Health Care Reform: The Law and its Implications

Implications for Insurers and Health Plans

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Overarching Impact

- Opportunities for increased enrollment via subsidies, mandates, exchanges and pools
- Burden of increased underwriting, enrollment/disenrollment and rate regulation
- Potential for greater transparency in competition on service and price in small group and individual market segments
- Death knell for state mandated benefits?
- May disadvantage smaller players if they were using underwriting practices to compete in underserved niches
- Potential for changes in health care delivery

Is your briefcase big enough?
Increased Demand for Health Insurance
Beginning January 1, 2014, most U.S. citizens and legal residents must obtain and maintain “minimum essential” health insurance coverage – such as Medicare, Medicaid, SCHIP, TRICARE for Life, veterans’ programs, eligible employer-sponsored plans, plans sold in State individual health insurance markets, and coverage offered by State high-risk pools.

Individuals must get coverage for themselves and any dependents, or pay a penalty -- greater of $695 per year per family, up to a maximum of three times that amount, or 2.5% of taxable household income.

Penalty phases in over three years.

Religious objectors, individuals not lawfully present in the United States, and prison inmates are exempt.

Also exempt -- people whose lowest cost coverage option exceeds eight percent of household income, individuals with income below the federal income tax filing threshold, members of Indian tribes, individuals who were uninsured for less than three months, and individuals with a hardship waiver from the Secretary.
Reduced cost sharing for qualifying individuals

- Cost-sharing (via., e.g., adjustment out-of-pocket expense limits) are provided to individuals if income exceeds 100%, but is not more than 400%, of the federal poverty line for a family of the size involved.
- The Secretary makes payments to the health plan to cover the value of the difference.
Tax credit for individual enrollees

- Taxpayers enrolled in qualified plan can qualify for a refundable “premium assistance” tax credit if they meet eligibility criteria.
Starting January 1, 2014 large employers (>50) face tax penalties if at least one full-time employee receives a premium tax credit or cost sharing reduction for purchasing health insurance.
Small employer tax credit

- Small employers can qualify for tax credits to subsidize their contributions toward health insurance for their employees.
Market Reforms
Minimum Expense Ratios

- Required medical loss ratio reporting for health insurance issuers (including grandfathered plans).
- Report must include premium amount spent on (1) clinical services, (2) activities to improve quality, and (3) all other non-claims costs.
- NAIC to develop definitions and standardized methodologies for calculating measures.
Beginning 1/1/2011, annual enrollee rebates required by health insurance issuers for:

» Large group plans that spend less than 85% of premium on clinical services and quality

» Small group and individual plans that spend less than 80% of premium on clinical services and quality

States may set higher percentages.
Minimum Expense Ratios (cont’d)

  - Actual MLR Experience and Minimum MLR Standards
  - Uniform Definitions and Calculation Methodologies
  - Level of Aggregation
  - Data Submission and Public Reporting
  - Rebates
Beginning with plan year 2010, HHS and States to establish annual premium increase review process.

» Issuers to submit justification for “unreasonable” premium increase prior to implementation

» Issuers to post this information on website

» Increase can be basis for exclusion from Exchange
Lifetime and Annual Limits

- Lifetime limits on dollar value of essential health benefits are prohibited.
- Until 2014, plans may impose a restricted annual limit on dollar value of “essential health benefits.” Effective 1/1/2014, annual limits on dollar value of such benefits are prohibited.
- Annual or lifetime limits on non-essential health benefits are permitted if allowed under state or federal law.
Prohibition on Rescissions

- Individual and group health issuers may not rescind coverage of enrollee except for:
  - Fraud
  - Intentional misrepresentation
- Prior notice of cancellation required.
- HIPAA exceptions to guaranteed renewability still apply.
Coverage of Preventive Health Services

- Minimum coverage without cost-sharing required for:
  - Preventive services and immunizations recommended by US Preventive Services Task Force and CDC
  - Child preventive services recommended by Health Resources and Services Administration (HRSA)
  - Women’s preventive care and screening recommended by HRSA
Extension of Dependent Coverage

- Plans that offer dependent coverage must continue to make dependent coverage available to dependents until age 26 – regardless of marital status.

