American Hospital Association

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May 12, 2014

Submitted electronically via www.regulations.gov

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

Re: CMS—9943—IFC, Third Party Payment of Qualified Health Plan Premiums

Dear Ms. Tavenner:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, I am writing to urge the Centers for Medicare & Medicaid Services (CMS) to issue an Interim Final Rule (IFR) with comment period requiring that qualified health plans (QHPs) offered through the Health Insurance Marketplaces accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations, just as it did for the Ryan White HIV/AIDS program in the IFR issued on March 14.

In that rule, CMS required issuers of QHPs "to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium and cost-sharing support for specific individuals, and Indian tribes, tribal organizations, and urban Indian Organizations." In the preamble, however, CMS stated that the rule does not prevent QHPs from having "contractual prohibitions" on the acceptance of premium and cost-sharing payments from third-party payers other than those specified in the regulation. Further, CMS advised that it continues to discourage third-party payments by hospitals, other health care providers and other commercial entities, and encourages QHPs to reject such payments. The rule was silent regarding subsidies provided by charitable foundations.

Any effort to limit the ability of hospitals or hospital-affiliated foundations and other charitable organizations to help individuals in need obtain access to health insurance coverage is bad public

policy. Not only does it undermine one of the core objectives of the Affordable Care Act (ACA) – making affordable insurance coverage available to the uninsured – it would adversely impact those who need it most, the poor and sick. The entire "Marketplace" approach is based on the notion that any individual (with limited exceptions for incarcerated individuals and undocumented immigrants) can choose to purchase any QHP offered through an exchange. As long as the premium for that plan is paid, the insurer has to accept that individual and enroll him or her in the chosen plan (again, with limited exceptions). As in any other commercial market, it should not matter who actually pays the insurance premium – the enrollee, the enrollee's relative or another person or organization.

Hospitals have engaged in significant efforts to assist individuals with enrollment in QHPs. It has been their experience that, even with federal subsidies, cost can be an impediment to an individual obtaining coverage and the access it provides to important preventive and other health services. Hospital and foundation subsidy programs are especially important for individuals residing in states that have chosen not to expand their Medicaid programs and could help fill the gap in making affordable coverage available to meet the needs in those communities. Moreover, the policy articulated in the March 14 IFR is at odds with the position repeatedly espoused by the administration that insurance coverage is far preferable to a patchwork of treatment, most often accessed by the uninsured through the emergency department (ED).[1] [2]

CMS's rationale in requiring QHPs to accept Ryan White HIV/AIDS program subsidies applies equally to requiring the acceptance of 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." President Obama explicitly stated that "no American should go without the health care that they need; that no family should be bankrupt because somebody in that family gets sick, because no parent should have to be worried about whether they can afford treatment because they're worried that they don't want to have to burden their children; the idea that everybody in this country can get decent health care – that goal is achievable."[3]

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[1] "Our health care system has forced too many uninsured Americans to depend on the emergency room for the care they need. We cannot wait for reform that gives all Americans the high-quality, affordable care they need and helps prevent illnesses from turning into emergencies." Sec. Kathleen Sebelius, *New Data Say Uninsured Account for Nearly One-Fifth of Emergency Room Visits* (July 15, 2009), https://web.archive.org/web/20090715182733/http://www.hhs.gov/news/press/2009pres/07/20090715b.html.

[2] "Today, too many uninsured Americans turn to the emergency room for care and can't pay their bills. Insuring more Americans will decrease the hidden tax states and consumers with insurance pay to cover the cost of caring for the uninsured." Administrator Marilyn Tavenner, Press Release, *Affordable Care Act Will Ensure Health Coverage for Millions of Americans* (Mar. 16, 2012), *available at* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2012-Press-releases-items/2012-03-16.html.

[3] *Remarks by the President on the Affordable Care Act* (April 1, 2014), *available at* http://www.whitehouse.gov/the-press-office/2014/04/01/remarks-president-affordable-care-act).

While CMS spokespersons have said that the failure to address payments by charitable foundations did not represent a change in the views expressed in the agency's Feb. 7 Frequently Asked Question (FAQ) that it did not discourage subsidies from charitable foundations, a clear and definitive prohibition on QHPs rejecting such payments is needed. And while CMS has expressed its preference that QHPs reject such payments by hospitals, that policy is not supported by law. In both the first FAQ issued by CMS on this topic on Nov. 4, 2013 and the preamble discussion in the March 14 IFR, CMS stopped short of attempting to prohibit hospitals and other providers from furnishing premium and cost-sharing payment assistance through a regulation. Indeed, we believe the agency lacks authority to adopt such a prohibition; the cited authorities for issuing the IFR provide no support for enforcing the agency's views against hospitals and other providers. As in the single paragraph Nov. 4 FAQ, CMS offered no explanation, facts or other evidence to support its purported concerns. Instead, CMS simply repeated that premium assistance to uninsured individuals "could skew the insurance risk pool and create an unlevel field in the Marketplaces." In other words, CMS does not even offer a persuasive argument supporting the agency's non-binding views.

In fact, the regulations implementing the federal premium tax subsidy clearly contemplate that, in many cases, another person or organization might pay the premium for an individual to enroll in a QHP. For purposes of determining whether an individual is eligible for a federal premium tax credit for a given month, the regulations provide that premiums paid by "another person," such as by another individual or by an Indian tribe, are treated as "paid by the [enrollee]." In other words, an individual enrolled in a QHP can be eligible for a federal subsidy if another person pays for that individual's insurance premium. Thus, it is contrary to the regulations to encourage insurers to reject premium payments made by certain third parties on behalf of individuals enrolling in that insurer's QHP. (Hospitals recognize that they would still need to ensure that involvement in the process of assisting a patient to enroll in a QHP is consistent with federal and state law, including health privacy and conflict of interest rules.)

Finally, in encouraging insurers to reject premium subsidies paid by hospitals and other providers, CMS is arguably advocating a policy that is inconsistent with yet another core principle of the ACA – the prohibition of discrimination against individuals with certain diseases, conditions or other significant health care needs. As CMS is well-aware, uninsured individuals who are otherwise qualified to purchase insurance through the Marketplaces, but who have certain debilitating diseases or conditions, may not be able to afford health insurance, even after any federal subsidy. Those individuals would likely benefit from premium subsidies paid on their behalf. By encouraging insurers to reject premium subsidies paid by hospitals on behalf of such individuals, CMS is effectively condoning the exclusion of the disabled from coverage.

The rationale for an IFR to require the acceptance of Ryan White HIV/AIDS program subsidies applies equally here and provides good cause, under 5 U.S.C. 553(b)(B), to find that the notice-and-comment requirements of the Administrative Procedure Act would be impracticable and contrary to the public interest with respect to requiring that QHPs accept premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations for individuals in need. Also, for the reasons outlined above, the public interest requires that new regulations be immediately enforced.

The AHA and its members will continue to work to enable as many Americans as possible to obtain health care coverage, especially those with limited resources who have no other means of coverage. We urge CMS to remove the impediments it has created for hospitals to achieve that goal. Thank you for the opportunity to comment.

If you have questions, please contact me or Melinda Hatton, senior vice president and general counsel, at (202) 626-2336, or mhatton@aha.org.

Sincerely,

/s/

Rich Umbdenstock
President and CEO