STATE OF WASHINGTON

January 8, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9922-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: **Patient Protection and Affordable Care Act; Exchange Program Integrity [CMS-9922-P]**

Dear Administrator Verma:

We are writing to express our strong opposition to the proposed requirement for separate billing and payment for certain abortion services for which federal funding is prohibited. The proposal threatens to disrupt and increase costs in Washington's individual health insurance market without increasing compliance with federal law. Washington State strongly urges the Centers for Medicare and Medicaid Services (CMS) to remove these duplicative and harmful requirements from the final version of these rules.

The proposed change is contrary to the Trump administration's goals of increasing state flexibility, reducing administrative burdens on issuers and states and honoring the role of states as the primary regulators of their health insurance markets. It will result in significant consumer confusion, increased consumer costs and administrative burdens, more consumers entering grace periods for failure to pay Qualified Health Plan (QHP) premiums in full, and the potential loss of coverage. Based upon information that we have received from issuers offering QHP's in Washington State, it will impose costs far greater than those estimated in the proposed rule.

<u>The Proposed Change is Contrary to Current Federal Policy Intended to Decrease Administrative Burden and Cost and Increase State Flexibility</u>

Over the past two years, policies issued by the federal government related to interpretation and administration of the Affordable Care Act (ACA) have expressed a clear intent to increase state flexibility and reduce administrative burdens on issuers and states. These policies also acknowledge the role of states as the primary regulators of their health insurance markets. These fundamental principles are imbedded in numerous actions taken since January 2017.

For example, on January 20, 2017, President Trump issued Executive Order 13765, which directed executive agencies to exercise all authority and discretion to reduce the fiscal and regulatory burden on states, individuals and health insurers under the ACA.[i] The HHS Notice of Benefit and Payment Parameters for 2019[ii] focused on providing states with additional flexibility and reducing unnecessary regulatory burden on stakeholders, including SHOP administration, risk adjustment transfers and medical loss ratio standards. The final Short-Term Limited Duration Insurance and Association Health Plan rules[iii] both acknowledge and reinforce states' authority to regulate their insurance markets.

Yet, the proposed amendment to 45 C.F.R. 156.280 would have the opposite effect – reducing state flexibility, putting coverage at risk for QHP enrollees and substantially increasing the administrative burden and costs for states and issuers.

A duplicate billing requirement is unnecessary in Washington State. In 2013, in anticipation of implementation of our Health Benefit Exchange and enrollment in QHPs, the Office of the Insurance Commissioner adopted a rule to ensure issuer compliance with the accounting and segregation of funds requirements of section 1303 of the ACA. The rule requires that issuers implement, after receiving written approval from the Commissioner, an accounting practice plan for segregating premiums allocated to abortion coverage for which federal funding is prohibited and ensuring that expenditures for those services come from the appropriate allocation account.[iv] Each issuer must file an annual supplemental information schedule containing a reconciliation of all segregated account activity for the year and an affirmation that their financial accounting systems meet the requirements for segregated accounts under the ACA. Through adoption and enforcement of this state rule, Washington State already ensures that federal funds are not used to pay for abortions for which federal funding is prohibited.

In addition to being unnecessary, the proposed duplicate billing requirement would be especially disruptive in Washington State. During its 2018 session, the Washington State Legislature enacted SSB 6219, the Reproductive Parity Act.[v] Under the Act, if a health plan issued on or after January 1, 2019 covers maternity care or services, it also must

provide coverage for abortion. In enacting the law, the legislature found that restrictions on abortion coverage interfere with a woman's health and well-being and her constitutionally protected right to safe and legal medical abortion care.

Given the provisions of the Reproductive Parity Act, every QHP policy subscriber in Washington State would receive two separate bills and be instructed to pay those bills in two separate transactions. In other words, for Washington State QHP issuers and enrollees/policy subscribers, a federal mandate for this pervasive level of duplication is unreasonable.

The Proposed Change will Cause Consumer Confusion, Increase Burdens on Consumers and Result in Loss of Coverage

The proposed billing and payment requirements will cause significant harm to individual market enrollees in Washington State. The increased costs to issuers described below will harm consumers by causing their premiums to increase. The proposed rules are also likely to cause widespread 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.

Consumer Confusion

Consumers receiving two bills, one for $1 per enrollee and identified as attributable to abortion benefits, 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 extensive misunderstanding. Consumers could easily 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, which will cause even greater confusion.

Consumer uncertainty arising from receipt of two separate bills will result in an increase in consumers entering grace periods for failure to pay QHP premiums in full. Consumers will receive additional correspondence 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.

The confusion and disruption resulting from these proposed changes will 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.

Disenrollment for Nonpayment

We are very concerned that a significant number of Exchange consumers will lose their health coverage as a result of this proposed rule. Based on the Exchange's experience with consumer behavior, additional billing and complications with billing result in increased 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 they will lose coverage as soon as 30 days after failing to make a monthly payment in full, leaving little time for resolution of confusion caused by multiple bills. 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 also will increase as a result of these proposed changes, as the increases to issuer costs described below are reflected in higher rates. Any prospect of an increase in the number of people without health insurance in Washington raises the risk of increases in uncompensated costs. Based upon our experience in Washington State, each one percentage point decline in the uninsured rate is associated with a $167 million drop in uncompensated care.[vi]

<u>The Proposed Change will Result in Increased Cost and Administrative Burden for Issuers and States</u>

Issuer Cost and Operational Impacts

In preparing these comments, we sought input from the issuers offering coverage on our Health Benefit Exchange through the Association of Washington Healthcare Plans. They

expressed their strong concern that the proposed rule will be unreasonably expensive, both in implementation costs and ongoing administration. Their estimates below are much higher than those described in the Collection of Information Requirements in the preamble to the proposed rule.

