

INVESTING IN THE ILL: THE NEED TO CURB THIRD-PARTY PAYMENT OF QUALIFIED HEALTH PLAN PREMIUMS

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Abstract

Hospitals and physicians have begun encouraging their high-cost patients to switch from Medicare or Medicaid to government-subsidized Qualified Health Plans by offering to pay their insurance premiums. Providers make these third-party payments because insurance payouts are much higher under Qualified Health Plans than under Medicare or Medicaid. However, this practice is not always in the best interests of patients, issuers, and the health-care Marketplace. This Note delineates the regulatory responses to this issue, as well as the various advantages and disadvantages that stem from the practice in different contexts. This Note argues that a federal criminal statute is needed to eliminate the harmful effects of third-party payments and preserve the positive effects they can have in certain contexts. Finally, this Note proposes a model federal criminal statute that can serve as a mechanism to combat improper uses of third-party payments. In brief, this Note argues that the harms caused by third-party payments are too significant to be ignored and urges that a narrow federal criminal statute is the best way to address the third-party-payment problem.

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INTRODUCTION

Since the Patient Protection and Affordable Care Act (ACA)¹ was enacted on March 23, 2010, a flurry of case law interpreting the legislation and defining the roles of federal, state, and local government in the administration of the ACA has sprung into existence.² Although likened to “[p]atches on a patchwork” by at least one critic, the ACA, like any other legislative overhaul, needs time, reflection, and judicial effort to smooth down its rough edges.³

One such rough edge is the developing issue of third-party payers (i.e., physicians and hospitals),⁴ paying—directly or indirectly—their patients’

1. Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 42 U.S.C.).

2. *See generally* King v. Burwell, 135 S. Ct. 2480, 2494, 2496 (2015) (holding that the ACA’s tax credits are constitutional); Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2775 (2014) (holding that the Department of Health and Human Services’s contraceptive mandate implemented under the ACA was substantially burdensome on the exercise of religious beliefs); Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2594, 2600 (2012) (finding that the individual mandate is actually a tax within Congress’s taxing powers). Additionally, by February 3, 2015, there had already been at least sixty attempts to repeal the ACA by the House and Senate. *60 Repeal Attempts for ObamaCare*, OBAMACAREFACTS.COM (Feb. 3, 2015), <http://obamacarefacts.com/2015/02/03/60-repeal-attempts-obamacare/>.

3. Jon Greenberg, *Tom Graves Says Obama Has Changed the Affordable Care Act 19 Times*, POLITIFACT (Sept. 25, 2013, 10:24 AM), <http://www.politifact.com/truth-o-meter/statements/2013/sep/25/tom-graves/rep-graves-says-obama-has-changed-aca-19-times/> (quoting Professor Ted Marmor).

4. A more precise definition of a third-party payer in this context would be anyone who pays for the health-insurance premiums of another with the expectation that she will receive some sort of benefit, monetary or otherwise. Physicians and hospitals (providers) are the main culprits that this Note focuses on, but it is worth noting that some issuers have used third-party payments to shirk their costliest policyholders.

Qualified Health Plan (QHP)⁵ premiums in order to steer them away from Medicare or Medicaid, and toward health insurance policies with higher physician payouts.⁶ Physicians and hospitals prefer their patients to have QHP coverage over Medicare or Medicaid for one simple reason—private insurance pays more.⁷ It could be said that providers are investing in their patients' health. The problem is, they are investing in their patients' health in the same way that a day trader invests in the stock market.⁸ Further, some hospitals and providers have begun using nonprofit organizations to steer their patients, who may qualify for Medicare or Medicaid, toward QHPs in an effort to provide legitimacy to an otherwise avaricious practice.⁹ Moreover, the Premium Tax Credit provides an opportunity for providers to reduce the individual cost of covering their patients' premiums, which provides a further incentive to engage in this behavior.¹⁰ Unsurprisingly, issuers¹¹ are not thrilled about high-cost patients being steered onto their QHPs, and their frustration has resulted in some of the first litigation on this topic.¹²

The third-party-payment problem does not lend itself to an easy solution, as evidenced by the Centers for Medicare and Medicaid Services's (CMS)¹³ various responses to the growing trend.¹⁴ There are

5. See Treas. Reg. § 1.36B-1(c) (2016), *referring to* 42 U.S.C. § 18021 (2012). The specific definition of QHP under the statute is unimportant for the discussion in this Note. For the purposes of this discussion, a QHP can simply be understood as an insurance plan that satisfies ACA requirements.

6. See Kat Greene, *UnitedHealthcare Sues Kidney Clinics over Millions in Bills*, LAW360 (July 1, 2016, 8:34 PM), <http://www.law360.com/articles/813612/unitedhealthcare-sues-kidney-clinics-over-millions-in-bills>.

7. See Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, FLA. B.J., Feb. 2016, at 23, 24 (“On average, commercial insurers pay hospitals 1.6 times Medicare rates.”).

8. For those unfamiliar with day trading, see Allison Clare Gordon's article, which gives a colorful description of the practice that parallels how providers treat their patients in the context of third-party payments. See Allison Clare Gordon, Comment, *The “Day Trading” Phenomenon: An Educated Investment or a Day at the Casino?*, 30 SW. U. L. REV. 353, 353–54 (2001).

9. See Request for Information, 81 Fed. Reg. 57,554, 57,555 (Aug. 23, 2016) (to be codified at 42 C.F.R. pts. 402, 420 & 455).

10. See *infra* Part II.

11. In keeping with the language of the health-care industry, this Note uses the term “issuers” to refer to health insurance providers.

12. See Kat Greene, *Blue Shield Sues Public Health Plan for Patient Shifting*, LAW360 (July 14, 2016, 7:42 PM), <http://www.law360.com/articles/817563/blue-shield-sues-public-health-plan-for-patient-shifting>; Greene, *supra* note 6.

13. CMS was originally designated as the Health Care Finance Administration, but was re-designated as CMS in 2001. Reorganization Order, 66 Fed. Reg. 35,437, 35,437 (July 5, 2001). As a sub-agency of the Department of Health and Human Services, CMS administers oversight of Medicare and the federal portion of Medicaid.

14. See *infra* Section I.A.

legitimate concerns on both sides. America's Health Insurance Plans (AHIP)¹⁵ has called on CMS to prohibit providers from funding their patients' premiums, citing the negative effect the practice has on insurance risk pools and national health-care costs.¹⁶ However, there is concern that a prohibition on third-party payments will prevent legitimate nonprofits from aiding vulnerable populations that desperately need medical care, and thwart the ACA's overarching goal of expanding health coverage to more Americans.¹⁷ Additionally, some have argued that the use of third-party payments¹⁸ could stabilize the health-care market by encouraging price competition and better spreading risk.¹⁹ Any palatable solution to the third-party payment issue will need to address the interest in both protecting vulnerable patients and ensuring that insurance risk pools and overall health costs are not adversely affected through health-care-provider exploitation.

This Note will proceed in four Parts. Part I details the evolution of current regulation and guidance concerning third-party payments. This Part also addresses the significant harms that result from third-party payments, including those experienced by individuals and the overall negative effect on the health-care Marketplace. It also takes a brief look at the future of regulation under the new government administration and argues that regulation is not the likely answer to the third-party-payment problem.

Part II introduces the Premium Tax Credit and explains its role within the health-care market. Additionally, this Part argues that the risk of

15. AHIP is a national trade association that represents the United States' health-insurance community. *See About Us*, AMERICA'S HEALTH INS. PLANS, <https://www.ahip.org/about-us/> (last visited Apr. 16, 2017).

16. Letter from Matthew Eyles, Exec. Vice President, Am.'s Health Ins. Plans, to Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs. (Sept. 22, 2016), <http://assets.law360news.com/0843000/843815/final%20rfi%20tpp%20comments%209.22.2016%20copy.pdf> (“[T]hese practices are harming patients and undermining the individual market by skewing the risk pool and driving up overall health care costs and premiums.”).

