CONNECT for HEALTH COLORADO®

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Submitted via the Federal eRulemaking Portal at http://www.regulations.gov

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9922-P
P.O. Box 8016
Baltimore, MD 21244-8010

Re: *Patient Protection and Affordable Care Act; Exchange Program Integrity* Proposed Rule (CMS-9922-P)

Dear Administrator Verma:

The staff of Connect for Health Colorado, the state-based health insurance marketplace (SBM) for Colorado, greatly appreciates the opportunity provided by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to comment on the *Exchange Program Integrity* proposed rule published in the *Federal Register* on November 9, 2018.

Since the creation of Connect for Health Colorado, we have worked closely with CMS and our federal partners to ensure compliance with a wide range of federal standards. As an SBM, we are supportive of ensuring consumers are receiving the appropriate coverage, including receiving correct amounts of Advanced Premium Tax Credits (APTC) or Cost-Sharing Reductions (CSR), reducing potential tax reconciliation risks for consumers, and ensuring financial integrity of federal funds.

However, we write with specific concerns, comments, and requests for clarification on the proposed rule as detailed below.

1. General Program Integrity and Oversight (§155.1200)

CMS proposes several changes related to programmatic audit and reporting requirements for SBMs. The changes ostensibly clarify the scope of the annual programmatic audits that SBMs are required to conduct. The rule would also eliminate the April 1st deadline to provide financial statements to align the financial reporting deadline with other annual submissions such as the annual State-based Marketplace Annual Reporting Tool (SMART) submission.

We support eliminating the April 1st financial statement deadline to better align with the other annual submissions. However, we are concerned with the timing and potential cost of additional programmatic audits and reporting requirements.

Our annual budgeting cycle occurs within the first half of the year, as our fiscal year runs July 1st to June 30th. We plan and allocate resources for the annual audits well in advance of the audits taking place. Additionally, as an SBM, we have specific processes and procedures that need to be adhered to when selecting vendors and independent external auditing entities to perform annual financial and programmatic audits. We would thus need adequate time to ensure funding and staffing resources are available, as well as time to secure new auditors or renegotiate contracts and requirements with current auditors, as related to any newly expanded or targeted auditing requirements.

We therefore request that SBMs be provided with as much advance notice regarding the specifics of the new audit requirements as possible so that we may prepare and budget accordingly. To appropriately plan for expanded audit requirements, we request that specific changes related to auditing requirements not occur before the plan year 2019 audit cycle (which would normally occur in early 2020).

2. <u>Verification Process Related to Eligibility for Insurance Affordability Programs (§155.320) & Eligibility Redetermination During a Benefit Year (§155.330)</u>

a. <u>Medicaid/CHIP</u>

The proposed rule would require SBMs to conduct Medicare and Medicaid/CHIP periodic data matching (PDM) twice per calendar year starting in 2020 for enrollees in a QHP who are receiving APTC or CSR.

We are generally supportive of this new definition of "periodically" as "twice per calendar year." However, we would welcome additional conversations with CMS to clarify details around technical implementation hurdles arising with Federal Data Services Hub (FDSH) connections and services.

Furthermore, we request clarification on the "deemed compliance" path for SBMs with "fully integrated eligibility systems." The proposed rule does not adequately define "fully integrated eligibility system" or spell out the criteria for such a system. To this point, CMS should allow flexibility for SBMs that it considers not "fully integrated" to offer alternative approaches which might be deemed to be in compliance. We would welcome clarification either in the rule itself

or in guidance on how a "fully integrated eligibility system" would be defined or recognized by CMS.

Lastly, SBMs are uniquely situated to help manage the population likely to churn between financially assisted QHP coverage and Medicaid/CHIP coverage – the population which is likely to have overlapping coverage. We also urge CMS to consider clarifying regulations around coverage effective dates and terminations when individuals are found newly eligible for Medicaid/CHIP.[1]

b. Medicare

SBMs are uniquely positioned to help matriculate individuals who are, or will soon become, Medicare-eligible from QHP coverage into the Medicare system. We are encouraged by the solutions used in the FFM application and PDM process to help individuals who are Medicare-eligible or enrolled ensure they are enrolled in the appropriate coverage and understand the financial implications and risks of having dual-enrollment in both QHP and Medicare.

As trusted sources of information on health coverage options, we would welcome additional opportunities to collaborate with CMS on ways SBMs can assist this population in navigating their transition between coverage types. We would be interested in learning best practices and lessons from CMS on how to best help these consumers.

Additionally, many of our QHP issuers offer Medicare Advantage or Medicare Supplement Insurance (Medigap) products which may help ease transitions between coverage types by maintaining both continuous insurance coverage and continuity of care through provider networks. We again welcome opportunities in which we may more closely coordinate with issuers or partner with our State Health Insurance Assistance Program (SHIP) in assisting these consumers, including sharing of best practices from both CMS and other SBMs.

