

# Assessing the Promise and Risks of Income-Based Third-Party Payment Programs

**Stan Dorn**  
Senior Fellow  
Families USA

## ABSTRACT

**ISSUE:** Consumers' concerns about affordability limit participation in ACA marketplaces. Funded by local hospital systems and run by independent nonprofits, third-party payment (TPP) programs improve affordability for low-income consumers by paying premium costs not covered by tax credits.

**GOAL:** To assess the potential of TPP to make marketplace coverage more affordable, without harming insurance risk pools.

**METHODS:** Interviews in May and June 2016 with program administrators, hospital systems, carriers, and consumer groups in five localities and the Washington State marketplace.

**KEY FINDINGS:** The most effective local program reached 1,148 people, or 25 percent of all eligible marketplace enrollees. Other local programs served between 202 and 934 consumers; the Washington State program reached 1,133. Findings suggest that without TPP, numerous beneficiaries would have remained uninsured. Hospitals funding these programs reported net financial benefits, with declines in uncompensated care exceeding program costs. Carriers reported no adverse selection in these carefully designed programs.

**CONCLUSIONS:** Widespread adoption of TPP could help additional low-income consumers obtain marketplace coverage. Hospitals' financial gains from TPP programs make replication more feasible. However, broader policies, such as increased premium tax credits and cost-sharing reductions, are likely needed for major nationwide improvements to affordability.

## KEY TAKEAWAYS

- ▶ **Third-party payment (TPP) programs improve affordability for low-income consumers by paying premium costs not covered by ACA tax credits.**
- ▶ **Hospitals funding TPP programs reported net financial benefits and declines in uncompensated care; insurers reported no adverse selection.**
- ▶ **Widespread adoption of TPP programs could help additional low-income consumers obtain marketplace coverage.**

## INTRODUCTION

With roughly 20 million Americans gaining coverage under the Affordable Care Act (ACA), the United States has made enormous progress in reducing the number of uninsured.<sup>1</sup> Nevertheless, 28.6 million people remained without health coverage in 2016,<sup>2</sup> of whom an estimated 62 percent qualified for Medicaid or marketplace coverage.<sup>3</sup> As of June 2015, only 35 percent of consumers eligible for advance premium tax credits — which lower monthly health insurance payments — had enrolled in marketplace plans.<sup>4</sup> Research suggests that the most important obstacle to increased enrollment has been consumers' belief that coverage is unaffordable.<sup>5</sup>

Currently, the future of the ACA remains unresolved, but the basic framework of the legislation could well remain intact. If so, stakeholders and policymakers will need to revisit these affordability concerns. A fully effective solution

would likely include higher premium tax credits and cost-sharing reductions. Until such a solution is considered, more incremental strategies may be needed, like third-party payment (TPP) programs, through which health care providers pay low-income consumers' share of enrollment costs.

History suggests that TPP programs can address low-income consumers' affordability concerns on a large scale. Long before the ACA, Washington State's Basic Health Program let nonprofit organizations pay the premium charges of eligible consumers using donations from safety-net providers. The state stopped most new enrollment in the early 2000s. Before then, this TPP initiative achieved significant gains, enrolling nearly a quarter of all 133,000 consumers who received subsidized coverage when the state's Basic Health Program reached its high-water mark in 2001.<sup>6</sup>

### FEDERAL LEGAL FRAMEWORK FOR THIRD-PARTY PAYMENT PROGRAMS

According to regulations governing health insurance marketplaces, qualified health plans (QHPs) must accept payments made by governmental and tribal TPP programs.<sup>a</sup> To avoid adverse selection, QHPs are discouraged from participating in TPP programs administered by providers, which could primarily enroll the providers' patients who have health problems.<sup>b</sup> On the other hand, private nonprofit organizations can make payments "on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status," so long as payments continue through the end of the plan year.<sup>c</sup>

A long-standing federal law that limits provider self-referral — the "anti-kickback" statute — does not apply to marketplace coverage, according to letters from the secretary of the U.S. Department of Health and Human Services. The secretary ruled that marketplace coverage is not a "federal health care program" and so is not subject to the law.<sup>d</sup> Nevertheless, since a future secretary could conceivably change this interpretation, some legal observers urge nonprofits that administer TPP programs to take additional steps to protect themselves from potential liability.<sup>e</sup>

For a more detailed description of how policy evolved in this area, see Timothy S. Jost, "Implementing Health Reform: Third-Party Payments and Reference Pricing," *Health Affairs Blog*, May 22, 2014, <https://www.healthaffairs.org/doi/10.1377/hblog20140522.039182/full/>.

a. 45 CFR 156.1250.

b. Centers for Medicare and Medicaid Services, *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces* (CMS, Nov. 4, 2013), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>.

