



National Health Council

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May 5, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

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

Dear Administrator Tavenner:

The National Health Council (NHC) appreciates the opportunity to provide comments to CMS-9943-IFC, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums. In addition to supporting CMS' ruling to allow cost-sharing assistance by government entities, we urge unambiguous guidance to allow access to:

- Premium and cost-sharing assistance provided by private non-profit organizations
- Cost-sharing assistance provided by commercial entities

The NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities as well as their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes the nation's leading patient advocacy groups, which control its governance. Other members include professional societies and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, medical device, biotechnology, and insurance companies.

Qualified health plans (QHPs) have nearly no limits to the cost sharing they may assign to any particular services. In fact, a review of more than 600 exchange plans revealed that patients face high cost-sharing amounts, which will contribute to reaching the out-of-pocket maximum faster regardless of income level. For example, an analysis of 145 benefit designs for silver plans' fourth tier showed copayments ranged from \$50 to \$500, while coinsurance ranged from 0% to 50%.¹ These high cost-sharing requirements for specialty tier drugs will disproportionately affect people with chronic diseases and disabilities, and jeopardize their ability to afford life-saving branded prescription drugs that have

¹ Avalere Health. *Avalere PlanScape*, Updated November 1, 2013. Avalere collected plan information from both federally-facilitated and state-based exchanges and captured a sample of over 600 plans for the analysis.

no generic equivalents. Therefore, it is crucial that people with chronic diseases and disabilities have access to financial assistance help them afford needed medical services.

In the interim final rule (IFR) Third Party Payment of Qualified Health Plan Premiums, CMS states that QHPs, including stand-alone dental plans (SADPs), are required to accept premium and cost-sharing payments on behalf of enrollees in the Ryan White HIV/AIDS program, other federal and state government programs that provide premium and cost-sharing support for specific individuals, and payments made by Indian tribes, tribal organizations, and urban Indian organizations. Within this interim final rule, CMS also notes that this requirement does not preclude QHPs from having contractual prohibitions on accepting payments of premium and cost sharing from third-party payers other than those specified in the interim final rule. CMS further states that it continues to discourage such third-party payments of premiums and cost sharing.

Though we appreciate the requirement that QHPs must accept the third-party payments from entities specifically outlined in the IFR, we believe there is a great deal of confusion remaining in the patient advocacy community that some independent public charities that provide premium and cost-sharing assistance might, as a result of not being specifically named in the IFR, be barred from these activities by QHPs.

Though CMS issued an FAQ on February 7, 2014, that intended to clarify the situation for charities offering assistance for premiums and cost sharing to QHP enrollees, the FAQ fails to do so. Specifically, question 2 states: “The concerns addressed in the November 4, 2013, FAQ would not apply to payments from private, not-for-profit foundations if: (a) they are described in Question 1, or (b) if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees’ health status.”^{2,3} It is unclear whether CMS means that the charity may not consider health status in its provision of assistance.

Many charitable organizations offer premium assistance to individuals with limited income and one or more particular conditions that are a specific focus of the organization. This FAQ seems to indicate that charitable organizations must offer premium and/or cost-sharing assistance to anyone on the basis of financial need, regardless of whether the person has any condition-specific need that the charitable organization aims to address. This lack of clarity has left organizations such as the American Kidney Fund and Patient Services, Inc. uncertain as to the viability of their assistance programs. In fact, both organizations have had payments on behalf of the patients they serve refused by insurers, despite the fact that CMS has indicated that their discouragement of third-party payments does not apply to charitable organizations.

We also wish to voice our continued and growing frustration about the lack of clarity surrounding the provision of direct cost-sharing assistance to patients enrolled in plans operating in the health insurance marketplace. We are deeply troubled that confusion created by contradictory communications from HHS is leading some pharmaceutical manufacturers to indicate that they would not extend their cost-sharing assistance programs to patients in exchange plans.⁴ These and other companies are evaluating the situation and are unsure as to whether or not they can legally continue their programs. To ensure patients continue to have access to the vital medicines they need,

² : <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf>.

³ <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>

⁴Rockoff, J. (2014, March 26). Merck, Glaxo Hold Off on Help With Affordable Care Act Copays. Move Comes Amid Mixed Signals About Whether Assistance Is Legal. *Wall Street Journal*. Retrieved from: <http://online.wsj.com/news/articles/SB10001424052702304418404579463410068747596>

we again urge you to work with the Office of Inspector General (OIG) to make clear that cost-sharing assistance programs will be permitted for enrollees of marketplace plans.

CMS' statements in this IFR and in its November 4 FAQ publication have increased confusion surrounding the ability of pharmaceutical companies to provide direct cost-sharing assistance to patients. In particular, these statements appear to contradict HHS' communication on October 30, 2013, to Representative McDermott (D-WA) indicating that the agency does not consider QHPs purchased through insurance exchanges to be federal health care programs and thus implying that such plans will not be subject to federal anti-kickback rules.

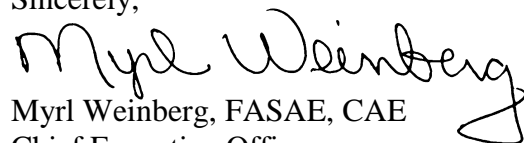
Given these mixed messages, we are troubled that drug manufacturers will continue to abandon affordability programs for patients enrolled in marketplace plans. It is vital for people living with chronic diseases and disabilities to have access to affordable care and prescription drugs offered through QHPs, and many of them depend on financial assistance programs, including cost-sharing assistance from pharmaceutical companies, to pay for their medications. This assistance is of particular importance for patients who take medications placed on the highest tiers of marketplace plans. Very often, these medications have no generic or less expensive alternative, forcing patients to make tough choices about paying rent, putting food on the table, or accessing their lifesaving medication.

CMS cites in its FAQ as one of its reasons to discourage third-party payments is that such payments skew the insurance marketplace risk pool. However, the uneven acceptance of third-party payments from charities is a notable issue that will undoubtedly skew the risk pools of insurers. Patients with expensive healthcare needs who rely on cost-sharing assistance will be incentivized to choose plans that allow third-party assistance payments. Uneven application of requirements by different issuers will inevitably lead to disparate risk pools in plans that accept such payments than in plans that refuse such payments. This seems to be exactly the situation CMS is seeking to avoid. A clear requirement, with associated enforcement efforts as needed, could go a long way to ensuring that patients with expensive health care needs are not being forced into enrolling in a select subset of plans in a state.

We strongly encourage HHS/OIG to issue clear, unambiguous guidance to allow QHP enrollees access to cost-sharing and premium assistance programs sponsored by non-profit organizations, and cost-sharing assistance by pharmaceutical manufacturers. Such a decision will allow people with chronic conditions to be protected from the high cost-sharing benefit designs inherent in the qualified health plans.

Please do not hesitate to contact Eric Gascho, our Assistant Vice President of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org. You may also reach me on my direct, private line at 202-973-0546 or via e-mail at mweinberg@nhcouncil.org.

Sincerely,

A handwritten signature in black ink that reads "Myrl Weinberg". The signature is fluid and cursive, with the first name "Myrl" and last name "Weinberg" clearly distinguishable.

Myrl Weinberg, FASAE, CAE
Chief Executive Officer