Navigating Health Care Reform

Provider Education and Resources

Univera Healthcare and Univera Community Health are dedicated to working with you to improve the health and well-being of patients. Together, we have the opportunity to shape our health care system and ensure high-quality care today and for future generations.

This guide is designed to provide general background information and resources to help your office or facility navigate health care reform.

The information provided in this guide is not intended to advise you on how to comply with any provisions of the referenced legislation or related legislation or regulations, nor is it otherwise intended to impart any legal advice.
As you read through this guide, there may be terms that are unfamiliar. To assist, a glossary is included in the back of this guide.

**Health Care Reform at a Glance**

On March 23, 2010, the Affordable Care Act, or as it was originally called the Patient Protection and Affordable Care Act (PPACA), was signed into law. The various federal requirements under this law are commonly referred to as health care reform.

*Health care reform:*

- Focuses on coverage expansion and insurance market reform
- Maintains the employer-based system
- Changes the purchasing model for individuals and small groups
- Causes financial implications for individuals, employers, providers and insurers

**Individuals & Families**

**Mandatory Coverage**

Under the individual mandate, most U.S. citizens and legal residents will be required to have health insurance coverage in 2014. The penalty for individuals without coverage will either be a flat dollar amount per person or a percentage of a household’s taxable income, whichever is greater.

**Exchange for Health Insurance**

An exchange is a marketplace where individuals and small employers will be able to research, compare and shop for health insurance coverage. Exchanges must be set up by October 1, 2013, for policies that will go into effect on January 1, 2014. The exchanges will also direct people to Medicaid, the government health insurance program for the poor, if they're eligible.

New York state is developing the “New York state Health Exchange,” and we are working closely with the state to prepare. The initial open enrollment period for the health care exchange is slated for October 1, 2013, through
March 31, 2014. After the initial enrollment period, coverage may be purchased annually between October 15 and December 7.

**Assistance Available on Exchanges**

The government will provide assistance to moderate and low-income individuals who purchase coverage through the exchange. Many individuals who are not currently eligible for Family Health Plus, Child Health Plus and Medicaid Managed Care will be eligible for a tax credit to offset the cost of purchasing health insurance. The tax credit is based on annual household income.

In addition, individuals who do not have employer-sponsored health insurance may be eligible to receive a tax credit if they purchase coverage on the exchange. To qualify for the tax credit, an individual must be enrolled in a health plan offered through the exchange and have a household income no greater than four times the federal poverty level for his/her family size.

**Specific Requirements for Exchange Products**

**All plans must cover essential health benefits**

Essential health benefits are core service categories established by the U.S. Department of Health and Human Services, including:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services
- Prescription drugs
- Rehabilitative and habilitative care
- Laboratory services
- Preventive and wellness service and chronic disease management
- Pediatric services, including oral and vision care

**Insurers may offer up to four coverage tiers:**

- New York state requires insurers that participate in the exchange to offer platinum, gold, silver and bronze plans. The various levels of coverage are defined according to their “actuarial value” — that is, the amount that the plan would pay for covered benefits as compared to the amount that the member would pay out of pocket for the benefits covered by the plan. The bronze, silver, gold and platinum level plans would cover 60, 70, 80 or 90 percent of costs, respectively.

- Plans may offer catastrophic coverage that doesn’t meet one of the four levels of coverage, but only to individuals younger than age 30 who are unable to obtain affordable coverage from an employer, or to individuals who would otherwise be exempt from the requirement to purchase coverage because the premium exceeds 9.5 percent of their income. Catastrophic plans offer less coverage, but at a lower premium. Preventive services and coverage for three primary care provider visits are exempt from the deductible.

For official New York Health Benefit Exchange information and resources, visit: [www.healthbenefitexchange.ny.gov](http://www.healthbenefitexchange.ny.gov)
**Coverage Up to Age 26**

Health plans are now required to provide dependent coverage for young adults up to age 26. By allowing children to stay on their parents’ plan, it makes it easier and more affordable for young adults to get coverage.

Adult children can join or remain on their parent’s plan whether or not they are:
- Married;
- Living with their parent(s);
- In school;
- Financially dependent on their parent(s);
- Eligible to enroll in their employer’s plan, with one temporary exception. Until 2014, grandfathered group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for employer-sponsored group coverage outside of their parents’ plan. Note: Information on grandfathered plans is provided later in this guide.

Products excluded from this policy include:
- Medicaid
- Family Health Plus
- Child Health Plus
- Medicare Supplemental products
- Medicare Advantage products
- Stand-alone dental and vision products

**Grandfathered Plans**

According to health care reform regulations, a group health plan that existed on March 23, 2010, is a grandfathered plan. New employees (whether newly hired or newly enrolled) and new family members may be added to that plan without the loss of grandfathered status.