c. Centers for Medicare and Medicaid Services, *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces* (CMS, Feb. 7, 2014), <https://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>, cited with approval in Centers for Medicare and Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule," *Federal Register* 81, no. 45 (Mar. 8, 2016): 12204–352, <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

d. See, for example, *Letter from HHS Secretary Sebelius to Member of Congress Jim McDermott* (U.S. Department of Health and Human Services, Oct. 30, 2013), <https://www.hiregulation.com/files/2013/10/The-Honorable-Jim-McDermott.pdf>.

e. See the discussion in the end notes that cite Catherine E. Livingston, Gerald M. Griffith, and Rebekah N. Plowman, "Third-Party Payment of Premiums for Private Health Insurance Offered on the Exchanges," *Journal of Health & Life Sciences Law* 8, no. 2 (Feb. 2015): 1–44. A version of the paper, which includes all of the material quoted in this issue brief, is posted online at [https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC14/c\\_livingston.pdf](https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC14/c_livingston.pdf).

Some carriers have expressed concerns that TPP programs could skew risk pools by triggering “adverse selection,” or disproportionately high enrollment of consumers with serious health problems. For example, carriers have raised concerns about health care providers increasing their payments for kidney dialysis and other high-cost conditions by steering patients who qualify for Medicaid or Medicare to nonprofit organizations, which in turn enroll the patients into marketplace plans that pay higher reimbursement rates.<sup>7</sup> After seeing “problematic” effects on consumers and risk pools, the Centers for Medicare and Medicaid Services (CMS) circulated regulations in late 2016 limiting TPP programs that focus on dialysis patients.<sup>8</sup> Those regulations soon became the subject of litigation,<sup>9</sup> and a broader policy debate continues around TPP programs that serve patients with specific diagnoses.<sup>10</sup>

This issue brief focuses on different TPP programs: those that base eligibility on income rather than the presence of particular health conditions. Based on interviews conducted in May and June 2016 with nonprofit program administrators, hospital systems, carriers, and consumer groups in five localities and the Washington State marketplace, we examine whether income-based TPP programs can improve enrollment and retention without triggering harmful adverse selection.<sup>11</sup> We also explore whether income-based TPP programs could be implemented on a much larger scale. For detailed information on our methods, see [How We Conducted This Study](#).

## KEY FINDINGS

### How the Programs Developed

The five local programs we studied began when community groups and providers worried that the ACA’s premium tax credits might not be sufficient to make coverage affordable for many low-income consumers. To reduce uncompensated care amounts and improve population health, area hospitals decided to fund efforts by independent community groups to pay the remaining premium costs for low-income, uninsured residents who qualified for tax credits. By requiring the receipt of tax credits as a condition of eligibility, hospital funding leveraged much larger premium payments from the federal

government. The resulting reduction in uncompensated care, compared to hospital payments — in other words, the financial return on investment — seemed particularly promising for TPP programs serving the lowest-income consumers, who qualify for the largest credits, and who receive coverage with especially low deductibles.<sup>12</sup>

Proponents of TPP programs had to overcome carriers’ concerns about adverse selection. Insurers also were concerned about the administrative cost of changing payment-processing systems to accept funds from local nonprofits, not just from members.

### Program Structure

The local TPP programs we examined are funded by hospital systems. In some areas, all hospital systems jointly fund the program. Each program is administered by a preexisting local nonprofit organization, with all administrative costs paid by the funding hospital systems. The nonprofits, rather than the hospitals, set program rules and determine individual consumers’ eligibility.

To qualify, people must: have incomes below a specified percentage of the federal poverty level, reside in particular counties, have already qualified for advance premium tax credits, and have used their tax credits to enroll in silver-level qualified health plans. Generally, the maximum income threshold is 200 percent of poverty. After consumers choose a qualified health plan (QHP) and the marketplace determines household income and tax credit eligibility, the TPP programs determine if the consumers qualify for TPP assistance. Such leveraging of tax credit eligibility determinations protects program integrity while limiting TPP programs’ administrative costs. It also ensures that TPP beneficiaries have been found ineligible for Medicare and Medicaid, thus preventing practices like those described earlier involving kidney-dialysis providers.

Programs directly pay carriers all premiums not covered by tax credits, from the time of enrollment through the end of the plan year. They do not help with out-of-pocket cost-sharing, as a general rule. TPP programs tell carriers which members they are assisting. In most programs, multiple QHPs accept TPP payment.

The most significant differences between programs are in outreach and referral. Only one program that we examined conducts broad outreach throughout the community. On the other end of the spectrum, we saw that one program handled concerns about adverse selection by prohibiting

any mention of the TPP until after a consumer selects a QHP that participates in the program. Other localities require referrals from funding hospital systems or other partners, like community health centers.<sup>13</sup> See Exhibit 1 for additional information on program features.

