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September 22, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-6074-NC: Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (more than 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) regarding third-party payment of premiums. Specifically, the agency seeks information on whether (and, if so, how) providers may be inappropriately steering Medicare- and/or Medicaid-eligible individuals into individual market plans and paying the premiums for the purpose of obtaining higher payment rates.

The AHA agrees that truly inappropriate steerage could harm consumers, who may later face late-enrollment penalties or not receive protections afforded them through the Medicare and/or Medicaid programs, and we encourage the agency to take action to prevent such inappropriate steerage. However, we strongly caution the agency against using this as a pretext to further restrict the ability of certain third parties to help individuals with their premiums and cost-sharing responsibilities. Third-party payment of premiums – whether by a family member, a community-based organization, a government program, providers or a charitable organization – is an important tool for expanding coverage for vulnerable Americans. Indeed, access to coverage and routine health care should take precedent over any concerns about the risk pool, which can be addressed through other policy vehicles and through broader enrollment of younger, healthier individuals. The AHA urges CMS to prioritize the needs of vulnerable Americans by explicitly requiring qualified health plans to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations for individuals not eligible for Medicare or Medicaid.

In this Request for Information (RFI), CMS inquired as to how providers help enroll individuals in coverage. America's hospitals and health systems have a long history of providing eligibility



and enrollment assistance to their communities. Prior to implementation of the Affordable Care Act (ACA), hospitals and health systems assisted uninsured patients in obtaining coverage either by directly providing eligibility and enrollment services or by connecting them to community-based resources that helped them apply for and enroll in state Medicaid and other coverage programs. Upon implementation of the Health Insurance Marketplaces, many hospitals and other community organizations across the U.S. became certified application counselor (CAC) entities. They proactively took on the responsibility of training staff and volunteers to become CACs, who, in turn, have served patients and other members of the community. These CACs – which may include social workers, other staff, and volunteers – have contributed significantly to the level of enrollment that has been achieved, especially in those states with a federally-facilitated marketplace.

To help enroll their patients, hospitals generally use a screening form that collects information that is commonly used to determine eligibility for government-sponsored programs, or, if applicable, private programs sponsored by the hospital, a foundation or other charitable organization. Such information often includes, but is not limited to, the applicant's income, age, disability status, geographic location, and whether the individual has a specific medical condition (a factor used for some disease- or condition-specific programs, such as the Ryan White HIV/AIDS program). For some programs, such as Medicaid and the marketplaces, the assister may help the individual complete the application onsite, e.g., by guiding the individual through the Healthcare.gov platform, or they may connect them to the appropriate source of coverage to complete an application, such as by directing them to 1-800-MEDICARE or a charitable foundation.

Conflict of interest rules prevent hospitals and health systems that help consumers connect to and apply for coverage from steering them to a specific health plan. For example, the rules governing CACs prohibit steering applicants or otherwise suggesting any preference be given to plans with which the CAC has contracts. Hospitals and health systems abide by the CAC rules and embrace their role of ensuring that consumers understand their plan options and make the choice that works best for them. **As such, the AHA again reiterates its support for a prohibition on truly inappropriate steering of Medicare and/or Medicaid enrollees into the individual market.**

In response to CMS's questions regarding how to prevent and respond to truly inappropriate steering, the AHA supports targeted efforts by CMS to identify and take action to stop offenders given that potential abuses by third parties are likely to be relatively isolated. We are strongly opposed to broad-brush approaches that would impact all hospitals, such as ubiquitous reporting requirements or modification of the Conditions of Participation. Such mechanisms could reduce hospitals' ability to help patients enroll in coverage.

It is critical that we do not impede this important pathway to coverage when more than 27 million Americans remain uninsured.¹ Many of these individuals are poor or near-poor: the Centers for Disease Control and Prevention recently found that approximately 24 percent of

¹ "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2016," Centers for Disease Control and Prevention, September 2016.

