

Federal Healthcare Reform Begins for Health Plans

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The passage of federal healthcare reform in 2010 marks a new era for employer-sponsored health plans. Along with the requirements of other recently passed laws, group health plans must comply with several new provisions of the Patient Protection and Affordable Care Act (“PPACA”) summarized below. This article only addresses the impact of PPACA on employer-sponsored group health plans, and not the many issues for hospitals, doctors, and other medical providers. Unless otherwise noted, these changes took effect after September 23, 2010 (January 1, 2011 for calendar year plans).

One of the first health care reform changes to take effect was the change in the taxation of health coverage for children, effective March 30, 2010. Prior to health care reform, the taxation of health coverage of children depended on whether the children qualified as tax dependents for health care purposes under complicated definitions of “qualifying child” or “qualifying relative.” Now, health care coverage can be provided on a tax-free basis for children (including adopted children, children placed for adoption, stepchildren and foster children) through the calendar year in which the child turns 26.

This rule applies regardless of the marital status of the child, the residence of the child, or whether the child is financially dependent upon the employee or the employee’s spouse.

PPACA requires group health plans that cover children to extend the children’s eligibility until the child’s 26th birthday. Eligibility for children under age 26 cannot depend on the child’s student, marital, dependency or employment status. The only allowable exception is that certain grandfathered plans may exclude adult children who have access to employer-sponsored coverage, but

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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the News and its contents, please reply to dpeel@cahcnews.com.

Letter from the Publisher and Editor



Dear Reader,

Reports continue to be published that health-care employers have increased hiring.

In a December 15, 2010 article, Chen May Yee of the Star Tribune (Minneapolis) wrote, “While the pace of new jobs remains far below that of a few years ago, healthcare organizations have more job postings up right now than they have for months.”

On December 1, 2010, The Conference Board, a well known source for national online job board activity and other economic data, reported online job postings for healthcare positions totaled 667,000 in November 2010 versus 607,000 in November 2009.

If you’re now ready to advertise your open jobs consider using the California Healthcare News. Our thirty day postings include participation in a monthly email announcement to over 19,500 healthcare professionals. You can learn more about our online job board services by visiting www.cahcnews.com. Until next month,

David Peel, Publisher and Editor

California Healthcare News 2011 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2011	Hospitals	December 1, 2010	December 27, 2010
February 2011	Human Resources	January 4, 2011	January 24, 2011
March 2011	Hospitals	February 1, 2011	February 21, 2011
April 2011	Insurance	March 1, 2011	March 21, 2011
May 2011	Clinics	April 1, 2011	April 18, 2011
June 2011	Human Resources	May 2, 2011	May 23, 2011
July 2011	Hospitals	June 1, 2011	June 20, 2011
August 2011	Hospitals	July 5, 2011	July 18, 2011
September 2011	Clinics	August 1, 2011	August 22, 2011
October 2011	Human Resources	September 1, 2011	September 19, 2011
November 2011	Hospitals	October 3, 2011	October 24, 2011
December 2011	Clinics	November 1, 2011	November 21, 2011

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this exception only applies until 2014. Regulations adopted under PPACA also require that plans treat all children under age 26 the same, including charging the same premium for all children under age 26. PPACA does not require plans to cover the child's spouse or the child's own children.

In a significant change for consumer-driven health care, over-the-counter drugs will not be reimbursable through health savings accounts ("HSAs"), health flexible spending accounts and health reimbursement arrangements ("HRAs"), unless the drugs are prescribed or are insulin.

PPACA requires that employers with more than 200 employees automatically enroll full-time employees into health plans when they are first eligible to join the plan and automatically continue enrollment of current employees. Employees will have a right to opt out of the coverage. This provision takes effect when the Department of Labor issues regulations clarifying the details of this requirement, such as what benefit option will be subject to the rule for employers offering multiple health plans or health plan options.

PPACA prohibits aggregate lifetime limits and lifetime limits on "essential health benefits." Essential health benefits will be defined by the Secretary of Health and Human Services and must include, at a minimum, benefits in the following categories:

- Ambulatory patient services;
- Emergency services;
- Maternity and newborn care;

- Prescription drugs;
- Hospitalization;
- Laboratory services;
- Mental health and substance use disorder services;
- Rehabilitative and habilitative services and devices;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Regulations interpreting the meaning of these terms have not been released at the time of this writing. The regulatory agencies have indicated that they will take into account good-faith efforts to comply with a reasonable interpretation of the term "essential health benefits" until additional guidance is issued. Lifetime and annual limits on non-essential health benefits are still allowed, as are exclusions for benefits for specific conditions.

