



What to Expect from Payors

Compliance in the Post-Reform World

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Objectives

- Understanding payor challenges and opportunities
- Quality measures and impact on reimbursement
- Compliance implications of new service lines and evolving regulations

[Insurance Reforms ...]

The legislation fundamentally reforms the insurance market ... both in changing the system for the insured and providing access to the uninsured:

- State health insurance Exchanges (for individuals and small employers up to 100 employees) estimated to provide coverage to 24 million
- New coverage alternatives, such as COOPs and benefit plan levels

[Insurance Reforms ...]

- Individual responsibility requirement and employer requirements/penalties for not offering coverage
- Subsidies and tax credits to offset insurance premiums
- Temporary high risk pool established until 2014 to provide coverage to those who can't obtain insurance due to health status or a pre-existing condition
- New voluntary long term care insurance program for individuals with functional limitations

Insurance Reforms ...

- *Effective 2010:*
 - Lifetime caps ended
 - Children up to age 26 covered on their parents policies and up to age 19 obtain coverage with no pre-existing condition exclusions
 - Prohibition on rescissions except in the case of fraud or intentional misrepresentation
 - New rate review authority process established
- *Effective 2011:*
 - Establishment of standard MLRs for all plans
 - Uniform health plan documents created
- *Effective 2014:*
 - Guarantee issue coverage for all
 - No exclusions for pre-existing conditions
 - Minimum, essential benefits and standard benefit offerings
 - Insurance industry annual tax begins
- *Effective 2018:*
 - High value plan excise tax begins

Payor Challenges/Opportunities

- **Medicaid:**
 - More opportunity than challenges
 - Potential for dramatic improvements in the Medicaid eligibility process through requirements that the new “health exchanges” create a harmonized front and eligibility framework that could ease initial enrollment and make continued enrollment easier.
 - Numerous demonstration projects to test out new models of delivery and finance

Payor Challenges/Opportunities

■ Medicaid - Timeframe:

- 2010: increase in Medicaid drug rebate percentage – state option to increase Medicaid eligibility to 133% FPL
- 2010-2011: State plan option for Medicaid Health Home Program; Health Insurance regulations promulgated
- 2012: Education campaign around new Medicaid eligibility requirements and the Health Insurance Exchange
- 2013: Medicaid applications available
- January 2014: Medicaid eligibility requirements change and Health Insurance Exchange Opens
- February 2014: Demand for services increase

Payor Challenges/Opportunities

- Medicare Advantage Reforms - MA rate reforms are estimated to save the federal government \$136 billion over 10 years
 - Starting in 2012, MA payment benchmarks will be phased in relative to local Medicare FFS costs, and quality bonuses will be phased in based on a five star rating system
 - Starting in 2014, MA plans are subject to a new minimum medical loss ratio (MLR) requirement of 85%
 - MA and Prescription Drug Plan (PDP) enrollment period changes
 - In 2011, the January - March MA open enrollment period (OEP) for beneficiaries is eliminated and replaced with an opportunity to move to a FFS plan from January 1 - February 15
 - In 2012, the MA and PDP annual election period (AEP) is moved up to October 15 - December 7

Payor Challenges/Opportunities

Medicare Advantage Reforms (cont'd)

- Medicare beneficiaries are entitled to an annual wellness visit with no copayment or deductible. Cost sharing is also removed for immunizations, screening tests and preventative services
- A new Independent Payment Advisory Board is established to present proposals to the President and Congress to reduce excess cost growth, improve quality of care for Medicare beneficiaries, and slow the growth national health expenditures
- An MA bid may be denied if it proposes significant increases in cost sharing or decreases in benefits, starting with the 2011 contract year
- Premium tax on all health plans beginning in 2014

Payor Challenges/Opportunities

- Part D Coverage Gap (“Donut Hole” Coverage)
 - A \$250 rebate will be given to beneficiaries who enter the coverage gap in 2010
 - The donut hole will be closed by 2020 by reducing coinsurance to 25% for all spending between the deductible and the catastrophic limit for both generic and brand name drugs
 - In 2011, pharmaceutical manufacturers whose drugs are covered in Part D must provide a 50% discount for brand-name drugs
 - A generic drug discount in the form of a federal subsidy is also provided to eligible beneficiaries in the donut hole beginning in 2011

