Hospital Subsidy of Patient Health Insurance Premiums

As a result of an increase in the amount of uncompensated indigent care provided by tax-exempt hospitals, some hospitals have considered whether subsidizing patient health insurance premiums for qualified health plans (QHPs) on the health insurance exchanges (HIEs or Exchanges) could reduce the amount of uncompensated care that hospitals provide. Subsidizing the premiums would result in more patients having insurance coverage to pay for services provided by the hospitals.

Government Guidance Under the Anti-Kickback Statute

Initially, the Anti-Kickback Statute (AKS) and the Civil Monetary Penalty (CMP) laws were potential barriers to a hospital’s ability to subsidize patient insurance premiums on health insurance exchanges on the basis that the programs likely were “federal health care programs” under the AKS, and that the payment of patient premiums by hospitals or other health care providers could be an inducement for the patient to utilize the services of the hospital or other health care provider in violation of the AKS and/or CMP.¹

The AKS defines a “federal health care program” as “any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government.”

Because the AKS is implicated only when an arrangement involves services or items for which payment may be made under a federal health care program, a threshold question is whether the proposed premium payment involves a federal health care program. The following summary shows the development of the government’s current position as to whether or not the QHPs are federal health care programs under the AKS and to what extent the payment of premiums by health care providers for QHPs is prohibited.

- **October 30, 2013:** Department of Health and Human Services (HHS) Secretary Kathleen Sebelius affirmed in a letter to Representative Jim McDermott, Wash-7th Congressional District, that premium payments for coverage through HIEs does not implicate the AKS or, presumably, the CMP law, because HHS does not consider QHPs to be federal health care programs within the meaning of the AKS.

- **November 4, 2013:** The Centers for Medicare and Medicaid Services (CMS) advised in an FAQ that it has significant concerns with the practice of hospitals and other health care providers subsidizing premium payments and cost-sharing obligations with respect to QHPs purchased by patients on HIEs because it could skew the insurance risk pool and create an unlevel field on the Exchanges.² CMS confirmed that it discourages this practice and encouraged issuers to reject such third-party payments. CMS re-affirmed its broad authority to regulate HIEs and its intent to monitor the practice of third-party payments and to take appropriate action, if necessary. Based on this guidance, CMS’s primary concern seems to be that providers will selectively target patients who are very sick and are high utilizers of services. In such a scenario, costs to insurers could grow and potentially result in higher QHP premiums for all consumers.

- **November 7, 2013:** Sen. Charles Grassley, R-iowa, wrote a letter to Secretary Sebelius and Attorney General Eric Holder arguing that QHPs are federal health care programs and should be subject to the AKS because they receive substantial federal subsidies. Secretary Sebelius
responded to Sen. Grassley and reiterated that HHS does not consider QHPs to be federal health care programs. On February 12, 2014, Sen. Grassley wrote to Secretary Sebelius again asserting that if HHS is concerned about the possibility of hospitals and other health care providers supporting premium payments and cost-sharing obligations, Congress has already created a mechanism to deal with such practices – the AKS. He questioned why HHS does not use the existing AKS mechanism rather than issuing mere guidance to “discourage” the practice.

- **February 7, 2014:** CMS released further guidance to clarify that the concerns addressed in the November 4, 2013 FAQ would not apply to payments from private, not-for-profit foundations on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees’ health status. In this situation, CMS would expect that the premium and any cost-sharing payments cover the entire policy year. This is HHS’s current position on the issue.

- **March 19, 2014:** CMS published an interim final rule that 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, and Indian organizations. CMS cautioned, though, that third-party payments of premiums and cost sharing provided by hospitals and other health care providers could be problematic, reiterating concerns that such payments “could skew the insurance risk pool and create an unlevel competitive field in the insurance market.” CMS encouraged QHPs to reject such payments. Additionally, CMS stated that the rule does not prevent QHPs from contractually prohibiting payments of premiums and cost sharing from third-party payors other than those specified in the interim final rule.

- **May 21, 2014:** Secretary Sebelius sent a letter to Richard Umbdenstock, president of the American Hospital Association, advising that HHS had concluded that it does not consider QHPs to be federal health care programs within the meaning of the AKS. She made clear HHS’s current position, stating: “We believe that existing guidance related to third-party payments of premiums and cost sharing made on behalf of Marketplace QHP enrollees by private, not-for-profit foundations is sufficient to put the public on notice that as a general matter, such payments are not prohibited by HHS’s rules to the extent they are provided in a manner consistent with the February 7, 2014 FAQ.” She went on to advise that HHS does not currently intend to issue additional guidance on the issue.

