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in the news

Health Policy Monitor

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Health Reform and Related Health Policy News

In this Issue:

An executive summary of political, legal and regulatory issues that may impact your business, prepared by Polsinelli Health Care legal and Public Policy professionals.

Top News

HHS Gives Mixed Messages Regarding Federal Health Care Program-Status of Qualified Health Care Plans (QHPs)

On October 30, 2013, Department of Health and Human Services (HHS) Secretary Kathleen Sebelius issued a response letter clarifying whether Qualified Health Plans (QHPs) available on health insurance exchanges would be considered "federal health care programs" under the Social Security Act. Status as a federal health care program would subject arrangements involving QHPs to legal scrutiny under the federal Anti-Kickback statute.

According to the letter, which was written in response to an inquiry from Rep. Jim McDermott (D-Wash.), HHS does not consider QHPs, other programs related to the federally-facilitated marketplace, and other programs under Title I of the Affordable Care Act to be "federal health care programs". The scope of this exemption includes, but is not limited to, (a) State-based and Federally-facilitated Health Insurance Marketplaces (i.e., exchanges); (b) the cost-sharing reductions and advance payments of the premium tax credit; (c) navigators for federally-facilitated exchanges and other federally funded consumer assistance programs; (d) consumer-oriented and operated

health insurance plans; and (e) the risk adjustment, reinsurance and risk corridor programs.

However, less than a week later on November 4, 2013, the CMS Center for Consumer Information & Insurance Oversight (CCIIO) released a FAQ that addressed whether third party payors were permitted to make premium payments to health insurance issuers for QHPs on behalf of enrolled individuals. Highlighting suggestions that "hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations" with respect to QHPs purchased in the health insurance exchanges, the statement reflected significant concerns with the practice, including skewing of the insurance risk pool and creation of an uneven playing field in the exchanges. The statement urged issuers to reject such third party payments and noted HHS' intention to monitor the practice and take appropriate action.

The release of the HHS letter and at times conflicting CCIIO FAQ has created much uncertainty among providers about the legality of premium payments on behalf of beneficiaries and other arrangements.

HHS Issues Health Insurance Marketplace Enrollment Report Snapshot

On November 13, 2013, the Department of Health and Human Services (HHS), specifically HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE), issued a "snapshot" report of national and state-level enrollment-related information for the first month of the Health Insurance Marketplace (Marketplace) initial open enrollment period. The initial Affordable Care Act ("ACA") open enrollment period is from October 1 to March 31, 2014, and people must pay their first month's premium by December 15 for coverage to start January 1, 2014. The report includes highlights, graphics and comparisons of enrollment data for all states and the District of Columbia. No data are available based on age or health status, but more detailed information will be provided in the future, HHS' Secretary Kathleen Sebelius said.

The enrollment report provides that 106,185 people have selected health plans from the ACA health insurance marketplaces between Oct. 1 and Nov. 2, and another 975,407 applied for coverage and received an eligibility determination but have not yet selected a plan. An additional 396,261 individuals have been determined to be eligible for Medicaid or the Children's Health Insurance Program (CHIP). In the report, HHS states that, in total, 502,466 are positioned to have health coverage in 2014, either through Medicaid, CHIP or a plan selected in the Marketplace.

The report provides additional information stating that 26,794 people (about 25% of the total) enrolled through the federally facilitated marketplaces used in the 36 states that rely on the Healthcare.gov website. About 79,391 people (the remaining 75% percent) enrolled through state-based marketplaces, which have are generally working better than the federal site. Of the individuals determined to be eligible for Medicaid or CHIP, state-based marketplaces that provided data for the report accounted for 212,865 (53.7 percent), while the federally facilitated marketplaces accounted for 183,396 (46.3 percent). Enrollment includes people who have selected a qualified health plan, who either have or haven't paid the first month's premium, the HHS said in the release. Secretary Sebelius has stated that such information will be available by December 15th.

Secretary Sebelius, HHS officials and health care analysts have stated that it is necessary to read these initial

enrollment numbers in the context of other recent expansions of government insurance which also began slowly and took time to grow. Many others point to the troubled federal website as a hurdle for enrollment in the federally facilitated marketplaces. Secretary Sebelius said HealthCare.gov and state marketplace sites have received nearly 26.9 million unique visitors, and both national and state call centers have received more than 3.1 million calls. The report states that, in spite of the recent information system and website issues, interest in the marketplaces is high. Ultimately, HHS expects marketplace enrollment to increase as technical issues are resolved.

President Obama Announces Administrative Fix for Cancelled Health Plans

In a speech on November 14, President Obama announced an administrative fix to make good on his promise that "if you like your health plan, you can keep it." The announcement comes in response to the much-publicized experience of plan enrollees in the individual market receiving cancellations of their current health insurance.