Payor Challenges/Opportunities

- Medicare Benefit Changes
 - Beginning in 2011, Medicare beneficiaries are covered for annual wellness visit providing a personalized prevention plan based on a health risk assessment (HRA) with no co-payment or deductible
 - Beginning in 2011, removes cost sharing for immunizations, screening and preventive services
 - Additional efforts to better coordinate care such as:
 - Federal Coordinated Health Care Office (CHCO) to more effectively coordinate care for dual eligible's
 - Center for Medicare and Medicaid Innovation (CMI) to test innovative models
 - Medicare shared savings program for ACOs
 - FFS hospital readmissions reduction program

Payor Challenges/Opportunities

- Reducing Fraud, Waste and Abuse
 - Requires new provider screening standards for participation in Medicare, Medicaid and CHIP
 - Physicians must provide documentation for referrals to high risk providers or programs (2010)
 - Requires face to face encounter to order home health or DME services (2010)
 - Increases penalties for false claims act violations. Expands violations to Parts C and D, including for enrolling or transferring individuals without their consent, for marketing violations (2010)
 - Expands the Recovery Audit Contractors (RAC) program to Medicaid and Medicare Parts C and D by January 1, 2010. RACs must confirm MA or Part D plans have an anti-fraud program in place, examine claims for reinsurance under Part D and review estimates of high cost beneficiaries submitted to the Secretary.
 - Requires a new integrated data repository for Medicare, Medicaid, CHIP, TRICARE, SSA and the Indian Health Service to match records and identify potential fraud or waste.

Quality Measures

■ Quality Ratings = Pay for Performance:

- Plans are rated by CMS using a five star rating system. These ratings are based upon clinical and operational quality measures derived from HEDIS, CAHPS, and HOS data.
- Starting in 2012, quality bonuses will be provided to plans rated 4 stars and above. These bonuses will be phased in over a three year period
- Quality bonus payments are doubled for 4 star and above plans if the plan operates in an "urban floor" county, with at least 25% MA penetration and FFS costs that are less than the national average.

Quality Measures

■ Quality Bonus:

- Beginning in 2012, the current 75% level of rebate retention will be reduced based upon plans' quality scores. The rebate percentages will phase down to 70% for plans rated 4.5 to 5 stars, 65% for at least 3.5 stars and less than 4.5 stars, and 50% for less than 3.5 stars. This change will also be phased in over three years.
- Quality bonuses must be used to provide supplemental benefits to members, with a prioritized list of specific uses (reducing cost sharing first, adding preventive and wellness benefits second and non-covered benefits third).

[Compliance Implications]

- **Medicaid:**
 - Where is your program today?
 - Over 17 million new Medicaid recipients
 - 58 Medicaid State Plans
 - Increased enforcement
 - New or expanded service lines

[Compliance Implications]

- **Medicare:**
 - Shorter selling season = great compliance risk
 - Agent/Broker Area
 - Operations
 - Materials & Fulfillment
 - New or Expanded Service Lines

[Compliance Implications]

- **Demonstration Projects:**
 - Accountable Care Organizations
 - New models create new compliance risks
 - The rush to implementation
 - and customers to exercise sound ethical practices when collecting, using, disclosing personal information
 - State Option to Provide Health Homes
 - New service line with a new model
 - Reimbursement opportunities create reimbursement challenges

[Compliance Implications]

- **Fraud and Abuse:**
 - Health Benefits Exchanges
 - Payments made in connection with the new Health Benefits Exchanges will fall within the scope of the FCA, to the extent that such payments include any federal funds
 - Additional Administrative Penalties
 - Additional Enforcement Resources

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**Just another day in the life of a
privacy compliance professional ...**

*Some days you are the bug,
some days you are the windshield.*

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Questions

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Jenny O'Brien, JD, CHC, CHCP

UnitedHealthcare Medicare & Retirement

Chief Medicare Compliance Officer

(952) 931-5444

jennifer.obrien@uhc.com