American Hospital Association®
Legal Advisory
April 8, 2014

CMS Interim Final Rule: Premium Subsidies

AT A GLANCE

The Issue:
The Centers for Medicare & Medicaid Services (CMS) recently released an interim final rule requiring issuers of qualified health plans (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." However, the rule does not prevent QHPs from having "contractual provisions" prohibiting the acceptance of premiums and cost-sharing from third-party payers other than those specified in the regulation, and CMS continues to discourage third-party payments by hospitals, other health care providers, and other commercial entities, and encourages QHPs to reject such payments.

Our Take:
We are extremely disappointed that CMS failed to prohibit issuers of QHPs from rejecting premium or cost-sharing payments from hospitals or affiliated foundations on behalf of needy enrollees. In addition, we are disappointed that CMS failed to reiterate its Feb. 7, 2014 guidance stating that it *did not* discourage the use of charitable foundations to provide premium and cost-sharing payments.

While spokespersons have told us that the new rule "in no way changes" the Feb. 7 guidance, the AHA is pressing for a confirming public statement from Health and Human Services officials that it is not discouraging hospital-affiliated and other charitable foundations from subsidizing premiums or cost sharing. The AHA will continue to advocate that issuers of QHPs be prohibited from rejecting premium or cost-sharing payments from hospitals or related foundations committed to ensuring that needy patients receive comprehensive preventive and restorative care.

The attached advisory provides a legal analysis of the implications of the latest developments and is an update to the Nov. 13, 2013 Legal Advisory on subsidies.

What You Can Do:
Share this advisory with your leadership team, legal counsel and those in your organization responsible for your financial assistance program. If you are considering offering subsidies to pay for health insurance coverage, determine how to incorporate this type of assistance into your financial assistance policies.

Further Questions:
Please contact Maureen Mudron, deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, senior vice president and general counsel, at (202) 626-2336 or mhatton@aha.org.

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BACKGROUND

The Health Insurance Marketplaces (or exchanges) created by the Affordable Care Act (ACA) are designed to give individuals, especially those who were previously uninsured, an opportunity to purchase health insurance coverage from one of a number of qualified health plans (QHPs). Recognizing that an individual's share of the cost of a premium or for services received may be prohibitive, even with a federal premium subsidy, hospitals and health systems have expressed interest in providing subsidies for the purchase of premiums and cost sharing and have inquired whether there are any legal barriers to providing assistance if they wish to do so.

This advisory provides a legal analysis of the implications of the latest developments at HHS regarding subsidies and is an update to the Legal Advisory on subsidies issued on Nov. 13, 2013.

AS IT STANDS

The interim final rule recently issued by the Centers for Medicare & Medicaid Services (CMS) on third-party payment of QHP premiums is the fourth in a series of pronouncements by the Department of Health and Human Services (HHS) related to third-party subsidies. On Oct. 30, 2013, Secretary Sebelius announced in a letter to Rep. Jim McDermott (D-WA), on behalf of the entire Department, the official position of HHS that exchanges and QHPs were not "federal health care programs." The result was that certain federal laws applicable only to federal health care programs (e.g., self-referral, anti-kickback, civil monetary penalty provisions) did not apply, and the Secretary's letter removed them as potential barriers to providing subsidies. In November 2013, however, CMS stated that HHS had "significant concerns" about hospitals and other providers offering subsidies and encouraged QHPs to reject such payments. In follow-up guidance in February, CMS clarified that that the concerns expressed in October did not apply to subsidies by the Ryan White/AIDS program, Indian tribes, state or federal government programs, or private foundations.

Specifically, the interim final rule requires 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." However, the rule does not prevent QHPs from having "contractual provisions" prohibiting the acceptance of premiums and cost-sharing from third-party payers other than those specified in the regulation, and CMS continues to discourage third-party payments by hospitals, other health care providers, and other commercial entities, and encourages QHPs to reject such payments.

The AHA will continue to advocate that issuers of QHPs be prohibited from rejecting premium or cost-sharing payments from hospitals or related foundations committed to ensuring that needy patients receive comprehensive preventive and restorative care. The AHA also is seeking confirmation that HHS *is not* discouraging the use of charitable foundations to provide premium and cost sharing payments. While HHS spokespersons have told the AHA that the interim final rule "in no way changes" the February Q&A, AHA is pressing for a confirming public statement from the Secretary.

