INSURANCE EXCHANGES — EXPERT PERSPECTIVES HELP YOU PREPARE

Bloomberg BNA

Bloomberg BNA

Health Insurance Report™

VOL. 19, NO. 30 JULY 24, 2013

Insurers Must Evaluate Marketplaces State by State, Plan by Plan, Experts Say

Health insurers need to evaluate whether to participate in the online health insurance marketplaces being set up under the Affordable Care Act on a state-by-state, plan-by-plan basis, legal and industry experts advise. Insurers face the risk that covering many previously uninsured people with medical problems will drive up premiums, but they also face the risk of losing market share if they do not participate in the marketplaces, also known as exchanges.

The marketplaces open for enrollment Oct. 1 to sell health plans that take effect beginning in 2014. Plans sold in the marketplaces must be standardized qualified health plans (QHPs) that must cover at least 60 percent of medical claims as well as essential health benefits defined by the law.

For the first year, the open enrollment period will last through March 2014, although to ensure coverage for Jan. 1, 2014, enrollment must be completed by Dec. 15, Sarah Lueck, senior policy analyst for the Center on Budget and Policy Priorities, told BNA. After the initial enrollment period, the federally facilitated marketplaces (FFMs) operated by the Department of Health and Human Services will hold open enrollment from Oct. 15 through Dec. 7, Lueck said. States operating their own state-based marketplaces (SBMs) have the option of creating additional open enrollment periods or they can require guaranteed issue, under which insurers must sell policies to applicants, throughout the year, she said.

The marketplaces are the backbone of ACA. They are intended to allow consumers to compare QHPs and enroll in coverage, and the aim is to make health insurance markets more competitive and reduce premiums.

Individual and Small Business Marketplaces. Two types of marketplaces are being created under ACA: American Health Benefit Exchanges for individuals, who are required to have health insurance or pay a tax, and Small Business Health Options Program (SHOP) marketplaces for small businesses.

Advance premium tax credit (APTC) subsidies for households with incomes between 100 percent and 400 percent of the federal poverty level, as well as cost-sharing subsidies for households up to 250 percent of the poverty level, are only available by applying for coverage through the marketplaces, and small businesses with fewer than 25 employees must apply through the marketplaces in order to qualify for small business tax credits as well.

The marketplaces represent the first major opportunity in many years for insurers to increase their markets. In May, the Congressional Budget Office estimated 7 million people will enroll in the marketplaces in 2014, rising to 24 million enrollees in 2023. Another 2 million people are forecast to get enrolled through the SHOP marketplaces in 2014, rising to 4 million by 2023. CBO forecast marketplace subsidies to individuals to be $26 billion and small employer tax credits to be $1 billion in 2014.

At a June briefing, Gary Cohen, director of the Center for Consumer Information and Insurance Oversight (CCIIO) in HHS, said the agency was reviewing plans offered by more than 120 issuers for the marketplaces that will be operated by HHS.

How Marketplaces Will Operate

The marketplaces were originally intended to be operated by states. But:

- only 17 states and the District of Columbia have applied for HHS approval to operate state-based marketplaces, and they have received conditional approval;
- seven states will operate state partnership marketplaces with HHS in which the states will review plans for compliance with ACA and state insurance laws, conduct consumer assistance, or both; and
- in 26 states, HHS will operate federally facilitated marketplaces.

Operational Problems Looming? Operational problems are feared looming. Two reports released in June by the Government Accountability Office call into question whether HHS will be ready to operate the individual or the SHOP exchanges on time.

The Obama administration's surprise announcement July 2 that delayed ACA's requirement that employers

 ISSN 2154-8986

with the equivalent of at least 50 full-time employees offer coverage or make large ''shared responsibility'' payments has heightened questions about HHS's readiness to operate the marketplaces by Oct. 1.

Nevertheless, HHS officials have repeatedly insisted that marketplaces will open in all 50 states and the District of Columbia on time. In a July 9 blog post, Centers for Medicare & Medicaid Services Administrator Marilyn Tavenner said, ''We are on track to open the Marketplace on October 1.''

Still, the possibility of operational problems presents a risk to insurers who are early participants in the marketplaces, Mark Hamelburg, senior counsel in the Health and Life Sciences sector of Dentons law firm, told BNA. ''There are lots of places where there is potential for major operational problems, especially in the early years,'' he said. ''There is a risk carriers get blamed, even if it isn't their fault.''

