

REMOVING BARRIERS TO COVERAGE AND ACCESS: THIRD PARTY FOUNDATIONS OFFER PREMIUM AND COST-SHARING ASSISTANCE

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The new health insurance coverage options provided through the marketplaces established by the Affordable Care Act (ACA) have filled a critical need for many vulnerable individuals served by safety net providers, such as health centers and essential hospitals, many of whom were previously uninsured. Specifically, advanced premium tax credits (APTCs) and cost-sharing subsidies make the cost of coverage more affordable for low-income individuals. Despite the success of the ACA in improving overall access, some individuals and families across the United States find that the cost of premiums for marketplace coverage and cost-sharing responsibilities associated with their plans can be significant barriers to care. In addition, co-pays and co-insurance are applied to various services depending on the plan that is chosen. This is particularly burdensome for enrollees with chronic conditions requiring on-going treatment, such as expensive medications, the out-of-pocket cost can be unaffordable. Deductibles in marketplace plans vary and the cost-sharing limit can be as high as [\\$2,250 for an individual, or \\$4,500 for a family](#), which may be difficult for those with annual income between \$11,670 and \$17,505. Non-medical financial burdens can cause individuals to forego medical care or stop paying premiums. For providers, unmet cost-sharing obligations and a loss of coverage of their patients may result in an increase in uncompensated care.

Recognizing that individuals in their communities may require additional support to maintain marketplace insurance coverage and translate insurance into access to care, health centers and essential hospitals have been exploring ways to provide premium and cost-sharing assistance to those facing financial challenges. Reports from [America's Essential Hospitals](#) and the [National Association of Community Health Centers](#) highlight the issues faced by health care providers in the development of innovative assistance strategies and programs. Federal guidance on third-party payments for premium and cost-sharing assistance has addressed questions about the application of policies to new programs, but some aspects of policy still remain unclear. In November 2013, the Department of Health and Human Services (HHS) indicated that the [marketplaces are not considered a federal program](#) with regard to the anti-kickback statute but raised concerns that patient assistance programs may skew the risk pools. The Centers for Medicare and Medicaid Services (CMS) has [advised those interested in offering premium and cost-sharing assistance](#) to do so through a nonprofit foundation and to provide assistance based only on financial need, and not health status. In February 2015, CMS also issued a Final Rule indicating that Qualified Health Plans (QHPs) in the marketplace are required to accept premium and cost-sharing payments from [the following third parties](#): 1) the Ryan White HIV/AIDS program; 2) Indian tribes, tribal organizations, and urban Indian organizations; and 3) other Federal and State government programs. According to this guidance, certain types of foundations are acceptable entities through which to deliver premium and cost-sharing assistance. It is unclear whether health centers and essential hospitals are included in any of the required groups from which health plans are required to accept third party payments. However, some organizations have developed models for providing premium and cost-sharing assistance that fall within guidelines, and are described below.

FOUNDATIONS THAT PROVIDE FINANCIAL ASSISTANCE FOR UNDERINSURED AND UNINSURED INDIVIDUALS

In response to a growing interest among safety net providers in the development of financial assistance programs, the National Partnership for the Health Care Safety Net (the Partnership) conducted a series of interviews with key individuals at third-party foundations that provide financial assistance for cost-sharing or premium payments.¹ Some programs were developed prior to the ACA to address the needs of underinsured individuals, and others developed specifically in response to issues faced by low-income individuals enrolled in health plans through the marketplace. Although the programs that were not developed in response to the ACA have a different focus, the development and implementation of the programs can still offer valuable insights for those interested in addressing the financial burdens faced by enrollees in the marketplace.

Below, the Partnership provides an overview of the key components of four of the foundations interviewed, as well as a summary of lessons learned and recommendations for implementation.² Two of the programs highlighted are “Copayment Assistance Organizations” that primarily focus on treatments for health conditions, and two of the programs are “Marketplace Premium Assistance Programs” and target enrollees in the marketplace.

COPAYMENT ASSISTANCE ORGANIZATIONS

The HealthWell Foundation

Overview: Founded in 2003, the [HealthWell Foundation](#) was developed to assist individuals with premiums, copayments, coinsurance, and deductibles for certain treatments. The HealthWell Foundation has assisted more than 225,000 underinsured Americans in over 50 disease areas in accessing critical medical treatments.

Eligibility: To qualify, participants must be insured, have an annual income up to 400 to 500% FPL, and have a diagnosis in a disease category for which the foundation has an open fund.

Enrollment: Individuals may enroll using the Foundation’s online application or by calling the hotline to speak to a HealthWell representative. Individuals may re-enroll at the end of their 12-month grant cycle. Re-enrollments are based on eligibility and available funding.

