Tenet Health	Regulatory Compliance Policy	No. COMP-RCC 4.55
	Title:	Page: 1 of 5
		Effective Date: 02-23-17
	PAYMENT OF PATIENT INSURANCE PREMIUMS	Retires Policy Dated: 02-09-15
		Previous Versions Dated: 09-27-11; 01-19-11

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to provide directions regarding the limited circumstances under which Tenet Facilities may make insurance premium payments on behalf of patients.

III. DEFINITIONS:

A. "**Affordable Care Act**" means The Patient Protection and Affordable Care Act.

B. "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1986, under which covered employees and their qualified beneficiaries have the opportunity to continue health insurance coverage under company health and dental plans for specified periods of time when a "qualifying event" would normally result in the loss of eligibility. Continued coverage under the company health plan requires the payment of a premium by the individual.

C. "**COBRA Eligible Patients**," for purposes of this policy only, mean patients who have no active health insurance coverage, but who are eligible for COBRA benefits. Eligible Patients do not include individuals who are currently covered under Medicare or any other federal health care program. Eligible Patients do not include physicians[1] or a physician's immediate family member.[2]

D. "**COBRA Qualifying Events**" include the resignation, termination of employment, or death of an employee. Reduction of an employee's hours, divorce or legal separation, or a dependent child who no longer meets eligibility requirements are also potential qualifying events.

E. "**Federal or State Marketplace**" means the health insurance exchanges established under the Affordable Care Act, where individuals not covered by employer-based or governmental health insurance can purchase a qualified health plan.

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[1]Physician means a duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or chiropractor.

[2]Immediate Family Member means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

F. "**Federal or State Marketplace Patient**" for purposes of this policy, means a patient who has health insurance coverage purchased through a Federal or State Marketplace.

G. "**Federal or State Marketplace Patient with past-due exchange premiums**" for purposes of this policy, means a Federal or State Marketplace Patient who is delinquent in paying insurance premiums, but who is still within the applicable "grace period" to retain full coverage.

H. "**Qualifying Private, Not-For-Profit Foundation**" means a private, not-for-profit foundation that provides financial assistance to pay premiums for health insurance coverage purchased through a Federal or State Marketplace. To be a Qualifying Private, Not-For-Profit Foundation under this policy, the Foundation must make determinations to provide support to individuals based on defined criteria pertaining to financial status (not health status), and any premium and/or cost sharing payments made by the Foundation on behalf of the individual should cover the entire policy year. Further, the Foundation shall make determinations to assist individuals without regard to: (i) the interests of any donor or any donor affiliates; (ii) the applicant's choice of product, provider, practitioner, supplier, or insurance company; (iii) the identity of the referring organization, including whether the referring organization is a donor; or (iv) the amount of contributions made by any donor whose services or products are used or may be used by the patient.

IV. POLICY:

A. Tenet Facilities may make COBRA premium payments on behalf of COBRA Eligible Patients, if such payments are made in accordance with the terms of this policy. Such premium payments shall not be considered a payment or gift to a patient under Tenet's Code of Conduct or Regulatory Compliance policy COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals, nor shall the requirements of Law Department policy L-6 Hospital-Provided Post-Discharge Assistance to Federal Health Care Program Beneficiaries apply to the premium payments. Tenet Facilities may not make COBRA premium payments on behalf of patients who are not COBRA Eligible Patients as defined by this policy.

B. Tenet Facilities may not make premium payments on behalf of Federal or State Marketplace Patients, as the United States Department of Health and Human Services has expressed significant concerns with the practice as it may unnecessarily attract patients into the Marketplaces who will require more health care services, disrupting the risk pool. However, Tenet Facilities may refer Federal or State Marketplace Patients to a Qualifying Private, Not-For-Profit Foundation for potential financial assistance.