State and Market Analysis. ''The question about whether to participate in the exchange is really a state exchange analysis, a market-by-market analysis,'' Anne Hance, a partner in the Washington office of McDermott Will & Emery LLP, told BNA. Hance is a member of the law firm's Health Industry Advisory Practice Group and co-chair of its Insurance/Payors Affinity Group.

Factors that health insurers should consider in weighing whether to participate in the marketplaces ''will vary with respect to the exchange being considered, and the factors generally will vary on an issuer-specific level,'' she said.

While there will undoubtedly be overlapping factors that insurers should consider in evaluating whether to participate in the marketplaces, ''It's not a one-dimensional decision,'' Hance said. Insurers are not deciding to offer all their plans in all the marketplaces, she said.

Risks for health insurers operating in the marketplaces fall into two categories—legal and regulatory, and business strategy, Hance said.

Legal and Regulatory Risks. Many commercial insurers are sensitive to False Claims Act liability, Hance said. ''Issuers that participate in the Medicare Advantage, Medicare Part D, and Medicaid world are familiar with False Claims Act (FCA) risk with respect to payments received from or paid to the government,'' Hance said.

''The commercial health insurance market typically has not been dealing with those types of government payments and have not been subject to the False Claims Act,'' with the exception of insurers who participate in the Federal Employees Health Benefits Program, she said.

Insurers will receive the APTCs through the marketplaces, as well as payments from ACA's reinsurance and risk corridors programs that will operate from 2014 through 2016 to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets, Hance said.

Insurers and self-insured plans will be required to contribute to a reinsurance program that will be used to cover a percentage of claims that exceed a specified point for individual policies that are subject to health insurance market reforms. That spreads the liability to entities that both make and collect the payments, Hance said.

FFMs More Consistent Than SBMs. While the administration of SBMs and regulations governing them will vary, there will be more consistency in the way the FFMs are administered and regulated by HHS, Hance said.

Some states may adopt standards that go beyond the minimum requirements set out in ACA, she said. That could include states, such as California, that are ''active purchasers'' that negotiate rates with insurers, instead of allowing all qualified plans to participate, she said.

The key incentive for insurers to participate in the marketplaces is to capture a new population of customers, Jeremy Earl, an attorney with McDermott, Will & Emery, tells BNA. ''Based on projections we've seen, anywhere from 16 [million] to 20 million uninsured may enroll over the next several years.''

HHS has said the FFMs will be open to all QHPs in 2014. However, at the June briefing, Cohen said the agency is also conducting an ''outlier analysis'' on rates outside the normal range. For any such rates, the agency may communicate with the issuer or the state insurance department where the plan would be offered, he said.

Plans in states operated by FFMs that have at least a 20 percent market share are required to participate in the SHOP marketplaces in order to sell through the individual marketplace, another factor that plans need to analyze in deciding whether to participate in each state, Hance said.

Blue Cross and Blue Shield plans, which hold a significant share of many state health insurance markets and are participating widely in the ACA marketplaces, have complained about the requirement. They argue that the mandate will put them at a disadvantage since they will have to pay a user fee of 3.5 percent of premiums to participate in the SHOP marketplaces, in addition to a 3.5 percent user fee to participate in the individual marketplaces.

  HIR ISSN 2154-8986

Business Strategy. The key incentive for health insurers to participate in the marketplaces is to capture a new population of customers, Jeremy Earl, an attorney with McDermott, Will & Emery, told BNA. ''Based on projections we've seen, anywhere from 16 [million] to 20 million uninsured may enroll over the next several years.''

Since APTCs and cost-sharing reductions are only available through the marketplaces, ''that will be a main draw to get people to enroll,'' Earl said. ''To capture that population that will become eligible, participation in the exchange is mandatory.''

Insurers need to consider the extent of their participation in the individual market, Earl advised. ''The portion receiving subsidies will be a significant portion of the individual market.''

For insurers that are able to get into the marketplaces early and capture market share, the people they enroll for the first time in 2014 are more likely to stay with them, Earl said. For issuers trying to compete for the first time in 2015 or 2016, it may be harder to get into the market. ''Getting in right away and trying to capture this insured population is going to be important,'' he said.

But, he advised, ''In 2014 one of the risks of participation is the health status and demographics of that population is unknown. Everyone is making educated guesses. The unknown nature of the risk pool counterbalances the increase in the insured population.''

