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Hospitals Seek To Help Consumers With Obamacare Premiums

TOPICS: HEALTH COSTS, STATES, UNINSURED, INSURANCE

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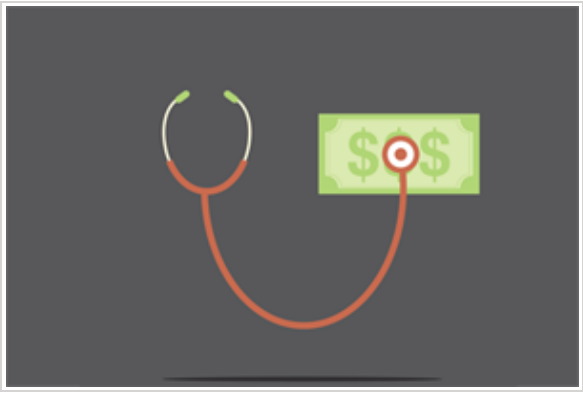
Low-income consumers struggling to pay their premiums may soon be able to get help from their local hospital or United Way.



Some hospitals in New York, Florida and Wisconsin are exploring ways to help individuals and families pay their share of the costs of government-subsidized policies purchased though the health law's marketplaces – at least partly to guarantee the hospitals get paid when the consumers seek care.

But the hospitals' efforts have set up a conflict with insurers, who worry that premium assistance programs will skew their enrollee pools by expanding the number of sicker people who need more services.

"Entities acting in their [own] financial interest" could drive up costs for everyone and discourage healthier people from buying coverage, insurers wrote recently to the Obama administration.

Insurers are asking the federal government, which regulates the health insurance marketplaces, to restrict the practice.

To date, regulators have sent mixed messages about whether they will permit such programs—even as providers across the country are moving to set them up.

"We saw the need in our community," said Sarah Listug, spokeswoman for United Way of Dane County, a Wisconsin group that is using $2 million donated by a local hospital system to help more than 650 near-poverty-level policyholders pay their premiums. "We have had calls from all over the U.S. asking how to set up partnerships like this."

The South Florida Hospital and Healthcare Association is seeking at least $5 million in donations from its 45 member hospitals toward premiums for first-time insurance buyers next year.

And members of the Healthcare Association of New York State, which represents 500 hospitals and nursing homes, are considering expanding existing consumer assistance programs to help people pay their premiums "to the extent that is legal and proper," said Jeffrey Gold, senior vice president and special counsel.

Providers Have Financial Incentive

Hospitals or their foundations have long paid premiums for some patients— often those who fell behind after leaving their jobs and taking on the entire cost of coverage under a 1986 law known as COBRA.

But the issue of "third-party payments" has taken on new urgency because of a provision in the federal health law that could leave providers on the hook for unpaid bills. Under the law, insurers must give subsidy-eligible enrollees who fall behind on payments a 90-day "grace period" before cancelling their policies.

While insurers must cover bills for the first 30 days, they may hold off paying those bills for the next 60 -- and ultimately, deny payment if the patient doesn't catch up on premiums. That means doctors and hospitals face the prospect of not getting paid for their services, or having to seek payment directly from their patients.

That's a big incentive for providers to help pay those premiums.

"It's a situation where patients will be better off and the providers are better off as well if patients are able to maintain coverage," said Mark Rukavina, a Massachusetts-based expert on medical debt who consults for the hospital industry. "But it does raise questions."

Insurers argue that if federal regulators permit such programs, they should bar hospitals from selecting participants based on their health, or from directly paying the premiums.

"If third parties provide incentives to gain coverage only once someone is sick, that will -- as the administration has warned -- clearly lead to a less healthy risk pool and put upward pressure on premiums for everyone," said Brendan Buck, a spokesman for the trade group, America's Health Insurance Plans (AHIP).

But Gold of the New York hospital group thinks insurers' concerns are overblown. He says insurers have already calculated into their rates that a certain percentage of policyholders will be sicker than average.

"If a couple of people who show up at hospitals or other providers have a premium lapse, I don't understand why someone making them whole [by paying their premiums] would skew the risk pool," he said.

Hospitals Try To Allay Fears

To avoid problems, hospitals are drafting selection criteria tied to income level -- and are paying consumers' premiums for an entire year, rather than simply when they lapse.

In the Wisconsin program, for example, eligible residents must live in Dane County, earn between 100 percent and 150 percent of the federal poverty level – about $11,490 to $17,235 for an individual— and enroll in a subsidized silver plan.

The program, called HealthConnect, pays the difference between the subsidy and the cost of the plan for the entire year, which could be as little as $20 to $50 a month for individuals, although it runs higher for families. Money for the program comes from the University of Wisconsin-Madison health system.

In South Florida, meanwhile, “we’re not talking about making premium payments for those who enrolled, then fell behind, but only [for] first-time buyers,” said Linda Quick of hospital group, which has not yet finalized its plans.

The association plans to enlist several local United Way chapters to help find and enroll eligible residents.

Still, Quick acknowledges that getting the program off the ground may be difficult because of the cost to hospitals.

“I have a couple of systems where we’re talking about half a million dollars” in contributions, she said.

And the enrollees who are helped may never need hospital care, in which case those facilities would see no return on their investment.

Regulators Send Mixed Messages

To date, the administration has said insurers must accept payments toward premiums and other costs from government programs such as the Ryan White HIV/AIDS Program, which helps provide medical services and defrays costs for people living with HIV/AIDS.

But it has been less clear about the role hospitals and other health care providers might play.

Last October, a letter from the administration to Rep. Jim McDermott, D-Wash., indicated that hospitals and drugmakers could help subsidized policyholders pay their premiums.

But that was quickly followed by a Nov. 4 online FAQ discouraging such “third party payments” by hospitals and others because they could “skew the risk pool.”

After protests by patient groups, another advisory said insurers could also accept premium payments from not-for-profit foundations which set financial eligibility criteria and do not consider enrollees’ health status.

An interim final rule in March left out any mention of payments by charitable foundations, although it reiterated concern about payments made directly by hospitals.

Both the insurance industry and hospital groups are seeking clarification.

AHIP, the insurers’ trade lobby, has asked the government not to allow hospital-affiliated foundations to run aid programs. The funds “must be donated to a legally independent foundation that is separate from the organization with a potential financial interest,” AHIP said.

The hospital industry, meanwhile, wants insurers to be required to accept premium payments made by health systems as well as by their foundations.

“Any effort to limit the ability of hospitals or hospital-affiliated foundations to help individuals in need to obtain access to health insurance coverage is bad public policy,” wrote Rich Umbdenstock, president and CEO of the American Hospital Association.