COST-SHARING ASSISTANCE SUPPORTS PATIENTS, STRENGTHENS MARKETPLACES, AND PROMOTES THE ACA

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KEY POINTS

- Affordable Care Act coverage, while subsidized, might still prove unaffordable for many people.
- Cost-sharing assistance by hospitals, through charity care policies and foundations, can help vulnerable people access vital health care services.
- Federal guidance should clarify that hospital-provided cost-sharing assistance is permitted and cannot be barred by qualified health plans.
- Hospitals should consider the impact of IRS financial assistance policies and the potential impact of cost-sharing support on DSH payments.
- It is critically important to identify ways to ease the impact of cost-sharing on the vulnerable patients essential hospitals serve.

U.S. Department of Health and Human Services (HHS) officials report that, as of mid-August 2014, 7.3 million Americans had enrolled in and paid for health plans offered through Affordable Care Act (ACA) health insurance marketplaces (exchanges).[1] The Congressional Budget Office (CBO) projects that number will increase to 25 million by 2018.[2]

More patients are obtaining access to coverage through the marketplaces. But for the vulnerable populations members of America's Essential Hospitals serve, affording that coverage is challenging. The ACA does provide income-related subsidies to help low-income enrollees afford premiums and some cost-sharing responsibilities. But for enrollees with limited financial means, that assistance might still fall short of need.

As America's Essential Hospitals outlined in its June 2014 policy brief, *Premium Assistance Programs*, these new marketplace enrollees are relatively older, less educated, poorer, and more racially diverse than today's commercially insured population. A majority are transitioning from being uninsured. As the June brief highlights, assistance from providers to pay the cost of monthly insurance premiums for this population promotes the success of the marketplaces and a fundamental goal of the ACA: making affordable, meaningful coverage more widely available to the uninsured and the underinsured.

Although allowing premium assistance from providers is vital to strengthening the marketplaces and promoting the ACA, it is just one tool for addressing the barriers to care access for individuals enrolled in marketplace plans.

Even with subsidies, many vulnerable patients may find that they simply cannot afford their cost-sharing responsibilities.

Cost-sharing requirements, such as deductibles, copayments, and high out-of-pocket limits, also pose a barrier to access to care for individuals enrolled in the marketplace plans. Even with subsidies, many vulnerable patients may find that they simply cannot afford their cost-sharing responsibilities. Recognizing the financial challenges vulnerable populations face accessing health care coverage, America's Essential Hospitals has committed to working with the Centers for Medicare & Medicaid Services (CMS) to allow appropriate private and hospital-based

support for cost-sharing so that access to appropriate care by those most in need is not jeopardized.

COST-SHARING ASSISTANCE MAKES A DIFFERENCE

The ACA does not set specific, detailed cost-sharing policy, but does set cost-sharing parameters for qualified health plans (QHPs) in several ways. First, it establishes the so-called "metal levels" that prescribe the actuarial value (AV) of marketplace plans, which is the percentage of total average costs for benefits a plan would cover:

- bronze: AV of 60 percent
- silver: AV of 70 percent
- gold: AV of 80 percent
- platinum: AV of 90 percent

Second, the law sets maximum out-of-pocket limits for covered benefits—$6,600 for individuals and $13,200 for families in 2015.

Last, for individuals with income up to 250 percent of the federal poverty level (FPL), the ACA reduces the cost-sharing required in the silver plan by providing an extra subsidy. It does this in two ways: It increases the AV and reduces the maximum out-of-pocket limit. The parameters are described in Table 1.

QHPs are free to set and modify cost-sharing policies as long as they stay within these parameters.

Even with the income-related subsidies, individuals and families may find the cost-sharing unaffordable. For example, individuals with annual income between $11,670 and $17,505 (100 percent to 150 percent of the FPL) are unlikely to have the $2,250 in coinsurance for a covered hospital stay that could result under the maximum out-of-pocket limit. That would be in addition to the 2 percent to 4 percent of their income they would pay for the plan premium. Individuals and families earning more than these subsidized levels still might find it difficult to cover the $6,600 individual or $13,200 family maximum obligations if they need a lot of medical care. This means access to care essential to meet medical needs remains constrained. It also raises questions for these vulnerable individuals, the providers that serve them, QHPs, and policymakers.

TABLE 1 COST-SHARING PARAMETERS FOR QHPS QUALFIED HEALTH PLANS, 2015

BASIC SILVER PLAN	AV OF PLAN	MAXIMUM OUT-OF-POCKET LIMIT (INDIVIDUAL/FAMILY)
Enrollee not eligible for subsidies	70 percent	$6,600/$13,200
Enrollee with income 200-250% of FPL	73 percent	$5,200/$10,400
Enrollee with income 150-200% of FPL	87 percent	$2,250/$4,500
Enrollee with income 100-150% of FPL	94 percent	$2,250/$4,500

Note: For 2014, the federal poverty level (FPL) is $11,670 for an individual, and increases by family size. For example, for a family of four, it is $23,850. Individuals and families below 100 percent of FPL are not eligible for subsidies.