- Coverage for dependents of adult dependents is not required.
No Discrimination in Favor of Highly Compensated Individuals

- Subjects insured group health plans to rules governing self-insured plans.
- Insured group health plans cannot establish eligibility rules for any full-time employee that are based on total hourly or annual salary of the employee or otherwise establish rules (including benefits) that discriminate in favor of higher wage employees.
Appeals Process

- Plans required to implement effective internal appeals process for coverage determinations and claims.
  - Follow DOL procedures if applicable
  - Otherwise, following state procedures until HHS establishes process
- Plans required to comply with State external review process.
- If no State external process or plan is self-funded, follow HHS-established process.
- Plans’ existing external process may be adequate.
Patient Protections

- Enrollees allowed to select their PCP, or pediatrician for children, from among any available participating PCP.
- Prior authorization and increased cost-sharing on emergency services prohibited.
- Plans can’t require authorization or referral for OB/GYN services by a participating specialist in these areas.
Temporary High Risk Pool Program

- Within 90 days of enactment, HHS to establish high risk pool program for eligible individuals:
  - US citizen, US national or person lawfully residing in US
  - Has not had creditable coverage during six month period prior to application to program
  - Has preexisting condition
- Program to be run by HHS or contracted non-profit entities.
Grandfathered Plans

- A range of new requirements don’t apply to “grandfathered” plans – plans in which individuals were enrolled on date of law’s enactment in March 2010.
- New family members may be added.
- New employees and their families may be added.
Grandfathered Plans (cont’d)

- Requirements that will be applicable to grandfathered plans
  - Expense ratio caps and rebates
  - Uniform coverage documents
  - Prohibition on excessive waiting periods
  - Prohibition on lifetime limits
  - Prohibition on rescissions
  - Adult child coverage
Additional requirements applicable to group health plans only

- Prohibition on annual limits
- Prohibition on pre-existing condition exclusions
- Adult child coverage but only if dependent is not eligible to enroll under an eligible employer-sponsored health plan (applies to plan years before January 1, 2014)
Focus on Access to Information

- Offices of health insurance consumer assistance or health insurance ombudsman programs.
- Uniform explanation of coverage documents and standardized definitions.
- Plan reporting requirements on benefits and provider reimbursement structures that improve quality.
- Availability of information on health options for individuals and small businesses.
Establishment of permissible rating factors for individual and small group markets:

- Family structure
- Rating area
- Age (limited to 3:1 for adults)
- Tobacco use (limited to 1.5:1)

Limitations also apply to large group issuers offering such coverage through Exchange.
- Guaranteed availability and renewability.
- Prohibition on preexisting condition exclusions and other forms of discrimination based on health status (no pre-ex on kids - effective 9/23/2010).
- Non-discrimination against providers acting within scope of license with respect to plan participation – but not an any willing provider requirement.
Longer Term Market Reforms (cont’d)

- Essential health benefits requirement for issuers in individual and small group markets.
- No group health plan waiting periods greater than 90 days.
- Coverage for participants in approved clinical trials.
- Uniform application of rating reforms.
Finding some dollars to pay for it

- Health insurers will pay an annual fee. Beginning in 2014, this non-deductible fee will be allocated across the industry according to market share of net premiums written. It will only apply to companies whose net premiums written are more than $25 million.

- Beginning in 2013, the employer tax deduction for health benefit expenses is reduced by an amount equal to the employer’s federal subsidy for maintaining its own prescription drug plans for their Medicare Part D eligible retirees.

