Third-party payments can raise overall health care system costs, leading to higher premiums for consumers and further destabilization of the individual market.

Conflicts between providers’ financial interests and patients’ interests has led providers to inappropriately steer patients toward certain coverage in a way that could put patients’ lives and well-being at risk.

Recommendations HHS can take to help protect patients include prohibiting third-party provider payments to entities in which the provider has financial interests, clarifying existing guidance, not expanding the list of third-party payers, and increasing transparency for these payments.
The Risks of Third-Party Payments

There has been much discussion recently about “third-party payments.” What are they? Let’s start with the basics. These are payments made for consumers by outside entities, such as health care providers, pharmaceutical companies, foundations, or other entities.

These payments can play a role in helping people pay their health care premiums or related cost sharing to access coverage. However, many of the organizations interested in making these payments stand to benefit financially through greater reimbursement by steering these patients to the individual market. These payments lead to higher premiums for all consumers in the individual market and could leave patients financially exposed and without access to care once payments are no longer being made. **It is critical to have guardrails in place to ensure that payments made by third-party entities are truly in the best interests of the patient, are not motivated by financial gain for the provider, and do not result in market destabilization.**

Concerns about third-party payments have led to their general prohibition in public programs, with only clearly-specifed exceptions. The federal anti-kickback statute generally prohibits third-party payments in the Medicare and Medicaid programs because of inherent conflicts of interest that often arise between the provider’s financial interest and the best interest of the patient.

There has been less clarity regarding third-party payments in the individual market. The Department of Health and Human Services (HHS) has identified a limited roster of entities from which issuers must accept third-party payments, including Ryan White and HIV/AIDS programs, Indian tribes, and state and local programs. However, issuers in the individual market have seen a rise in third-party payments from entities steering Medicare and Medicaid eligible beneficiaries into qualified health plans (QHPs) sold through the Affordable Care Act (ACA) marketplaces. This can increase the number of older and less healthy individuals in the individual market risk pool, resulting in higher premiums for all consumers and further destabilizing the market.

The Negative Effects of Inappropriate Third-Party Payments

The December 2016 interim final rule was informed by an HHS request for information seeking public comment regarding inappropriate steering of individuals eligible for Medicare or Medicaid to an individual market plan. In response to the December 2016 request for information, HHS received comments from a range of stakeholders—including patients, providers and provider-affiliated organizations involved in financing care for patients, health insurance providers, and social workers—and concluded that enrolling end state renal disease (ESRD) patients in individual market coverage is in the financial best interest of dialysis facilities and has the potential to harm patients.¹ HHS found this conflict between providers’ financial interests and patients’ interests has led providers to inappropriately steer patients toward certain coverage in a way that could put patients’ lives and well-being at risk. Specifically, HHS identified three types of harm that third-party payment arrangements create for ESRD patients:
How Third-Party Premium Payments Can Harm Consumers and Destabilize Markets

Federal Guidance and Regulations for the Individual Market

Since 2013, HHS has issued a series of rulemaking and guidance that generally discouraged such payments due to their potential to harm consumers from a financial and health perspective and their negative effects on the individual market. In December 2016, HHS issued an interim final rule (IFR) outlining a narrow set of circumstances in which third-party payments by dialysis facilities are allowed, if certain guardrails are met, and advised issuers to reject all other third-party payments. However, the IFR has not yet been implemented due to ongoing litigation.

Conditions for Coverage for End-Stage Renal Disease
Third-Party Payment Interim Final Rule

- **Dec 2016**: Interim Final Rule released effective 1/13/17
- **Jan 2017**: Dialysis Patient Citizens vs Burwell is filed; effective date delayed
- **2018**: HHS plans new rulemaking

- Requires dialysis facilities that make premium payments to disclose detailed information to patients on:
  - the full range of health care coverage options available to them, including Medicare, Medicaid, CHIP, and individual market plans;
  - how each coverage option would impact the patient’s transplant eligibility;
  - potential gaps in coverage or penalties if Medicare enrollment is delayed; and
  - limits on premium assistance programs, including potential mid-year terminations that could result in a gap in coverage.
- Requires facilities to provide patients with information about reimbursements they receive for services because of subsidizing enrollment costs.
- Requires facilities to disclose third-party payments to health insurance providers and document that issuers have agreed to accept such payments.

