Week of January 9, 2012

Health Care Policy Weekly Update:

CMS Finalizes Regulations Authorizing Release of Medicare Data for Performance Measurement: As we reported earlier last month, on Monday, December 5, the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) issued final regulations making claims data from Medicare and private health purchasers available to "qualified entities" that would aggregate the information and develop profiles of provider performance. The rules also include important safeguards intended to assure that the information released to evaluate provider performance is accurate and used appropriately, while also safeguarding patient privacy.

These rules were initially proposed in June 2011 and NBCH's Government Affairs Committee submitted comments to CMS on August 8th regarding the proposed rule. To access a copy of our comments, please link to: http://www.nbch.org/Where-We-Stand. Among the changes from the original proposed rule are provisions (1) making the data less cost for qualified entities, and (2) giving qualified organizations additional flexibility in their use of Medicare data to create performance reports for consumers. The final regulations become effective 30 days after publication in the Federal Register, which was released December 7, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-12-07/html/2011-31232.htm

In response to the proposed regulations, NBCH expressed strong support for the increased availability of Medicare data, strengthening access to and standardization of all-payer claims data that is essential to national public reporting, as well as the burgeoning payment reform initiatives. We also stated that proposed regulations impose numerous administrative and cost barriers to coalitions, independent consumer groups, and research organizations to access the raw data needed to measure and improve health care.

CMS received approximately 100 comments from a wide variety of individuals and organizations. About half of the comments were from providers and suppliers, or organizations representing providers and suppliers. The other half of the comments were from organizations engaged in performance measurement or data aggregation that may potentially be approved to receive Medicare data as qualified entities under this program. CMS also received a number of comments from consumer advocacy organizations.

How NBCH Fared in the Medicare Data Access Final Regulations: Given the numerous recommendations that were referenced in our comments, we thought it would be a helpful exercise to reconciled our proposed rule feedback to CMS with the final regulations (**segments highlighted in the attachment**) to determine the outcome on the issues of most importance to us.

IRS Revises Guidance on Form W-2 Informational Reporting Under ACA: On January 3, the Treasury Department and Internal Revenue Service (IRS) issued Notice 2012 09<http://64.78.15.115/

documents2012/irs_notice2012-09.pdf>, which restates and amends interim guidance regarding informational reporting to employees of the cost of their employer-sponsored group health plan coverage, as required by the Patient Protection and Affordable Care Act (ACA). ACA, the health care reform law, requires employer health plan sponsors to report the cost of coverage under an employer-sponsored group health plan on the Form W-2. Notice 2012-09 is applicable beginning with 2012 Forms W-2 (forms that employers are required to give employees by the end of January 2013).

Notice 2012-09 supersedes "question-and-answer" interim guidance initially provided under Notice 2011-28<http://www.americanbenefitscouncil.org/documents/irs_notice2011-28.pdf> (issued in March 2011). The new notice modifies some of the prior Q&As and provides additional guidance through new Q&As. **Modifications to interim guidance made by Notice 2012-9 include:**

· Clarification that the reporting requirement does not apply to coverage under a health FSA if contributions occur only through employee salary reduction elections (Q&A-19); and

· Clarification that an employer is not required to report the cost of coverage under a dental or vision plan if the plan satisfies requirements for being excepted benefits under HIPAA (Q&A-20).

Notice 2012-09 also provides the following additional guidance through new Q&As:

· The guidance clarifies that employers are not required to include the cost of coverage under an employee assistance program (EAP), wellness program, or on-site medical clinic in the reportable amount if the employer does not charge a premium with respect to that type of coverage provided under COBRA to a qualifying beneficiary (Q&A-32).

· The guidance clarifies that an employer may include in the aggregate reportable cost Form W-2 the cost of coverage that is not required to be reported under applicable interim relief, including for example, the cost of coverage under a Health Reimbursement Account (HRA), a multi-employer plan, an EAP, wellness plan or on-site medical clinic, provided the calculation of such costs satisfies guidance requirements and constitutes applicable employer-sponsored coverage.

· The guidance clarifies how to calculate the reportable cost of coverage under programs, such as long-term disability programs, where only a portion of the program constitutes coverage under a group health plan (Q&A-34).