17. Letter from Thomas P. Nickels, Exec. Vice President, Am. Hosp. Assoc., to Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs. (Dec. 18, 2015), <http://www.aha.org/advocacy-issues/letter/2015/151218-cl-cms-9937-p-rin0938-aS57.pdf> (“Any effort to limit the ability of hospitals or hospital-affiliated foundations and other charitable organizations to help individuals in need obtain access to health insurance coverage is bad public policy. Not only does it undermine one of the core objectives of the ACA—making affordable insurance coverage available to the uninsured—it also adversely impacts those who need it most, the poor and sick.”).

18. Third-party payments are also commonly referred to as cost-sharing payments. This Note will only use the term third-party payments for the sake of clarity.

19. *See*, AMERICA'S ESSENTIAL HOSPITALS, PREMIUM ASSISTANCE PROGRAMS 1 (2014), <http://essentialhospitals.org/wp-content/uploads/2014/08/Premium-Assistance-brief.pdf> (“[I]ncreasing the number of enrollees in the marketplaces through provider-based premium assistance also can help stabilize the marketplaces and spread risk more broadly, which will attract new plans and promote price competition.”).

patient harm, as well as the overall cost of health care, rise when the Premium Tax Credit is used in conjunction with third-party payments. It concludes by arguing that Premium Tax Credits should not be allowed to be used in conjunction with third-party payments.

Part III examines the potential benefits that third-party payments may confer on patients. Specifically, Part III examines scenarios where third-party payments can be legitimately used to help vulnerable individuals without increasing tax burdens or creating excessive health-care costs. This Part also advances several arguments made by proponents of third-party payments and then addresses them in turn.

Part IV concludes by proposing a federal criminal statute similar to the Anti-Kickback Statute that narrowly addresses third-party payments. The overall aim of this statute is to preserve charitable giving while addressing the need to prohibit exploitation of a glaring ACA loophole. This Part then explains the significance of various provisions of the proposed statute.

I. CURRENT REGULATION AND GUIDANCE ON THIRD-PARTY PAYMENTS

Third-party payments of QHP premiums are a recent phenomenon that has become increasingly popular in the past four years. This Part elucidates the regulatory responses to third-party payments and explains the negative effects that this practice can have on patients and the overall health-care market. This Part also takes a brief look at the future of the third-party-payment problem under a new government administration.

A. HHS and CMS Responses to Third-Party Payments

In a December 2010 letter, the Department of Health and Human Services (HHS) first addressed third-party payments in the context of Pre-Existing Condition Insurance Plans²⁰ (PCIPs).²¹ In that letter, HHS acknowledged the problems that third-party payments could cause; namely, they have the potential for “dumping, fraud, waste, and abuse.”²² HHS also anticipated that it would issue further guidance on third-party payments, to the extent that they unnecessarily increased health-care spending.²³

20. PCIPs were interim insurance pools established under the ACA to provide health coverage to individuals with pre-existing health conditions, which were in use from March 23, 2010 to January 1, 2014. *See* 42 U.S.C. § 18001(a) (2012).

21. Letter from Richard Popper, Deputy Dir., Office of Ins. Programs, to Federal High Risk Pool Contractors (Dec. 28, 2010), https://www.cms.gov/CCIIO/Resources/Files/Downloads/12-28-2010portability_of_coverage-ltr.pdf.

22. *Id.*

23. *Id.*

Congress has also participated in the development of third-party-payment regulation, to a limited extent. In August 2013, Congressman Jim McDermott sent a letter to Kathleen Sebelius, Secretary of HHS, seeking clarification on whether QHPs qualify as federal health-care programs on the exchange.²⁴ The ultimate purpose of this letter was to determine whether government subsidies provided to QHPs made QHPs susceptible to the definition of federal health programs under the Anti-Kickback Statute,²⁵ which prohibits remuneration for referring individuals to services that are a part of a federal health-care program.²⁶

The answer to whether QHPs qualified as federal health-care programs was critical to determining the future of third-party payments. If QHPs did qualify as federal health-care programs, then providers who paid, directly or indirectly, their patients' premiums in anticipation of higher payouts could be found in violation of the Anti-Kickback Statute, and could face criminal penalties of \$25,000 and up to five years of imprisonment for each violation.²⁷ A finding that QHPs qualified as federal health-care programs could have been the demise of third-party payments.²⁸

However, any hope of utilizing the Anti-Kickback Statute to prohibit third-party payments has apparently fallen flat. In a response to Congressman McDermott's letter, Secretary Sebelius specified that QHPs do not fit the definition of federal health-care programs.²⁹ The response claims that "[t]his conclusion was based upon a careful review of the definition of 'Federal health care program' and an assessment of the various aspects of each program under Title I of the Affordable Care

24. Letter from Jim McDermott, Congressman, to Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs. (Aug. 6, 2013), <https://thebeatatcooleyhealth.files.wordpress.com/2013/11/letter-august-6-2013.pdf>.

25. 42 U.S.C. § 1320a-7b(f) (2012).

26. *Id.* § 1320a-7b(b).

27. *Id.*

28. However, one could argue that the use of the Anti-Kickback Statute to prosecute third-party payments would be overly restrictive because of its low intent requirement. See Elizabeth R. Sheyn, *Toward a Specific Intent Requirement in White Collar Crime Statutes: How the Patient Protection and Affordable Care Act of 2010 Sheds Light on the "General Intent Revolution,"* 64 FLA. L. REV. 449, 481 (2012) (arguing that the amendment to the Anti-Kickback Statute lowering the intent requirement should be reversed because it unnecessarily increases health-care-fraud litigation).

29. Letter from Kathleen Sebelius, Sec'y, Dep't of Health & Human Servs., to Jim McDermott, Congressman (Oct. 30, 2013), <http://www.hlregulation.com/files/2013/10/The-Honorable-Jim-McDermott.pdf>. This determination by Secretary Sebelius could be challenged in the courts. So far there has been no attempt to do so, but there is always a possibility that a court could rule against this determination. For now, the Anti-Kickback Statute will not apply to third-party payments.

Act and consultation with the Department of Justice.”³⁰ Glaringly absent from this letter is any mention of the reasoning used to conclude that QHPs do not fit the definition of a federal health-care program.³¹ In another letter, U.S. Senator Charles Grassley expressed concern that QHPs were not defined as federal health-care programs.³² In response, Secretary Sebelius simply reiterated her original response that the HHS made the determination through consultation with the Office of the Inspector General and the Department of Justice.³³

CMS also addressed third-party payments by publishing a short frequently-asked-questions document in November 2013.³⁴ In this document, CMS expressed “significant concerns” with third-party payments because they could “skew the insurance risk pool and create an unlevel field in the Marketplaces.”³⁵ Further, CMS encouraged issuers to reject third-party payments and explained that it would take appropriate action in the future, if necessary.³⁶ Some issuers have followed this advice.³⁷

On February 7, 2014, CMS published another frequently-asked-questions document regarding third-party payments of QHP premiums.³⁸ In this document, CMS clarified that their skepticism regarding third-party payments does not apply to payments made by “Indian tribes, tribal organizations, urban Indian organizations, and state and federal

30. *Id.*

31. *See id.*

32. Letter from Charles E. Grassley, U.S. Senator to Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs. & Eric Holder, Jr., Att’y Gen., Dep’t of Justice (Nov. 7, 2013), <https://thebeatatcooleyhealth.files.wordpress.com/2013/11/grassley-letter.pdf> (“I am alarmed at indications that the Administration may try to exempt the Patient Protection and Affordable Care Act (PPACA) from certain federal anti-fraud provisions. PPACA provides for billions of dollars in subsidies to be paid directly to insurance companies. These taxpayer dollars should be subject to the full arsenal of civil and criminal anti-fraud protections provided by Congress.”).

33. Letter from Kathleen Sebelius, Sec’y, Dep’t of Health & Human Servs., to Charles E. Grassley, U.S. Senator (Feb. 6, 2014), <http://online.wsj.com/public/resources/documents/SebeliusLetter0219.pdf>.

34. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., *THIRD PARTY PAYMENTS OF PREMIUMS FOR QUALIFIED HEALTH PLANS IN THE MARKETPLACES* (2013), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>.

35. *Id.*

36. *Id.*

37. *See, e.g., Third-Party Payments of Premiums and/or Cost-Sharing*, BLUE CROSS BLUE SHIELD MINN., <https://www.bluecrossmn.com/healthy/public/personal/home/shopplans/shop-individual-family-plans/third-party-premium-payment> (last visited Apr. 16, 2017).

38. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T FOR HEALTH & HUMAN SERVS., *THIRD PARTY PAYMENTS OF PREMIUMS FOR QUALIFIED HEALTH PLANS IN THE MARKETPLACES 1* (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>.

government programs or grantees (such as the Ryan White HIV/AIDS Program).”³⁹ Further, CMS said that its concerns would not apply to payments made by private, nonprofit organizations, so long as their selection of enrollees is based off of financial status and does not consider health status.⁴⁰

Most recently, HHS published an interim final rule related to the use of third-party payments by Medicare-certified dialysis centers that was scheduled to go into effect on January 13, 2017.⁴¹ In the background section of that rule, HHS identified the types of harm that third-party payments could have on dialysis patients:

[E]nrollment in individual market coverage paid for by dialysis facilities or organizations affiliated with dialysis facilities can lead to three types of harm to patients: Negatively impacting their determination of readiness for a kidney transplant, potentially exposing patients to additional costs for health care services, and putting them at significant risk of a mid-year disruption in health care coverage. Based on these comments, HHS has concluded that the differences between providers’ and suppliers’ financial interests and patients’ interests may result in providers and suppliers taking actions that put patients’ lives and wellbeing at risk.⁴²

In this rule, HHS articulated the overarching issue with third-party payments—they are at odds with the wellbeing and best interests of patients.⁴³ Third-party payments also run the risk of coverage disruption, which is problematic for all patients, but especially for those who have high-risk medical conditions⁴⁴ that require high-cost medical services.⁴⁵ As discussed previously, QHP issuers are under no obligation to accept third-party payments,⁴⁶ and if they discover that such payments are being

39. *Id.* at 1.

40. *Id.* at 2.

41. Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities—Third Party Payment, 81 Fed. Reg. 90,211, 90,212 (Dec. 14, 2016) (to be codified at 42 C.F.R. pt. 494).

42. *Id.* at 90,214.

43. *Id.*

44. In this context, these patients need constant dialysis treatments or a liver transplant to live. This could mean deciding between paying out-of-pocket for the expensive treatment during the gap in coverage or not getting treatment. This is not much of a decision considering dialysis treatments mean the difference between life and death for these patients. *Id.* at 90,212.

45. *Id.* at 90,217.

46. Recall that CMS and HHS have even encouraged issuers to reject third-party payments. See *supra* notes 36–37 and accompanying text. However, they have also carved out exceptions for certain groups of individuals. See *supra* note 39 and accompanying text.

made, they may—and often do—reject the payments.⁴⁷

To address the risks that third-party payments pose for dialysis patients, HHS dictated disclosure requirements for Medicare-certified dialysis centers in its interim final rule.⁴⁸ First, Medicare-certified dialysis centers must initially disclose to new patients (and thereafter on an annual basis) how enrollment in QHP plans “will affect the patient’s access to and costs for the providers and suppliers, services, and prescription drugs that are currently within the individual’s care plan, as well as those likely to result from other documented health care needs.”⁴⁹ This rule requires the disclosure to include information on the health-related and financial risks of both QHPs and other plans outside of the Marketplace.⁵⁰ This rule also explicitly requires disclosure of the effect that various plans will have on transplant-related costs.⁵¹ In order to prevent patient coverage disruptions, this rule also requires that Medicare-certified dialysis centers develop “reasonable procedures” for communicating with issuers and obtaining documentation that the issuer has consented to receive third-party payments on behalf of their enrollees.⁵² If the issuer refuses to accept the third-party payments, the provider must “take reasonable steps to ensure that such payments are not made by any third parties to which the facility contributes.”⁵³ It is important to note that these disclosure requirements only apply to Medicare-certified dialysis centers who make third-party payments directly or indirectly for their patients.⁵⁴

HHS’s reasons for implementing disclosure requirements for dialysis patients who receive third-party payments are apparent. If third-party payments are stressing issuers’ risk pools and overall costs, then disclosure of patients whose premium payments are being made by a third party should lead to those issuers rejecting those payments. The patient disclosure requirement also means that each patient would be aware of the risks associated with third-party payments, which would likely lessen the number of individuals who would allow third-party payments to be made on their behalf when they might otherwise qualify for Medicare or Medicaid. The aggregate effect of these two disclosure requirements would be a substantial decrease in the use of third-party payments.

47. In some cases, the insurance contract includes a provision that makes the contract void if a payment is made by someone other than the beneficiary. Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities—Third Party Payment, 81 Fed. Reg. at 90,217.

48. *Id.* at 90,219.

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 90,220.

53. *Id.*

54. *Id.* at 90,219.

Are disclosure requirements the solution to the third-party-payment problem? Could a regulation requiring these disclosures for all providers who make third-party payments stymie the negative effects of the practice? In theory, maybe, but probably not in the current political climate. For instance, although HHS's final rule was limited solely to Medicare-certified dialysis centers, the U.S. District Court for the Eastern District of Texas recently granted a preliminary injunction that bars HHS from implementing and enforcing the rule.⁵⁵ In the Order, the court not only criticized HHS for not following notice and comment procedures, but also found the rule "arbitrary and capricious."⁵⁶ The court found that HHS failed to consider the advantages of QHPs and the disadvantages of the rule.⁵⁷ Although this is merely one court's ruling, it reflects the disdain for health care regulation that was a pillar of President Donald Trump's election campaign. Indeed, President Trump's recent Executive Order requiring agencies to pinpoint two regulations to be eliminated for every new proposed regulation reflects the distaste for regulatory oversight in general.⁵⁸ These examples, when viewed alongside CMS and HHS's piecemeal responses, suggest that a regulatory solution to the third-party payment problem is unlikely.⁵⁹

B. Regulation Under a New Administration

After a presidential election result that no one saw coming, the future of third-party-payment regulation and the ACA in general is unclear. President Trump originally promised to submit a "repeal and replace" plan as soon as his nominee for secretary of HHS was approved.⁶⁰ However, many, including congressmen in President Trump's own party, expressed disbelief that the ACA could be repealed and replaced as quickly and easily as he claimed—they were right.⁶¹ On March 24, 2017, Republicans had to withdraw their ACA replacement bill after they

55. *Dialysis Patient Citizens v. Burwell*, No. 4:17-CV-16, 2017 WL 365271, at *3 (E.D. Tex. Jan. 25, 2017).

56. *Id.* at *6.

57. *Id.*

58. See Exec. Order No. 13,771, 82 Fed. Reg. 9339 (Feb. 3, 2017).

59. These responses have targeted only providers that make third-party payments for some of the highest risk patients such as dialysis and HIV/AIDS patients. See *supra* notes 39–41 and accompanying text. No attempt to address the full problem has been made.

60. Dan Mangan, *Donald Trump Says Obamacare Repeal and Replacement to Come with Confirmation of Price as HHS Chief*, CNBC (Jan. 11, 2017, 1:46 PM), <http://www.cnbc.com/2017/01/11/donald-trump-addresses-obamacare-repeal-and-replacement-at-press-conference-in-new-york.html>.

