PREMIUM ASSISTANCE PROGRAMS

Authored by:
America's Essential Hospitals staff

KEY FINDINGS

- Even with government subsidies, families may be unable to afford marketplace coverage.
- Being uninsured, even intermittently, disrupts care, results in poorer health outcomes, and increases system costs.
- Premium assistance from providers will promote more stable and successful marketplaces that increase access to coverage for low-income individuals.
- Recent federal guidance on marketplace assistance programs has left providers uncertain about their options for offering assistance.
- By working together to identify permissible means of support, providers and the government can enable better health outcomes for patients and lower costs for our health care system.

PROVIDER-SUPPLIED PREMIUM ASSISTANCE STRENGTHENS MARKETPLACES, PROMOTES THE ACA

By the end of March, more than 7 million Americans had enrolled in health plans offered through Affordable Care Act (ACA) health insurance marketplaces (also known as exchanges), the Obama administration reports. The Congressional Budget Office (CBO) estimates the number will increase to 27 million by 2018. These new marketplace enrollees are relatively older, less educated, poorer, and more racially diverse than today's commercially insured population. A majority also are transitioning from being uninsured. Although the ACA provides subsidies to help low-income enrollees afford the cost of monthly insurance premiums, this assistance will not be enough for those with limited financial means.

A 2011 Commonwealth Fund study found that some low-income families, particularly in high-cost areas, will not have room in their budgets to purchase marketplace insurance and pay the required cost-sharing—even after accounting for the subsidies.[1] Members of America's Essential Hospitals also are concerned that some of their patients may not be able to afford coverage, particularly in states with more limited marketplace plan options (and, therefore, higher-priced plans) and in states that choose not to expand their Medicaid Program. In non-expansion states, marketplace coverage will almost certainly be unaffordable for individuals below 100 percent of the federal poverty level because these individuals will not be eligible for federal subsidies.

To help patients realize the full health benefits of coverage, some hospitals have considered offering patients assistance with their premiums.

America's Essential Hospitals believes assistance offered by providers to pay for the cost of monthly insurance premiums will promote the success of the marketplaces and a fundamental goal of the ACA: making affordable, meaningful coverage more widely available to the uninsured and underinsured. Such provider-supplemented assistance can help low-income individuals keep their insurance if already enrolled or afford to buy insurance if not yet enrolled. Moreover, increasing the number of enrollees in the marketplaces through provider-based premium assistance also can help stabilize the marketplaces and spread risk more broadly, which will attract new plans and promote price competition.

Despite these benefits, the Centers for Medicare & Medicaid Services (CMS) has expressed concern, including in a March 14 interim final rule, that provider-sponsored premium assistance could "skew the insurance risk pool," except if offered through a nonprofit foundation solely on the basis of financial need. America's Essential Hospitals continues to work with CMS to allow providers additional flexibility in structuring provider-sponsored premium assistance programs.

VULNERABLE POPULATIONS HIT PARTICULARLY HARD BY DISRUPTIONS IN COVERAGE

The populations our hospitals treat, particularly those who may struggle with the affordability of marketplace coverage, also are often the most in need of access to continuous, coordinated care in an appropriate setting. As such, they are the most likely to benefit from comprehensive, stable coverage through the marketplaces.

Studies consistently demonstrate that being uninsured, even intermittently, and churning between various coverage or uninsured status significantly disrupts care, results in poorer health outcomes, increases the administrative burden for payers, and generates higher costs to the broader health care system. For example, the Institute of Medicine (IOM) recently concluded that, "despite the availability of care for the uninsured through safety net providers, insurance coverage makes a substantial difference in both access and outcomes."[2] The IOM found uninsured adults forgo preventive services that can reduce unnecessary morbidity and premature death. In particular, the IOM reported, chronically ill individuals delay or forgo physician visits and clinically effective therapies, such as prescription medications, resulting in "poorer health outcomes, greater limitations in quality of life, and premature death."[3]

The IOM also found that high uninsurance rates impact not only uninsured individuals, but also entire communities, as privately insured adults express lower levels of access to and satisfaction with health care where uninsurance rates are higher.[4] For these reasons, the IOM has labeled uninsurance a "crisis." Likewise, the Medicaid and CHIP Payment and Access Commission (MACPAC) recently concluded that "[m]inimizing frequent coverage changes, which have the potential to negatively affect health, costs, and administrative burden, is in the best interests of enrollees, providers, plans, and states."[5] Low-income individuals who obtain stable coverage through a marketplace plan are more likely to gain access to care in the right setting at the right time. This increases appropriate health care utilization, minimizes inappropriate utilization, and improves health outcomes and cost efficiencies for the entire health care system.

