AMERICA'S ESSENTIAL HOSPITALS

May 13, 2014

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave., SW
Washington, DC 20201

Ref: CMS-9943-IFC: Patient Protection and Affordable Care Act; Third-Party Payment of Qualified Health Plan Premiums

Dear Ms. Tavenner,

America's Essential Hospitals appreciates the opportunity to submit comments on the above-captioned interim final rule, which addresses third-party premium assistance for individuals seeking coverage through the health insurance marketplaces (exchanges) established under the Affordable Care Act (ACA). We support the Centers for Medicare & Medicaid Services' (CMS') efforts to facilitate coverage expansion through the marketplaces by continuing to refine the requirements for qualified health plans (QHPs) to accept payments from certain third parties on behalf of marketplace enrollees.

Specifically, we support the flexibility CMS has shown by issuing hardship exemptions to certain individuals, allowing them to continue to enroll in coverage through the marketplaces even though the open enrollment period is over. These exemptions pertain to individuals who lost coverage or could not enroll in coverage during open enrollment because plan issuers refused to accept their third-party premium or cost-sharing payments.

However, we remain concerned that the above-captioned rule continues to discourage providers from offering premium assistance programs, which

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
1301 Pennsylvania Ave NW Ste 950
Washington DC 20004

t: 202.585.0100
f: 202.585.0101
e: info@essentialhospitals.org

may leave many of our most vulnerable patients unable to access needed health care services.

America's Essential Hospitals represents more than 200 essential hospitals and health systems across the country. Our members are essential community providers who provide care with excellence to vulnerable populations, the uninsured and patients covered by public programs. Specifically, our members provide a disproportionate share of the nation's uncompensated care and devote more than half of their inpatient and outpatient care to uninsured or Medicaid patients. Our members provide this care while operating on margins substantially lower than the rest of the hospital industry—with an average operating margin of 0.88 percent, compared to 5.5 percent for hospitals nationally.[1]

Many of our hospitals' patients will likely gain coverage for the first time through the marketplaces. Recognizing these patients have limited finances, the ACA does provide critical premium subsidies for low-income enrollees. This key support enables many to purchase needed health insurance coverage. However, for some patients, premium subsidies are simply not enough. And the expense of monthly insurance premiums and the required cost-sharing remains too high.[2]

Providers such as members of America's Essential Hospitals are working to increase access to coverage for low-income individuals, often through generous financial assistance policies. Our hospitals have a long history of serving the low-income and uninsured. With that comes deep experience and expertise in helping patients access all available financial resources and coverage options. Patients, in fact, have come to rely on this support.

Offering provider-supplemented premium and cost-sharing assistance for marketplace coverage is a natural extension of these services, and the benefits are crucial. This assistance would make needed preventive care affordable for patients. It would also help patients remain covered over the long term, thus maintaining continuity in their care. Low-income individuals who obtain stable coverage through a marketplace plan are more likely to gain access to care in the right setting at the right time. This

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[1]America's Essential Hospitals Annual Hospital Characteristics Survey, FY 2012. Results to be published.
[2]Gruber J, Perry I. Commonwealth Fund. Realizing Health Reform's Potential: Will the Affordable Care Act Make Health Insurance Affordable?
http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Apr/1493_Gruber_will_affordable_care_act_make_hlt_ins_affordable_reform_brief_compressed.pdf. Last modified April 2011. Accessed April 2014.

increases appropriate health care utilization, minimizes inappropriate utilization, and improves health outcomes and cost efficiencies for the entire health care system.[3]

Allowing providers to directly assist low-income populations in obtaining and maintaining coverage could also increase marketplace enrollment, thus creating greater marketplace stabilization and success.

As CMS continues to refine the regulations that require QHP issuers to accept third-party premium assistance for marketplace enrollees, we ask the agency to consider the following comments.

1. CMS should allow providers additional flexibility in structuring provider-based premium and cost-sharing assistance programs to ensure marketplace success.

CMS should allow provider-supplemented premium assistance and cost-sharing for individuals obtaining marketplace coverage to further strengthen the marketplaces and ensure vulnerable populations have uninterrupted access to affordable, meaningful health insurance coverage.

One of the fundamental goals of the ACA is to help the nation's uninsured and underinsured obtain affordable health insurance coverage. To facilitate coverage enrollment, the ACA created marketplaces through which patients could choose the coverage best suited for their needs. However, providers such as our essential hospitals are concerned about the affordability of that coverage for their patients. Although the ACA provides subsidies for low-income marketplace enrollees, patients still may not be able to afford needed coverage. This is particularly worrisome in states with a limited number of marketplace plan options and in states that have chosen not to expand their Medicaid Program.

In non-expansion states, coverage almost certainly will be unattainable for those below 100 percent of the federal poverty line, who are not eligible for the federal subsidies. Though this situation was not intended by the ACA, which attempts to bring all patients into the health care system, it was an

[3]Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. http://www.medpac.gov/documents/Mar13_entirereport.pdf. Last modified March 2013. Accessed April 2014.

unfortunate outcome of the Supreme Court decision to render the ACA's Medicaid expansion optional.

However, providers such as essential hospitals are keenly interested in boosting patient access and helping patients realize the full benefits of coverage. These providers are also dependent on coverage expansion to support their essential health care services. As such, many are considering providing financial support to low-income patients to help them gain coverage.

