general information and a general understanding of the law, it is not intended to provide nor does it constitute legal advice. The presentation should not be used as a substitute for specific legal advice from a licensed professional attorney. Further, the subject matter contained in this presentation is complex and subject to change. Any tax statements in this material are not intended to suggest the avoidance of U.S. federal, state or local tax penalties.