The biggest difference between grandfathered and non-grandfathered plans is that grandfathered plans are not required to make certain benefit changes. However, to maintain grandfathered status, they must follow specific guidelines.

Grandfathered plans are exempt from:
- Cost-sharing requirements for preventive care;
- Nondiscrimination testing of insured plans;
- Establishing a pediatrician as a PCP;
- Referrals for OB/GYN services;

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**What does HCR mean for your office or facility?**

*Many individuals who have not had health care coverage in the past will now have insurance and will begin accessing care. Your office or facility will likely see an increase in the number of patients it treats.*

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**Is your patient’s plan grandfathered?**

*Remember the importance of checking benefits and eligibility prior to rendering services. If a patient’s plan is grandfathered, he/she may not have full coverage for mandated benefits. You must access our website or call service to verify benefits and eligibility.*
Internal appeals and, for self-funded groups, an external review procedure

Obtaining preauthorization for emergency services, which will be treated as in-network benefits

Coverage for Preventive Services

Preventive services such as mammograms and colonoscopies help prevent and detect diseases early. This benefit ensures that preventive services, such as screening tests and immunizations, are provided without a cost-share when received in-network.

All plans that are not grandfathered are required to provide this benefit.

Univera Healthcare offers a Preventive Services Grid for providers to access via the health care reform section of our website: https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/

Click on the “Provider” tab to access.

The Preventive Services Grid outlines the mandated preventive services and indicates codes for which modifier 33 or modifier PT is required. As explained above, copayments, coinsurances or deductibles required under the member’s benefit plan are not applicable for these services. However, if the preventive care is provided during an office visit, cost-sharing may apply if: either the preventive care is not the primary purpose of the office visit, or the preventive service is billed with other services that require copayment.

Women’s Preventive Services

Univera Healthcare implemented Women's Preventive Services at $0 member cost-share for in-network providers on August 1, 2012.

It’s important to note that some employer groups are exempt from the mandate due to a grandfather clause in their plan, and certain religious employers and group plans are exempt from the requirement to cover contraceptive services in full.

Additionally, there is a safe harbor transition period to accommodate certain employers that are not exempt religious employers, but that object to providing coverage for contraceptive services for religious reasons.

Employers falling within the safe harbor have an extended time frame to comply with the contraceptive coverage requirements.

To learn more, visit: http://www.hhs.gov/news/press/2011pres/08/20110801b.html

Prior to rendering services, please check your patient’s benefits and verify eligibility...

It’s important to verify benefits and eligibility when delivering any preventive services included in the mandate - not all Univera Healthcare plans have preventive benefits.

You can verify this information by accessing our website, or by calling Customer Service.
Women’s Preventive Services Summary of Changes

- **Gestational Diabetes Screening**: Screening is already covered under most benefit plans; however, all laboratory services are now also covered-in-full.

- **Human Papillomavirus Testing**: (usually done as part of covered Pap smear) All associated laboratory services are covered-in-full.

- **HIV Counseling and Testing**: Expands current mandate by requiring coverage of annual HIV counseling and testing for all sexually active women. Laboratory services associated with the screening are covered at no member cost-share.

- **Contraceptive Methods and Counseling**: Sterilization procedures, Food and Drug Administration-approved over-the-counter contraceptive methods and generic contraceptive drugs for all women with reproductive capacity will be covered-in-full regardless of whether a prescription drug benefit exists under the member’s policy (Note: Only generic contraceptive drugs are covered-in-full. Brand-name contraceptive drugs will continue to require a copay/coinsurance).

- **Breastfeeding Support, Supplies and Counseling**: Comprehensive lactation support and counseling during pregnancy and/or postpartum, including the cost of breastfeeding equipment, is covered-in-full for as long as the woman is breastfeeding.

- **Domestic Violence Screening and Counseling**: All screening and counseling related to domestic violence is covered-in-full.

Our Preventive Services Grid, which includes Women’s Preventive Services, can be accessed via our website at: https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/

**Claims and Appeals**

The rules for internal claims, initial requests for services, appeals and external review processes for group health plans and insurance coverage have changed. This change became effective for new plans and plan renewals on or after September 23, 2010.

All commercial non-grandfathered insured products, including group, direct pay and Healthy NY, are affected. Self-funded groups and product offerings are affected by this provision.

This does not apply to the following products: Child Health Plus, Medicaid, Family Health Plus, Medicare Advantage, Medicare Supplement Insurance, group and individual grandfathered policies.