ESSENTIAL HOSPITALS: EXPERTS IN HELPING THE VULNERABLE FIND COVERAGE

America's Essential Hospitals and its members have particular expertise and experience promoting access for low-income and vulnerable populations, including through generous financial assistance policies. Our members routinely assist in linking patients to all available financial resources and enrolling patients in available coverage. In this role, our members have gained insight into the unique barriers that low-income and vulnerable patients face in accessing care.

Offering premium assistance for marketplace coverage would be a natural extension of our members' work and would allow our members to go one step further in helping these patients maintain long-term, continuous coverage under the ACA's meaningful patient protections.

By supporting their patients' ability to retain marketplace coverage, our members would ensure patients could begin to receive preventive and coordinated care, rather than episodically accessing health care, often through the emergency department.

PREMIUM ASSISTANCE CAN HELP

In short, it is critically important to ensure adequate support for low-income and vulnerable populations to enroll in and maintain long-term coverage through marketplace plans. While we are hopeful the assistance provided by the ACA will be sufficient for many individuals, the studies cited above and our members' experiences with their patients suggest that, in some cases, it will not.

Premium assistance, whether offered by the federal government, states, or providers (through a foundation or not), is a key tool to encourage and maintain enrollment.

By emphasizing the availability of federal subsidies as an enrollment tool, the U.S. Department of Health and Human Services (HHS) has acknowledged that subsidies such as premium assistance can be a critical driver of marketplace enrollment.[6] We believe the same can be true of provider-subsidized assistance.

Marketplace assistance programs also present an important opportunity for providers to help smooth the transition into the new insurance marketplaces—and keep people covered once they are there. These programs can increase the number of enrollees in the marketplaces and help stabilize the marketplaces and spread risk more broadly.

RECENT GUIDANCE HAS LEFT PROVIDERS WITH LIMITED OPTIONS FOR OFFERING ASSISTANCE

Initially, federal guidance on marketplace assistance programs funded by providers was inconsistent and informal, leaving us and our members with unanswered questions. More recently, CMS issued two question and answer (Q&A) documents and an interim final rule clarifying its position, permitting providers to offer premium assistance only through a foundation.

In 2011, in response to comments received during rulemaking on the establishment of marketplaces and qualified health plans (QHPs), HHS appeared to support supplemental premium assistance offered by third parties, including states.[7]

In an October 30, 2013, letter to Rep. Jim McDermott (D-WA), the HHS secretary determined that both state-based and federally facilitated marketplaces—and related programs and payments, including federally subsidized premium tax credits and cost-sharing reductions—will not be considered "federal health care programs" subject to the federal anti-kickback statute. While not explicitly addressing supplemental premium support programs, this guidance appeared to eliminate one of the most significant legal hurdles to the adoption of marketplace assistance programs funded by health care providers.

Days later, on November 4, 2013, the Center for Consumer Information and Insurance Oversight (CCIIO) released a brief Q&A document targeted specifically at such programs.[8] In that document, CCIIO indicated that "HHS has significant concerns with [premium assistance programs offered by hospitals, other providers, and other commercial entities] because [the programs] could skew the insurance risk pool and create an unlevel field in the Marketplaces." CCIIO discouraged providers from adopting such programs and "encourage[d] issuers to reject such third party payments."

On February 7, 2014, CCIIO released a follow-up Q&A on the same topic. In this guidance, CCIIO clarified the concern raised in the November 4 Q&A does not apply to payments made by nonprofit foundations if the payments are made on behalf of QHP enrollees based on their financial status and not health status. Any payments the nonprofit foundations make also would have to cover the entire policy year. While this guidance opened the door for providers to offer marketplace assistance programs through certain foundations, it did not address the ability of providers to do the same directly.