Exhibit 1. Features of Local Third-Party Payment (TPP) Programs

Nonprofit sponsor	ELIGIBILITY REQUIREMENTS			Valid with all available silver QHPs?	Outreach and referrals	BENEFITS		Funding hospital systems	Has enrollment ever closed?
	FPL limit	Geographic limits on residence	Referral requirements or limits			Tobacco surcharge	Deductibles, out-of-pocket costs		
<b>United Way of Dane County</b>	150%*	Dane County, Wisconsin	None	Yes	Broad outreach through job centers, door-to-door canvassing, navigators and assisters, churches, brokers, health centers	Consumer must pay	No help	One of several local hospital systems	No
<b>United Way of the Greater Triangle</b>	175%*	Three counties in Research Triangle, North Carolina	Consumers may not be enrolled at funding hospitals or by groups that serve patients with particular diseases	No. Only with low-cost QHPs of the single carrier that takes TPP	Assisters and brokers are not supposed to mention TPP until consumer picks QHP	Program pays	No help	Subset of hospital systems	Yes, in one of three counties
<b>Project Access</b>	200%	Three counties in Portland, Oregon, area	Referral must come from funding hospital or from another partner	No. Only with five carriers that take TPP	Some initial outreach. Mostly reliant on referrals from partners (including funding hospitals).	n/a**	Funding hospitals may waive charges for care provided in their facilities	All six local hospital systems	No
<b>Project Access Northwest</b>	250%	Counties where funding hospitals are located	Referral must come from funding hospital, affirming that consumer cannot pay premium	Yes	No broad public education	n/a**	Funding hospitals may waive charges for care provided in their facilities	Some but not all local hospital systems	No
<b>Pierce County Project Access</b>	400%	Pierce County, Washington	Referral must come from funding hospital or from a broker or other partner affirming that consumer cannot pay premium	Yes	No broad public education	n/a**	Funding hospitals may waive charges for care provided in their facilities	Both local hospital systems	Yes

Data: 2016 interviews with program administrators, carriers, hospitals, and consumer advocates.

Notes: Program details may have changed since 2016 interviews. FPL = federal poverty level. QHPs = qualified health plans.

\* State did not expand Medicaid eligibility, so premium tax credit eligibility included consumers with incomes as low as 100 percent of poverty.

\*\* State did not permit surcharges for tobacco use.

## CONSUMER PARTICIPATION

Among TPP programs we analyzed, the Dane County program in Wisconsin — the one program engaging in broad, communitywide outreach — achieved the highest enrollment levels. The program reported that 1,148 Dane County residents participated in June 2015,<sup>14</sup> representing 25 percent of marketplace enrollees with incomes low enough to qualify.<sup>15</sup> Other local programs reached between 202 and 934 people.<sup>16</sup> As of June 2016, the Washington State marketplace had 1,133 sponsored enrollees.<sup>17</sup>

Nearly all interviewees reported that without TPP many participating consumers would be uninsured. One program asked beneficiaries how they would have obtained health care if not for the TPP program. Fifty-three percent said they would have been uninsured, 29 percent said they would have bought more limited insurance, and 16 percent did not know what they would have done; only 2 percent said their coverage would have been unaffected.<sup>18</sup>

A natural experiment occurred in Dane County when the program decided, starting in 2015, to deny TPP payment of premium surcharges for smokers — a form of risk-rating allowed in Wisconsin. The median smoker surcharge was \$70 a month.<sup>19</sup> Among enrollees who had surcharges imposed at renewal, 59 percent continued their coverage. Among nonsmoking enrollees who were unaffected by surcharges, 89 percent renewed. In other words, renewal rates were 51 percent higher when TPP covered all premium costs than when consumers had to pay roughly \$70 a month.

### Outcomes for Other Stakeholders

**Funding hospitals.** Hospital system interviewees reported that their funding of TPP programs generated a positive financial return on investment. The program caused reductions in uncompensated care that exceeded hospitals' TPP sponsorship costs. Additional benefits were generated — to both hospitals and consumers — when the receipt of health insurance allowed consumers to obtain treatment earlier in the course of disease development, preventing health problems from becoming medical emergencies that generated significant uncompensated

### HOW IT WORKS IN WASHINGTON STATE: MARKETPLACE-BASED TPP

The Washington Health Benefit Exchange (WAHBE) is the country's only state-based marketplace that facilitates and oversees local TPP programs, which are dubbed "sponsors." State law<sup>a</sup> requires all QHPs to accept premium payments from sponsorship programs registered with WAHBE — a step that spreads risks among carriers.<sup>b</sup> Sponsors, rather than the marketplace, must decide whether federal law permits them to pay premiums.<sup>c</sup>

After providing WAHBE with eligibility requirements and lists showing which TPP beneficiaries are enrolled with which QHP, the sponsor pays the carrier each consumer's share of premium not covered by tax credits.<sup>d</sup> The sponsor may not restrict the consumer's choice of plan or prevent the consumer from seeing all available options. However, a sponsor may limit the use of TPP to particular metal levels, carriers, or plans. While enrolling through WAHBE, consumers inform the marketplace if they are sponsored.