In concert with the President's announcement, the Centers for Medicare & Medicaid Services Center for Consumer Information & Insurance Oversight (CCIIO) wrote a letter to State Insurance Commissioners detailing the new "transitional policy" allowing insurers to continue to offer plans for another year if coverage was in effect on October 1, 2013. According to the letter, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected consumers may choose to re-enroll in such coverage. Plans will be not considered out of compliance with certain market reforms in the Affordable Care Act if they comply with specified conditions. Among the market reform exemptions are those relating to (a) fair health insurance premiums; (b) guaranteed availability and renewability of coverage; (c) prohibition of pre-existing exclusions or other health-status based discrimination prohibitions; and (d) comprehensive health insurance coverage.

To be exempt from the market reforms above, issuers must send a notice to all individuals and small business that have received, or would otherwise receive, a notice of termination, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms.

Early responses from the insurance industry and state insurance commissioners have been mixed. California's Insurance Commissioner, Dave Jones, urged the state's insurers to continue the policies for the Californians who have had their policies canceled. Washington State Insurance Commissioner Mike Kreidler issued a statement that insurers will not be allowed to extend their policies. Montana Insurance Commissioner, Monica Lindeen, also a vice president of the National Association of Insurance Commissioners, stated that it is not necessarily the case that Insurance Commissioners always have the authority to compel insurers to follow the new policy, noting that insurance companies will make the decision in her state.

State News

Covered California Leads the Way in State-Based, Federal Exchange Success

The California Department of Health Care Services (DHCS) issued a release on November 13, 2013 reporting applications were started for an estimated 370,000 individuals seeking coverage through its state-based marketplace, Covered California. According to the release, of those who started the application process, nearly 86,000 were determined to be eligible to participate in subsidized or unsubsidized coverage through Covered California. And 72,007 were determined to be likely eligible for Medi-Cal, with coverage beginning in January 2014. These enrollment numbers indicate that California has enrolled more people than any other state-run exchange in the country, and has enrolled more than the federal exchange serving 36 states.

In October, 30,830 individuals, or about a thousand per day, enrolled in health care coverage through Covered California. Through Nov. 12, another 29,000 individuals not only were determined to be eligible, but also selected and enrolled in their Covered California health insurance plan — more than seven weeks in advance of when coverage will begin. Since October 1, more than 59,000 individuals have enrolled in Covered California health insurance plans. Peter V. Lee, executive director of the exchange, said "The numbers are better than encouraging. They show momentum and very high consumer interest."

In addition to releasing the enrollment figures, Covered California and DHCS released the results of surveys of those who completed the enrollment process during the last three weeks of October. Overall, nearly 70% of consumers who completed the survey found the application process easy to complete, and 88% of customers visiting the CoveredCA.com found the information needed to choose a health plan that was right for them.

Michigan Senate Bill Could Expand APNs Role

The Michigan Senate passed legislation that allows advanced practice nurses (APNs), including midwives and nurse practitioners, to be able to diagnose, treat and prescribe patients drugs, without physician supervision on November 13, 2013. The legislation would amend the Michigan Public Health Code to provide certifications for registered nurses with advanced training so they could practice independent of physicians. There were about 6,500 Michigan nurses in those nursing categories as of 2010, according to the Michigan Nurses Association.

Senators voted 20-18 to pass Senate Bill 2 after several amendments were added, including one that would hold nurses to the same standards of acceptable professional practice as physicians in malpractice or licensure removal actions. The legislation was sent to the House, where it was referred to the Health Policy Committee.

According to the Senate Fiscal Agency analysis, Michigan is one of 21 states that don't recognize APNs. Supporters of Senate Bill 2 say its passage would improve access to quality care, especially given the Michigan's physician shortage and increased demand that comes with an aging population and additional individuals with insurance under the Affordable Care Act. The Michigan State Medical Society opposes the bill, saying it poses risks to patients, and that it can create a culture of physician substitutes.

District Court Grants Partial Judgment to United States Finding Halifax Hospital Violated Stark Law

On November 13, 2013, the United States District Court for the Middle District of Florida (Court) issued an order granting partial summary judgment in favor of the United States in connection with its motion against Halifax Hospital Medical Center (Halifax Hospital), finding that Halifax Hospital's submission of claims for designated health services (DHS) referred by employed oncologists violated the Stark Law. More specifically, at issue was whether a bonus pool set up by Halifax Hospital for its employed oncologists took into account the volume or value of referrals under the bona fide employment exception to the Stark Law.

Halifax Hospital had a financial relationship with six oncologists who had employment agreements with its staffing group that employed these oncologists to work in the hospital. The employment agreements provided for a base salary and an incentive bonus. Between 2005 and 2008, the bonus was generated from an incentive compensation pool equaling 15% of the operating margin of Halifax Hospital's oncology program, including fees for DHS that were not personally performed by the oncologists, such as fees for outpatient prescription drugs and other outpatient services. Halifax Hospital proportionally distributed the resulting bonuses based on each oncologist's personally performed services.