- Effective for 2010, non-profit Blue Cross and Blue Shield plans and certain other qualifying non-profit plans who want to continue qualifying for a special tax deduction will have to maintain a medical loss ratio of 85 percent.
Exchanges and Other New Insurance Offering Options
**Exchanges**

- Each State must establish by 1/1/2014 an American Health Benefit Exchange that will make insurers’ “qualified health plans” ("QHPs") available to individuals and small groups.
- **Outside the Exchange:**
  - Individuals and employers may purchase non-Exchange health plans, and employers may self-insure.
- A State can have one Exchange for individual coverage and another for a Small Business Health Options Program ("SHOP Exchange") or may merge them.
- An Exchange can be a government agency or a non-profit entity “established by” the State.
- Multi-state Exchanges are permitted.
- Exchanges can charge insurers user fees.
Exchange Functions

- Certify QHPs for participation
- Determine insurer products to include in Exchange offerings
- Provide ratings of plan premiums and quality
- Internet portal for consumers
- Can contract for administrative support, but not with a health insurer or any entity related to an insurer
“Navigators” act essentially as consumer ombudsmen, educating the public, distributing information about QHPs, availability of premium tax credits and cost-sharing reductions, “facilitating” enrollment, providing referrals related to grievances or complaints or questions about health plans or coverage or claim determinations.

“Navigators” can be trade or professional associations, consumer groups, unions, chambers of commerce, insurance agents and brokers, and resource partners of the Small Business Administration, chosen by the Exchange.

Navigators must meet standards and may not be health insurance issuers.
Eligible Individuals

- Any person qualifies for individual Exchange QHP coverage if he or she lives in the State, is not incarcerated (except for those awaiting disposition of charges) and is a citizen or an alien anticipated to be lawfully in the country for the enrollment period.
A small employer with an ERISA group health plan can participate in the Exchange if all full-time employees are eligible for coverage.

“Small group” means an employer that in the previous year averaged 1 or more employees but not more than 100.

» Until 2016, a State can substitute 50 for 100.

A small employer in the Exchange will continue to be treated as small until it leaves the Exchange, even if it becomes larger.
Large Groups

- Large groups may not participate in state Exchanges until 2017.
- Starting in 2017, a State may permit insurers to provide coverage for large employers through the Exchange.
- The law clearly provides that States can “permit” issuers to include large employers in Exchange products in 2017.
  - Other language suggests that if the State does so, an employer electing to buy through the Exchange cannot be denied participation by an insurer.
The Secretary will set minimum standards that Exchanges must use in certifying QHPs for participation. Required standards will be set for:

- marketing;
- network adequacy;
- inclusion of “essential community providers” willing to accept the “generally applicable payment rates” of the plan;
- accreditation;
- quality improvement;
- uniform enrollment forms; and
- standardized benefit presentation format permitting consumer comparisons.
Each QHP must offer a core set of “essential health benefits” set by HHS.

The scope of essential health benefits must equal the scope of benefits provided under a typical employer plan.

Financial incentives will discourage States from requiring Exchange plans to offer additional benefits.

If a State mandates additional benefits, it must provide payment to the enrollee, or to the plan on the individual’s behalf, for the incremental premium cost attributable to the extra mandated benefit.

No impact on state benefit mandates outside Exchange.
Levels of Coverage

- Plans will be offered at bronze, silver, gold and platinum levels, representing 60, 70, 80 and 90% actuarial value of the full covered benefits (i.e., as if there were no cost sharing provisions).
- Employer contributions to HSAs to count in determining actuarial value of a plan.
- If a QHP is offered through the Exchange at any of the four levels, the issuer must also offer it as a separate QHP for individuals under the age of 21.
- Catastrophic plan may also be a QHP, but only for those under age 30 or those who satisfy hardship or prior uninsured status requirements.
- Employer can choose the level of coverage (e.g., bronze, silver, gold or platinum) to support via contribution.
Employer small group plans in Exchange may not have deductibles >$2,000 for individual coverage and >$4,000 for family coverage.

These may be increased by employer contributions under flexible spending plans.

The cap rises by a percentage formula for years after 2014 and is then rounded up to the nearest $50 increment.
Massachusetts Exchange – Visiting the “Connector”

You need health insurance. The state’s Health Connector can help.

We’re your connection to good health, Massachusetts!
The Health Connector is an independent state agency that helps you find the right health insurance plan.

Commonwealth Choice offers many options from brand-name health insurance plans. They all carry our Seal of Approval for quality and value.

Commonwealth Care is low or no-cost health insurance for people who qualify.
Avoid tax penalties. Find out what’s available to you.