Source: U.S. Department of Health and Human Services. HHS Notice of Benefit and Payment Parameters for 2015. 79 Federal Register 13744. March 11, 2014.

FEDERAL GUIDANCE ON THIRD-PARTY COST-SHARING

HHS has expressed concern about third-party payments for cost-sharing and premiums, but has never clearly explained how its concerns relate to provider cost-sharing assistance. Beginning with its November 4, 2013, frequently asked questions (FAQ) document[3] and repeated in the preamble to its interim final rule on March 19, 2014,[4] the department noted its concern that third-party payments of premiums and cost-sharing by hospitals, other health care providers, or other commercial entities could skew the insurance risk pool and create an unlevel playing field in the marketplaces. HHS discouraged the practice and encouraged QHPs to reject such third-party payments.

In response to questions raised by the FAQ, HHS has restated its overall concern, but also clarified its position related to payments from certain designated programs and entities, and from private, not-for-profit foundations.

First, it issued guidance in FAQs on February 7, 2014,[5] that was formalized in the March 19, 2014, interim final rule at 45 CFR 156.1250, stating that QHPs, including stand-alone dental plans, must accept both premium and cost-sharing payments from the following third party entities on behalf of plan enrollees:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act
- Indian tribes, tribal organizations, or urban Indian organizations
- state and federal government programs

The preamble to the interim final rule says the policy applies to all individual market QHPs, regardless of whether they are offered through the marketplace or outside it.

Second, in its February 7, 2014, guidance and in a May 21, 2014, letter from HHS Secretary Kathleen Sebelius, HHS also responded to questions from the hospital community about whether this concern about payments from third-party entities applies to premium and cost-sharing payments from private, not-for-profit foundations. The secretary's letter restates guidance initially provided in the February 7, 2014, FAQ: The department's concerns about third-party payments do not apply to payments from private, not-for-profit foundations if they are made on behalf of QHP enrollees who meet criteria based on financial status and that do not consider enrollees' health status. Further, CMS expects that premium and any cost-sharing payments would cover the entire policy year.

Although the guidance released to date answers some questions about third-party cost-sharing support, a few issues continue to lack clarity.

Although the guidance released to date answers some questions about third-party cost-sharing support, a few issues continue to lack clarity. First, the guidance focuses on third-party payments to QHPs. But hospital-provided cost-sharing assistance most often takes the form of patient cost-sharing reductions or waivers consistent with hospital charity care policies. Payments are not made to QHPs, and so, technically, are not within the scope of CMS statements encouraging QHPs to reject third-party payments. Nor should cost-sharing discounts draw the same CMS concerns that such assistance will skew the insurance pool or create an unlevel competitive field in the insurance market. Nonetheless, some health plan contracts prohibit hospitals from providing such charity care assistance with patient cost-sharing obligations. CMS should make it clear to QHPs that they cannot interfere with valid hospital charity care and financial assistance policies.

Second, to the extent that foundations, including hospital foundations, wish to provide cost-sharing assistance to patients, the guidance should explicitly allow them to do so. Unlike the interim final rule that listed specific programs from which QHPs must accept premium and cost-sharing payments, there appears to be no similar requirement for cost-sharing assistance by private, not-for-profit foundations, even if they meet the criteria above. HHS simply says that its concerns about third-party payments do not apply. It will be important to clarify that not-for-profit foundations and hospitals have this option, regardless of a QHP's policies.

At this point, none of the HHS guidance documents comments specifically on hospital-affiliated, not-for-profit foundations that meet the criteria above—the department does not explicitly include or exclude hospital-affiliated foundations from its foundation policy.

Last, while the regulatory policy related to Ryan White, American Indian, and government programs clearly applies to QHP enrollees inside and outside the ACA marketplace, it is not clear whether the same can be said about the policy for private, not-for-profit foundations. For example, even if an issuer decides to allow third-party payments made on behalf of a patient covered by a marketplace plan, it is unclear whether that issuer would choose to apply the same decision to enrollees of the same plan outside the marketplace. Thus, clarity is needed, as an issuer might offer a QHP both inside and outside a marketplace (although this is probably uncommon).

Hospitals should consult their state DSH payment methodologies to determine whether the provision of cost-sharing assistance will impact DSH payments.