But in the above-captioned rule, CMS continues to express concern with providers offering premium and cost-sharing support to marketplace enrollees, citing the possibility of skewing the insurance risk pools. To mitigate those concerns, provider-based assistance can be structured to minimize any risk pool concerns (e.g., through financial-based assistance rather than health status- based assistance). Moreover, the patients providers would be assisting are already eligible for coverage through the marketplaces, they just can't afford it.

CMS has already recognized financial assistance should be permitted for populations that have been targeted for such assistance under federal or state law (e.g., those targeted under the Ryan White CARE Act) despite risk pool concerns. The vulnerable patient populations served by essential hospitals would benefit greatly from the same type of protections and assistance afforded to Ryan White and other targeted patient populations.

Provider-supplemented assistance allows low-income individuals to keep the coverage they have or enables them to enroll for the first time in coverage through the marketplaces. This will lead to a greater number of enrollees in the QHPs offered through the marketplaces, spreading risk more broadly and leading to stabilization, which attracts new plans and promotes price competition. In this way, provider assistance will boost marketplace success and the overall goal of the ACA—to help individuals obtain and maintain meaningful health insurance coverage.

For these reasons, CMS should retract its position discouraging issuers from accepting premium support from providers. Instead, CMS should work with providers to determine acceptable financial support structures for insurance coverage to benefit the health of low-income enrollees and further strengthen the marketplaces for all individuals.

2. CMS should include language requiring QHPs to accept third-party payments from private, nonprofit foundations.

CMS should revise its proposed regulations to require QHPs to also accept premium and cost-sharing assistance from private, nonprofit foundations to ensure marketplace enrollees' coverage is not disrupted. In a previously issued question and answer (Q&A) document, CMS addressed concerns over whether or not QHPs could accept payments from private, nonprofit foundations. CMS clarified that QHPs could accept assistance payments from foundations if they are made on behalf of enrollees based on financial, not health, status and the payments cover the entire policy year.[4] This clarification alleviated plans' concerns over whether they can accept foundation-based premium support and allowed providers to offer marketplace assistance through certain foundations.

However, that language has been omitted from the above-captioned rule. Although the interim final rule does not prevent foundations from providing assistance, the omission of explicit language allowing these payments could lead to renewed concerns over whether QHPs are permitted to accept payments from foundations on behalf of marketplace enrollees.

These concerns could ultimately disrupt coverage for individuals who have enrolled in a marketplace QHP with assistance from a foundation. Without the explicit clarification CMS provided previously, QHPs may be hesitant to accept payments from foundations in the future. Thus, individuals with plans dependent on this assistance could lose coverage, which causes patient churning in and out of marketplace coverage.

Patients who struggle with affordability of marketplace coverage are often the most in need of continuous, coordinated care and benefit from the stable, comprehensive coverage of QHPs. Countless studies have shown that churning between different coverage options and uninsured status significantly disrupts care and leads to poorer health outcomes. Uninsured individuals are likely to delay or forgo needed preventive care, including prescription medications, which leads to unnecessary morbidity and

[4]CMS Question and Answer Document. Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces. 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. Last modified Feb. 7, 2014. Assessed April 2014.

premature death.[5] Additionally, frequent coverage changes have the potential to adversely impact not only an enrollee's health status, but also the costs to providers of supplying needed care for patients and the administrative burden on public and private insurance issuers. As such, minimizing frequent coverage changes for enrollees is in the best interest of patients, providers, plans, and states.[6]

For these reasons, CMS should incorporate the agency's previous clarification into the final rule, requiring QHPs to accept premium and cost-sharing assistance from private, nonprofit foundations.

3. CMS should clarify that the requirement to accept premium and cost-sharing payments from state programs also pertains to programs adopted by the state's political subdivisions.

In the preamble of the above-captioned rule, CMS should include language that states the requirement for QHPs to accept premium payments from state and federal government programs also extends to local government programs. We believe, as CMS has shared previously, the agency views local governments such as counties and municipalities as political subdivisions of the state. Therefore, CMS should clarify that QHPs are required to accept premium assistance payments from any programs administered through a state's political subdivisions. Including this clarification will ensure states have the flexibility to continue to utilize their local governments to distribute care and financial assistance to their most vulnerable populations.

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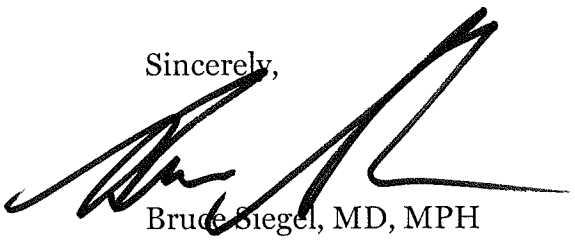
[5]Institute of Medicine. America's Uninsured Crisis: Consequences for Health and Health Care. http://www.iom.edu/~/media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf. Last modified February 2009. Accessed April 2014.

[6]Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP. http://www.medpac.gov/documents/Mar13_entirereport.pdf. Last modified March 2013. Accessed April 2014. .

America's Essential Hospitals appreciates the opportunity to submit these comments. If you have any questions, please contact Xiaoyi Huang at 202-585-0127.

Sincerely,



Bruce Siegel, MD, MPH
President and CEO