Glad to be insured

“I was young, healthy. I always thought that I was invincible. It never even crossed my mind that I could get hurt,” Andrew Herlihy, Malden.
Hear Andrew’s story and more...

Already a Commonwealth Care member?
- Register for access to your account
- Log in to choose a health plan and view account information
- Do you have a question?
  - 1099 HC Information
Find Insurance

LOOKING FOR HEALTH INSURANCE?

You have options.
The Health Connector works with insurance carriers to offer the health coverage that you need. We also work to put that health coverage within your reach.
The way you look at health insurance depends on who you are and what you need.
We can help. Let's begin.

Individuals & Families
Looking for health insurance without an employer's help.

Young Adults
Young Adults (18-26 year olds), click here to get insured.

Employees
Offered a Health Connector plan through an employer.

Employers
Offer health benefits and tax savings to employees.

Brokers
Help employers offer health benefits.
Find Insurance: *Individuals & Families*

**FIND INSURANCE TODAY**
We can help you find health insurance that is a good value. Explore the choices. Find the plan that is right for you.
Use the box at right to get started.

**EXEMPTIONS FROM THE MANDATE**
Don’t think that you can afford health insurance? Learn if you might be exempt from the Health Care Reform law’s penalties.
More on exemptions...

**RENEWING YOUR COMMONWEALTH CHOICE PLAN?**
Want to change your plan during your open enrollment or renewal period? Call 1-866-638-4654. The TTY line for hearing or speech-impaired callers is 1-888-213-8163.

**DID YOUR EMPLOYER SEND YOU?**
Use your employer ID number to shop for a Commonwealth Choice plan.
Go to “for employees” area

**SELF EMPLOYED?**
Commonwealth Choice could be a good option for you. But if you’re trying to qualify for Commonwealth Care, income standards are based on total business income, as reported on your federal tax return.
Contact us
Choose the type of plans that will meet your needs.

**Bronze**
- Lower monthly cost
- Higher costs when you receive medical services

Who chooses Bronze plans?
See Bronze Plans

**Silver**
- Monthly cost can run higher than Bronze
- Lower costs when you receive medical services compared to Bronze

Who chooses Silver plans?
See Silver Plans

**Gold**
- Highest monthly cost
- Lowest costs when you receive medical services

Who chooses Gold plans?
See Gold Plans
**Browse Plans: 7 Benefits Packages** *(What's a benefits package)? [42 plans]*

You've Selected:
- Benefits Package
  - Bronze
  - Silver
  - Gold

Narrow Your Plans by:
- Monthly Cost
  - $301 - $400 (0)
  - $401 - $500 (0)
  - $501 - $600 (0)
  - $601 - $700 (0)
  - $701 - $800 (0)
  - $801 - $900 (3)
  - Greater than $900 (39)
- Annual Deductible
  - None (12)
  - $250 - $500 (6)
  - $500 - $1,000 (6)
  - $1,000 - $2,000 (6)
  - $2,000 - $4,000 (12)
- Insurance Carrier
  - Blue Cross Blue Shield of Massachusetts (7)
  - CeltCare (7)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

### Bronze Low Benefits Package
- Monthly Cost: as low as $818
- Annual Deductible: $2,000 (ind.), $4,000 (fam.)
- Annual Out of Pocket Max.: $6,000 (ind.), $10,000 (fam.)
- Doctor Visit: annual deductible, then $25 copay
- Generic Rx: annual deductible, then $15 copay
- Emergency Room: annual deductible, then $100 copay
- Hospital Stay: annual deductible, then $200 copay

### Bronze Medium Benefits Package
- Monthly Cost: as low as $883
- Annual Deductible: $2,000 (ind.), $4,000 (fam.)
- Annual Out of Pocket Max.: $5,000 (ind.), $10,000 (fam.)
- Doctor Visit: $30 copay
- Generic Rx: $10 copay
- Emergency Room: annual deductible, then $150 copay
- Hospital Stay: annual deductible, then $500 copay

### Bronze High Benefits Package
- Monthly Cost: as low as $949
- Annual Deductible: $250 (ind.), $500 (fam.)
- Annual Out of Pocket Max.: $6,000 (ind.), $10,000 (fam.)
- Doctor Visit: $25 copay
- Generic Rx: $15 copay
- Emergency Room: annual deductible, then $150 copay
- Hospital Stay: annual deductible, then $500 copay