Federal Anti-Kickback Statute

The anti-kickback statute applies only to a "federal health care program," a term defined by Congress. In an Oct. 30 letter to Rep. Jim McDermott (D-WA), Secretary Sebelius announced, on behalf of the entire Department, the official position of HHS that the federal antikickback statute (AKS) does not apply to QHPs because QHPs and other programs related to federal or state health exchanges are not "federal health care programs."

In the letter, the Secretary stated: "This conclusion was based upon a careful review of the definition of 'federal health care program' and an assessment of the various aspects of the [relevant programs] of the Affordable Care Act and consultation with the Department of Justice." HHS has authority to impose civil monetary penalties for violations of the AKS; DOJ prosecutes criminal violations. The Secretary, who speaks for all of HHS including the Office of Inspector General, clearly removed the AKS as a potential barrier and, as a result, the AKS will not affect the ability of hospitals or health systems to offer premium subsidies. Indeed, the Secretary's letter effectively forecloses any claim of intent to act in violation of the AKS and senior HHS officials confirmed this.

November 2013 "Q&A"

In a Nov. 4, 2013 question and answer (Q&A) document, CMS inexplicably attempted to cast doubt on the permissibility of hospitals subsidizing the purchase of premiums or cost sharing, stating that HHS had "significant concerns" about these types of subsidies and "discourages this practice and encourages issuers to reject such third party payments."

The Q&A stated: "It has been suggested that hospitals, other health care providers, and other commercial entities may be considering supporting premium

payments and cost-sharing obligations with respect to qualified health plans purchased by patients in the Marketplaces. …HHS intends to monitor this practice and to take appropriate action, if necessary."

The Q&A cited no authority to support discouraging subsidies or encouraging rejection of third party payments, nor any authority to "take appropriate action." While HHS may have broad authority to issue regulations to set standards for the offering of QHPs through the exchanges and "such other requirements as the Secretary [of HHS] determines appropriate," its attempt to discourage hospitals from offering premium subsidies finds no support in the ACA statute. The Q&A appears to have no legal force or effect on hospitals (or insurers) and to be unenforceable.

Interim Final Rule

The interim final rule issued on March 14 reiterates but does not correct the infirmities of the Q&A. While the discussion in the preamble to the rule repeats the admonition that HHS continues to discourage payments by hospitals and other providers and encourages QHPs to reject these payments, CMS stopped short of attempting to impose the agency's views through a regulation. Indeed, the cited authorities for issuing the interim final rule would provide no support for enforcing HHS's views against hospitals and other providers.

As with the single paragraph Q&A, CMS offers no explanation, facts or other evidence to support HHS's purported concerns. Instead, CMS simply repeats that premium assistance to uninsured individuals "could skew the insurance risk pool and create an unlevel field in the Marketplaces." In other words, not even a persuasive argument supporting the agency's non-binding views.

In addition, such a policy would undermine one of the core objectives of the ACA – making more affordable insurance coverage available to the uninsured – and worse, would do so for those poor and sick individuals most in need of health insurance. 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.

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 individuals enrolling in that insurer's QHP. (The hospital would still need to ensure that its 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, it is important to note that the interim final rule was silent on subsidies being provided by charitable foundations. While HHS spokespersons have told the AHA that the interim final rule "in no way changes" the February Q&A, the AHA is pressing for a confirming public statement from the Secretary that HHS is not discouraging hospital affiliated and other charitable foundations from subsidizing premiums or cost sharing.

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.

Tax Exemption Considerations

The AHA continues to believe that existing Internal Revenue Service (IRS) precedent strongly supports a determination that providing financial assistance-based subsidy programs advances the charitable purpose of hospitals and that any benefit to insurers is incidental to achieving the larger public good of making health care available to those with financial need. The IRS has given no indication that providing premium subsidies for individuals in need of financial assistance would cause any concern, much less jeopardize a hospital's tax-exempt status.

The ACA requires tax-exempt hospitals to have a written financial assistance policy that describes the criteria that will be applied and the financial assistance that will be provided to help patients afford health care. Premium subsidies could be one form of financial assistance. To the extent that premium subsidies provide a benefit to a private health insurance company, that benefit would be incidental in the same way that any benefit to drug and medical device suppliers is incidental when the hospital purchases their products as part of providing free care to a needy patient. IRS rulings recognize that when private benefit is only incidental to achieving a charitable purpose, it does not jeopardize exemption (e.g., a hospital subsidizing liability insurance for a physician recruited to serve unmet needs in the community).

FURTHER QUESTIONS

Please contact Maureen Mudron, deputy general counsel, at (202) 626-2301 or mmudron@aha.org, or Mindy Hatton, senior vice-president and general counsel, at (202) 626-2336 or mhatton@aha.org.