61. See Dierdre Walsh & MJ Lee, *Trump Wants Obamacare Repeal 'Quickly,' but Republicans Aren't Ready*, CNN (Jan. 10, 2017, 6:05 PM), <http://www.cnn.com/2017/01/10/politics/paul-ryan-obamacare-repeal-and-replace/>.

realized it would not receive the necessary votes.⁶² However, the U.S. House of Representatives later managed to narrowly pass legislation to repeal and replace the ACA on May 4, 2017.⁶³ Although the U.S. Senate subsequently mustered the votes to open debate on the legislation, a proposal to repeal the ACA without replacement failed on July 26, 2017.⁶⁴ Following that failure, Republicans again suffered a devastating defeat when Senator John McCain cast the decisive vote to reject a scaled-down version of the repeal and replace bill.⁶⁵ After this defeat, it is unclear whether Republicans will make further attempts to dismantle the ACA. However, the uncertainty regarding the future of the ACA casts doubt on what the state of third-party payments will look like in the near future.

However, there is good reason to think that third-party-payment abuse will remain an ongoing issue, even if Congress repeals and replaces the ACA. Even if QHPs are renamed to something more politically identifiable to the new administration, they will likely function in the same manner. Perhaps government subsidies for QHPs will be eliminated altogether. In that case, hospitals still retain an incentive to steer their patients to private health insurance plans with higher physician payouts.⁶⁶ As long as public health coverage like Medicare and Medicaid exists, so will a need for legislation addressing third-party-payment abuse. Of course, a repeal of the ACA would have implications for the third-party-payment problem, but the underlying issue would remain.⁶⁷ The important thing to realize is that the third-party-payment problem is a result of a health-care loophole that is not unique to any political party. It

62. See Robert Pear et al., *In Major Defeat for Trump, Push to Repeal Health Law Fails*, N.Y. TIMES (Mar. 24, 2017), <https://www.nytimes.com/2017/03/24/us/politics/health-care-affordable-care-act.html>. The fact that Republicans only needed to garner votes from their own party to reach the threshold to pass the bill signals that repealing and replacing the ACA is a more difficult task than President Trump originally believed.

63. Thomas Kaplan & Robert Pear, *House Passes Measure to Repeal and Replace the Affordable Care Act*, N.Y. TIMES (May 4, 2017), <https://www.nytimes.com/2017/05/04/us/politics/health-care-bill-vote.html?mcubz=1>.

64. Thomas Kaplan & Eileen Sullivan, *Health Care Vote: Senate Rejects Repeal Without Replace*, N.Y. TIMES (July 26, 2017), <https://www.nytimes.com/2017/07/26/us/politics/health-care-senate-vote.html?mcubz=1>.

65. Robert Pear & Thomas Kaplan, *Senate Rejects Slimmed-Down Obamacare Repeal as McCain Votes No*, N.Y. TIMES (July 27, 2017), <https://www.nytimes.com/2017/07/27/us/politics/obamacare-partial-repeal-senate-republicans-revolt.html?mcubz=1>.

66. Although their incentive may be lessened by the absence of government subsidies, hospitals and physicians would still stand to make a healthy profit from steering their patients away from Medicare and Medicaid and into private insurance coverage.

67. For instance, the repeal of the ACA could mean that Premium Tax Credits no longer exist, but they are only a slight motivator for providers to engage in third-party payments, given the amount they stand to profit from the practice altogether. See *infra* Part II.

is an issue that will persist until corrected, whether the United States has a Democrat or Republican in its highest office.⁶⁸

II. THE INTERSECTION OF PREMIUM TAX CREDITS AND THIRD-PARTY PAYMENTS

Premium Tax Credits assist those in low-income brackets with making their QHP premium payments. However, when these tax credits are used in conjunction with third-party payments, the financial risk to the patient increases. Further, this conjunction increases the financial strain on federal funds. This Part first explains the credits and then argues that these credits should not be allowed in conjunction with third-party payments.

A. *Understanding the Premium Tax Credit*

Individuals who wish to participate in the Marketplace may be eligible for financial assistance through a Premium Tax Credit (PTC), which provides a refund, on a sliding income scale, for low-income individuals enrolled in a QHP.⁶⁹ The overall goal of the PTC is to assist low-income individuals who do not qualify for Medicare or Medicaid in obtaining health coverage in the Marketplace.⁷⁰ To qualify for a PTC, an individual must: enroll with a QHP for at least one month of the year, be ineligible for minimum essential coverage,⁷¹ pay the remaining share of premiums on time each month, earn an adjusted gross income between 100–400% of the federal poverty line,⁷² not file a married filing separately tax return,

68. When incentives are improperly aligned, problems invariably arise and persist until addressed. These types of issues cut across the political spectrum and persist despite the coming and going of various political administrations. One such issue similar to the third-party-payment problem is the use of diagnosis-related groups (DRGs) to manage hospital reimbursement. See Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 253 (1999). The use of DRGs to calculate reimbursement has led to upcoding, whereby a physician or hospital bills for treatment of a specific disease in order to ensure payment for a patient's treatment, even if it is an incorrect diagnosis. *Id.* at 296. This practice, like third-party payments, puts patients at risk and raises the issue of economically-motivated provider fraud. *Id.* at 296–97. The upcoding issue persists, despite its lengthy existence. This lends support to the idea that issues of improper incentive alignment, like the third-party-payment problem, will remain until addressed.

69. Treas. Reg. § 1.36B-2 (2016).

70. *Questions and Answers on the Premium Tax Credit*, IRS, <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit> (last visited Apr. 16, 2017).

71. For the purposes of this Note, consider minimum essential coverage to include government-sponsored plans like Medicare and Medicaid, although there are other types of health benefit coverage that qualify under this definition. See Treas. Reg. § 1.36B-2(c) (2016).

72. The 2016 Federal Poverty guidelines set the federal poverty line for an individual at \$11,880. Annual Update of the HHS Poverty Guidelines, 81 Fed. Reg. 4036, 4036 (Jan. 25, 2016).

and not be claimed as a dependent.⁷³ Note that most individuals that receive third-party payments are of a low-income status, so many will satisfy the initial requirements for a PTC.⁷⁴ Although PTCs can be applied as a refund at the end of each tax year, low-income individuals who are already struggling to make timely premium payments would likely prefer to receive their refund through the Advance Premium Tax Credit (APTC) option, which pays a portion of the refund directly to the issuer each month in order to offset premiums.⁷⁵

One of the pitfalls of APTCs is that the amount paid to the issuer each month is calculated using income estimates and household information—which are subject to speculation and unforeseen change—provided by the individual in their Marketplace application.⁷⁶ If the total amount of APTC money paid to the issuer exceeds what the individual's yearly income entitles them to, then the individual must repay that excess amount to the federal government.⁷⁷ It is easy to imagine several common events that could significantly alter the estimates provided in an initial application, including changes in employment, marital status, or residence.⁷⁸ Therefore, there is a risk that individuals who undergo any serious change of position, and who do not request an adjustment to their monthly APTCs,⁷⁹ will end up with a hefty tax burden.

Inefficiencies and poor administration of the APTC system have left the door open for mistake and fraud. For instance, until April 2016, CMS did not have an adequate process for ensuring APTC payments to QHP issuers were made only for individuals who had paid their premiums.⁸⁰ By failing to use an adequate verification mechanism, CMS invited fraudulent reporting from QHP issuers, whose sole obligation was to

Extrapolating from that figure, 100–400% of the 2016 federal poverty line for an individual equates to \$11,880–\$47,520 of adjusted gross income.

73. Treas. Reg. § 1.36B-2 (2016).

74. *See id.*

75. *See* 42 U.S.C. § 18082(c) (2012).

76. *See Premium Tax Credit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/premium-tax-credit/> (last visited Apr. 16, 2017).

77. *Id.*

78. *The Premium Tax Credit*, IRS, <https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit> (last visited Apr. 16, 2017).

79. It is highly unlikely that most beneficiaries of these credits are going to be aware that they need to ask for a reduction in their APTC payments, much less be aware that a change in their income or household has triggered the need to do so.

80. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., POLICY-BASED PAYMENTS BULLETIN TRANSITION IN APRIL 2016 – INFORMATION 2 (Mar. 22, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FT_PBPGuidance_5CR_032116.pdf.

attest that their APTC information was accurate.⁸¹ CMS did not address this deficiency until the Office of the Inspector General issued a report on the matter.⁸² Thus, APTCs used in conjunction with third-party payments not only present a financial risk to patients who utilize them, but also have been so poorly implemented that the potential risk for abuse by issuers has been heightened.