### Silver Low Benefits Package
- Monthly Cost: as low as $1,073
- Annual Deductible: $1,000 (ind.), $2,000 (fam.)
- Annual Out of Pocket Max.: $2,000 (ind.), $4,000 (fam.)
- Doctor Visit: $20 copay
- Generic Rx: $15 copay
- Emergency Room: annual deductible, then $100 copay
- Hospital Stay: annual deductible, then $350 copay

### Silver Medium Benefits Package
- Monthly Cost: as low as $1,138
- Annual Deductible: $1,000 (ind.), $2,000 (fam.)
- Annual Out of Pocket Max.: $2,000 (ind.), $4,000 (fam.)
- Doctor Visit: $20 copay
- Generic Rx: $15 copay
- Emergency Room: $100 copay
- Hospital Stay: $500 copay

### Silver High Benefits Package
- Monthly Cost: as low as $1,229
- Annual Deductible: None
- Annual Out of Pocket Max.: $2,000 (ind.), $4,000 (fam.)
- Doctor Visit: $25 copay
- Generic Rx: $15 copay
- Emergency Room: annual deductible, then $100 copay
- Hospital Stay: annual deductible, then $500 copay

### Standard Benefits for All Bronze Low Plans

### Standard Benefits for All Bronze Medium Plans

### Standard Benefits for All Bronze High Plans

### Standard Benefits for All Silver Low Plans

### Standard Benefits for All Silver Medium Plans

### Standard Benefits for All Silver High Plans

### Standard Benefits for All Gold Plans
Exchange coverage insurers must agree to charge the same premium for each QHP it issues, whether it is offered through an Exchange, directly from the issuer or through an agent. The Act does not provide further detail on this requirement of uniform pricing both within and outside the Exchange.

- **Same community rating type rules apply in Exchange and out.**
- **Insurers can vary rates within state by “rating area.”**
- **There are specific risk pooling requirements for QHP issuers.**
  - All individual enrollees (except in grandfathered plans), including those who do not enroll through the Exchange, are members of a single risk pool.
  - All small group enrollees in a State are also to be considered a single risk pool (excluding grandfathered plan enrollment).
  - A State may require these individual and small group pools to be combined.
**“Medical Home” Plans**

- QHPs can provide coverage through a “qualified direct primary care medical home plan” that meets regulatory criteria if the medical home plan services are coordinated with the entity offering the QHP.
- “Medical home” model of care is “coordinated and integrated care” that includes:
  - personal physicians for individual enrollee;
  - evidence-informed medicine;
  - use of health information technology;
  - continuous quality improvements;
  - expanded access to care; and
  - payment that recognizes added value from additional components of patient-centered care.
CO-OPs

- Up to $6 billion in loan and grant money by 7/1/2013 to seed new non-profit “Consumer Operated and Oriented Plans” (“CO–OPs”) to offer QHPs to individuals and small groups.
- HHS to ensure that there is enough funding to establish at least one new CO-OP in each State.
  - HHS to give priority to funding CO-OPs that will offer QHPs on a state-wide basis, will utilize integrated care models, and have significant “private support”.
- CO-OP cannot be an entity that is already an insurer or that is affiliated with an entity already an insurer as of July 2009.
- CO-OP must be governed by its members, and governing documents must protect against insurance industry involvement and interference.
- CO-OPs may form a private purchasing council to do collective purchasing, such as for claims administration, administrative services, and health information technology.
States can establish a “basic health program” outside the Exchange, that offers a “standard health plan” with essential health benefits for individuals who qualify based on income.

Basic health program can provide benefits directly or through contract with the following:

- Licensed HMOs or insurance issuers;
- “Network[s] of health care providers established to offer services under the program” can contract with the state to provide the “standard health plan”
States may create “health care choice compacts.”

QHP could be offered in the individual market in each of the States, but will largely be subject to the laws only of the State which the plan was written or issued” (i.e., not where it was delivered).