Adverse Selection. The first people to sign up for coverage are likely to be people with health problems who have been unable to get insurance, or who have not been able to afford high rates for their coverage, John Gorman, executive chairman of Gorman Health Group, told BNA. ''Most actuaries are looking at the exchanges almost like they are under-65 dual eligibles,'' he said, referring to people who are eligible for both Medicare and Medicaid, who are the sickest and most costly patients.

That potentially could lead to adverse selection, in which covering a sicker population leads to higher rates, which in turn drives away healthy enrollees and puts further upward pressure on rates.

To counterbalance that, ACA includes three risk abatement programs to help protect insurers, Earl said. A permanent risk adjustment program will spread financial risk by transferring funds from all ''non-grandfathered'' plans that took effect after ACA was signed into law March 23, 2010, that enroll the lowest-risk individuals to plans that enroll the highest-risk individuals.

The reinsurance and risk corridor programs will operate from 2014 through 2016. All health insurers, self-insured group health plans, and third party administrators acting on behalf of self-insured plans must contribute $63 per enrollee in 2014 to pay for the reinsurance program. The total amount that is to be collected for the program decreases in 2015 and 2016, Earl noted, so the ''cushion against adverse selection through reinsurance payments is greatest in 2014.''

Insurers that collect insufficient premiums also will be protected against losses through risk corridor payments from the federal government, Earl said. Issuers may calculate that it is worth taking the initial unknown risk of participating in the marketplaces early to capture market share in light of the risk abatement mechanisms, he said.

Some issuers are taking a different approach, Earl added. ''Given the unknown nature of the risk pool, they are taking a wait-and-see approach for the first few years,'' he said. ''They'll make a decision down the road when they have more information.''

Insurers' Plans for Marketplaces. The largest health insurers are being ''very selective'' about which marketplaces they enter, Gorman said.

Gorman predicts that oversight of the FFMs will, by necessity, be less intensive than that of the SBMs, which should reduce the regulatory burden for insurers. ''You're going to be operating in a pretty loose regulatory environment for the first couple of years,'' he said. ''The first year will be about getting the pig through the python.'' The focus will be on basics, such as, ''Did the member get the right enrollment card?''

Stephen Hemsley, chief executive officer of UnitedHealth Group Inc. (UHG), commented in a January teleconference that ''there are still many significant unknowns with respect to how exchange will begin and actually work . . . so we are holding back on making specific decisions in many cases until greater clarity can be established.''

Hemsley said UHG's ''level of interest in exchanges will be driven by how we assess each local market—how the exchange and its rules are set up state by state—and our market position relative to others in the market—as we see it today and as we evaluate it going forward.'' Hemsley estimated UHG would participate in ''10 to 25 or more'' marketplaces ''with absolutely no firm commitment to that range.'' UHG's individual and small group health benefits business contributed about 10 percent of the company's earnings at that time, he said.

Matthew Wiggin, spokesman for Aetna Inc., told BNA in an email that Aetna ''will participate in exchanges that create a viable marketplace and where we can deliver the greatest value to consumers. We continue to evaluate and monitor states' progress as exchanges develop. We are focusing on the ease of administration interactions, affordability of products, and choice to the consumers, as well as the overall regulations and marketplaces they create.''

Aetna plans to participate in ''up to 14 states'' in 2014, Wiggin said. ''We will gain experience from that participation, assess the results, and make decisions on where to participate in 2015.''

WellPoint Inc. spokesman Jerry Slowey told BNA in an email, ''As a market place leader in the individual and small employer markets, WellPoint and its affiliated plans are uniquely positioned to succeed in the Health Benefits Exchanges. WellPoint is actively creating product solutions for each of its 14 affiliated plan states. Our strategy is based on our current understanding of the state-specific exchange marketplace.''

BlueCross BlueShield Plans. Participation by BlueCross BlueShield plans, which have a dominant share of many state health insurance markets, is expected to be broad and deep, the Blue Cross and Blue Shield Association says.

However, on July 1, Wellmark Blue Cross and Blue Shield announced it would delay participating in the marketplaces in Iowa and South Dakota for a year until the 2015 enrollment period. ''Given what we know to-

day, we do not believe during the first year of the public exchange we could ensure the exceptional level of service our members have come to expect from Wellmark,'' Chairman and Chief Executive Officer John Forsyth said in releases.