Univera Healthcare revised its internal claims, utilization review and appeals processes, including denial notices, in support of these changes. The changes are summarized as follows:
Adverse Determination Notifications, Explanation of Benefits (EOBs), Grievance Letters and Appeals Letters: Notices will contain additional information including: rationale used in the determination, instructions outlining how to obtain additional information about denial and treatment codes and explanation of these codes, and health insurance consumer assistance contact information to assist with the appeals process.

Non-English Language Availability: Individual and Group Plans: Notices related to adverse determinations, explanation of benefits, grievance and appeals letters will be provided in a language other than English when at least 10 percent of the residents in the county where a claimant resides are only literate in the same non-English language. If the above thresholds of non-English speakers are met, notices will be offered in that non-English language, upon request. Additionally, customer service through our call center is available in non-English languages.

External Appeals:
- **Insured Groups:** These plans will continue to use the New York state external appeal process.
- **Self-Funded Groups:** These plans must implement their own external appeal process that complies with federal requirements. Self-funded groups will not be allowed to use the New York state external appeal process.

Time frames:
- **Urgent Appeal:** The time frame for determining urgent appeals remains at 72 hours.
- **External Appeal with NYS** (if not satisfied with final adverse determination): The time frame to file an external appeal with New York state, after the issuance of a final adverse determination on internal appeal, is four months.

Expansion of Medicaid
As of January 1, 2014, Medicaid will expand to include non-elderly, non-pregnant individuals who are at or below 133 percent of the federal poverty level based on household income.

**More Medicaid Patients**
Your office will likely see an influx of patients — it is anticipated that 16 million people will be added to Medicaid in the coming years.

Elimination of Annual and Lifetime Limits
Health care reform prohibits imposing annual limits on essential health benefits and any lifetime or annual dollar limits. The services covered under a plan do not change, but any service designated as essential no longer has an annual and/or lifetime dollar limit.

Policy Cancellation (rescissions)
The rules for rescissions and retroactive terminations for group health plans and insurance coverage have changed. This change ensures that health insurance coverage can only be retroactively cancelled due to fraud, an intentional misrepresentation of material facts or failure to pay the premium.
Products that are included or excluded from rescissions:

**Included Products:**
- Group health plans, including HMOs
- Healthy NY – group product
- Medicare Complimentary

* Grandfathered or non-grandfathered, insured or self-insured

**Excluded Products:**
- Health Insurance Portability and Accountability-exceptioned benefits, such as:
  - Dental only
  - Vision only
  - Medicare Advantage
  - Medicare Supplement Insurance

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**Employers**

The employer responsibility provisions of health care reform require employers to provide group health coverage to their employees, either directly or through subsidized employer-sponsored coverage. While most of the employer mandates affect only “large” employers, all group health plan sponsors will be impacted to some degree.

**Small Employer “SHOP” Opens in 2013**

Small employer groups (fewer than 50 employees) are able to purchase coverage from the SHOP Exchange beginning October 1, 2013, for a January 1, 2014, effective date. If they obtain coverage from the SHOP, they are eligible for a tax credit of up to 50 percent of the premiums paid for their employees.

To qualify for the tax credit, small groups must meet certain requirements including: employing fewer than 25 employees, providing an average salary of less than $50,000, and offering at least 50 percent employer contribution to premium.

Penalties do not apply to groups with fewer than 50 employees, according to the new health care reform formula released December 28, 2012. The formula only determines if the group is subject to employer penalties, not the type of coverage the group is purchasing.

Tax credits for these small employers will end in 2016.

**Small Groups Must Meet Essential Health Benefits On and Off the Exchange**

- New York state announced that the Oxford Small Group EPO will be used as the model
- Small group packages will need to be modified to meet the new standards
- Large groups are not required to offer essential health benefits, but if they offer the benefit, they must meet the same standard as the Oxford plan
- For details, visit: [http://www.healthcarereform.ny.gov/health_insurance_exchange/](http://www.healthcarereform.ny.gov/health_insurance_exchange/)
Large Employers

A large employer is one that, during the prior year, had an average of 50 or more full-time employees (performing, on average, at least 30 hours of service per week), as determined on a controlled group basis.

Solely for purposes of determining “large” employer status, full-time equivalents must be included in the number of full-time employees. Full-time equivalents are calculated by adding the total hours worked in a month by employees, other than full-time employees, and dividing by 120. Seasonal workers may be excluded under certain circumstances.

