ALSTON&BIRD LLP

TO: American Orthotic & Prosthetic Association

FROM: Alston & Bird LLP

DATE: September 3, 2013

RE: Analysis of State-Level and National Health Insurance Exchange Concerns and Essential Health Benefits Issues for Orthotic and Prosthetic Providers

This memorandum provides a brief overview of various State-level and national concerns for orthotic and prosthetic providers to consider as States begin to operate health insurance exchanges and implement the Affordable Care Act's (ACA's)[1] health insurance coverage expansion.

I. Health Insurance Exchange Issues

The ACA requires the development of health insurance exchanges, where otherwise uninsured individuals (with incomes between 100 and 400 percent of Federal Poverty Level, or "FPL") will be able to purchase qualified health coverage on a tax-subsidized basis using newly established premium tax credits.[2] If a State elects not to establish its own "Exchange", the Department of Health & Human Services (HHS) is required to establish and operate a "federally-facilitated exchange" (FFE) in the State. States were also allowed to establish "Partnership Exchanges" in conjunction with HHS, in which certain Exchange operation responsibilities would be handled by the State government, while other responsibilities would be handled by HHS.

For 2014, a total of 16 States and the District of Columbia elected to establish and operate their own State-Based Exchanges, while another 7 States chose to create Partnership Exchanges with HHS. For the remaining 27 States, HHS will operate an FFE.[3] Open enrollment for the 2014 plan year is expected to commence on October 1, 2013 on all 50 Exchanges.

a. Health Plan Competition, Premium Variations, and Role of "Active Purchaser" States in Pushing Down Health Plan Bid Pricing

Analysts' estimates project that on average, each State Exchange will have 15 qualified health plans (QHPs) competing to enroll new Exchange-participating consumers for the 2014 plan year, with New York projected to have the most carriers participating as QHPs with 16, and New Hampshire projected to have the fewest carriers competing as QHPs with only 1 projected.[4] Research also suggests that 2 out 3 new entrants to the individual market are in States where there is currently a single dominant insurer in the individual market.[5] Both of these trends should be welcome developments for orthotic and

[1] "Patient Protection and Affordable Care Act" (Pub. L. 111-148), as amended by the "Health Care and Education Reconciliation Act" (Pub. L. 111-152), and referred to collectively as the "Affordable Care Act" or "ACA".

[2] 42 U.S.C. § 13031, as added by ACA § 1311. *Note:* Uninsured individuals with income above 400 percent of FPL are still eligible to purchase health coverage on Exchanges, although these individuals will not be eligible for health insurance premium assistance tax credits.

[3] Kaiser Family Foundation, "State Decisions For Creating Health Insurance Exchanges, as of May 28, 2013," May 2013. *available at* http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

[4] Deloitte LLP, "Health Insurance Exchanges: Individual Market Competition," 2, Aug. 26, 2013. *available at* http://www.deloitte.com/view/en_US/us/Industries/health-plans/0bf02f31a32ff310VgnVCM2000003356f70aRCRD.htm?id=us:el:dc:hixmapinf:awa:chs:hixmarkets:082613#

[5] *Id.*

prosthetic providers. Any increase in the number of Exchange-participating insurers in the State should help to alleviate market concentration of dominant carriers within a State, and improve negotiation positions of providers in terms of setting network reimbursement rates. Moreover, the fact that new market entrants are focusing their efforts on entering State marketplaces where one insurer has previously dominated the individual market is encouraging.

