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May 13, 2014

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-9943-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted via www.regulations.gov

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

To Whom It May Concern:

The National Association of Community Health Centers, Inc. ("NACHC") is pleased to respond to the above-referenced Interim Final Rule with Comment Period published by the Centers for Medicare & Medicaid Services ("CMS") on March 19, 2014 (79 Fed. Reg. 15,240) ("the Interim Final Rule"). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is a Section 501(c)(3) tax-exempt organization.

Through this Interim Final Rule, CMS is promulgating a new regulation in 45 C.F.R. Part 156, which contains the standards for health insurance issuers under the Affordable Care Act. The regulation sets forth specific classes of entities from which qualified health plan ("QHP") issuers are required to accept premium payments on behalf of enrollees ("third-party premium payments"). In addition, the preamble contains language similar to what has appeared in previous informal guidance, which discouraged QHP issuers from accepting third-party payments of premium and cost sharing provided by "hospitals, other healthcare providers, and other commercial entities."

NACHC recommends that CMS clarify in a Final Rule that health centers are a type of entity from which issuers must accept third-party premium payments. This could be done either by adding health centers to the list of entities in the regulation, or by including preamble language noting that an existing category in the regulation ("State and Federal Government programs") includes health centers. We believe that such a clarification would be consistent with the purpose of the Interim Final Rule. As explained in more detail below, by statute as well as recent Health Resources and Services Administration / Bureau of Primary Health Care ("HRSA/BPHC") guidance, health centers have the discretion to spend program income associated with HRSA/BPHC operating grants under Section 330 of the Public Health Service Act for any purpose that furthers the objectives of the Section 330 project. This standard would clearly contemplate the use of program income to assist low-income individuals with insurance premiums in order to facilitate their access to all covered services under an insurance plan.

I. Background on Health Centers

There are, at present, almost 1,300 health centers with more than 9,300 sites serving more than 22 million patients nationwide. Most of these health centers receive Federal grants under Section 330 of the PHS Act, 42 U.S.C. § 254b, from the Bureau of Primary Health Care ("BPHC"), within HRSA. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be serving a federally-designated medically underserved area or a medically underserved population. In addition, at least fifty-one percent (51%) of the health center's board of directors must be made up of users of the health center's services, and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. As of 2012, approximately 39 percent of health center patients were Medicaid recipients, approximately 36 percent were uninsured, and approximately 15 percent were privately insured. Approximately 10 percent of FQHC patients were covered by Medicare or other private insurance.

II. Background on Exchange QHP Premiums

The Affordable Care Act (ACA) required the creation of Exchanges (sometimes called Marketplaces) to make it easier for individuals to directly purchase private insurance. Patient Protection and Affordable Care Act (PPACA) § 1331, Pub. L. No. 111-148. A significant portion of health centers' uninsured population – which numbers nearly 8 million today – is eligible to enroll in subsidized coverage offered through the Exchanges.

The ACA required the federal government to provide assistance with purchasing a QHP on the Exchange for persons with household income below specified thresholds, through the creation of a federally-funded income tax credit to defray the cost of premiums ("premium tax credit") and a subsidy to relieve some of the costs of copayments, coinsurance, and deductibles ("cost sharing reduction"). PPACA §§ 1401, 1402.

Enrollee premiums under the ACA are limited by minimum actuarial values set forth in the law for each level of health plan. For example, a "silver" plan must have an actuarial value of at least 70 percent, which means that the health plan pays for at least 70 percent of the total allowed cost of benefits. The rest of the cost of coverage is borne by the enrollee through premiums and cost sharing.[1] 45 C.F.R. §§ 156.20, 156.140(b). The premium tax credit is offered under the ACA to enrollees with household income between 100% and 400% of the Federal Poverty Level (FPL), and to lawfully present noncitizens with household income under 100% FPL. 26 U.S.C. § 36B(c)(1)(A); PPACA § 1401(a); 45 C.F.R. § 155.305(f)(i). The tax credit limits premium liability as a percentage of income.

[1] The term "cost sharing" refers collectively to premiums, deductibles, coinsurance, and copayments.