- They negatively impact a patient’s priority for a kidney transplant, placing the patient’s health and well-being at risk;
- They could expose the patient to significant additional costs for avoidable health care services had the individual been enrolled in coverage through Medicare or Medicaid; and
- They place the patient at risk for mid-year disruptions in coverage, particularly if the third party stops making premium and cost-sharing payments once initial treatment is received, which could result in serious or life-threatening interruptions in access to care.
This practice raises overall health system costs and results in significant increases in premiums for the entire commercial population. When the risk pool is skewed and medical expenses exceed premium payment, costs go up for everyone. It is also potentially harmful to patient care and poses a barrier to appropriate coordination of care. The abuse of third party payments undermines the system for everyone, including good actors who are sincerely invested in ensuring patients have access to the right care and coverage. Although health plans undertake a number of activities to control the medical expenses incurred by such individuals (e.g., care management, value-based provider arrangements), the steering a vulnerable, high-cost population to the individual market can destabilize the market and lead to increased rates and affordability concerns. It is critical that patients be enrolled in the coverage designed to meet their needs to ensure a stable, sustainable individual market.

The Growth of Drug Coupons, Copay Cards, and Charity Programs

In addition to steering patients to the individual market, inappropriate third-party payments extend beyond ESRD providers. Another example is the growing use of prescription drug coupons, copay assistance cards, and charity programs. Researchers have concluded that such programs, while portrayed as a consumer-friendly benefit, actually increase overall costs and drive up premiums. Health Affairs has reported that drug coupons lead to unnecessary spending by health insurance providers that is then passed on to consumers through higher premiums and more limited coverage options.2

Researchers at UCLA have also assessed the significant spending impact of copay coupons for branded drugs, finding that coupons increased sales of branded drugs that have generic alternatives by over 60 percent. During the first five years a generic alternative enters the market, it has been estimated that coupons increased total spending of 23 branded drugs by a range of $700 million to $2.7 billion.3 And the use of coupon programs continues to grow with copay cards being used for 8 percent of all branded prescriptions with use in some expensive specialty drug classes much higher—as high as 70 percent for multiple sclerosis and rheumatoid arthritis drugs.4 In fact, the federal government prohibits the use of coupons in federal health care programs for these very reasons.

A recent analysis highlights significant growth in such charities, demonstrating that the vast majority of their funding comes from pharmaceutical companies – of the top 15 largest national foundations, 10 were funded by pharmaceutical manufacturers.5 This raises questions about whether these charities are operating as intended and whether pharmaceutical companies are driving how the charities allocate their funds.6

Recommendations to Address Inappropriate Third-Party Payments

In addition to the range of existing tools, HHS can take additional steps to help protect patients from inappropriate third-party steering. Specifically, HHS should:7

Prohibit direct and indirect premium payments by providers to entities in which the provider has a financial interest by using HHS’ broad rulemaking authority under Medicare and Medicaid. HHS has the clear authority to take action through its general rulemaking authority as well as through its Conditions of Participation requirements for
Medicare and its provider enrollment rules for Medicare and Medicaid to prohibit such direct or indirect payments by providers. HHS can also consider health care providers out of compliance with Conditions of Coverage if they fail to provide information to consumers on their full range of coverage options.

Clarify existing guidance and establish that federal rules supersede state guidance. HHS’ long-standing policy is that health insurance providers may deny any third-party payments that are outside the federal requirements, however current regulations should be amended to include this language as well.8 Additional regulatory guidance in the following areas would help address concerns:

- Clarification of acceptable and unacceptable foundation entities as well as examples of allowed and disallowed payments
- Clear guidelines for how a foundation must market its assistance to ensure that individuals are meeting financial criteria as opposed to targeting enrollees based on health status
- Requirement for proportional enrollment across health plans to prevent risk pool issues
- Ability of health plans to reject premium payments if an individual is not enrolled for the entire year
- Clarification that federal rules regarding third-party payments supersede state guidance.