Each participating State’s laws would continue to apply in the areas of market conduct, unfair trade practices, network adequacy and consumer protection standards.

Issuers would either have to be licensed in each participating State or submit to the jurisdiction of each State for permitted regulation.
Federal Multi-State Plan Contracts

- Office of Personnel Management ("OPM") to contract with health insurance issuers to offer two multi-state QHPs to be available through each Exchange.
  - "Issuer" may be group of issuers affiliated by common control or common use of national licensed service mark.
  - At least one of the contracts must be with a non-profit entity.
- Federal government will negotiate premiums, profit margin and medical loss ratio.
  - Contracting process modeled after FEHBP practice for experience rated carriers
- Approved multi-state QHPs are deemed certified for Exchange participation.
- By its fourth year, multi-state QHP must cover whole country.
By January 1, 2014, each State should establish or contract with reinsurance entities for a program under which health insurers, and TPAs “on behalf of group health plans,” must make payments, except for plans that have a “grandfather” exception.

Collected premiums paid out as risk adjustments to participating health insurance issuers that cover “high risk individuals” in the individual market.

Contributions will proportionally reflect issuer’s fully insured commercial book of business for major medical products and the total value of fees charged by the issuer and the costs of coverage administered by the issuer as a TPA.

Additional amounts may be assessed to fund the reinsurance entity’s administrative expenses.
Risk Corridors for Exchange Plans

- HHS will set up risk corridors for 2014-2016 for QHPs in the individual or small group market based on ratio of “allowable costs” to the plan’s aggregate premium.
- If costs are more than 103%, but not more than 108%, of a “target amount”:
  » HHS will pay the plan 50% of the excess in costs over 103% of the target.
- If costs are more than 108% of the target:
  » HHS will pay the plan 2.5% of the target, plus 80% of the costs exceeding 108% of the target.
- If costs are less than 97%, but not less than 92%, of target:
  » plan will pay HHS 50% of the excess of 97% of the target over the costs.
- If costs are less than 92% of the target:
  » plan will pay HHS 2.5% of the target amount, plus 80% of the excess of 92% of the target over the costs.
Each State will assess a charge on “low actuarial risk plans” – group health plans and health insurance issuers where the actuarial risk of their enrollees is less than the average actuarial risk for all enrollees in plans or coverage in the State that are not self-insured group health plans.

The State will make a corresponding payment to “high actuarial risk plans” whose enrollments’ actuarial risk is higher than the average.

Risk adjustment program applies to health plans and issuers providing coverage in the individual or small group market in a state.

The risk adjustment provisions do not apply to “grandfathered health plans” or the issuers of such plans.
Coverage by private health insurance issuers is exempt from a broad range of federal and state laws if a QHP under the CO-OP or a new Exchange multi-state QHP is not subject to the same law, including:

- licensure;
- rating, solvency and other financial requirements;
- guaranteed renewal, non-discrimination and preexisting conditions;
- quality improvement and reporting;
- fraud and abuse;
- market conduct;
- prompt payment;
- appeals and grievances;
- privacy and confidentiality; and
- benefit plan materials or information.
Medicare Advantage and Part D
Changes to the Medicare Advantage and Part D programs may make participation less attractive to plans

» Increased obligations/government scrutiny/penalties under PPACA and April 15th final rule
» PPACA froze MA payments for 2011 and implements new blended benchmark payment methodology

Plans still dealing with MIPPA implementation

» E.g., MIPPA’s network requirements for PFFS plans are effective for 2011 plan year
PPACA’s Changes to Medicare Advantage

- Froze 2011 payments at 2010 levels
- Created blended benchmark payment methodology starting in 2012 that includes bonus adjustments based on quality ratings
- Changed beneficiary rebate requirements
- Established minimum medical loss ratio
MA Payment Changes

- PPACA froze 2011 MA payment rates at 2010 levels
  » However, for 2011, CMS will apply a 3.41% reduction to each Part C beneficiary’s risk score
  » Risk score reduction unrelated to PPACA
Beginning in 2012, MA benchmark based on ½ of the “applicable amount” and ½ of “base payment amount” multiplied by “applicable percentage”

