IRON MOUNTAIN®

WHITE PAPER

HEALTHCARE

RECORDS MANAGEMENT IMPLICATIONS OF THE AFFORDABLE CARE ACT

Contents

The breadth of the Affordable Care Act requires all organizations to adopt more comprehensive recordkeeping practices that capture changes in retention requirements.

Introduction

Signed into law on March 23, 2010, The Patient Protection and Affordable Care Act fundamentally altered the healthcare system in America, sending a tsunami of change through the health insurance industry and rippling to employers, health care providers and individuals across the nation. Also referred to as the Affordable Care Act (ACA) or Obamacare, it was amended by the Health Care and Education Reconciliation Act and survived a constitutional challenge. Thus far, the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) have issued the majority of the regulations required by the ACA. The Internal Revenue Service has jurisdiction over the portions of the ACA that amend the Social Security Act and the Internal Revenue Code to create new taxes and credits. The ACA also contains amendments to the Employee Retirement Income Security Act of 1974, causing the Employee Benefits Security Administration of the Department of Labor (DOL) to issue new regulations. With major provisions of the law set to be implemented in 2014, organizations must meet the challenge of complying with a daunting array of changes in how they do business, along with complex regulatory compliance and recordkeeping requirements.

INFORMATION IS...
YOUR ADVANTAGE

OVERVIEW OF THE AFFORDABLE CARE ACT

The ACA touches many facets of the healthcare landscape. Some of its provisions will impact individuals and employers while others will more directly affect organizations that offer health insurance or provide healthcare in return for payment from Medicare and Medicaid. In broad terms, the ACA institutes the following key changes:

Improved coverage	The ACA imposes new rules on health insurance companies. Insurers can no longer set lifetime or annual limits on payouts, or rescind coverage for enrollees. Insurers are required to cover preventative health services and must extend coverage of dependent children until the child turns 26 years of age. In addition, uninsured individuals with preexisting conditions are guaranteed immediate access to insurance via a temporary high-risk health insurance pool that will operate until January 1, 2014 when coverage through qualified health plans offered through an Exchange[1] will commence.
Essential health benefits	Beginning on January 1, 2014, health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace,[2] must offer a comprehensive package of items and services known as essential health benefits. Essential health benefits must include the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[3]
General reform	Under the ACA, insurers are prohibited from discriminating against individuals based on health status and may no longer deny coverage for preexisting conditions. Rules (referred to as "guaranteed issue") are imposed on rates to prevent discriminatory premiums and to ensure that consumers are guaranteed availability and renewability of coverage, as well as to eliminate waiting periods longer than 90 days.[4]
Implementation of Insurance Exchanges	Insurance Exchanges will provide a competitive marketplace where individuals and small businesses will be able to compare plans and purchase coverage. The Exchanges began open enrollment for the first time on October 1, 2013.[5]
Individual mandate	Within certain income parameters, individuals are required to obtain basic health insurance coverage by January 1, 2014 or pay a penalty fee.[6]
Employer mandate	Organizations that employ more than 200 full-time employees must automatically enroll new full-time employees in one of the plans offered by the employer.[7]
Existing coverage provisions (grandfather clause)	Individuals and employers are entitled to keep their existing health coverage if the coverage continues to meet certain conditions. Grandfathered health plan coverage means coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as the plan maintains grandfather status under the rules of this section).[8]
Tax credits and taxes	New tax credits will be available to qualifying individuals and small businesses that purchase insurance through an Exchange.[9] Newly created excise taxes and fees will fund the costs associated with the ACA.[10]
Transition to "bundled payments"	This represents a major shift from the established "fee for service" model in which providers are paid for each service rendered. The ACA sets the stage for a change in Medicare reimbursement by introducing the "bundled payment" model which bases payments on an entire episode of care for an individual. An episode of care can be defined in several ways: for example, as a single hospital admission, or as a hospital admission plus related care or readmissions during a set period (30, 60 or 90 days) after discharge. CMS has established a pilot program to study the bundled payments reimbursement model.[11]
Improvements to Medicaid	In states that elect to participate, Medicaid will expand coverage to a greater number of individuals.[12]
Improvements to Medicare	Insurers and healthcare providers must comply with new Medicare requirements, including a policy to adjust provider payments up or down depending on the quality of care that they provide,[13] improvements to Medicare Part D prescription drug plans, including closing the coverage gap known as the "donut-hole,"[14] programs to improve the quality of healthcare[15] and to increase transparency and integrity.[16]

[1] Exchange means a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and makes qualified health plans available to qualified individuals and qualified employers.