Penalty for Not Offering Health Coverage

Large employers that do not offer any health coverage to their full-time employees are subject to a monthly penalty if any full-time employee enrolls in an insurance plan offered through the exchange and qualifies for taxpayer-subsidized coverage for the month. The amount of the monthly penalty is $2,000 divided by 12, multiplied by the number of full-time employees employed during the applicable month, not counting the first 30 full-time employees. Only full-time employees (not full-time equivalents) are counted for purposes of the penalty.

Notice to Employees

In 2013, all employers (not just large employers) must notify existing and new employees of:

(a) Their right to purchase insurance through the exchange,

(b) Their potential eligibility for a premium tax credit and a cost-sharing reduction if the employer covers less than 60 percent of the allowed costs under the plan and the employee elects to purchase insurance through the exchange, and

(c) Their potential loss of the employer contribution if coverage is purchased through the exchange (unless the employee receives a free choice voucher).

Employers are prohibited from discharging or discriminating against employees who receive taxpayer-subsidized coverage.

The initial regulation stated a compliance date of March 1, 2013; however, the date has been delayed by HHS, and a notification is pending for the new compliance date.

Flexible Spending Accounts

For plan years effective on or after January 1, 2013, the maximum allowable salary reduction contribution to a cafeteria plan (Section 125 plan) flexible spending account will be $2,500.
Market Implications

Premium Rate Reviews and Reporting

Health care reform establishes a regulatory process for federal and state governments to review increases in medical plan premiums. Health plans are now required to report the proportion of premium dollars spent on clinical services, quality and other costs annually.

Federal standards, as they apply to New York state insurance customers, set the minimum level of benefits to be 82 percent of premium revenues in the small group market and 85 percent for large groups. This benefit-to-premium target is referred to as a medical loss ratio.

For example, in 2011, Univera Healthcare spent 90.9 percent of premium revenues on medical benefits for small and large groups. This means that $255 million more was spent on hospital and physician services, prescriptions and other medical benefits than federal and state standards required in 2011 under the provisions of the federal Patient Protection and Affordable Care Act. As such, Univera Healthcare was not required to rebate premium for 2011.

Community and School-based Health Centers

An additional $11 billion in funding for community health centers will be provided over the next five years. Community health centers deliver quality preventive care to low-income residents. Services can include primary care, dental care, women's health, podiatry, counseling services, health promotion and education, physiotherapy, advocacy and intervention.

Medical Malpractice Tort Reform

Health care reform provides $50 million in state grants for developing alternatives to resolving medical malpractice disputes through lawsuits. Alternative resolutions will emphasize patient safety, disclosure of health care errors and timely resolution.

Increased Demand for Health Care Services

With the expected increase in individuals buying health insurance, the demand for health care services is likely to rise as well, especially for those who have not had access to health care for some time. In addition, it is expected that a large percentage of individuals who purchase on exchanges will have had little to no experience with health insurance. They will need assistance understanding the basics of how coverage works.

What does Health Care Reform Mean?

Implications for Employer

Large employers must make “play or pay” decisions
As employers begin pondering the "play or pay" question, the answer is not necessarily as straightforward as expected. More than a few employers plan to maintain the status quo on their health benefit programs and focus on making sure that their health plan offerings meet the affordability and other requirements under health care reform.

These employers are not necessarily making a long-term commitment to providing health benefits to employees. Instead, they are postponing a decision until they see:

- How difficult and costly it is to comply with the "shared responsibility" provision requiring that employers provide coverage to all full-time equivalent employees.
- How the state health insurance exchanges will operate and what types of plans they will offer at what prices.
- The impact of all of these changes on the overall cost of health benefits.

All aspects of health care reform compliance will be very specific to the employer involved. Everything from differences in employee demographics and income levels to hours worked and benefits strategy will have a tremendous impact on compliance and decision-making. However, there are a few key things for all employers to keep in mind.

Small employers must decide if and where to purchase coverage

Under health care reform, an estimated 4 million small businesses nationwide could qualify for a small business tax credit this year. Small employers with fewer than 25 full-time equivalent employees and average annual wages of less than $50,000 that purchase health insurance for employees are eligible for the tax credit. The maximum credit will be available to employers with 10 or fewer full-time equivalent employees and average annual wages of less than $25,000. To be eligible for a tax credit, the employer must contribute at least 50 percent of the total premium cost. Businesses that receive state health care tax credits may also qualify for the federal tax credit. Dental and vision care qualify for the credit as well.

Through 2013, eligible employers will receive a small business credit for up to 35 percent of their contribution toward the employee’s health insurance premium. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 25 percent of their contribution.

For 2014 and beyond, small employers who purchase coverage through the new exchanges can receive a tax credit for two years of up to 50 percent of their contribution. Tax-exempt small businesses meeting the above requirements are eligible for tax credits of up to 35 percent of their contribution.