B. *The Use of Premium Tax Credits Exacerbates the Issues Underlying Third-Party Payments*

Provider-affiliated nonprofits can encourage patients to utilize the APTC to decrease the overall cost of making third-party payments for their patients. Thus, these programs make it even less risky for providers to coordinate third-party payments through nonprofits. The reason is obvious: Making third-party payments for patients is already lucrative for providers, and decreasing the investment cost lessens the risk that they will not see a return on that investment. However, this is a zero-sum game. The money must come out of someone else's pocket. In this case, it is taxpayers who must bear that burden, while providers reap the benefits.⁸³ Due to this undeserved cost shifting alone, providers and provider-affiliated nonprofits should be barred from encouraging their patients to use the APTC. Accepting for a moment that third-party payments should be allowed at all, providers should still not get to take advantage of a federal tax credit for the purposes of exploiting an ACA loophole. Nonetheless, there are other reasons these types of organizations should not be allowed to use APTCs in conjunction with third-party payments.

The strongest reason for disallowing the use of APTCs in conjunction with third-party payments is that it heightens the financial risks borne by a patient who is receiving third-party payment assistance.⁸⁴ These patients, who are already in precarious financial situations, may face a hefty tax burden during tax season if their income estimates or household

81. See DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GEN., CMS COULD NOT EFFECTIVELY ENSURE THAT ADVANCE PREMIUM TAX CREDIT PAYMENTS MADE UNDER AFFORDABLE CARE ACT WERE ONLY FOR ENROLLEES WHO PAID THEIR PREMIUMS 4–5 (2015), <https://oig.hhs.gov/oas/reports/region2/21402025.pdf>.

82. See *id.* at 8.

83. The costs of the PTC and APTC are already significant without the potential for abuse. See *Premium Tax Credits*, HEALTH AFFAIRS (Aug. 1, 2013), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=97 (“The premium tax credit subsidies are estimated to cost the federal government \$16 billion in outlays and \$3 billion in reduced revenues in fiscal year 2014, rising to \$115 billion in outlays and \$16 billion in reduced revenues in fiscal year 2023, the tenth year.”).

84. See *supra* notes 76–79 and accompanying text.

information prove to be incorrect.⁸⁵ Placing vulnerable patients in this risky situation only serves the interests of providers.⁸⁶ Therefore, if provider-affiliated nonprofits should be allowed to make third-party payments at all, they should pay the full price of their patients' QHP premiums and not unjustly put their patients in further financial risk, while also burdening federal funds.⁸⁷

III. ANALYZING THE ARGUMENTS FOR ALLOWING THIRD-PARTY PAYMENTS

This Part first discusses the laudable uses for third-party payments as well as several arguments that support the use of third-party payments by providers and provider-affiliated nonprofits. This Part then rebuts each of those arguments in turn.

A. *Arguments for Allowing Third-Party Payments*

Although third-party payments carry a serious potential for abuse, some independent nonprofits use third-party payments as a way to ensure that seriously ill and poor individuals receive the medical care they need.⁸⁸ These nonprofits use third-party payments to cover the remainder of QHP premiums after federal subsidies are deducted.⁸⁹ For instance, one individual with multiple sclerosis, enrolled in a QHP, with an annual income of \$11,000⁹⁰ must still pay a \$33 monthly premium after federal subsidies are applied.⁹¹ At first glance, this premium payment might seem fairly low; however, this payment is a substantial burden for someone with a serious chronic illness who is already living below the federal poverty line.⁹² Therefore, third-party payments, when used for a laudable

85. See *supra* notes 76–79 and accompanying text.

86. This is assuming that if the APTC was not available, providers would still want to make third-party payments on behalf of their high-cost patients, even though the cost of doing so would be somewhat higher.

87. One could also make the argument that patients who have third-party payments made on their behalf should not be allowed to reap the benefits of the PTC. The argument is that they have not actually made the premium payments out of their limited income, so they should not be eligible for a refund.

88. See Phil Galewitz, *Insurers, Hospitals Clash over Help Paying Obamacare Premiums*, KAISER HEALTH NEWS (Oct. 31, 2016), <http://khn.org/news/insurers-hospitals-clash-over-help-paying-obamacare-premiums/>.

89. *Id.*

90. This annual salary for an unmarried individual is below the 2016 federal poverty line. Annual Update of the HHS Poverty Guidelines, 81 Fed. Reg. 4036, 4036 (Jan. 25, 2016).

91. Galewitz, *supra* note 88.

92. See Annual Update of the HHS Poverty Guidelines, 81 Fed. Reg. at 4036; Galewitz, *supra* note 88.

purpose, can help high-risk individuals maintain the insurance coverage they need to receive necessary treatment.⁹³

Additionally, some argue that there are legitimate reasons for chronically ill patients to opt for QHP coverage over Medicare or Medicaid coverage.⁹⁴ Recently, the American Kidney Fund, in a letter addressed to CMS, argued that a final rule on third-party payments which disallows individuals with end-stage renal disease from using third-party payments would amount to a denial of a right to choose their health coverage.⁹⁵ The American Kidney Fund argues that this choice is pivotal to many individuals with end-stage renal disease who may end up paying 20%⁹⁶ in out-of-pocket costs with Medicare coverage.⁹⁷ Additionally, individuals with end-stage renal disease might prefer to enroll in a QHP over Medicare because QHPs have less out-of-pocket costs for medications.⁹⁸ Individuals with end-stage renal disease may find this consideration especially important since the disease is associated with several comorbidities.⁹⁹

There is a strong argument that prohibiting nonprofits from making third-party payments will cause significant harm to vulnerable populations.¹⁰⁰ The basic argument is that nonprofits that provide third-party payments do so for the benefit of vulnerable populations,¹⁰¹ and prohibiting the practice would unjustly strip financial assistance from these individuals.¹⁰² In fact, CMS seemed to give that argument significant weight when it issued an interim rule stating that Ryan White

93. See Galewitz, *supra* note 88.

94. See *American Kidney Fund Asks CMS to Protect ESRD Patients' Rights to Insurance Choice and Charitable Assistance*, PRWEB (Oct. 10, 2016), <http://www.prweb.com/releases/2016/10/prweb13751981.htm>.

95. Letter from LaVarne A. Burton, President & CEO, Am. Kidney Fund, to Andrew M. Slavitt, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs. (Oct. 6, 2016), <http://www.kidneyfund.org/assets/pdf/advocacy/american-kidney-fund-comments-2018-nbpb.pdf>.

96. This figure is for individuals enrolled in Medicare who reside in a state that does not provide Medigap coverage, which covers the out-of-pocket expenses. Medigap coverage is currently only available in twenty-seven states. See *id.*

97. *Id.*

98. See *id.*

99. *Living with Comorbidities and Chronic Kidney Disease*, DAVITA, <https://www.davita.com/kidney-disease/overview/living-with-ckd/living-with-comorbidities-and-chronic-kidney-disease/e/4892> (last visited Apr. 16, 2017) (“Many chronic kidney disease patients may have one or more comorbidities, a disease or condition that exists alongside another disease. . . . Patients with comorbidities often take multiple medicines.”).

100. See Burton, *supra* note 95.

101. E.g., low-income and chronically ill individuals.

102. See Burton, *supra* note 95. A similar issue is that an overly inclusive regulatory rule or criminal statute would cost nonprofits a significant amount of funding in compliance costs. An overly inclusive statute could also result in nonprofits abandoning the practice altogether over fear of litigation.

