

Health Care Reform in 2012

By Malinda Shafman

There are several pieces of the Health Care Reform law that will be going into effect in 2012. Many of the regulations you may not feel the impact of but will hear about them in the news, including:

- Accountable Care Organizations (ACOs) – the law allows providers organized as ACOs that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Medicare Advantage plans – the rebates paid to Medicare Advantage plans are being reduced and bonus payments are being provided to high-quality plans.
- Medicare Independence At Home Demonstration projects – creates the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home.

Two changes that may impact you if you participate in a group health plan or have individual health insurance include:

1) Medical Loss Ratio Rule

Medical Loss Ratio (MLR) is a financial measurement used in health care reform to encourage health plans to provide value to enrollees. The MLR reporting and rebate process is intended to increase insurance companies' transparency. MLR reports for 2011 calendar year experience must be submitted to the Department of Health and Human Services (HHS) by June 1, 2012. Insurance companies must report the following in each state it does business: total earned premiums, total reimbursement for clinical services, total spending on activities to improve quality, and total spending on all other non-claims costs excluding federal and state taxes and fees. These reports will be posted publicly by HHS so residents of every state will have information on the value of health plans offered by insurance companies in their state.

Insurance companies have to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities in the individual and small group markets; and at least 85 percent in the large group market. Insurance companies not meeting a medical loss ratio standard will be required to provide rebates to their consumers beginning in 2012 (if a rebate amount is owed for 2011 experience, it must be paid by Aug. 1, 2012). **BCBSMT** has added the following **PREMIUM REBATES LANGUAGE** to its Member Guide that each health insurance participant receives:

Distribution and Accounting of Premium (Dues) Rebates

In the event federal or state law requires Blue Cross and Blue Shield of Montana (BCBSMT) to rebate a portion of an annual premium (dues) payment, BCBSMT will pay the Group the total rebate applicable to the Contract, and the Group will distribute from the rebate a pro-rata share of the rebate to each Employee and former Employee based upon their respective contribution to the premium (dues) rebated.

The Group shall assure appropriate notification to federal and state tax agencies and that each payment to Employees and former Employees will be accompanied by appropriate federal and state documentation. The Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to BCBSMT as follows:

1. Prior to March 15, the following information will be required for the prior year:

- (A) The % of the premium (dues) paid by each Employee;*
- (B) The % of the premium (dues) paid by the Group;*
- (C) The % of the rebate to be provided to each Employee;*
- (D) The % of the rebate to be retained by the Group; and*
- (E) The % of any unclaimed rebate and how and when it will be or was distributed.*

2. Following actual distribution of the rebate, the following information will be required:

- (A) Amount of rebate paid to each Employee;*
- (B) Amount of rebate retained by the Group; and*
- (C) Amount of any unclaimed rebate and how it will be reported to the State. The Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Employee's state of domicile.*

COBRA

If BCBSMT does not administer the Group's COBRA requirements, then the rebate payment will include COBRA premiums that the Group must return to each COBRA recipient.

2) Consumer Uniform Summary of Benefits and Coverage (SBC)

The law requires individual and group health plans to provide a uniform summary of benefits and coverage (SBC) to all applicants and enrollees. The intent is to help consumers compare health plan options before they enroll and help them understand their plan once they enroll. The summary cannot exceed 4 pages double sided and the type font must be at least size 12. The SBC must include specific information as defined by the Department of Health and Human Services. The summary must be ready for distribution by March 23, 2012.

More information on all impacts of the Health Care Reform law can be found at www.healthcare.gov.