[2] The Health Insurance Marketplace was created by the ACA and consists of organizations that facilitate the selection and purchase of health insurance.

[3] Sec. 1302, Patient Protection and Affordable Care Act (2010).

[4] Sec. 1201, Patient Protection and Affordable Care Act (2010).

[5] Secs. 1311 – 1324, Patient Protection and Affordable Care Act (2010).

[6] Sec. 1501, Patient Protection and Affordable Care Act (2010).

[7] Sec. 1511, Patient Protection and Affordable Care Act (2010).

[8] Secs. 1251 – 1253, Patient Protection and Affordable Care Act (2010), 26 CFR § 54.9815-1251T, 29 CFR § 2590.715-1251, 45 CFR § 147.140.

[9] Secs. 1401 – 1421, Patient Protection and Affordable Care Act (2010).

[10] Secs. 9001 – 9023 and 10601 – 10909, Patient Protection and Affordable Care Act (2010).

[11] Sec. 3023, Patient Protection and Affordable Care Act (2010).

[12] Sec. 2001, Patient Protection and Affordable Care Act (2010).

[13] Secs. 3001 – 3008, Patient Protection and Affordable Care Act (2010).

[14] Secs. 3301 – 3315, Patient Protection and Affordable Care Act (2010).

[15] Secs. 3501 – 3602, Patient Protection and Affordable Care Act (2010).

[16] Secs. 6001 – 6801, Patient Protection and Affordable Care Act (2010).

The ACA affects every employer in the United States, but has the greatest impact on large employers, defined as any business that has 51 or more full-time employees. A full-time employee is defined as any employee who works on average at least 30 hours per week.[17] Employers are now required to provide to each employee, either by March 1, 2013 for existing employees or on the date of hire for new employees, a written notice containing information regarding the existence and nature of the Insurance Exchange, and tax and compensation information relevant to that employee.[18] The DOL has issued model notices to assist employers with complying with this requirement. Employers will need to use their employee time and attendance records to demonstrate the full- or part-time status of their employees, as well as records of the coverage offered so that they can prove compliance with the employer mandate.[19] In addition, from tax year 2012 on, employers must report the value of health-care coverage provided to employees on the annual W-2 forms.[20]

Grandfathered Health Plans and Recordkeeping Requirements

The ACA allows existing health plans to avoid complying with some of the coverage requirements and limitations provided they meet certain ongoing criteria. In order to qualify for these exemptions, a so-called "grandfathered health plan" must have had at least one individual enrolled in it on March 23, 2010. A grandfathered plan must comply with some, but not all, of the new coverage requirements under the Act. In their "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," the DHHS provided Appendix 1 (on page 7) to organize the provisions of the ACA that are and are not applicable to grandfathered plans.[21]

In order to maintain its status as a grandfathered plan, an eligible plan must include in the materials provided to the participants a statement that it believes it is a grandfathered health plan within the meaning of section 1251 of the ACA. It must also provide contact information for questions and complaints. The plan must also maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain or clarify its status as a grandfathered health plan.[22]

If a plan entered into a new policy, certificate or contract of insurance after March 23, 2010 and was effective before November 15, 2010, then the plan is no longer eligible to be a grandfathered health plan. The regulations governing grandfathered plans also have certain anti-abuse measures that provide that a plan will lose its status as a grandfathered health plan if a merger, acquisition, or similar business restructuring occurs for the principal purpose of covering new individuals under a grandfathered health plan, or if employees are transferred into a grandfathered plan for a non-bona fide employment reason, such as for the purpose of changing the terms or cost of coverage.[23]

[17] Sec. 1513, Patient Protection and Affordable Care Act (2010).
[18] Sec. 1512, Patient Protection and Affordable Care Act (2010).
[19] IRS Notice 2012-58.
[20] 26 USC 6051(a)(14).
[21] 75 FR 34541, June 17, 2010.
[22] 26 CFR § 54.9815-1251T, 29 CFR § 2590.715-1251, 45 CFR § 147.140.
[23] 45 CFR § 147.140.