HIV/AIDS Program beneficiaries receiving third-party payment assistance could not be rejected by issuers.¹⁰³ Here, the rationale seemed to be that allowing issuers to reject third-party payments for people with HIV or AIDS would unduly harm a vulnerable population.¹⁰⁴ In that vein, the American Hospital Association (AHA) has argued that there is no justifiable reason to allow the Ryan White HIV/AIDS Program to make third-party payments that benefit a vulnerable population, while simultaneously rejecting the same payments from hospitals, hospital-affiliated organizations, and other nonprofits.¹⁰⁵

Further, some have argued that by encouraging issuers to reject third-party payments from hospitals and providers,¹⁰⁶ CMS is advocating a policy that conflicts with the principles underlying the ACA.¹⁰⁷ The claim is that CMS is advocating a position that conflicts with the ACA's "prohibition of discrimination against individuals with certain diseases, conditions or other significant health care needs."¹⁰⁸ The AHA says this position condones the exclusion of the disabled by allowing issuers to reject third-party premiums made by hospitals, which may be their only way to maintain adequate health coverage.¹⁰⁹

There is also an argument that CMS already sufficiently regulates third-party payments,¹¹⁰ and therefore CMS's ban on third-party payments made by hospitals and hospital-affiliated nonprofits should be lifted.¹¹¹ Essentially, this argument rests on the belief that CMS's requirements that eligibility criteria be based solely on financial need and not health status, and that premium payments be made for an entire coverage year,¹¹² are sufficient to prevent fraud and waste.¹¹³ However, the AHA goes so far as to claim that the health status of individuals should not generally be prohibited because it is "appropriate and logical" to consider an individual's health status when allocating limited resources.¹¹⁴

103. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 1.

104. This is also reflected in CMS's requirements for how nonprofits select individuals to make third-party payments for. See *id.* at 2.

105. See Nickels, *supra* note 17.

106. See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 34.

107. See Nickels, *supra* note 17.

108. *Id.*

109. *Id.*

110. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 1–2.

111. See Nickels, *supra* note 17.

112. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 2.

113. See Nickels, *supra* note 17.

114. *Id.*

B. *Addressing the Arguments for Allowing Third-Party Payments*

Although CMS's recent guidance leaves something to be desired, the contention that discrimination results from CMS's prohibition of third-party payments made by providers is a stretch.¹¹⁵ While it is likely that this policy may lead to some issuers rejecting third-party payments for vulnerable individuals, the underlying reasons for this policy outweigh the incidental harms.¹¹⁶ There are good reasons to prohibit providers from making third-party payments, such as the negative impact that the practice has on insurance risk pools, the Marketplace, and overall health-care costs nationwide.¹¹⁷ Additionally, CMS has stated that there is no prohibition of independent nonprofits making third-party payments,¹¹⁸ so long as they abide by the previously discussed requirements.¹¹⁹ CMS's guidance up to this point indicates that it does not want to impede charitable assistance for vulnerable individuals, but recognizes that measures must be taken to curtail inappropriate steering and fraud by providers.¹²⁰ CMS's responses do not suggest discrimination against vulnerable populations, but instead show a justified response to provider exploitation of the Marketplace.¹²¹

The argument that hospitals and hospital-affiliated nonprofits should be allowed to make third-party payments because CMS has required issuers to accept third-party payments for Ryan White HIV/AIDS Program beneficiaries is faulty.¹²² CMS appears to have made a distinction between hospitals and hospital-affiliated nonprofits and independent nonprofits because the risk of fraud and inappropriate steering is distinct between the two groups.¹²³ As previously discussed, hospitals and hospital-affiliated nonprofits have an incentive to use third-party payments to steer patients toward QHP plans that have higher payouts than Medicare and Medicaid.¹²⁴ On the other hand, a truly independent nonprofit will not have any incentive to steer patients toward a QHP. A truly independent nonprofit assisting a vulnerable individual to secure health-care coverage will only be concerned with whether the

115. *See id.*

116. *See id.*

117. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 34.

118. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 2.

119. *See supra* note 40 and accompanying text.

120. *See supra* Section I.A.

121. *See* Eyles, *supra* note 16.

122. *See* Nickels, *supra* note 17.

123. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 1–2.

124. *See supra* notes 4–10 and accompanying text.

coverage is appropriate for that individual's medical needs.¹²⁵ There is no incentive for an independent nonprofit to steer individuals toward functionally equivalent health coverage that has higher physician payouts. In sum, over one type of entity looms the inherent risk of acting in the interest of profits—to the detriment of the individual—while the other is free of this temptation.¹²⁶

The argument that current regulation by CMS is sufficient to curtail fraud and waste is also lacking.¹²⁷ Although these regulations provide a start, they would not have equal force when applied to hospitals and hospital-affiliated nonprofits.¹²⁸ The reason is simple—hospitals and hospital-affiliated nonprofits hold too much risk for fraud and waste because they have a profit incentive to steer patients toward QHPs.¹²⁹ It seems likely that CMS views their requirements—nonprofits paying for an enrollee's premiums must select enrollees solely on the basis of financial need, and the premium payments must cover the entire policy year—as safeguards for patients, rather than as a way to prevent provider fraud and waste.¹³⁰ Further, the supplementary argument, that health status should be allowed in determining eligibility because it is a logical way to allocate resources, suffers from a similar problem.¹³¹ CMS likely excluded health status as a way to determine eligibility for third-party-payment programs because it opens the door for providers to target their most costly patients and steer them toward QHPs, thus increasing their payout and reducing their cost of providing medical care.¹³² Therefore, these arguments should be rejected because adopting their conclusions would only increase the opportunity for fraud and waste, as well as perpetuate harm to the Marketplace.¹³³

Others have argued that third-party payments confer an overall benefit to local communities.¹³⁴ When hospitals pay their patients' premiums, communities benefit because overall access to health care increases.¹³⁵ Additionally, as more uninsured patients obtain health coverage, a

125. This assumes that the motivations of the nonprofit are pure. Unfortunately, there is the chance that the nonprofit is fraudulently acting in the interests of a few individuals. See *infra* note 175 and accompanying text.

126. See Eyles, *supra* note 16.

127. See Nickels, *supra* note 17.

128. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 2.

129. See Greene, *supra* note 6.

130. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 2.

131. See Nickels, *supra* note 17.

132. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 38, at 2.

133. See Eyles, *supra* note 16.

134. See Catherine E. Livingston et al., *Third-Party Payment of Premiums for Private Health Insurance Offered on the Exchanges*, 8 J. HEALTH & LIFE SCI. L. 1, 32 (2015).

135. *Id.*

hospital's cost of care decreases.¹³⁶ Proponents of this argument suggest that nonprofit hospitals should be able to make third-party payments and claim these payments as community-benefit expenditures on their taxes.¹³⁷

However, the nonprofit designation of certain hospitals can be misleading, and it is a poor justification for allowing these types of institutions to make third-party payments.¹³⁸ While many might visualize a nonprofit hospital as an institution that makes meager profits or simply breaks even each year, this is not an accurate picture.¹³⁹ In fact, a recent study based on profits from patient-care services found that of the top ten most profitable U.S. hospitals, seven of them held nonprofit status.¹⁴⁰ In 2013, the nonprofits included in this list made profits from patient-care services that ranged from \$163.5 million to \$302.5 million.¹⁴¹ While some of these nonprofit hospitals have responded that they reinvest their profits into programs and initiatives that improve the facilities or benefit the public,¹⁴² critics point to rising health-care costs and question whether nonprofits should be generating so much profit.¹⁴³ Additionally, a landmark study found that in 2009, nonprofits spent only 7.5% of their operating expenses on community benefits, which makes it difficult to justify the immense tax breaks they receive.¹⁴⁴ In sum, nonprofit hospitals are not disinterested in profits, and therefore they should not be allowed to make third-party payments simply because they are tax-exempt.¹⁴⁵

136. *Id.* This decrease in health-care costs in no way necessitates that this benefit is passed on to the hospital's patients. It is likely that such a benefit only confers upon the hospital itself.

137. *Id.* at 40–41.

138. See Lena H. Sun, *These Hospitals Make the Most Money Off Patients – and They're Mostly Nonprofits*, WASH. POST (May 3, 2016), <https://www.washingtonpost.com/news/to-your-health/wp/2016/05/02/these-hospitals-make-the-most-money-off-patients-and-theyre-mostly-nonprofits/>.

