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RE: AN ACT to amend the public health law and the insurance law, in relation to requiring health insurers to accept third party payments for coverage

A144 (Cahill)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shield Plans strongly oppose enactment of this legislation, which feigns compliance with recently promulgated Affordable Care Act regulations in an effort to require health plans to accept third party premium and cost sharing payments from providers in contravention of State and Federal law.

Contrary to the assertions made in the Sponsor's Memorandum, this Bill **does not conform** to Federal guidance or recently promulgated U.S. Department of Health & Human Services (HHS) regulations. On March 19, 2014, HHS promulgated an interim final regulation[1] that **only requires** Qualified Health Plans to accept premium and cost-sharing payments on behalf of enrollees from the following organizations: Ryan White HIV/AIDS Programs, Indian Tribes and Tribal Organizations, and State and Federal Government programs. In addition, HHS explicitly provided in the preamble to the interim final regulation that this new standard "does not prevent QHPs and SADPs (Standalone Dental Plans) from having contractual prohibitions on accepting payments of premium and cost sharing from third party payers other than those specified in this interim final regulation."[2] Yet, despite this clear directive, this Bill seeks to add "private, not for profit foundations" to the list of organizations plans must accept third party premium and cost sharing payments from, and attempts to pass this off as being consistent with HHS guidance,

[1] 45 CFR 156.1250 (Acceptance of certain third party payments) states the following: Issuers offering individual market QHPs, including stand-alone dental plans, must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

(a) Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
(b) Indian tribes, tribal organizations or urban Indian organizations; and
(c) State and Federal Government programs.

For more on the Federal regulation, please see 79 FR 15240, *Federal Register*, March 19, 2014, *available at* https://www.federalregister.gov/articles/2014/03/19/2014-06031/patient-protection-and-affordable-care-act-third-party-payment-of-qualified-health-plan-premiums

[2] 79 FR 15240, *Federal Register*, March 19, 2014, P.15242, col.2, *available at* https://www.federalregister.gov/articles/2014/03/19/2014-06031/patient-protection-and-affordable-care-act-third-party-payment-of-qualified-health-plan-premiums

when clearly it is not. To be clear, there was a prior FAQ released by HHS in February[3] , whereby HHS indicated that it does not prohibit third party premium and cost sharing payments that are made by private, not-for-profit foundations under certain limited circumstances. This FAQ was, however, only intended to clarify that organizations like Ryan H. White *could* be allowed to make third party payments, if permitted by health plans.

Clearly though, "does not prohibit" is very different from "plans must accept", and to now attempt to include private foundations in this Bill that requires plans to accept payment from certain organizations, under the auspices that this inclusion is somehow consistent with Federal guidelines, is misleading. This is particularly so when applied to the issue at bar, as HHS' number one concern throughout the rulemaking process has been to ensure that the regulation and associated guidance in no way permits any third party premium payments and cost sharing by hospitals and other healthcare providers.[4] **Yet, this Legislation, and the very inclusion of private foundations within it, is solely intended to create an indirect path for providers to take part in this prohibited practice through their wholly owned private foundations**. Recent amendments to this Bill only eliminated the blatantly illegal language that expressly authorized third party premium payments by hospitals and providers. The amended Bill still seeks to accomplish the same end, but now indirectly, using private foundations and the appearance of compliance to create a backdoor for providers to accomplish that which is prohibited under State and Federal law and HHS policy.

1. **Third Party Premium and Cost Sharing Payments Made by Hospitals and Providers is Prohibited under New York Law**

New York has held a longstanding position reflected in both Attorney General enforcement actions and Department of Financial Services ("DFS") legal policy prohibiting providers from assuming or waiving cost sharing or premium payments on behalf of individuals. In particular, numerous DFS Counsel Opinions provide that if a health care provider, as a general business practice, "waives otherwise required co-insurance requirements, that provider may be guilty of insurance fraud."[5] The situation described in the OGC opinion is analogous to the situation

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[3] Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Feb. 7, 2014), *available at* 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

[4] *See* 79 FR 15240, *Federal Register*, March 19, 2014, P.15242, col.2*; see also* Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Nov. 4, 2013), *available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf.