Courtney Greene, spokeswoman for the Des Moines, Iowa-based company, said participating in the individual marketplaces would have required it to participate in the SHOP marketplaces as well. That would have meant additional fees of 3.5 percent of premiums, she said.

Holding Market Share. Joel Ario, a managing director at Manatt Health Solutions, told BNA that carriers with large market shares in particular markets have to evaluate their plans with an eye toward holding their market share. For BlueCross BlueShield plans, ''it's so much more difficult for them to make a decision not to participate. Plus they have a community responsibility.'' Ario was director of the Office of Health Insurance Exchanges in HHS, and he was Pennsylvania insurance commissioner as well as Oregon insurance administrator.

Plans that do not participate in the marketplaces in 2014 may have to wait until 2016 to enter, Joel Ario, Manatt Health Solutions, warns.

Plans that do not participate in the marketplaces in 2014 may have to wait until 2016 to enter, Ario warned. Decisions for participation in the marketplaces in 2015 will have to be made in spring 2014, he said.

''You're not going to have a whole lot more information in the spring of 2014'' than is currently available, he said. Full information on the risk pool of the marketplaces will not be known that early, he said. ''If you're cautious this year you may be cautious again next year. Then you're giving your competitors a two-year head start on building market share and market allegiance.''

New Entrants. Staying out of the marketplaces carries the risk that new entrants may take market share, Dentons' Hamelburg said.

At the briefing in June, CCIIO's Cohen said that a ''number of new entrants'' have applied to offer plans in the FFMs. ''Some carriers, say for employer group coverage, may be concerned about competition coming in that might not otherwise be there'' in the marketplaces, Hamelburg said.

''Nobody entirely knows the response of employers, in the small group market or more significantly in the large group market,'' where most people get health coverage, Hamelburg said. While current expectations are that large employers will continue offering coverage to employees and avoid paying the $2,000 per employee ''shared responsibility'' payment, which is not deductible for tax purposes, ''what if they're wrong?'' Hamelburg said.

Over time, large employers may drop health coverage, pushing their employees to the marketplaces for coverage, he said. If that happens ''you may see a big shift to the individual market. If you're late to the game, that may be a problem.''

More Competition. The most efficient insurers will reap rewards by gaining new business in the marketplaces, Randy Madry, senior vice president of Schooner Healthcare Services LLC, told BNA. The Annapolis, Md.-based firm provides consulting services to health care companies.

The ease with which consumers should be able to compare plans in the marketplaces will result in greater price competition, he said. ''The most efficient ones could benefit by being able to participate.''

A big question mark is whether insurers will become more cost-competitive by ''really cranking down on their provider networks,'' resulting in ''very limited'' choices of providers, he said. ''My concern is a lot of individuals are going to go for the cheapest product and then get very upset when they find out they've got a very limited provider network.''

The biggest unknowns about the marketplaces are how many young, healthy people will enroll through them, as well as how many doctors will participate in the restricted provider networks, Madry said. ''I'm not making any predictions to my clients.''

By Sara Hansard

  HIR ISSN 2154-8986

Special Report

Insurance Marketplaces to Bring Benefits, Uncertainty for Hospitals

Beneficiaries can begin enrolling in the Affordable Care Act's health insurance marketplaces, or exchanges, Oct. 1, and while stakeholders and health care experts say there will be definite benefits for hospitals, there is still a level of uncertainty about how hospitals will be affected and how they should prepare.

In a series of interviews, hospital representatives, consultants, and other stakeholders told BNA that while it is still unclear exactly how health marketplaces will come together, there are steps hospitals are taking, and can take, to be prepared.

Hospitals should be "actively involved in enrolling beneficiaries. The opportunities are there for people to get insured, but it doesn't happen automatically."

—Timothy Gens, Massachusetts Hospital Association

The insurance marketplaces are scheduled to open for enrollment in October, and go live in January 2014. Individuals will be able to compare, select, and purchase an insurance plan from a menu of qualified options. Additionally, some individuals will be eligible for tax credits that they can use to purchase insurance.

The marketplaces will most likely result in a major influx of insured patients, which should be mostly good news for hospitals worried about escalating uncompensated care costs. ''The immediate upside is better insurance coverage,'' Dan Mendelson, chief executive officer at consulting firm Avalere Health, told BNA. ''A lot of people getting insured are relatively low income,'' so that will be better for hospitals, Mendelson said.