139. See *id.* For a more detailed discussion of the issues surrounding nonprofit hospitals and community-benefit expenditures, see Dan Diamond, *How Hospitals Got Richer off Obamacare*, POLITICO (July 17, 2017), <http://www.politico.com/interactives/2017/obamacare-non-profit-hospital-taxes/>.

140. Ge Bai & Gerard F. Anderson, *A More Detailed Understanding of Factors Associated with Hospital Profitability*, 35 HEALTH AFF. 889, 893 (2016).

141. *Id.*

142. See Sun, *supra* note 138.

143. Bruce Y. Lee, *Very Profitable Nonprofit Hospitals...But Where are the Profits Going?*, FORBES (May 8, 2016, 11:34 AM), <http://www.forbes.com/sites/brucelee/2016/05/08/very-profitable-nonprofit-hospitals-but-where-are-the-profits-going/#3c4de7275035>.

144. Gary J. Young et al., *Provision of Community Benefits by Tax-Exempt U.S. Hospitals*, 368 NEW ENG. J. MED. 1519, 1522 (2013).

145. *But see* Livingston et al., *supra* note 134, at 32–33.

IV. CRAFTING A NARROW CRIMINAL STATUTE TO ADDRESS THIRD-PARTY PAYMENTS

Independent nonprofits that operate—without ulterior motives—to help the seriously ill and poor through third-party payments should be allowed to do so without significant interference. These efforts represent a contribution to society that, as a matter of public policy and general morality, we should be wary of discouraging.¹⁴⁶ At the same time, providers should not be allowed to profit off the Marketplace through the exploitative use of third-party payments. To ensure that legitimate charities in this sector can flourish, a narrow rule must be crafted that prevents hospital-affiliated nonprofits from taking advantage of the Marketplace. As discussed previously, the line between legitimate and illegitimate third-party payments is often blurry.¹⁴⁷ Therefore, a proper solution must put into place a mechanism that can differentiate between legitimate nonprofits and those acting as a hospital front.

A. Proposed Federal Criminal Statute

HHS's refusal to define QHPs as federal health-care programs has made the Anti-Kickback Statute ineffectual for addressing the third-party-payment problem.¹⁴⁸ Yet, there are compelling interests that should be protected from third-party-payment abuse, including consumers, issuers, and the overall health-care Marketplace.¹⁴⁹ Given these interests, an alternative to the Anti-Kickback Statute is needed—one that addresses the need to protect legitimate charitable giving, while still having enough bite to discourage third-party-payment abuse by hospitals and hospital-affiliated nonprofits.

This Note proposes that the following criminal statute be enacted to address the third-party-payment problem:

- (A) Whoever intentionally pays an individual's health insurance premiums with the expectation or realization of future profits or non-incidental benefits shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$50,000 or imprisoned for not more than five years, or both for each violation.¹⁵⁰
- (B) Whoever intentionally coordinates with or utilizes a nonprofit organization to steer an individual to transition from public health coverage to a Qualified

146. *See supra* notes 88–93 and accompanying text.

147. *See supra* note 9 and accompanying text.

148. *See supra* notes 24–33 and accompanying text.

149. *See discussion supra* Section I.A.

150. Sections (A) and (B) incorporate some language from the Anti-Kickback Statute relating to the fines and jail time for a violation. *See* 42 U.S.C. § 1320a-7b(b) (2012).

Health Plan (or other private health insurance coverage) with the expectation of future profits or non-incidentals benefits shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$50,000 or imprisoned for not more than five years, or both for each violation.

(C) In this section—

- (1) The term ‘non-incidentals benefits’ means any gain, monetary or otherwise, that does not occur by chance.
- (2) The term ‘public health coverage’ means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is administered by the United States Government and includes any health care program administered by a state.¹⁵¹

(D) Exceptions:

- (1) This section shall not apply to an individual who pays the health-insurance premiums of another with the expectation of receiving interest on the money loaned.
- (2) This section does not prevent independent charitable organizations from recommending health-insurance coverage to their clients or assisting in paying the premiums and other costs associated with that coverage. It does however prohibit such conduct when done for the purpose of conferring a non-incidentals benefit on a hospital or physician.
- (3) This section shall not apply to employers who pay for or otherwise contribute any portion of their employees’ health-insurance premiums and other health-related costs.
- (4) This section shall not apply to any payment made by a state or the United States Government related to health coverage.

151. This language is loosely based on the definition of a “federal health care program” included in the Anti-Kickback Statute. *See id.* §§ 1320a-7b(f)(1)–(2).

- (E) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.¹⁵²

B. *Analysis of the Proposed Statute*

The proposed statute attempts to limit the abuse of third-party payments without stifling charitable giving to vulnerable individuals. To that end, the statute is narrow in defining the types of intentional activity that violate it, but it is broad in defining the types of expected or realized benefits that are disallowed. The proposed statute uses the Anti-Kickback Statute as a starting point, but then eliminates troublesome portions and focuses the scope to third-party payments, rather than fraud generally.¹⁵³

One way in which this statute departs from the Anti-Kickback statute is in how the intentionality standard is articulated.¹⁵⁴ The Anti-Kickback statute uses the standard of knowing and willful conduct, while the proposed statute simply requires that an individual perform the prohibited act intentionally.¹⁵⁵ The knowing-and-willful standard has caused much ambiguity in the implementation of the Anti-Kickback Statute.¹⁵⁶ This confusion finally resulted in the addition of provision (h) to the Anti-Kickback Statute through the ACA,¹⁵⁷ clarifying that “a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”¹⁵⁸ To eliminate any ambiguity as to the scienter requirement of the proposed statute, the *knowing and willful* language has

152. This language was taken directly from a provision of the Anti-Kickback Statute. *Id.* § 1320a-7b(h).

153. Although the HHS has not disclosed its reasoning for finding that QHPs do not fall under the definition of federal health-care programs in relation to the Anti-Kickback Statute, this Note has previously identified some negative consequences that might have resulted from applying the statute to the third-party-payment problem. Those consequences include burdening legitimate nonprofits and preventing vulnerable individuals from receiving aid. *See* discussion *supra* Section III.A.

154. *See* 42 U.S.C. § 1320a-7b(b) (2012).

155. *Id.*

156. In 1995, the U.S. Court of Appeals for the Ninth Circuit interpreted the knowing and willfully language in the Anti-Kickback statute as requiring defendants to: “(1) know that § 1128B prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to disobey the law.” *Hanlester Network v. Shalala*, 51 F.3d 1390, 1400 (9th Cir. 1995). Later courts interpreted the intentionality standard differently, causing further confusion. *United States v. Jain*, 93 F.3d 436, 440 (8th Cir. 1996) (upholding the district court’s instruction to the jury that the term “willfully means unjustifiably and wrongfully” known to be such by the defendant).

157. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat. 119 (2010) (to be codified at 42 U.S.C. § 1320a-7b (2012)).

158. 42 U.S.C. § 1320a-7b(h) (2012).

been eliminated and provision (h) of the Anti-Kickback Statute has been incorporated.¹⁵⁹

Section (A) focuses on prohibiting hospitals and physicians from paying their patients' premiums "with the expectation or realization of future profits or non-incidental benefits."¹⁶⁰ The wording here is crucial to ensure that independent charitable organizations can help pay the premiums of vulnerable individuals who need assistance.¹⁶¹ So long as the organization or individual is not paying the premiums of another individual with the intent to derive some sort of non-incidental benefit, then their laudable activity will not be threatened. Here, the scienter requirement pairs with the benefit language to carve out a space where independent nonprofits can operate both without interference and with certainty about the legality of their activities.¹⁶² On the other hand, Section (A) clearly prohibits hospitals, physicians, and hospital-affiliated nonprofits from engaging in the abuse of third-party payments that this Note advocates against.

