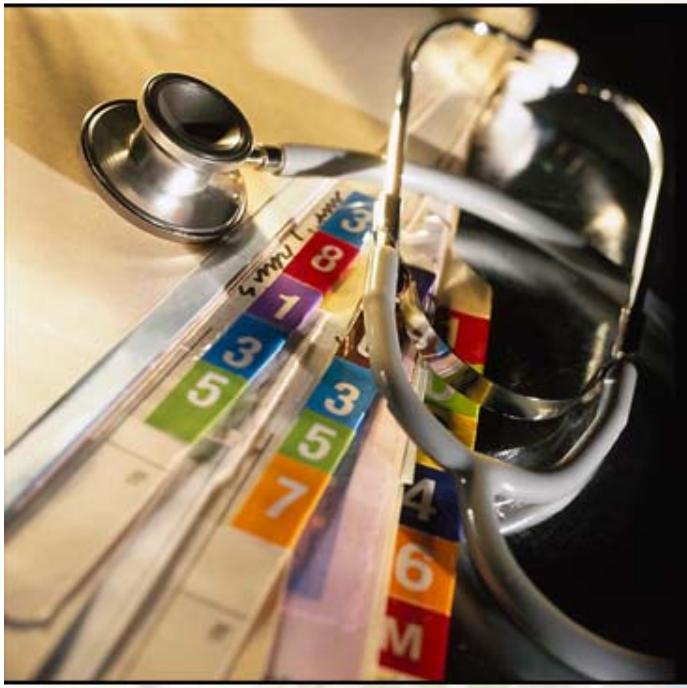

Healthcare Laws in 2013: Changes to HIPAA and the Health Insurance Marketplace

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November 21, 2013

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Presentation Overview

- Omnibus Rule Changes to HIPAA
- ACA, the Health Insurance Marketplace and Alaska
- Q & A

Omnibus Rule Changes

- Breach Analysis
- Business Associate Requirements
- Notice of Privacy Practices
- Patient Rights
- Marketing and Sales
- Immunization Records
- Decedents' PHI

What is a “breach”?

HITECH/HIPAA

- Acquisition, access, use or disclosure of PHI in a manner not permitted under HIPAA, which *compromises the security or privacy* of the PHI.
- Only applies to “unsecured PHI”, such as unencrypted data on a laptop, etc.

AK Personal Information Protection Act (AK PIPA)

- Unauthorized acquisition, or reasonable belief of unauthorized acquisition of personal information that *compromises the security, confidentiality or integrity* of the personal information.
- Only applies to “personal information”: not encrypted or redacted; combination of name and identifying number (SSN, DL#, credit card or bank account, etc.)

Exceptions to Breach

HIPAA/HITECH

- Secured PHI
- Unintentional, good faith acquisition, access or use by person working under authority of covered entity, if within scope of authority and no further use or disclosure.
- Disclosures within same entity, or between entity and business associate or OHCA, under same terms.
- Good faith belief that no information could have been retained.

AK PIPA

- Encrypted or Redacted PHI
- Good faith acquisition by an employee or agent for a legitimate purpose, as long as information not further disclosed.

DOCUMENT, DOCUMENT, DOCUMENT!!!!!!!!!!

Breach Analysis (Omnibus)

- Must demonstrate that there is a low probability that PHI was compromised based on assessment of:
  - Nature & extent of PHI involved, including types of identifiers and likelihood of re-identification
  - Unauthorized person who used the PHI or to whom the disclosure was made
  - Whether the PHI was actually acquired or viewed; and
  - The extent to which the risk to the PHI has been mitigated.

Omnibus Changes to BAAs

- Make sure it covers Security Rule requirements
- BA can’t use/disclose PHI if it would be illegal for Covered Entity
- BAs must have agreements with subcontractors
- BAs must notify Covered Entity of breaches and comply with breach notification – watch the 60 day deadline

Omnibus Changes to NOPP

- Changes to NOPP considered “material”, so new notice will need to be available.
  - Acknowledgement not required, but need to make it easily available for patients. Display in lobby or reception area.
  - September 23, 2013 – better late than never!
  - Update website as well
- Need to include requirement to notify affected individuals of a breach of unsecured PHI.

Omnibus Changes to NOPP

- Statement regarding authorizations, as follows: “The use or disclosure of psychotherapy notes, as well as the use or disclosure of PHI for marketing or sale of PHI require your authorization. Uses and disclosures for these purposes, as well as other uses and disclosures not described in this notice, will not be made without a HIPAA compliant, signed authorization.”

Omnibus Changes to NOPP

- Fundraising (if conducted): “This organization may contact you for fundraising purposes. You have the right to opt-out of such communications at any time.”
- If EHR: “You have the right to request your records in electronic format. If we are readily able to produce the records in the format requested, we will comply with your request. If we are unable to produce the records in the requested format, other options will be made available to you.”