Employers must understand qualified coverage requirements and whether they meet them

If employers do offer coverage, but the coverage does not meet certain parameters, they may still have to pay assessments.

- First, employers will be assessed if a plan is judged not to be comprehensive. This means the coverage must have an "actuarial value" of at least 60 percent. In other words, the employer pays on average at least 60 percent of health care expenses and the employee pays on average 40 percent of these expenses through deductibles and copayments.
- Second, employers will be assessed if the employees' premiums are considered unaffordable relative to their household incomes. Specifically, the employee’s share of the premium must not exceed 9.5 percent of his or her annual household income.

Starting in 2014, if either of these two conditions is not met, the employer must pay a $3,000 annual assessment for each employee who declines his or her employment-based insurance and obtains government-subsidized coverage through an exchange.
Employers must collect and report data and information that they may not currently have

Starting in 2014, large employers are required to report to the Internal Revenue Service whether they offer their full-time employees and their employees' dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and to provide certain other information. In addition, employers must provide written statements of the report to full-time employees. The report is meant to determine whether the employer is complying with the employer mandate and to provide full-time employees with a written statement of their coverage. Specifically, the employer's report must contain the following information:

- The employer's name, date and EIN
- A certification of whether the employer offers its full-time employees and their dependents the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan
- The number of full-time employees the employer has for each month during the calendar year
- The name, address and TIN of each full-time employee employed by the employer during the calendar year and the months (if any) during which the employee and any dependents were covered under a health benefit plan
- The months during the year for which minimum essential coverage under the plan was made available
- The monthly premium for the lowest cost option in each of the minimum essential coverage's enrollment categories
- The employer's share of the total allowed costs of benefits provided under the minimum essential coverage
- Any waiting period with respect to the minimum essential coverage
- Any other information required by the IRS

In addition to the information report submitted to the IRS, the insurer or employer must also provide a written statement to each covered individual whose name must be included in the IRS report. This statement must include the name, address and contact information of the reporting person or entity and the information required to be shown on the return with respect to that individual.

An employer failing to comply with the any of the above reporting requirements is subject to penalties.

Implications for Physicians and Hospitals

New health plans and/or increased price sensitivity may bring new risk to reimbursement

With the passage of health care reform, physician payment continues to be a focal point. The majority of payment arrangements are based on fee-for-service or cost per services rendered. Payment models are evolving that will require increased risk for providers. Conversion from fee-for-service to other models, such as pay-for- performance, may reduce inappropriate or unneeded care.

Credit and collection challenges with high cost-share

With increased cost-sharing plans, patients are responsible for larger portions of their bill, and providers must collect funds directly from the patient.

Providers can help ensure that money is collected in a timely manner by:

- Informing the patient of your policy regarding collection of payment at the time of service.
  - Keep a list of our allowances and if the patient has not met his or her deductible, collect the allowed amount at the time of service based upon CPT code.
Physicians may obtain our schedule of allowances via the secure section of our website. Log in and password is required.

For other health care professionals, each December, we mail to you an annual fee schedule notice that contains a schedule of allowance for the most commonly billed codes for your specialty.

If you have questions or need additional information about our schedule of allowances, please contact your Provider Relations representative.

- Always submit a claim, regardless of the patient's status in meeting his or her deductible.
- If your office or facility requires payment at the time of service, and it’s determined on the remittance invoice that too much was collected, you are required by law to promptly refund the difference to the patient.

Possible reimbursement cuts looming

The Medicaid expansion mandated by the Affordable Care Act is scheduled to take effect January 1, 2014. This mandate is projected to move an additional 16 million people to Medicaid. As a result, it is projected that states will still see a 2.8 percent increase in Medicaid cost due to the expanded enrollment.

Capacity to meet increased demand

As the pool of insured people grows, more and more Americans will be looking for care, particularly from a primary care physician. Both physicians and hospitals are likely to experience an increase in patient load.

Currently, some areas in the nation face shortages of critical health care workers, including primary care physicians, nurses, behavioral health and long-term care workers, as well as public health and human service professionals. Moreover, this problem is anticipated to increase in the coming years. More than 64 million people currently live in a primary care health professional shortage area, and others live in smaller areas with health professional shortages. More than half of the counties in the U.S. have no behavioral health worker at all. With the implementation of health care reform and the resulting expansion of health insurance coverage, demand for services of primary care professionals will increase substantially.