However, to the extent that new competition amongst QHPs causes traditional carriers in the State to work to reduce health care premiums to compete for Exchange enrollees, there could be pressure for QHPs to negotiate more aggressively with providers over reimbursement rate updates—as a method of cost containment. This concern is particularly relevant in the six States (which include California and New York) that have established an "active purchaser" role in their respective State-Based Exchanges. Active purchaser States will attempt to use their authority in determining whether an applicant insurer can participate in the Exchange as a QHP to limit Exchange participation to those plans that submit low-premium bids—rather than simply accepting all applicant insurers that meet minimum federal and State licensure standards. Again, if health plans (that are applying to participate as QHPs on State-Based Exchanges run by "active purchasers") are forced to take aggressive steps to reduce premium amounts in order to meet thresholds set by "active purchasers," the plans will likely turn to reductions in negotiated reimbursement rates for providers as a method for containing premiums.

b. Ability for QHPs to "Pend" Claims Payments to Providers During the Second and Third Month of the Mandatory "90-Day Grace Period"

Under section 1412(c) of the ACA, QHPs are prohibited from terminating coverage for an enrollee (that is receiving advance premium tax credits) on the grounds of non-payment of premiums, for 90 days after the initial non-payment of the individual's portion of the premium. If the enrollee fails to re-pay all past due premiums during the 90-day grace period, the QHP is allowed to terminate coverage for the enrollee.

HHS regulations implementing ACA § 1412(c) indicate that QHPs must pay all appropriate claims for services rendered to the enrollee during the first month of the 90-day grace period.[6] However, QHPs may pend claims for services rendered to the enrollee in the second and third months of the grace period.[7] The regulations and HHS guidance on the subject currently require that QHPs notify providers that an enrollee has lapsed in his or her premium payments *after a provider has submitted a claim*.[8] The guidance only requires *advance notification* for "potentially affected providers as soon as practicable,"[9] and leaves the QHP with the discretion in determining which providers, if any, are "potentially affected" and also gives the QHP the discretion to determine how timely the notification must be in order to be "as soon as practicable."

For providers that accept patients and administer health care services on the basis that the patient currently has QHP coverage at the time of service, this allowance for the "pending" of claims during the second and third months of the 90-day grace period presents serious concerns. In recent comments to

[6] 45 CFR 156.270(d)

[7] *Id.*

[8] Centers for Medicare and Medicaid Services, "Affordable Exchanges Guidance: Letters to Issuers on Federally-facilitated and State Partnership Exchanges," 42 (April 5, 2013). *available at* http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

[9] *Id.*

press, representatives from the Medical Group Management Association (MGMA) expressed concern over QHPs' discretion to determine what level of prior notification was "practicable."[10] MGMA asserts that a QHP should be required to provide the information at any time a physician requests an eligibility determination for a patient.

c. Information Technology Issues During Upcoming Open Enrollment

Publicly, the Obama Administration continues to assert that the open enrollment period for QHP enrollment for the 2014 plan year will operate smoothly, as scheduled beginning October 1, 2013; but many analysts and stakeholders continue to raise concerns regarding the capabilities of the information technology (IT) infrastructure needed to support Exchange enrollment operations. Specifically, Exchanges will be required intake enrollee applicant information through an internet portal, and then verify certain information reported by the applicant with the Internal Revenue Service (IRS) and the State's Medicaid program, among others. Many observers have questioned whether the Exchanges will have the capabilities to verify and cross-reference this information digitally, given the different agencies' IT systems that will be involved.

On August 5, 2013, the HHS-Office of the Inspector General (HHS-OIG) issued a report that reviewed the Centers for Medicare & Medicaid Services' (CMS) implementation of the federal "Data Services Hub" from a security perspective.[11] The Data Services Hub will act as a router of information between the Exchanges and other government agencies to assist in determining the eligibility of consumers applying for enrollment in the Exchanges, as well as the related advance premium tax credits that will help consumers purchase health insurance in the Exchanges. In the report, HHS-OIG found that several critical tasks remain to be completed in a short period of time, such as the final independent testing of the Hub's security controls, remediating security vulnerabilities identified during testing, and obtaining the security authorization decision for the Hub before opening the Exchanges.

Observers have suggested that if testing and interoperability of the IT systems and the Hub falls behind, Exchanges and the other participating government agencies may be forced to use print form copies of information entered online by applicants to verify information against printed records of income and citizenship information to determine Exchange eligibility. In this scenario, extensive delays could result in patients presenting at a health care provider and seeking service beginning in January 2014, under the assumption that they have Exchange coverage, only to learn that their eligibility has not yet been verified. This scenario would create obvious burdens on providers during the early months of 2014, while eligibility verification issues are ironed out.

