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Health Care Reform

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "Act") consists of almost one thousand pages of legislation, with effective dates beginning immediately through 2020. Below is a summary of the most significant provisions of the Act that become effective in 2010 or 2011.

Insurance Reform

- **Preexisting Conditions** - Effective September 23, 2010, payors are prohibited from imposing any preexisting condition exclusions for children who are under age 19. This prohibition extends to adults for plan years beginning on or after January 1, 2014.

- **Extension of Dependent Coverage** - Effective September 23, 2010, all health insurance policies providing dependent coverage must allow children of insureds to be covered as dependents up to age 26.

- **Lifetime Limits** - Effective September 23, 2010, payors are prohibited from placing lifetime dollar limits on medical claims.

- **Annual Limits** - Effective September 23, 2010, payors may not place unreasonable annual dollar limits on claims. Annual limits will not be permitted at all after January 1, 2014.

- **Prohibition on Rescissions** - Effective September 23, 2010, payors may not rescind coverage unless the insured engages in fraud or misrepresents a material fact in violation of the policy terms.

- **Preventive Services** - As of September 23, 2010, payors must provide coverage for preventive services and immunizations without an out-of-pocket cost to the insured.

- **Designation of Primary Care Provider** - Effective September 23, 2010, payors must allow an insured to designate any participating primary care provider who is accepting patients as the insured's primary care provider.

- **Coverage of Emergency Services** - Effective September 23, 2010, payors must provide coverage of emergency services without prior authorization and without regard to whether the emergency department is a participating provider.

- **Women's Health** - Effective September 23, 2010, payors may not require an insured to

obtain authorization or a referral before seeking coverage for obstetrical or gynecological care provided by a participating provider.

- **Reporting Medical Loss Ratios and Premium Rebates** - Starting on January 1, 2011, health insurers must report their medical loss ratios and pay annual rebates to insureds under some circumstances.

New Provider Opportunities

- **Primary Care Training** - The Secretary (the "Secretary") of the Department of Health and Human Services ("HHS") is authorized to appropriate up to $125 million, in the form of contracts and grants, to develop training programs in the areas of family medicine, general internal medicine, or general pediatrics. Additional funding will be available in later years.

- **Graduate Medical Education Funding** - Effective July 1, 2010, any time spent by residents training in a nonhospital setting will be counted toward a hospital's direct graduate medical education costs as well as indirect medical education costs if the hospital incurs the costs of the stipends and fringe benefits.

- **Community-Based Care Transition Programs** - The Secretary will develop a program that provides funding for a five-year period to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission.

- **Expanded Participation in 340B Program** - Certain children's hospitals, cancer hospitals, critical access hospitals, community hospitals, and rural referral centers are now eligible to participate in the 340B Drug Pricing Program, which discounts the cost of certain drugs for eligible entities.

Program Integrity

- **Overpayments** - Medicare and Medicaid overpayments must now be reported and returned within sixty days of the later of the date the overpayment is identified or the date a corresponding cost report encompassing the date of the original claim is due. Any overpayment retained after the sixty-day deadline can result in liability under the False Claims Act.

- **Medicare Self-Referral Disclosure Protocol** - On or before September 23, 2010, HHS must establish a self-referral disclosure protocol ("SRDP") for health care providers to disclose an actual or potential violation of the Stark Law. The SRDP will allow HHS discretion to reduce the amount due for violations under the Stark Law, taking into consideration the following factors: (i) the nature and extent of the improper or illegal practice, (ii) the timeliness of such self-disclosure, (iii) the cooperation in providing information related to the disclosure, and (iv) other factors deemed relevant by the Secretary.

- **Anti-Kickback Statute** - Any claim that includes items or services resulting from a violation of the Anti-Kickback Statute ("AKS") now constitutes a false or fraudulent claim for purposes of the False Claims Act. A person is not required to have actual knowledge of the AKS, or specific intent to violate the AKS, but is still required to have the intent to induce purchasing of items or services or to induce referrals.

- **Recovery Audit Contractor Expansion** - By December 31, 2010, every state must contract with a recovery audit contractor ("RAC") to identify and collect underpayments and overpayments for Medicaid services. HHS is also required to expand the RAC program to include Medicare Parts C and D.

- **Termination of Medicaid Provider Participation If Terminated under Medicare or other State Plans** - States must terminate a provider's Medicaid participation status if such provider is terminated from participating in Medicare or another state's Medicaid

program.