Omnibus Changes to NOPP

- Clarification of right to request restrictions: “You have the right to request restrictions on certain uses and disclosures of PHI. The organization is not required to agree to a requested restriction, unless it is for a service that was paid for entirely out-of-pocket and the restriction is regarding information provided to your insurer.”

Omnibus Changes to Patient Rights

- Right to request restrictions
- Right to electronic format – only if readily producible in requested format

- This may require changes to policy and procedures for patient rights.

Additional Omnibus Changes

- Marketing and Sale of PHI – Now expressly requires signed authorization from patient.
- Disclosures of Immunization Records – now permitted with oral agreement to disclose.
- Decedents' PHI – Not PHI after 50 years. Also, can now disclose PHI to relatives, and others involved in care, unless specifically requested that it not be disclosed.
- Other minor changes not relevant to small providers or not requiring document changes

Main Topics Covered by Legislation

- Titles I & II: Health Care and Insurance Coverage
- Title III: Delivery of Health Care
- Title IV: Prevention and Public Health
- Title V: Health Care Workforce
- Title VI: Fraud and Abuse
- Title VII: Health Technology
- Title VIII: CLASS Act (Already eliminated)
- Title IX: Taxes and Fees (How are we paying for this?)
- Title X: Amendments

Health Reform: Timeline

- In effect now
  - Patient's Bill of Rights
  - Children cannot be denied coverage for pre-existing conditions (extended in 2014)
  - Rescission prohibited except for fraud
  - Dependent coverage extended to age 26
  - Annual limits restricted (prohibited for essential benefits in 2014)
  - Lifetime limits not allowed for essential benefits
  - Policy and renewal guaranteed
  - Funding for community health centers
  - Incentives for primary care and rural health care workers

Timeline (con't)

- 2014
  - Individual mandate
    - Tax credits and premium cost sharing
  - State exchanges available for individuals and small businesses
    - Small business tax credit increase
  - Expanded Medicaid coverage (if State elects)
  - Limits on insurers: cannot charge more based on health or gender; limits on premium variations based on age
- 2015
  - Employer obligation to provide "qualified health insurance coverage"

Health Reform and Individual Coverage

- Requirements (2014)
  - Required to have qualified health plan or pay the price
  - Tax penalty starts small ($95) and increases ($695)
    - Per person, per year
    - Families capped at 2.5% of income or 3X penalty, whichever is larger
  - Some exemptions apply: financial, religious, American Indian/Alaska Native
  - Persons with income below tax filing threshold or persons for whom the lowest price insurance plan would exceed 8% of their income are exempt. So if a person makes $20,000 and the annual cost of insurance would exceed $1600, they can choose not to buy and still avoid the penalty.

Health Reform and Individual Coverage

- Subsidies (2014)
  - Income between 100% and 400% of FPL
  - Income under 100% FPL not eligible
  - Cost Sharing for individuals/families that increases with level of income
- ALASKA - This leaves an interesting gap for those below 100% - no coverage and no subsidy.

Effects on Coverage in Alaska

Federal Poverty Level	Pre-Reform Status	Full Implementation Status	Status Under Current State Position
0-100% FPL	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA	Covered by Medicaid	**Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA**
100-133% FPL	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA	Covered by Medicaid or eligible for significant subsidies in Health Insurance Marketplace	Eligible for significant subsidies in Health Insurance Marketplace, but not otherwise covered
133-400% FPL	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA, but may be able to afford insurance	Eligible for subsidies in Health Insurance Marketplace with amount of subsidy decreasing as income increases	Eligible for subsidies in Health Insurance Marketplace with amount of subsidy decreasing as income increases
>400% FPL	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA, but may be able to afford insurance	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA, but may be able to afford insurance	Not covered unless eligible for Denali KidCare, Alaska Native Healthcare or VA, but may be able to afford insurance

Individual Options: Health Insurance Marketplace

- Health Insurance Marketplace (formerly Exchange) for individuals and small businesses
  - Less than 100 employees until 2017
  - Administered by government agency or non-profit
- Benefits:
  - Competitive market
  - Common rules on pricing and offering
  - Supposed to provide more information for consumers
  - Makes changing employment easier
- Enrollment began October 1, 2013

Marketplace Requirements

- Determine eligibility for QHPs “promptly and without undue delay”
- Redetermination of eligibility on annual basis
- Rely on existing electronic sources of data to verify information
- Maintain high levels of privacy and security
- Coordinate with Medicaid, CHIP and basic health programs
- Verify SSN with Social Security Administration
- Accept documentation to resolve inconsistencies in initial application
- Potentially verify whether applicant is or will be enrolled in employer sponsored insurance