These concerns come at a time when demand for services is increasing — particularly with an aging population with more frail seniors in need of care — and the health care system is grappling with quality of care concerns. Natural and manmade disasters can strain existing health care, public health and human service workforce capacity and require rapid identification and deployment of skilled professionals to affected areas. In addition, all health professions will need to be responsive to new challenges and realize the potential of new technologies. Innovative approaches, including improved preparation of primary care practitioners and the enhanced use of nurse practitioners and physician assistants, will be required to meet the increased demand. Moreover, new approaches using peer mentors, recovery coaches and care managers will be needed for persons with long-term care needs.

The HHS is addressing many of these workforce issues. Through implementation of the Affordable Care Act, HHS will fund scholarships and loan repayment programs to increase the number of primary care physicians, nurses, physician assistants, mental health providers and dentists in the areas of the country that need them most. With a comprehensive approach focusing on retention and enhanced educational opportunities, HHS is addressing the continuing need for a highly skilled, diverse nursing workforce. HHS is working with state, local and tribal governments to develop health workforce training, recruitment and retention strategies and to expand critical, timely access to care by funding the expansion, construction and operation of health centers throughout the U.S.

Providers, policymakers and consumers are likely to consider a broad range of strategies to address gaps in infrastructure and workforce: engaging students at younger ages, improving wages and benefits of direct care workers, tapping new worker pools, strengthening the skills that new workers bring at job entry and providing more useful continuing education and training. To learn more, visit: http://www.hhs.gov/secretary/about/goal5.html

Care delivery models are evolving - Accountable Care Organizations

Health care reform provides incentives for physicians to join together to form "Accountable Care Organizations." The goal is that through these groups, providers can better coordinate patient care and improve quality, help prevent disease and illness and reduce unnecessary hospital admissions.
If these organizations provide high-quality care and reduce costs to the health care system, they can keep some of the money that they have helped save. Additionally, a national pilot program will encourage hospitals, doctors and other providers to work together to improve coordination through payment “bundling.”

This means that hospitals, doctors and providers will be paid a flat rate for an episode of care rather than the current fragmented system where each service or test or bundle of items and services are billed separately to Medicare. It aligns the incentives of those delivering care, and savings are shared between providers and the Medicare program.

By January 2015, a new provision will tie physician payments to the quality of care they provide. Physicians will see their payments modified so that those who provide higher value will receive higher payments than those who provide lower quality care.

**New Reporting Requirements for Physicians and Hospitals**

Health care providers will have to adopt new methods of reporting, as the law establishes various new requirements, including quality measure reporting programs.

**Need to also make decisions as employer group offering coverage to employees**

Provider practices and hospitals are also employers, so just like other employer groups, decisions on coverage offerings will need to be made at your practice or facility.

**Implications for Insurers**

With health care reform, plans are navigating the following areas of strategic focus:

**Shift in Customer Base**

Exchanges will create movement from group plans to the individual market. Consumers will play a far more significant role in the health insurance decision-making process. Health plans will shift their go-to-market strategies from a traditional wholesale approach, where members were accessed through employers and brokers, to a more direct to-consumer approach.

**Cost of Care**

Reform is increasing the need for health plans to broaden their efforts in managing the cost of care. To address this issue, health plans need to manage new medical loss ratio requirements, optimize exchange products without the ability to underwrite and manage risk associated with the shifts in their customer base.

**Payer-Provider Convergence**

Health plans will collaborate with providers to manage costs, quality and outcomes. To achieve effective partnerships, platforms that facilitate real-time data exchange with providers, along with the use of analytic tools that allow them to forecast and track outcomes data, will need to be utilized. This data — particularly real-time patient admission and discharge clinical data often inaccessible today — can be used for better care navigation.

**On the Horizon**

Looking ahead, there are still many parts of health care reform that will impact providers, members and the way we all work together. Here are some of the significant provisions which will be implemented through 2016. As we continue to navigate through the many upcoming phases of health care reform, we will share additional details about how these changes may impact the way we do business with you.

**January 2013 – 2016: Administrative Simplification** - This provision requires the HHS Secretary to adopt and regularly update the standard, implementation, specifications and operating rules for electronic exchange and the use of electronic health information for the purposes of financial and administrative transactions. Providers will need
to continue to work with their clearinghouses to ensure that they are compliant with standards for electronic exchange.

**January 2014: Pre-existing Conditions** – Pre-existing conditions will no longer apply to non-grandfathered plan members (older than age 19).

**2014: Coverage for Clinical Trials** - Non-grandfathered plans must include coverage of routine patient costs for clinical trials of life-threatening diseases.