PPACA also prohibits most aggregate annual dollar limits on essential health benefits. However, regulations allow an annual dollar limit on essential health benefits for plan years starting between September 23, 2010 and September 23, 2011, if the annual dollar limit is at least \$750,000. This minimum annual limit increases to \$1.25 million for 2012 and \$2 million for 2013. These limits apply to each individual, not to each family.

Plans can no longer have preexisting condition exclusions for children under age 19. Preexisting condition exclusions are any limitations or exclusions based on the fact that the condition was present

before the date of coverage. For example, a plan may not exclude benefits for surgery resulting from an injury that occurred prior to the effective date of coverage. Beginning January 1, 2014, the prohibition on preexisting condition exclusions expands to include participants and beneficiaries age 19 and over.

PPACA imposes a number of new requirements on "new" plans, which are plans that are not "grandfathered." Grandfathered plans are plans that were in existence on March 23, 2010 and have not been amended in a way that causes them to lose their grandfathering status. Changes that will cause a loss of grandfathering status include:

- Eliminating all or substantially all benefits for a particular condition;
- Increasing the percentage of cost-sharing for non-fixed amounts (such as changing coinsurance from 10 percent to 20 percent);
- Certain increases to fixed-amount requirements, such as co-payments or deductibles;
- Decreasing the employer contribution percentage; or
- Adding or reducing annual dollar limits.

New plans are subject to the following requirements:

- New plans must provide preventive services without cost-sharing such as copayments or coinsurance. This includes all preventive care, screenings, immunizations and services recommended by certain gov-

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Essentials of Physician Reimbursement

By Dwight Johnson, FHFMA
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Physician reimbursement has been central to the extensive debate over health care reform. Understanding the essentials of physician reimbursement is fundamental to understanding healthcare finance, the recently approved changes to our health care system, and how to respond as those changes take effect. Any examination of physician reimbursement should begin with a discussion of Medicare.

When it was initiated in 1966, Medicare paid physicians based on physicians' usual and customary charges. The program was originally intended to cover only acute illnesses. The federal government worked with physicians to develop the Current Procedural Terminology (CPT) coding system, which

became the standard for submitting physician billing to Medicare.

After two decades, the government realized that the charge-based system it developed was performing a poor job of cost control. In 1989, Congress abandoned the usual and customary charge Medicare payment format, and instead started paying physicians according to variation in the services performed, the costs of providing services and the potential liability expense related to services provided. In essence, the federal government shifted from paying physicians based on what they charged per service to the actual and expected resources expended in the delivery of services. The new payment methodology developed was called the resource based relative value scale (RBRVS). The RBRVS system, like its hospital correlate the DRG system, was only peripherally concerned with charges. In addition, at the direction of the Congress, the RBRVS system engendered a monetary shift away from invasive surgical procedures toward primary care services.

The commercial insurance industry, seeing clearly the gain to be realized by moving away from a charge-based reimbursement structure, quickly adopted RBRVS. The RBRVS system became the standard for physician reimbursement in America, both commercial and governmental.

Payments under RBRVS are simi-

lar to the DRG system and its variants in that reimbursement occurs as the result of a weight assigned to care delivered multiplied by a dollar conversion factor. In general, the weighting assigned to a particular service is comprised of a physician's total work (50%); practice costs (45%); and malpractice costs (5%). Total work is captured by six characteristics: technical skill; time; mental effort; physical effort; stress and judgment. Practice costs are overhead expenses including office rent, equipment, supplies, and non-physician salaries.

The RBRVS weighting version is typically updated annually by CMS for Medicare and Medicaid use. Most commercial carriers use the CMS updated versions directly, or with certain carrier specific modifications applied. The commercial carriers tend to use differing RBRVS versions, some may use the current version, others may use older iterations. Typically, the commercial carriers will not use versions that are more than 2-3 years old, although exceptions may occur. Note that reimbursement can then vary widely, depending on the conversion factor and RBRVS version utilized. The result can be extensive negotiations between the commercial carriers and providers, both over the conversion factor and the RBRVS version.