Alaska Marketplace Options & Assistance

- Marketplace:
  - Premera Blue Cross Blue Shield
  - ODS
- Assistance:
  - Navigators
  - Enroll Alaska
- Available Plans:
  - Platinum – covers 90% of costs
  - Gold – covers 80% of costs
  - Silver – covers 70% of costs
  - Bronze – covers 60% of costs
  - Catastrophic

Individual Subsidies

- Individual with household income between 100% and 400% (approx. $117,000 for family of four in Alaska) of federal poverty level
- Nothing for those under 100% of FPL
- To be used in the Health Insurance Marketplace
- Individuals pay from 2% up to 9.5% of income
- Up to 250% of FPL ($60,000 for family of four) – eligible for cost-sharing subsidies that reduce out-of-pocket costs
- Alaska Natives have no cost-sharing or co-pay up to 300% of FPL

Costs in the Marketplace for Alaska

State	Average Number of QHPs[20]	27-Year-Old, Before Tax Credits				27-Year-Old with an Income of $25,000			Family of Four with an Income of $50,000[21]		
		Lowest Bronze	Lowest Silver	Lowest Gold	Lowest Catastrophic	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit	Second Lowest Silver Before Tax Credit	Second Lowest Silver After Tax Credit	Lowest Bronze After Tax Credit[22]
AK[23]	34	$254	$312	$401	$236	$312	$107	$48	$1,131	$205	$0

Family of Four with Income of $100,000 (340% FPL): $974/$792/$609

http://kff.org/interactive/subsidy-calculator/

Essential Health Benefits

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Health Reform and Health Care Delivery

- Testing new methods of payment and quality improvement:
  - Payments tied to quality metrics, including patient experience
  - Evidence Based Practice
  - Care Coordination and Service Integration
  - Bundled payments
  - Accountable Care Organizations
- Increased focus on innovation
- Maternal, Infant and Early Childhood Home Visitation Programs
- Community Wellness grants
- Healthy lifestyles incentives
- Immunization program

Health Reform and Health Care Delivery

- Primary Care enhancement
  - Increased pay
  - Medical homes (chronic conditions, mental illness)
  - Coverage of preventive services
    - No patient cost-sharing required (U.S. Preventive Services Task Force, CDC Immunization, HRSA's Bright Futures)
  - Thousands added to National Health Service Corps
- Health Center Trust Fund – supports health center growth
- Partnership for Patients – reducing preventable hospital-acquired conditions

Compliance Requirements

- Affordable Care Act requires compliance program for providers enrolled in Medicare or Medicaid (including Denali Kidcare)
- HHS and OIG supposed to issue guidance
- Timeline still unknown for small provider offices, but expected in next couple of years
- Auditors may be looking for compliance elements

Compliance Focus

- Effectively prevent, detect and correct noncompliance
- Also prevent and address fraud, waste and abuse
- Effective communication among all staff and leadership
- Seven Elements of an Effective Compliance Program

Seven Elements of an Effective Compliance Program

- Code of conduct w/written policies & procedures
- Compliance officer, committee and high-level oversight
- Effective training and education
- Effective lines of communication
- Well-publicized disciplinary standards
- Effective system for routine monitoring and auditing
- Prompt response to compliance issues

Compliance Checklist

- Develop written compliance program
- Develop employee standards and code of conduct
- Establish and train compliance committee
  - may vary depending on size of organization
- Distribute standards and code of conduct
- Conduct Board/owners training
- Conduct employee training, including info on how to access compliance documents
- Conduct specialized training as necessary
- Establish systems for monitoring

On-going Compliance Checklist

- Periodically review compliance program, employee standards and code of conduct
- Ensure that employee training is conducted and documented
- Manage and monitor employee reporting process
- Provide ongoing training, as needed
- Ensure that compliance related files are maintained as described in plan
- Ensure that monitoring and auditing systems are in place and working
- Make periodic reports to the Board/owners regarding compliance, even if no violations

ACA Repayment and Disclosures

- Congress clarified obligation to report and refund Medicare and Medicaid overpayments:
  - Now very clear that overpayments are to be reported and returned to Secretary, State, an intermediary, carrier or contractor as appropriate
  - Must notify Secretary, State, intermediary, carrier or contractor in writing of reason for overpayment
  - Must be done by later of:
    - 60 days after identification
    - Date any corresponding cost report is due
  - Problem: When is it “identified”? What about investigation?
  - Liability for anyone who knows of an overpayment and fails to report/return it

Health Reform Resources

- The law: http://www.hhs.gov/healthcare/rights/law/index.html
- Federal Guidance – http://www.healthcare.gov
- Kaiser Family Foundation - http://healthreform.kff.org/
- State Guidance - http://dhss.alaska.gov/ahcc/Pages/nhcr/default.aspx

Questions?

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