Additionally, the fine of \$25,000 included in the Anti-Kickback Statute has been doubled to \$50,000.¹⁶³ The reason for this change is practical. Since the government must meet a high burden by showing that a defendant committed an intentional act with the expectation of profits or non-incidental benefits, the monetary penalty should represent a steep enough consequence to deter hospitals from violating the proposed statute. Supporting the higher penalty is the idea that individual physicians and small physician groups are engaging in third-party-payment abuse much less frequently than large hospitals.¹⁶⁴ Therefore, the proposed statute must have fines that are large enough that aggregated violations would pose a costly burden for hospitals that generate millions of dollars of profit annually.¹⁶⁵ If the higher fine deters violations, the cost on the judicial system will be lessened.

By itself, Section (A) is not sufficient to quell all the problems stemming from third-party payments. Section (A) prohibits third-party payments by those who expect a non-incidental benefit from doing so.

159. *Id.*

160. *See supra* text accompanying note 150.

161. *See* discussion *supra* Section III.A.

162. *See supra* note 102.

163. 42 U.S.C. § 1320a-7b(b) (2012).

164. This is purely speculative. Since the third-party-payment problem is a recent phenomenon, there is no data on what entities most frequently engage in the practice. However, one could argue that since hospitals are the main provider of extremely high-cost medical services (major operations, transplants, chronic illness treatments, etc.), they have more incentives to make third-party payments for their patients than do small physician groups who mostly refer high-risk patients to specialists for treatment.

165. *See supra* notes 138–45 and accompanying text.

However, this provision alone would leave open to interpretation whether hospitals can donate money to hospital-affiliated nonprofits and then have those nonprofits steer their patients toward QHPs.¹⁶⁶ The rub here is that Section (A) requires that the entity commit the prohibited act with the expectation of a non-incidental benefit. It is ambiguous whether the hospital-affiliated nonprofit is receiving a benefit here. To eliminate this ambiguity, Section (B) finds that anyone who “intentionally coordinates with or utilizes a nonprofit organization to steer an individual to transition from public health coverage to a Qualified Health Plan (or other private health insurance coverage) with the expectation of future profits or non-incidental benefits” is guilty under the proposed statute.¹⁶⁷ Section (B) specifically prohibits hospitals from using nonprofits to make third-party payments, and thus closes the gap left open by Section (A). Additionally, by using the term “nonprofit organization,” the statute quashes the possibility that nonprofit hospitals would be allowed to directly make third-party payments for their patients.¹⁶⁸

It is worth noting that the definition of “public health coverage” in Section (C)(2) of the proposed statute is an altered version of the definition of “federal health care program” included in the Anti-Kickback Statute.¹⁶⁹ It has been altered to accommodate the fact that the proposed statute is making a distinction between public health coverage wholly managed by the states and the federal government, and QHPs, which are merely subsidized by the federal government.

Section (D)(1) provides an exception for individuals who pay another individual’s health-care premiums with the expectation of receiving interest from the money lent. This exception is used to further clarify the types of activity that the proposed statute wishes to deter. An entity providing a loan that is used for the purposes of paying health-care premiums is distinct from a hospital paying QHP premiums in order to receive higher payouts from administering medical services. Additionally, Section (D)(2) drives home the point that this statute does not intend to prevent vulnerable individuals from receiving health-care advice or assistance from independent nonprofits.

The aim of this statute is to encompass the issues that arise from third-party-payment abuse, while not disturbing the charitable activities related

166. As discussed previously, this is one way that hospitals have attempted to lend legitimacy to their third-party-payment schemes. *See supra* note 9 and accompanying text.

167. *See supra* Section IV.A.

168. As discussed previously, nonprofit status alone is a poor way to decide whether an organization should be allowed to make third-party payments. *See supra* notes 138–45 and accompanying text.

169. 42 U.S.C. §§ 1320a-7b(f)(1)–(2) (2012).

to health care.¹⁷⁰ There remains a possibility that another section could be added after Section (B) which addresses the issue of one health insurance provider paying its high risk (and thus, high cost) patients' premiums if they switch to a competitor's insurance plan.¹⁷¹ The proposed statute does not directly mention this issue. However, Section (A) seems broad enough to cover instances where an issuer wishes to shirk the health-care costs of its most costly patients by paying their premiums under another issuer.¹⁷² Section (A)'s inclusion of non-incidentals benefits is broad enough to capture the benefit an issuer would receive in a third-party-payment scheme involving issuer shirking.¹⁷³

A final lingering concern that the proposed statute does not address is that patients receiving third-party payments from independent charities still run the risk of disruption of their health coverage. Although the risks patients face from third-party payments made by providers and provider-affiliated nonprofits are much greater, they are not exclusive to those types of organizations. Charities sometimes go bankrupt, and such an occurrence could mean that patients relying on third-party payments from such a charitable organization could be put in a precarious situation.¹⁷⁴ Even worse, sometimes charities are fraudulent money-making schemes from the start.¹⁷⁵ In addition to the proposed statute, one solution could be to enact a broad regulation requiring any organization that makes third-party payments on behalf of a patient to disclose certain information, as HHS recently attempted to do.¹⁷⁶ Such a regulation could provide information that at least makes patients aware of the risks that

170. These are the two main aims of the statute. Added benefits of the statute are that it would eliminate excessive payment of QHP subsidies to issuers, as well as excessive payment of PTCs and APTCs to individuals. This equates to a lesser burden on federal funds.

171. Litigation on this issue is currently underway in California. Complaint at 1–2, Cal. Physicians' Serv. v. Santa Barbara San Luis Obispo Reg'l Health Auth., No. CGC-16-552950 (Cal. Super. Ct. July 11, 2016).

172. This issue is new enough that there is not enough data to know how often this practice occurs. However, it seems likely that providers would be more hesitant to engage in the practice because it presumably has higher litigation risks. In other words, large issuers are more likely to have the resources and desire to sue one another than patients are to sue large issuers.

173. In other words, a decrease in the costs associated with paying for medical treatments for high-risk patients through steering those patients to a competitor through third-party payments should be covered by the definition of non-incidentals benefits in Section (C)(1).

174. See *Medical Charity WonderWork Files for Bankruptcy Protection*, 4-TRADERS (Dec. 30, 2016, 10:06 AM), <http://www.4-traders.com/news/Medical-Charity-WonderWork-Files-for-Bankruptcy-Protection--23629084/> (discussing a charity going bankrupt that provided free surgeries to children and adults).

175. See Mark Iandolo, *Cancer Fund of America, Cancer Support Services to be Dissolved*, LEGAL NEWSLINE (Apr. 1, 2016, 12:09 PM), <http://legalnewsline.com/stories/510705034-cancer-fund-of-america-cancer-support-services-to-be-dissolved>.

176. See *supra* notes 48–54 and accompanying text.

authorizing any third-party payment runs.¹⁷⁷ However, such a regulation may not be achievable under the current administration.¹⁷⁸

CONCLUSION

Current regulation provides minimal guidance on third-party payments of QHP premiums. Regulations and guidance provided on the issue have been piecemeal and somewhat inconsistent. High-risk patients currently have minimal protection from the risks associated with the third-party-payment problem. Cost-shifting continues to harm the Marketplace. As it stands, the law does nothing to de-incentivize this predatory practice.

A narrow federal criminal statute barring the use of third-party payments by providers and provider-affiliated nonprofits would have a positive impact on not only high-risk patients, but the Marketplace as a whole. Such a statute would negate the improperly aligned incentives that underlie the third-party-payment problem. While the proposed statute cannot force providers to realize that their patients are human beings that should not be treated as investments, it can deter and offer the recourse necessary to punish those that do so.

177. These disclosures seem like a good idea considering that many Americans are perplexed by the health care system in general, much less a complex, developing portion of it. See Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES (Feb. 7, 2017), <https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html> (“[Thirty-five] percent of respondents [to a poll] said either they thought Obamacare and the Affordable Care Act were different policies (17 percent) or didn’t know if they were the same or different (18 percent).”).

178. See *supra* notes 48–59 and accompanying text.