Even for those eligible for the premium tax credits, QHP premium burdens can be substantial. For example, in 2014, for an individual with household income of 200% FPL, the premium (with tax credit) may not exceed 6.3% of household income. 26 U.S.C. § 36B(b)(3)(A)(i). This would mean that for a single person with household income of $22,000, the premium tax credit would cap annual premium liability at $1,300.

III. Comments

The Interim Final Rule is confusing in its application to health centers, and at the same time, the topic it treats is one of critical importance in health center operations. We therefore strongly urge CMS to clarify the regulation.

Many health centers are interested in helping their patients with the cost of premiums to enroll in Exchange QHPs. The rationales behind this concept are compelling. As noted above, nationwide, more than one-third of health center patients are uninsured. In addition, in 2012, about 93% of health center patients had household income at or below 200% of the federal poverty level (FPL). Uninsured low-income patients may encounter significant financial obstacles, as described above, in seeking to purchase QHP coverage despite their eligibility for the federal premium tax credit. In addition, in states that have chosen not to expand Medicaid, individuals with household income below 100% FPL who are not eligible for Exchange subsidies on account of their immigration status are in a difficult "coverage gap." Many of these individuals are not eligible for Medicaid, and yet they are also ineligible for subsidies to make Exchange coverage more affordable. The financial burdens of the premium could dissuade both of these categories of patients from enrolling in QHP coverage that would give them access to a wider spectrum of care than they would have as uninsured health center patients.

Even for those low-income health center patients who have initially succeeded in enrolling in QHP coverage without assistance from the health center, life situations sometimes make it difficult to continue paying premiums. For example, a patient may experience a car breakdown, and may be required to divert to car repairs the income that would have otherwise been used for the premiums. Or a patient or family member may fall ill, requiring the patient to quit a second job that provided the additional income needed to pay the QHP premium. In these instances, it benefits both the patient and the QHP for the health center to be able to step in on a short-term basis and use its program income to help cover the premium until the unforeseen event has been weathered.

The vague regulatory text and accompanying preamble language in the Interim Final Rule are difficult to decipher as they apply to health centers. NACHC urges CMS to clarify the regulation in order to make clear that QHP issuers must accept third-party payments of health insurance premiums by health centers.

A. The Regulation is Confusing and Requires Clarification.

45 C.F.R. § 156.1250, which took effect on March 14, 2014, sets forth three categories of entities from which QHP issuers must accept third-party premium payments: the Ryan White HIV/AIDS program; Indian tribes, tribal organizations, and urban Indian organizations; and "State and Federal Government programs." With respect to the last category, the preamble to the Interim Final Rule indicates that CMS specifically had in mind government programs for which federal or state law or policy contemplates third-party payment of premium and cost-sharing amounts. 79 Fed. Reg. at 15,241.

From the face of the regulation, it would appear that health centers are entities from which QHP issuers must accept third-party premium assistance payments. Health centers receive federal grant funds and/or federally-supported benefits in order to serve low-income and medically underserved individuals. As grantees or "look-alikes," individual health centers participate in the administration of a

"Federal Government program," per the terms of the regulation, and as explained in more detail below, both the Section 330 statute and informal HRSA/BPHC guidance authorize grantees to use program income for any purpose that broadly furthers the objectives of the Section 330 grant – including helping patients with insurance premiums.

However, in the *preamble* to the Interim Final Rule, CMS reiterated its prior statements in November 2013 and February 2014 informal guidance, to the effect that CMS was "concerned" about third-party payments of premium and cost-sharing amounts by "hospitals, other healthcare providers, and other commercial entities." CMS explained, both in those prior guidances and in the preamble, that these types of payments could "skew the insurance risk pool and create an unlevel competitive field in the insurance market." 79 Fed. Reg. at 15,242. CMS stated that it "encourage[d]" QHP issuers to reject those sorts of third-party premium payments. *Id.*

Health centers are indisputably "healthcare providers," and therefore arguably could be included in the admonitory language in the preamble as an entity from which issuers are *discouraged* from accepting premium payments. However, as explained further below, CMS's underlying concerns on this score (that "commercial" healthcare entities will make premium assistance payments that skew the insurance risk pool) are inapplicable to health centers, which are nonprofit entities whose mission is to direct their resources toward assistance to low-income patients with the goal of reducing barriers to care.