WAHBE facilitates the program's smooth operation by conveying information between sponsors and carriers, establishing program rules, and holding monthly meetings between sponsors and carriers.<sup>e</sup>

a. RCW 43.71.030 (3).

b. Washington Health Benefit Exchange, *WAHBE Premium Sponsorship Program for 2017 Coverage Year* (WAHBE, 2016), [http://www.wahb-exchange.org/wp-content/uploads/2013/05/HBE\\_POL\\_2017\\_Premium\\_Sponsorship\\_Program.pdf](http://www.wahb-exchange.org/wp-content/uploads/2013/05/HBE_POL_2017_Premium_Sponsorship_Program.pdf).

c. For example, employers cannot pay their employees' premiums on the marketplace if such employees also claim PTCs. Sponsors are responsible for preventing violations of this prohibition and other applicable limits.

d. Exceptions to this durational requirement — for example, if a sponsor experiences a sudden financial shortfall — are considered on a case-by-case basis.

e. For example, as a condition of offering QHPs, carriers must provide sponsors with a list of payments owed on behalf of each sponsored member, including past-due amounts. Unless the carrier and sponsor agree on a different process that is communicated, in writing, to WAHBE, the carrier must provide this information at least seven days before each month's payment deadline. Also, once a consumer identifies him/herself as sponsored, WAHBE informs the affected carriers of the consumer's sponsorship. In addition, the sponsoring program gives carriers a list of sponsored members. In some cases, WAHBE directly sends eligibility and enrollment correspondence to consumers and their authorized representatives.

costs. In addition, hospitals that were part of integrated health plans gained members. Many sponsoring hospitals saw their support of TPP programs as part of their community service mission; nonprofit hospitals could potentially consider their support as meeting community benefit obligations.<sup>20</sup> After observing TPP programs' initial results, all funding hospital systems renewed, and in some cases increased, their financial commitments.

**Carriers.** Carriers reported that their initial concerns about adverse selection proved unfounded, as TPP consumers did not present a different risk profile than other QHP members.<sup>21</sup> Sponsors and carriers worked together to address carriers' concerns about administrative burdens. By 2016, data-sharing and enrollment systems operated smoothly and imposed minimal ongoing burdens, according to health plan interviewees.<sup>22</sup>

#### **Nonprofit organizations administering TPP programs.**

Organizations reported that after start-up, ongoing administrative costs, which were paid by the funding hospitals, were manageable.<sup>23</sup> Most nonprofit interviewees believed that TPP programs aided their organizations by raising their community profiles and helping achieve core organizational missions.

## **LESSONS FOR FUTURE PROGRAMS**

Most TPP programs were considering or implementing an expansion in May–June 2016, when this study was conducted.<sup>24</sup> All interviewees recommended that other communities implement similar programs, given the substantial benefits for low-income consumers. Because of TPP programs' positive return for hospitals, informants thought that hospital systems in other areas would be motivated to participate.

Interviewees offered suggestions for stakeholders seeking to develop TPP programs elsewhere in the country:

- **Have all local hospital systems share funding responsibilities**, thus avoiding “free riders” and increasing the number of consumers who benefit by growing the program's funding base.

- **Require all QHPs to participate in approved TPP programs**, thereby spreading risk among carriers. This may be easiest to achieve in states with state-based marketplaces, but other states could pass legislation imposing such a requirement.
- **Work with carriers to design policies and procedures that minimize adverse selection and streamline operations.** Try to find champions within carriers who will work with their own internal stakeholders. Make sure that carriers and nonprofits each designate point people to handle problems when they arise.
- **State-based marketplaces can promote the development and improve the operation of TPP programs** by establishing ground rules, conveying data between carriers and TPP programs, holding regular meetings with carriers and TPP programs, and helping resolve disputes.

## **BROADER IMPLICATIONS**

The affordability problems facing low-income consumers purchasing marketplace coverage are unlikely to be solved on a national scale without major policy changes. Until such changes are made, TPP programs could make a meaningful contribution. Hospitals throughout the country could potentially be motivated to fund such programs, locally or statewide, if they anticipate a resulting drop in uncompensated care that exceeds their initial investment.