### Tax-Exemption Considerations

While HHS and CMS have provided some guidance regarding payment of patient premiums by hospitals, the Internal Revenue Service (IRS) has not indicated its views on the issue. It is possible the IRS could take the position that payment of insurance premiums on behalf of patients may affect a hospital’s or other provider’s status as a tax-exempt entity. In particular, tax-exempt entities must avoid providing any “private inurement” to insiders and must avoid engaging in “private benefit” transactions that serve private, rather than public, interests in more than an insubstantial way. It is possible that, in some cases, paying premiums might be construed as conferring private benefits (for example, to insurers), especially where there is inadequate documentation of financial need. The IRS’s private benefit doctrine is fact-intensive. Any hospital should consider safeguards to mitigate risk to its tax-exempt status. For example, financial need standards should be consistently applied and clearly documented, and a hospital might consider having any payment program funded and administered by its affiliated foundation, rather than making payments directly from the hospital. Hospitals should discuss premium payment programs with their auditors to confirm that the implementation of such programs will not jeopardize tax-exempt status.

Another alternative approach – which would be even more conservative from a tax perspective – would be to use an unrelated charitable foundation to administer the program (and potentially to pool resources with other area hospitals that might be willing to participate in the program). This approach has been considered or used by some hospitals.

### Private Insurance Contracts

It is possible that premium payments by a third party could be contractually prohibited, especially in light of HHS’s statement encouraging insurers to reject third-party payments made for coverage through the HIEs.

### Conclusion

The government’s guidance on the payment of patient QHP premiums by hospitals and other health care providers is developing. The latest guidance from CMS is that, consistent with the February 7, 2014 FAQ, private, not-for-profit
foundations may pay premiums of QHP enrollees who satisfy defined criteria that is based on financial status and does not consider the enrollees’ health status, as long as the hospital subsidizes the premium payments for the entire year. If a hospital chooses to subsidize premium payments, it should do so for the entire policy year. It does not currently appear that HHS or CMS has any plans to issue further guidance or statements on the subject of third-party payments.4

While the payment of patient QHP premiums by hospitals currently appears to be permissible under HHS guidance, this is an issue that is gaining attention of Congress and the insurance industry, and it is possible that future advisory opinions, interpretations, court decisions or rule-making could impact the practice or clarify that QHPs are in fact federal health care programs within the meaning of the AKS.

Implementation of a patient premium program will vary by hospital, but hospitals should ensure that:

• Any patient benefitting from the program is not a beneficiary of any federal health care program
• The patient satisfies the eligibility requirements of the hospital’s financial need program
• An affiliated or non-affiliated foundation makes the premium payment
• The hospital does not mandate that the patient use the hospital’s facilities or services
• The hospital subsidizes the premiums for the entire policy year

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1 If a patient is a beneficiary of a federal health care program, including Medicare and Medicaid, there is a risk in paying for insurance premiums. Under the AKS, it is a criminal offense to knowingly and willfully offer remuneration to induce or reward referrals of items or services reimbursable by a federal health care program (42 U.S.C. Section 1320a-7b(b)). Similarly, the CMP law prohibits a provider from offering a Medicare or Medicaid beneficiary any remuneration which is likely to influence the beneficiary to obtain items payable by Medicare or Medicaid from a particular provider (42 U.S.C. Section 1320a-7a(a)).

2 This is in part because providers could temporarily pay the QHP premiums of very sick patients, enabling these patients to obtain QHP coverage during their expensive treatment without maintaining insurance thereafter.

3 79 FR 15240.

4 According to an American Hospital Association advisory brief (which could be argued was more in the form of an advocacy document), HHS cannot currently take legal action against payments of this nature without rulemaking, as it has already declared QHPs to be separate from federal healthcare programs and not subject to the AKS. The brief states: “While it undoubtedly was intended to have a chilling effect on the willingness of hospitals to provide insurance subsidies for individuals in need, the CMS Q&A appears to have no legal force or effect on hospitals and to be unenforceable.” Even if HHS decided to pursue rulemaking, AHA doubts HHS has the authority to enforce a ban on healthcare providers helping their patients afford QHP premiums. See American Hospital Association Legal Advisory dated October 10, 2013.