The Interim Final Rule, when read together with the preamble, can reasonably be interpreted to require QHP issuers to accept premium assistance payments from health centers, but when the preamble language is considered, it might be read to discourage such payments. While we believe the former is the correct reading, as explained below, we strongly encourage CMS to clarify the vague wording of the regulation.

B. **Requiring QHP Issuers to Accept Premium Payments from Health Centers Is Consistent with the Policy Rationales in the Interim Final Rule.**

NACHC strongly urges CMS to amend the regulation to clarify that QHP issuers must accept third-party premium payments from health centers. This could be accomplished either by clarifying the term "State and Federal Government programs" in the regulation, by stating in preamble language that that category includes health centers, or by specifically adding health centers (including both Section 330 grantees and FQHC lookalikes) to the list of entities from which QHP issuers must accept payments.

In the preamble to the Interim Final Rule, CMS explained its rationale for selecting the entities it selected as entitled to make third-party premium payments as follows. (This statement explained CMS's rationale in issuing a February 7, 2014 FAQ document on third-party premium assistance, but the reasoning also appears to apply to the regulation.)

> CMS affirmatively encouraged QHP issuers to accept such payments given that *federal or state law or policy specifically envisions third party payment of premium and cost-sharing amounts by these entities.*

79 Fed. Reg. at 15,241 (emphasis added).

Issuers should be required to accept premium assistance payments from health centers because the italicized description above applies to health centers. Specifically, health centers that receive grants under Section 330 are authorized to use nongrant funds for a broad array of purposes that advance their patients' access to care, and that impliedly includes helping patients with insurance premium liability. "Look-alikes" – entities certified by HRSA as meeting

HRSA/BPHC regulatory requirements, but which do not receive Section 330 operating grants – are also authorized to use their operating revenue for those purposes.

As background, the amount of a health center's Section 330 operating grant is calculated to equal to the amount by which the health center's costs of operation for a fiscal year exceed the total of (1) "State, local, and other operational funding provided to the center"; and (2) "the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year." 42 U.S.C. § 254b(e)(5)(A). The health center's Section 330 grant is therefore intended to make up the difference between its operating budget and its sources of nongrant operational revenue.

Health centers are authorized to use the Section 330 grant for specific enumerated purposes, one of which is offering discounts off their standard charges to individuals with household income at or below 200% FPL through the use of standardized schedules of discounts. 42 U.S.C. § 254b(k)(3)(G)(i); 42 C.F.R. § 51c.303(f). In addition, the use of 330 grant funds by health centers that are nonprofit organizations is subject to the allowable cost principles in Office of Management and Budget (OMB) Circular A-122, and to the grants management rules in 45 C.F.R. Part 74.

By contrast, health centers have much greater flexibility in their use of nongrant funds. The Public Health Service Act, as amended in 1996, provides that nongrant funds,

> including any such funds in excess of those originally expected, shall be used as permitted under this section, and may be used for such other purposes as are not specifically prohibited under this section if such use furthers the objectives of the project.

Id. § 254b(e)(5)(D).

A Policy Information Notice (PIN) that HRSA published in March 2014 ("the HRSA Budget PIN") confirms health centers' flexibility in the use of nongrant funds. It states:

> Health centers can meet the standard of 'furthering the objectives of the project' by ensuring that the uses of non-grant funds *benefit the individual health center's target patient / target population*.

See HRSA, Policy Information Notice 2013-01, *Health Center Budgeting and Accounting Requirements,* Section V, pp. 6-7, *available at* http://bphc.hrsa.gov/policiesregulations/policies/pin201301.html (emphasis added). The HRSA Budget PIN goes on to note that the health center's governing board must provide oversight and monitoring of health center nongrant expenditures to ensure consistency with the health center's mission, goals and objectives.[2]

A health center's decision to use nongrant funds to help health center patients pay their insurance premiums, through supplementary payments to issuers, would clearly comply with the Public Health Service Act and HRSA guidance. Such assistance would help the health center's

[2] These same rules apply to FQHC look-alikes, as they are subject to the health center program requirements under Section 330. While the more restrictive rules concerning grant expenditures, for the most part, do not apply to look-alikes, the portions of the HRSA Budget PIN that apply to nongrant funds apply to look-alikes' expenditures. *See* HRSA Budget PIN, p. 3.