Halifax Hospital argued that the compensation arrangement fit within the employment exception. The United States argued that the agreements violated the Stark Law because the incentive bonus did not meet an exception and took into account the volume or value of referrals made by the physicians. The Court agreed with the United States, stating that the bonus pool itself was based on revenues from the physicians' referrals, and the Court distinguished between the bona fide employment exception's allowance for a productivity bonus based on personally performed services and one divided up based on personally performed services by the oncologists. Therefore, not meeting a Stark Law exception, the oncologists were prohibited from making referrals to Halifax Hospital for DHS, and Halifax Hospital was prohibited from submitting Medicare claims for services furnished pursuant to such referrals.

Only partial summary judgment was granted as the Court held that there was insufficient summary judgment evidence to establish the amount of the Stark Law damages and that a genuine issue of material fact remains as to whether Halifax Hospital's conduct also violated the False Claims Act.

Full text of the Court's order is available here.

Regulatory News

Mental Health Parity and Addiction Equity Act

The Internal Revenue Service, Employee Benefits Security Administration, and Centers for Medicare and Medicaid Services released a final rule, published in the Federal Register on November 13, on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA requires insurance companies and employers offering mental health coverage to do so on par with other medical benefits. The regulations apply to the first plan year beginning on or after July 1, 2014 (for calendar year plans on January 1, 2015). The final rule implements most

of the requirements reflected in the interim final rule, with a few exceptions relating mostly to consumer protections and parity requirements.

The final rule ensures that parity requirements apply to intermediate levels of care for mental health conditions and substance abuse disorders by requiring that plans first identify what is meant by intermediate levels of care and that such services be treated comparably within the structure of plan benefits. The parity requirements for nonquantitative treatment limitations (e.g., medical management techniques such as prior authorization) also now apply to restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration benefits.

Plans and issuers are required to provide to current or potential participants the criteria for medical necessity determinations with respect to mental health or substance abuse disorder benefits. In another FAQ released simultaneously the final rule, the government solicits additional comments on what other disclosure requirements would promote more transparency with respect to mental health benefits. Finally, the rule does not apply to employers with 50 or fewer employees, Medicaid managed care plans, alternative benefits plans, or the Children's Health Insurance Program.

IRS modifies "Use-or-Lose" Rule of Health Flexible Spending Arrangements (FSAs)

The Internal Revenue Service released a notice that relaxes its use-it-or-lose it rules for health Flexible Spending Arrangements (FSAs). The modification of the rule allows Section 125 cafeteria plans to be amended to allow up to $500 of unused amounts in a FSA remaining at the end of a plan year to be paid or reimbursed to plan participants for qualified medical expenses incurred the follow plan year. The $500 carryover does not affect the maximum amount of salary reduction contributions that the participant is permitted to make under the Internal Revenue Code. Also, unused amounts must be used only to pay or reimburse certain medical expenses (excluding health insurance, long-term care services or insurance).

Employers are free to set the annual contribution and carryover contributions lower than the IRS maximums. Plans that use the grace period, which allows reimbursements to be paid up to 2.5 months after the close of the plan year, cannot simultaneously use the new carryover rule. The notice goes into effect immediately, giving employers the opportunity to amend their plans for the 2013 plan year.

Additional Reading

- On November 5, 2013, Health Management Associates announced it is repaying a total of $31 million in Medicare and Medicaid Health Information Technology (HCIT) incentive payments to the Centers for Medicare and Medicaid Services for hospitals that did not meet the "meaningful use" criteria.

- On November 7, 2013, Department of Health and Human Services Secretary Kathleen Sebelius announced $150 million in awards under the Affordable Care Act to support 236 new community health center sites across the country which will help care for approximately 1.25 million additional patients and help uninsured residents enroll in new health insurance options available in the health insurance marketplaces.

- The American Medical Association and American Hospital Association issued a joint letter on November 8, 2013 to the Centers for Medicare and Medicaid Services (CMS) urging CMS to delay until 2014 its "two-midnight" inpatient review policy.
- The House Oversight and Government Reform Committee discussed the data security, vulnerabilities and future testing of the federal health insurance marketplace website, HealthCare.gov, on November 13, 2013. Testimony available here.

Federal Register

CMS released a notice to be published in the Federal Register on November 19, 2013, that describes the Quality Rating System (QRS) framework for rating Qualified Health Plans (QHPs) offered through an Exchange. The notice solicits comments on the list of QRS quality measures that QHP issuers would be required to collect and report, the structure of the measure sets, and the elements of the QRS rating methodology.

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