COST-SHARING FOR IN-NETWORK AND OUT-OF-NETWORK PROVIDERS

Hospitals seeking to offer cost-sharing assistance to QHP enrollees should first consult their contracts with the plans. When the hospital is contracted to be a provider in a plan's network, the terms of the contract could impact hospital financial assistance policies. Thus, the hospital will need to work within the context of its contracts with QHP issuers to ensure that the hospital financial assistance policy does not conflict with contract terms. In the case of a non-network provider, operating without a contract with the issuer, patients may face either no coverage or higher cost-sharing under the terms of their plan. In that situation, the hospital's decisions would not be governed by any contract with an issuer.

COST-SHARING, CHARITY CARE, AND DSH PAYMENTS

Hospitals that provide essential services to the nation's vulnerable patients do so with the support of Medicaid disproportionate share hospital (DSH) payments. Hospitals should consult their state DSH payment methodologies to determine whether the provision of cost-sharing assistance will impact DSH payments. For example, federal law requires that hospitals with a low income utiliza-

tion rate (LIUR) of 25 percent or more must be deemed a DSH hospital, and many states incorporate the LIUR into their DSH payment methodologies. The LIUR is partly based on hospital charity care. If a hospital amends its charity care policies to include cost-sharing reductions and waivers for QHP enrollees, it might also increase the hospital's LIUR and, in turn, impact its DSH payments. Or charity care (as distinct from bad debt) might in other ways factor into the state's DSH payment methodologies.

In contrast to Medicaid, Medicare DSH payments currently are not sensitive to hospital charity care policies, including cost-sharing support. This is because CMS currently uses each hospital's low-income Medicare and Medicaid days relative to all hospitals' low-income Medicare and Medicaid days as a proxy for distributing a substantial portion of Medicare DSH payments. CMS may one day develop a revised Medicare DSH payment policy that relies on uncompensated care cost information, as reported on worksheet S-10 of the Medicare cost report. Exactly how these calculations would be made, and specifically how discounts on third-party cost sharing will be treated, is not known at this time and will be subject to rulemaking involving opportunity for public comment.

COST-SHARING IN THE CONTEXT OF IRS FINANCIAL ASSISTANCE POLICY RULES

Hospitals that adopt charity care policies that provide assistance with QHP cost-sharing obligations should be mindful of the ACA's provisions on financial assistance policies of nonprofit or government hospitals with 501(c)(3) status.

In June 2012, the Internal Revenue Service (IRS) issued a proposed rule outlining the requirements added by the ACA for charitable hospitals. One of the requirements is that a hospital must outline a financial assistance policy, including eligibility criteria for financial assistance. A hospital might consider forgiveness or discounts of patient cost-sharing responsibilities as part of its financial assistance policy. However, whichever level of financial assistance a hospital chooses to support, it must then comply with the rest of the requirements governing financial assistance policies—such as notification requirements, prohibition against charging more than the amount generally billed, and prohibition against extraordinary billing and collection practices.

THIRD-PARTY COST-SHARING WOULD FURTHER MARKETPLACE SUCCESS

Cost-sharing must be affordable to protect patients' access to care and the ACA goal of ensuring the availability of marketplace coverage for those who need it most. America's Essential Hospitals and its members remain committed to these goals. HHS' current cost-sharing parameters leave substantial out-of-pocket exposure, even for those helped by low-income subsidies. It is critically important to identify other means to minimize the negative impact of cost-sharing on the most vulnerable populations that our members serve.

Cost-sharing must be affordable to protect patients' access to care and the ACA goal of ensuring the availability of marketplace coverage for those who need it most.

Hospitals should be encouraged to implement financial assistance policies for discounts or forgiveness of cost-sharing responsibility for vulnerable patient populations. Likewise, not-for-profit foundations, including hospital-affiliated foundations, should have flexibility to provide cost-sharing subsidies without potential constraints imposed by QHPs. CMS' concerns about such activities in the premium assistance context are not applicable in the cost sharing arena, where essential hospitals have, for years, provided charity care assistance to insured patients with unaffordable cost-sharing obligations. We are confident that by working together, we can successfully navigate a path to supporting coverage.

Notes

1. Radnofsky L. Obama Administration Says 7.3 Million Who Picked Health Plans on Exchanges Have Paid Premiums. *The Wall Street Journal*. September 18, 2014. http://online.wsj.com/articles/obama-administration-says-7-3-million-who-picked-health-plans-on-exchanges-have-paid-premiums-1411058425. Accessed September 2014.

2. Congressional Budget Office. Updated Estimates of the Effects of the Insurance Coverage Provisons of the Affordable Care Act. April 2014. http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf. Accessed September 2014.

3. Centers for Medicare & Medicaid Services. Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces. November 4, 2013. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf. Accessed September 2014.

4. Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums. *79 Federal Register*. 15240, 15245 March 19, 2014.

5. Centers for Medicare & Medicaid Services. Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces. February 7, 2014. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf. Accessed September 2014.