To fully realize the benefits of additional insured patients, Mendelson and other stakeholders said hospitals will need to undertake massive outreach efforts to make sure those patients actually enroll in the exchanges. Hospitals need to ''ensure that everyone who can enroll at subsidized levels are there. People with low income need to be enrolled,'' Mendelson said, so outreach is especially needed in low-income areas.

Timothy Gens, executive vice president and general counsel of the Massachusetts Hospital Association, agreed. Hospitals should be ''actively involved in enrolling beneficiaries. The opportunities are there for people to get insured, but it doesn't happen automatically,'' Gens said. Hospitals need to be active early in the process, and should already be educating patients on the benefits of being covered in the exchanges, he said. ''The exchange is about facilitating expanded coverage. All stakeholders should be engaged in outreach.''

IT Investments. To manage the new population, hospitals will have to make additional investments in health information technology, experts and stakeholders said. For example, Mendelson said patients may not need to be placed in the emergency room, and should be diverted to the least costly care setting. ''Make sure the IT can track quality and cost, and make sure patients don't bounce back,'' Mendelson told BNA.

Ellen Pryga, a director of policy at the American Hospital Association, told BNA that AHA is advising hospitals on a variety of IT changes that will occur as a result of the an increased patient population. For example, Pryga said hospitals should watch for changes related to administration simplification, like a common patient enrollment form. ''A lot of systems have to talk to each other,'' so there will be issues around interoperability, Pryga said.

Network Choices. Providers and health plans are talking to each other about exchange networks, but hospital executives will have to decide when, or if, they should partner with health plans or form their own payer groups.

The marketplaces will change the process of network contracting. Health plans are tightening their networks to get better pricing and assurances from hospitals that their focus will be on quality.

Under the Affordable Care Act, states can choose to establish a state-based exchange or default to a federally facilitated exchange. To date, 17 states and the District of Columbia chose to establish a state-based exchange, while 33 states defaulted to exchanges run by the federal government with varying degrees of state participation.

States have significant flexibility in designing their exchanges, including in areas such as governance, eligibility and enrollment functions, and long-term financing. However, there are certain requirements that the health plans within the exchanges have to meet. Blair Childs, vice president of public affairs at the Premier healthcare alliance, told BNA the exchanges will ''change the dynamic'' of the insurance marketplace.

For the first time, consumers will have essentially one-stop shopping to compare prices on standardized plans. Since plans will have to offer the same essential services, Childs said, the differences will be in pricing, and that will affect hospitals as well.

If hospitals want to ensure the patients who are purchasing health insurance inside the exchange can use their services, they need to be within the insurer's provider networks. AHA's Pryga said the exchanges will change the process of network contracting. AHA is keeping on eye on hospitals that get overtures from health plans. The association ''is trying to get a sense how prevalent that will be, and whether hospitals can survive,'' she said.

Health plans are also narrowing their networks, Pryga said. If a hospital is not in network, will there be any increase in covered patients, she asked.

What Can Hospitals Do To Prepare for the Marketplaces?

- Begin outreach efforts to make sure patients actually enroll in the insurance marketplaces.
- Ensure the health IT systems are interoperable, and can handle an influx of new patients.
- Establish programs that focus on improving care quality, especially on finding ways to reduce preventable readmissions.

Pryga said hospitals will also need to think about copay levels, and for hospitals in-network, they will need to comply with the clinical data and quality improvement initiatives that the health plans are required to report to the Department of Health and Human Services, such as methods to prevent hospital readmissions and reduce medical errors.

Avalere's Mendelson noted that ''as plans have contracted [with providers], they've decided to craft tighter networks.'' By doing so, the plans ''get better pricing, and assurances from hospitals that their focus will be on quality.''

Quality, Cost in Focus. According to experts, providers and payers will need to rethink their relationship and control costs together in order to have the best strategies for participating in, and succeeding under, the marketplaces. The marketplaces will also have an impact on the health care delivery system.

Hospital representatives told BNA that insurance companies and state Medicaid agencies will be looking to move away from traditional fee-for-service delivery, so hospitals will want to make sure they are also moving in that direction.