On March 14, 2014, CMS issued an interim final rule on third-party payment of QHP premiums requiring QHPs to accept premium assistance from the Ryan White HIV/AIDS Program, Indian tribes and tribal organizations, and other federal and state government programs. By contrast, CMS clarified that it "continue[s] to discourage … third party payments of premiums" by hospitals and other providers and commercial entities due to the risk pool concerns identified in the November 4 Q&A. CMS did not, however, retract its more recent Q&A permitting premium assistance by nonprofit foundations if based on financial status, not health status. Thus, presumably, providers can offer income-based assistance through a nonprofit foundation in compliance with available guidance.

In fact, on May 21, in response to an inquiry from the hospital industry, the HHS secretary clarified that the department's rules do not prohibit payments by private, nonprofit foundations if made in a manner consistent with the February 7 Q&A.[9]

PREMIUM ASSISTANCE OFFERED DIRECTLY BY PROVIDERS WOULD FURTHER MARKETPLACE SUCCESS

This option supports CMS' goals as well as the goals of the ACA by ensuring the availability of marketplace coverage for those who need it most and, in turn, improving health outcomes for newly enrolled individuals and lowering costs across the health care system. Consistent with CMS' vision of affordable care for all, America's Essential Hospitals has continually expressed our support for coverage expansion under the ACA and the critical importance of assisting low-income and vulnerable people with the costs of marketplace coverage. We believe an opportunity exists to increase enrollment in marketplace plans by allowing providers to offer direct assistance to patients who otherwise could not afford marketplace premiums. We recognize that CMS has expressed general concern about such programs in recent guidance but are confident that by working together to determine permissible means of supporting coverage, we can overcome those concerns. ■

For more information, please contact Xiaoyi Huang, director of policy, at xhuang@essentialhospitals.org or 202.585.0127.

Notes

1. Gruber J, Perry I. Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable? The Commonwealth Fund. April 27, 2011. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Apr/1493_Gruber_will_affordable_care_act_make_hlt_ins_affordable_reform_brief_compressed.pdf. Accessed May 2014.

2. Institute of Medicine. America's Uninsured Crisis: Consequences for Health and Health Care. The National Academies Press. 2009. http://www.iom.edu/reports/2009/americas-uninsured-crisis-consequences-for-health-and-health-care.aspx.

3. Ibid

4. Ibid.

5. Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. March 2013. https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2013-03-15_MACPAC_Report.pdf?attachauth=ANoY7crpqQ1mmyjrZEtQobjHZnMnxAeLObQYpyQU7_6gYFFWo_0UEanJpS7CBhBtOionnImgli49TDx7uOYh5q8Ild_uuqIpeTrH_WmG8a0CxygkgQ-vr4kGD9qEMUwdagk3D67uViPyrFNL_kT8R-Hikqc2y9FpKK28mEatMYMOBPf7j0nhClWWI-HOn-Bx3-91aK7zxtE7nSB6oFh-H6g%3D&attredirects=0.

6. See, e.g., U.S. Department of Health and Human Services, Affordable Care Act Health Insurance Marketplace Outreach and Enrollment Toolkit for Elected Officials ("[O]nly by shopping at the Marketplace will Americans be able to get lower costs on their monthly premiums—making more affordable coverage a new reality for many hard working Americans and their families.").

7. See, e.g., 26 U.S.C. § 1.36B-3 (treating premiums paid by third parties as premiums paid by a taxpayer for purposes of determining eligibility for premium tax credits for a particular month); 78 Fed. Reg. 15484 (March 11, 2013) (responding to a commenter's "concern[] about the ability of States to supplement cost-sharing reductions," HHS stated, "We intend to work with States to assess how the requirements regarding plan variations would interact with any supplemental cost-sharing reductions a State intends to provide").

8. CCIIO Question and Answer Document. Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces. November 2, 2013. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf. Accessed May 2014.

9. Letter to American Hospital Association President and CEO Richard Umbdenstock from HHS Secretary Kathleen Sebelius. May 21, 2014. http://essentialhospitals.org/wp-content/uploads/2014/05/140521-sebelius-umbdenstock.pdf. Accessed May 28, 2014.