Federal Health Reform and Virginia

by Alan S. Goldberg

The new Patient Protection and Affordable Care Act (PPACA) changes how health care will be delivered and paid for in the United States. Although attorneys general in several states, including Virginia, are challenging the act's constitutionality, pending litigation likely will not affect implementation and enforcement of the new law.

The PPACA will affect businesses in their capacities as employers, insurers in their capacities as payment and service providers, individuals as patients and employees, states as Medicaid program overseers, and Medicare and Medicaid providers as recipients of government reimbursements. Attorneys for these clients should be prepared to advise them on the law even before implementing regulations are in place. Attorneys should know the law's significant features and anticipate its implementation in drafting.

As its name indicates, the act is designed to protect patients and make health care affordable. Features of the PPACA that have received publicity include no lifetime or annual limits on health care insurance benefits, prohibition of rescissions, coverage of preventive health services, extension of dependent coverage, standardized definitions and explanations of coverage documents, elimination of discrimination based on salary, and quality-of-care standards.

Immediate actions required under the act include making insurance available for persons with preexisting conditions, providing reinsurance for early retirees, and providing information to help consumers identify affordable coverage options.

Information technology changes are a significant part of the PPACA; the legislation establishes standards and protocols that will expand the use of information technology in health care.

One longtime federal goal — set out in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended — is to establish a system through which health information can be exchanged electronically.

Before the enactment of HIPAA, there were no uniform federal standards for the many public and private health care claim- and payment-processing systems used by governments and others. HIPAA encourages and in some instances requires that electronic systems replace paper-based systems that are slow, not uniform, and inefficient. HIPAA requirements generally preempt standards set by states and others.

HIPAA requires that standardized electronic information be available for health claims, health plan enrollments, eligibility for a health plan, payment and remittances, premium payments, first reports of injury, status of claims, referral certification and authorization, and coordination of benefits.

However, health care providers are slow to adopt the practices, because they have found the process too variable, costly, and inefficient. The existing system of a combination of electronic and paper transactions with no uniform standards and few operating business rules delays payments, increases the likelihood of errors, and adds costs.

The Patient Protection and Affordable Care Act includes provisions to clear the roadblocks and provide business guidelines for complying with the HIPAA requirements.

The adoption of nationally observed business rules and guidelines for the electronic exchange of information surely will enhance the effectiveness of the established standards for health care transactions. New operating rules for electronic funds transfers and other transactions are to be adopted as well. With many more millions of individuals soon to be receiving health care benefits because of the PPACA, efficient claims processing and payment transactions will be more important than ever before.

Although these changes will be complex and require substantial time, effort, and money to implement, the standardized electronic information must be in place for the overall health reform initiative to meet its goals.