**2014-2016: Individual Mandate** - Most U.S. citizens and legal residents are required to have health care coverage. For citizens without health care coverage, a penalty will be phased in. Penalties are the greater of $95 per year in 2014, phasing in to $695 per year by 2016 or 1 percent of taxable income phasing in to 2.5 percent of taxable income by 2016. Some exemptions will be allowed for low-income individuals.

### Communicating Updates

Univera Healthcare and Univera Community Health are committed to keeping you informed as regulations are announced and business decisions are made. Here are some ways we will communicate with you regarding health care reform:

- Bulletins and eAlerts
- Articles in our *Examiner* newsletter
- Postings to our website: [https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/](https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/)
- Educational seminars

### Learn more, visit:

- Univera Healthcare: [https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/](https://www.univerahealthcare.com/wps/portal/xl/our/hpr/healthreform/)

### Sources:

http://www.healthcare.gov/
http://www.healthcarereform.ny.gov/
http://www.kff.org/
http://www.healthbenefitexchange.ny.gov
Glossary

**Accountable Care Organization (ACO):** These organizations coordinate patient care and provide the full range of health care services for patients. The health reform law provides incentives for providers who join together to form such organizations and who agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program and are assigned to the ACO.

**Actuarial Value:** The amount that the health plan would pay for covered benefits as compared to the amount that the member would pay out of pocket for the benefits covered by the plan.

**Catastrophic Coverage:** A coverage option with a limited benefit plan design accompanied by a high deductible. The plan design is intended to protect primarily against the cost for unforeseen and expensive illnesses or injuries. These plans are attractive to young adults in relatively good health.

**Consumer-Driven Health Plans:** These health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These plans usually have a high deductible accompanied by a savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs).

**Cost-Sharing:** Health plan members are required to pay a portion of the costs of their care. Examples of these costs include copayments, coinsurance and annual deductibles.

**Deductible:** The dollar amount that a plan member must pay for health care services each year before the insurer begins to reimburse for health care services. Beginning in 2014, deductibles for small group insurance plans will be limited to $2,000 for individual policies and $4,000 for family policies.

**Employer Mandate:** Beginning in 2014, pursuant to the health reform law, employers meeting size or revenue thresholds will be required to offer minimum essential health benefit packages or pay a set portion of the cost of those benefits for use in the Exchanges.

**Essential Health Benefits:** The health reform law places certain coverage requirements on essential health benefits, and provides a broad set of benefit categories that would be considered essential to a health benefits package — including hospitalization, outpatient services, emergency care, prescription drugs, maternity care, preventive services and other benefits.

**Exchange:** The health care reform law creates Exchanges (competitive insurance marketplaces) in each state, where individuals and employers can shop for health plans.

**Grandfathered Plan:** A health plan that was in place on March 23, 2010, when the health reform law was enacted, is exempt from complying with some parts of the health reform law, so long as the plan does not make certain changes (such as eliminating or reducing benefits, increasing cost-sharing, or reducing the employer contribution toward the premium). Once a health plan makes such a change, it becomes subject to other health reform provisions (e.g., appeals and cost sharing restrictions on preventive services).

**Group Health Plan:** Health insurance that is offered by a plan sponsor, typically an employer on behalf of its employees.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA):** This law sets standards for the security and privacy of personal health information. In addition, the law makes it easier for individuals to change jobs without the risk of extended waiting periods due to pre-existing conditions.

**Health Reimbursement Account (HRA):** A tax-exempt account that can be used to pay for qualified health expenses. HRAs are usually paired with a high-deductible health plan and are funded solely by employer contributions.

**Health Savings Account (HSA):** A tax-exempt savings account that can be used to pay for qualified medical expenses. Individuals can obtain HSAs from most financial institutions or through their employer. Both employers and employees can contribute to the plan. To open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan that has deductibles of at least $1,200 for an individual and $2,400 for a family in 2010.

**High-Deductible Health Plan:** These health insurance plans have higher deductibles and lower premiums than traditional insurance plans.

**Individual Mandate:** A requirement that most individuals obtain health insurance or pay a penalty beginning in 2014.

**Mandatory Benefits:** A state or federal requirement that health plans provide coverage for certain benefits, treatment or services.
Medical Loss Ratio (MLR): The minimum percentage of premium dollars a commercial insurance company must spend on the reimbursement of certain medical costs. The health reform law requires insurers in the large group market to have an MLR of 85 percent and insurers in the small group and individual markets to have an MLR of 80 percent (with some waivers granted to states to reduce the threshold for certain markets).