[5] Opinion of General Counsel No. 08-04-04. N.Y. Penal Law 176.05 provides, in relevant part:

> A fraudulent health care insurance act is committed by any person who, knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by, an insurer . . . or any agent thereof, . . . a claim for payment, services or other benefit pursuant to such policy, contract or plan, which he knows to: (a) contain materially false information concerning any material fact thereto; or (b) conceal, for the purpose of misleading, information concerning any fact material thereto.

described by this Bill, which would allow a provider to use a private foundation affiliated with their organization to pay an insured's copayment on their behalf. Permitting such third party payments would be used by providers to induce care, to adversely select which "healthy" patients whose premium they would pay, and would substantially increase the likelihood for fraud.

2. This Bill Would Result in False Claims Act and Anti-Kickback Statute Liability and Implicate Health Plans, the State, and Municipalities in this Fraudulent Scheme

Moreover, this Bill would subject the State and individual providers to potential False Claims Act and Anti-Kickback Statute liability that could result in millions of dollars in penalties, and countless more millions in fraud that would be perpetrated against the State.

The Anti-Kickback Statute prohibits the offering, paying, soliciting or receiving of anything of value to induce or reward referrals or generate Federal health care program business. Clearly, this Bill could expose the State and any provider that participates in the Exchanges, Medicare, or Medicaid to liability, as the simple act of using a foundation to pay for an enrollee's premium, who then visits the related provider for services, would violate this law. Similarly, HHS has clarified that the False Claims Act is another broad enforcement tool that applies to "any payments made by, through, or in connection with the Health Insurance Exchanges if the payment includes Federal funds".[6] Thus, the FCA would apply not just to government program claims but to activity provided in connection with the QHPs under the New York State of Health (NYSOH). The False Claims Act, in the health care context, has resulted in the proliferation of what is referred to as *qui tam* or whistleblower cases, where individuals who unearth health care fraud are able to receive a percentage (between 15-30%) of any recovery successfully obtained, with some earning them tens of millions of taxpayer dollars for their discoveries. This Bill would make New York ripe for potential fraud and abuse violations of the False Claims Act, among various other State law anti-fraud statutes, as individuals could unearth payments made by foundations to cash in on exposing the fraudulent activity.

Moreover, the legality of the HHS third party premium payment regulation has been called into question by legal commentators, including members of Congress who have noted it could violate Federal anti-fraud statutory measures. In an open letter to former U.S. Secretary of HHS Kathleen Sebelius, Congressman Charles E. Grassley, R- Iowa, noted that such actions are tantamount to exempting the Affordable Care Act from critical anti-fraud protections that will cost taxpayers billions of dollars, all in an effort to promote "Obamacare".[7]

The penalty for a violation of this provision includes either a sentence of imprisonment not to exceed 1 year or a fine not to exceed $5,000, or both. Also note that New York Insurance Law 403(c) authorizes the Department of Financial Services to impose a civil penalty, in addition to any criminal liability, not to exceed $5,000 and the amount of the claim for each violation for any person who has been found to have committed a fraudulent insurance act.

[6] Letter from Kathleen Sebelius, Secretary of Health and Human Services, to Charles E. Grassley, U.S. Senate (Feb. 6, 2014), http://online.wsj.com/public/resources/documents/SebeliusLetter0219.pdf

[7] Letter from Charles Grassley, U.S. Senate, to Kathleen Sebelius, Secretary of Health and Human Services (Nov. 7, 2013), http://www.grassley.senate.gov/issues/loader.cfm?csModule=security/getfile&pageid=47404

This will cost the State and its municipalities millions of taxpayer dollars in fraud and abuse that could have been prevented, and would firmly place the State in the crosshairs of Federal investigatory entities, such as the Office of the Inspector General (OIG, the enforcement arm of the HHS) as well as the Medicare Recovery Audit Contractors, as this Bill would put such entities on notice that New York is permitting illicit activity from its providers. Likewise, the increase in fraud and likelihood for investigatory action by Federal authorities would have a significant impact on the New York State Health Insurance Plan (NYSHIP), the State's largest insurer, and the countless municipalities who self-fund their plans, in addition to commercial insurers. In fact, just one such fraudulent *qui tam* recovery has the potential to put a county in severe financial distress for years to come. Collectively, this Bill would create a huge financial burden on the State that only stands to benefit those providers who successfully game taxpayer dollars for their own pecuniary benefit.

For all the foregoing reasons, the New York Conference of Blue Cross and Blue Shield Plans opposes the enactment of this bill.

Respectfully submitted,

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