Health care legislation update

AUGUST / SEPTEMBER 2012

New fees imposed by the Affordable Care Act

The Affordable Care Act (ACA) includes provisions that promote research to evaluate and compare health outcomes and the clinical effectiveness, risks, and benefits of medical treatments, services, procedures, drugs, and other strategies or items that treat, manage, diagnose, or prevent illness or injury.

As required by the ACA, the nonprofit corporation — the Patient-Centered Outcomes Research Institute (PCORI) — was established to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. PCORI is funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), which was authorized by Congress as part of the ACA and receives income from two funding streams: the general fund of the Treasury and a fee assessed on Medicare, private health insurance and self-insured plans. The institute is expected to receive an estimated $3.5 billion from the PCORTF to fund patient-centered outcomes research through September 30, 2019, the date in which the ACA authorizes it to remain in operation.

- For government fiscal years (FYs) 2010–2012, the PCORTF received $210 million total in appropriations from general fund revenues.
    - For FY 2010, $10 million
    - For FY 2011, $50 million
    - For FY 2012, $150 million
- For FY 2013, the PCORTF will receive $150 million a year from the general fund in appropriation plus an annual $1 fee per individual assessed on Medicare and private health insurance and self-insured plans. The combined estimated total is $320 million.
- For FYs 2014-2019, the PCORTF will receive $150 million per year from the general fund in appropriation plus an annual $2 fee per individual assessed on Medicare and private health insurance and self-insured plans and an adjustment for increase in healthcare spending. The combined estimated total averages $650 million per year.

Each year, 20 percent of PCORTF funding is directed by law to be transferred to the Department of Health and Human Services (HHS) to support dissemination and research capacity-building efforts. For these purposes, 80 percent of that amount is transferred to the Agency for Healthcare Research and Quality.

For more information about PCORI, please visit www.pcori.org.

Revenue offset provisions

Many of us in the health insurance industry have been asking, "How are we going to pay for all of this?" One way is through new fees that are being imposed under TITLE IX — REVENUE PROVISIONS Subtitle A — Revenue Offset Provisions.

Beginning with coverage effective January 1, 2013, issuers will be assessed fees based on the net premiums written during the calendar year for fully-insured medical policies, stop-loss policies, Medicare Advantage & Part D policies and Medicaid. Medicare Supplement is exempt from the fee.

How much is the fee? In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

Calendar year applicable amount

2014	$ 8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000

In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

How did ODS estimate the impact for upcoming renewals?

- ODS based its estimate on an Oliver Wyman study published October 2011, which expects to see increases in premium between 1.9 percent and 2.3 percent for the first year.

Summary of Benefits & Coverage

As part of the ACA's requirements to help simplify and allow for easier comparison of plans across multiple issuers, the Centers for Medicare and Medicaid Services (CMS), along with HHS, have developed the new summary of benefits and coverage, or Summary of Benefits & Coverage (SBC). All issuers are required to utilize the standardized SBC beginning with open enrollment, new enrollment, new applicants, and upon request on September 23, 2012 and after. The SBC applies to the following policy types:

- Insured policies
- ASO policies
- ERISA and non-ERISA groups
- Large and small medical groups
- Integrated dental
- Integrated vision
- Standalone pharmacy

- Individual medical

The SBC will replace the current summary of benefits for all ODS medical, pharmacy and medical/pharmacy combined summaries. Standalone dental and vision summaries will remain with the current format.

ODS intends to deliver SBCs via electronic methods in PDF format and will post SBCs in myODS, our static website. We will send electronic copies to our group policy holders for posting on their internal websites and in Speed eRates. Printed copies will be provided upon request.

For more information regarding the SBC and the delivery methods or how to obtain them, please contact your ODS sales or service representative.

Women's preventive care coverage

Over the last two years, we have all been working at implementing provisions of the ACA in our benefit plans. An expansion to the preventive care coverage guidelines went into effect for new and renewing policies on August 1, 2012 to add additional coverage for women's preventive care coverage with no cost share when services are received from an in-network provider.

There has been some confusion in the marketplace regarding this provision of the bill. Media outlets have stated that these services are now covered for all women, which is not accurate.

In accordance with the ACA, all new ODS policies with a start date of 8/1 or after will cover women's preventive care services with no cost share for services from an in-network provider.

Individual

- A new individual policy holder with an effective date of 8/1, 9/1 or 10/1 will have these services covered at no cost share from inception of their policy.
- Any existing policy holder with an original effective date prior to 8/1 will have these services added at no cost share upon renewal 11/1, and will be included in the renewal notifications.

Group

- Similar to individual, any new or renewing policy with an 8/1/12 or after effective date will have these services covered at no cost share when services are provided by an in-network provider. This is regardless of the size or funding arrangement. So, if you have a small group client whose policy renews 2/1/13, upon that renewal these services will be added at no cost share in-network.

ODS has developed preventive care grids for you and our mutual clients that give an overview of what services are covered at the no cost share, and include all services not just those that have been added. You can find these grids at www.odscompanies.com/reform. There, you will find both the adult and child preventive grids, which have been updated to include the added women's preventive care services.