- **Medicaid Exclusion from Participation Relating to Certain Ownership, Control, and Management Affiliations** - Medicaid agencies must exclude providers from participating in Medicaid for a specific period of time if such provider owns, controls, or manages an entity that (i) has unpaid overpayments during such period as defined by the Secretary; (ii) is suspended, excluded, or terminated from participation in any Medicaid program during such period; or (iii) is affiliated with another provider that has been suspended, excluded, or terminated from Medicaid participation during such period.

Increased Access to Coverage

- **Creation of High-Risk Pool** - Effective May 23, 2010, a temporary high-risk pool will offer insurance coverage to eligible individuals with preexisting conditions. The program expires in 2014 when the insurance exchanges become operational.

- **Reinsurance Program for Early Retirees** - Effective June 23, 2010, a temporary reinsurance program will be available to employers that provide health insurance to retirees over 55 who are not Medicare eligible. The reinsurance program expires in 2014 when the insurance exchanges become operational.

Medicare and Medicaid

- **Billing Agents, Clearinghouses, and Other Alternate Payees Required to Register under Medicaid** - Agents, clearinghouses, and other alternate payees that submit claims on behalf of a health care provider must register with the state in which they provide Medicaid services and with the Secretary in a form and manner specified by the Secretary.

- **Provider Screening** - HHS is required to create a new provider screening program for participation in Medicare and Medicaid. The screening program must include licensure checks and may include criminal background checks and fingerprinting. Upon implementation of the screening program, all health care providers will be required to have a compliance program as a condition of enrollment in Medicare and Medicaid. Screening must occur within one year for new health care providers and within two years for current providers.

- **DME and Home Health Services** - Physicians and midlevel providers are now required to have a face-to-face encounter with a patient prior to issuing a certification for home health services or written order for durable medical equipment ("DME"). Effective July 1, 2010, only physicians or midlevel practitioners who are enrolled in Medicare can order DME or home health services for Medicare beneficiaries.

- **Prescription Drug Rebates Extended to Medicaid Managed Care Organizations ("MCO")** - Medicaid MCOs are now eligible to receive rebates from prescription drug manufacturers.

- **Payment Prohibited for Health Care-Acquired Conditions** - Effective July 1, 2011, state Medicaid programs will no longer receive federal funds to pay for services relating to health care-acquired conditions, to be defined in regulations promulgated by the Secretary.

- **Increased Coordination of Benefits for Dual-Eligible Beneficiaries** - The government must establish a Federal Coordinated Health Care Office that is responsible for coordinating payment of Medicare and Medicaid benefits for individuals eligible for both programs.

- **Medicare Coverage of Preventive Services** - The Act provides coverage under Medicare for an annual wellness visit and for personalized prevention plan services, including a comprehensive health risk assessment, with no beneficiary copayment or deductible obligation. Beneficiary coinsurance and deductible requirements are waived for

most preventive services, requiring Medicare to cover 100 percent of the costs.

- **Permitting Physician Assistants to Order Post-Hospital Extended Care Services** - Effective January 1, 2011, physician assistants will be able to order skilled nursing care or other skilled rehabilitation services under the Medicare program.

- **Medicaid Chronic Disease Initiatives** - Grant funding will be available to states to provide incentives for Medicaid beneficiaries to participate in evidence-based, easily accessible programs providing incentives for healthy lifestyles. States are required to provide Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use, with no cost-sharing responsibility for the individual.

Tax Reform

- **Over-the-Counter Medication Prohibition** - Effective January 1, 2011, expenses for over-the-counter medications (except for insulin) are no longer eligible for tax-free reimbursement from Flexible Spending Accounts, Health Savings Accounts, and Health Reimbursement Arrangements.

- **Small Business Tax Credits** - Employers with fewer than 25 employees and less than $50,000 in average wages are now eligible for a tax credit for employer-provided health coverage. Through 2013, the tax credit is up to 35 percent (25 percent for certain small nonprofit organizations) of the employer's contribution if the employer contributes at least 50 percent of the premium.

Reimbursement

- **Improvements to Physician Quality Reporting Initiative** - Medicare incentive payments for eligible professionals who submit quality data to Medicare under the Physician Quality Reporting Initiative ("PQRI") were scheduled to end on December 31, 2010. They have been extended through December 31, 2014. For the years 2011 through 2014, eligible professionals who submit quality data through the new Maintenance of Certification program will receive an additional 0.5 percent of their Medicare reimbursement as a bonus. Beginning in 2015, eligible professionals who do not submit data on quality measures through the PQRI will have their Medicare payments reduced by 1.5 percent for services provided in 2015 and 2 percent t fter.

