

Washington Health Benefit Exchange Comments: Proposed Federal Rule – Patient Protection and Affordable Care Act; Exchange Program Integrity

The Washington State Health Benefit Exchange (WAHBE or the Exchange) appreciates the opportunity to submit comments regarding the proposed Exchange Program Integrity Rule, published by the United States Department of Health and Human Services (HHS) on November 9, 2018.

The Exchange supports HHS's intent to strengthen the integrity of exchanges and ensure the appropriate expenditure of federal funds. However, we believe that some of the proposed changes do not strike the right balance between the reasonable extension of federal regulatory authority and the state's role in regulating the insurance market and protecting consumer interests. The Exchange has significant concerns about the proposed changes to the requirements for separate billing and payment for non-Hyde abortion services, which will result in harm to all Exchange consumers enrolled in qualified health plans (QHPs). Moreover, Washington State fully regulates the segregation of funds received from consumers to fund abortion services and ensures the proper utilization of federal funds as required under the ACA, so these changes are unnecessary in Washington. We strongly urge HHS to remove these requirements from the proposed rule, in order to preserve state authority to regulate the insurance market and to protect consumers' continuous enrollment in health insurance coverage.

Separate Billing and Payment Requirements Will Harm Consumers

The proposed Program Integrity rule's separate billing and payment requirements will cause significant harm to residents of Washington State. As described in more detail in the joint comment letter submitted in response to these proposed regulations by the Governor of Washington State, the Washington State Insurance Commissioner, and the CEO of the Exchange, Washington State recently enacted SSB 6219, the Reproductive Parity Act, requiring that health plans issued on or after January 1, 2019 that cover maternity care or services must also provide coverage for abortion. The impact of the proposed rule in Washington State is that all Exchange consumers enrolled in individual market plans, and all carriers offering QHPs, will be subject to the burdensome billing and payment requirements of the proposed rule.

Changes that result in increased costs to insurance carriers harm consumers by increasing premiums. The proposed rules are likely to cause consumer confusion and result in an increased number of Washington consumers losing their health coverage. These negative impacts are likely to have a disproportionate impact on the state's most vulnerable residents.

The Proposed Rules Will Cause Significant Consumer Confusion

The proposed separate billing and payment rules will result in significant consumer confusion. Never before have consumers been billed separately for specific benefits, and this unprecedented approach is likely to result in consumer misunderstanding. Consumers are likely to mistake the separate bill for a notice regarding a claim for abortion services or a bill for an optional benefit under a policy rider in their plan. Every enrollee will receive a separate bill for abortion benefits, regardless of the potential for particular enrollees to actually use such benefits (e.g., men and children), which will cause greater confusion.

Consumer confusion arising from receipt of two separate bills will likely result in an increase in consumers entering grace periods for failure to pay QHP premiums in full. Consumers will receive additional correspondences related to being in a grace period and additional bills resulting in them owing different cumulative amounts each month. This will exacerbate the confusion that will already accompany receipt of multiple monthly bills and increase the number of enrollees that lose their health coverage.

The confusion and disruption resulting from these proposed changes is likely to have a disproportionate impact on the most vulnerable populations served by the Exchange, including those with limited English proficiency and our American Indian/Alaskan Native populations. These populations already experience significant barriers to enrolling in coverage and accessing care and are at high risk of losing tax credits and the ability to maintain coverage in an affordable health plan. The additional barriers to these groups presented by the proposed changes present significant concerns.

The proposed changes will increase the time, effort, and expense required for consumers to pay their health insurance premium each month. An enrollment experience that has become reliable for consumers in Washington State will become burdensome, inconsistent, unreliable, and untrusted.

The Proposed Rules Will Result in Consumers Losing Health Coverage

A significant number of consumers served by the Exchange could lose their health coverage as a result of this proposed rule. In 2018, 13% of QHP enrollees were disenrolled for nonpayment over the course of the year. Based on the Exchange's experience with consumer behavior, additional billing results in a significantly increased likelihood of disenrollment. The additional consumer confusion and burden associated with these proposed billing changes will result in an increase in the number of individuals failing to pay both bills for their QHP, and inadvertently losing their health coverage entirely.

Nearly 40% of Washington Exchange consumers are unsubsidized, and would lose coverage within 30 days after failing to make a monthly payment in full, leaving little time for resolution of confusion caused by multiple bills. Therefore, unsubsidized consumers are at the greatest risk of disenrollment. We also anticipate that disenrollment rates will be significantly higher in the 80% of Exchange QHP consumers – or roughly 150,000 enrollees – who are not currently enrolled in auto-pay programs with their carriers.

Consumer premiums will increase as a result of these proposed changes, as the cost burden the proposed rule will place on carriers will be reflected in higher rates.

