

---

## Health insurers begin to provide user-friendly plan guides

Mon, Sep 24 2012

WASHINGTON (Reuters) - The Obama administration on Monday began requiring health insurers to provide user-friendly guides to patients that explain their benefits, aiming to make buying insurance nearly as easy as scanning packages of food for nutrition facts.

Under President Barack Obama's healthcare reform law, employers and insurers must provide a summary of benefits and coverage in a clearly worded, standardized format that allows the private insurance market's 163 million beneficiaries to make side-by-side comparisons of plan offerings.

Consumers are also required to have access to a standardized glossary of insurance and medical terms. The rule takes effect just as insurers and employers prepare for annual enrollment periods, when employees select their coverage for 2013.

The benefit guides will also factor into the creation of new state-based health insurance markets due to begin offering subsidized, private coverage to moderate-income consumers in January 2014.

The Department of Health and Human Services released an eight-page sample benefits form to demonstrate how the actual summaries will outline everything from deductibles and out-of-pocket expenses to referrals and network providers.

The guides are also supposed to show what a plan covers for two common medical situations -- new births and adult diabetes.

U.S. officials compared the summaries to the Nutrition Facts label required for packaged food sold in the United States.

The rule has been criticized by the insurance industry as a new administrative burden that will increase the cost of healthcare coverage. (Reporting by David Morgan and Caroline Humer; Editing by Dan Grebler)

---

© Thomson Reuters 2011. All rights reserved. Users may download and print extracts of content from this website for their own personal and non-commercial use only. Republication or redistribution of Thomson Reuters content, including by framing or similar means, is expressly prohibited without the prior written consent of Thomson Reuters. Thomson Reuters and its logo are registered trademarks or trademarks of the Thomson Reuters group of companies around the world.

Thomson Reuters journalists are subject to an Editorial Handbook which requires fair presentation and disclosure of relevant interests.

This copy is for your personal, non-commercial use only. To order presentation-ready copies for distribution to colleagues, clients or customers, use the Reprints tool at the top of any article or visit: [www.reutersreprints.com](http://www.reutersreprints.com).

## HHS Watchdog Has ACA in Sights for 2013 Review

By David Pittman, Washington Correspondent, MedPage Today  
Published: October 08, 2012

WASHINGTON – Some aspects of the Affordable Care Act will get special attention in the coming year from the Department of Health and Human Services' (HHS) Office of Inspector General (OIG).

Among other things, the agency's independent watchdog will review the use of grants to establish the necessary insurance exchanges that are a backbone of the Affordable Care Act (ACA). HHS has provided funding to states to establish the exchanges, meant to be a one-stop shop for individuals and small businesses to use for purchasing health insurance starting in 2014.

Investigators are already looking into states' willingness to comply with requirements for the exchanges and for eligibility for Medicaid, the Children's Health Insurance Program, and health subsidy programs, according to the OIG's 2013 work plan, which was released last week.

The OIG also will review the use of the \$3.4 billion the ACA has authorized to fund the creation of new nonprofit health insurance issuers that will offer plans through the exchanges. These issuers are known as Consumer Operated and Oriented Plans, or CO-OPs.

"Given the substantial amount of federal funding, (HHS' Center for Consumer Information and Insurance Exchanges) must effectively monitor CO-OPs to ensure appropriate use of loans and enforce program requirements," the work plan stated.

The 148-page work plan outlines a wide range of other areas the OIG will investigate including those involving Medicare, Medicaid, and other HHS agencies:

The billing practices of provider-based physician practices will be reviewed. Billing under a so-called "provider-based status" -- rather than as a subordinate facility -- can result in additional payments, but the Medicare Payment Advisory Commission last year expressed concern about such financial incentives and suggested Medicare seek similar pay amounts for similar services.

Investigators will examine providers that received Medicare payments after being referred by the Centers for Medicare and Medicaid Services for not refunding overpayments. "We will determine the extent to which they ceased billing under one Medicare provider number but billed Medicare under a different number after being referred," the OIG stated.

Community mental health centers and rural health clinics are also getting special attention for their lack of compliance in billing for services.

The office also will review billing for services that should be performed by a physician and were instead done by a nonphysician provider. "A 2009 OIG review found that when Medicare allowed physicians' billings for more than 24 hours of services in a day, half of the services were not performed by a physician," the work plan stated. "We also found that unqualified nonphysicians performed 21% of the services that physicians did not personally perform."

The OIG will investigate physicians' and hospitals' experience with drug shortages. "In addition, we will ask providers to describe their behavior when facing a drug shortage as well as any effect on pricing, quality of care, and market availability," the work plan said.

Investigators will review Medicare and Medicaid incentives from last year to spot payments for establishing electronic health records to providers who should not have received them. They also will assess CMS' plans to oversee incentive payments and the agency's actions to remedy erroneous payments. The Congressional Budget Office estimates CMS will spend about \$20 billion in ACA and stimulus funding to encourage use of electronic health records.

The CDC's use of grants "to reduce chronic disease and promote healthy lifestyles" also will be examined. Some members of Congress have questioned the use of grants for such purposes, saying the CDC is crossing the line from public awareness campaigns to lobbying.

The OIG will examine the extent to which the FDA's risk evaluation and mitigation strategies programs, designed to identify risks and benefits of drugs, are adhered to.

Investigators will determine the extent to which Health Resources and Services Administration-funded health centers have adopted the CDC's recommendations for routine HIV testing.

Reports on the various issues will be released throughout the year. The OIG says it identified about \$20 billion in savings for fiscal 2011 for legislative, regulatory, and administrative actions based on its recommendations.

The same OIG report last year said the agency would review how many doctors were opting out of Medicare. The OIG's findings, issued in a memo released this past January, showed that Medicare

and its contractors don't adequately track which physicians are opting out of Medicare, making it nearly impossible to determine who is cutting ties with the program and why.

**® Add Your Knowledge™**

**Related Article(s):**

CDC on Obesity: Public Health or Politics?

OIG Details Health Investigation Plan for 2012

OIG: Feds Don't Know Who's Opted Out of Medicare