Hospitals ''need to start paying attention to readmissions,'' Mendelson said. ACA has begun to penalize hospitals for preventable readmissions for Medicare beneficiaries. Mendelson said the preparation hospitals are doing for the Medicare readmissions reduction program is the same they need to do to be ready for health plans' focus on quality.

Delivery reforms ''are interrelated,'' Mendelson said. ''Health plans have to field low costs in the exchanges,'' and those health plans are often also the same ones that offer Medicare Advantage. ''So they're looking for the same cost efficiencies,'' Mendelson said.

''Hospitals need to demonstrate quality and [know] their competitors' prices,'' Childs said. Private health plans have quality measures, and Medicare has its own quality measures, and hospitals will need to comply with both if they want to be successful.

''There are new market forces in place,'' Childs said. Consumers have access to, and are demanding, more information than ever about the quality and cost of their insurance plans. Delivery system change will not happen overnight, but the market pressure from the exchanges will make it happen, Childs said. As with Medicare payment reform, the ability to develop innovative ways to lower costs and improve quality—like bundled payments for services, and increased accountability for outcomes—will be key for providers in the exchanges.

Effect in States Not Expanding Medicaid. Under ACA, states will also have the option of expanding Medicaid. An increase in the number of insured will have an immediate impact on demand for provider services when the exchanges are launched in 2014, and hospitals that see a reduction in uncompensated care should be in a good position to respond to those demands. But what about hospitals located in states that chose not to expand Medicaid?

''We're in a precarious position,'' Dave Dillon, vice president of media relations at the Missouri Hospital Association, told BNA. Missouri's governor chose not to expand Medicaid, so the MHA ''is working to put together a program to gain maximum enrollment.''

Dillon said Missouri's hospitals need additional resources to help implement the marketplaces. ''We've been calling for additional enrollment, but since there's no Medicaid expansion, we will need additional resources, but probably won't have them.''

Missouri's governor chose not to expand Medicaid, so the Missouri Hospital Association ''is working to put together a program to gain maximum enrollment,'' MHA's Dave Dillon told BNA.

Dillon cited an increase in the utilization of inpatient and outpatient services but a decline in reimbursements. ''Can hospitals operate effectively,'' given that situation? ''It's a huge risk,'' Dillon said.

At least five hospitals have had to reduce staff amid growing concerns over uncompensated care costs, Dillon said. ''We just can't continue to have uncompensated care. We need additional patients linked to insurance plans.''

Theoretically, even if Missouri does not expand Medicaid, once beneficiaries start enrolling in the exchanges, Dillon said that should offset uncompensated care costs. But for some patients, the cost of the penalty for not enrolling in the exchange plans may be less than the cost of enrolling.

  HIR ISSN 2154-8986

''So we need to educate them'' about the benefits, Dillon said, like protections against high medical bills, the ability to manage their own care, and the ability to get insurance at a lower price through the exchange.

Dillon said MHA has partnered with various state health foundations to help the outreach efforts along. ''We are as far along or more so than peers in other states,'' Dillon said.

''Hospitals should staff up and prepare,'' Dillon said, but at least in Missouri, ''the scope of the enrollment effort will be defining for how hospitals will react.''

State Resources. On the other end of the spectrum from Missouri is Massachusetts, which has already developed an online tool for hospitals and consumers to use. The virtual gateway for patients helps them figure out which state-run health plans they are eligible for.

Dan McHale, senior director of state government finance and policy at the Massachusetts Hospital Association, said the ''one-stop processing'' system ''is hugely efficient.'' Hospitals provide information about their prices and quality to insurers, the site aggregates them, and patients can choose the best program.

Massachusetts hospitals have been reaching out to beneficiaries, but have already moved beyond education and outreach. The association's Tim Gens said the next step for hospitals is to focus on reforming the health care delivery system. ''First step is to get the maximum number of people with no subsidies enrolled,'' Gens told BNA. ''Then focus on how the system delivers care in the most efficient way possible.''

While Massachusetts has been supportive of health reform efforts, Gens acknowledged other providers may have to be more self-sufficient. ''Every state has their own resources. If it's not involved, [hospitals] need to find [their] own form of collaboration with stakeholders to ensure enrollment.''

BY NATHANIEL WEIXEL

Special Report

Fraud Enforcement and the Upcoming Health Insurance Marketplaces

As health care providers and insurers count down the remaining days until enrollment begins for the Affordable Care Act's health care marketplaces, formerly known as exchanges, they are facing numerous operational and compliance issues related to fraud, waste, and abuse. BNA spoke with several health care experts to piece together the new enforcement world awaiting the health care industry, as well as what can be done to minimize risk.