» Applicable amount = amount for the area for previous year increased by national per capita MA growth percentage

» Base payment amount = 100% of fee-for-service costs for 2012. For subsequent years, calculated by increasing previous year’s base amount and increasing it by national per capita MA growth percentage taking into account phase out of IME
Applicable percentage =

» 95% for MA plans in highest quartile ranking of payments for previous year;
» 100% for MA plans in second highest quartile ranking of payments for previous year;
» 107.5% for MA plans in third highest quartile ranking of payments for previous year; and
» 115% for MA plans in fourth highest quartile ranking of payments for previous year.
- Applicable percentage increase for quality care
  » Applicable percentage will be increased by 1.5% in 2012, 3% in 2013, and 5% in 2014, for MA plans that in 2012 have a quality rating of 4 stars or higher
- Low enrollment and new MA plans also eligible for quality increase
- Quality rating based on 5 star system
  » Rating based on data collected by CMS
  » Failure to report data will result in fewer than 3.5 stars rating
Enrollee Rebates

- Phase-in of the new rebate percentages starts in plan year 2012

- Rebate is sum of product of “old phase-in proportion” and 75%, and product of “new phase-in proportion” for the year and the final applicable percentage rebate
Enrollee Rebates (cont’d)

- For 2012
  - Old phase-in proportion is 2/3
  - New phase-in proportion is 1/3
- For 2013
  - Old phase-in proportion is 1/3
  - New phase-in proportion is 2/3
- For 2014 and after
  - Phase phase-in proportion is 0
  - New phase-in proportion is 1
- Final applicable rebate percentages
  - 70% for MA plan with at least 4.5 stars
  - 65% for MA plan with at least 3.5 and less than 4.5 stars
  - 50% for MA plan with less than 3.5 stars
Limitations on Cost-Sharing

- For plan years beginning on or after January 1, 2011, cost-sharing under MA plans may not exceed Part A and Part B cost-sharing amounts for:
  - chemotherapy administration services
  - renal dialysis services
  - skilled nursing care
  - such other services that CMS determines appropriate
Minimum Medical Loss Ratio

- Effective in 2014, MA plans must have a medical loss ratio (MLR) of at least 85%
- MA plans that fail to satisfy minimum MLR requirement will be required to remit to CMS an amount equal to the plan’s total revenue for the applicable contract year and the difference between 85% MLR and the plan’s actual MLR
- Plans that fail to meet the minimum MLR for three consecutive years will be prohibited from enrolling new beneficiaries for the second succeeding contract year
- The Secretary is required to terminate the MA contracts of plans that fail to meet the minimum MLR for five consecutive years
Change in MA and Part D Election Periods

- **PPACA changed annual, coordinated election period for MA and Part D starting for 2012 to October 15 through December 7**
- **PPACA eliminated the MA open enrollment period**
  - Starting in 2011, MA plan enrollees can choose during the first 45 days of the year to disenroll from their MA plan and return to traditional Medicare
  - Such enrollees may also elect to enroll in standalone PDP
PPACA Changes to Part D

- Eventual closing of donut hole/coverage gap
  - $250 rebate in 2010
  - Manufacturer discounts
  - Phase down of cost sharing requirements
- Created Medicare coverage gap discount program
- Voluntary *de minimis* policy for LIS eligibles
- Increased authority of CMS to establish formulary requirements
- Improved PDP and MA-PD complaint system
- Uniform exceptions and appeals process
Risk Adjustment Data Validation (RADV)

- Before rule, no process for appealing overpayments resulting from CMS’ risk adjustment data validation activities referenced in §422.310(e)

- Proposed Rule [74 FR 54634 (Oct. 22, 2009)] - New 42 C.F.R. §422.311
  - Process for submitting provider attestations for outpatient medical records with missing or illegible signature and/or credentials
  - Process for disputing errors arising from operational processing of medical records
  - Process for contract-level RADV payment error calculations
  - Added RADV audit and appeal-related definitions to 42 C.F.R. §422.2

- Final Rule
  - Finalized proposals
  - Added process for disputing medical record review determinations
  - Effective beginning contract year January 1, 2011
Significant revisions to 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