The way programs are structured will affect their overall impact and proponents' ability to address carriers' concerns. To improve outreach, TPP programs could conduct vigorous education campaigns and partner with community organizations and assisters.<sup>25</sup> By supplementing providers in generating TPP referrals, such outreach would guard against adverse selection and give nonprofit administrators additional protection from potential liability under federal anti-kickback rules.<sup>26</sup> State-based marketplaces could further boost participation by integrating TPPs into standard procedures to qualify for financial assistance and select a plan.<sup>27</sup>

To address concerns regarding adverse selection, TPP programs, state officials, or CMS could incorporate some of the following safeguards used by the programs interviewed for this brief:

- Bar TPP enrollment at the sites of funding providers<sup>28</sup>
- Base eligibility only on income and area of residence<sup>29</sup>
- Limit TPP to people who qualify for advance payment of premium tax credits and who claim them in full, using them to enroll in silver-level coverage<sup>30</sup>
- Assure that the administering nonprofit is fully independent of the funding hospital systems<sup>31</sup>
- Allow carriers to track TPP enrollment by having programs pay carriers directly and by having state-based marketplaces identify sponsored members to their qualified health plans
- Pay consumers' premium shares from the point of enrollment through the end of the coverage year, thus preventing short-term enrollment that ends once a course of treatment is complete, and
- Require all qualified health plans to accept TPP and let consumers use it with any participating carrier, thereby spreading risks among insurers.

## CONCLUSION

Although TPP programs currently serve relatively few consumers, they could be scaled up to serve more people, since hospital systems have financial incentives to provide funding. Careful program structuring could help prevent adverse selection. Many low-income consumers who earn too much for Medicaid require more help with premiums than tax credits currently provide. But if policymakers want to improve affordability and increase enrollment among relatively healthy, low-income consumers on a national scale, they will need to take steps beyond the broader implementation of TPP programs.<sup>32</sup>

## HOW WE CONDUCTED THIS STUDY

In May and June 2016, we conducted more than 20 interviews. Key informants included nonprofit program administrators, funders of TPP programs, carriers, and consumer groups involved with programs operating in Dane County, Wisconsin; the Research Triangle area of North Carolina; Portland, Oregon; and Washington State, including locally sponsored programs based in Seattle and Pierce County.

We also interviewed Washington marketplace officials involved in TPP program administration. Informants were promised confidentiality. Telephone interviews used semistructured protocols to explore program history and structure; effects on consumers and other stakeholders; and possibilities for future expansion. Each interviewee had an opportunity to review and comment on the portions of a draft report that concerned the programs discussed by the interviewee.

## NOTES

1. Namrata Uberoi, Kenneth Finegold, and Emily Gee, *Health Insurance Coverage and the Affordable Care Act, 2010–2016* (Assistant Secretary for Planning and Evaluation, Mar. 3, 2016), <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>.
2. Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2016* (National Center for Health Statistics, May 2017), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf>.
3. The latter figure includes 12 percent who are ineligible for marketplace subsidies because their income is above 400 percent of poverty. This estimate is for 2015. Rachel Garfield et al., *New Estimates of Eligibility for ACA Coverage Among the Uninsured* (Henry J. Kaiser Family Foundation, updated Oct. 25, 2017), <http://kff.org/uninsured/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/>.
4. APTC-eligible consumers include both the uninsured and those receiving individual coverage. Matthew Buettgens, Genevieve M. Kenney, and Clare Pan, *Variation in Marketplace Enrollment Rates in 2015 by State and Income* (Urban Institute, Oct. 2015), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000487-Variation-In-Marketplace-Enrollment-Rates-In-2015-By-State-And-Income.pdf>.
5. Sara R. Collins et al., *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not* (Commonwealth Fund, Sept. 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/to-enroll-or-not-to-enroll>; PerryUndem Research/Communications, *Reaching Consumers in OE3: Who Are They and What Do They Need to Hear? Takeaways from Two RWJF Studies* (Enroll America, Nov. 3, 2015), <https://www.slideshare.net/EnrollAmerica/reaching-consumers-in-the-third-open-enrollment-period-who-are-they-and-what-do-they-need-to-hear>; and Stan Dorn, *Affordability of Marketplace Coverage: Challenges to Enrollment and State Options to Lower Consumer Costs* (Urban Institute, Dec. 2014), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000039-Affordability-of-Marketplace-Coverage.pdf>.
6. State of Washington Health Care Authority, *A Study of Washington State Basic Health Program* (HCA, June 2002), <http://www.statecoverage.org/files/A%20Study%20of%20Washington%20State%20Basic%20Health%20Plan.pdf>.
7. Reed Abelson and Katie Thomas, “UnitedHealthcare Sues Dialysis Chain Over Billing,” *New York Times*, July 1, 2016, [http://www.nytimes.com/2016/07/02/business/unitedhealthcare-sues-dialysis-chain-over-billing.html?\\_r=0](http://www.nytimes.com/2016/07/02/business/unitedhealthcare-sues-dialysis-chain-over-billing.html?_r=0).
8. Centers for Medicare and Medicaid Services, “Medicare Program; Conditions for Coverage for End Stage Renal Disease Facilities — Third Party Payment,” *Federal Register* 81, no. 240 (Dec. 14, 2016): 90211–28, <https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-30016.pdf>.
9. Ryan Kocian, “Federal Judge Grants Relief to Dialysis Patients,” *Courthouse News Service*, Jan. 30, 2017, <https://www.courthousenews.com/federal-judge-grants-relief-to-dialysis-patients/>.
10. See, for example, Hall, Render, Killian, Heath & Lyman, “Calls for a Second Wind to Third Party Premium Payments with Changing Circumstances in Health Care,” *Health Law News*, June 5, 2017, <http://www.hallrender.com/2017/06/05/third-party-premium-payments-revisited-amid-changing-circumstances-health-care/>; and Families USA, Comments on “Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums; Interim Final Rule [CMS-9943-IFC]” (Families USA, May 13, 2014), <https://www.regulations.gov/document?D=CMS-2014-0035-0174>.
11. No central data repository identifies income-based TPP programs, but some exist in areas beyond those profiled here. For example, one program operated in Texarkana, Texas, and another operated in Houston, Texas, through