We also believe this is an opportunity for CMS to clarify and update its FAQs regarding Medicare and the Marketplace, especially as related to the anti-duplication provisions of the Social

[1] For example, 45 C.F.R. § 155.430(d)(2) states that the last day of Exchange enrollment should be the "day before the individual is determined eligible" for Medicaid/CHIP. This has caused confusion where, for example, Medicaid coverage is retroactive or where the enrollee does not timely notify the Exchange to terminate coverage. Additionally, in these cases, the Exchange is not permitted to initiate a termination from QHP coverage, but only ends APTC or CSR. This creates consumer confusion when they then receive the next monthly billing statement for a full month's premium without financial assistance.

Security Act.[2] In order for consumers, brokers, and assisters to more fully understand their coverage options, we recommend issuing this information in more formal guidance.

3. Non-Hyde Abortion Services (§156.280)

CMS proposes new requirements on Exchange issuers covering non-Hyde abortion services to separately bill enrollees for the cost of such coverage, and for consumers to separately pay for such coverage apart from their normal monthly premium for their health insurance.

We are strongly opposed to this proposed change due to the inadvertent adverse impacts associated with its implementation. As detailed more fully below, this proposed change is unworkable and unnecessary; it would cause serious and costly operational challenges for many QHP issuers, impose new costs on consumers, and result in significant consumer confusion leading to loss of coverage. We recommend that CMS not finalize proposed changes to §156.280 regarding separate billing and payment for non-Hyde abortion services.

a. State Authority & Federalism

We commend the CMS for recognizing that "states are the entities primarily responsible for implementing and enforcing the provisions in section 1303 of the PPACA related to individual market QHP coverage of non-Hyde abortion services."[3] In Colorado, the state Division of Insurance (DOI) within the Department of Regulatory Affairs (DORA) regulates the insurance industry, monitoring issuer compliance with the law, including state law regarding grace periods and terminations.[4]

We applaud the CMS's ongoing commitment to state flexibility and appreciate the opportunities for states to continue to exercise their own authority and discretion, addressing this issue as best fits each state's unique context.

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[2] See "Frequently Asked Questions Regarding Medicare and the Marketplace," available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html.

[3] Patient Protection and Affordable Care Act; Exchange Program Integrity, 83 Fed. Reg. 56015, 56023 (Nov. 9, 2018).

[4] The Regulatory Impact Statement does not include the proposed changes to §156.280 among the rule changes with Federalism implications. See 83 Fed. Reg. at 56029.

b. Administrative Burden & Costs to Issuers and Exchanges

One of the Administration's first acts in office was to sign several Executive Orders aimed at reducing regulatory burdens. As stated in Executive Order 13777, "[i]t is the policy of the United States to alleviate unnecessary regulatory burden placed on the American people."[5] Similarly, Executive Order 13771 articulates an objective to help minimize the cost of compliance with Federal regulations.[6] The proposed changes to §156.280 significantly conflict with these principles.

Through stakeholder consultation, CMS has also sought ways to "alleviate burdens facing patients and issuers."[7] The proposed changes to §156.280 do the opposite – they impose unjustifiable new burdens and costs on patients and issuers.

Issuers will need to make substantial system changes to allow for multiple billing statements and payments. There would be significant one-time implementation costs to update IT systems and infrastructure. In addition to the upfront costs, there are considerable associated ongoing costs with the proposed changes.

CMS's estimate of an annual burden to issuers of approximately $800,000 is significantly understated. For instance, the printing and postage costs for each separate invoice mailed by the issuer, and the return postage costs for the consumer, far outweigh the actual cost of non-Hyde abortion services. The estimate also fails to account for the increased cost of processing separate payments (e.g., fees charged for debit or credit card transactions) on issuers. It does not appear that any of these costs are taken into consideration in the Regulatory Impact Statement.[8]

Importantly, whatever the true costs of the proposed changes imposed onto issuers, this will ultimately trickle down into premiums, indirectly costing *all* consumers and the federal government more money in the long run.

There will also be costs to Exchanges as a result of the proposed changes. Exchanges will need to help communicate the new separate billing and payment requirements to consumers. This will require us to update consumer education and outreach materials regarding paying premiums and effectuating coverage, including customer service center training and scripting to address

[5] Exec. Order No. 13777, *Enforcing the Regulatory Reform Agenda*, 82 Fed. Reg. 12285 (March 1, 2017).
[6] Exec. Order No. 13771, *Reducing Regulation and Controlling Regulatory Costs*, 82 Fed. Reg. 42751 (Sept. 12, 2017).
[7] 83 Fed. Reg. at 56018.
[8] 83 Fed. Reg. at 56026-56030.

questions about multiple payments, and annual training materials used to certify brokers and assisters. CMS did not consider these costs in the Regulatory Impact Statement.[9] Issuers will also face similar challenges in communicating and educating their consumers regarding the separate bills and payments.

CMS has also offered almost no evidence to justify this significant shift in policy. The only evidence cited is the 2014 report by the U.S. Government Accountability Office that indicated carrier compliance concerns with respect to Section 1303. However, CMS previously considered the 2014 report in developing both its 2015 regulation and 2017 guidance.[10] The proposed rule fails to articulate why the status quo is failing to meet the objective of Section 1303.