Recordkeeping Requirements for Health Insurers & Providers

Many new recordkeeping requirements have been issued in accordance with the Act. While the following list is not exhaustive, it includes the most noteworthy of the new recordkeeping requirements created under the ACA.

MEDICAL LOSS RATIO

One of the more significant reforms instituted by the ACA centers around the medical loss ratio, which is the percentage of consumers' premium dollars that the insurance company spends on medical care versus the percentage that is pure profit or spent on administrative costs. The ACA requires health insurance companies to report data to substantiate the proportion of premium revenue spent on medical care and quality improvement. An insurance company that fails to spend 80-85% of premium dollars on medical care must pay a rebate to its customers.

Recent recordkeeping requirements require Medicare Advantage organizations to keep documents and records related to their medical loss ratio for 10 years from the date that calculations were reported to CMS.[24] Part D (prescription drug plan) sponsors are also required to maintain documentation pertaining to their medical loss ratio for 10 years.[25]

HEALTH INSURANCE COMPANIES & RELATED ENTITIES

- Beginning August 1, 2013 group purchasing organizations[26] and drug and medical device manufacturers must report to CMS all direct and indirect payments or other transfers of value, and ownership and investment interests held by a physician or an immediate family member of a physician during the preceding calendar year. These reports and the supporting records must be kept for five years from the date the payment or other transfer of value, or ownership or investment interest is published publicly.[27] This rule originated in the Physician Payments Sunshine Act, which was incorporated into and passed as a part of the ACA.[28]
- Health insurance issuers offering individual health insurance coverage are required to maintain for six years records of all claims and notices associated with the internal claims and appeals process.[29]
- Third-party administrators[30] may qualify for an adjustment in their Federally-facilitated Exchange user fee if they make payments for contraceptive services. For any adjustments made, the third-party administrator must keep detailed documentation of payments for contraceptive services for 10 years following the calendar year in which the adjustment was made.[31]
- Qualified health plans[32] must maintain records of coverage terminations in accordance with the requirements of the Exchange.[33]

[24] 42 CFR 422.

[25] 42 CFR 423.2480.

[26] Group purchasing organizations are defined as entities that purchase, arrange for or negotiate the purchase of a covered drug, device, biological, or medical supply for a group of individuals or entities.

[27] 42 CFR 403.912.

[28] Sec. 6002, Patient Protection and Affordable Care Act (2010); 78 FR 9458.

[29] 45 CFR 147.136.

[30] Third-party administrator means an organization that processes insurance claims for other entities.

[31] 45 CFR 156.50.

[32] A qualified health plan (QHP) is a health plan that has in effect a certification that it meets standards imposed by the ACA or is recognized by each Exchange through which the plan is offered.

[33] 45 CFR 156.270.

EXCHANGES AND THE HEALTH INSURANCE MARKETPLACE

- An Exchange or Small Business Health Options Program (SHOP)[34] may elect to provide information regarding licensed agents and brokers on its website for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to data regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process. If a consumer completes a qualified health plan (QHP) selection using an agent or broker's Internet website, the site is required to maintain related audit trails and records in an electronic format for a minimum of 10 years.[35]
- Exchanges must maintain records of all enrollments in QHPs made through the Exchange,[36] and must also maintain records relating to terminations of coverage by QHP issuers in order to facilitate audit functions.[37]
- SHOPs must:
  i. Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuer from the qualified employer;
  ii. Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees;
  iii. Maintain books, records, documents and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years;[38] and
  iv. Receive and maintain for at least 10 years records of enrollment in QHPs, including identification of qualified employers participating in the SHOP and qualified employees enrolled in QHPs.[39]

MEDICAL PROVIDERS

Physicians and practitioners who order diagnostic testing, including x-rays, laboratory and other tests, must maintain documentation of medical necessity in the beneficiary's medical record. An entity submitting a claim must maintain the documentation that it receives from the ordering physician and proof of accuracy.[40]

Physicians and practitioners who order diagnostic testing, including x-rays, laboratory and other tests must maintain documentation of medical necessity in the beneficiary's medical record.