Out-of-Pocket Costs: Health care costs that are not covered by insurance, such as deductibles, copayments and coinsurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: An annual limit on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding premiums. The health reform law, beginning in 2014, prevents an employer from imposing cost sharing in amounts greater than the current out-of-pocket limits for high-deductible health plans ($5,950 for an individual policy or $11,900 for a family policy in 2010). These amounts will be adjusted annually.

Patient Protection and Affordable Care Act (PPACA): Also referred to as the “health reform law,” this Act begins the implementation of a staged set of rules with an initial effective date of March 23, 2010. The law is intended to increase access to health care for more Americans, and includes many changes that impact the commercial health insurance market, Medicare and Medicaid.

Pay-for-Performance: A payment system where health care providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay-for-performance programs is to improve the quality of care over time.

Pre-existing Condition: An illness or medical condition for which a person is diagnosed or treated within a specified period of time prior to becoming insured in a new plan. The health reform law prohibits the denial of coverage due to a pre-existing condition for plan and policy years beginning after September 23, 2010, for children younger than 19, and for all others beginning in 2014.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Subsidies: A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health insurance. The health reform law provides premium subsidies to individuals with incomes between 133 percent and 400 percent of the federal poverty level when they purchase policies through the exchanges beginning in 2014.

Preventive Care Services: Health care that emphasizes the early detection and treatment of disease. The health reform law requires certain health plans (excludes grandfathered plans) to provide coverage without member cost-sharing for certain preventive services.

Qualified Health Plan: Insurance plans that are sold through an exchange must have been certified as meeting a minimum benchmark of benefits (i.e., essential health benefits) under the health reform law.

Reinsurance: Insurance purchased by insurance companies and employers that self-insure their employees’ medical costs, to limit liability or exposure to high claims or increased cost trends. The health reform law includes a temporary federal reinsurance program for employers that insure early retirees older than age 55 who are not eligible for Medicare.

Rescission: Refers to a practice where an approved policy is voided from its inception by the insurer, usually on the grounds of material misrepresentation or omission on the initial application. Under health reform, rescissions are prohibited except in cases of fraud or intentional misrepresentation.

Section 125 Plan: These plans are otherwise known as a “cafeteria plan” offered pursuant to Section 125 of the Internal Revenue Code. Its name comes from a set of benefit plans that allows employees to choose between different types of benefits, similar to the ability of a customer to choose among available items in a cafeteria, and the employees’ pretax contributions are not subject to federal, state or Social Security taxes.

Self-Insured Plan: The employer assumes the financial responsibility of health care benefits for its employees in a self-insured or self-funded plan. Employer-sponsored self-insured plans typically contract with a third-party administrator to provide administrative services for the plan.

Small Business Health Options Program (SHOP): SHOP is a competitive private health insurance marketplace where small businesses and their employees will have access to affordable coverage and the same insurance choices as members of Congress.

Small Business Tax Credit: The health reform law includes a tax credit equal to 50 percent (35 percent in the case of tax-exempt eligible small employers) for qualified small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees with average annual wages of less than $50,000.

Small Group Market: Businesses with typically two to 50 employees, or eligible employees depending on applicable state law, can purchase health insurance for their employees through this market, which is regulated by states.
**Tax Credit:** An amount that a person or business can subtract from the income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the credit is greater than the amount of tax the payer would otherwise owe.
Test Your HCR Knowledge

1) On March 23, 2010, the Affordable Care Act was signed into law. What was the Act's original name?

2) What is an exchange?

3) Will NYS have an exchange?

4) When is the initial open enrollment date for the exchange?

5) True or False? Health plans are now required to provide dependent coverage for young adults up to age 29.

6) Fill in the blanks: To qualify for the tax credit, consumers must be enrolled in a health plan offered through the ____________ and have a household income no greater than ________________ for their family size.

7) Has the time frame to file an urgent appeal changed?

8) True or False? Smoking cessation counseling is a mandated service for Women’s Preventive Health

9) How will Univera Healthcare communicate HCR updates to your office or facility?

10) Choose one: For plan years effective on or after January 1, 2013, the maximum allowable salary reduction contribution to a flexible spending account will be:

   a. $100
   b. $5,000
   c. $250
   d. $2,500

Answers:
1. Patient Protection and Affordable Care Act (PPACA)
2. A marketplace of insurance plans run by a government or nonprofit agency, to help individuals and small employers obtain health insurance coverage.
3. Yes – NYS Health Exchange
4. October 1, 2013
5. False- age 26
6. Exchange and four times the Federal Poverty Level
7. No
8. False
9. D
10. Examiner newsletter, website postings, eAlerts, bulletins, seminars
We hope this information helps you navigate health care reform!

If you have questions, please contact your Provider Relations representative.

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