at least 2015. See Phil Galewitz, “Insurers, Hospitals Clash Over Help Paying Obamacare Premiums,” *Kaiser Health News*, Oct. 31, 2016, <https://khn.org/news/insurers-hospitals-clash-over-help-paying-obamacare-premiums/>; and Markian Hawryluk, “Harris Health Slashes Eligibility for Subsidized Care; Will Encourage Obamacare Enrollment,” *Houston Chronicle*, Sept. 24, 2015, <https://www.houstonchronicle.com/news/health/article/Harris-Health-slashes-eligibility-for-subsidized-6527864.php>.

12. Consumers with incomes at or below 200 percent of the federal policy level qualify for cost-sharing reductions that substantially cut deductibles in silver-level plans. Those between 200 percent and 250 percent of poverty qualify for much smaller deductible reductions.

13. In such cases, the referring provider must indicate that, without TPP, the consumer would not enroll into coverage.

14. United Way of Dane County, *Impact Report: Health Connect Results* (UWDC, Sept. 2015).

15. Assistant Secretary for Planning and Evaluation, “2015 Qualified Health Plan Selections in the Health Insurance Marketplace by Age Group and County, as of February 22, 2015” (ASPE, 2015), <https://aspe.hhs.gov/sites/default/files/aspe-files/106911/county-level-data-2-22-2015.xlsx>, finding 4,521 Dane County enrollees with incomes between 100 percent and 150 percent of the federal poverty level. The actual percentage is likely higher than that stated in the text, for two reasons. First, marketplace participation levels for all Dane County residents were calculated at the end of open enrollment; that number was likely smaller by June 2015, the date of TPP program participation stated in the text. Second, estimated marketplace enrollment includes all metal levels, and marketplace consumers who chose other than silver plans were ineligible for TPP. No data show metal-level enrollment for Dane County consumers between 100 percent and 150 percent FPL, but the number of those in non-silver plans may have been more than trivial. Altogether, 18 percent of the County’s marketplace enrollees with incomes at or below 250 percent FPL had foregone cost-sharing reductions by enrolling in non-silver coverage. Author’s calculations, ASPE, “2015 Qualified Health Plan Selections,” 2015.

16. The program in Research Triangle, North Carolina, served 934 people in three counties as of May 2016. By August 19, 2016, attrition had reduced the number of participants to 852. By December 2015, the Portland program served 370 consumers. The program in Pierce County, Washington, aided 229 consumers during 2015. The program based in Seattle, Washington, assisted 202 people in February 2016.

17. In addition to the Seattle-based and Pierce County programs described above, a program focusing on consumers with HIV/AIDS sponsored approximately 600 consumers, and tribal sponsors helped roughly 150.

18. Apparently, respondents could give more than one answer. Sixty-one percent gave one or more responses consistent with being uninsured: without TPP assistance, they would not have paid for insurance or gone to the doctor (41%); would have paid a tax fine (11%); would have used hospital financial aid or emergency room care (7%); and would have stayed in a separate donated-care program managed by the same nonprofit agency (2%). Twenty-nine percent said they would have selected a less costly plan; 2 percent said they would have chosen the same plan; and 16 percent did not know what they would have done. Pierce County Project Access, *Premium Assistance Mid-Year Check-In* (Pierce County Medical Society, July 2015). These results may not apply to the full range of TPP programs, however. Pierce County limits enrollment to consumers who say they could not afford coverage without TPP.