[34] A Small Business Health Options Program (SHOP) is operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

[35] 45 CFR 155.220.

[36] 45 CFR 155.400.

[37] 45 CFR 155.430.

[38] 45 CFR 155.705.

[39] 45 CFR 155.720.

[40] 45 CFR 410.32.

Actions to Take for Corporate Compliance

Whether you need to comply with the ACA because your organization falls under the definition of a large employer or because your organization is an issuer of health insurance plans or performs other covered functions, the following are implementation suggestions that you should consider to enable compliance:

- Analyze your organization's Records Retention Schedule to identify records governed by new recordkeeping requirements and ensure that the retention period is sufficient for compliance. In some cases, the retention period may need to be increased.
- Determine whether new classes of records need to be kept to satisfy new recordkeeping requirements.
- Reach out to the business unit users impacted by the regulations to apprise them of the changes and their new responsibilities.
- Update any applications, systems, processes or repositories that use retention rules to manage the regulated records.
- Foster collaboration between Records Management and IT to determine how to comply with storage requirements.

Conclusion

Iron Mountain is regularly capturing recordkeeping requirements issued under the Affordable Care Act, and incorporating them into our records management programs. Iron Mountain Consulting is prepared to help our clients ensure that their records management programs are in full compliance with the latest requirements. Our continuously updated legal research repository will link the new requirements to your Records Retention Schedule, and associated records.

For more information about how Iron Mountain can help you ensure that your organization is ACA-compliant, contact Iron Mountain at consulting@ironmountain.com.

APPENDIX 1 – LIST OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS[41] ACT THAT APPLY TO GRANDFATHERED HEALTH PLANS

PHS Act statutory provisions:	Application to grandfathered health plans:
§ 2704 Prohibition of preexisting condition exclusion or other discrimination based on health status.	Applicable to grandfathered group health plans and group health insurance coverage. Not applicable to grandfathered individual health insurance coverage.
§ 2708 Prohibition on excessive waiting periods.	Applicable.
§ 2711 No lifetime or annual limits.	Lifetime limits: Applicable. Annual limits: Applicable to grandfathered group health plans and group health insurance coverage; not applicable to grandfathered individual health insurance coverage.
§ 2712 Prohibition on rescissions.[42]	Applicable.
§ 2714 Extension of dependent coverage until age.	Applicable.*
§ 2715 Development and utilization of uniform explanation of coverage documents and standardized definitions.	Applicable.
§ 2718 Bringing down cost of health care coverage (for insured coverage).	Applicable to insured grandfathered health plans.

* For a group health plan or group health insurance coverage that is a grandfathered health plan for plan years beginning before January 1, 2014, PHS Act section 2714 is applicable in the case of an adult child only if the adult child is not eligible for other employer-sponsored health plan coverage. The interim final regulations relating to PHS Act section 2714, published in 75 FR 27122 (May 13, 2010), and these interim final regulations clarify that, in the case of an adult child who is eligible for coverage under the employer-sponsored plans of both parents, neither parent's plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the other parent's employer-sponsored plan.

[41] Public Health Service Act.

[42] Rescission is a cancellation or discontinuance of insurance coverage that has a retroactive effect.

DISCLAIMER

The information provided here is for reference use only and does not constitute the rendering of legal, financial or other professional advice or recommendations by Iron Mountain. If you require legal advice, you should consult with an attorney. While Iron Mountain has made every effort to ensure the accuracy and completeness of this document, it assumes no responsibility for the consequences to users of any errors that may be contained herein. The information in this document is subject to change without notice and should not be considered a commitment by Iron Mountain.

IRON MOUNTAIN®

ABOUT IRON MOUNTAIN. Iron Mountain Incorporated (NYSE: IRM) provides information management services that help organizations lower the costs, risks and inefficiencies of managing their physical and digital data. Founded in 1951, Iron Mountain manages billions of information assets, including backup and archival data , electronic records, document imaging, business records, secure shredding, and more, for organizations around the world. Visit the company website at www.ironmountain.com for more information.