Periodic Data Matching

WAHBE is supportive of HHS's proposal to deem state-based exchanges with fully integrated eligibility systems in compliance with the requirement to perform Medicaid/CHIP Periodic Data Matching (PDM). WAHBE already operates a shared, integrated eligibility system with Washington's Medicaid and CHIP programs. The design of WAHBE's rules engine for eligibility determinations prevents dual enrollment in APTC/CSRs and Medicaid/CHIP programs, and therefore far exceeds the proposed requirements to conduct Medicaid/CHIP PDM at least twice a year.

WAHBE agrees that Exchanges should play a role in helping consumers determine their eligibility for and enrollment in coverage that maximizes affordability, prevents duplication of benefits, and reduces risk for tax liability for advance premium tax credits (APTC) received during months of dual enrollment. WAHBE is supportive of adopting Medicare PDM processes with regular frequency and finds the proposal to

conduct PDM checks twice a year to be reasonable. However, the significant consumer and operational impacts of implementing these processes for *all* enrollees (i.e. regardless of age or whether receiving APTC/CSRs) are not justified by the problem HHS is aiming to solve with the use of PDM for Medicare. WAHBE's experience with enrollees dually enrolled in Medicare and QHP corresponds with the FFM's experience in that many of the consumers are inadvertently enrolled in Medicare and QHP coverage at the same time by aging into Medicare and failing to terminate QHP coverage during their Medicare initial enrollment period. The requirement as proposed would result in the Exchange redetermining eligibility for of approximately 200,000 enrollees twice a year, which will result in a significant burden on consumers and increase in the caseloads for Exchange enrollment, eligibility, and appeals staff. Any time redetermination occurs there is the possibility for business and technical errors, updated eligibility (including conditional eligibility and program churn), correspondence generation, enrollment changes, and appeals. WAHBE's population aging into Medicare is ~2,000 enrollees annually. Redetermining *all* enrollees is inefficient and will create an unnecessary administrative burden that could be avoided by targeting PDM for Medicare to the identifiable population aging into Medicare.

In addition, implementing PDM for any number of enrollees will require significant time and resources to implement. Necessary changes include updates to WAHBE's single streamlined application, batch processes that call the Federal Hub Services and terminate federal subsidies, correspondences, and enrollment and operational business processes. The Exchange requests that HHS give state-based exchanges the flexibility to make the necessary technology changes as soon as they are able to do so securely and successfully.

Given the significant consumer, operational and information technology impacts of PDM as proposed, WAHBE urges HHS to extend the implementation timeline for performing Medicare PDM twice a year and permit states flexibility in determining the enrollees to be included in the PDM.

General Program Integrity and Oversight Requirements

WAHBE has concerns regarding the proposals to modify the program integrity and oversight requirements (§155.1200). First, the proposed changes to §155.1200(b)(2) are more vague and broader than the current "eligibility and enrollment reports" requirement in §155.1200(b)(2). WAHBE has developed reporting processes and systems to meet the current reporting requirements. The vagueness of the proposed "annual reports" to be submitted "by applicable deadlines specified by HHS" does not provide WAHBE with adequate notice to support compliance. Second, targeted reporting (§155.1200(b)(2)) and audits (§155.1200(d)(2)) will place greater administrative burden on state-based exchanges since exchanges will need to develop customized reports, in addition to eligibility/enrollment reports currently submitted, and purchase additional audits to comply with HHS's requirements. Planning and specificity help reduce overall administrative costs. Under the proposed regulations, WAHBE would be unable to plan or resource effectively and administrative overhead would increase. WAHBE urges HHS to retain the language of §155.1200(b)(2) and §155.1200(d)(2) as is and continue to leverage the SMART report in order to limit administrative burden on exchanges and provide adequate notice as to the program areas exchanges would be required to report and be audited on.

The Exchange supports the change proposed by HHS with respect to ensuring accuracy of eligibility and enrollment transactions (§155.1200(d)(4)). WAHBE's external audits currently implement testing procedures that utilize statistically valid sampling methods and assess whether WAHBE is conducting accurate eligibility determinations and enrollment transactions under 45 CFR 155 subparts D and E.

WAHBE opposes changing the April 1 deadline to a deadline to be set by HHS without the proposed deadline being identified and an opportunity for state-based exchanges to provide feedback (§155.1200(b)(1) and introductory text to §155.1200(b)). As a state-based exchange, WAHBE must comply with both Washington State reporting requirements and federal reporting requirements. WAHBE encourages HHS to provide flexibility to align reporting deadlines with state fiscal years. Multiple audits and fiscal reports annually will have a resource impact and increase administrative burden. WAHBE will need to hire additional staff and increase its budget as a result. WAHBE urges HHS to work with state-based exchanges to set deadlines that align with state fiscal deadlines.