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Alerts

Health Care Reform Introduces Array of Cost Containment Measures

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Hinshaw Health Law Alert

This is the ninth in a series of Health Care Alerts that Hinshaw & Culbertson LLP will publish on the topic of health care reform.

The Congressional Budget Office has estimated that the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, will produce a net reduction in the federal deficit of $124 billion over the next nine years deriving from its health care and revenue provisions. Because cost containment is one of the primary goals of the legislation, many of the provisions addressed in previous Hinshaw Health Care Alerts have also addressed that objective. This Health Care Alert highlights two additional provisions that focus on containing health care costs: (1) the further "administrative simplification" of transactions between health plans, providers and patients; and (2) the creation of an Independent Payment Advisory Board to make annual proposals to constrain the growth rate of Medicare costs and to make recommendations to the private sector.

Administrative Simplification
PPACA amends and expands the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Social Security Act and requires the United States Secretary of Health and Human Services (Secretary) to adopt uniform standards and operating rules governing transactions with health plans. Cost containment is to be achieved by reducing administrative and clerical burdens and encouraging the use of electronic funds transfers.

Under existing administrative simplification provisions, administrative waste was reported to be a significant expense, comprising up to 14 percent of revenue in physician practices. PPACA requires the Secretary to establish a unique health plan identifier for payers, effective no later than October 1, 2012, to facilitate claims management. Additionally, PPACA requires the Secretary to issue (and health plans to certify compliance with) new uniform standards and associated operating rules aimed at addressing many common concerns under the present regulations. Payers and providers can expect further modifications because PPACA requires a designated "review committee" to, beginning in 2014 and at least biennially, review the standards and rules and to recommend updates and improvements.

More specifically, the Secretary must develop new uniform standards which: (1) enable eligibility and financial responsibility determinations to be made prior to or at the point of care; (2) minimize the need to supplement claims with paper attachments or other communication; (3) provide for timely acknowledgment, response and status reporting of claims (including claim denial, adjudication and appeals); (4) describe all data elements (including reason and remark codes) in unambiguous terms; and (5) provide that data elements must be required or conditioned upon set values in other fields and prohibit additional conditions (except where necessary to implement state or federal law or to protect against fraud and abuse). PPACA specifically requires the Secretary to develop a standard concerning electronic funds transfers and a standard for health claims attachments that is consistent with X12 Version 5010.

Operating rules for each transaction standard will also be issued for the following categories:

- Eligibility for a health plan

- Health claim status
- Electronic funds transfers
- Payment and remittance advice (allowing for automated reconciliation)
- Health claims or equivalent encounter information
- Enrollment and disenrollment in a health plan
- Premium payments
- Referral certification and authorization

The effective dates of these rules are expected to be staggered from January 2013 through January 2016.

Health plans will be required to certify that their data and information systems are in compliance with any applicable standards and operating rules. To be in compliance, a health plan must document that it conducts electronic transactions in a manner that fully complies with the Secretary's regulations and that the plan has completed end-to-end testing for such transactions with its partners, such as hospitals and physicians. Certification deadlines will vary by standard and rule but will begin as early as December 31, 2013. Under PPACA, a health plan is responsible for ensuring that all entities it contracts with to provide services also timely comply with the applicable standards and operating rules and certify their compliance.

The Secretary is to conduct periodic audits of health plans to assess compliance and, no later than April 1, 2014, to assess penalty fees in the amount of $1 per covered life per day against any health plan not in compliance with effective standards and rules, until certification of compliance is complete. This fee is to be increased on an annual basis by the annual percentage increase in total national health care expenditures, up to $20 per covered life per day. Fees are doubled if a health plan misrepresents its compliance.

Independent Payment Advisory Board
PPACA also establishes an Independent Payment Advisory Board to make annual proposals to Congress to constrain the rate of Medicare cost growth and to make recommendations concerning cost growth in the private sector. The Board's Medicare proposals will automatically take effect in years when Medicare costs are projected to be unsustainable, unless Congress passes an alternative measure that achieves the same level of savings. (The first set of recommendations could be implemented in 2015.) For years in which Medicare growth is below the targeted growth rate, the recommendations would be non-binding. The Board cannot make proposals that ration care, raise taxes or change Medicare benefit or eligibility standards.

The Board is also directed to make annual recommendations to the President, Congress and private entities regarding cost containment and quality improvement in the private sector. The Congressional Budget Office estimates that establishment of this Board will save $15.5 billion between 2015 and 2019. The establishment of the Board and the weight to be given its proposals suggests that providers, health plans and all stakeholders in American health care can expect a climate of ongoing reform in the coming years.