V. PROCEDURE:

A. Tenet Facility Implementation

1. At patient registration or at patient bedside screening, if the patient indicates a recent change in health insurance status due to what may constitute a "COBRA qualifying event:"

   a. A registrar, patient access representative, medical eligibility representative or case manager will perform the appropriate screens to determine if the patient is currently a federal program beneficiary or beneficiary under other commercial coverage benefits.

   b. If a patient is found to not be a current federal program beneficiary or beneficiary under other commercial coverage benefits, a registrar, responsible patient access representative, medical eligibility representative or case manager will also assist the patient in obtaining employer health benefit information, and with the patient's permission, will contact the patient's employer to obtain COBRA eligibility information, including identification of the COBRA qualifying event, date of qualifying event, benefit coverage information, premium amounts, and payment deadlines. (See Attachment A: Consent to Determine Eligibility for COBRA Benefits.)

   c. The patient access representative, medical eligibility representative, registrar, or Director of Revenue Analysis (DRA) will present this information to the Tenet Facility Chief Financial Officer (CFO) to obtain approval for the premium payment. The premium payment may be made by the Tenet Facility on behalf of the Eligible Patient to the extent the CFO determines making such payment is financially prudent. (See Attachment B: CFO Financial Decision Making Tool). The COBRA premium payment must not be furnished directly to the Eligible Patient.

   d. Payment information must be scanned into VIWeb.

   e. The costs of COBRA premium payments must not be included, directly or indirectly, in any federal health care program cost report or claim or otherwise shifted to any federal health care program. These costs must be allocated to a non-allowable cost center.

2. At patient registration or at patient bedside screening, if the patient indicates that he or she may be a Federal or State Marketplace Patient with past-due exchange premiums, a registrar, patient access representative, medical eligibility representative, or case manager will follow-up with the patient's insurer in order to determine whether the patient is still within a grace period to pay missed premiums and retain insurance coverage, and if so, determine the premium amount due to retain coverage.

   a. The registrar, patient access representative, medical eligibility representative, or case manager will present this information to the patient, and encourage the patient to pay his or her past-due premiums.

   b. The Tenet Facility may also refer the patient to a Qualifying Private, Not-For-Profit Foundation for evaluation of potential assistance with his or her premiums provided that the Foundation makes the determination of financial assistance in its sole discretion without influence or involvement from the Facility.

B. Tenet Facility Donations to Qualifying Private, Not-For-Profit Foundations

1. Tenet Facilities may not make donations to a Qualifying Private, Not-For-Profit Foundation to which the Tenet facility also refers patients for financial assistance with exchange premiums, unless such donations are specifically restricted for uses other than providing individuals with financial assistance with exchange premiums. A Tenet Facility's proposal to make such a donation requires the prior written approval of the Tenet Facility's Region/Market CEO, who may establish additional guidelines or restrictions on the frequency and/or amount of such contributions.

2. A Tenet Facility is prohibited from internally compiling information in order to correlate the amount or frequency of its donations to a Qualifying Private, Not-For-Profit Foundation with the number of patients who use its services, or the volume of those services as a result of such donations.

C. Responsible Person

The Tenet Facility CFO is responsible for ensuring that all individuals adhere to the requirements of this policy. If the CFO is unable to create adherence to this policy, the CFO shall immediately report the non-adherence to this policy to the Compliance Officer.

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- U.S. Department of Labor Guidance, Continuation of Health Coverage - COBRA

- Code of Conduct

- Regulatory Compliance policy COMP-RCC 4.50 Offering Free or Discounted Goods and Services to Individuals

- Law Department policy L-6 Hospital-Provided Post-Discharge Assistance to Federal Health Care Program Beneficiaries

- CMS Center for Consumer Information and Insurance Oversight FAQ, 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.

- CMS Center for Consumer Information and Insurance Oversight FAQ, 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.

- Letter from Kathleen Sebelius, Secretary of United States Department of Health and Human Services to Richard Umbdenstock, President of the American Hospital Association (May 21, 2014).

- OIG Advisory Opinions No. 13-19; No. 07-11; No. 97-1.

VII. ATTACHMENTS:

- Attachment A: Consent to Determine Eligibility for COBRA Benefits

- Attachment B: CFO Financial Decision Making Tool