"target population" – low-income, medically underserved patients – secure access to a broader continuum of health care services, including hospitalization and specialty care. Such a use would "further[] the objectives" of the Section 330 grant: to increase the availability and accessibility of and to enhance the quality of health services for medically underserved populations.

While the key rationale that CMS cites to explain allowing some entities to directly fund premiums is applicable to health centers, the main criterion that CMS cites as its ground for *discouraging* insurance issuers from accepting other sources of third-party payments is inapplicable. Specifically, CMS explains in the preamble that it is discouraging QHP issuers from accepting third-party payments from "hospitals, other healthcare providers, and other commercial entities" because it is concerned that payments to issuers from such entities "could skew the insurance risk pool and create an unlevel playing field in the insurance market." 79 Fed. Reg. at 15,242.

The legal basis of CMS's statement above is not clearly articulated, either in the Interim Final Rule preamble or in the informal guidance that preceded it. However, it appears that CMS's primary concern is that commercial healthcare entities will use their market power to sway patients to enroll with specific insurers, or to give undue leverage in the insurance market to some individual enrollees. These concerns are misplaced with respect to health centers, which have a mission of serving low-income and medically underserved individuals. Health centers' premium assistance payments would not "create an unlevel playing field" in the market, but instead would help very low-income patients who otherwise might find the premium obligations associated with QHP coverage to be an insurmountable obstacle (even taking into account the premium tax credit). Requiring issuers to accept the payments when health centers voluntarily expend their operational revenue in this manner would promote the participation of low-income individuals in Exchange coverage.

C. CMS Should Include Additional Clarifications in the Preamble.

NACHC strongly recommends that CMS include two additional clarifications in the preamble to its Final Rule.

First, we recommend that CMS include in the preamble an assurance that any third-party premium assistance provided by an entity listed in 45 C.F.R. § 156.1250 would not be considered "remuneration," for purposes of the Anti-Kickback Statute (AKS), Social Security Act § 1128B(b). We do not believe that premium assistance provided by a health center using nongrant funds, in compliance with Section 330 and HRSA/BPHC guidance, would run the risk of violating the AKS. Such assistance would be intended to increase access to health care services, and not as an inducement to refer individuals to the entity or as an inducement to purchase, lease, order or arrange for services or items that may be paid for under a "federal health care program."[3] In the unlikely event that the HHS Office of

[3] In this regard, we note that Former HHS Secretary Sebelius' October 30, 2013 letter to U.S. Representative Jim McDermott, opining that HHS "does not consider QHPs, other programs related to the Federally-facilitated Marketplace, and other programs under Title I of the [ACA] [including the cost sharing reduction and premium tax credit] to be federal health care programs," is of some comfort. However, that communication does not completely dispel the concerns of health centers and other similarly-situated entities that assist with premiums and cost-sharing (such as Ryan White providers and Indian Health Service providers), for two reasons. First, Sec. Sebelius' letter is not binding legal

Inspector General (HHS OIG) informed an entity that it considered the premium assistance payments as improper remuneration, however, the entity could not invoke any specific AKS safe harbor. We request that CMS at minimum provide assurance in the preamble to the Final Rule that it does not consider the premium assistance to be "remuneration." Preferably, CMS should consult with HHS OIG on this point in order to ensure that HHS OIG is in agreement. Such consultation is necessary so that the types of entities listed in 45 C.F.R. § 156.1250 are not placed in a bind where they provide assistance pursuant to the terms of an HHS program, but yet fear that that same assistance raises compliance concerns for HHS OIG.

In addition, we request that CMS clarify in the preamble to its Final Rule that merely because a QHP issuer is required to accept premium assistance payments from an entity per the terms of 45 C.F.R. § 156.1250, that does not mean that the donor entity has any obligation to provide such payments with respect to an individual enrollee. Instead, the terms of the premium assistance (including its scope and whether it is mandatory or voluntary) are governed by the terms of the relevant federal or state government program.

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Thank you for the opportunity to comment on the Interim Final Rule. Please do not hesitate to contact me by telephone at (202) 296-0158 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison

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authority. Second, the very federal programs that fund health centers, Ryan White providers, and Indian Health Service providers could, themselves, be considered "federal health care programs."