- **Extension of Exceptions for Medicare Physical Therapy Caps** - Medicare beneficiaries currently can obtain an exception from the financial caps placed on certain physical therapy and speech language pathology services if such services are medically necessary. This exception has been extended through December 31, 2010.

- **Extension of Physician Fee Schedule Mental Health Add-On** - The 5 percent increase in Medicare reimbursement for certain psychiatric procedures, such as insight-oriented, behavior-modifying, or support psychotherapy or interactive psychotherapy, performed in an outpatient setting, inpatient hospital, partial hospital, or residential care facility setting will be extended through the end of 2010.

- **Improved Access for Certified Nurse-Midwife Services** - Medicare reimbursement for certified nurse-midwife-covered services provided after January 1, 2011, is increased from 65 percent to 100 percent of the physician rate of the fee schedule amount paid to physicians for the same services.

Health Care Quality

- **Initiatives for Identifying and Disseminating "Best Practices" in Health Care Quality, Safety, and Value** - The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (the "Center") is established to perform research and provide grants and contracts encouraging innovative methodologies and strategies that represent "best practices" in health care quality, safety, and value across diverse health care settings.

- **Patient-Centered Medical Home Initiatives** - HHS will make available grants and contracts to states and state-designated entities to establish community-based, interdisciplinary, interprofessional teams to support primary care practices, including obstetrical and gynecologic practices. Among other obligations, these care teams must contract with primary care practices to support patient-centered medical homes.

- **Chronic Disease Medical Management Initiatives** - HHS will establish a program to provide grants or contracts for eligible entities to implement medication management services by licensed pharmacists through a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases.

- **Grants to Trauma Care Centers** - The Secretary will establish programs to award grants to qualified public and Indian trauma centers that incur substantial uncompensated care costs. The grants will provide emergency financial relief to ensure the continued availability of trauma services in underserved areas susceptible to funding and workforce shortages.

- **Programs to Facilitate Shared Decision Making Between Patients and Providers** - HHS will establish a program for the development, testing, and dissemination of educational tools to help patients, caregivers, and authorized representatives engage in a collaborative decision-making process with clinicians. These educational tools, or "patient decision aids," will help patients communicate their beliefs and preferences regarding treatment options and formulate a care plan based on options, scientific evidence, circumstances, beliefs, and preferences. Grants will also be available for eligible health care providers to develop, implement, and assess shared decision-making techniques.

- **Public Reporting of Performance Information** - Not later than January 1, 2011, the Secretary must develop a Physician Compare Internet Web site that provides comparable information to the public on quality and patient experience measures involving physicians participating in Medicare and other eligible professionals participating in PQRI.

- **Publication of Hospital Charges** - Effective September 23, 2010, hospitals must publish an annual list of their standard charges (including for diagnosis-related groups).

- **National Strategy to Improve Health Care Quality** - The Secretary must establish and annually update a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The Secretary will develop quality measures that are consistent with the national strategy and that will be used in reporting to, and receiving payment under, federal health care programs. The Secretary will develop a plan to collect and aggregate data on quality and resource use measures from information systems used to support health care delivery. The Secretary will also develop and publicly report on provider-level outcome measures for hospitals, physicians, and other providers as determined by the Secretary.

- **Comparative Effectiveness Research** - The Act creates a nonprofit Patient-Centered Outcomes Research Institute (the "Institute"), which identifies research priorities, carries out research projects, and collects data regarding comparative outcomes research.

- **Standardizing Prescription Drug Risk and Benefit Summaries** - The Food and Drug Administration will evaluate and determine whether the addition of prescription drug risk and benefit summaries in a standardized format (such as a drug fact box) in advertising and other forms of communication for prescription medications would improve the decision making of clinicians, patients, and consumers.

- **Quality Improvement and Patient Safety Training for Health Professionals** - The Secretary will make grant funding available to certain academic institutions to develop and implement academic curricula that integrate quality improvement and patient safety into health professionals' clinical education.

- **Federal Coordination of Women's Health Initiatives** - The Act provides for the creation

of women's health offices at various federal agencies to improve prevention, treatment, and research for women in health programs.

Many provisions of the Act have implementation dates after 2011 or require federal agencies to promulgate regulations or other guidance to implement the provisions of the Act. The Health Care Group of Robinson & Cole will publish additional alerts as this guidance becomes available. Please call any member of the Health Care Group at Robinson & Cole if you have any questions with respect to the Act.

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