With respect to implementation costs, issuers found that implementation would require material changes to billing and recordkeeping platforms. Implementing the requirements in the proposed rule would impact numerous internal teams and functions, including Membership IT systems, EDI Enrollment IT, Collateral IT, Mail Services, Customer Service, Membership Services, Compliance, Strategic Communications, Finance, Project Accounting, Customer Service, Marketing/Brand, Public Affairs, executive leadership and the issuers' legislative/regulatory policy teams.

Due to the level of complexity involved, the issuers estimate that the time needed to implement the proposed change in billing would range from six to eight months. While costs might vary due to the differences in issuer operations, the range for deploying a solution is between $100,000 and $500,000 per issuer.

With respect to ongoing administration, the issuers noted that ongoing administration of the proposed rule would require hiring new staff. Ongoing costs would primarily relate to mailing and postage. Monthly estimates range from $26,000 to $36,000, which would drive annual costs of between $312,000 and $465,000.

Exchange Operational Impacts

The proposed changes will impose additional resource burdens on Exchange operations in several areas. Consumer confusion caused by the proposed billing changes will result in increased calls to the Exchange's customer service center by at least 30% of households enrolled in a QHP, resulting in an additional cost to the Exchange of approximately $250,000 annually. Staff resources will be needed to resolve consumer complaints and appeals that will arise from the rule's proposed billing and payment changes, increasing Exchange costs by approximately $19,000 annually. The Exchange will need to provide outreach to consumers informing them that they will need to pay two bills each month to effectuate and maintain their health coverage at an additional cost to the Exchange of approximately $152,000 per year.

Because these proposed changes will lead to decreased QHP enrollment, the proposed rules will cause a corresponding loss of revenue to the Exchange.

Impacts on Insurance Brokers, Navigators and Enrollment Assisters

Washington State navigators and in-person enrollment assisters are closely engaged with the populations who would be disproportionately impacted by these proposed changes, including the most financially vulnerable and those with limited English proficiency. Navigators and in-person assisters will need to invest time and training resources necessary to ensure that they can provide support to these populations as they struggle to understand the additional steps needed to maintain coverage as a result of the proposed changes.

Insurance brokers, many of whom operate as small businesses, will be required to dedicate more time to customer service and support to help consumers understand these billing changes on an ongoing basis. Any level of QHP disenrollment resulting from the proposed changes will result in decreased broker revenue and potential loss of broker participation in the market. The Exchange has received feedback from brokers that these proposed changes create additional barriers to enrollment and would result in a significant number of individual market consumers not enrolling in a QHP or losing their coverage inadvertently.

Office of the Insurance Commissioner

CMS proposes that the requirement for separate billing and payments would be effective upon the effective date of the final rule, and thus likely would occur mid-year. Health plan enrollee applications include information related to billing and payment. Carriers would need to re-file their applications for all affected plans and the Office of the Insurance Commissioner would need to review those applications in a timely manner to ensure compliance. Individual and small group plan filings require prior approval, and thus would have an immediate impact. Carriers would need to revise and resubmit their accounting practice plans with accompanying review and approval by OIC. Similar to the impact on the Health Benefit Exchange, consumer confusion caused by the proposed billing changes will result in increased calls to OIC's consumer hotline.

Conclusion

The proposed billing and payment requirements will cause serious disruption to our state's individual health insurance market, and are unnecessary to ensure compliance with federal law. They will create widespread consumer confusion, put coverage at risk, and increase administrative cost and burden for consumers, issuers and Washington State. The guidance regarding separate payments provided in the HHS Notice of Benefit and

Payment Parameters for 2016 strikes the appropriate balance to ensure compliance with the intent of section 1303. It provides flexibility to states and QHP issuers to satisfy the separate payment requirement by allowing issuers to send enrollees a single monthly invoice or bill that separately itemizes the premium amount for abortion services that cannot be paid for with federal funds. Through enforcement of the requirements of WAC 284-07-540, Congressional intent to ensure that federal funds are not used to pay for abortions for which federal funding is prohibited will continue to be met.

We strongly urge CMS to withdraw these unnecessary and harmful requirements from the final rules in order to protect consumers, support their continued coverage, and uphold the Trump Administration's commitment to reduce administrative costs and burden on consumers, issuers and states.

Very Truly Yours,

Jay Inslee
Governor of Washington State

Mike Kreidler
Washington State Insurance Commissioner

Pam MacEwan
Chief Executive Officer
Washington Health Benefit Exchange

[i] 82 Fed. Reg. 8351 (January 20, 2107)
[ii] 83 Fed. Reg. 16930 (April 17, 2018)
[iii] 83 Fed. Reg. 38212 (August 3, 2018), 83 Fed. Reg. 28912 (June 21, 2018)
[iv] WAC 284-07-540
[v] Washington State Legislature SSB 6219, codified at RCW 48.43.072
[vi] Washington has significantly reduced uncompensated care since 2014. This reduction appears to be closely associated with the decline in the uninsured rate. As the uninsured rate declined from 14 percent in 2013 to 5.4 percent in 2016, the uncompensated care in Washington dropped from $2,368 million to $932 million.