How it’s funded: Funding primarily comes from pharmaceutical or biotech companies. The Foundation has also received funding from over 10,000 individual donors – many of whom were once grant recipients.

How payment works: For copays and deductibles, the Foundation sets up direct bill and pharmacy cards for participants. For premiums, after a participant has incurred a cost for treatment for the eligible disease, the Foundation can pay the participant directly or pay the insurance company.

Continued on next page

¹ Interviews were conducted with program directors or managers between July and September 2014.

² HealthConnect is also highlighted in: <https://www.enrollamerica.org/third-party-payment-an-innovative-financial-help-model/>

Patient Access Network (PAN) Foundation

Overview: Founded in 2004, [PAN](#) has helped 300,000 underinsured individuals nationwide with chronic or life-threatening illnesses for whom cost limits their access to breakthrough medical treatments. PAN provides financial assistance for pharmaceutical co-payments and out-of-pocket costs through nearly 60 disease-specific programs.

Eligibility: To qualify, individuals must be insured, have a diagnosis for an eligible disease under the program, meet income requirements for that program (i.e. have an annual income up to 500% FPL), and receive treatment and reside in the United States.

Enrollment: Individuals are referred by providers, patient advocacy groups and specialty pharmacies and can enroll through the website.

How it's funded: Funding primarily comes from pharmaceutical companies, but PAN also receives funding from disease-specific patient advocacy groups (e.g. asthma, hepatitis C, breast cancer), the health care industry and charitable groups.

How payment works: Payments are made directly to the insurance company and/or the provider.

MARKETPLACE PREMIUM ASSISTANCE PROGRAMS

HealthConnect

Overview: Founded in 2013, [HealthConnect](#) is a health insurance premium assistance program administered by United Way of Dane County and supported by University of Wisconsin Health, a health system and health plan. The program covers insurance premiums in the Exchange after the APTC. Wisconsin did not expand Medicaid but provides Medicaid coverage through BadgerCare to individuals with incomes below 100% FPL. Previously Medicaid-eligible individuals with incomes between 100-138% FPL were enrolled in the federally-facilitated marketplace.

Eligibility: To qualify, individuals must be enrolled in a silver plan, apply through the marketplace (although not through a broker), have an annual income between 100 and 150% FPL, and be a resident of Dane County.

Enrollment: Individuals are referred by enrollment assisters and can enroll through the website.

How it's funded: Funding is provided by University of Wisconsin Health.

How payment works: Payments are made directly to the insurance company.

Project Access Northwest

Overview: Founded in 2013, [Project Access Northwest](#) collaborates with the Washington State Hospital Association to cover insurance premiums in the Exchange after the APTC. Washington has expanded Medicaid and runs a state-based Exchange.

Eligibility: To qualify, individuals must enroll in a silver plan, be eligible for insurance in the marketplace and not eligible for Medicaid, have an annual income up to 250% FPL, and receive care in King, Kitsap, and Snohomish counties.

Enrollment: Individuals are referred by enrollment assisters.

How it's funded: Funding comes from five hospital systems.

How payment works: Payments are made directly to the insurance company.

KEY CONSIDERATIONS

Not surprisingly, a common challenge with setting up a financial assistance program was the difficulty of determining how to allocate a finite number of resources. Programs had to decide between providing a large amount of financial assistance to a limited number of individuals or a lesser amount of assistance for a greater number of individuals. For those programs offering premium assistance for marketplace plans, by targeting enrollees who qualify for the APTC that lower the premium cost, and choose a silver plan with cost-sharing subsidies, programs are able to enroll more individuals and maximize the use of limited funds.

Even after providing assistance with premiums, premium assistance programs reported that financial barriers continued to exist for enrollees. As noted above, co-pays and deductibles, and specifically the cost of prescription drugs, were reported to be significant challenges. In some states, enrollees are required to pay a tobacco surcharge that increases the premium cost, which may not be covered under the assistance program.

Some of the recommendations for the implementation of financial assistance programs include:

Building Support

- Form partnerships with patient advocacy groups.
- Start with a small pilot program that can be expanded later.

Operations

- Work closely with individuals with expertise in legal, regulatory and financial considerations.
- Set up a comprehensive database for tracking participants.

Patient Engagement

- Use a call center or hotline for participant questions.
- Develop a website with patient portals so that participants can easily monitor their benefits and payments.

Overall, program staff felt strongly that the premium and cost-sharing assistance program positively impacted their communities, particularly for those individuals who were previously uninsured and had little or no experience with health insurance plans. In fact, individuals receiving assistance often called the program when they no longer needed the financial assistance so that the funds could be offered to another individual in need. As providers that serve many low-income patients with financial need, health centers and essential hospitals may determine that collaborative efforts with foundations and other interested organizations to support patients in maintaining and utilizing coverage may be a model for maximizing the impact of ACA insurance expansions for their patients.