19. Deedra Atkinson and Rick Spiel, *Business Review: Health Connect* (United Way of Dane County, Aug. 18, 2015).

20. Suggesting that premium payments could be used to meet community benefit obligations, see Catherine E. Livingston, Gerald M. Griffith, and Rebekah N. Plowman, “Third-Party Payment of Premiums for Private Health Insurance Offered on the Exchanges,” *Journal of Health & Life Sciences Law* 8, no. 2 (Feb. 2015): 1–44. A version of the paper, which includes all of the material quoted in this issue brief, is posted online at [https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC14/c\\_livingston.pdf](https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC14/c_livingston.pdf).

21. By requiring all carriers to cover TPP beneficiaries, Washington State also spread risks among competing insurers, offering an additional safeguard against adverse selection harming any particular carrier.

22. Local affiliates of national carriers also imported procedures from other states that had already done work in this area. Such borrowing further streamlined TPP operations.

23. Staffing requirements ranged from 1.3 and 1.5 full-time equivalent workers (FTE) in Pierce County, Washington, and Portland, Oregon, respectively, to 4 or 5 FTEs in Dane County, Wisconsin.

24. Dane County, Wisconsin, Portland, Oregon, and Seattle, Washington, were considering expanding eligibility to higher income levels. One of the funding hospitals in Pierce County, Washington, had increased its contribution amount. Also, the state hospital association in Oregon expressed support for expanding the Portland program to operate statewide.

25. Dane County, Wisconsin's successful initiative took this approach.

26. "A charity following the [Anti-Kickback Statute, or AKS, safeguards that apply to federal health care programs] would publicize its premium assistance program through hospitals, providers, and other charitable and social service organizations in the community. With referrals coming from a variety of sources, the charity could not assume that individuals who are referred for assistance are patients of specific providers." Livingston, Griffith, and Plowman, "Third-Party Payment," 2015. See also the further discussion of AKS guardrails below. Note that the U.S. Department of Health and Human Services (HHS) has ruled that marketplace coverage is not a "federal health care program," so AKS prohibitions do not apply to TPP programs. These further safeguards furnish an additional layer of protection, should HHS change its former policy. Except for Dane County, Wisconsin, the TPP programs profiled here limit outreach and enrollment.

These limitations all have legitimate goals, which could potentially be accomplished alongside a broad public education and enrollment campaign. Programs in areas like the Research Triangle, North Carolina, where only some qualified health plans (QHPs) accept TPP, could conduct broad community education and let application assisters and brokers identify participating QHPs before consumers pick a plan. According to some interviewees, a number of Research Triangle assisters already do this. Just as, for example, they may describe one QHP as having a low deductible for prescription drugs, so they characterize another as qualifying for TPP premium payment. This approach lets consumers assess the relative importance of TPP payment and other plan features. TPP programs that serve patients referred by funding hospitals, like those in Oregon and Washington, may find that such hospitals experience a positive return on investment, even if consumers can sign up for TPP programs without a hospital referral. That has been the experience of programs in Dane County and the Research Triangle. Also, when Pierce County, Washington, expanded intake from funding hospitals to other community partners, hospitals continued to support the program; one even increased its funding commitment. Although, in theory, the Seattle-based program requires a referral from a funding hospital system, low-income, uninsured consumers are often sent by the administering nonprofit, community health centers, and other program partners to hospital systems' financial counsellors so the consumers can sign up for TPP.

27. A state-based marketplace could automatically identify QHP applicants who qualify for TPP programs that base eligibility entirely on income and area of residence. These consumers would receive both advanced premium tax credits and TPP, based on a single application. Such automated enrollment could be limited to a certain number of enrollees, specified by the TPP program to avoid exceeding the program's total funding.

28. The Research Triangle, North Carolina, program goes further, to bar solicitation at the site of any health care provider, including those unaffiliated with funding hospital systems.

29. The Dane County, Wisconsin, and Research Triangle, North Carolina, programs took this approach.

30. This would avoid the problem of providers increasing reimbursement, potentially at the expense of consumers' access to care, by enrolling Medicaid- or Medicare-eligible people into marketplace coverage.