· The guidance clarifies that the aggregate reportable cost for a calendar year on Form W-2 may be based on information available to the employer as of December 31 of the calendar year (Q&A-35).

· The guidance clarifies how an employer may treat a coverage period, such as the final payroll period of a calendar year, that continues into a subsequent calendar year for purposes of allocating the cost of coverage (Q&A-36).

· The guidance clarifies that an employer is not required to include the cost of coverage provided under hospital indemnity or other fixed indemnity insurance, or the cost of coverage for specified disease or illness in the aggregate reportable cost for W2 reporting if those benefits are offered as independent, non-coordinated benefits and the employee pays the full amount of the premium with after-tax dollars (Q&A-38).

· The guidance clarifies that aggregate reportable cost is not required to be reported on a Form W-2 furnished by a third-party sick pay provider (Q&A-39).

Notice 2012-09 states that this interim guidance is applicable until further guidance is issued, with Treasury and IRS continuing to consider comments submitted on Notice 2011-28 as they work to develop regulations under Section 6051(a)(14). (Source: American Benefits Council , BenefitsBytes, January 5, 2012)

"Private Exchanges May Be Poised to Spread — With Uncertain Impact on Health Law"- Insurers and employers may be on the verge of spurring the formation of private insurance exchanges around the United States — a move that could make government exchanges less attractive to consumers.

Exchanges — a centerpiece of the health care law's insurance market overhaul — are places consumers can compare health plans and sign up for the one they like best.

The law's architects see them as essential to structuring markets in a way that forces insurers to make money by competing on cost and quality, rather than simply by avoiding high-cost enrollees. The law (PL 111-148, PL 111-152) calls for the creation of government-sponsored exchanges in all 50 states.

But private-sector interests see an opening to creating exchanges that are more to their liking. To the extent that these private exchanges pop up around the country and siphon off customers, particularly healthy people with few medical expenses, the health plans sold through government exchanges may not be as affordable to consumers.

That may make it harder to cover the uninsured with the available federal subsidy money. Or it may force lawmakers to appropriate more subsidies under the health law than originally forecast by the Congressional Budget Office (CBO), making the overhaul more costly.

Private exchanges may become a fixture of the marketplace even if the health law is struck down by the Supreme Court or repealed by the next Congress. Christopher E. Condeluci, a former Senate Finance Committee staffer now in private practice with the Washington, D.C.-based law firm Venable LLP. Condeluci says the private exchange concept is gaining popularity on its own, apart from the influence of the health law in causing the industry to create alternative private exchanges.

"I think that private exchanges are the future," he says.

Laying the Foundation

To be sure, the health law is the impetus behind the growing interest in exchanges.

Under the law, each state must open an exchange in 2014 and offer insurance to uninsured individual Americans. States also can set up "shop" exchanges to offer coverage to small businesses. Or they can choose to operate a single exchange that sells to both individuals and small businesses. If a state doesn't run its own exchange, the law requires the federal government to do so.

The health law has popularized the term "exchange" and has led to much discussion and debate at the state level about setting them up.

The concept is attractive because most Americans don't have a choice of health plans. They take what their employers offer. At least in theory, the exchange will give them a choice, new tools and web-based computer programs to help them compare the cost and quality of health plans.

"Industry folks feel that the exchange concept is one that can work and is generally catching on among consumers buying health insurance," says Condeluci, whose clients include companies involved in operating private exchanges.

“What makes private exchanges unique,” he adds, “is their use of creative, interactive technology. Every private exchange utilizes an online web portal that allows the health care consumer to shop from among a wide variety of insurance products. The technology even recommends insurance packages custom-built for the consumer.”

Exchanges created under the health law are also supposed to have web portals that make it easy to compare and enroll in plans. But Condeluci doesn’t think government will be as nimble as business in developing the software to make it easy for consumers to find the particular plan that best suits them.

Industry executives are skeptical that “the exchanges created under the new law are going to be up and running by 2014, and if they are, many believe they’re not going to be nearly as attractive as current private exchanges or private exchanges that might be created between now and 2014,” Condeluci added.

Many states have far to go to build exchanges. If a state can’t get its act together by 2014, “the industry believes there is a stigma with the federal government running the exchange on behalf of a state,” Condeluci says. “So when it comes to attracting consumers to an exchange, consumers are more likely to be attracted to a private exchange,” he asserts.