Americans between the ages 18 to 64 who were poor or near-poor were uninsured, compared to 6.5 percent for those who were not poor.² Unsurprisingly, cost is a significant barrier to coverage. According to a recent survey conducted by the Commonwealth Fund, 85 percent of uninsured individuals who explored coverage options but did not purchase a plan cited affordability as a challenge.³ Finding affordable coverage is particularly problematic in states that have not expanded Medicaid. In these markets, some of the poorest residents are ineligible for both Medicaid and marketplace subsidies, resulting in unfair gaps in coverage and, by extension, access to routine care.

Consistent with their charitable missions, some AHA members would like to assist individuals who cannot afford coverage by paying their portion of the premium and cost sharing. In making these payments, our members agree with two of the “guardrails” CMS outlined in a Feb. 7, 2014 Frequently Asked Question document: 1) subsidies would be awarded based on financial need; and 2) the premium or cost-sharing payments would cover the entire policy year (which should be clarified to include the balance of a premium year in the event the need for financial support arises during a policy year). We do not, however, support the third parameter identified by CMS, which would place a general prohibition on third-party payers factoring in health status when identifying individuals for assistance. When allocating limited resources among those with a financial need, it is appropriate and logical to also include consideration of the medical needs of each individual.

CMS and insurers have expressed concerns that enrollees receiving help from third-party payers are likely to be poorer and sicker and, therefore, have a negative impact on the risk pool. This may be true; however, by rejecting premium subsidies paid by hospitals and other providers, health plans are arguably acting in a discriminatory manner against lower-income individuals and individuals with certain diseases, conditions or other significant health care needs, which would be a violation of Section 1557 of the ACA. This section of the law prohibits discrimination on the basis of race, color, national origin, sex, age *or disability* in certain health programs or activities, including the Health Insurance Marketplaces. We are concerned that CMS is not only permitting plans to discriminate against some potentially high-cost individuals, but that the agency is inconsistent in its application of this policy. For example, CMS explicitly requires health plans to accept third-party payments from certain payers, such as Ryan White HIV/AIDS programs, which presumably make payments on behalf of potentially high-cost individuals. Yet, the agency allows plans to reject third-party payments on behalf of other potentially high-cost individuals due to the potential negative impact on the risk pool. It is unclear why payments for some potentially high-cost individuals are protected while others are not, especially when the impact on the risk pool of both populations could be similar. In addition, CMS’s rationale in requiring plans to accept Ryan White HIV/AIDS program subsidies applies equally to payments from hospitals, hospital-affiliated and other charitable organizations: “a delay in coverage for people who rely on...third parties...to pay their premiums could result in worsening medical conditions.” **We urge the agency to amend its policies to require that**

² “Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–March 2016,” Centers for Disease Control and Prevention, September 2016.

³ “Who Are the Remaining Uninsured and Why Haven’t They Signed Up for Coverage?” The Commonwealth Fund, August 18, 2016.

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plans accept payments from hospitals, hospital-affiliated foundations and other charitable organizations that seek to expand access to coverage in their communities.

Finally, CMS asks whether insurers have considered paying Medicare rates under private marketplace contracts, presumably to remove an incentive from *would-be offenders*, or reducing payments to Medicare rates when steerage has occurred. We are unclear about the purpose of these questions as it appears that CMS may be attempting to influence routine rate negotiations between private insurers and providers, including in instances where truly inappropriate steerage has not occurred. We strongly caution CMS against engaging in private market negotiations, which have generally been protected from government interference, and request that the agency carefully consider the potential negative consequences of allowing or encouraging insurers to reduce payments to providers in instances where truly inappropriate steerage may have occurred. We question whether insurers will be able to definitively identify when an individual was inappropriately steered and then target payment reductions to the responsible provider. For example, does CMS anticipate that insurers would reduce payments to a hospital when the hospital was not involved in inappropriately steering the individual or paying the premiums or cost sharing? How will CMS monitor whether insurers unfairly reduce rates using this scenario as grounds? We strongly urge CMS to not codify a policy with a high potential for error and unintended negative consequences.

Thank you for the opportunity to provide input. Please contact me if you have questions, or feel free to have your team contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President