31. AKS law incorporates best practices for such independence. Livingston and colleagues explain that, under long-standing rules, “charitable entities can deliver financial assistance, including grants for the costs of health insurance premiums, to financially needy beneficiaries of federal health care programs provided that the charity is independent of [the health care providers [that pay for assistance]]; that the charity makes an independent determination of need (not influenced by a particular provider); and that the beneficiary’s receipt of an item or service is not dependent, directly or indirectly, on the beneficiary’s use of any particular provider.” Livingston and colleagues further note that, the HHS Office of Inspector General has identified “structural and operational safeguards” that allow the provision of patient assistance (including premium payments) without risking AKS liability: “(1) ensuring that the donors do not directly or indirectly exert control over the charity; (2) [the charity] having a board composed predominantly or exclusively of individuals with no relationship to providers who are donors; (3) publicizing the charity’s patient assistance program through physicians, other providers, and patient advocacy groups as well as the charity itself; (4) applying objective criteria set by the charity for determining who receives financial assistance; (5) a prohibition on earmarking donations for use in supporting any particular individual; (6) prohibiting the identity of donors funding financial assistance from being disclosed to patients or otherwise used for tracking purposes (regardless of whether the donors are providers of services or suppliers of medical equipment or pharmaceuticals); and (7) allowing patients who are beneficiaries to have freedom of choice in selecting providers and insurers.”

32. For examples of such steps, see John Holahan and Linda J. Blumberg, *Instead of ACA Repeal and Replace, Fix It* (Urban Institute, Jan. 2017), [http://www.urban.org/sites/default/files/publication/87076/2001054-repeal-and-replace-aca-fix-it\\_2.pdf](http://www.urban.org/sites/default/files/publication/87076/2001054-repeal-and-replace-aca-fix-it_2.pdf); and Sabrina Corlette, “Fix It, Don’t End It: Common Sense Prescriptions for Individual Market Stability,” *CHIRblog*, Georgetown University Health Policy Institute, Center on Health Insurance Reforms, Mar. 27, 2017, <http://chirblog.org/fix-it-dont-end-it-common-sense-prescriptions/>.

## CONTACT INFORMATION

### Dane County, Wisconsin

Deedra Atkinson  
Executive Vice President of Community  
Impact and Strategy  
United Way of Dane County  
608.246.4345  
[Deedra.Atkinson@uwdc.org](mailto:Deedra.Atkinson@uwdc.org)

Sandy Erickson  
HealthConnect Program Manager  
United Way of Dane County  
608.246.4354  
[Sandy.erickson@uwdc.org](mailto:Sandy.erickson@uwdc.org)

### Research Triangle, North Carolina

Tiki Windley  
Director, [PremiumHelp.org](http://PremiumHelp.org)  
United Way of the Greater Triangle  
919.463.5032  
[twindley@unitedwaytriangle.org](mailto:twindley@unitedwaytriangle.org)

### Portland, Oregon

Sheila M. Hale  
Director of Operations  
Project Access Now  
971.254.2760  
[sheila.hale@projectaccessnow.org](mailto:sheila.hale@projectaccessnow.org)

### Seattle/Pierce County, Washington

Gary Renville  
Executive Director  
Project Access Northwest  
206.406.1590  
[garyr@projectaccessnw.org](mailto:garyr@projectaccessnw.org)

Leanne Noren  
Executive Director  
Pierce County Project Access  
253.732.4798  
[leanne@pcmswa.org](mailto:leanne@pcmswa.org)

## ABOUT THE AUTHOR

When this study was conducted, Stan Dorn, J.D., was a senior fellow at the Urban Institute's Health Policy Center. He has been involved in health policy at the state and national levels for more than 30 years, focusing on low-income consumers, Medicaid, the Children's Health Insurance Program, the uninsured, and private markets. Previously, Dorn was a senior policy analyst at the Economic and Social Research Institute, director of the Health Consumer Alliance in California, and director of the Health Division of the Children's Defense Fund. Dorn also directed the Washington, D.C., office of the National Health Law Program and served as a staff attorney in its Los Angeles headquarters. He is a graduate of Harvard College and the Boalt Hall School of Law at the University of California, Berkeley. Dorn is now a senior fellow at Families USA.

.....  
*Editorial support was provided by Deborah Lorber.*

## ACKNOWLEDGMENTS

The author appreciates the assistance of Brigette Courtot of the Urban Institute's Health Policy Center, who reviewed an earlier draft of this paper. The author thanks the many interviewees who generously gave their time to answer questions about TPP programs and to review and comment on earlier drafts of the paper. Finally, the author is grateful to the Commonwealth Fund, which provided the support that made this paper possible and editing that greatly improved the report. Neither those individuals, the Commonwealth Fund, the Urban Institute, any of the Urban Institute's trustees or funders, nor Families USA are responsible for the opinions expressed in this report, which are the author's.

### For more information about this brief, please contact:

Stan Dorn, J.D.  
Senior Fellow  
Families USA  
[SDorn@familiesusa.org](mailto:SDorn@familiesusa.org)

### About the Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the author and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

