Health Care Alert: Qualified Health Plans on the Marketplace Are Not Subject to the Anti-Kickback Statute, but There's More to the Story...

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On October 30, 2013, in a letter to Representative Jim McDermott, U.S. Department of Health and Human Services (HHS) Secretary, Kathleen Sebelius clarified that qualified health plans (QHPs) available in the health insurance Marketplaces created under the Affordable Care Act (ACA) are not "federal health care programs."

The letter states:

> *"The Department of Health and Human Services 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. This includes the state-based and federally-facilitated Marketplaces; the cost-sharing reductions and advance payments of the premium tax credit; Navigators for the federally facilitated Marketplaces and other federally funded consumer assistance programs; consumer-oriented and operated health plan; and the risk adjustment, reinsurance, and risk corridor programs."*

Under the Social Security Act, "federal health care programs" are subject to the Anti-Kickback Statute (AKS), which makes it a crime to pay or receive anything of value in return for the referral of patients for, or as an inducement for patients to buy goods and services reimbursed by federal health care programs. The letter indicates that, because QHPs sold in the Marketplace are not considered to be federal health care programs, the federal AKS does not apply.

Because the availability of federal subsidies in conjunction with QHPs is arguably similar to federal health care programs, providers were concerned that the AKS would prohibit them from subsidizing premiums of those enrolled in QHPs. This letter clarifies that QHPs will be considered commercial insurance, and not a government program and, therefore, providers can legally pay premiums for patients with QHP coverage without violating the federal AKS. However, since most states also have their own "mini-AKSs," providers should also consider whether the states in which they operate would view this issue the

same way.

The secretary's letter was viewed by some as helping providers who were concerned that they would not get paid due to the three month premium grace period afforded to QHP enrollees, which shifts the risk of non-payment to providers. QHPs must provide a grace period of three consecutive months if an enrollee who received payment of the premium tax credit paid at least one month's premium. QHPs must pay all allowable claims during the first month of the grace period, but may pend claims in the second and third months of the grace period, leaving providers with the inability to get paid by the QHPs. Additionally, providers would be unable to determine whether coverage is actually in place and being paid, when they see patients who are in the second and third months of the grace period.

Less than one week after the secretary's letter was released, the Centers for Medicare and Medicaid Services (CMS) issued a memo discouraging issuers from accepting third party (e.g., provider) premium payments for those enrolled in QHPs through the Marketplaces.

The Q&A Memo states:

> *"It has been suggested that hospitals, other health care 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."*

The Q&A Memo makes clear that the False Claims Act and other federal and state criminal and civil laws will apply to oversight of the Marketplaces, and will be utilized to protect federal funds. It is possible that this Q&A Memo was issued after HHS received complaints about the possible market distortions that could be caused by allowing providers to pay premiums for patients insured under QHPs. Therefore, HHS initially blessed provider payment of QHP premiums, but days later, CMS discouraged insurers from actually accepting those payments.

According to a recent advisory letter to its members, the American Hospital Association (AHA) seems to disagree with this recent Q&A Memo. In its letter, the AHA asserts that the federal government does not have legal authority to prohibit hospitals from paying their patient's QHP premiums. Further, the AHA states that IRS precedent would support hospitals paying this type of subsidy as part of their charitable purpose of making health care available to those in need.

At this point, this issue remains very up in the air. If hospitals start to take advantage of the option to pay QHP premiums in 2014, they could strategically ensure insurance payments for their most expensive patients, thereby avoiding the potential pitfalls associated with the QHP grace period. How such payments impact charity care and the reaction of insurers will then have to play out. Providers should continue to stay tuned as more guidance is released.