Do not expand the list of third-party entities from which issuers must currently accept premium and cost-sharing payments. Third-party payments continue to detrimentally affect the exchange risk pool in certain markets, such as the individual market; employer provided coverage; and Medicare Supplemental insurance. Any expansion of eligible entities will result in higher premiums and decreased affordability.

Increase transparency of third-party payments. Increased transparency is crucial to assure visibility and proper oversight of such payments. Unfortunately, today there is no systematic way to capture this information. Rather, these activities are often identified after the fact when health plans see unusual spikes in enrollment trends or claims costs in certain geographic areas. Such a post hoc approach is insufficient for identifying issues that could greatly harm consumers. Specifically, HHS should require third-party organizations that make premium or cost sharing payments on behalf of individual market enrollees to report certain information to CMS and attest that they meet the requirements as specified by HHS guidance and FAQs. HHS should collect the following information:

- Number of consumers for whom the entity makes payments (by state or rating area);
- Volume of payments over a specified period;
- Contact information and tax ID and filing status;
- Governance (e.g., leadership, members of Board of Directors, principal shareholders);
- Funding sources;
- Information on relationships with provider organizations (financial or other); and
- Information on relationships with pharmaceutical companies (financial or other).

Enhance consumer education regarding third-party payments. HHS should consider approaches that would help consumers better understand issues around third-party payments, including the type of third-party
payments that are allowed and not allowed in the individual market.

**Examine and assess the growing use of pharmaceutical manufacturer patient assistance programs.** HHS should outline a strategy to assess and address another concerning area of third-party payments—prescription drug coupons, copay assistance cards, and charity programs. Such an approach should include pharmaceutical companies donating product to charitable organizations. An examination of such efforts is critical to ensure these charities operate as intended, that pharmaceutical companies are not exerting influence over how charities allocate their funding, and that drug coupons are not inducing higher utilization and costs for federal health care programs.

**Utilize the Healthcare Fraud Prevention Partnership.** The partnership has become an important venue for sharing information regarding health care fraud and abuse schemes involving drug abuse, sober homes, and urine screening tests. We suggest the partnership could and should deepen its focus on these issues, including cooperation with its members to identify and combat health insurance premium payment by third parties that are a part of health care fraud and abuse schemes.

**Conclusion**

The practice of entities making third-party payments steering Medicare and Medicaid eligible beneficiaries into the individual market can increase the number of older and less healthy individuals in the individual market risk pool, resulting in higher premiums for all consumers and further destabilizing the market. It is critical to have guardrails in place to ensure that payments made by third-party entities are truly in the best interests of the patient, are not motivated by financial gain for the provider, and do not result in market destabilization. HHS should take a number of actions to protect consumers from the negative effects of these payments, including prohibiting third-party provider payments to entities in which the provider has financial interests, clarifying existing guidance, not expanding the list of third-party payers, increasing transparency for these payments, and examining the growing use of pharmaceutical manufacturer drug coupon and copay card programs.

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3 UCLA Anderson School of Management (2016) – “When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization”


5 Based on top 15 largest foundations in 2014 by total annual giving: [http://data.foundationcenter.org/#/foundations/all/nationwide/top:giving/list/2014](http://data.foundationcenter.org/#/foundations/all/nationwide/top:giving/list/2014)


7 More detail regarding HHS’ statutory authority for these recommendations can be found in AHIP’s comments submitted to the RFI on September 22, 2016: [https://www.ahip.org/ahip-comments-regarding-medicare-and-medicaid-benefits-to-individual-market-plans/](https://www.ahip.org/ahip-comments-regarding-medicare-and-medicaid-benefits-to-individual-market-plans/)

8 See 45 CFR §156.1250