Of course, under the health law, uninsured Americans purchasing insurance in the individual market can only get subsidies to buy coverage if they go to a government-sponsored exchange. So, seemingly, private exchanges organized to sell to individuals would not compete with government exchanges serving the individual market.

But insurers and private exchange companies could apply pressure to get that changed by lobbying for a clarification of the health law under which state regulations could be issued providing that a private exchange meeting certain conditions may be deemed an exchange for purposes of the subsidies. In that case, an individual could go to a private exchange and buy coverage with a subsidy.

“Here, a private exchange would serve as an extension of the exchange” created in a state under the health law, Condeluci says.

Private exchanges could compete directly with state exchanges in the case of small employers. The health care law does not mandate that small employers get their coverage from exchanges created under the law. By creating simple private exchanges, insurers could try to lock in those customers and lessen the chances that they would go to the state exchange.

Private exchanges also may gain popularity as a way to serve employers too large to send employees to a state exchange. Paul Fronstin, an analyst with the Employee Benefit Research Institute, predicts strong interest on the part of employers in coming years in offering “defined contribution” rather than “defined benefit” coverage.

Rather than getting a package of benefits every year through a particular health plan, an employee would get a sum of money with which to buy coverage. Private exchanges would be organized to handle employees with such defined contributions. Employers would be better able to control what they spend on health care by specifying how much they give out each year in the form of a defined contribution rather than promising to provide a particular health plan with a particular package of benefits.

So far, private exchanges are primarily a regional phenomenon. But last fall, three insurers announced a venture to offer a nationwide private exchange serving employees with defined contributions. Blue Cross-Blue Shield of Michigan, Wellpoint and Health Care Service Corporation announced that they had assumed a majority stake in a private exchange called Bloom Health, based in Minneapolis.

“We believe private exchanges will be an important solution as the rising costs of health care leave employers searching for more predictability in their health care spending,” said Ken Goulet, CEO of WellPoint’s commercial business Unit.

Similarly, Buffalo-based Liazon serves small employers in a number of states through its private "Bright Choices" exchange. The company's website notes that "Bright Choices asks each person a short series of questions and then, using sophisticated analytics, actually recommends the benefits that best meet their needs."

The exchange "offers benefits that are better than most Fortune 500 companies, and helps your employees make the right decisions using award-winning technology and individualized support," the company promises.

What does the trend mean for exchanges created under the health care law?

Timothy Jost, a supporter of the overhaul measure and a law professor at Washington and Lee University, said that the way the law is now written is designed to prevent state exchanges from becoming a dumping ground for high-cost enrollees. The overhaul is designed to keep insurers from charging more for a plan it sells inside the exchange than for the same product outside.

And the availability of subsidies only through the state exchanges is meant to attract a large bloc of business and a mix of high- and low-cost enrollees that would keep premiums affordable overall in state exchanges.

But in practice, it's difficult to keep insurers from figuring out ways to segment the market and offer lower rates to customers who are better insurance risks, he says. And to the extent that private exchanges are able to get customers who are better insurance risks who otherwise would go to government exchanges, insurers have less of an incentive to offer attractive rates.

"In principle, having a private small-business exchange is not a bad idea," Jost said. "I think in practice it's going to be very hard to make it work in coordination with the public exchange because again you're going have smaller pools, you're going to almost certainly have cherry-picking."

Private exchanges are "probably going to offer or potentially will offer lower value products," he says. "They'll almost necessarily cost less because they'll probably offer fewer services and benefits than the public exchange."

There are many things that state exchanges are supposed to do other than simply be a website, he adds. "And so if you have somebody who just sets up a website, says I'm an exchange and says come do business with me, they're not going to offer the same range of services."

Jost added that "if you have a bunch of exchanges out there, each exchange, but particularly the public exchange, will probably have less bargaining power in dealing with the insurers."

These factors create significant concern that the state exchanges won't succeed, he says.

"I think it is a concern and I think it is a potential threat and I'm hoping that the states react appropriately," Jost says. (Source: By John Reichard, CQ HealthBeat Editor, January 6, 2012)