The proposed separate billing and separate payment requirement would not enhance Exchange program integrity with respect to appropriate use of federal funds. QHP issuers already segregate federal payments to ensure no APTC is used to pay for coverage of non-Hyde services. The burden and costs far outweigh any benefit of the newly proposed policy to require separate bills and payments and should not be finalized.

c. Consumer Confusion & Costs

In addition to the burden and cost on issuers and Exchanges, the proposed changes would impose unnecessary costs on consumers and the healthcare system generally.

This policy will create unnecessary consumer confusion, complaints, and potentially plan terminations. CMS estimates a cost of $30 million to enrollees and acknowledges the significant consumer confusion this policy change would create. However, the Regulatory Impact Statement does not include the costs associated with consumer education and training caused by this confusion to either consumers, issuers, or Exchanges.[11]

A recent report from Accenture found that "health insurers and employers spend $26 more on administration for every consumer with low healthcare system literacy" which translates to nearly $5 billion annually in administrative costs to the U.S. healthcare system.[12] If the proposed new separate billing and payment requirement is finalized, this would exacerbate issues of

[9] *Id.*
[10] "CMS Bulletin Addressing Enforcement of Section 1303 of the Patient Protection and Affordable Care Act" (Oct. 6, 2017), available at: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Section-1303-Bulletin-10-6-2017-FINAL-508.pdf.
[11] 83 Fed. Reg. at 56026-56030.
[12] Jean-Pierre Stephan, Loren McCaghy, and Michael Brombach, "The Hidden Cost of Health System Complexity," (Accenture) (Sept. 6, 2018), available at: https://www.accenture.com/us-en/insights/health/hidden-cost-healthcare-system-complexity.

healthcare literacy and create additional unnecessary costs to the healthcare system. The proposed changes instill more inefficiency into the healthcare system, which will cause premiums to rise, and indirectly cost all purchasers of healthcare more money.

Additionally, consumers will be required to make two separate payments requiring two separate checks, envelopes, and stamps. The cost of a stamp alone ($0.55 in 2019) highlights the unreasonable burden of sending a separate $1 payment, when funds are already reasonably segregated under current policy. Again, it does not appear that CMS has accounted for these direct costs in its estimate.[13] The Regulatory Impact Statement estimates dramatically undervalue the true cost of the proposed changes.

d. Loss of Coverage and Risk Pool Implications

Under the proposal, non-payment of any premium due, including non-payment of the portion of the consumer's premium attributable to non-Hyde abortion coverage, would be subject to state and federal rules regarding grace periods and termination. However, this returns us to your recognition that "states are the entities primarily responsible for implementing and enforcing the provisions in section 1303 of the PPACA related to individual market QHP coverage of non-Hyde abortion services."[14] As we stated above, we applaud this recognition and ask that you formally recognize in any final version of this regulation that individual states would retain the authority to determine if the failure to pay separately billed premium attributable for non-Hyde abortion coverage will be allowed to trigger grace periods and termination under state law.

We believe that policies should be developed with the goal of encouraging initial and ongoing enrollment, rather than creating more dysfunction in the individual market. Continuous enrollment best maintains public health and helps maintain the integrity of the individual market risk pool.

While we urge CMS to withdraw the changes to §156.280 completely, should CMS move ahead with finalizing these changes, we request clarification in the final rule that non-payment of the portion of premium attributable to the non-Hyde abortion coverage would not be grounds for either triggering a grace period or terminating coverage. Losing one's health insurance coverage over an amount as small as $1 is simply indefensible.

[13] 83 Fed. Reg. at 56026-56030.

[14] 83 Fed. Reg. at 56023.

e. Timing of Implementation

Again, we ask that CMS not finalize any changes related to §156.280. However, should CMS move forward with these changes, we strongly urge CMS to consider postponing implementation of any changes until January 1, 2021 to coincide with plan year 2021.

CMS proposes that the requirement for separate billing and payments would be effective upon the effective date of the final rule, which can be reasonably expected during 2019. We are deeply concerned about mid-year disruptions to the individual marketplaces and consumers; a mid-year implementation of these changes would cause significant consumer confusion.

Moreover, we do not believe issuers could bring their systems and operations into compliance without a reasonable timeframe for implementation. We also note that a mid-year implementation may not allow for state regulators to appropriately review potentially required changes to issuer policy forms and other plan documents. This would make the proposed mid-year changes unworkable and burdensome on both states and issuers, who are already planning and working on plan year 2020 filings.

Delaying the effective date to coincide with plan year 2021 will allow issuers sufficient time to update systems and appropriately prepare operations, as well as time for state regulators to review and approve necessary changes. It would allow issuers, state regulators, SBMs, and consumer groups to also begin developing consumer education materials aimed at reducing the muddle created by separate bills and payments.

Conclusion

Thank you for considering our comments on issues that will directly impact Colorado consumers and our individual health insurance market. We look forward to working with CMS on continued implementation and refinement of the ACA.

Sincerely,

Connect for Health Colorado Staff