However, several experts told BNA that the government may downplay enforcement measures during the start-up of the maketplaces to allow organizations to take part in them and grow more comfortable with them.

Fraud risks include False Claims Act liability and violations of the anti-kickback statute, and providers and insurers will have to ensure they are maintaining effective compliance programs.

Additionally, the Department of Health and Human Services June 10 published a proposed rule outlining program integrity measures for the health insurance marketplaces.

For example, the proposed rule says ''the State Exchange must submit to HHS financial reports and must oversee its activities to ensure that it is complying with Federal requirements, such as those governing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions.''

The annual reports to HHS would also disclose any incidences of fraud and abuse, as well as any made in determining a patients eligibility for the exchange.

The health insurance marketplaces themselves are scheduled to open for enrollment in October, and go live in January 2014. Under the marketplaces, individuals will be able to compare, select, and purchase an insurance plan from a menu of qualified options. Additionally, some individuals will be eligible for tax credits that they can use to purchase insurance.

Currently, 17 states and the District of Columbia are working to create state-based health insurance marketplaces. Marketplaces within the remaining 33 states will be run by the federal government.

Different Compliance Standards. Kirk Nahra, an attorney with Wiley Rein, Washington, told BNA that compliance standards may be lighter for some elements of the marketplaces.

''For the new specifics about the exchanges (pricing, premiums, refunds, evaluation of appropriate coverage, etc.), where the details are complicated and new, the government still has to make sure that these programs will work,'' Nahra said.

''I think the government will give those entities a reasonable amount of time to work things out, as long as they seem to be trying to get them right,'' he said.

Nahra said that for anything that is currently covered by general fraud laws, such as billing for treatment, the standards will most likely be applied in exactly the same as they are in other government program.

He said the start-up of the marketplaces could be similar to the early days of the Medicare Part D program, where the government let organizations work through their issues without strict enforcement.

OIG Areas of Interest

OIG has several insurance exchange-related reviews in progress, according to the Fiscal Year 2013 Work Plan, including:

- a review of CMS oversight of the insurance exchange establishment grant program, as well as a review of state plans for preventing fraud, waste, and abuse in their marketplaces (a report is expected in FY 2014). States that are developing their own exchange can apply to CMS for an establishment grant to help with exchange development;
- a review of eligibility and enrollment requirements for state marketplaces (a report is expected in FY 2013);
- a review of CMS oversight of the Consumer Operated and Oriented Plan (CO-OP) Loan and Grant Program. The CO-OP program is designed to assist in the creation of qualified nonprofit insurers who can offer plans in the marketplaces. OIG will make sure CMS is monitoring the program to ensure that loans are being used appropriately (a report is expected in FY 2013); and
- a review of the process CMS uses to select recipients of CO-OP funding. The Affordable Care Act designates $3.4 billion in funding for the CO-OP program (a report is expected in FY 2013).

''There is real pressure to make the exchanges work, and being too aggressive on fraud, particularly where there are reasonable compliance efforts in place, will be totally counterproductive,'' Nahra said.

Ankur Goel, an attorney with McDermott Will & Emery LLP in Washington, also told BNA that the enforcement is not likely to be a priority during the beginning of the marketplaces.

HIR ISSN 2154-8986

''HHS has said that its early focus will be on compliance assistance and education, as opposed to enforcement,'' Goel said.

''There is a real focus on getting the exchanges up and running and at this time enforcement is a secondary message,'' he said.

However, Goel said states will still play a significant role in monitoring and enforcement related to the exchanges, and insurers will also have to be wary of the Department of Justice and qui tam whistleblower relators.

''There is real pressure to make the exchanges work, and being too aggressive on fraud, particularly where there are reasonable compliance efforts in place, will be totally counterproductive.''

—KIRK NAHRA, WILEY REIN

Enforcement Questions Remain. Beyond a potential deemphasis on enforcement of the exchanges, it remains to be seen whether the Department of Health and Human Services will announce that exchange-offered quality health plans (QHPs) are federal health care programs, according to Kirk Ogrosky, an attorney with Arnold & Porter LLP and former head of criminal enforcement for the Department of Justice.