- CMS concerned about “paper” compliance programs
- Provide the “minimum” amount of information CMS expects to see in an “effective” compliance program
- Not intended to be “prescriptive” as to choice of processes or procedures
- Effective June 7, 2010
(vi) Adopt and implement an effective compliance plan program, which must include measures that prevent, detect, and correct noncompliance with CMS’ program requirements as well as measures to that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum shall, include the following core requirements:
(A) Written policies, procedures, and standards of conduct that—

1. Articulate the organization's commitment to comply with all applicable Federal and State standards.

2. Describe compliance expectations as embodied in the standards of conduct.

3. Implement the operation of the compliance program.

4. Provide guidance to employees and others on dealing with potential compliance issues.

5. Identify how to communicate compliance issues to appropriate compliance personnel.

6. Describe how potential compliance issues are investigated and resolved by the organization; and

7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
(B) The designation of a compliance officer and compliance committee that report directly and are accountable to the organization’s chief executive or other senior management.

(1) The compliance officer, vested with the day-to-day operations of the compliance program, must be an employee of the MA organization, parent organization or corporate affiliate. The compliance officer may not be an employee of the MA organization’s first tier, downstream or related entity.

(2) The compliance officer and the compliance committee must periodically report directly to the governing body of the MA organization on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

(3) The governing body of the MA organization must be knowledgeable about the content and operation of the compliance program and must exercise reasonable oversight with respect to the implementation and effectiveness of the compliance programs.
MA Organizations

(C) (1) Each **MA organization must establish and implement effective** training and education between the compliance officer and [the MA] organization[’s] employees, the **MA organization’s chief executive or other senior administrator**, managers and [directors] governing body members, and the MA organization’s first tier, downstream, and related entities. **Such training and education must occur at a minimum annually and must be made a part of the orientation for a new employee, new first tier, downstream and related entities, and new appointment to a chief executive, manager, or governing body member.**

(2) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.
Part D Plans

(C)(1) Each Part D plan must establish, implement and provide effective training and education [between the compliance officer and the Part D plan sponsor’s] for its employees including, the chief executive [managers], and [directors] senior administrators or managers; governing body members; and [the Part D plan sponsor’s] first tier, downstream, and related entities.

(2) The training and education must occur at least annually and be a part of the orientation for new employees including, the chief executive and senior administrators or managers; governing body members; and first tier, downstream, and related entities.

(3) First tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.
(D) Establishment **and implementation of effective** lines of communication, **ensuring confidentiality**, between the compliance officer, members of the compliance committee, the MA organization's employees, managers and [directors] **governing body**, and the MA organization’s first tier, downstream, and related entities. **Such lines of communication must be accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified.**
(E) [Enforcement of standards through well-publicized disciplinary guidelines standards through implementation of procedures which encourage good faith participation in the compliance program by all affected individuals. These standards must include policies that —

1. Articulate expectations for reporting compliance issues and assist in their resolution;
2. Identify non-compliance or unethical behavior; and
3. Provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined.
MA Organizations

(F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include [Procedures for] internal monitoring and audits[ing] and, as appropriate, external audits, to evaluate the MA organization, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

Part D Plans

(F) [Procedures for] Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits[ing.] and, as appropriate, external audits, to evaluate the Part D plan sponsors, including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.
(G) Establishment and implementation of procedures and a system for ensuring promptly [response to detected offenses and development of corrective action initiatives relating to the organization’s MA contract] responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

MA Organizations

(7) Not have terminated a contract by mutual consent under which, as a condition of the consent, the MA organization agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per § 422.508(c) of this subpart.

Part D Plans

(6) Not have terminated a contract by mutual consent under which, as a condition of the consent, the Part D plan sponsor agreed that it was not eligible to apply for new contracts or service area expansions for a period of 2 years per § 423.508(e) of this subpart.
Implementation Issues

» Timing and cost

» MA Organizations should become familiar with Chapter 9 of Prescription Drug Benefit Manual

» Waiting on sub-regulatory guidance from CMS on training of first tier, downstream, and related entities (how to provide, content)