In 1997, Congress initiated the

sustainable growth rate, or SGR, for the Medicare program. The SGR either increases or decreases physician reimbursement annually based on a comparison of total overall expenditures on physician services to per capita gross domestic product. In recent years the annual calculation has consistently called for decreases in payments to physicians for services provided to Medicare enrollees, with subsequent political debate and ultimately the elimination of planned decreases in payments. On June 25, 2010 President Obama signed legislation postponing the planned 21.3 percent cut in Medicare payments retroactive to June 1 and through November 30, 2010. This action also gave a 2.2 percent in-

crease in Part B reimbursement for services delivered from June 1 through November 30.

Many believe that the current RBRVS based system is flawed, for a variety of reasons. The annual Medicare updates under SGR clearly do not keep pace with practice costs, and the annual drama surrounding the Medicare/SGR/Congressional process only heightens physician frustration. Momentum is building behind adaptation of reimbursement based on episodic care, or a medical home approach. Under this approach, reimbursement would reflect the value of care provided beyond that delivered in an individual patient/physician encounter, instead spanning the entirety of the spectrum of care

delivered and providers participating in treating patients and keeping them well. There are many pilot projects existing at present related to medical home, but at present the traditional RBRVS system remains the standard.

In conclusion, physician reimbursement has been a complex and controversial issue for many decades. While the nature of physician reimbursement in the future may be uncertain, it is certain that the complexity and controversy surrounding it will continue.

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- ernmental agencies; however, plans may refuse to cover or may impose cost-sharing for out-of-network services.
- New plans must meet new internal and external review process standards, including:
 - o both ERISA and non-ERISA plans must comply with ERISA claims procedures;
 - o plans must comply with new internal claims procedures, including issuing determinations on urgent care claims within 24 hours and ensuring the independence and impartiality of decision makers; and
 - o plans must comply with an external review process that meets certain minimum consumer protection standards modeled on standards of the National Association of In-

urance Commissioners.

- New plans must pay the same benefits for emergency care, whether provided in-network or out-of-network.
- New plans must allow the designation of any primary care physician or pediatrician as the primary care physician.
- New plans cannot require authorization or referral for obstetrics/gynecology services or emergency care.
- New insured plans must meet nondiscrimination requirements.

Plans will be carefully considering the costs and benefits of losing grandfathered status in light of these requirements.

Complying with health care reform will be the main focus for group health plans this year and for the next several years. In addition to implementing required plan design

changes and sending out required notices, plans and employers will be carefully monitoring health coverage costs.

Howard Bye is of counsel in the Seattle office of Stoel Rives LLP. He assists clients with employee benefit matters relating to health, cafeteria, and other welfare plans. Mr. Bye has both written and spoken on health care reform, HIPAA, Medicare Part D, wellness programs, ERISA, the Americans with Disabilities Act, and other state and federal law benefit topics. He can be reached at (206) 386-7631 or hdbye@stoel.com.

Erin Lennon is an associate in the Seattle office of Stoel Rives LLP. Her practice includes all areas of employee benefits law, including qualified retirement plans, non-qualified deferred compensation plans, health and welfare plans, and fringe benefit plans. She can be reached at (206) 386-7554 or ellennon@stoel.com.

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Job Summary: This position is accountable for overall direction, coordination and evaluation of the Pre-Op and Pre-Admission Departments.

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Education and/or Experience:

Completion of an accredited nursing program. Bachelor's degree in Nursing preferred. Two years previous Pre-Op Unit, Intensive Care Unit (ICU) or Emergency Room (ER) experience preferred.

License and/or Certification:

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Supervisor of PACU (Fresno, CA)

Job Summary: This position is accountable for overall direction, coordination and evaluation of the Post Anesthesia Care Unit Department.

Duties and Responsibilities:

Plans and organizes activities in the Perianesthesia Care Unit to ensure patient needs are met in accordance with instruction of surgeons, anesthesiologists and hospital administrative procedures. Promotes through education and personal examples, and atmosphere of caring for the "whole person" by meeting the needs of the patients, family member and visitors. Provide clinical support and acts as a resource to nursing staff in order to provide optimal patient care.

Education and/or Experience:

Completion of an accredited nursing program. Bachelor's degree in Nursing preferred. Two years previous Perianesthesia Care Unit (PACU), Intensive Care Unit (ICU) or Emergency Room (ER) experience preferred.

License and/or Certification:

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