''To the extent that QHPs obtain federal funding to subsidize premiums and cost-sharing for certain enrollees, I presume that OIG will categorize the plans in a way to make the anti-kickback statute (AKS) applicable,'' Ogrosky told BNA.

If QHPs are designated as being federal health care programs, Ogrosky said he would look for OIG to focus on issues related to beneficiary inducement, loss-ratio certification, risk adjustment, and pull-through arrangements.

''Declaring QHPs to be federal health care programs will have dramatic repercussions for AKS and qui tam enforcement,'' Ogrosky said.

Policing Pull-Through Arrangements. Pull-through arrangements, Ogrosky said, are similar to allegations contained in a $214 million 2011 settlement between Quest Diagnostic and California.

In the settlement, California alleged that Quest provided insurers with below-cost pricing in exchange for the insurers directing their in-network physicians to refer testing to Quest.

Subsequent to the settlement, Sens. Chuck Grassley (R-Iowa) and Max Baucus (D-Mont.) sent letters in November 2011 to Cigna, Aetna, and UnitedHealth, LabCorp, and Quest Diagnostic, asking for further information on pull-through arrangements.

OIG issued advisory opinions in 1999 and 2004 stating that pull-through arrangements are ''particularly suspect.''

Ogrosky said that while insurers have some experience with ''enforcement-style regulation,'' they have not subject to a flood of qui tam cases.

''Given the amount of money flowing through QHPs, relators' counsel will be lining up to bring cases against QHPs,'' Ogrosky said.

He said he anticipated DOJ, OIG, and relators to allege AKS violations against QHPs as the basis for FCA liability.

''Given the amount of money flowing through QHPs, relators' counsel will be lining up to bring cases against QHPs.''

—KIRK OGROSKY, ARNOLD & PORTER

Unique Environment. Goel said that the upcoming health insurance marketplaces present a unique environment for health care insurers.

While the marketplaces are designed to let individuals buy health insurance, they also include a significant amount of government funding, he said.

''The entity running the exchange (the state or federal government depending on the state) will have an interest in monitoring the overall conduct of health insurance issuers that sell products on the exchanges, and the federal government will have an interest in monitoring the money it spends,'' he said.

For example, Goel said, the government will have an interest in the accuracy of issuers calculations of the portion of individuals' claims expenses that are eligible to be subsidized by the government, such as cost-sharing subsidies and reinsurance.

''Not all issuers will be participating on the exchanges and there may be some that are unfamiliar with government programs,'' he said.

As a result, insurers should review their compliance programs and modify them based on issues that are specific to the exchanges, Goel said.

Provider Enforcement. While the main focus of exchange enforcement is likely to be focused on insurers, Goel said the exchange federal funding also has an indirect effect on hospitals and other providers, as in some case a portion of their claims be eventually be paid by the federal government, due to the cost-sharing subsidies and reinsurance program.

''Providers' compliance efforts to accurately bill services will help them avoid any risks from this federal funding,'' Goel said.

Additionally, providers' diagnoses will also affect transfers of money between issuers under the risk adjustment program, Goel said, and as a result providers may see additional medical record requests for purposes of auditing their diagnosis coding.

Unknown Fraud Risks. While insurers and providers can work to improve their compliance programs prior to the start of the exchanges, it's still unknown what OIG will be looking for in terms of enforcement, Jana Kolarik Anderson, an attorney with Nelson Mullins Riley & Scarborough LLP, told BNA.

''Based on discussions that I have had with OIG personnel, they are aware that abuses could occur, so the OIG will be vigilant, but as far as a list of what OIG will be looking for, it does not exist yet,'' Anderson said.

Anderson did say that OIG's *Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2012* included a section on the challenges associated with implementing the Affordable Care Act, including the marketplaces.

According to the OIG report, HHS employees responsible for ACA contracts and grants ''should be trained on effective internal controls and best practices for preventing and detecting fraud, waste, and abuse.''

BY JAMES SWANN

  HIR ISSN 2154-8986

NOW WITH STATE LAWS AND REGULATIONS

GAIN INSIGHT

Health Law Resource Center™

Industry-leading health law news and analysis. PPACA implementation tracking. Compliance guidance and enforcement actions. Specialized practice tools. Keep an eye on the fast-moving health law landscape.

TO START YOUR FREE TRIAL CALL 800.372.1033 OR VISIT www.bna.com/hlrc-mobile

Bloomberg BNA