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Practice Group(s):

Health Care

Insurance Coverage

Healthcare Complexity: Do Exchange Plans Qualify as Federal Healthcare Programs

By Carla M. DewBerry

As the healthcare community readies itself for patients securing health coverage through the exchanges, various techniques are being considered to encourage and facilitate patient enrollment in a health plan. One question which affects the legality of various techniques is whether plans purchased through the exchanges qualify as federal healthcare programs in light of the possible federal premium tax credits and cost-sharing subsidies available to some patients.[1]

Rep. Jim McDermott addressed this concern in a letter to Kathleen Sebelius, the Secretary of the U.S. Department of Health and Human Services. He asked the following three specific questions (referring to plans purchased through the exchanges as qualified health plans or "QHPs"):

1. In the event a QHP is deemed a federal health care program, will a QHP offered on the Exchange then be permitted to offer certain beneficiary inducements, such as nominal rewards for maintaining blood pressure within a certain range, which would otherwise be proscribed under the Anti-Kickback Statute and/or the Civil Monetary Penalty statute?
2. In the event a QHP is deemed a federal health care program, will this status impact downstream contractual arrangements? For example, if a QHP offered on the Exchange contracts with a hospital, will the hospital be required to structure its contracts with employed physicians in any particular way?
3. In the event QHPs are not deemed federal health care programs, what tools will be available to the Department of Health and Human Services (HHS) to ensure that such QHPs operate in a manner that ensures compliance with laws, rules, and regulations deemed essential to protecting consumers and the solvency of the federally funded programs?

See http://mcdermott.house.gov/images/Letter%20August%206%202013.pdf. Last visited November 5, 2013.

As has been widely reported, Secretary Sebelius replied stating that QHPs are not federal healthcare programs, but she did not address each of Rep. McDermott's questions. See http://mcdermott.house.gov/images/The%20Honorable%20Jim%20McDermott.pdf. Last visited November 6, 2013. The Secretary's conclusion has not been tested in a court, and a judge may not agree.

Less widely reported are the balance of Secretary Sebelius' comments to Rep. McDermott. In responding she emphasized that (1) HHS has oversight authority over plans in the federally-facilitated exchange; (2) HHS and the Office of Inspector General (OIG) have

[1] **Note:** There is ongoing litigation that challenges the availability of subsidies for patients who access insurance through the federally established exchanges in two cases: *Halbig v. Sebelius* (U.S. District Court for District of Columbia) and *Pruitt v. Sebelius* (U.S. District Court for the Eastern District of Oklahoma).

authority to investigate the affairs of an exchange; and (3) the OIG has jurisdiction to audit, investigate, and evaluate the HHS-administered programs in Title I of the Affordable Care Act.

Secretary Sebelius followed her letter with a news release on November 4, 2013, which addresses the premium subsidy issue and cautions hospitals, other healthcare providers and third parties against contributing towards patient premiums or other cost-sharing obligations (without stating that HHS has the authority to prohibit or sanction this practice). Her comments are as follows:

> Q: Are third-party payors permitted to make premium payments to health insurance issuers for qualified health plans on behalf of enrolled individuals?
>
> A: The Department of Health and Human Services (HHS) has broad authority to regulate the Federal and State Marketplaces (e.g., section 1321(a) of the Affordable Care Act). It has been suggested that hospitals, other healthcare providers, and other commercial entities may be considering supporting premium payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take appropriate action, if necessary.

See http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf. Last visited November 6, 2013.

As suggested by Rep. McDermott's initial letter to Secretary Sebelius, federal (and some state laws) limit the market advantage which a healthcare provider can obtain by providing a financial benefit to patients. (Exceptions generally apply for the indigent patient who qualifies for charity.) The scope of the Secretary's authority over healthcare insurers selling policies through the exchanges to patients not enrolled in Medicaid, is yet to be addressed by the courts. However, we note that the Secretary's caution references both hospitals, other healthcare providers and other "commercial entities." The reference to "commercial entities" may refer to insurance companies in light of the evolving trend for healthcare providers to move into the insurance realm. It is unclear whether a state or a government entity is included in the scope of the caution.

The impact of a subsidy program raises complex issues. You are likely aware that HHS has long been concerned about the impact of state subsidized premiums and cost sharing for Medicaid coverage purchased through the exchanges. See discussion of how HHS has addressed this concern in an article entitled Premium Assistance in Medicaid by Health Affairs, on the Web at: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=94.

This is but one more complexity in the healthcare field.

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Healthcare Complexity

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