II. Scope of Essential Health Benefits Coverage

Under section 1302(b) of the ACA, the Secretary of HHS is charged with defining the essential health benefits (EHB). Such benefits must at least include items and services covered within the following categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. In January of 2014, all health plans offered in the

[10] Lotven, Amy, "Providers Worried About Liability Due To ACA's 3-Month Grace Period," Inside Health Policy, Jul. 31, 2013.

[11] HHS-OIG, "Observations Noted During the OIG Review of CMS's Implementation of the Health Insurance Exchange-Data Services Hub," 3-4, (Aug. 2, 2013). *available at* http://oig.hhs.gov/oas/reports/region1/181330070.asp

individual and small group markets and in Exchanges will be required to include EHB in benefit packages. Starting in 2014, States must offer at least the EHB to Medicaid enrollees with an alternative benefit package referred to as "benchmark" or "benchmark-equivalent" coverage. Individuals receiving Medicaid coverage under the ACA's Medicaid expansion will receive coverage governed by the benchmark requirements, meaning that the EHB must be covered for these individuals, regardless of whether the Medicaid beneficiaries are enrolled in Medicaid FFS coverage or Medicaid managed care.

HHS regulations governing EHB provide that each State has the option of selecting an existing health plan benefit package within the State that will serve as the "EHB benchmark." Under this framework, all plans that are required to cover EHB must provide coverage of all of the benefits included in the EHB benchmark for their State. In the regulations, HHS clarifies that the menu of plans for States to choose from in determining an EHB benchmark (that HHS will accept as EHB benchmark plans) is limited to the following: (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. The default benchmark plan for each State is the largest small group market plan in the State.

So far, 20 States and the District of Columbia have selected a small group plan as the State's EHB benchmark. Three States, Utah, Arizona, and Maryland, chose a State employee health plan as the benchmark. North Dakota, Connecticut, Michigan, and Vermont opted to make their State's largest commercial HMO plan the EHB benchmark. Nebraska's Governor submitted an EHB recommendation for a state-defined benefit plan; however, the plan was ultimately not approved by HHS. For the remaining 24 States, the failure to select an EHB benchmark results in HHS's default of the "State's largest small group plan by enrollment" being used to set the EHB Benchmark.

While prosthetics and artificial limbs are included in coverage under the EHB benchmark plan in every State, the EHB benchmark plans employ a variety of restrictions on coverage, which will then likely be replicated by QHPs governed by each individual EHB benchmark plan. Seven EHB benchmark plans require some form of prior authorization and approval for coverage of prosthetic devices. Four EHB benchmark plans establish some form of cap on the annual or lifetime dollar amount of coverage for either durable medical equipment (DME) in general or prosthetics specifically. Six EHB benchmark plans established coverage exclusions for certain classes of prosthetic devices, including exclusions for "deluxe prosthetics," robotic prosthetics, bioelectric or computer-programmed prosthetics, and biomechanical devices. Another three EHB benchmark plans established coverage exclusions for fitting, adjustment, or repairs of prosthetics. Finally, four EHB benchmark plans place a limit on the number of prosthetic devices that may be covered per lifetime of an enrollee.

Although section 2711 of the Public Health Service (PHS) Act, as added by section 1001 of the ACA, prohibits QHPs from applying the dollar-value caps on annual and lifetime coverage for prosthetics even if those limits are included in the various EHB benchmark plans noted above, QHPs will be allowed to convert the dollar-value annual and lifetime limits to actuarially equivalent limits on devices per year, or per lifetime. HHS guidance provides that if a benefit included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit, but plans would be permitted to make actuarially equivalent substitutions within statutory

categories.[12] Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

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We hope this analysis and memorandum was helpful to you. Please do not hesitate to contact us if you have any questions.

[12] CMS Center for Consumer Information and Insurance Oversight, "Frequently Asked Questions on the Essential Health Benefits Bulletin," 4, Feb. 17, 2012. *Available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf